Optimizing High-Risk Care Management

The most costly 1% of patients account for one-fifth of national health expenditures—accruing average annual expenses of nearly $90 000 per person.1 These individuals typically have several complex, co-occurring conditions for which they often receive poorly coordinated care, driving unnecessary utilization and poor outcomes. Given these characteristics, high-risk care management programs have potential to improve care and reduce costs for this population.2,3 The structure of these programs varies, but most involve care managers who work with panels of high-risk patients to coordinate care across clinicians, engage patients in setting and achieving health-related goals, and monitor and track health outcomes. Although these programs have traditionally been managed by payers or third-party vendors, clinicians and health care organizations are increasingly adopting programs of their own.2,4

High-risk care management is quickly becoming a cornerstone of health reform efforts. Over the past decade, Medicare has funded 6 rounds of demonstration projects aimed at improving care and reducing costs for high-risk patients.5 In the private sector, purchasers are seeking payers that provide these services; by this year, roughly 75% of large employers expect to contract with a health plan that offers disease management services.6 Within care delivery organizations, new payment contracts that tie reimbursement to cost and quality trends are prompting experiments with new delivery strategies for high-risk patients.1

Excitement over the growth and potential of high-risk care management programs is tempered by the uneven results of previous efforts. Despite some isolated successes, most evaluated high-risk care management programs failed to significantly affect the cost and quality of care provided to their targeted patient populations.4,5 This suggests that prevailing approaches to high-risk care management are not optimally designed. As activity continues to accelerate in this area, it is necessary to consider the optimal approach to organizing and financing these activities.

Despite increasing evidence that programs led by clinicians and health care organizations are most effective, the majority of care management programs remain under the purview of payers.4,5 This is likely a key factor behind the lackluster results of previous efforts. However, prevailing regulations support this status quo. Payers are reluctant to cede control of care management programs to care delivery organizations. A frequently cited reason for such reluctance is that transfer of this responsibility would jeopardize National Committee for Quality Assurance (NCQA) health plan accreditation, which requires health plans to provide disease and complex case management services to beneficiaries. The NCQA has processes for delegating medical management responsibilities while maintaining accreditation. However, in discussions with payer colleagues, we have heard that current processes for delegation are cumbersome and could jeopardize accreditation. Continued efforts by the NCQA to simplify and streamline the delegation process are needed.

While important, removing regulatory barriers to physician-led care management is only one element of the transformation needed to harness the substantial cost and quality opportunity presented by high-risk care management. Optimizing these programs will require a system-level approach that takes advantage of each stakeholder’s unique capabilities. Simultaneous initiatives from payers and care delivery organizations are unnecessary and wasteful.

Drawing on our experience implementing these programs across a large, integrated health system, we propose 3 overarching principles to guide the design and implementation of high-risk care management services.

Practice-based: High-risk care management programs are most effective when they are anchored in the practices where patients receive their care. Care managers co-located within practices are able to build strong, trusting relationships with patients that promote patient engagement through planning and adherence. The primacy of in-person contact and integration within clinical practices is underscored by the results of several studies. An analysis of the Medicare demonstration for high-cost beneficiaries found that programs in which care managers had direct, in-person interaction with patients and their physicians reduced expenditures by 7%, whereas those in which payer-based or third-party care managers interacted with patients via telephone had no effect.5 A review of both private and public programs reached similar conclusions, finding that programs that embedded in-person care managers into practices were more effective than those in which communication was outsourced to payers or third-party vendors.4 There is simply no substitute for person-to-person contact.

Payer-catalyzed: As care financiers and plan administrators, payers have a fundamental role to play in creating an environment that enables and encourages the delivery of care management services. Most important is developing payment models that promote investment in high-risk care management capacities by clinicians and health care organizations. Traditional fee-for-service reimbursement actively hinders experimentation with care management. On the other hand, shared savings arrangements, capitated payments, and per-member, per-month payments for complex long-term care management all afford care delivery organizations with the flexibility to reengineer care and create an environment where success improves financial per-
formance. For example, most Medicare Pioneer accountable care organizations have implemented high-risk care management programs, with promising initial results. Payers can further support effective care management by supplying health care organizations with comprehensive claims data and analytic support. Timely feedback on health care utilization is necessary to assess and adapt programs for managing complex patients. In their interaction with purchasers, payers should also encourage support of payer-blind approaches to high-risk care management.

**Purchaser-supported:** Purchasers also have a fundamental role to play in promoting effective high-risk care management for their covered populations. Employers and other purchasers of health care are the ultimate beneficiaries of any savings borne by successful care management, but they have little ability to engage in these activities directly. Although indirect, health plan contracting is an exquisitely powerful lever to drive the adoption and refinement of high-risk care management programs. Purchasers can assume a more activist role in using their purchasing power to promote more effective and efficient high-risk care management programs, a trend that has begun to increase in recent years. For some large employers, this could mean contracting directly with care delivery organizations that have demonstrated capacity in high-risk care management. For most employers, it will entail working with payers to (1) promote a shift away from payer- and third party-led systems and (2) drive employees to clinicians and health systems that can offer these services more effectively.

Achieving the potential of high-risk care management will require a coordinated strategy in which purchasers, payers, and health care organizations leverage their unique capabilities without redundancy or duplication. In this era of financial austerity, limited health care dollars should not be spent on programs that are not optimally effective or efficient. High-risk care management programs that are practice-based, payer-catalyzed, and purchaser-supported have the greatest potential to deliver better care at lower cost.

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