# HIGH COST MEMBERS IN MEDICARE ADVANTAGE PLANS: STRATEGIES FOR SUCCESS

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## Introduction

The management of high cost or complex condition members is a vital component of a successful Care Management program. These members make up a disproportionate level of costs, and losses, to Medicare Advantage Organizations (MAOs). On average, the costs associated with high-cost members are more than three times greater than the risk-adjusted revenue received from the Centers for Medicare and Medicaid Services (CMS). Investment into the management of these patients will have an out-sized impact on member experience and total plan financial performance.

In this paper we will review:

1. Medical expense history and demographic profile of high-cost members
2. Processes for predicting high-cost members in advance
3. Opportunities to manage cost and other impactful levers

### High Cost Member Experience

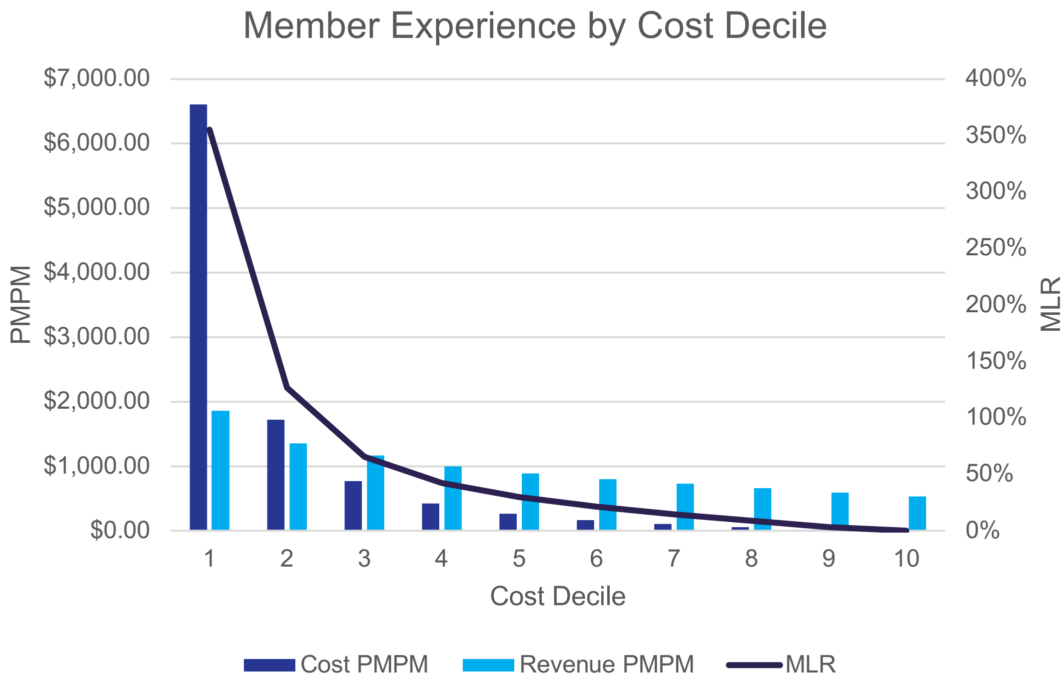
*The risk score assigned to high-cost members is materially less than the true risk these members pose to MAOs.*

In this report, high-cost members are defined as Non-End Stage Renal Dialysis (Non-ESRD) beneficiaries in the top decile of spend. Based on data from the 2022 Nationwide Medicare Fee For Service (FFS) 5% sample, these beneficiaries had nearly $30K in annual medical paid costs. Members in this cohort are typically impacted by multiple chronic conditions and have complex health needs. As expected, a higher percentage of high-cost members are dually eligible for both Medicare and Medicaid and older in age relative to average. The table below shows more detail on the demographic and claim experience differences between high cost and lower cost members.

| High-Cost Members by the Numbers[1] | High-Cost | Low Cost |
|---|---|---|
| Cost Percentile | 90% | 0% - 50% |
| | | |
| Medical Cost PMPM | $6,610.81 | $69.36 |
| Derived Revenue PMPM | $1,861.06 | $661.95 |
| Derived MLR | 355% | 11% |
| | | |
| Average Age | 73.7 | 70.2 |
| Dual Eligible % | 25% | 16% |
| HCCs per Member | 3.2 | 0.8 |
| Primary Care Visits per Member | 12.6 | 3.5 |
| Inpatient Admits per Member | 1.7 | 0.0 |
| Inpatient Re-Admits per Member | 0.5 | 0.0 |
| | | |
| % of Total Plan Costs | 59% | 5% |
| % Inpatient Admits | 66% | 0.4% |
| % Emergency Room Visits | 30% | 15% |
| | | |
| Diabetes Prevalence | 37% | 19% |
| Vascular Prevalence | 32% | 9% |
| Heart Arrhythmias Prevalence | 28% | 8% |

The risk score assigned to high-cost members is significantly lower than the actual risk they pose to MAOs. While the top decile of cost is more than six times higher than the average, risk scores for these members are only twice as high. The FFS 5% sample shows that 93% of beneficiaries in the top cost decile have a derived MLR of over 100%. This suggests that the current MA reimbursement methodology undercompensates MAOs for these high-cost members. In contrast, only 16% of other members have a derived MLR over 100%, indicating that lower-cost members are generally overcompensated by the MA reimbursement methodology.

[1] Data summarized from the 2022 Medicare FFS 5% Sample.




To understand how high-cost member experience and prevalence varies for members enrolled in managed care plans, we leveraged the Wakely's Medicare Advantage De-identified dataset. This database includes enrollment and claims data for over 1 million MA members.

Using this dataset of MA beneficiaries, we found that the percentage of members above the $30K threshold was noticeably lower, at only 7.7%. The actual top decile threshold for the included MA plans in the Wakely dataset is approximately $22K. For members above this threshold, their average cost is 20% lower than for beneficiaries in the FFS top decile. Based on these findings, there appears to be evidence that there is a level of management that MA plans can implement to prevent as many members from reaching the $30K threshold as in FFS. This savings is worth an estimated $132 PMPM[2].

For members above the $30K threshold, the average cost and revenue of included MA members is very similar to FFS beneficiary experience (the included MA members have an MLR of 354% vs. the 355% of the FFS beneficiaries). This highlights the importance of advanced planning and management for potential high-cost members, as once they reach a certain threshold, further actions to bend the cost curve appear be more challenging.

[2] The savings is calculated as = 20% (Lower Cost of Top Decile Members) * $6,610.81 (FFS Top Decile Cost) * 10% (Percent of Members in the Top Decile).

## Predicting Which Members Will Be High-Cost

Predicting which members will incur high costs is crucial for effective management for MA plans. Accurate identification allows for targeted interventions that can improve health outcomes and reduce expenditures.

Predictive analytics can employ statistical techniques and machine learning algorithms to analyze historical claims, demographics, and chronic condition data to make predictions on the likelihood of high-cost events. Based on models developed at Wakely, we believe member prediction can be improved by ~30% relative to using previous year cost or number of chronic conditions alone.

This information can enable organizations to better utilize their care management resources in developing proactive strategies and allocating care to the members who need it the most.

Identifying high-cost members involves examining various indicators that signal increased risk. Key predictors include:

- **Demographics**
    - **Age:** The average age of top decile beneficiaries is 2.5 years older than the average across all beneficiaries. For beneficiaries older than 85, ~20% of beneficiaries are in the top decile.
    - **Dual Status:** Dual eligible beneficiaries have a ~5% higher likelihood to be in the top decile of cost relative to non-dual eligible beneficiaries.
    - **Chronic Conditions:** Beneficiaries with multiple chronic illnesses such as diabetes, heart disease, and COPD are at a significantly higher risk for elevated costs. With three or more chronic conditions, ~25% of beneficiaries are in the top decile. 15% of beneficiaries with one or more chronic condition are in the top decile.
    - **Gender:** We did not find any correlation for either Males or Females to have a higher percentage of beneficiaries in the top decile of spend relative to average.
- **Medical Claims Experience:**
    - **Professional Services:** We found that professional and other Part B services contributed more to future year predictions than Inpatient DRGs. Key procedures include: 99232 (Subsequent Hospital Care), 99223 (Initial Hospital Inpatient or Observation Care Visit), A0425 (Ambulance), 99285 (Emergency Room), 99214 (Office Visit).
    - **Part B Rx:** Many utilizers of high-cost Part B drugs were high cost in both the measurement year and performance year.
    - **Recent services:** Reviewing prior costs quarterly (or even monthly) helps to add significant accuracy to future year predictions, rather than using full prior year costs as a predictor.

- **Member Engagement:**
  - **Medication Adherence:** Poor adherence to prescribed drugs can result in disease progression and increased healthcare costs. Monitoring refill rates and medication compliance can serve as an indicator of future healthcare utilization.
  - **Engagement in Preventive Care:** Beneficiaries who do not engage in preventive services, such as annual wellness visits or screenings, are more at risk to experience avoidable complications and hospitalizations. That said, only 8% of beneficiaries in the top decile of spend did not have any Primary Care visits in the prior year. Thus, plans will likely have some insight into the member profile of beneficiaries who are at risk to be high cost.

While predictive analytics offers significant advantages, several limitations and challenges must also be considered:

- **Data Availability:** Particularly for value-based care (VBC) organizations, there are obstacles in accessing comprehensive, standardized, and timely costs and demographic data. This information is critical to be able to identify beneficiaries in advance of high-cost events.
- **Dynamic Nature of Health Needs:** A member's health status can change rapidly due to various factors and random events that cannot all be captured by predictive models.
- **Number of Variables:** The model set up must incorporate many variables that can contribute to future member experience. The creates challenges for data size and processing speed.
- **Bias in Predictive Models:** Predictive models can inadvertently perpetuate existing biases if they rely on incomplete or unrepresentative data. For instance, socioeconomic factors may not be fully accounted for, leading to disparities in care for certain populations.
- **Application of Results:** Clinical experts must be equipped with the supporting information to be able to use the predictive output to implement care strategies. The output must also be produced in a timely manner for when the intervention can be of most value.

## Methods for Achieving Savings

Once target potential high-cost members are identified, the next step is to apply effective care management techniques to manage these patients' health and cost. Per CMS and other sources[3], effective care management services can include some of the following:

- Person-centered, comprehensive care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and inventory of resources and supports
- Continuous patient relationship with chosen care team member
- 24/7 patient access to care and health information

[3] May 2024 CMS Report "Chronic Care Management Services". https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

- Patient receiving preventive care
- Patient and caregiver engagement
- Managing unnecessary tests and procedures while ensuring appropriate care
- Use of telehealth and digital health solutions to enhance member engagement
- Focus on educating members and promoting self-management of chronic conditions
- Collaborating with local resources to address social determinants of health

However, while these services can be effective for some patients, research has been inconclusive on the effectiveness of these standard techniques on complex patients.[4] This has led to a growing recognition that, when care cannot be avoided, there are still several important value considerations that can be addressed to improve outcomes and deliver value to patients and MAOs:

- **Site of Care and Care Transitions** – The location where care is provided can significantly influence both the quality and cost of treatment. Ensuring that patients are receiving care in the most appropriate setting—whether at home, an outpatient clinic, or an acute care facility—can reduce unnecessary hospitalizations and enhance outcomes. Additionally, managing transitions between care settings, such as from hospital to home, can prevent gaps that could lead to readmissions or complications.
- **Network (In-Network Providers, Fee Schedules, Most Efficient Providers)** – The efficiency and quality of care can vary widely between providers. If services need to be rendered, it is crucial to guide patients to high-performing in-network providers who offer the best value for the services performed.
- **Appropriate Intervention** – A critical aspect of care management is ensuring that the interventions provided are appropriate for the patient's condition and stage of illness, rather than using one-size-fits-all approaches. While intensive and personalized care approach management is more appropriate for high-risk individuals, it is likely an excessive cost for lower risk individuals who would benefit from standard preventative measures.
- **Timing and Duration of Outcomes and Reporting of Results** – Understanding the expected duration of treatment is vital in managing resource utilization and aligning care goals with expected outcomes. Results of a program may not be evident in the short term for a program designed to influence behavior in the long term.
- **ESRD and Hospice Identification Integrity** – Early and accurate identification of patients who may be eligible for End-Stage Renal Disease (ESRD) treatments or hospice care is crucial for ensuring appropriate care that aligns with the patient's goals. Timely intervention can both improve the quality of life for these patients and reduce the costs associated with unnecessary acute care. For ESRD

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[4] Baker JM, Grant RW, Gopalan A. A systematic review of care management interventions targeting multimorbidity and high care utilization. BMC Health Serv Res. 2018 Jan 30;18(1):65. doi: 10.1186/s12913-018-2881-8. PMID: 29382327; PMCID: PMC5791200. https://pmc.ncbi.nlm.nih.gov/articles/PMC5791200/

patients, appropriate reporting will ensure that CMS revenue is aligned with the more expensive cost needs.

- **Revenue Development** – Accurate reporting and member engagement can lead to better tracking of disease progression and ensure that risk-adjustable diagnosis codes reflect the full scope of a patient's health status. Effective care management can also support member satisfaction which can benefit a MA plan's Star Rating.

## Conclusion

Given the proportion of losses that high-cost members drive to MAOs, investment in the management of these patients can have the most impactful impact on member experience and total plan financial performance. Based on review of the medical claim history of MA plans relative to FFS beneficiaries, we believe that outcomes can be improved for these patients. The key to improvement is early detection and focusing on all of the value considerations for these patients.

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## OUR STORY

**Five decades.** Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

**Wakely is now a subsidiary of Health Management Associates.** HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

**Broad healthcare knowledge.** Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

**Your advocate.** Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

**Our Vision:** To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

**Our Mission:** We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com