

HEALTHCARE

BUILDING PAYER-PROVIDER PARTNERSHIPS FOR CARE MANAGEMENT

8 Strategies for Success from Leading Provider-Sponsored Health Plans

Managing complex, high-cost members is one of the top challenges health plans and providers face. With United States healthcare expenditures composing more than 18%¹ of gross domestic product in 2018 and healthcare premiums expected to rise 5.5%² this year, use of innovative care management to direct targeted care interventions to members with intricate medical and socioeconomic needs has emerged as a must-have strategy in an era of value.

Care management is an area where, in theory, a provider-sponsored health plan (PSHP) or integrated delivery network should be able to win against national players because of their:

- Access to expanded, comprehensive information on their members.
- Integration with their communities and their local brand.
- Staff who live in the same communities as their members, know the area, understand the resources available, and have strong working relationships with providers in the community.

But launching a care management initiative, even for integrated plans and systems, often is fraught with difficulty. Efforts typically are duplicated in different business units, leading to waste. Access to data that can inform the right approach for the right member at the right time may be hindered by disparate systems and silos on both the payer and provider side. The level of collaboration across the continuum of care may be influenced by the politics of the organization and divergent business and clinical interests. And physicians and staff may not be open to integrating care management resources at the point of care.

When these barriers are not addressed effectively, the ability to tightly coordinate care for high-cost and emerging-risk members

is compromised — and efforts to improve health outcomes while reducing per member per month (PMPM) costs deliver limited return on investment.

The experiences of three PSHPs — Geisinger Health Plan, Intermountain Healthcare’s SelectHealth, and Adventist Health System — point to key ways payers and providers can more effectively collaborate in developing a highly targeted, high-impact approach to care management — and the lessons learned that could better position organizations for success.

NAVIGATING THE COMPLEXITIES OF CARE MANAGEMENT

Care management is a vital tool in improving member health and reducing care costs. But the goals of care management often vary between payers and providers — and this can inhibit the ability to effectively manage target populations.

“Culturally, even provider-sponsored health plans can have an ‘us vs. them’ mindset between the health plan and the provider organization, similar to the conflict between big health plans and providers,” says Katherine Ziegler, BSN, MHA, director for Navigant Consulting, Inc. “That hasn’t changed as much as I think we might have imagined, even in an era of value.”



KATHERINE ZIEGLER

Even the definition of care management varies among and between providers and health plans, further complicating efforts to gain agreement around what a care management strategy

1. CMS.gov Press Release, “CMS Office of the Actuary releases 2017-2026 Projections of National Health Expenditures,” February 14, 2018, <https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2017-2026-projections-national-health-expenditures>.
 2. Stephen Miller, “Health Premiums Expected to Rise 5.5% in 2018, Driving Cost Management Steps,” Society for Human Resource Management, August 9, 2017, <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/employers-benefits-costs-rise.aspx>.

WHAT IS CARE MANAGEMENT?

“Care management is the integration, coordination, and alignment of services wrapped around a select population. It’s a variety of interventions using diverse clinical services, and it varies by payer; by line of business; by provider group.” **Janet Tomcavage, RN, MSN, chief population health officer, Geisinger Health Plan**

“There is no simple definition of care management. A decade ago, the focus was on how to reduce emergency department and lower lengths of hospital stays. Now, we’re evolving in our understanding that an effective care management program needs to be much more comprehensive. To effectively manage the health needs of a population, you must involve more people who have insight into the total needs of the members the plan is serving.” **Sara Neese, RN, chief operations officer, Learning & Innovation, Health Plan Alliance**

“In our world, we’ve gotten away from using the term ‘care management’ and have begun branding our activities as health management. I’ve found that whenever I use the term care management, all people think about is chronic disease management, and as a population health services organization, we have a variety of programs that are risk-stratified and highly targeted toward the needs of the individual patient.” **Jill Piazza, vice president of Care Integration, Adventist Health System Population Health Services Organization**

should look like, the way in which it should be implemented, and how to measure success.

“I think the way in which payers and providers view care management is as different as night and day,” says Sara Neese, RN, chief operations officer, Learning & Innovation, for Health Plan Alliance. “From the payer perspective, the goals are typically centered around initiatives designed to manage utilization and cost within a defined benefit plan. Among providers, their focus is centered around the clinical needs of the patient and efforts to ensure that the patient’s healthcare needs are managed. In a fee-for-service environment, these differences create challenges for both payers and providers. As providers begin to assume risk, they are realizing the benefits of more comprehensive care management activities and that plans can become valuable partners to them in this transition.”



SARA NEESE

As the move toward value-based contracts accelerates, some providers are thinking about care management in new ways. Providers that have begun to take on risk are starting to act like insurers and develop the competencies needed to better manage a population.

Meanwhile, members’ expectations of payers and providers are changing.

“Today, the ability of health plans to attract members and employers depends on their ability to offer high-tech, high-touch tools for member engagement and to expand the role of care managers to meet patients where they are,” says James Smith, FACHE, managing director for Navigant.



JAMES SMITH

The influence of members’ desire for increased touchpoints with health plans and providers has prompted a flurry of technological innovation focused on the member experience. Leading health plans now offer technologies that deliver real-time, personalized care instructions from the touch of a mobile device. One health plan created an app that uses GPS monitoring to track when a member with chronic disease seeks care from an emergency department (ED). The member’s care manager is automatically alerted, enabling the care manager to follow up with the member within minutes to learn what prompted the visit and to offer assistance to the care team. It’s an approach that supports higher-quality care while helping to reduce PMPM costs.

Another health plan app uses the member’s wearable tech device to upload critical care data such as blood sugar levels, heart rate, and medication adherence patterns directly into the patient’s electronic health record (EHR). When the data point to health patterns that could require follow-up, the health plan’s chronic disease unit is automatically notified so the appropriate measures can be initiated. The result: increased peace of mind for members — and avoided urgent-care costs.

But for most health plans and providers, while steps toward member-facing innovation have demonstrated return on investment through increased satisfaction and engagement, technology investments on the administrative side have not kept up with changing

organizational needs. As a result, member data is inadequate, inaccurate, and inaccessible. Simply being able to gain actionable information about a member with complex medical needs at the point of care is a significant hurdle. When combined with lack of interoperability with other provider systems, this leaves physicians dependent on members to share when a member has been cared for in the ED, admitted to an out-of-network facility, or failed to fill a recent prescription.

“The cost of implementing new technologies for care management can be really daunting,” Ziegler says. “Conversations around adding new tools for care management versus using tools within the EHR are very real, because physicians don’t want to use a lot of new tools. There’s also a process piece to that conversion: How do you implement new technologies that are relatively low-cost and that interface with the EHR to put the information directly in front of the provider at the point of care?”

Other care management challenges typically encountered include:

- Increased pressure to demonstrate value and improved outcomes.
- Lack of a systematic approach to care.
- An expectation that patients should coordinate care on their own.
- Limited success via telephonic care management — an approach typically deployed by health plans for high-need, high-cost populations — to effectively engage patients in managing their health.

8 STRATEGIES FOR SUCCESS

How can payers and providers successfully collaborate to develop care management strategies that provide strong return on investment? Following are eight strategies leaders should consider.

1. Focus care management on the areas of greatest impact.

“If you want to reduce PMPM costs, you need to know where your costs are coming from, and that varies by line of business and whether the plan is commercial, Medicare, or Medicaid,” says Janet Tomcavage, RN, MSN, chief population health officer for Geisinger Health Plan.



JANET TOMCAVAGE

“In a Medicare population, most of the costs are coming from hospital admissions, ED visits, and post-acute care,” Tomcavage continued. “If you can prevent the inpatient admission, you’ll also prevent a skilled nursing facility admission. The impact on cost is significant, since an avoided hospital admission for a Medicare patient saves on average around \$12,000. If the patient has more complex medical conditions, that amount could increase to \$18,000 to \$20,000.”

KEY CHALLENGES OF CARE MANAGEMENT

“As a health system that’s focused on whole-person care, we fundamentally believe that population health management must progress beyond members of risk-based contracts. Our desire is to get to the point that we are able to provide the longitudinal programs we’ve put in place to all of our patients, but the reality is, we’re still surviving in an era of fee-for-service while trying to advance into value-based care. So how do you pace that work and fund it? Those are probably two of the biggest long-term challenges we face.”

Jill Piazza, vice president of Care Integration, Adventist Health System Population Health Services Organization

“We need to think about how providers look at data and the types of data they look at. They want data that is accurate and data that is available closer to real time, as well as data that shows how they are doing against benchmarks and their peers.”

Joann Sciandra, RN, BSN, CCM, vice president, Population Health, Geisinger Health Plan

“In my former payer experience, two of the biggest challenges we faced in working with providers around care management were: How do we speak the same language? And, how do we leverage the skills of both organizations in working together?”

Katherine Ziegler, Navigant

“One of the biggest questions payers and providers must answer around care management is: Where should care teams be embedded? You have to be thoughtful about creating member density with PSHPs. You also need to think about the integration of IT with these health plans and how that might impact workflow for providers.”

James Smith, Navigant

Determining where to focus care management activities is one of the biggest decisions payers and providers will face, Ziegler says. A deep understanding of the population being served and the goals of the care management program will inform an organization's strategy.

"For providers, it's difficult not to offer care management for everyone, but the financial models simply don't allow for that," she says. "It's important to focus not only on which members are highest-cost, but also the population where you can make the greatest impact. There are some members for whom there is very little you can do to reduce costs of care."

Case Study: Geisinger Health Plan

One of the keys to Geisinger Health Plan's success is its decision to decentralize care management. Care managers for Geisinger are placed within each of Geisinger's primary care offices, where both the physicians and the health plan can refer patients for care management services. Patients also can be referred for care management through hospital discharge and proactive medical claims review.

"Our health plan has a fairly dense penetration of care management," says Joann Sciandra, RN, BSN, CCM, vice president, Population Health, for Geisinger Health Plan. "We try to manage 15% to 20% of our Medicare population, for example. In a traditional payer model, typically the top 5% of the population is managed. That's because most plans incorporate a telephonic approach to care management, so their ability to respond to members' needs and impact member health is not as robust."



JOANN SCIANDRA

Geisinger also integrated its care management model under one organizational structure that leverages the knowledge of health plans in a delivery model located directly in the provider offices. This structure has reporting alignment with both health plan and clinical enterprise senior leadership.

"The concept was somewhat of a concern at first," Tomcavage says. "Day-to-day clinical interventions are driven by the clinical team, but the health plan has developed the training program and provides the operational support that assures care managers are focused on work that encompasses meaningful

case management activities and not clinic-type tasks, such as when a staff person calls off for the day. Having that clear demarcation of the care manager's focus is one of our biggest wins."

With specialized training in diabetes, heart failure, chronic lung disease, advanced illness, and more, Geisinger's care management team brings a level of expertise to physician services that most offices would be hard-pressed to find.

The results have been outstanding:

- By providing diabetes patients and their families³ with the food and recipes to prepare five fresh meals per week, Geisinger Health Plan saved more than **\$90,000** for each member who participated in the program per year.
- Efforts to lower acute inpatient stays saved **19% PMPM**.
- Total health spending among Geisinger Health employees decreased **13%**.

"It's important to remember that care management doesn't work by itself in isolation. It's the model that changed," Sciandra says. "Some organizations want to just look at the care manager impact, and I think that's a failure. It's what you do with care management services and how you embed them into your team that drives results."

3. Dr. Andrea T. Feinberg et al, "How Geisinger Treats Diabetes by Giving Away Free, Healthy Food," *Harvard Business Review*, October 25, 2017, <https://hbr.org/2017/10/how-geisinger-treats-diabetes-by-giving-away-free-healthy-food>.

2. Adopt a holistic approach to care management.

“As our understanding of care management has evolved, we’ve begun to move away from disease management toward longitudinal care management,” says Teresa Hall, director of health services for SelectHealth, the insurance division of Intermountain Healthcare. “We’re getting much better at ‘predict and prevent,’ using risk-prediction models to identify which members may be at risk of experiencing a care event and deploying targeted interventions that improve health and health outcomes.”



TERESA HALL

Putting the provider side in the lead for care management also is key. “In our clients’ experience, we’ve found that’s where the function should sit to provide the most value,” Neese says.

3. Define shared goals.

This helps ensure both payers and providers are invested in the approach. Determine which metrics will be used and strive to incorporate metrics that also are used to evaluate performance around other initiatives within the organization. Additionally, be diligent about assessing the value of the functions associated with your care management program. For example, are you spending too much money on precertification of services without any yield in terms of understanding the member population? What is the value of the individual activities your organization is undertaking?

4. Dedicate the right staff resources.

What are the skill sets attached to care management activities, and to what extent are these the right skill sets for the target population?

“At Geisinger, we’ve gone from a heavy nurse model for care management to a nurse-and-social worker model and, over the past three to five years, to adding licensed community health workers and peer support,” Tomcavage says. “Our model features a spectrum of resources and services that help provide care coordination as well as clinical and social optimization.”

5. Invest in high-touch, high-tech solutions for member engagement.

SelectHealth partnered with a vendor to develop a mobile pharmacy benefit app that helps members save money on their prescriptions. The mobile app provides information around:

- Drug prices and potential lower-cost alternatives.
- Medications covered by the plan.
- Tier statuses of prescription drugs.
- The member’s prescription copays and benefits.
- Maintenance drugs.
- Explanation of benefits for the members’ drug claims.
- Preauthorization and step-therapy requirements.
- Participating pharmacies.

“The most effective tools enable members to do things themselves, such as schedule appointments with specialists, check their prescriptions, and transfer records,” says Eric Cannon, Pharm.D., FAMCP, associate vice president of pharmacy benefits for SelectHealth.



ERIC CANNON

Case Study: SelectHealth

In 2016, Intermountain Healthcare, a not-for-profit health system in Salt Lake City, launched SelectHealth Share Network, a health plan with a goal of keeping yearly rate increases to one-third to one-half that of many employers.

It was a lofty goal, even for a health system that was a leader in determining its cost to collect, reducing unnecessary expense, and improving quality of care.

Today, the health plan, which covers **900,000** members, has demonstrated considerable success in reducing employer healthcare costs:

- In 2017, Utah employers who were early adopters of the health plan's SelectHealth Share product reduced their medical costs by **8.1%**.
- Members recorded **4.5%** fewer ED visits and a **3.8%** lower hospital admission rate compared with SelectHealth members on other large employer health plans.
- More than **70%** of employees on SelectHealth Share plans are actively engaging in fitness campaigns, completing health assessments, and participating in digital health coaching.

Hall says the health plan's move away from disease management to longitudinal care management has been key to its continued success.

"When the health plan was first formed, we looked at disease states to determine where we could make the greatest impact," Hall says. Now, SelectHealth has adopted a "predict and prevent" approach to further define which members could most benefit from targeted interventions based on risk-adjusted claims analysis.

Multiple touchpoints between payers and providers, as well as with members, also have been key to SelectHealth's success, Cannon says.

SelectHealth's care management services are offered free of charge to all members. For nontargeted interactions, nurses and social workers assist members in coordinating access to care, understanding their benefits, providing education around the medications members are taking, and providing tools to help members identify symptoms they may be experiencing.

SelectHealth also owns its own pharmacy benefit management company, which better positions the health plan to help curb rising specialty drug costs, which hit a record high.⁴ Specialty drugs are particularly difficult to manage because they require special handling, strict adherence, appropriate monitoring for potential side effects, and effective cost controls.

"We've seen more intense focus on medication management under care management initiatives in recent years, and not just because the cost of medications is rising," Cannon says. "Our approach to managing medication adherence and specialty drug spend is driving greater value, with the savings passed on to members."

6. Build care management into provider workflows.

Integrating actionable data into physician workflows is essential to success, but the reality is, the technology often acts as a barrier to this effort.

For example, Adventist Health System gave all of its physicians access to business intelligence software to view members' care gaps. But the technology wasn't integrated with their workflow, requiring physicians to remember a separate username and password and take time out of their day to log in, so it wasn't used.

While it may seem like a step backward, the system then moved to providing printed paper reports to medical staff, and physicians love it. The reports itemize care gaps and the health management status

of each member, so physicians know whether the member refused to participate in programs or doesn't need care management. The provider can then engage members and encourage them to make the behavior changes needed to improve health.

"The more member-level data you can provide a physician — and the more you can integrate that information into the physician's EHR workflow — the better," says Jill Piazza, vice president of Care Integration, Adventist Health System Population Health Services Organization.



JILL PIAZZA

4. Laurie Toich, "Specialty Drug Cost Increases Hit Record High," Specialty Pharmacy Times, September 15, 2017, <https://www.specialtypharmacytimes.com/news/specialty-drug-cost-increases-hit-record-high>.

Case Study: Adventist Health System

Adventist Health System's vision for care management is reflected in its decision to refer to its work as "health management."

"Health management describes the longitudinal, whole-person models we are putting in place that help to pave the path to health," Piazza says. "We keep people healthier and give them the power to manage their own health conditions."

Three years ago, Adventist Health System formed a population health services organization (PHSO) to support its developing strategy for clinically integrated networks. Piazza describes the health system as being fairly early on its value-based journey but advancing quickly.

In 2016, the PHSO supported services for its 58,000-member, self-funded employee health plan in Florida. Today, the PHSO provides services to support the 210,000 lives attributed to its clinically integrated networks and accountable care organization in Florida, as well as additional services to support value-based contracts for its organizations and networks outside of Florida.

Among Adventist Health System's Florida employee population alone, the health plan has achieved promising results:

- An **8.1%** decrease in admissions per **1,000** members of its employee population year over year.
- A **3.1%** decrease in PMPM costs for its employee population year over year.

One of the keys to Adventist Health System's success: Health management team members developed a set of guiding principles that linked the team's work back to the health system's mission and its brand promise.

"When we acquire a new member population, we continually focus on: How do we promote whole-person care? How does our mission align with our efforts? Then, we link our strategy back to our aspiration," Piazza says. "Reminding our employees of our mission really helps to inspire them and aligns their efforts. When you begin to care for people holistically, this has a significant impact on improving outcomes and reducing costs over the long run."

Piazza and her team also make sure to regularly share success stories with front-line health managers as well as senior leaders.

"This is hard work," Piazza says. "Trying to change human behavior among people who have battled chronic illness for sometimes decades is no easy undertaking. We strive to remind our folks of the impact they are making on our members every day."

She shares the following lessons learned in reducing PMPM costs:

- Improve primary care access to reduce ED utilization.
- Be proactive in working to close gaps in care.
- Benefit plan design changes can help foster access in the right setting. Make sure copay amounts incentivize patients to seek care in lower-cost settings.
- Share actionable data with physicians and team members.

7. Be careful to avoid duplicative effort.

Navigant's Ziegler believes there is such a thing as too much care management. "I've run patient focus groups where patients have said they've received 11 phone calls on the day they came home from the hospital, from 11 different people, with 11 different sets of instructions," Ziegler says. "The hospital calls to make sure it will receive a good patient experience score; the health plan calls; etc. If these players could partner with each other and share information through an integrated platform, this would go a long way toward reducing redundancy and improving the patient experience."

8. Have an end date for care management in mind for every patient.

"Make sure patients know when they're going to 'graduate' from care management," Ziegler says. "Care managers can be reluctant to end care management. There should be a clear endgame when you start the relationship."

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About the Health Plan Alliance

The Health Plan Alliance is a national organization that brings provider-sponsored and independently-owned health plans together with their health system and provider group leaders for unparalleled peer-to-peer collaboration. Alliance member health plans are well represented across various stages of development and all lines of business. For more than 20 years, Health Plan Alliance members have leveraged the collective knowledge of our community to enhance their business acumen and advance the quality of health care delivery in their communities. For more information visit www.healthplanalliance.org or email info@healthplanalliance.org.

