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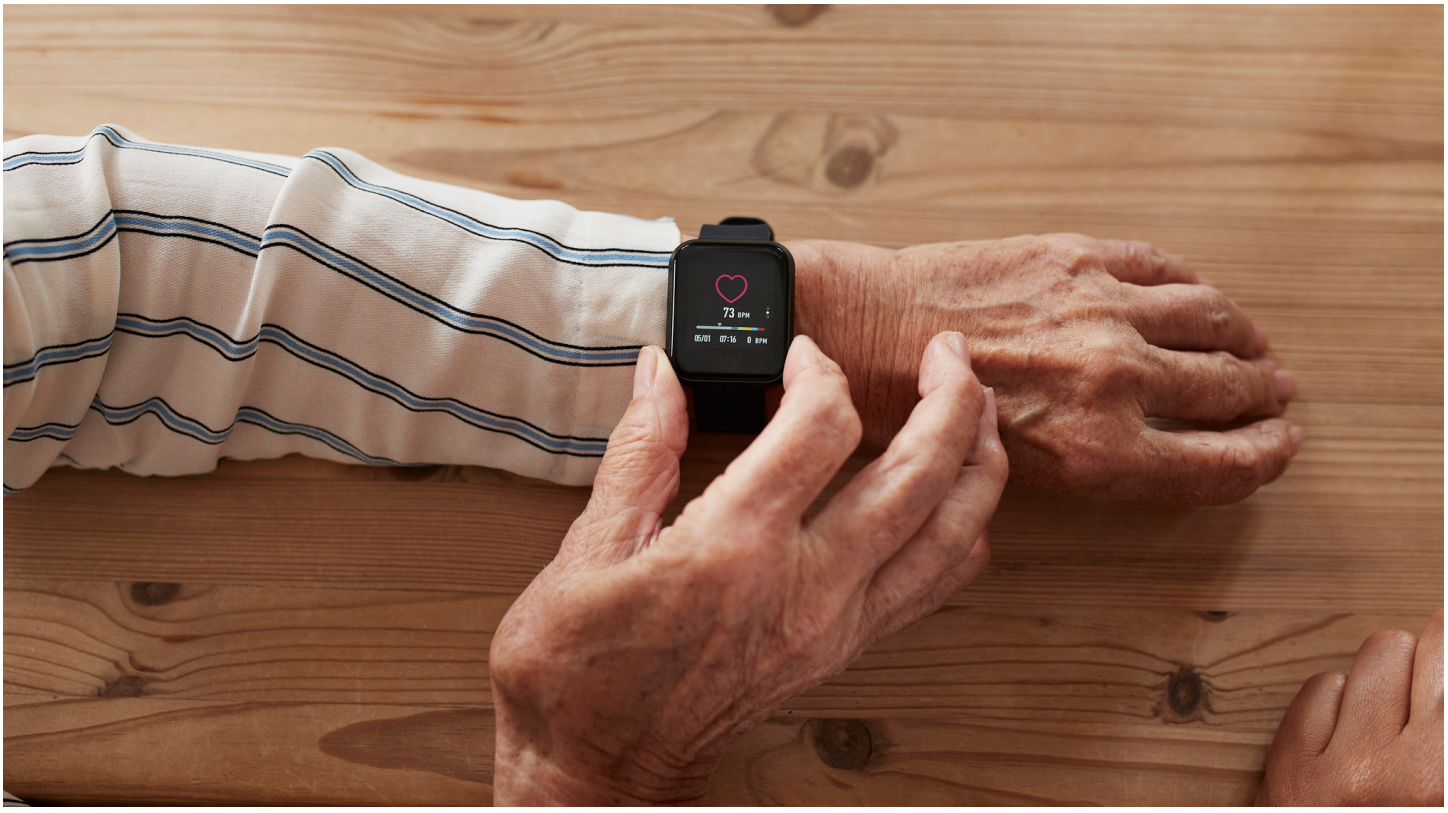
Elevating Care: The Role of Remote Patient Monitoring in Enhancing Member Experience and Closing Care Gaps

Introduction

In today's rapidly evolving healthcare landscape, the need to cost effectively improve care coordination and enhance member experience is crucial, especially for Healthplan populations. This whitepaper delves into the practical significance of integrating Remote Patient Monitoring (RPM) programs, specifically Personal Emergency Response System (PERS) devices to not only address care gaps but also to elevate member experience, ensuring a more engaged and empowered patient community. This approach aligns with the goal of surpassing Healthcare Effectiveness Data and Information Set (HEDIS) measures.

As we navigate the complexities of healthcare delivery, traditional methods often fall short in providing a continuous, engaging, and personalized experience for members. RPM, however, serves as a pragmatic solution, fostering a collaborative ecosystem where patients, healthcare providers, and insurers work together to optimize health outcomes and keep members safe.

This study spotlights how enhanced engagement and care coordination leveraging RPM programs can cost effectively close gaps in care, improve HEDIS scores, collect and address barriers to care and prioritize member experience. By exploring the intersection of technology, data insights, and patient-centric care, we uncover how RPM not only drives care gap closure, but also enriches the healthcare journey for Healthplan beneficiaries, offering a pathway to improved well-being and satisfaction.



Executive Summary

In 2022, a Healthplan partnered with Modivcare, a leading provider of supportive care services to Medicare and Medicaid payers, on a program to leverage the PERS benefit to increase member engagement, close HEDIS member specific gaps in care, improve the overall member experience and impact total cost of care (TCOC). All participants were provided a PERS unit that in addition to functioning as a medical alert system, was used as a communication tool to engage members to educate and facilitate HEDIS gap closure targeting 8 HEDIS metrics. The Study Group (comprised of participants meeting the criteria identified in the "Methodology" section below) was compared to a matched Control Group and achieved the following results:

- **Increased engagement** | **68%** increase in the percent of Study Group participants utilizing the PERS service in a given month compared to the basic PERS program design
- **Improved gap closure** - Study Group participants closed **20%** more total gaps in care than the Control Group, and **22%** more Study Group members closed at least one gap compared to the Control Group.
- **Gap closure improved with increased length of time on program** - Study Group participants enrolled in the program for 2 years showed further improvements with a
  - **33%** increase in number of gaps closed compared to control, and 10% increase compared to participants enrolled for only 1 year
  - **50%** more members close at least one gap compared to control
- **Reduced Total Cost of Care (TCOC)** - Although not a primary goal of the study, the programs impact on reducing total cost of care was analyzed with the following results:
  - **$81** pmpm TCOC gross savings compared to baseline period for Study Group
  - **$313** pmpm TCOC savings for study participants with greater than $10,000 in annualized TCOC in baseline

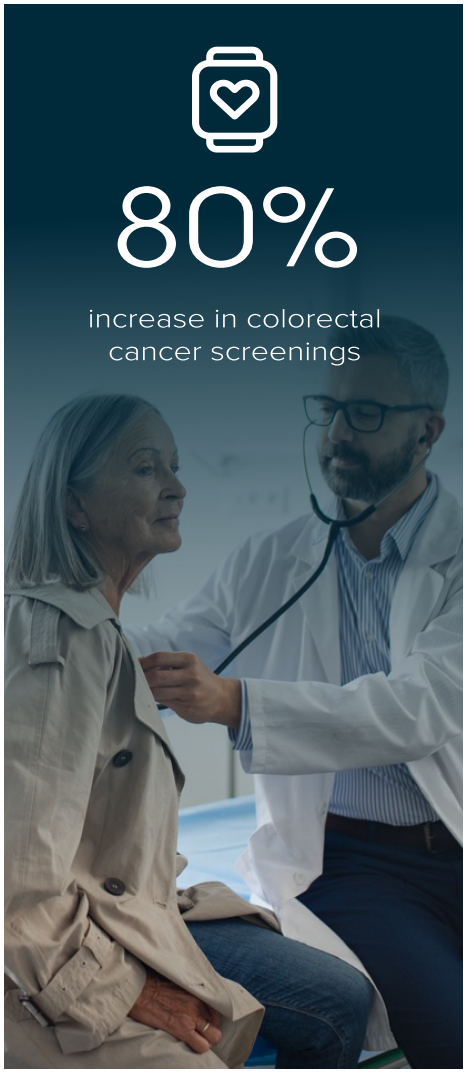
Background

As healthcare costs continue to rise, and government agencies like CMS move to value-based healthcare arrangements, there is an increased emphasis on preventive health measures targeting both general health as well as those with chronic illness. The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used performance measurement tool developed by CMS to assess the quality of certain Healthplans and a critical factor in overall STAR ratings. Among the more than 90 HEDIS quality measures are care gaps that identify missing recommended preventive care services. Through this study, Modivcare

and the Plan leveraged PERS as a benefit to drive member engagement through educational messages and member specific open gap in care reminders resulting in improved gap closure.

Partnering with Modivcare, the Plan has been offering PERS as a benefit to select Medicare plan designs since 2017. The benefit comprises a wearable electronic device connected to Modivcare's 24/7 Care Center. If a member needs help, they press the button on their device and are connected to a representative ready to triage and if necessary, dispatch the appropriate level of assistance. A unique aspect of the Modivcare PERS program is the use of PERS to address non-emergent issues including loneliness and social determinants of health. Modivcare's industry leading Care Center has no talk time constraints and engagement specialists are specially trained in active listening to achieve its overall goal of "Hear a Problem, Solve a Problem."

Beginning in 2020, Modivcare and the Plan partnered on a pilot program to leverage the unique engagement opportunity resulting from the Modivcare PERS program structure, capitalizing on non-emergent interactions, to study whether PERS could be used as a tool to improve member engagement, impact health outcomes, specifically select HEDIS gaps in care, and enhance the overall member experience. The initial 5-month pilot program resulted in the Study Group (472 participants) closing **42%** more overall gaps in care compared to a matched control and proved to be particularly impactful with an **80%** increase in colorectal cancer screenings, and a **56%** increase in breast cancer screenings compared to the control group. In 2021, a similar but larger pilot (3900+ Study Group participants) focused on members living with diabetes from 5 healthplan markets, demonstrated similar results with participants demonstrating **25%** improved gap closure when compared to a control group. Additionally, **36%** of study participants were referred to a healthplan Member Services for assistance.



Building on previous programs' successes, in 2022 the Plan partnered with Modivcare on a similar program focused on impacting gap closure. To enhance the program's success, the Plan provided Modivcare with more robust information around available member services and benefits. The hypothesis was that with this information, Modivcare could more immediately address participant barriers to care not only improving gap closure but also greatly improving member experience.

Program Design

To achieve the stated goals, Modivcare and the Plan developed a program design, that included a mix of general monthly health educational messages, targeted gaps in care messaging, and member specific benefit information.

Enrollment and Engagement

During enrollment, members were educated regarding the key elements of the program, the importance of testing their device regularly and the 24/7 availability of the Modivcare Care Center. Members were welcomed by a dedicated engagement team specially trained on the program elements and empathic listening. **40%+** of all eligible members agreed to enroll in the program.

Monthly Educational Messages

The 10-month intervention calendar program included member nonspecific educational messages focused on general health topics including diet, exercise, medications, vaccinations, etc.

The monthly educational calendar was as follows:

March	April	May	June	July	August	September	Octover	November	December
Annual Flu Vaccine	Annual Wellness Visit	Medication Adherence	Levels of Care	Behavioral Health	Medication Review	Annual Flu Vaccine	Annual Wellness Visit	Medication Adherence	Levels of Care
Gaps in Care	Gaps in Care	Gaps in Care	Gap in Care	Gaps in Care	Gaps in Care	Gaps in Care	Gaps in Care	Gaps in Care	Gaps in Care

Targeted Gaps in Care

The Plan provided Modivcare with monthly data on participant open gaps in care allowing Modivcare to deliver messaging to participants regarding their specific open gaps in care. Equally as important was the monthly data updates allowing Modivcare to cease messaging on gaps the participant closed, thereby optimizing the member experience, and limiting member abrasion.

Gaps included in the 2022 program were as follows:

- HbA1c
- Diabetic Retinal Eye Exam
- Blood Pressure Check
- Diabetic Kidney Function Tests
- Colorectal Cancer Screening
- Mammogram
- Statin Therapy for Diabetics and
- Statin Therapy for Cardiovascular Disease

Message Delivery

Program messaging (general education and gaps in care) was delivered during non-emergent interactions with participants. Given the Program's focus on gap closure, gaps in care messages were given priority over monthly educational messages. To optimize impact and avoid overwhelming the member, typically no more than two topics were covered during each interaction.

Messages were delivered by Modivcare's Care Center staff comprised of non-clinical resources.

In addition to delivering Plan approved talking points, Care Center staff documented any barriers to care and provided participants with information regarding available programs and benefits that would eliminate the barriers, facilitate gap closure, optimize benefit utilization, and address any additional participant questions or concerns. Examples include information on colorectal home test kits and how to access transportation to medical appointments.

Integration with a healthplan Care Coordination

The Plan and Modivcare created escalation and reporting protocols designed to integrate seamlessly into existing Plan Care Coordination workflows. Pathways were created for both urgent and routine issues and designed with member experience top of mind.

Study Methodology

The analysis utilized matched control methodology to compare a Study Group to a statistically similar Control Group. Additional analysis compared participant experience in a baseline period (12-months prior to the program) to the study period.

Study Group

- **3,055** participants met all criteria to be included in the analysis:
  - Inclusion Criteria
    - » Members were enrolled in the 2022 PERS + E3 program and were assigned at least one program-specific gap reminder message
    - » Members are in the HEDIS Measure data for measurement year 2022 provided by the Plan in July 2023
    - » Members have at least one program-specific gap in the Plan HEDIS measure that meets all eligibility criteria to be included in HEDIS measurement

- Member meets HEDIS definition of the measurement population (eg – For colorectal cancer screening, members 50–75 years of age who had appropriate screening for colorectal cancer)
- Members do not meet any exclusionary criteria, such as hospice or frailty indicators during measurement year 2022

Control Group

- **5,957** members were included in the Control Group
- Inclusion Criteria
  - Matched with Study Group on age and gender
  - Members in the HEDIS Measure data for measurement year 2022 provided by the Plan in July 2023
  - Members have at least one program-specific gap in the Plan's HEDIS Measure data that meets all eligibility criteria to be included in HEDIS measurement
    - Member meets HEDIS definition of the measurement population (eg – For colorectal cancer screening, members 50–75 years of age who had appropriate screening for colorectal cancer)
    - Members do not meet any exclusionary criteria, such as hospice or frailty indicators during measurement year 2022
  - Members were not enrolled in any VRI E3 program (2021, 2022, or 2023)
  - To match demographics with Program cohort, control members must also have been included in a Modivcare lead file

Study Period

The measurement period for gap closure is HEDIS Measurement Year 2022. Therefore, any gap for which members were eligible to have closed from January 1, 2022, through December 31, 2022, is included in this analysis. Gap reminder messages were delivered to participants between March 7, 2022, and December 31, 2022.

Included HEDIS Gaps

The program is focused on the following 8 gaps in care.

1. Kidney Health Evaluation for People with Diabetes (KED)
2. Statin Therapy for Patients with Cardiovascular Disease (SPC)
3. Statin Therapy for Patients with Diabetes (SPD)
4. Breast Cancer Screening (BCS)
5. Colorectal Cancer Screening (COL)
6. HBA1C < 8 (HBD)
7. Blood Pressure Check (CBD)
8. Diabetic Reinal Eye Exam (EED)

Results

Engagement

Sustained member engagement is critical to maximize appropriate benefit utilization, improve health outcomes and drive high member satisfaction and retention.

The basic PERS program that Modivcare provides across the Plan's population results in an average of **22%** of unique participants utilizing their device in a given month. In 2022, the enhanced engagement driven by the above Program Design, resulted in an average of **38%** of Study Group participants utilizing their device in a given month throughout the study period.

Gaps in Care Closure

The increased engagement combined with participant specific gaps in care messaging led to the Study Group closing **58%** of their total open gaps in care compared to a **48%** closure rate for the Control Group. This represents a **20%** improvement. Of note is the significant Study Group outperformance for both colorectal and diabetic retinal eye exam showing a **37%** and **29%** increase respectively over the Control Group.

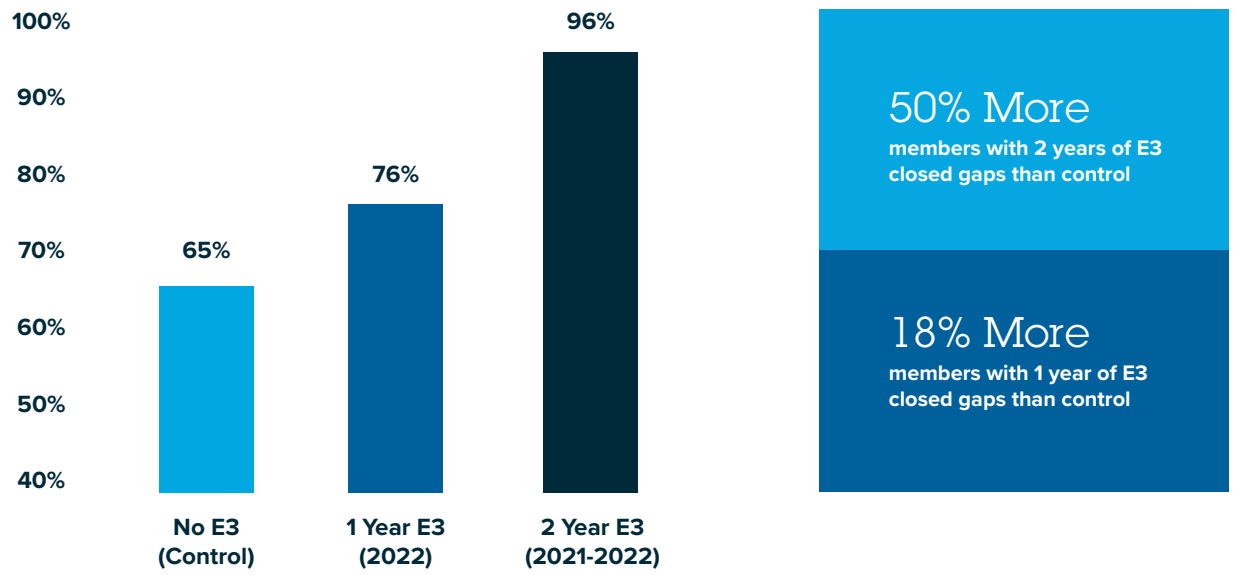
Progrm (N=3055)			Control (N=5957)		
	Gap Closure Rate	**N**	**Gap Closure Rate**	**N**	**Percent Increase Over Control**
COL	60%	1950	43%	2999	37%
KED	35%	1252	32%	1634	9%
BCS	70%	853	59%	1086	19%

Progrm (N=3055)			Control (N=5957)		
SPD	88%	913	88%	1073	1%
SPC	81%	138	84%	153	-3%
HBD	39%	1246	32%	1944	23%
EED	73%	1246	57%	1944	29%
CBP	54%	2106	49%	3570	10%
Total	**58%**	**9704**	**48%**	**14403**	**20%**

Multi-Year Program Participation Drives Further Improvements

To demonstrate that sustained engagement further improves results, the analysis looked at gap closure performance for members who were part of the Study Group in 2022, and also participated in the 2021 Program. Illustrated in the below graph, multi-year participants showed continued increases in gap closure rates as measured by the percent of the Study Group who closed at least one gap in care. **96%** of Study Group members with 2 years of program participation closed at least one gap in care, compared to **76%** for those who only participated in 2022 and **65%** for the control group.

Total Cost of Care Reduced



Although not a primary goal of the program, utilizing cost data provided by the Plan, the analysis examined the program's impact on total cost of care for Study Group participants compared to a matched Control Group's costs during the program year (2022). In addition to the variables already used to create a statistically matched control group, this analysis also accounted for the distribution of "high-" and "low-cost" members in each group. For purposes of this analysis, "High Cost" is defined as participants with greater than $10,000 in total annualized baseline costs.

Additional analysis examined impacts to costs by place of service and inpatient admission rates.

Impressively, the Study Group showed a **$81** pmpm decrease in total cost of care compared to baseline representing a **3:1** gross ROI.

PMPM Savings

$81 Total Cost **$104** In-Patient

Reduced In-patient Admissions

Decrease of 105 admits per **1,000** per year

High-Cost Participants

Looking at "high-cost" participants specifically, the analysis showed the following:

Gross PMPM Savings

- **$313 less Total Cost**
- **$258 less In-Patient Cost**
- **$30 less ER Cost**
- **$31 more OP Cost**

Reduced In-patient Admissions

- **Decrease of 280** admits per 1,000 members per year

Cost Trends

- **25% more** Study Group members are moved from high-cost in 2021 to low-cost in 2022 compared to Control*

As the above demonstrates, the program is particularly impactful with high-cost participants with **$313** lowered TCOC, and **280** fewer IP admissions per 1,000 members per year. Interestingly, in addition to lower TCOC for IP and ER, high-cost participant showed a **$31** pmpm increase in outpatient costs. This increase is likely the result of the program's positive impact on gap closure with high-cost members improving compliance with required preventative and diagnostic tests. Further analysis showed that **25%** more Study Group participants moved from "high-cost" to "low-cost" when comparing their baseline to Study Group costs.*

**High cost members had >$10k in annualized costs. Low cost members had <$10k in annualized cost.*

Conclusion

Modivcare's unique PERS program approach through enhanced member engagement focused on health education and closing gaps in care, drives measurable improvement in gap closure rates, reduces total cost of care and delivers high member satisfaction. Outcomes are further improved with both sustained participant engagement over multiple years and a program design targeting "high-cost" members. The resulting **3:1+** program ROI, offer a unique value proposition leveraging PERS as both a needed benefit, and a tool to improve quality and reduce costs. This is especially valuable in a tight Medicare funding environment.

At the time of this writing, the 2023 Program had just concluded. Program enhancements for 2023 included the addition of SDOH and Member Experience surveying. Modivcare looks forward to demonstrating how these enhancements further improve program results.

About Modivcare

Modivcare Inc. (Nasdaq: MODV) is a technology-enabled healthcare services company that provides a platform of integrated supportive care solutions for public and private payors and their members. Our value-based solutions address the social determinants of health (SDoH), enable greater access to care, reduce costs, and improve outcomes. We are a leading provider of non-emergency medical transportation (NEMT), personal care and remote patient monitoring. To learn more about Modivcare, please visit **www.modivcare.com**.

Contact

For more information about this study and to learn how Modivcare's RPM programs can improve quality, enhance member experience, and reduce total cost of care, please contact:

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