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SELECTING THE RIGHT TECHNOLOGY PLATFORM TO COUPLE CARE MANAGEMENT WITH CDHPs

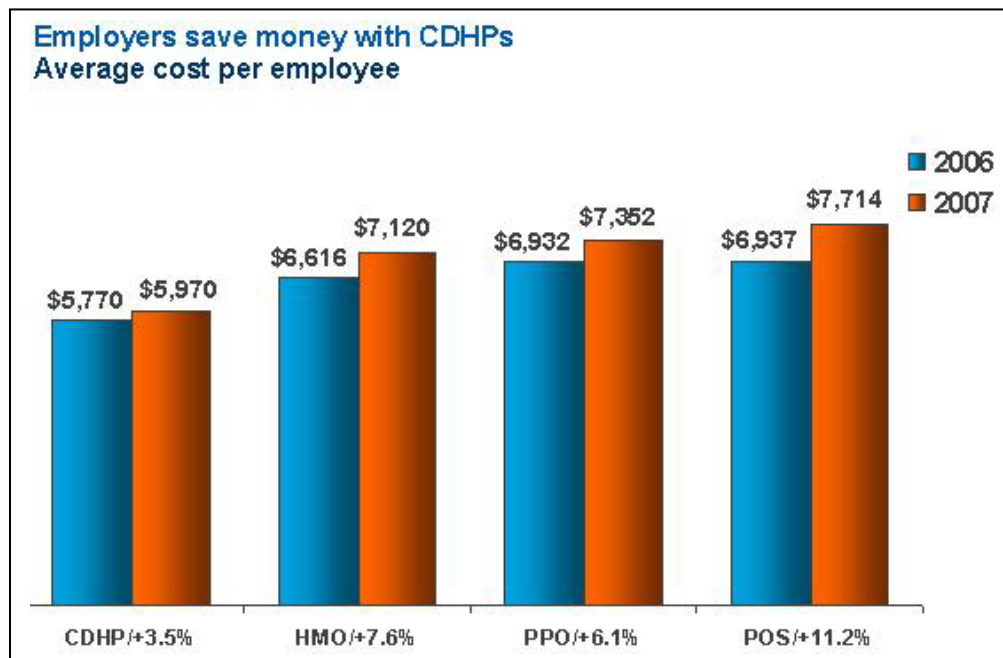
Powerful Combo Can Cut Costs & Put Payers Back in Driver's Seat

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The early returns are in. Despite their brief history and penetration of just 5 percent of covered employees, consumer-driven health plans (CDHPs) have yielded savings for large and small employers across the country. "CDHPs," reports Mercer, "delivered substantially lower cost per employee than either PPOs or HMOs in 2007." CDHP cost averaged just \$5,970 per employee, compared to \$7,120 for HMOs and \$7,352 for PPOs.² (See Figure 1.)

Figure 1



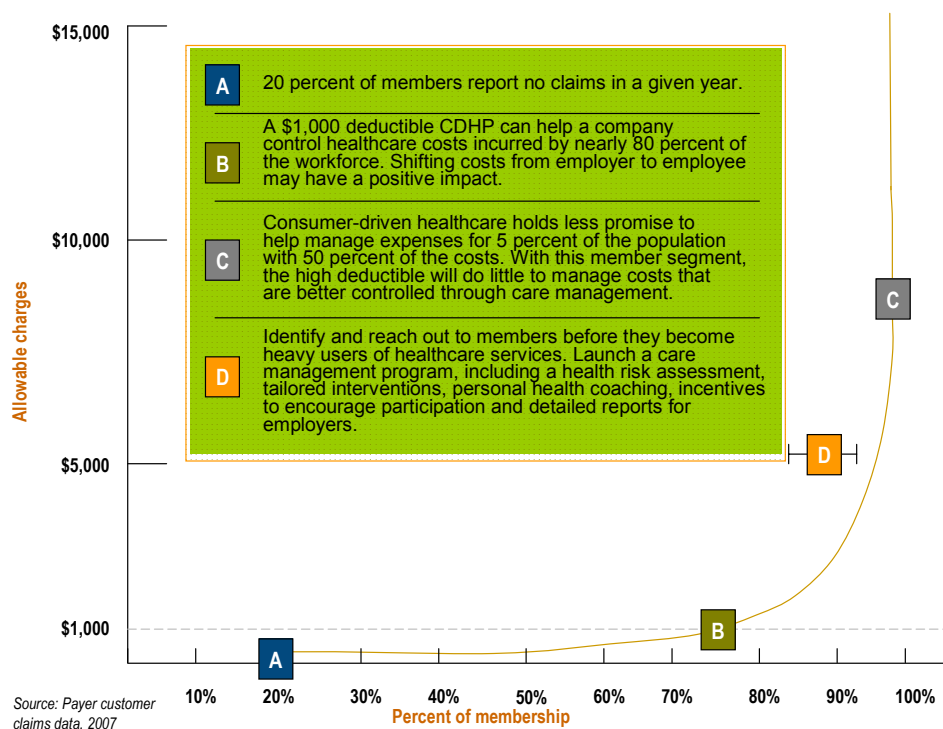
Source: Mercer, National Survey of Employer-Sponsored Health Plans, November 2007.

Impressive, to be sure, but health savings accounts and health reimbursement accounts are no panacea for rising employer premiums, which more than doubled between 2000 and 2007.³ Due to high premiums, many small businesses no longer offer health benefits. Among firms with fewer than 200 employees, health coverage prevalence fell from 69 percent in 2001 to 61 percent in 2007.⁴

However, if payers and employers couple CDHPs with comprehensive care management programs, they can reduce the growth in their healthcare spend. Here’s why. About 5 percent of a workforce typical of the general population accounts for 50 percent of healthcare costs.⁵ This small group faces chronic or even catastrophic conditions that require expensive, long-term care. These workers and family members are often in an acute medical state and unable to make decisions that factor in cost. With treatments ranging from \$25,000 to \$1 million, a \$2,500 individual or \$5,000 family CDHP deductible, for example, does little to mitigate the total medical cost to payers and employers for this small but significant population. (See Figure 2.)

Figure 2

CDHPs alone cannot control claim costs of critically or chronically ill



Care management programs include two components – disease management and case management – that target the 5 percent of members who account for 50 percent of medical costs: employees and family members who are hospitalized for acute episodes or who suffer from asthma, diabetes and other chronic illnesses. A third component of comprehensive care management programs -- wellness -- helps relatively healthy individuals remain free of costly acute or chronic illness. Worksite wellness initiatives incent participation by members, identified by health risk assessment (HRA) results or medical claims, in programs that address “controllable behaviors”: smoking, overeating and physical inactivity. These behaviors account for nearly 25 percent of all U.S. healthcare spending.⁶

A successful care management program requires the following:

- Employer support from the top – CEO on down – with care management champions in the home office and field locations.
- Employer incentives that spur broad participation in health risk assessments and intervention programs.
- Concrete, reportable results – for example, financial ROI, clinical outcomes, participation rates and year-over-year biometric improvements.
- Sufficient staffing by the payer, including personalized nursing and coaching.
- Compliance with HIPAA, ADA, ERISA and federal and state tax laws.
- A payer's integrated, member-centric software system. The platform should automate care management for greater cost efficiency, provide program nurses with a 360-degree view of the member, encourage member participation with robust web resources and support data and information-sharing between members, providers, the employer and its health plan.

In evaluating a care management software system, the payer organization should ask itself eight questions:

1. Can your workforce focus on care?

Can your current system readily identify members who would benefit from care management? Can it automate nurse-supported clinical interventions for the right populations, at the right acuity levels? The best medical management staff can become even more effective when it employs applications that improve member health, streamline workflow and reduce costs.

2. How is quality of care affecting your membership?

Effective care management systems improve the quality of care by identifying and stratifying populations and helping determine the appropriate value-based and quality-oriented outreach for the individual member.

In addition to identifying appropriate interventions, the best applications provide interactive, personalized, multi-channel engagement tools that promote behavior change, self-care and evidence-based compliance. Platforms that offer the right health information at the right time to the right people can optimize care management functions, truly engage members and help them make appropriate lifestyle changes.

3. Do you in-source or outsource care management functions?

A care management system that is flexible enough to support any resource pool, whether in-house or outsourced, is critical. Flexibility will enable your organization to respond readily as the product portfolio evolves and as staffing requirements and clinical risk management needs change. Exercising direct control over clinical programs is highly important to some payers but less so to others.

4. What are your near-term care management goals?

To improve your care management staff's daily workflow, your application should support a single, cohesive program, presenting a 360-degree view of the member. If the nurses who are providing disease, case and utilization management can share this integrated data source, the impact on workflow can be significant and immediate. The system's near-term value will increase when all care

managers are viewing and responding to the same data, which can reduce redundancy and errors. The best systems also allow members to contribute data through a personal health record, managed on the same Web-based platform that your medical management staff uses. This integration not only enhances the capabilities of nurses who provide care management engagements, but also enables:

- Workflow efficiencies
- Member interactions across the continuum of care
- More-informed dialogue regarding members' care concerns, across all stakeholders
- Greater likelihood of self-care based on clinical content that supports effective decision-making

5. What are your long-term management goals?

Systems built on flexible architecture can enable dynamic engagement capabilities and promote multi-channel intervention tools. These, in turn, make possible long-term, positive behavioral changes that can reduce excessive and inappropriate use of healthcare resources. The best platforms provide members with meaningful information at the right time and right level of readiness to change, thereby aiding in healthcare decision-making and supporting healthy lifestyle choices. Applications that provide disease management support on an integrated system allow for cross-functional use of a single database. This member-centric infrastructure drives automated disease management capabilities that push relevant health information, allowing personalized interventions that support compliance, control of members' conditions and clinical risk management. The right care management system can reduce gaps in care and enable long-term risk management, while helping reduce trend.

6. How effectively can you leverage member data in support of care management?

Innovative care management systems leverage member data from multiple sources and manage it on a single platform in order to provide greater workflow efficiency and enable a better, more helpful experience for members. By leveraging diverse data, these applications also engage members in more personalized ways and can help you deliver tailored incentives that drive real behavioral change.

7. Are you prepared to address change management internally?

More configurable systems, which adapt easily to your changing needs and unique workflows, enable use of both legacy technology and newer, more sophisticated data sources. By minimizing change management and maximizing data flow and utilization, your care management staff can enjoy greater productivity and manage an increased case load.

8. Are you deploying your workforce to support members who have the greatest need?

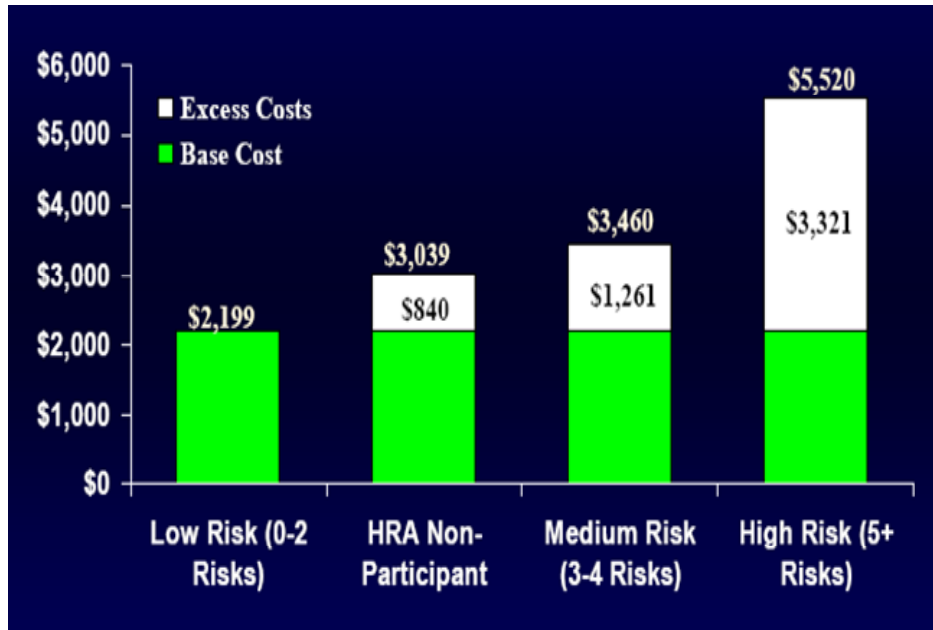
The best systems offer transparency into your population through their identification and stratification capabilities. By understanding the complex needs within your population, you can support members appropriately, improve care, optimize staff performance and reduce medical costs. To help you achieve this, the best platforms automate the evaluation of multi-dimensional member data, stratify populations, identify members who would benefit from care management and initiate the appropriate interventions for these members.

Risk stratification is the process of categorizing members based on the number of high health risks – for instance, 0 to 2 high risks, 3 to 4 high risks and 5 or more high risks. High health risks include consumption of more than 14 drinks a week, a body mass index equal to or greater than 27.5 and

cholesterol greater than 239 mg/dl. There are 13 such high risks, researchers and clinicians agree.⁷ Significantly, as an individual's high risks increase in number, so increases the individual's healthcare costs,⁸ which is why it's critical that a care management platform support ongoing risk stratification. (See Figure 3.)

Figure 3

Linking rising medical costs with rising health risks



Source: Edington, D.W., University of Michigan Health Management Resource Center, "Lost Productivity, the High Cost of Doing Nothing," updated PowerPoint presentation of findings originally reported in 2001 edition of American Journal of Health Promotion and based on data drawn from nearly two dozen companies, with an eight- to 18-year time horizon, 2006.

"Drive thy business or it will drive thee," intoned Benjamin Franklin. And it's spot-on advice for payer organizations in view of the rise in healthcare costs and decline in the number of employers offering health benefits. The powerful coupling of care management and CDHPs, enabled by the right technology platform, could bring discipline to healthcare costs and put payers back in the driver's seat.

Footnotes:

1. Mercer, National Survey of Employer-Sponsored Health Plans, November 2007.
2. *Ibid.*
3. Kaiser/HRET, Survey of Employer-Sponsored Health Benefits, 2007.
4. *Op. cit.*, Mercer.
5. Kaiser Family Foundation calculations using data from U.S. Dept. of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2005.
6. IFTF, Center for Disease Control and Prevention, 2002 and 2003; Whitmer, R., Pelletier, K., Anderson, D., et. al., "A Wake-up Call for Corporate America," *Journal of Occupational and Environmental Medicine*, September 2003.
7. Edington, D.W., University of Michigan Health Management Research Center, "Lost Productivity, the High Cost of Doing Nothing," updated PowerPoint presentation of findings originally reported in 2001 edition of *American Journal of Health Promotion* and based on data drawn from nearly two dozen companies, with an eight- to 18-year time horizon, 2006.
8. *Ibid.*

About the Author



Joseph Manheim is senior vice president of cost and quality of care and benefits administration for The TriZetto Group, Inc. A 25-year veteran of the healthcare payer and services industries, Manheim is responsible for leveraging TriZetto's position to develop new growth opportunities for the company's CareAdvance Enterprise[®] applications and third-party benefits administration business. Most recently, Manheim served as president of Interplan Health Group (IHG), a \$60 million, multi-regional, managed-care PPO and cost-containment company. He also served as president of JBC Healthcare Partners, a regional PPO retiree medical program, and he was senior vice president and chief operating officer of CCN Managed Care, a wholly-owned subsidiary of HCA Healthcare. Manheim's career has included leadership positions at Unilab Corporation, where he was vice president of business development; Preferred Health Network, where he was senior vice president and chief operating officer; Admar Corporation, where he was vice president of network operations; and Humana Corporation, where he served as director of respiratory therapy and the pulmonary laboratory, then as market manager of the Humana Care Plus and Humana Health Plans for Southern Calif. Manheim holds an associate's degree in Respiratory Therapy from Ventura Community College, and teaching credentials from the University of California at Santa Barbara. He completed business administration coursework at the University of Redlands.