# Health Care Reform: A Catalyst For Integrated Medical Management

**REFORMED LANDSCAPE…*OR NOT***

Passage of sweeping health care reform is now in doubt. However, the year-long debate served as a catalyst to health plans, large and small, for one important area of focus: effective, integrated medical management. The prospect of unmet demand of 25 million uninsured individuals seeking health coverage for the first time and tight Medical Loss Ratio (MLR) standards served as an important wake-up call—health plans need the ability to leverage the power of local physician and hospital relationships to structure a collaborative payer-provider care delivery model. It's clear that going forward innovative health plans can gain a significant competitive edge if they are prepared with a well-crafted strategic vision, maintain a capacity to be tactically nimble, and develop a set of tools built on an integrated medical management platform.

The House and Senate bills set the stage for a renewed focus on primary care through increased Medicare payments, workforce training and educational incentives, and pilot programs such as medical homes and Accountable Care Organizations. In addition, the model of medical management is expanded to include patients and family caregivers moving towards a "patient centered" model of care delivery. The bills also recognized the need for funding for research and pilot programs such as Patient Centered Outcomes Research and support for Medicare and Medicaid Innovation Centers intended to develop new models of integrated, patient centered care that incorporate changes in reimbursement, new approaches to communication, and greater accountability for quality outcomes. The bills recognized a need to foster programs to reduce over-utilization, better manage transitions of care, decrease unnecessary errors and readmissions, and promote more effective patient-provider shared decision making.

**CHRONIC CARE MANAGEMENT**

Chronic medical conditions account for $3 out of every $4 spent on health care in the United States. Eighty percent of seniors have at least one chronic condition. And, for the 3.8 million boomers aging into Medicare every year starting in 2011, sixty percent have a chronic condition. There is no doubt that the number of seniors with chronic medical conditions will continue to increase. It is estimated that by 2030, over 20% of the population will be ages 65 or older and those with chronic medical conditions will continue to consume a majority of the health care spending in the United States.

***Regardless of legislative empowerment, Washington's future benchmark for health plans is clear—what's your ability to bend the cost curve?*** Management of chronic medical conditions is critical to success. Members with chronic conditions have a tremendous impact on health plans. In Medicare Advantage, we find the "5/60 rule" where 5% of membership typically accounts for 60% or more of medical expense. This trend is not much different in the commercial segment. Costs associated with these conditions will continue to challenge health plans' financial performance unless plans become aggressive in identifying these patients by using a multidisciplinary team approach with a laser-focused medical management for high cost members.

Historically, health plan efforts to manage these members have been stifled by a fragmented delivery system and lack of true care coordination. This simply will not be sustainable going forward. Plans need to start now with a strong business case for medical management grounded in evidence-based clinical practices, predictive outcomes modeling, member engagement, and multidisciplinary professional collaboration. New medical management partnerships can dramatically enhance care management, reduce hospital readmissions, integrate pharmacy into medical management, and break new ground by applying information technology to track the cost of managing complex chronic conditions.

A new era of chronic care management is set to emerge, allowing health plans to identify, treat and improve outcomes of costly chronic conditions, in an accountable, patient-centered approach—comprehensive care, structured around primary care physician-directed team that is accessible, continuous, and family-centric. The concept of "patient centeredness" as defined by the Institute of Medicine, refers to health care that establishes a partnership among practitioners, patients and their families to ensure that decisions respect patients' wants, needs and preferences; and ensure they have access to education and support to make decisions and participate in their own care.

**NEW MODEL, NEW STRUCTURE**

Patient centeredness has given rise to two hot trends gaining traction in the marketplace: medical home and accountable care organizations. With a new emphasis on next generation medical management tactics, the market will now see an acceleration of these trends.

A medical home is an approach to providing comprehensive primary care. And, it has an impressive track record after more than a decade of widespread pilot programs. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centric, compassionate, and culturally effective. A "whole person" orientation to health care delivery is at the core of the medical home. A personal physician is responsible for coordinating all the patient's healthcare needs. Care is aligned across all components of the patient's healthcare community – hospitals, specialty physicians, pharmacists, social services, home health, nursing homes, and ancillary providers.

Under a medical home model, a patient's engagement in the management of their chronic conditions is improved along with their overall health care experience and level of satisfaction. Medical homes are saving money, empowering members, and allowing providers to coordinate care in a multidisciplinary approach. It's a win-win for all.

The second trend is Accountable Care Organizations. ACOs are local and regional provider organizations responsible for the cost and quality of care received by a specific group of patients, usually joined by common referral patterns. Payment incentives (and disincentives) are built in so that physician groups and hospitals become financially "at-risk" to meet quality and cost targets.

***ACOs are quickly gaining momentum as a preferred solution to improve medical management.*** They provide a reimbursement environment that fosters management of an entire episode of care in an integrated patient-centered structure while promoting proactive care planning and budgeting – all among a network of providers already familiar with working together. The result is providers having a stake in the outcome of medical management, resulting in better care coordination, reduced waste, improved administrative efficiencies, information technology innovations, and reliance on actionable, timely patient-centered data. As ACOs continue to emerge, they will undoubtedly serve as the framework for improving the value of health care by helping to reduce cost and improve quality of health care especially for those with costly chronic medical conditions.

These trends represent a vastly different mindset for many health plans and providers. Patient-centered programs are not just a reinvention of utilization management and prior authorization. Health plans are put in the role of facilitating, not limiting, providers. They become a central resource for directing communications with members through the doctor-patient relationship. It also means supporting clinician partners with reliable, complete information… giving front-line professionals the data and tools to "connect the dots" of the patient care continuum. This includes using claim data to provide 360-degree visibility of medical and pharmacological care being received by a patient, using predictive modeling to alert practitioners to impending problems, providing digestible bites of evidence-based best practice information, and supporting practitioners' efforts to communicate with their patients through practice-based care management and patient education.

**TIME FOR ACTION**

"*Bending the cost curve*" depends on effective medical management. Over the years, most health plans have embraced utilization management for inpatient care with disease management focused on an outpatient setting. That approach has led to a spotlight on "setting of care" rather than the "individual receiving the care". Tomorrow's integrated medical management will shift toward being patient-centered, primary care driven, and measured by accountability: member engagement, provider quality and health plan collaboration.

***Tomorrow's competitive landscape will put an inordinate amount of pressure on plans to be better care coordinators.*** This is especially relevant for the chronic population consuming the majority of the health care dollar. The impetus to be aggressive in this area is clear: more patients, with more complex chronic medical conditions are costing more, with no significant improvement in quality of care. The time is now for health plans to stand and deliver value. And, they have the two most powerful weapons: money and data.

Medicare Advantage plans have the added pressure of reimbursement adjustments happening within a compressed timeline aimed at achieving parity with Medicare fee-for-service. This ups the ante on cost management, both operationally such as enrollment adjudication, risk adjustment, and claims processing, as well as high-impact MLR actions, especially chronic care management.

Plans need to begin now with an effort to:

1) Design patient-centric strategies and re-engineer existing medical management activities;
2) Initiate transparent, collaborative communication with physicians, pharmacists, and other health care providers around patient care management and improvement;
3) Change reimbursement methodologies to better align incentives around primary care and chronic disease management;
4) Deploy integrated multi-disciplinary care teams to address complex care management though patient centered medical homes and Accountable Care Organizations.

The future of successful health plans is finding ways to provide better access to health care for millions of Americans and effectively managing health conditions they bring with them. This means a philosophy of doing the right thing, for the right people, at the right time. Medical management is the right thing to do; targeting high cost members is the right focus, and there has never been a better time to reduce health care costs and improve quality than in a marketplace emboldened by a historic health care reform debate.

**Executive Briefing #2: Health Care Reform and Its Impact on Medicare Advantage and Part D**

**Contact us at lresnick@gormanhealthgroup.com for more information.**

**About Gorman Health Group | www.gormanhealthgroup.com**

**The premier Medicare, health insurance and federal programs consultancy provides thought leadership, strategic insight and business solutions to the private sector. By leveraging extensive subject matter expertise and in-market learning, a team of former health plan executives and seasoned regulators brings clients the vision, technical acumen, and operational savvy to excel in competitive markets.**

**Copyright © 2010 Gorman Health Group, LLC**