

Care Management 2012: Market Sensing, Trends & Predictions

Presented by:

casenet^o

Health Management
...As if *You* Designed It

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2012 Top Trends & Predictions

Below are top strategic areas of interest and investment across organizations involved in Care Management and Care Coordination:

Trend Index	Position	Initiative
Hot 	Taking Action	➤ Shift Back to In-House Care Management
Hot 	Taking Action	➤ Non-medical services related to Home and Community Services, Transportation Management
Hot 	Taking Action	➤ Collaboration & Automated Workflow and Alerts
Hot 	Taking Action	➤ Compliance & New Business Model Adaptation
Warm 	Mixed	➤ Interoperability & Business Intelligence (BI)
Warm 	Mixed	➤ Member / Provider Portals

#1: In-House Care Management

Organizations are shifting back to “in-house” CM, DM and UM programs or expanding existing programs to new lines of business

- **Outsourced, Third Party Services reporting marginal performance**
 - Plan Cost of an indirect patient relationship. Some regulations necessitate CM programs.
 - Plan Cost of brand recognition.
 - “Outsourced” or “Contingency” model challenges.
 - Lack of control, Lack of customization and responsiveness to market needs/changes for population segments.
- **Health Plan rebranding to “health and care”**
 - Re-establishing value to members, providers, partners, constituents and market.
- **Lack of a Single, Integrated Care Management Platform**
 - Fragmented and confusing member / patient and provider experience.
- **Legacy System Challenges**
 - Information and communications integration challenges, Lack of common data model.
 - Expensive interface third party maintenance and upgrades.
 - Data sharing, accuracy and quality Shift to “real-time” care.

#2: HCS & Transportation Services

48 States support benefits for HCS & Transportation services

“Forty-eight States and the District of Columbia offer services through HCBS waivers ... currently there are approximately 287 active HCBS waiver programs in operation throughout the country.” (Source: CMS.gov)

➤ Home and Community Services (HCS)

- Home-based care and services as an alternative to LTC facility admission
- Traditional UM, CM and DM functionality does not support the HCS service
- Authorize, schedule, track and manage HCS services for eligible Members
- Member drives care planning, goal development & approval of services
- “Team” based care model and group task assignment for health plan resources
- HCS specific assessments, tasks, challenges, interventions and correspondence
- States have different requirements, program framework needs to be flexible
- Track member’s satisfaction, service effectiveness and outcomes

➤ Transportation Management (Ride Requests)

- Contain cost and prevent abuse of Transportation benefits (ride requests)
- Traditional UM and CM functionality does not support this service
- Authorize, schedule, track and manage ride requests for eligible Members

#3 – Collaboration & Workflow

Efficient Workflow & Care Team Collaboration

➤ **Single Member Record**

- Integrated, Automated Care Plans
- Automated, Integrated and Proactive Communication / Alerts
 - Less of a single point of contact focus. Integration of technologies that support communications/alerts coordination evolve so that all the points of contact have access to information, communications, activities and interactions.
- Automated Workflow & Proactive “Actions” identifying care opportunities

➤ **Efficient Workflow & Care Team collaboration**

- **End User customizable business rules for unique product, program attributes by LOB, population or individual**
- **Greater flexibility and agility to respond to rapidly changing health, market and regulatory priorities**

#4 – Compliance & New Business

Adapting to Industry Change and Contractual Requirements

➤ Industry Change Management

- Ongoing NCQA and URAC accreditation / re-certification
- Medicare / Medicaid compliance audits and quality ratings (STAR)
- ICD-10

➤ Regulatory Change Management

- CMS Shared Savings Program – ACO Final Rule (11/2/2011)
 - Quality & Cost reporting requirements
 - Satisfaction Surveys & Patient Engagement requirements
- CMS also has quality based payment programs outside of ACO rule which enables more care management technology adoption and importance.
- Starting Fall 2011, the federal Medicare program will withhold 1% of a vital payment—totaling an estimated \$850 million, with the percentage doubling to 2% in 2017 (source: Wall Street Journal)

➤ Customer Contracts

- Wellness programs, Quality ratings
- Utilization, cost avoidance and cost containment performance measures

#5 – Interoperability & BI

Data integration & mining powers shift to support proactive care

➤ **Integrated Workflows and Data Exchange between systems**

- EMR / EHR interfaces with CM & DM Automated Workflow & Business Rules
 - By 2015, when Medicare plans to impose financial penalties on doctors who have not digitized their records, physician adoption could exceed 80%²
- Pharmacy and Lab data integration
- Predictive modeling
- Learning systems to promote best practices and outcomes

➤ **Align Care Providers with Care Teams**

- Integrated plans, tasks, alerts and notifications become bi-directional
- Automated Care Opportunity (Gap in Care) identification & communications

➤ **Data Quality and Accuracy**

- Quality reporting
- Member care planning and monitoring of overall health status
- Support quality-based & evidence-based clinical decision making

➤ **Exception-based automated workflow, alerts and notifications**

#6: Member / Provider Portals

Making “Member-Centered” a reality... from a Patient’s POV

- **Member adoption is broadly hovering between 5% to 20%**
 - Varies by many demographic, social, economic and health condition factors
- **Provider adoption is broadly hovering between 10% to 30%**
 - EMR adoption predicted to be 80% by 2015²
 - Limits future need for Health Plan Portal as EMR & Real-Time services increase
- **Improving experience, service & satisfaction**
 - Improved Online Access & Collaboration Tools
 - Better Communication & Follow-up (multi-channel approach)
 - Automated Workflow & Proactive “actions”
 - ACO Shared Savings rule requires surveys & engagement
 - Customizable communications channels, by LOB, by patient
- **Wellness incentive programs and Health Coaching**
- **Efficient workflow & Care Team collaboration**
 - An accurate, 360 degree view of the patient, care activities and communications

Summary

Care management solutions is the new “strategic hub” for health data and managed care organizations.

“In the rapidly evolving reform decade, healthcare payers — traditional health insurance plans and emerging nontraditional risk-bearing, incentive-based organizations such as accountable care organizations (ACOs) — will differentiate themselves through their ability to improve outcomes, demonstrate performance, and control costs. Key drivers are:

- Strategic focus on illness avoidance (health and wellness) and then best practice, cost-effective clinical care, when needed
- Integrated reimbursement strategy linking payments and incentives to outcome and performance
- Enhanced consumer engagement and incentive programs to increase personal responsibility, commitment to health and wellness, and participation in care management programs
- The emergence of value-based sales and payment strategies linked to outcomes and performance

In response, healthcare payers are shifting business and technology resources to health, wellness, and health management initiatives, and the related business intelligence solutions that support these efforts.”¹

Acknowledgements

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Footnotes:

- ¹Janice Young, IDC Health Insights. “Care Management: The Reform Era Strategic Hub”. December 2011
- ²Colleen Woods, New Jersey Health Information Technology

About Casenet, LLC

www.casenetllc.com

Casenet, LLC provides a comprehensive suite of member-centered care management software and service solutions, including Case Management, Disease Management, Utilization Management, Appeals, Health and Wellness, TruRemote, Total Population Management, Portals, and Operational Reporting that enable organizations to align to their unique requirements and to adapt quickly to changing market and regulatory dynamics. At the heart of the system is a highly client-configurable foundation called Differential Care Management (DCM). DCM enables organizations to isolate and target populations having unique risk characteristics and to deliver specific care management programs for those members.