Industry Perspectives on Future Trends in Population Health and Care Management
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Collaboration is the Key to Success

The information silos that have traditionally stood between payer and provider are coming down. As the two groups work together under shared risk for financial and clinical outcomes, success will depend heavily on how connected and aligned they can become. While risk-sharing isn’t a new concept in healthcare, the level of technology previously available was insufficient to support the connectivity, data gathering and information sharing needed for effective management of medical costs—key to innovation in delivery and payment. As innovations in Healthcare Information Technology (HCIT) advance, new capabilities enable the medical management necessary for payers and providers to automate and manage payment arrangements and delivery models.

Care management and the evolving population health management (PHM) model have benefitted greatly from these technological advancements. Care management, with its focus on controlling the high medical costs associated with long-term conditions, and PHM, which applies broader strategies and evidence-based practices to address the needs of large groups, both depend on a high level of connectivity, analytics, and information-sharing. Aided by new technology, these two concepts provide many of the capabilities and processes payers and providers need to be successful in the era of healthcare reform.

To gain industry perspectives on future trends in care management and PHM, TriZetto conducted a survey of over 250 providers and payers across eight segments of healthcare. The respondents represented commercial and Medicare/Medicaid-only payers, hospital systems, operational ACOs, Integrated Delivery Networks (IDNs) with and without integrated health plans, and both primary care and multi-specialty physician practices. Survey results indicate:

- There will be a high rate of growth in PHM development, and a commitment to continue investment in care management programs
- Payers and providers share strong similarities in relation to the financial drivers and critical capabilities sought for care management and PHM programs
- The greatest barrier to coordination and collaboration between payers and providers is integration between each group’s systems and workflows

The convergence of roles among payers and providers is driving the development of technologies to support more collaborative medical management and care coordination. Collaboration is the key to driving healthier behavior for members/patients while better controlling costs and maximizing reimbursement within new payment models.

Survey respondents were provided with the following definitions for Population Health Management and Care Management:

**Population Health Management—**
A model to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with, and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions. (CareContinuum Alliance)

**Care Management—**
Healthcare services, programs and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care Management typically encompasses Disease Management (DM), Case Management (CM), Utilization Management (UM) and Wellness. Care Management’s primary goal is to prevent the sick from getting sicker, and avoid acute care events.
The Movement Toward Population Health

Tremendous growth is anticipated in PHM with 86 percent of payers adding capabilities within 12 months and 80 percent of providers growing their PHM programs in the same time period. Although survey results show that care management investment to date exceeds that of population health management, future investment in PHM is set to significantly outpace that of care management.

Care management will always be needed to deliver the high-touch, individualized care coordination to help direct members to appropriate care and control costs for the chronically ill. However, new shared-risk arrangements will also require the ability to analyze, track and address the health needs of large groups of members. While many of the core capabilities of care management programs are directly applicable to population health, there are important components unique to the PHM model which must be developed and deployed separately.

PHM leverages key capabilities of traditional care management to support a provider-directed model that shares risk and controls costs at the population level. Where traditional care management seeks to personalize and coordinate care for the individual in order to stabilize high medical costs, PHM allows broader strategies and evidence-based practices to be applied to larger groups, reducing medical spending across a system, practice or delivery network.

The lower growth of care management versus PHM is reflective of the early stage in which the PHM model exist; however, the continued investment commitment to care management reveals that payers and providers believe these solutions will live side-by-side as complimentary capabilities.

The significant investment already being made by payers in care management programs, and the level of investment planned, reflects an understanding shared by both payers and providers that care management and PHM initiatives will both be necessary to the success of new payment arrangements under health reform.

**Significant Growth Anticipated in Care Management**

Survey results show that not only are payers and providers already making significant investments in care management and PHM capabilities, but both groups are planning significant future growth in these areas.
Despite differing views on ROI measurement, and the often-challenged results of large-scale programs, the model remains a core component of payer and provider strategy. As Figure 2 shows, 82 percent of health plans and 66 percent of providers surveyed indicated they had already implemented care management programs.

Our research confirms that payers aren’t abandoning these activities. In fact, 98 percent of payers we surveyed said they would be investing in care management initiatives over the following 12 months, with 93 percent of providers indicating they would be making additional investments in care management in the coming year as well.

**Personalizing Care While Managing the Broader Population**

The survey found several key financial drivers spurring the growth of care management and PHM investment, and discovered that payers and providers have already been trying to address similar pain points.

For providers seeking care management solutions, patient population risk stratification and identification, utilization cost and quality management, and predictive modeling-based targeted interventions were identified as most critical to their objectives.
The top financial driver for payers and providers acquiring care management and PHM solutions is the challenge of lengthy or frequent readmissions, as shown in Figure 3. Both groups need the capabilities to address the significant costs associated with length of stay and re-admissions. Care management offers the type of personal, preventive, transitional, and follow-up care needed to manage post-acute member health to drive down costs in these areas. PHM will be effective in identifying and predicting which individuals will require these intensive, high-touch interventions.

Focusing on and improving quality will also be essential to maximizing the level of reimbursements in value-based payment arrangements. For example, it is imperative for Medicare Advantage plans to focus on improving quality in order to maintain or improve their star rating as determined by a number of measures set forth by the Centers for Medicare and Medicaid. For providers and payers participating in ACOs, PHM will provide analytics capabilities, evidence-based practices and unified delivery for groups, while care management will allow key individual metrics to be addressed at the member/patient level.

Payers and providers also recognize that reviewing and managing utilization while complying with healthcare reform will have the most positive impact on cost containment and revenue opportunities—care management and PHM will be core to strategy addressing both challenges.

**The Essentials for Collaborative Care**

Payers and providers were asked to identify the most important care management and PHM components for solving their organizational goals. The survey offered more than 40 capabilities from which respondents could select what they believed to be the most critical to successful programs.

As seen in Figure 4, the commercial plans surveyed are seeking capabilities in member population risk identification and stratification (47%); utilization management to redirect future care to the most appropriate levels (47%); provider incentive management (41%); and promotion of health and wellness (41%).
It is notable that Medicaid/Medicare-only payers identified slightly different important capabilities for PHM. They listed predictive modeling-based targeted interventions, and health program effectiveness and analytics as their second and third most critical capabilities.

Meanwhile, the top three capabilities sought by providers for PHM initiatives are predictive modeling-based targeted interventions, patient population risk stratification and identification, and UM to redirect future care to the most efficient and appropriate settings or physicians. This list is nearly identical to the providers’ list of critical care management capabilities, highlighting the fact that these are the capabilities providers will need most to successfully adopt risk-based payment arrangements and effectively control costs for individuals and large groups of patients.

The most critical care management capabilities sought by all payers in the study were: utilization cost and quality management (50%); mainstream chronic disease management (DM) for the “Big Five” core chronic illnesses [AST, DIA, COPD, CHF, HYP] (27%); patient population risk stratification and identification (27%); and predictive modeling-based interventions (27%). For providers seeking care management solutions, patient population risk stratification and identification, utilization cost and quality management, and predictive modeling-based targeted interventions were identified as most critical to their objectives.

The overall results suggest that payers agree on the need to effectively identify and stratify chronically ill members to stabilize their health with appropriate interventions as a crucial strategy for accomplishing business goals. Providers seem to understand well that the solution to effectively manage financial risk lies not only in adopting traditional payer practices for risk and care management, but also in leveraging their own strengths and experiences with utilization review and management activities.

Interest in effective predictive modeling, population risk stratification and clinical decision support is common among commercial and Medicare/Medicaid-only payers, but results show consistently that Medicare/Medicaid-only plans are more interested in HIE integration than commercial payers.

Care management and PHM solutions for Medicare/Medicaid plans must be able to leverage information already captured in a variety of systems. For Medicaid and Medicare-only plans, whose members qualify for and utilize a variety of services across a wide range of resource providers, the ability to effectively track members as they access all of these services and centralize data and information is a significant challenge.

Commercial plans are focusing heavily on improving administrative efficiency in their provider networks, while improving effectiveness in utilization management of members. Commercial payers are looking to connect multiple systems as well, and need the ability to track the progress and ROI on the many different programs they’ve developed and deployed.

**Mounting Frustrations with the Lack of Technology Integration**

Administrative challenges have mounted for payers and providers as they have found it necessary to acquire and implement a variety of solutions in order to execute care management and PHM strategies. Oftentimes, these capabilities must be acquired from separate vendors in order to manage networks, evaluate claims, analyze patient population health and outcomes, engage individuals and coordinate care. Connecting separate solutions is costly, time consuming and often does not provide the interoperability needed for the value of these solutions to be realized.

Focusing on improving collaboration with their providers, payers are looking to achieve bi-directional communication and information exchange between core systems and provider patient registries, health alerts, care plans, and gaps-in-care. Ninety percent of payers surveyed identified their top integration challenge as implementing the tools and credible information to extend care management solutions into the provider office using portal-based, bi-directional information flow (Figure 5).

Meanwhile, providers need to link Electronic Health Records (EHRs) to a variety of new and existing solutions required for compliance and effective health management. Figure 5 shows that over 70 percent of providers in all categories listed connecting hospital and physician group EHRs as their top integration challenge.
Implications of Aligning Patient Care and Coordination with Payment Models

The goals, responsibilities and needs of payers and providers are converging. Both groups realize the need to implement and connect solutions that facilitate real-time and meaningful information exchange beyond batch claims transfer, paper reporting and multiple portal solutions. To be successful, payers and providers will need to dismantle existing barriers and find new ways to work collaboratively.

Payers and providers are engaged and actively developing capabilities to align patient care and coordination with new reimbursement models. Helping patients and members effectively navigate care, establishing a foundation for greater accountability, facilitating better decision-making, and creating a better picture of the health and activities of populations are all priorities. Driven by this convergence of traditional roles and responsibilities, and with a renewed emphasis on better consumer engagement, payers and providers will require the connection of new solutions with existing systems to centralize and share information for all decision-makers.

HCIT leaders are focused on delivering solutions that enable new levels of collaboration and medical cost management previously unattainable by payers and providers. Care management and PHM programs provide many opportunities and connection points for payers and providers to collaborate, but the solutions supporting these programs must work together, as well as with other components and processes to execute the overall payer and provider strategies.

While the similarities between the currently proposed arrangements and models from the past are striking, significant advancements in technology since previous reform efforts provide hope for payers and providers to successfully establish a new, more accountable relationship.

For more information on how TriZetto helps payers and providers collaborate to improve care and meet business objectives, call 1-800-569-1222, or visit www.trizetto.com