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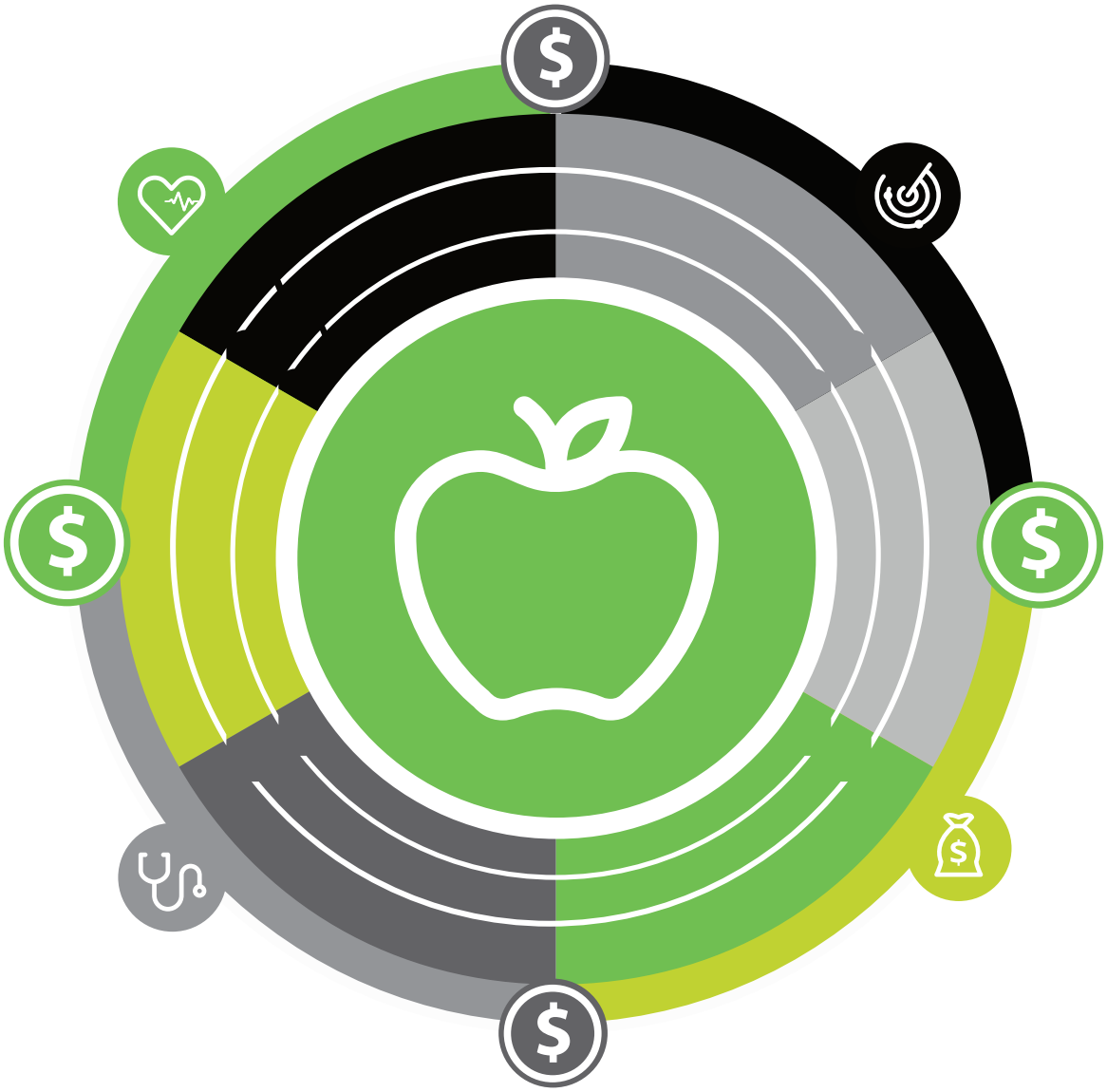

Care model redesign affordability
Care management can be a silo-connecting bridge for value-based models

Care management can be a silo-connecting bridge for value-based models

Fueled by recent regulatory action such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), many health care stakeholders are beginning to embrace the concept of value-based care. They also are looking to care management as a core strategic investment that can help them succeed under the new payment incentives. These stakeholders, however, generally do not agree on how to build programs that work. Unfortunately, there are no cookie-cutter templates to follow.

At Deloitte, we work closely with health plans and providers around the country—big and small, urban and rural. Even though we have seen a spike in initiatives related to care-management capabilities this year, we have seen that a care-management model that works well for one health plan might not work as well, or at all, for another. Models that target certain member populations can vary widely based on the prevalence of chronic disease, income levels, and the medical resources in the community. For example, chronically ill seniors have very high health care costs, which means there is a significant improvement opportunity for care management. Once a system selects an approach, it should be flexible enough to keep pace with changing member characteristics.

The impact of care management on some patient populations can be significant, especially when clinicians engage patients through care-coordination programs (e.g., fewer readmissions or emergency room visits). Those short-term savings can be invested into programs where results take longer to be realized. (Figure 1 provides an example of where longer-term investment may yield financial savings.) Engagement- and biometric-based metrics can help confirm adherence and might be able to demonstrate enough progress to encourage further investment.

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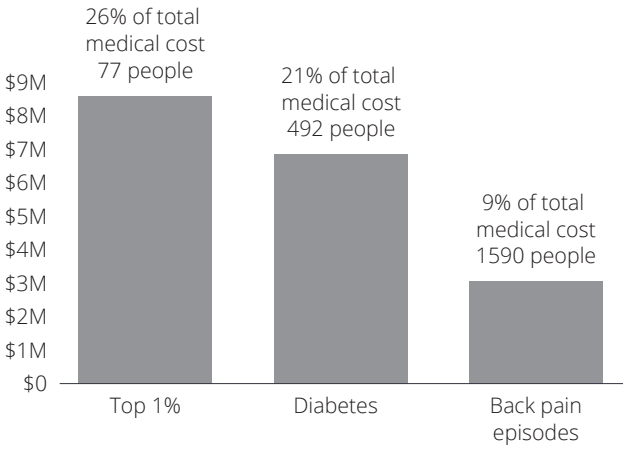
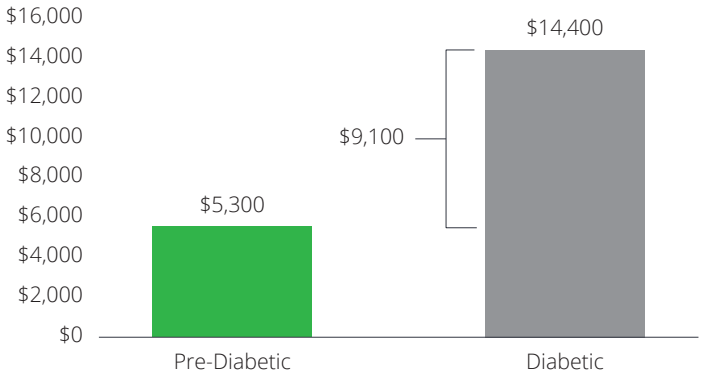
Figure 1. Preventive care opportunity: Diabetes

Top drivers of medical costs for a commercial population



- The top 1% of the Members incurred $8.4 million dollars in medical costs in FY 2010, represent 26% of total medical costs
- Diabetes related treatment represents 21% of the total medical costs
- Back pain episodes represent 9% of total medical costs; the top 17% of these cases represent 75% of the costs

Preview of preventative care opportunity



(Based on actuarial analysis of a hospital employee population.)

- Currently, 6% of the member population is diabetic
- Another 20–40% of the member population (1,500–3,000 individuals) is pre-diabetic
- Preventative care for this diabetic population could save $9,100 per pre-diabetic member

What should be included in a care-management program?

While there is no magic formula, typically care-management programs should have three elements:

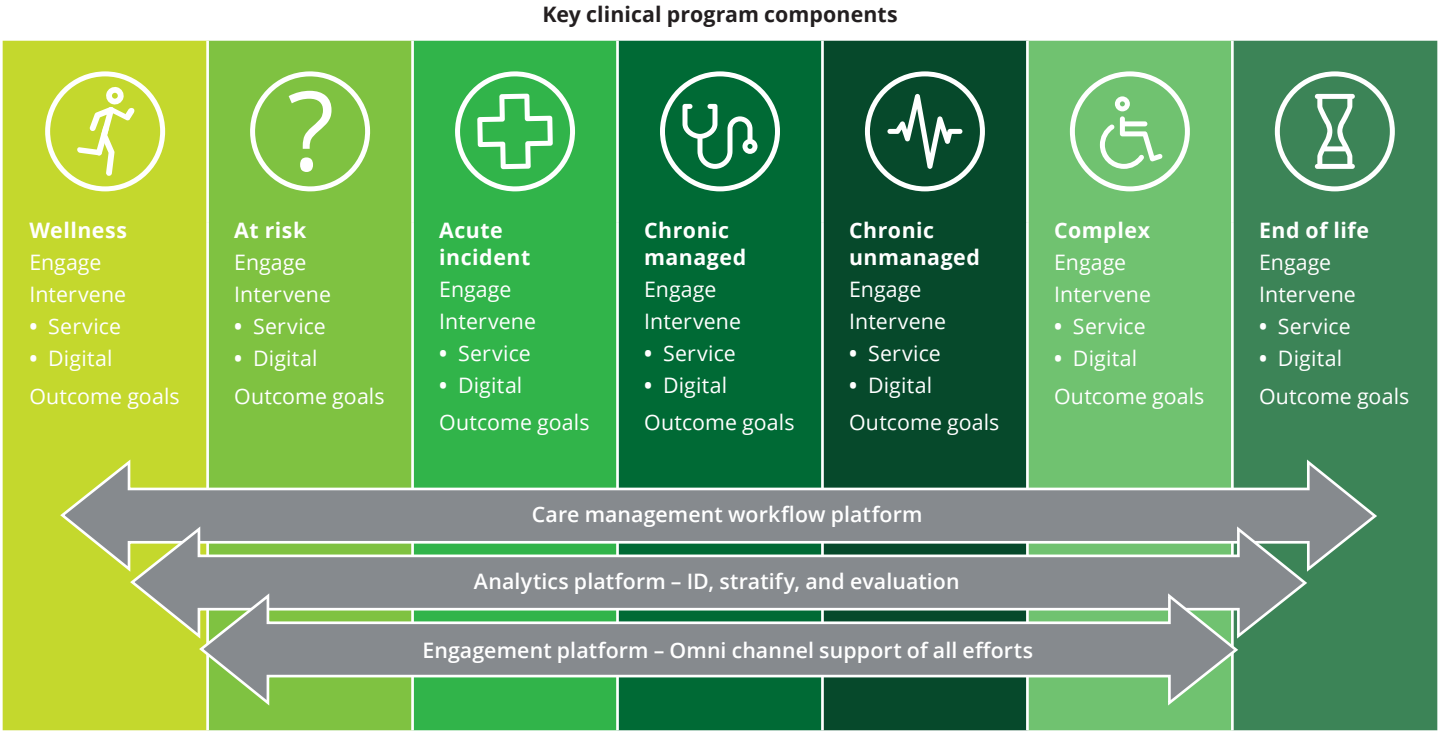
- **Core capabilities.** The rapidly changing landscape demands a broad-based and flexible approach to care management fundamentals. Utilization management efforts are still needed in a value-based world to identify patients who are in need and to help find care that is being delivered outside of the core network provider. While the management of chronically ill patients is important, new technologies should be considered to boost effectiveness. Provider-sponsored case-management programs can enhance the engagement and coordination of care.
- **Cross-continuum integration and collaboration.** To help ensure the best possible outcomes, medical care needs to include expertise in a wide range of integrated specialty care. Several health plans have found that integrating behavioral health, pharmacy, social determinants of health, and post-acute care support can be an asset in developing a portfolio of care-management options to support providers. As health care providers build out their care-management capabilities, if things remain as they are, there is a possibility that efforts will be duplicated between health plans and providers. To minimize this duplication, organizations should consider an integrated approach. The health plan, for example, might target the well and at-risk for health coaching, whereas providers' efforts could be focused on more complex patients with multiple chronic conditions.
- **Population-based analytics.** As hospitals and physicians are asked to take on more risk, their appetite for data will likely become voracious. Along with data and tools, health plans might be able to equip providers with actionable insights that help them identify and manage medical spending at a population level, as well as at the point of service. Providers and health plans could also pool their data to create both a clinical and a financial view. Early identification of members who will need high levels of care can allow for early intervention.

Moreover, health plans, hospitals, and health systems should consider incorporating these design concepts when building a care-management program:

- **Data-driven prioritization.** A deep analysis and benchmarking of historical medical costs can help define the priorities for each population. This typically involves more immediate focus on the acutely ill and less investment on healthy members (particularly in the early years of the program, or in situations with considerable member/patient churn).
- **Provider-led models.** Integrating care management into a physician-led model can increase patient engagement substantially even when the program is delivered virtually, or driven by the health plan as a back-office engine. Physicians should be able to track patient utilization rates and per-member-per-month (PMPM) costs so that they can identify trends within a population and determine where to focus resources.
- **Build vs. buy.** While care management should be a key skill set for most health plans, as well as a point of differentiation, they can still leverage purchased services to improve their impact in the short- and medium-term.
- **Data and analytics.** Regardless of the population, care model, setting, or use of vendors, a health plan or health system with solid data and analytics capabilities is most likely to thrive. Health plans should have ongoing population-level analyses to identify trends and opportunities. But they should also be able to offer providers a prioritized list of patients who would benefit from immediate intervention at the point of service. (Figure 2 shows the types of analytics data available to health plans.)

"A health plan or health system with solid data and analytics capabilities is most likely to thrive."

Figure 2. Core capabilities required



Health plans and health systems might benefit from collaborating around population health analytics. (Figure 3 shows how care management, driven by health analytics, can be the center of an effective health plan–payer–provider relationship.) Health plans have claims and other administrative data and sometimes have insight into how members respond to incentives and health messages. Health systems tend to have detailed clinical information from electronic health records and a close relationship with patients. However, recent Deloitte research found that just 16 percent of health plan survey respondents said collaboration with providers is a priority for their analytics investments, demonstrating a disconnect between health plans' goals and their ability to influence the critical patient/provider experience.

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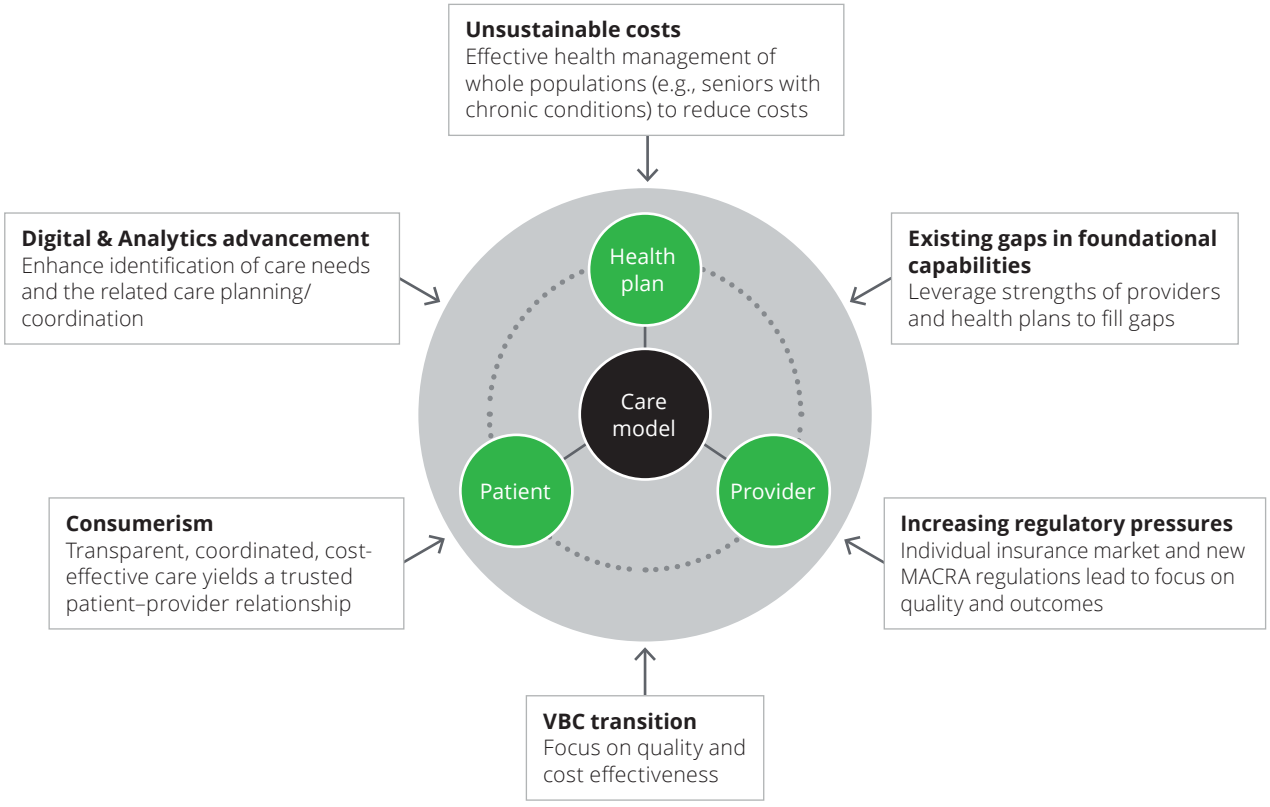
Source: 2017 US Health Plan Analytics Survey, Deloitte Center for Health Solutions

Figure 3. The reasons to undertake care management model redesign



Executives from health plans and health systems often ask us about the leading practice models that work well for others. We cannot answer that question until we know much more about their enrolled or assigned population. We do know, however, that if done correctly, care management can be a tool that connects health plans and health systems to let them succeed under value-based care models.

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