COPE HEALTH SOLUTIONS

Gaining Control of the Total Cost of Care: Designing Effective Organizational Care Management

Yomi Ajao
Senior Vice President

Shanah Tirado
Manager

Background

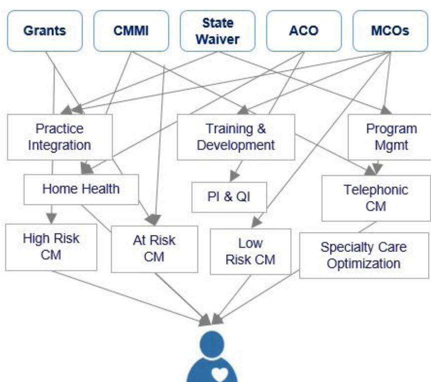
A health care organization can only profitably bear as much financial risk as it can consistently manage the utilization and health outcomes of its attributed population. In today's market, being a risk bearing entity is to be in the business of care management. Health care organizations across the continuum are engaging in strategic experimentation on financially sustainable yet clinically effective care management strategies. Successful care management is a critical competency that organizations must either own or subcontract in order to remain economically sustainable in a value based payment (VBP) environment. Local markets across the country are hitting their tipping point of VBP penetration, and the country is currently in second and third iterations of various federal and state demonstration projects. The Center for Medicaid and Medicare Innovation (the CMS Innovation Center) has begun to collect and distribute toolkits and best practice information (such as the ACO Care Management Toolkit) to support businesses in design and implementation of VBP strategies. Specifically, these toolkits highlight specific initiatives that have proven successful in managing cost and quality.

Care management, like most aspects of business, is not one-size-fits-all. While the market is beginning to converge on *what* to do, there is still the hurdle of figuring out *how* to do it within *your* organization. Furthermore, while understanding what to do for specific care transitions, populations or service lines is essential knowledge, building a cohesive care management strategy that supports a suite of initiatives is more complex. Scale, interoperability and cross-functional involvement are critical success factors in managing total cost of care. To be impactful on the bottom line and on population health, care management must tightly coordinate with contracting, finance and network development at an organizational level, while initiatives are tools to drive broader strategic goals. **This article discusses a framework to consider while navigating the operational and financial challenges inherent in any care management organization formation.**

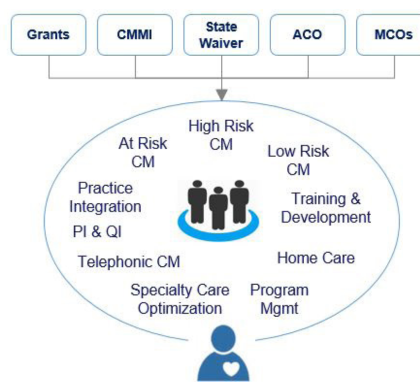
"Care management, like most aspects of business, is not one-size-fits-all. While the market is beginning to converge on *what* to do, there is still the hurdle of figuring out *how* to do it within *your* organization."

Delegated, Federated and Centralized Models

Today: Condition and Funding-based Care Management



Tomorrow: Proactive Centralized, Whole-Person Care Management



Legend

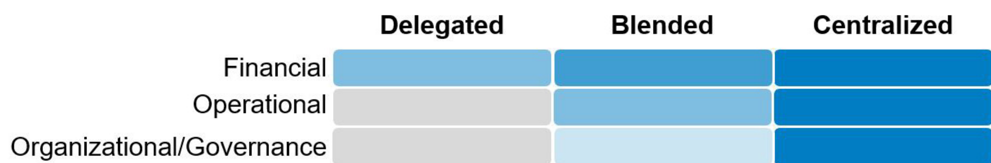
CMMI = Center for Medicare & Medicaid Innovation
ACO = Accountable Care Organization
MCO = Managed Care Organization
PI QI = Process and Quality Improvement
CM = Care Management

Most organizations seeking to establish care management programs attempt to build on a service-line-by-service-line or condition-by-condition basis, narrowly defining the scope of care management teams and executing staffing plans to meet the envisioned scope within a single, silo unit or initiative. This usually results in redundant programs and ineffective patient engagement/adherence. This also results in the development of reactive IT solutions to meet individual documentation and reporting needs and multiple workflows, IT platforms and processes that reduce efficiency and make care coordination challenging.

More sophisticated and robust approaches to care management embed this competency throughout the organization, identifying and targeting care management transactions that take place across a broad array of settings and establishing roles and responsibilities to ensure the patient's needs are met regardless of where the transition in care takes place.

In these more comprehensive models of care, leadership formally establishes key relationships, clearly defined roles and standard processes that drive care management success. Leaders then develop success metrics and implement integrated technology essential to successful care transitions and management. Providers proactively identify patient needs and trigger pre-defined processes, limiting reactivity and improving the efficiency and quality of care delivery. This ethos must extend beyond a single provider organization and into the network of community providers that each play a role in member care. Importantly, this is inclusive of social service providers not traditionally embedded into core workflows, network development efforts, contracting models and billing infrastructure. A robust care management strategy integrates clinical and social determinants of health (SDOH) into all aspects of the model.

In designing an approach to building out a care management function, considering current state market dynamics, payor relationships, existing provider network, data access capabilities, care coordination infrastructure and internal organization dynamic is an essential first step. On a high level, care management can exist on a continuum of delegated to centralized, with increasing scope of influence across three levers – financial, operational, and organizational/governance.



- Little to no influence
- Some influence and alignment efforts, no accountability
- Moderate influence, shared consequences to poor alignment
- Indirect influence and shared accountability
- Direct influence and shared accountability

In any scenario, these levers of influence are how risk-bearing entities can promote the achievement of performance measures and quality care delivery.

Financial

Financial influence is fundamentally independent of the model chosen and allows the risk-bearing entity to align and orient all stakeholders toward the common goals of care coordination, cost and utilization management and quality performance. While some process metrics are tied to financial incentives, this lever alone cannot define how an organization coordinates care or manages costs and utilization. Its primary motivator is to capture of savings with high levels of autonomy across

providers. Notably, influence diminishes the “further away” from the actual contract arrangement. For example, when delegating care management to a provider or group, there is significant reliance on that provider to successfully incentivize and manage downstream clinical and SDOH partners. This places emphasis on the importance of contract structure and deliberate communications to establish visibility and timely corrective action as needed. As care management becomes more centralized, the number and variability of contracts is reduced, and organizational oversight increases, increasing influence and standardizing the care model throughout the network. Increased influence fosters confidence in committing to more ambitious performance targets and accessing more premium in risk based contract arrangements.

In all cases, a deliberate contracting strategy is paramount. First, improved alignment across contracts allows for clarity in operationalizing clinical and SDOH initiatives and measuring both risk and ROI. Secondly, a tight relationship between contracting, finance, UM and clinical teams builds alignment between contracts and operations, translating ROI potential into reality. Lastly, contract design promotes alignment where direct operational and organizational oversight is limited. This is accomplished through contract features such as tying care management fees to specific activities – such as participation in care team huddles - and quality bonuses tied to HEDIS measures and/or strategic process indicators to promote alignment to the centralized care model. There are seemingly infinite ways to customized contracts and prudent organizations harness access to multiple payment sources and contract elements.

Operational

This lever aims to standardize care models, utilization management and general core operational processes. Independent of where the process is defined, it must address and codify the following activities:

1. Member Identification – understand the population and for whom a health system is at risk
2. Risk Stratification – using data and logic to determine which members are most likely to be impacted by care management interventions and wellness/prevention initiatives
3. Member Attribution – systematic assignment of members eligible for care management to a care team that will be accountable for patient outcomes
4. Care Management Delivery – designing evidence-based care management interventions and wellness/prevention initiatives that meet the clinical and SDOH needs of both the member and the organization
5. Care Management Workforce – staffing the care management interventions with the adequate number of clinical and non-clinical resources and skill sets to meet member volume and needs
6. Evaluation and Reporting – identifying key performance indicators that will support program and outcome evaluation without unnecessary overhead
7. Enabling Infrastructure – integrating other core infrastructure to support population health management programs including IT solutions, scheduling and call center, social service organizations/programs, etc.

In a federated model, there are some partnerships, and perhaps even some employed providers that are aligned around organizational processes at minimum for specific populations and at care transitions. While IT systems and resourcing may not be supported centrally, financial incentives support active participation in care teams for managed members, with clear processes and workflows in place to facilitate coordination of care. Some organizations with ample scale are able to establish care management hubs that operate consistently and coordinate through partnerships and workflows with other network providers. Most organizations are able to establish a federated model, under the goal of creating robust hubs and tight coordination with network providers. Hubs can begin to establish elements of a centralized model within their patient panels.

In a centralized model, operational alignment goes beyond workflows and is supported and considered within broader organizational decisions. It enables resource management aligned with priority initiatives for the broader organization, more fully shared savings (and losses), and participation in risk pools to support investments in care management initiatives at the point of care. Alignment at this level fosters control over utilization and referrals, driving volumes to appropriate care settings and high performing providers. Similarly, it facilitates information sharing and enables patient-centered care. The ability to monitor performance, set targets and deploy resources rests on the establishment of some organizational forum or shared governance to facilitate decision making.

Organizational/Governance

In developing a centralized care management function, accountability and authority runs through a clear reporting structure to a central care management organization. This requires thoughtful inclusion of network members on boards, committees and workgroups to develop and implement care models, evaluate network and provider performance and correct course of action. These structures work closely with internal finance and managed care contracting functions to bring alignment to the structure of payor and MCO incentives down through the prioritization of populations and clinical interventions and downstream contracting. Utilization management evolves from a barrier to a partner in care management. Preauthorizations are leveraged in alignment to member needs and care plans to limit avoidable barriers to care. Financial goals are tempered with clinical perspectives on feasibility and resource needs; contracted financial and performance targets are informed by the feasibility given stage and scope of clinical initiatives. Similarly, resourcing and funding for these initiatives is informed by such targets instead of legacy budgeting and silo resource management. The ROI of embedded models, investments, and resource deployment becomes more transparent and targeted. While a fully integrated and centralized model is difficult to establish, many features of that model can be embedded into the organization to drive strategic and financial rigor and prepare the network for more advanced VBP models.

To learn more about building a care management strategy right for your organization, please contact Shanah Tirado at stirado@copehealthsolutions.com or (213)-369-7415.

COPE Health Solutions is a national leader in helping health care organizations succeed amid complexity and uncertainty

For more information, please contact Shanah Tirado, Manager, COPE Health Solutions at stirado@copehealthsolutions.com or call (213)-369-7415.