



PBGH
PACIFIC BUSINESS
GROUP ON HEALTH

Best Practices in Care Management Contracting for the High-Need, High-Cost Population

July 2018

Executive Summary

Health care providers across the country are increasingly adopting programs to better serve high-need, high-cost (HNHC) patients. This report and the accompanying contracting guidance are led by the Pacific Business Group on Health (PBGH) and the Health Care Transformation Task Force (HCTTF), with support from The Commonwealth Fund and The SCAN Foundation. This work discusses strategies and terms underlying payer-provider arrangements that can help organizations effectively contract for programs that improve the health and outcomes of HNHC individuals.

This report is structured into two sections, in accordance with the provider roles that are likely to find this work most relevant. The first section focuses on strategic insights for Delivery System Executives. The second section addresses tactics for Contracting and Clinical Program Management, such as Contracting, Finance, and Clinical Program Managers/Directors, who develop contracts and design programs in accordance with the provider organization's strategy.

Contracting strategies will also differ based on the populations included in the contract. Organizations may create contracts for the entire patient population with a subset of medically complex patients receiving unique services, or contract primarily for medically complex patients. Where applicable, guidance is provided for the different populations: Whole-Population Contracting, which includes management of a smaller subset of HNHC-eligible individuals, and HNHC-Targeted Contracting for vulnerable populations, typically including full or mostly capitated contract arrangements.

Strategic Insights for Delivery System Executives

Health care decisionmakers should consider the following insights in their strategic planning:

HNHC-Targeted Contracting

- Conduct a thorough readiness assessment of organizational culture, infrastructure needs, operational capability, and performance measurement capabilities before moving toward advanced risk or fully capitated contracts;
- Ensure that contracts last between three to five years to give the organization time to fully develop its program and appropriately calibrate to the managed population; and
- Factor in the importance of service area demographic variations when designing programs and developing contracts.

Whole-Population Contracting

- Consider investing internal resources in care management as part of a longer-term strategy to support population health, rather than relying on potentially unstable external reimbursement;
- Establish a culture of open communication between business units so that clinical and operational decisions align with contract structures and expected financial return; and
- Seek to enhance the connection between administrative/clinical leadership and front-line care delivery providers to ensure that providers are equipped with adequate tools and resources to support multiple populations and lines of business.

Tactics for Contracting and Clinical Program Management

Staff leads should consider the following tactics for contracting and program development in 4 areas (or categories):

1. Identification and Segmentation of the Target Population

Identifying individuals with persistently high needs and costs through risk stratification, then further segmenting by specific need type, is critical to improved outcomes and financial sustainability. Specific tactics for identification and segmentation include:

HNHC-Targeted Contracting

- Develop systems and processes to proactively identify target geographic areas and specific HNHC individuals the organization hopes to serve.

Both HNHC-Targeted & Whole-Population Contracting

- Employ highly refined internal segmentation criteria to ensure that HNHC individuals are appropriately slotted into relevant disease-specific care management programs and can receive appropriate medical and social support services.

2. Care Management Program Design

Care management program design and the level of internal investment must be synergistic with contract structure and the organization's ability to capture utilization savings. Insights/recommendations for program design are dependent on contract type, and include:

HNHC-Targeted Contracting

- Consider how the organization can build additional flexibility into operational infrastructure to respond to an HNHC population with extensive and diverse needs, such as fluid team-based care structures that tailor services and staff to the individual.

Whole-Population Contracting

- Ensure robust communication processes are established between clinical operations, contracting, and finance.

Both HNHC-Targeted & Whole-Population Contracting

- Build alternative care team structures that utilize non-clinical staff as primary points of contact;
- Consider panel size — as well as an organization's ability to tier patients within a panel based on acuity level — as critical to program sustainability; and
- Determine whether it is an organizational necessity to subcontract for services such as behavioral health.

3. Ensuring Access to Data

Guaranteed access to data is critical for successful care management, as is ensuring contractual specifications on both the type of data and the frequency with which it is shared. Insights for data contracting include:

Both HNHC-Targeted & Whole-Population Contracting

- Contract to receive daily census data and/or real-time alerts when individuals are admitted to a facility and/or transitioned from one health care setting to another;
- Push for access to supplemental health information, such as social determinants of health and behavioral health information, as available; and
- Share HNHC program enrollment data with as many relevant parties as necessary, including payers and downstream providers.

4. Financial Sustainability and Return on Investment

For an HNHC care management program to be truly sustainable, the program should provide a return on investment (ROI) over the course of multiple years and meet specified contractual targets. Insights for successfully generating ROI include:

Both HNHC-Targeted & Whole-Population Contracting

- Develop processes for continual refinement of ROI calculations; and
- Build organizational capacity for data-driven analysis.

Introduction

Health care providers are increasingly adopting programs to better serve high-need, high-cost (HNHC) patients, a small percentage of individuals with complex medical, social, and behavioral needs who utilize the largest proportion of national health care resources.¹ A significant barrier to widespread adoption of these HNHC programs is garnering adequate payment for services. By establishing a deeper understanding of how to optimize payment and contracting approaches, providers can develop better methods for sustainability.

There are two broad underlying payment structures for HNHC individuals: payment based on an individual encounter, or fee-for-service, and responsibility for a population's total cost of care, or capitation/global payment. Within each of these categories, there are a variety of ways in which payments can be structured.²

This project, led by the Pacific Business Group on Health (PBGH) and the Health Care Transformation Task Force (HCTTF) with support and guidance from The Commonwealth Fund and The SCAN Foundation, expands upon the models described above. It examines contracting strategies and terms underpinning the payment arrangements between payers and providers to support effective care management programs for those who are HNHC across all lines of business (Medicare, Medicaid, and Commercial) and at varying stages of risk. The primary goal of this report and accompanying contracting guidance is to help provider organizations understand how to effectively contract for programs that improve health and outcomes of HNHC patients.

Project Overview

This report and the accompanying contracting guidance are products of in-depth interviews with organizations who have operated sustainable, effective care management programs for those who are HNHC for at least two years. To identify and select organizations, PBGH and the HCTTF engaged a panel of experts. Program inclusion criteria were defined as:

- Care model evidence of improved person-level outcomes and cost reduction;
- Business sustainability for at least two years without grant funding; and
- Applicability to the current business environment and replicability across multiple sites.

Target Audience

As the interviewees were largely health systems, integrated care delivery systems, or physician organizations, the insights and recommendations in this report are primarily targeted toward provider organizations that are considering creating programs, are currently in the development process, or have already established programs for HNHC individuals and now seek payment for these services. While many providers may have HNHC programs already in operation, the guidance may be helpful for those looking to make a strategic contracting decision and/or create a business case for an HNHC program.^{3,4}

1 Often described as the top 5% of patients who account for nearly 50% of total spending. *NIHC Concentration of Health Care Spending* (Washington, DC: National Institute for Health Care Management Foundation, July 2012). <http://www.nihcm.org/pdf/DataBrief3%20Final.pdf>

2 Fee-for-service categories include: simple fee-for-service, fee-for-service linked to value, and alternative payment models built on fee-for-service architecture. Whole-population subcategories include: condition-specific (partial) capitated payment, full capitated payment, and integrated delivery system/global budgets. These categories were identified by the Health Care Payment Learning and Action Network, and can be viewed in greater detail at: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

For additional information on how these categories can be applied to the HNHC population: https://hcttf.org/wp-content/uploads/2018/01/HCTTF_PaymenttoPromoteSustainabilityofCareManagementModelsforHi...pdf

3 While this report is written primarily for a provider audience, this paper will be instructive to payer organizations interested in implementing effective provider-focused programs through network contracts. Readers who are payers may find the accompanying tool, which provides specific guidelines for contract inclusions, particularly helpful. We recognize that health plans can be very effective drivers of care management programs; however, health plans were not the primary interviewees for this project, so our findings are less specific to this group.

4 This research did not go into detail on where care management programs are located within the organization (i.e., co-located with primary care practices, etc.). However, it should be noted that interviewees had different approaches to care management locality.

Within provider organizations, two audiences are likely to benefit most from this research: strategic decisionmakers and contracting and clinical program management. The report is structured into two sections with the following provider audiences in mind:

- Delivery System Executives making strategic decisions on investing in care management programs for HNHC populations. This section addresses the key strategic decisions that leaders need to address before contracting teams or clinical leaders can execute successfully.
- Contracting and Clinical Program Management, including Contracting, Finance, and Clinical Program Manager/Directors, who design contracts, conduct financial assessments, and develop clinical care management programs as aligned with the provider organization's strategy. This section includes tactical and operational guidance to help these individuals successfully execute on the contracting strategy.

Strategic Decisions for Delivery System Executives

Organizational care models and contracting practices are deeply intertwined, but varying organizational strategies alter how one influences the other. In some cases, an organization creates a successful care model for HNHC individuals and negotiates contracts to support it. In others, the organization uses the terms of the contract to define the care model deployed. Much of the organization's strategy, and therefore operational execution, depends on:

- Whether the organization is serving HNHC populations as part of a whole-population contracting strategy (such as through accountable care contracts) or contracting targeted at HNHC individuals (HNHC-targeted contracting) as their core business model; and
- The type and degree of contracted risk.

We have identified distinct sets of key insights and recommendations based on the type of contracting strategy a provider organization uses to support its care management programs. It is important to note that this report uses the term 'Whole-Population' not as a synonym for capitated payment, but rather as a distinction between contracting approaches for a general population versus a targeted HNHC population.

HNHC-Targeted Contracting

Five out of 11 interviewees contract primarily for vulnerable populations such as elderly and special needs, which typically translate to the HNHC segment of the broader population. These organizations (Landmark, ChenMed, Brooklyn Health Home, and Virginia Care Transitions) have built their organizational models and care management programs to successfully treat individuals who are at higher risk for becoming HNHC.

All of the HNHC-specific contracting organizations interviewed are in full or mostly capitated arrangements that focus on providing coordinated care to patients with unmet needs. While the savings opportunity is significant, so is the potential for losses.

Key Insights and Recommendations:

Results-Driven

Interviewed organizations also noted that contracts were typically created after the organization had developed both a robust program design and method for estimating the cost and services required for the HNHC population. Essentially, the organizations let their care models drive contract negotiations.

Readiness is Key

For organizations that are still developing their programs and/or have not engaged in advanced risk contracting before, executives should conduct a thorough organizational readiness assessment of organizational culture,

infrastructure needs, operational capability, and performance measurement capabilities before moving toward advanced risk or fully capitated contracts.⁵

Long-Term Engagement/Investment

Relatedly, organizations also articulated that expectations for ROI on care management programs should be reasonable and appropriately timed. Executive leaders stressed that annual contracts are simply not long enough for organizations to recoup investments in care management infrastructure. New contracts should ideally last between two to five years to give the organization time to fully develop its program and appropriately calibrate to the managed population.⁶

Service Area Definition

Furthermore, these organizations typically put more emphasis on locating services geographically near target HNHC populations. Geographic locality is important and a driver of program success.

"...We will look at demographics and find the areas where the people have been dramatically underserved, as we see it, and that is where we put up centers. HNHC is not merely a percentage that we have to figure out, it's the focal point for our mission."

-Physician Group Executive

Whole-Population Contacting

Five of the 11 interviewees utilize whole-population contracting for their care management programs. These organizations (Denver Health, Partners HealthCare, Sharp Rees-Stealy, Sutter Health, and Trinity Health) pursue contracts across multiple lines of business and build care management programs to be successful within their population-based contracts.⁷ These organizations' contracts may include a fixed per-member/per-month or per-member/per-year (PMPM/PMPY) fee for care management services as part of a larger population health contract, or may incorporate care management as part of a broader value-based strategy such as an accountable care organization (ACO).

Key Insights and Recommendations:

Movement Toward Risk

Participants revealed that higher levels of care management investment typically occur when organizations have made a commitment to pursue value-based care as part of a longer-term population health strategy, often related to moving from fee-for-service to advanced risk contracting. Even if contracted reimbursement for HNHC care management is insufficient for some populations in the short term, a broader strategic perspective on the value of investing in infrastructure and resources to support these programs, and a commitment to enrolling individuals based on need, leads to better population health management than selectively enrolling individuals only if they surpass a baseline contracted PMPM/PMPY reimbursement amount.

5 HCTTF has developed a strategic framework and accompanying reports for executives interested in helping their organizations transition from fee-for-service to value-based payment. Framework and reports are available at: <https://hcttf.org/2017-9-13-the-transformation-to-value-a-leadership-guide/>.

6 While some experts suggest that contracts should last between three to five years, new research suggests that two years may be a sufficient time frame. Source: KPMG, Investing in social services as a core strategy for healthcare organizations: Developing the business case. 2018. <http://www.kpmg-institutes.com/content/dam/kpmg/governmentinstitute/pdf/2018/investing-social-services.PDF>

7 One interviewee, Aetna, fell between categories. The broader organization has several different business lines and many different types of contracting, from whole-population to specific populations such as special need dual-eligibles (D-SNP). We interviewed representatives from the Florida D-SNP program.

Communication

Understanding how contract negotiations may or may not impact HNHC programs is critically important, regardless of whether an organization has committed to a longer-term population health strategy. Cross-departmental communication is needed so that clinical and operational decisions align with contract structures and expected financial return. Therefore, delivery system executives should establish a robust culture of open communication to promote collaboration between business units such as clinical operations, contracting, and finance.

Collaboration

Interviewees also expressed the importance of connection between administrative/clinical leadership and front-line care delivery providers. It is critical to ensure that care delivery providers are supported and equipped with the right tools, incentives, and data — especially when managing multiple populations with widely varying needs. Administrative executives and strategic decisionmakers must make it a priority to understand the clinical and social nuances of the populations their organization serves, and develop processes for ensuring that continued front-line feedback and innovation is incorporated into broader strategic program decisions.

“You have to be able to save money but also improve quality, decrease mortality and admissions to the hospital, and improve patient satisfaction. At the same time, you have to make sure that the program is adding value to the clinical work life of the practices where these patients live. So the program cannot represent additional burden to clinicians that are already burdened on the ground. Rather, it has to be something that they can walk away from the table later on and say, ‘I am so happy this program is here. It has made me a better doctor, a better nurse, a better nurse practitioner. And it has made me get home 10 minutes earlier every day.’”

-Physician Group Executive

Tactics for Contracting and Clinical Program Management

Organizational strategic direction directly informs contracting and clinical program management. This section addresses tactics for contracting and clinical program management across four main areas: (1) identification and segmentation of the target population; (2) care management program design; (3) ensuring access to data; and (4) financial sustainability and return on investment.

Identification and Segmentation of the Target Population

Identifying and segmenting individuals whose needs are aligned with an organization’s service offerings is critical to achieve both improved outcomes and financial sustainability. While many organizations initially identify individuals with consistently high-risk profiles and costs through risk stratification, segmentation helps further program success by subgrouping high-risk individuals based on disease-specific needs.^{8,9}

Interviewed programs highlighted the importance of segmenting individuals with persistently high-risk profiles and costs, rather than those with episodic high costs. These assertions are consistent with previously documented best practices for identifying the HNHC population.^{10,11} In the majority of cases, organizational emphasis is on identifying

8 Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health. National Academy of Medicine. June 2017. <https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf>

9 Population Segmentation and Targeting of Health Care Resources: Findings from a Literature Review. Mathematica Policy Research. December 2017. <https://www.mathematica-mpr.com/our-publications-and-findings/publications/population-segmentation-and-targeting-of-health-care-resources-findings-from-a-literature-review>

10 Proactively Identifying the High Cost Population: Insights from the Health Care Transformation Task Force. <https://hcttf.org/2015-5-14-whitepaper/>

11 Better Care Playbook. The Commonwealth Fund, The John A. Hartford Foundation, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation. <http://www.bettercareplaybook.org>

those who are “rising risk” — meaning they may present with chronic conditions that are not optimally managed, may have functional limitations, and are thus at risk for future avoidable hospitalizations and/or costly interventions.

“What’s unique about these patients is that they’re not necessarily the highest cost patients every year, but they are the highest risk patients every year, which means their chronic disease burden indicates that they’re going to have a persistent and significant spend year over year.”

-Home Health Provider

While identification and segmentation of individuals for program inclusion is essential regardless of contract type, different key insights and recommendations emerged between organizations contracting primarily for HNHC populations versus organizations contracting for whole populations.

Key Insights and Recommendations:

HNHC-TARGETED CONTRACTING

Geographic Targeting

Organizations contracting primarily for HNHC populations should consider developing systems and processes to identify target geographic areas and potential HNHC populations they hope to serve. For example, some interviewees conducted detailed market research to identify medically underserved areas that could be considered “primary care deserts,” where longtime residents have little-to-no access to primary care. These populations tend to have complex chronic health and social needs and may be covered through Medicare Advantage or Dual-Eligible Special Needs Population (D-SNP) contracts with commercial payers.

Preliminary Identification

Provider organizations may go a step further and proactively work with health plans to identify individuals who are likely to be categorized as HNHC; specifically, those with five or more chronic conditions who have had persistently high spend over time. These organizations tend to have sophisticated actuarial/data analysis processes for predicting costs, and use that cost forecasting to inform reimbursement negotiations. These processes generally take place before contracting; once individuals are covered under a contract, the provider will then take the additional step of segmenting those individuals into risk categories and appropriately targeting interventions.

“We need durability of spend over time from an actuarial standpoint to take risk. And so that’s why we look for patients based on their chronic disease profile and their cost profile.”

-Home Health Provider

BOTH HNHC-TARGETED & WHOLE-POPULATION CONTRACTING

Internal Segmentation

All organizations, regardless of whether they specifically target the HNHC population or engage in whole-population contracting, need to employ highly refined internal segmentation criteria to ensure that HNHC individuals are appropriately slotted into care management programs with relevant disease-specific focus after they have been contracted for coverage. For example, some organizations utilized internal risk algorithms to target HNHC individuals for specific programs; a few provider organizations then received final attribution approval by the individual’s primary care physician. It is essential that staff work collaboratively with payers to ensure they have access to sufficient claims data for segmentation.

Vignette

Using Algorithms to Risk Stratify in an Integrated Delivery System

For Denver Health, an integrated delivery system, risk stratification is critically informed by data from both delivery system and health plan. The organization uses sophisticated software to stratify individuals based on age, gender, diagnosis, and pharmacy claims into nine categories of risk, with more serious chronic conditions receiving higher scores. Using those risk scores, individuals are further segmented into four tiers, using clinical judgment to determine who may benefit most from enrollment in targeted care management programs.

“Where the health plan information comes in is when we don’t perfectly capture diagnosis information; people might fill their prescription medication somewhere other than our system, or go to a different hospital. All of those things are relevant in our tiering algorithm.”

- Health System Executive

Care Management Program Design¹²

All organizations interviewed employ the elements associated with better outcomes for HNHC populations: a person-centered approach to care, delivered by a multi-disciplinary team building trusting relationships with patients and their caregivers.¹³ A few structured their programs by payer — such as Medicare, Medicaid, or Dual-Eligibles — but most offered a single program providing tailored support to HNHC populations across several lines of business.

In the simplest terms, financial sustainability is achieved when investment in care management is less than cost savings. Program design is generally related to how directly the organization captures inpatient savings through payer contracts. Some contracts, such as full risk, return greater savings to the delivery system for preventing inpatient stays than shared savings arrangements. Therefore, the level of investment needs to be sensitive to contract structure, and in particular, ability to capture savings in hospital or emergency department utilization. Interviewed organizations revealed a set of different key insights and recommendations for program design depending on contract type, as well as some applicable to both types.

Key Insights and Recommendations:

HNHC-TARGETED CONTRACTING

Operational Flexibility

HNHC-specific contracting organizations need to have flexibility in their operational infrastructure to respond to a population with diverse needs. These organizations typically operate under full risk contracts, which allows maximum flexibility to offer non-medical services to address underlying needs. Due to the complexity of the entire contracted population, these organizations emphasize flexibility in staff roles and responsibilities to meet patient needs; for example, utilizing a team-based approach that encourages clinical staff to flex between medical care delivery and care management administration, and pulling in non-clinical staff such as social workers to support on a case-by-case basis. While this structure is not exclusive to an HNHC-focused organization, the level of flexibility required to meet the significant and varying needs of a complex population is arguably significantly higher than in organizations with a lower proportion of HNHC individuals.

¹² Care Management, in this context, includes care transitions, as poorly managed transitions can result in increased inpatient utilization.

¹³ For more details on effective care management programs, see the National Academy of Medicine’s Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health. Available at: <https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf>

One organization emphasized the importance of a team-based approach:

“Our care managers work in teams or pods ... Dependent upon what the member’s main needs are, different team members may have more interaction with a particular member at any given time. But generally, it’s a team-based approach.”

-Health Insurance Executive

WHOLE-POPULATION CONTRACTING

Coordination Across Contracts and Lines of Business

Organizations contracting for whole populations typically hold payer contract arrangements ranging from FFS to advanced alternative payment models. Balancing multiple contracts and lines of business can make program sustainability a challenge, and requires ongoing communication between clinical operations, contracting, and finance. Each team lead plays an important role: the clinical program leader brings content knowledge about care management programs and models, the finance lead can calculate the potential program returns, and the contract lead understands how to structure reimbursement and clinical terms in the contracting agreement. In these collaborative conversations, where contractual returns are lower (i.e., under shared risk contracts), the organization may need to invest less in care management to be financially sustainable.

Access Determination

Additionally, when caring for individuals under different payer contracts, organizations need to decide which individuals will have access to care management programs. A few organizations limit program enrollment only to individuals covered by supportive contracts, and/or allocated limited resources to programs with a higher profile. Other organizations see investment in care management — even if not financially lucrative across all lines of business — as an imperative for the organization to move toward higher levels of risk.

BOTH HNHC-TARGETED & WHOLE-POPULATION CONTRACTING

Alternative Care Team Structures

Both types of organizations may benefit from alternative care management team structures that utilize non-clinical staff as a primary point of contact. For example, a nurse care manager may lead the team and provide clinical oversight, but the primary patient relationship is with another team member such as a community health worker, social worker, or other licensed or unlicensed staff. Alternative care team structures allow professionals to practice at the top of their licenses, which promotes higher job satisfaction and better value to the organization; individuals may also benefit from more direct contact with professionals who are specifically trained in the area of greatest need.

Targeted Resource Investment

Panel size, as well as an organization’s ability to tier patients within a panel based on acuity level, is critical to program sustainability. Most organizations tier the HNHC population to properly invest staff resources based on calculated risk level. Ratios of care-manager-to-individual can range significantly.

“The best practice for staffing ratios is really somewhere between 40 and 50 patients to a care manager. In some places that’s higher and some places it’s lower. We’re working to stratify different levels of risk, and the intensity of service that people need and base case flows off of those numbers — which would probably be around 12:1 for the very highest needs folks.”

-Health Home Leader

Subcontracting

Finally, organizations should decide whether to subcontract services. Providers can subcontract for different types of services; two common types include 1) clinical specialty services such as cardiology and behavioral health and 2) community support services such as transportation. Only a few interviewed programs subcontracted services for clinical services; however, the practice of subcontracting may be more prevalent

amongst a larger universe of providers, with subcontracted services not limited exclusively to HNHC patients. Those who chose not to subcontract for clinical services may still contract with community-based services to supplement in-house capabilities.

Vignette

How Lack of Communication Can Impact Program Sustainability

One anonymous health system clinical lead described the challenges associated with funding allocation for targeted care management programs. The disconnect between executive decisionmakers, clinical operations, and contracting officers resulted in heavy contractual emphasis on certain quality metrics, and consequently organizational focus on one particular screening program at the cost of other successful care management initiatives:

“We had a big push to get our cervical cancer screening rates up; it was associated with the pay-for-performance programs. It had high visibility and was just very easy to track whether a cervical cancer screening had happened. Navigators were pulled off [other projects] and onto the cervical cancer screening program. The discussion really wasn’t around competing interests and a fixed number of resources. It was more around relative visibility.”

-Health Home Leader

Ensuring Access to Data

Guaranteed access to individuals’ data is an essential tactic to success in care management programs. All organizations interviewed stressed the importance of claims data for two purposes: 1) claims are required to identify the HNHC segment within population-based contracts; and 2) regular, frequent information about use of services, both inside and outside the organization, is needed for ongoing management of the HNHC population. Claims data is also critically important to adequately track ROI and program impact.

Many programs noted the need to specify access to claims as part of their payer contracts. Despite contractual obligations to share these data, however, several providers interviewed expressed frustration that they did not have optimal access to the type or frequency of data from payers such as daily hospital census data that is essential for care management, and/or did not have the internal systems to fully integrate this data into their day-to-day workflow management.

Key Insights and Recommendations:

BOTH HNHC-TARGETED & WHOLE-POPULATION CONTRACTING

Real-Time Data

Contracting arrangements that specify real-time notifications are the gold standard for HNHC care management. When available and accessible, programs should contract to receive daily census data and/or real-time alerts when individuals are admitted to the emergency room (ER) or hospital to engage the patient in care management.

Supplemental Health Information

The interviewed organizations also stressed the importance of pushing for access to supplemental health information. Participants acknowledged that behavioral health and social determinants of health information

are invaluable to informing care for those with high needs and should be acquired whenever possible. However, legal and operational barriers (such as sharing substance use disorder records under 42 CFR Part 2)¹⁴ inhibit the ability of providers to acquire this kind of data unless it is generated in-house.

Enrollment Data Sharing

Organizations identified enrollment data sharing as critical. Sharing HNHC program enrollment with providers both inside the organization and outside (such as social service providers) improves program effectiveness by assuring all providers are aware of the services a patient is receiving outside of their office. One provider organization does this by marking HNHC electronic medical records with a specific icon to notify all providers of the individual's enrollment in the program.

Vignette

Payer Data-Sharing and Care Management: ChenMed's Approach

For ChenMed, an organization devoted to caring for older, at-risk individuals with previously limited access to primary care resources, payer claims and census data from health insurers is critical. This data allows its doctors, along with support from business intelligence, care coordination, and clinical and quality teams, to truly understand their patients' needs and keep track of events such as hospital admissions.

"The doctor has the ball. But if they don't have the data, then the model does not work well. It becomes a very risky model, and people fall through the cracks. The data is so important."

- Provider Executive

Financial Sustainability and Return on Investment

For an HNHC care management program to be truly sustainable, the program should provide an ROI over the course of multiple years and reach certain contractual targets. The capacity to calculate ROI is critical to determining program success. Given that financial stability over two or more years was a criterion for participation in this project, the organizations interviewed saw ROI calculation as a strategic business necessity and developed their skills in this area. It is worth noting that annual returns may be difficult to generate in the early years of the care management program; this may be due to challenges collecting/obtaining the necessary data to evaluate ROI, and may also be due to natural variations in predicted versus actual costs and savings. Significant up-front investment from the organization sponsoring the program may be necessary for program launch.

Key Insights and Recommendations:

BOTH HNHC-TARGETED & WHOLE-POPULATION CONTRACTING

Continual Refinement

Similar key insights and recommendations for financial sustainability and ROI emerged regardless of contract type. Most participants continually refine their ROI calculation processes. Typical financial and economic forecasting considers factors such as reduced admissions/readmissions, length of stay, and lower expenditures

¹⁴ <https://www.psychiatry.org/psychiatrists/practice/practice-management/hipaa/42-cfr-part-2>

from process changes. Drilling down into specific services or components of a program, rather than simply calculating general program ROI, can allow for more accurate predictions and can help organizations more easily pinpoint areas where they need to make adjustments.

Expanded Data Analysis Capabilities

Organizations will benefit from building their capacity for data-driven analysis. While interviewees vary in the level of sophistication with which they are able to calculate ROI, the most innovative organizations pull in expertise from various areas – such as actuarial and data analysis – along with insurer data, to generate predictions for program cost. Such expertise, which has historically been reserved only for larger payers and some providers, is now being applied to smaller, agile physician practices that have the capability to design and tweak their care delivery models in accordance with their sophisticated risk predictions.

Prediction And Risk

Additionally, ROI predictions seemed to correlate with the amount of risk a provider organization was willing to take on; those with more refined ROI models are more confident assuming risk over the total cost of care management than those with less refined ROI models.

Limitations

Organizations may face certain challenges in calculating ROI due to the limitations of predictive models and access to historical data. One provider noted the challenge of calculating an ROI without having a control group to compare it to. Still, calculating ROI on care management programs, even without sophisticated modeling, is important before or during the contracting as it provides a baseline for setting appropriate payment rates.

Methodology

In recognizing the need for a clearer and deeper understanding of the payment models that successfully address the complex needs of high-risk patients, PBGH and HCTTF embarked on a qualitative study analyzing key elements of care management contracting, and the development of contracting guidance to share best practices. The study began with the convening of an 11-member expert panel comprised of roughly half academic subject matter experts and half industry representatives. The expert panel provided guidance on the proposed list of interviewees, selection criteria, and overall project progression. Interviewees were selected on the following criteria:

1. Care model evidence of both improved person-level outcomes and cost reduction
 - Program listed on The Better Care Playbook website in the Quick Reference Guide to Promising Care Models (Table 1) with evidence of improved person-level outcomes and cost reduction;^{15, 16} or
 - Program listed on The Better Care Playbook website in the Center for Health Care Strategies (CHCS) Fact Sheet: Programs Focusing on High-Need, High-Cost Populations¹⁷ with internally generated evidence on improved patient outcomes; or
 - Program recommended by expert panel members or other subject matter experts, with evidence of improved outcomes and cost reduction
2. Business sustainability
 - Program has sustained for two years without grant funding for services, or reliance on temporary government funding

15 Available at: <http://www.bettercareplaybook.org/>

16 Available at: <http://www.commonwealthfund.org/interactives/2016/modelsguide/table1.pdf>

17 Available at: https://www.chcs.org/media/HNHC-Programs_Fact-Sheet-041516.pdf

3. Replicability and applicability

- Program has evidence of replication at multiple sites or programs that are most applicable in the current business environment

The expert panel identified a list of 26 potential interviewees that met selection criteria and program staff ultimately interviewed 11 organizations, including two medical groups, four health systems, two integrated delivery systems, one health home, one insurer, and one Area Agency on Aging. Interviewees were asked to complete a pre-interview template consisting of organizational and care management program background information. All interviews were one-hour and utilized the same interview question guide. Organizations submitted any follow-up documentation, including the pre-interview template if not provided earlier, as needed or requested during the interview. Interviews were recorded and transcribed using professional transcription services; transcripts were then analyzed for common themes and significant findings. After comparing organizations and collected data in a summary analysis document, additional follow-up contact was made with each organization to fill in any gaps in information and clarify any remaining questions. All quotes in this report are drawn from these interviews and written transcripts.

Appendix I: Organizational Information

Organization	Program	Patient Population	Lines of Business	Clinical Model Key Features	Types of Reimbursement
Aetna Healthier insurer	Florida D-SNP Care Management Program	Beneficiaries dually eligible for Medicare and Medicaid who enroll in an Aetna DSNP plan. Members are stratified as high, moderate, or low based on medical, behavior, and socioeconomic need.	Medicare Advantage	Care pod w/ nurse case manager, non-clinical care coordinator, case worker, pharmacist Care pod can pull in additional outside resources as necessary Minimum outreach once/3 mos.	Capitation
Brooklyn Health Home (Maimonides Medical Center) Health home	Brooklyn Health Home	Medicaid + 2 or more chronic conditions OR serious mental illness, HIV/AIDS	Medicaid Dual-Eligible	Small care management caseload, 12:1 for highest need patients	Medicaid DSRIP funding (PMPM)
CareMore Integrated health plan and care delivery system	Various (SNPs, Behavioral Health Program, Multi-Chronic Program, Dementia Program)	Underserved, high-risk Medicare, Medicaid, and Duals	Medicare Medicaid	Actively seek higher-risk patients NPs do care management "Neighborhood" organizing principle	Capitation Encounter-specific payment FFS (PMPM)
ChenMed Medical group	N/A	Underserved low-income seniors w/ complex chronic conditions	Medicare Advantage Dual-Eligible	Target underserved in primary care deserts Heavy touch model and small patient caseload	Capitation
Denver Health Integrated health plan and care delivery system	21 st Century Care	Identified by diagnosis grouper, clinical judgement, utilization history	Medicare Medicaid/CHIP Dual-Eligible Commercial Uninsured	Enhanced care team members embedded in regular primary care practices as well as high intensity clinics	Capitation FFS (PMPM)
Landmark Health Home health provider	N/A	Identified by 5-7 chronic conditions, persistent and significant spend history	Medicare Advantage Medicaid Dual-Eligible Commercial	At home care services Care pod w/e physician, nurse care manager, clinical ambassador	Capitation Shared savings (50%) MLR-based savings (MA)

Appendix I, continued

Organization	Program	Patient Population	Lines of Business	Clinical Model Key Features	Types of Reimbursement
Trinity Health and its Regional Health Ministries Health system	Care Coordination Population Health Program	Identified by risk scores, HARP (Medicaid) in NY, Duals segment	Medicare Medicaid Dual-Eligible Commercial	Establish individual patient goals, small care coordinator caseload, face-to-face visits	Shared Savings (Medicare ACO) FFS (PMPM)
Partners HealthCare Health system	Integrated Care Management Program	Algorithm selects based on risk score, utilization, high risk conditions, PCP approves	Medicare Medicaid Commercial	Behaviorial health support is core of program, social workers leverage HC system and community resources for long-term solution	Shared savings
Sharp Rees-Stealy Health system	Senior Enhanced Care Mangement	Identified by high risk criteria list, physician referral, inpatient care managers	Medicare Commercial	Complex case management, chronic care managment, diabetes/ COPD/heart failure disease management, nurse navigation	Capitation FFS (PMPM)
Sutter Health Health system	FQHC Care Transition Nurse Program Case Management Care Plan Program	Identified by 10+ ED visits, 5+ inpatient visits	Medicare Medicaid Commercial	Community health worker to link patients to community-based services	No direct risk-sharing
VAAACares® Bay Aging d/b/a VAAACares® Local aging program	Care Transition Program® (CTP) and Care Coordination	Patients assigned by Health systems/MCOs; each identify and define high risk patients differently	Medicare Medicaid	Home visits using CTP® and incorporating tele-education initiatives, evidence-based prevention programs and referring for social determinants as needed. Care coordination within Medicaid guidelines for acuity level of patients population	Capitated payment per episode for CTP® PMPM for care coordination

Appendix II: Glossary

Capitation: Fixed, pre-arranged payments, usually made on a monthly basis, from health insurers to providers, to cover the cost of an individual's care. Capitated payments are negotiated within the terms of a contract.

Fee-for-Service: A payment model where services are paid for separately, per individual encounter. Traditional fee-for-service has been shown to promote greater use of services than value-based payment models.

High-Need, High-Cost Population: A small percentage of individuals with complex medical, social, and behavioral needs who utilize the largest proportion of national health care resources. Often described as the top 5% of patients who account for nearly 50% of total spending.

Identification: The process of determining whether an individual should be considered high-need and high-cost. Typically occurs in conjunction with risk stratification.

Primary Care Desert: A geographic area – particularly a rural area – where there is a dearth of primary care physicians.

Return on Investment: A measurement of the gain or loss created by an investment in relation to the amount of money invested.

Risk Stratification: The process of separating, or tiering, patient populations into high-risk, low-risk, and rising-risk groups. Usually done using a specific algorithm, technological platform, and existing patient data.¹⁸

Segmentation: The process of efficiently targeting resources to the highest risk, and potentially most costly, patients in health care organizations to improve quality of life and maximize efficient use of health care resources.¹⁹

Acknowledgments

This report was produced by the Health Care Transformation Task Force and the Pacific Business Group on Health. The authors would like to thank the following organizations for their participation in the interview process:

Aetna	Loyola Medicine (Trinity Health)
Brooklyn Health Home	Partners HealthCare
CareMore	Sharp Rees-Stealy
ChenMed	Sutter Health
Denver Health	Virginia Association of Area Agencies on Aging
Lanmark Health	

18 Health Catalyst. Understanding Risk Stratification, Comorbidities, and the Future of Healthcare. <https://www.healthcatalyst.com/understanding-risk-stratification-comorbidities/>

19 Population Segmentation and Targeting of Health Care Resources: Findings from a Literature Review. Mathematica Policy Research. December 2017. <https://www.mathematica-mpr.com/-/media/.../population-segmentation-wp58.pdf>

The authors would also like to thank the following individuals for their insight and expertise:

Nancy Markle
Greenville Health System

Mary Mailloux, MD
Aetna

Vanessa Flint
Aetna

Robert Mirsky, MD
Aetna

Janet Jones
Ascension Care Management

Harpreet Cheema
Trinity Health

Sheila Johnson
Trinity Health

Allison Hamblin
Center for Health Care Strategies

Katherine Hayes, JD
Bipartisan Policy Center

Douglas McCarthy
The Commonwealth Fund

Gerard Anderson, PhD
Johns Hopkins University

Finally, the authors would like to express their gratitude to Erin Westphal of The SCAN Foundation and Tanya Shah of The Commonwealth Fund for their guidance and support of this project.

This work is funded by The Commonwealth Fund and The SCAN Foundation.

The Commonwealth Fund is a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.