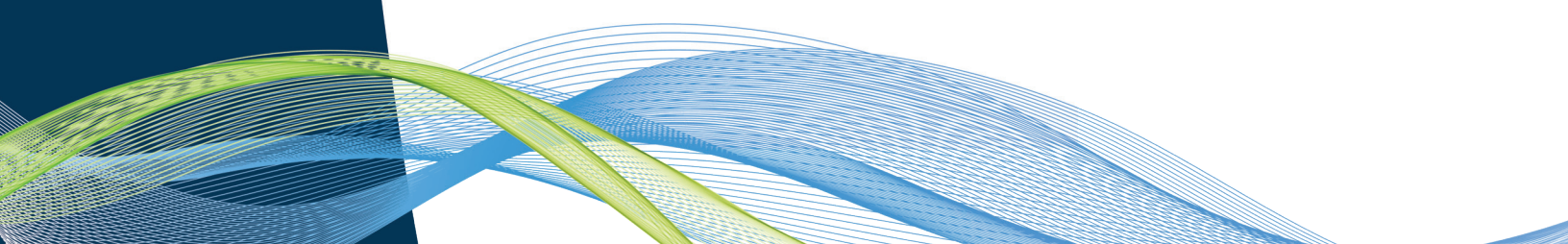




KEY CONSIDERATIONS FOR TPAs
HOW TO RESPOND TO DISRUPTIVE CHANGES
WITH POPULATION HEALTH PROGRAMS



LEADING THE WAY IN CARE MANAGEMENT SOFTWARE



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As the cost of healthcare services continues to climb, the patient is becoming increasingly aware and active in the processing of their healthcare services. The Affordable Care Act may have accelerated the transition from a fee-for-service reimbursement method to a value-based reimbursement method, but this shift in strategy was in motion prior to 2010, both in commercial and publicly funded plans. These industry changes combined with the increasing adoption of new technologies that supplies new data opportunities to health programs, as well as the expanding amount of information available to patients, to contribute to inevitable changes that promise to forever alter the U.S. healthcare system.

A recent publication for Ernst & Young highlighted several disruptive changes that inevitably will affect health insurers.¹ As these disrupters certainly apply to the self-insured as well as the traditional health insurer, this paper provides a closer look at four of these disruptors while also addressing the available opportunity for TPAs to enhance their service offerings with Population Health and Care Management programs to capitalize on the disruption instead of being displaced by the disrupters.

Background: The Four Disrupters

1. Chronic Disease Crisis: The Centers for Disease Control (CDC) reports that as of 2012 about one half of the adults in the United States suffered from one or more chronic conditions and 70% of the top ten causes of death were chronic, non-communicable, conditions. Only two conditions, heart disease and cancer, were responsible for nearly half of all deaths. Furthermore, the CDC indicates that the incidence of obesity is increasing with one third of adults and 20% of youths suffering from obesity.² The increase in chronic conditions has a well-established and unquestionable link to our expanding collective waistlines.

It is well documented that 86% of all healthcare spending is on the treatment of people with one or more chronic conditions.³ However, most chronic conditions are directly linked to health behaviors, either failure to perform a behavior (e.g., failure to engage regular aerobic exercise) or performing an unhealthy behavior (e.g., smoking or excess alcohol consumption). In addition to the direct cost associated with chronic conditions, employers experience indirect costs due to the incidence of absenteeism and presenteeism associated with chronic diseases. Recognizing the behavioral contribution to chronic disease helps to identify the opportunity to improve.⁴

Clearly, there is an opportunity to improve these metrics and improve the health status and quality of life while reducing what are ultimately avoidable healthcare costs.

2. The Move to Outcomes and Value: The National Business Coalition on Health (NBCH) has identified VBP, also known as Value Based Reimbursement, as “a demand-side strategy to measure, report and reward excellence in healthcare delivery.”⁵ Essentially, the most effective, efficient and highest performing health providers and systems will receive enhanced reputations, reimbursement, and market share.

3. “mHealth” Technologies: The World Health Organization (WHO) has defined mobile health (mHealth) as “medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices.”⁶ Most experts predict growth in the utilization of and adoption of mHealth devices like personal health trackers (i.e., Fitbit™, Apple Watch™) and that health IT systems will increasingly be able to access the data from these devices.⁷ These personal health trackers, along with other mobile devices dispersed by healthcare providers (i.e., Wi-Fi enabled scales, blood pressure cuffs, glucose monitors, pill cases), will provide a treasure trove of health data that is certain to radically change the healthcare landscape. Physicians and other clinical staff will be able to see health data that extends beyond a traditional visit with a healthcare provider and begin to offer more tailored approaches to provide proactive outreach to their patients and health system populations.

4. The “Big-data” Revolution: Historically, medical records were a “paper and pen” operation with very little in the way of digitized data. In response to incentives introduced in the HITECH program (part of the American Reinvestment and Recovery Act of 2009) as well as the rise of available mHealth data, the volume of digitized health data has increased exponentially. Reports from as recently as 2013 estimate a total of 153 exabytes (one billion gigabytes) of digitalized health-related data and projections that will swell to 2,314 exabytes by 2020.⁸ Meanwhile, many firms are attempting to make sense of, analyze, and utilize the data to make predictions about individuals within a population as a result of this newly available data.⁹ The buzzwords “predictive modeling” may have given way to “predictive analytics”, but the concept is the same – use machine learning to examine large volumes of data and then identify individuals at early stages of disease progression or increased risk of avoidable hospitalization and work to reduce those risks. The idea of analyzing data to identify and mitigate risk is not new. But the volume of digital data and the power of machine learning are, and these new factors are radically changing the landscape.

Responding to Changes – Planning Population Health and Proactive Care Management Programs

Healthcare financiers recognize that though the population may be increasingly suffering from chronic diseases, the costs associated with those disease states can be mitigated with the strategic use of interventions. In addition, as the industry transitions towards emphasizing outcomes and values, the focus of healthcare services shifts from increasing volume to increasing the quality and impact those services have in truly creating a healthy person and population. These two factors, in conjunction with mobile health IT and big data, are driving the traditionally passive self-insurers to consider new strategies to increase outreach and help their employees to improve their health. Specifically, these new strategies include Care Management and Population Health Management (which is increasingly being referred to as “population medicine”).

Population Health Management (PHM), for the purposes of this paper, is defined as “design, delivery, coordination, and payment of high-quality healthcare services...for a population using the best resources we have available to us within the healthcare system.”¹⁰ Thus, the current population health management strategies are moving beyond the care management interventions of our recent past, utilization management, complex case management and disease management, towards a continuum of outreach and intervention strategies designed to help patients access necessary services to improve their health status in both the immediate and longer term futures. Kevin Schlotman, Director of Employee Benefits at Benovation, a Third Party Administrator in Cincinnati, Ohio, wrote last year, “Population Health Management (PHM) is the critical core component that all self-funded plans must consider if they want to improve results.” Schlotman then explains, “PHM works as the ‘Big Data’ application within your health plan, with an improvement on the not-so-new legacy Predictive Modeling programs.”¹¹

The authors of this paper spoke with proven Population Health Management program managers for TPAs and service providers to discuss considerations for TPAs who are considering the implementation of a PHM or Care Management program. The following five factors emerged as important considerations for TPAs and service providers in this situation:

1. In-House vs. Outsource (also on-site vs. telephonic): (also on-site vs. telephonic): TPAs that are considering the addition or enhancement of PHM services must consider if they have the expertise in house, if they want to build the expertise, or, whether it makes more sense to find a proven service provider and outsource part, or all, of the PHM programs. There are good arguments on either side of this question.

According to Dawn Kind, VP of Clinical and Operational Informatics at Prairie States in Sheboygan, Wisconsin, “We believe that the employer (client) benefits by having all of their services provided under one roof and that we are able to be much more timely in our responsiveness to the employer.”

Additional considerations are presented by Amy Gasbarro, President for MCM Solutions for Better Health in Chicago, Illinois, “A TPA considering building a care management program should consider not just the costs of staffing and supporting the program, but will they be able to find and recruit the qualified nurses, social workers and therapists, with the specialty certifications assuring their expertise?” She further adds that “what we provide to TPAs and their employer customers is the assurance of independence in medical reviews and care management.” On a related note, Dwight Mankin and Joseph Swee- ney argue that TPAs and self-insured employers need to go beyond considering providing the case management service and move to ensure the case manager is providing the services “on-site,” instead of merely over the phone, for patients suffering from more severe diseases. They state that, “for more complex conditions and longer term, high-dollar claims, telephonic case management can fall short of providing a thorough evaluation of the patient’s care and long-term prognosis.”¹²

2. **Create A Seamless Continuum of PHM/CM Strategies:** Both Kind and Gasbarro describe a continuum of clinical services under the PHM or CM umbrella. Kind reported, “each member moves back and forth or up and down the PHM/CM continuum (wellness <-> complex CM) as their condition and status change.” Through this strategy, the patient and their caregivers or family appreciate the fact that they have support and feel well taken care of all along the way. She gives the example of “a health coach in the FiveStar Health Program might encounter a patient and find out they have many complex health needs for which they haven’t been seeing providers and will refer to the Specialty Case Management program to help that patient get fully connected to the healthcare system, then navigate through that system, ensuring the patient gets timely and appropriate health services.”
3. **Single Platform/Data Transparency:** Given the goal of having a continuum of clinical care management services, it is important that the staff working in each program have visibility into what the others may be doing with the patient. Gasbarro shares, “Each clinician is able to see the actions of the others who might be involved, or were involved, in the care management of the patient over time.”

This became apparent when MCM acquired a competitor’s case management service company. “The clinical staff were used to using a limited DOS-based software system but were otherwise doing things on paper. Bringing them onto the same platform as was being used by the clinical staff in our home office allowed continuity between the two programs as we brought them together into one.” Kind reinforces this by sharing, “Having all of the care management staff on a single platform enhances the holistic nature of the care management program. The level 1 and level 2 case management cases are all entered as cases in the ACUITY™ platform and assigned to team members accordingly. As case needs arise and new encounters need to be documented, those can be associated with the case or a specific UM record allowing an easy-to-use workflow matched with the 360° patient summary.”

4. **Robust Reporting:** PHM and Care Management programs must be able to demonstrate their effectiveness. As noted previously, we are in the age of big data and a program that cannot generate its own data should be questioned. To this point, Schlotman emphasizes the benefits of robust reporting, stating that “baseline statistics will establish measurable events, such as inpatient hospital admissions, length of stay, and the number and cost of events associated with chronic conditions – all of which can be compared year over year to establish whether or not the plan is having the desired impact.”¹¹

When discussing this factor, Kind emphasized that “reports can be customized to meet the needs of the individual employers.” She explained that more recently they’ve begun to “marry the claims data with the care management data to produce a more comprehensive and meaningful report for the employers.”

Gasbarro further elaborates on MCM reporting needs, which are more complex as they interact with multiple TPAs and their respective claims systems, employer reporting, etc. “Most clients these days want automated daily or weekly reporting that not only allows them to see what is happening from a care delivery perspective but also feeds directly into their claims system, providing no-touch claim adjudication for those requiring UR authorizations. Most clients are getting an authorization extract for claims adjudication on a nightly basis. TPAs also need regular reporting for their stop-loss carriers. We work to customize the reporting needs and ensure this gets to the stop-loss carriers to help mitigate issues down the road.”

5. Workflow Support and Automation: Clinical staff are often some of the most expensive members of the labor pool, especially as they tend to be highly specialized. With robust information systems, anyone considering creating or enhancing a PHM/CM program must seek opportunities to automate elements in the process. Gasbarro shared some of the automation techniques used by MCM. She explained, “We use a stratification and automation tool to build a robust program of referrals and actions based on data triggers. This then automates case creation and communication with patients and providers.”

Ultimately, every TPA knows that the employer is their customer and it is incumbent on the TPA to help the employers to maximize their healthcare dollars and to help enhance the health status of the employees. In regards to the payoff for TPAs, Kevin Schlotman states that “40-60 percent of your claims expense is the direct result of chronic, preventable illness. An effective program that makes just a 10 percent dent in these costs will save four to six percent.”¹¹ Implementing a PHM or Care Management strategy will certainly be cost effective, but it’s also important to remember that such a strategy will also enhance the life and well-being of the employees that are so vital to the success of every employer. ▲

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References

- ¹ The Future of Health Insurance: A Road Map Through Change. *Ernst & Young*. March 2016. [http://www.ey.com/publication/vwluassets/ey-the-future-of-health-insurance/\\$file/ey-the-future-of-health-insurance.pdf](http://www.ey.com/publication/vwluassets/ey-the-future-of-health-insurance/$file/ey-the-future-of-health-insurance.pdf). Accessed April 20, 2016.
- ² Chronic Disease Overview. Chronic Disease Prevention and Health Promotion. <http://www.cdc.gov/chronicdisease/overview/>. Published August 26, 2015. Accessed April 20, 2016.
- ³ Chronic Disease Overview. Chronic Disease Prevention and Health Promotion. <http://www.cdc.gov/chronicdisease/overview/>. Published August 26, 2015. Accessed April 17, 2016.
- ⁴ Hemp P. Presenteeism: At Work–But Out of It. *Harvard Business Review*. October 2004. <https://hbr.org/2004/10/presenteeism-at-work-but-out-of-it>. Accessed April 20, 2016.
- ⁵ Value-based Purchasing: A Definition. NBCH: Value-based Purchasing Guide. <http://www.nbch.org/value-based-purchasing-a-definition>. Accessed June 17, 2016.
- ⁶ *MHealth: New Horizons for Health through Mobile Technologies*. Vol 3. Geneva: World Health Organization; 2011. http://www.who.int/goe/publications/goe_mhealth_web.pdf. Accessed April 15, 2016.
- ⁷ 2016 HIMSS Connected Health Survey Suggests Positive Future for Connected Health Technologies in U.S. Hospitals. HIMSS: Transforming health through IT. <http://www.himss.org/news/2016-himss-connected-health-survey-suggests-positive-future-connected-health-technologies-us?itemnumber=47223>. Published March 2, 2016. Accessed April 17, 2016.
- ⁸ Industry Brief: Digital Universe Driving Data Growth in Healthcare. EMC: Healthcare and Life Sciences Solutions. <http://www.emc.com/analyst-report/digital-universe-healthcare-vertical-report-ar.pdf>. Published November 26, 2014. Accessed April 20, 2016.
- ⁹ Hede K. How Predictive Analytics Are Transforming Health Care. *H&HN Daily*. <http://www.hhnmag.com/articles/7011-moneyball-mindset-is-transforming-health-care>. Published April 7, 2016. Accessed April 20, 2016.
- ¹⁰ Gauthier J. Populations, Population Health, and the Evolution of Population Management: Making Sense of the Terminology in US Health Care Today. IHI Leadership Blog. http://www.ihl.org/communities/blogs/_layouts/ihl/community/blog/itemview.aspx?list=81ca4a47-4ccd-4e9e-89d9-14d88ec59e8d&id=50. Published March 19, 2014. Accessed April 15, 2016.
- ¹¹ Schlotman K. How to Transform Your Self-Funded Plan from Good to Great. *Self-Funding Magazine*. March 2015. <http://www.selffundingmagazine.com/article/how-to-transform-your-self-funded-plan-from-good-to-great.html>. Accessed April 17, 2016.
- ¹² Mankin D, Sweeney J. Onsite Case Management an Effective Way to Control Shock Claim Costs. *Self-Insurer*. 2016;91(May):22-24. https://issuu.com/sipconline/docs/self-insurer_may_2016. Accessed May 25, 2016.



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