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HEALTHCARE MANAGEMENT ADVISORS

Designing Financially Sustainable Care Management

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Bundled payment, the Medicare Shared Savings program, and commercial value-based payment programs have caused many providers to develop care management programs focused on readmission reduction and chronic disease management. Our experience suggests that it is essential to apply both clinical and financial expertise when redesigning care.

Financial professionals can add important perspective to a clinical redesign team, helping to create appropriate, effective, and financially feasible interventions. Here are some examples of how financial expertise can improve the sustainability of care redesign.

IDENTIFYING STAFFING MODEL SKILL MIX

The staffing complement and mix of your care teams can significantly impact the cost-effectiveness of your intervention, and a financial professional can help you determine what is feasible. The care management skill mix should be appropriate to the patient risk level.

For example, while RNs or NPs may be needed to manage the highest risk patients, non-clinical staff can support 90 to 95 percent of the population. The per member per month (pmpm) cost of care management programs staffed by NPs or RNs can be five times that of those staffed by non-clinicians. Be sure staff are working at the top of their license.

MATCHING INTENSITY TO TARGET POPULATION STATUS

Some patients require extremely intense care management interventions at specific times, but can be supported with less intensity at other times. Other patients may never need high intensity. If the care management program provides a greater level of intervention than required at any point, its costs may outweigh its savings.

For example, one hospital participating in the congestive heart failure bundle made about 40 contacts per patient in the 90-day period. This intense intervention requires a total of 15 hours of nursing time per patient. After three quarters, they are just starting to realize some savings.

An alternative to putting everyone in an intensive model is testing different approaches. For example, an "A/B" tests could provide one group with a lower level of intensity than the other toward the end of the 90-day period. Then the results of the two groups could be compared. Or more resources could be targeted to the highest risk patients within the bundle, and fewer to lower risk patients. Fine-tuning program intensity, and measuring results, is critical to optimizing programs.

TARGETING THE RIGHT PATIENTS

Care management typically reduces utilization and therefore revenues, but offsets losses to some extent with shared savings. Clinical staff who see that a care management program is benefitting patients in a value-based payment program may want to extend the program to other patients. This is what CMS was hoping to accomplish—but it's absolutely critical to make sure it is financially sustainable.

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One of our clients manages high risk chronically ill patients in a capitated Medicaid contract at a cost of $325 pmpm. This client was considering extending the same care management program to patients with other payers, although there were no value-based payment contracts in place to support care management programs for those patients.

They might better use the improved outcomes from the first program to encourage other payers to reward them for their care management programs. Long term, you want *all* payers to do that; until a payer does, providing care management to those they insure is unlikely to be sustainable.

AVOIDING DUPLICATION

We have found that a surprising number of providers have multiple care managers working with the same patient, and that these managers often fail to communicate with each other. This is costly, inefficient, and confusing for patients. It can also be prevented. Care management programs can be inventoried and centralized in one department, or even within the clinically integrated network or accountable care organization.

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