



Key Issues in Population Health Management – Industry Outlook for 2012



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The Care Continuum Alliance, the primary industry advocate for population health management – wellness, prevention and chronic disease risk reduction and care – recently surveyed industry leaders within and outside its membership to assess the state of the market and forecast key issues for 2012.

Various market forces will influence the course of health care delivery in 2012 and expand opportunities for population health management. The survey revealed two overarching themes that frame many of the specific issues respondents identified. First, significant market movement will occur toward accountability and value creation in health care, driven partly by new physician-guided and collaborative models; and second, population health management is well-positioned to add value to and support these emerging models, but must continue to build the case for wellness and prevention.

Not surprisingly, many of the issues cited have roots in the Patient Protection and Affordable Care Act (ACA), reflecting the reform law's broad reach throughout the delivery system next year and beyond. Industry leaders are generally optimistic about ACA support for wellness and prevention, but cautiously so, given the unsettled political climate surrounding the law and its status as a target of deficit reduction measures. But respondents agreed that, policy debate aside, growing societal awareness of the value in wellness and prevention bodes well for population health management in coming years. "Ultimately, unprecedented interest is being focused on prevention" and chronic care management, one respondent commented. "This, coupled with the urgent need for cost containment in medicine, will create fantastic opportunities for credible programs with well-documented outcomes."

A Bright Future Overall

Survey respondents generally expressed optimism about the outlook for population health management in 2012, with nearly 90 percent reporting being either "strongly optimistic" or "somewhat optimistic" about the industry's prospects.

They identified innovation and new product development as key drivers behind business growth, illustrating the industry's generally proactive stance. The most promising markets for population health management in 2012 include Medicare Advantage plans, employer-sponsored group plans, hospital systems, Medicaid and physician practice care coordination support, the survey found.

Key Issues for 2012

The Care Continuum Alliance asked industry leaders to assess various high-profile issues in the context of the opportunity or challenge each presents for population health management. Survey respondents also suggested other market forces on the horizon and provide commentary, much of which has been included in this report. Below are the top issues identified as presenting the greatest opportunities or challenges for the industry – or, as often the case, both. As one respondent remarked, “Challenges are just the other side of opportunity.”

Accountable Care and the Medicare Shared Savings Program

Accountable care and collaborative models – and federal support for both – drew a great deal of comment from survey respondents as a key area of opportunity for population health management in 2012. The response is not surprising, given the buzz of the past year surrounding accountable care organizations and Medicare’s Shared Savings Program, which launches Jan. 1, 2012.

As outlined by the Care Continuum Alliance in its 2011 guide, “Achieving Accountable Care: Essential Population Health Management Tools for ACOs,” population health has much to offer collaborative care: health risk assessment and predictive modeling, HIT infrastructure, data analytics, care coordination, patient engagement expertise and other core competencies. One survey respondent summed it up this way: “Global economic drivers make more accountable care inevitable – it’s a question of who owns that accountability (government vs. health plans vs. providers) and how to achieve it. Population health management provides vital tools, capabilities, expertise and experience which, if marketed appropriately and adapted to accountable models of care delivery, should find an increasingly receptive marketplace.”

But tempering optimism around accountable care models were caveats:

- “Accountable care (in and out of Medicare [fee for service] and Advantage) and other value-based purchasing arrangements are, in my view, the biggest opportunity, as they militate toward population management strategies, albeit with a continuum of care. The industry is going to have to have much better strategies for managing high-risk individuals. It’s also going to need to sharpen its efforts to enabling providers and other vectors for community-based care.”
- “The opportunity will be to figure out what components of [population health management] will be the most useful in helping the delivery system adapt to and thrive under the new payment models.”
- “If ACOs become a reality and are structured in a way that provides a real incentive for managing health, they could be a major market opportunity. If they just become HMOs redux, not much will change.”

Consumer Use of Mobile and eHealth Technologies

The explosive growth of electronic health (eHealth) and mobile health (mHealth) technologies over the past five years has spurred significant opportunities for wellness and population health management, survey respondents said. Data from two recent market analyses bear this out – one forecasting global revenue in the telehealth market of \$990 million by 2015¹ and another predicting a “vibrant” market for mHealth, with 142 million downloads of health-related smartphone apps by 2016².

Population health management has been both a driver and benefactor of the rise in eHealth and mHealth technologies. Remote biometric monitoring, Web-enabled health coaching, online health references and calculators, personal health record apps and other innovations all have responded to growing consumer and provider demands for ease of access to health management tools. That demand, as one survey respondent said, will drive health care “to adopt...a patient-centered, consumer-empowered, pull-rather-than-push model, which has been already been realized in the music, travel, book and news industries.”

Survey respondents also noted the importance of social media coupled with mobile technology as a tool for patient engagement and shared decision-making. That perspective echoes findings from a joint survey released earlier this year by QuantiaMD and Care Continuum Alliance on provider use of social media. The survey found that more than 65 percent of physicians have used social media to support their professional practice and that a strong majority – nearly 80 percent – view social media as a promising tool for patient education.³ “The virtues of active shared decision-making between patients and providers will be demonstrated definitively and will lead to escalated use of services, tools, and capabilities to support shared decision-making,” one industry leader predicted.

Reducing Avoidable Hospital Readmissions in Medicare

The ACA established the Hospital Readmissions Reduction Program (HRRP), which looms large for hospitals and programs to improve care coordination and care transitions in 2012. For discharges from most hospitals on or after Oct. 1, 2012, Medicare will track readmissions within 30 days for three conditions – heart failure, acute myocardial infarction and pneumonia – and reduce payments to hospitals to account for excess readmissions. The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary projects that the HRRP, when fully implemented, will reduce Medicare costs by \$8.2 billion through 2019. Further, the law gives CMS the authority to consider additional conditions in 2015.

Supporting hospital compliance with the HRRP through increased care coordination presents a “big opportunity for companies who have developed proven strategies for reducing hospital readmissions,” one survey respondent said. “What’s more, the infrastructure exists for many in the sector already.” That infrastructure aligns well with needed services to prevent readmissions: medication adherence support, diet and lifestyle changes, coordination of follow-up care among various physician and non-physician providers, such as physical therapists.

Recognized the alignment between population health management and case management for aiding care transitions, the Care Continuum Alliance partnered with the Case Management Society of America in 2009 to develop a Case Management Model Act, a framework of important standards for case management services at the federal and state levels. The Model Act explicitly identifies care transitions support as a key element of comprehensive case management programs and a case manager's responsibilities. Further, it establishes a strong link between population health and case management by defining related case management activities to include "Population Health Management through wellness, disease and chronic care management, and promoting transitions of care services."⁴

If the HRRP provides a stick to reduce avoidable readmissions, a related ACA provision offers a carrot that could tap population health management resources in 2012: the Community-Based Care Transitions Program (CCTP). The CCTP, backed by \$500 million in federal funding through 2015, will test models for improving care transitions from hospitals to other settings and reducing readmissions for high-risk Medicare beneficiaries. CMS has said population health management providers would be among the groups considered for CCTP participation.

Quality Improvement in Medicare Advantage

Beginning in 2012, Medicare Advantage (MA) will award bonus payments to plans under a "stars" rating system to assess performance on a host of measures, including an expected selection of new quality indicators that population health management can change for the better: smoking cessation, adult body-mass index, medication adherence and others. The Care Continuum Alliance was active in the debate surrounding the transformation of the stars system from a simple consumer comparison tool to bonus payment system. The developing stars system appears headed toward a structure consistent with industry-advocated changes, including additional wellness and prevention measures and retirement of process-related measures – a shift in focus toward outcomes, as the Care Continuum Alliance has recommended.

Combined with continued strong growth in the Medicare Advantage population, the need for plans to demonstrate improvement in wellness and chronic care measures will drive expanded opportunities in the Medicare managed care market, industry experts predict. Likewise, Special Needs Plans (SNPs) – Medicare Advantage plans targeting the chronically ill, certain institutionalized beneficiaries and dual eligibles – will face new quality requirements in 2012, including National Committee for Quality Assurance approval, that could further bolster the case for the expertise and tools population health management provides. Challenges remain, though, including an unfunded ACA mandate that dual eligible SNPs enter into contracts with state Medicaid agencies by 2013 and broader Medicare Advantage spending reductions contained in the reform law.

Build vs. Buy?

An industry challenged at times by payer decisions to build rather than buy care management programs could face additional competitive pressure in 2012: the collaborative and accountable care models also cited

among the coming year's top opportunities. "The market will continue challenging the value of each program and, with the consolidation in the [managed care] industry, will continue looking at insourcing vs. outsourcing," one industry leader said. "ACOs may be a greater opportunity, but. . .these groups will often favor their own solutions rather than those from the outside." Another respondent struck a more optimistic note: "From a service provider's point of view, insourcing might be a challenge unless you manage to support this trend" with various tools and technology.

To that point, many components of population health management likely will prove particularly valuable to health plans in 2012, regardless of the build or buy decision. As noted in the previous section, Medicare Advantage plans, responding to the star performance ratings system's financial incentives, could provide fertile ground for new population health management business as the plans work to improve wellness and chronic care scores and meet other quality goals.

Improving Care Coordination for Dual Eligibles

Dual eligibles – individuals eligible for both Medicare and Medicaid benefits – attracted significant attention from policymakers in 2011 as economic pressures created an imperative for savings in both programs. The more than 9 million dual eligibles are among the most chronically ill and costly beneficiaries in federal health programs. Sixty percent having multiple chronic conditions and 19 percent live in institutional settings compared with 3 percent of non-dually eligible beneficiaries. The need to reduce costs associated with this population is especially high: 16 percent of Medicare enrollees are dually eligible, but account for 27 percent of Medicare spending, federal figures show. In Medicaid, 15 percent of enrollees are dually eligible, but account for 40 percent of program spending. As one survey respondent said, "Focus on improved care coordination for complex, multi-morbid patients is a must."

Congress and the administration recognized the savings possible through better care coordination for dual eligibles by formalizing federal oversight of the population in the ACA, which established a Federal Coordinated Health Care Office, or "Duals Office." This heightened federal recognition, which includes significant federal dollars toward testing new models of care delivery for duals, places a premium on care coordination services, such as those population health management provides. Toward promoting the important role population health management can play in dual eligibles' care, the Care Continuum Alliance in 2011 established a member panel dedicated to the issue, the Dual Eligibles Work Group. The work group is nearing completion of a white paper on core components of comprehensive, integrated dual-eligible payment and care delivery models.

Federal Support for Prevention and Wellness

Although the ongoing deficit reduction debate in Congress has jeopardized federal support for wellness and prevention as envisioned in the ACA, population health management industry leaders remain optimistic about federal program opportunities. The \$15 billion Prevention and Public Health Fund, a bipartisan target

for deficit-reducing cuts, is an important part of the federal effort, but only one element of a broader prevention and wellness strategy encompassed by the ACA.

Since the law's passage, Medicare has added annual wellness visits and expanded coverage of obesity and cardiovascular disease prevention services, and the federal government has made significant grant funding available to states and communities for prevention and care coordination initiatives. The law also resulted in a revised calculation for health plan medical loss ratio that places a higher value on wellness and care coordination services; and established an essential benefits package for its nascent Health Insurance Exchanges that includes wellness, prevention and chronic care services.

Survey respondents were clearly sanguine about the prospects for population health in light of the changes. "The greatest opportunities," one said, "will result from unprecedented interest in prevention and disease management that is resulting from various health care reform-related" provisions. One fly in the ointment, however, remains: enforcement of the Genetic Information Non-Discrimination Act (GINA). The regulation limited use of family medical history in health risk assessments and wellness programs and diverged from statutory language by classifying financial incentives and disease management as prohibited "underwriting" when linked to genetic information collection. Ongoing uncertainty surrounding regulators' interpretation of GINA and related provisions under the Americans with Disabilities Act remains a hot-button issue for wellness leaders even now, two years after the regulation's start date. A strict reading of the rules has the "potential to eliminate or hamstring employer and group health plan use of incentives for health risk assessments and other program components," one respondent suggested.

Development of ACA Health Insurance Exchanges

Development of the reform law's Health Insurance Exchanges, scheduled to open their doors in 2014, will draw significant attention in 2012, especially with respect to how CMS structures the essential benefits package all participating plans must offer. The challenge, industry leaders say, is ensuring the package is comprehensive and that plans don't dilute population health services to maintain competitive pricing in the exchange market. The law does include "preventive and wellness services and chronic disease management" among 10 required benefits categories, putting the exchanges squarely in the opportunity column, as well. But concerns remain that the plans could mirror inadequacies in preventive services sometimes found in small employer plans, given a requirement that the exchange plans' scope of benefits not exceed the national average premium of the typical small employer offering. Dec. 16 CMS guidance might ease that concern somewhat by allowing for additional benchmarks, including large state employee and commercial HMO plans.⁵

The Care Continuum Alliance responded recently to another potential challenge: a lack of flexibility in the wellness and preventive services offered by exchange plans. In a November 2011 comment letter, the Care Continuum Alliance urged regulators to ensure flexibility in services offered and to preserve coverage of services based on health status, claims history and referrals, regardless of the explicit listing of services in benefits descriptions.⁶ The Dec. 16 guidance said CMS' final plan would afford flexibility in benefits design.

Moving Forward

Regardless of differences in respondents' outlook, they agree on one point: Population health management will play a central role in helping the health care system improve health, raise care quality and reduce cost. As the nation's chronic disease burden grows, strategies to identify disease risk, avert the onset or progress of chronic conditions and help the well maintain a healthy state of being must be embraced and promoted.

About the Care Continuum Alliance and Population Health Management

The Care Continuum Alliance convenes all stakeholders along the continuum of care toward improving the health of populations. Through advocacy, research and education, Care Continuum Alliance advances population health management strategies to improve care quality and health outcomes and to reduce preventable costs for those who are healthy, at risk of or currently managing chronic conditions. Our diverse membership of more than 200 organizations and individuals includes physician groups, nurses, other health care professionals, hospital systems, wellness and prevention providers, population health management organizations, pharmaceutical manufacturers, pharmacies and pharmacy benefit managers, health information technology innovators, employers, researchers and academics.

The Care Continuum Alliance defines "population health management" as a set of services and interventions designed to address health needs at all points along the continuum of health and well-being through participation of, engagement with and targeted interventions for the population. The core components of a population health management program include: population identification; population health assessment; population risk stratification; engagement and communication; health management interventions; and outcomes measurement.

The goal of a population health management program is to maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions and interventions. These health management interventions include: health promotion and wellness; health risk management; care coordination; and disease and case management. They are determined and offered based on an individual's health status and need.

Increasingly important components of health management interventions are wellness, health promotion and risk prevention. While chronic care management focuses on optimizing medical care for individuals with specific chronic conditions, wellness programs seek to prevent such illness, minimize risk and improve general health. The Care Continuum Alliance defines wellness programs and chronic care management programs as subsets of population health management programs.

Care Continuum Alliance research has defined wellness programs as strategies designed to:

- Help individuals maintain and improve their level of health and well-being by identifying health risks and educating them about ways to mitigate these risks.
- Increase awareness of factors that can affect health and longevity.
- Enable individuals to take greater responsibility for their health behaviors.
- Prevent or delay the onset of disease.
- Promote healthful lifestyles and general well-being.

Specific health needs and risk statuses vary across populations. As such, effective wellness programs employ a variety of behavior change techniques and lifestyle management strategies. Not all programs, populations or individuals will require the same combinations of strategies. Examples of common wellness program components include health risk appraisal; biometric screening (e.g. blood pressure, cholesterol); smoking cessation; weight loss; diet and nutrition; stress reduction; exercise and fitness programs; ergonomic programs; safety (both in the workplace and at home); sleep hygiene; health advocacy; disease screening; and immunization.

To learn more about Care Continuum Alliance and to become a member, call (202) 737-5980 or write to info@carecontinuum.org. Visit the Care Continuum Alliance online at www.carecontinuum.org.

¹ InMedica. Competition in the Telehealth Market Set to Intensify. 28 Nov. 2011. Web. 14 Dec. 2011. <http://in-medica.com/press-release/Competition_in_the_Telehealth_Market_Set_to_Intensify>.

² Juniper Research. Mobile Healthcare and Medical App Downloads to Reach 44 Million Next Year, Rising to 142 Million in 2016. 29 Nov. 2011. Web. 14 Dec. 2011. <<http://www.juniperresearch.com/viewpressrelease.php?pr=275>>.

³ Modahl, Mary, Lea Tompsett, and Tracey Moorhead. Doctors, Patients & Social Media. Rep. Washington, DC: QuantiaMD/Care Continuum Alliance, 2011. Print

⁴ Case Management Model Act of 2009. Little Rock, AR: Case Management Society of America, 27 Aug. 2009. PDF.

⁵ Centers for Medicare & Medicaid Services. Center for Consumer Information and Insurance Oversight. Essential Health Benefits Bulletin. Washington, DC: Centers for Medicare & Medicaid Services, 2011. Print.

⁶ Moorhead, Tracey. "Essential Health Benefits Development." Letter to Steve Larsen and Sherry Glied. 21 Nov. 2011. MS. Washington, DC.



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