Overcoming Payer Care Management Challenges in 2020 and Beyond

by Matt Gagalis

As we move into 2020, it is clear that the Medicare Advantage market will continue to evolve and expand. CMS has announced that premiums will drop an average of 14 percent, which combined with more than 1,200 new plan choices nationwide will help to grow the total Medicare Advantage population by more than 2 million members.

Payers have long realized the need for effective care management, and larger member populations and increased competition will continue to underscore the importance of initiatives that effectively and efficiently help identify and manage high-risk, high-cost and complex patients. Outlined below are several areas where payers can focus in 2020 to support this effort and address care management challenges.

Incorporating real-time data

Payers have invested significantly in analytics and other capabilities powered by claims data to support member identification, risk stratification and care management efforts. Generally, these initiatives have yielded positive clinical and financial outcomes. Claims data, however, is not without its limitations and may be insufficient in delivering the results expected of high-performing plans in 2020. Given the three- to six-month lag in claims data, as well as the lack of clinical information in claims, many payers may struggle to succeed in quality measures that are closely tied to acute and post-acute care.

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Quality care requires knowing when and where a patient receives care, such as when a patient presents at the emergency department or has been discharged to skilled care or home. Today, solutions exist that are capable of providing access to real-time data. With continued policy focus on healthcare data interoperability, the availability of such solutions will only increase. To improve care coordination in 2020 and beyond, payers must incorporate real-time data sources and implement solutions that enable clinically appropriate follow-up and clearer visibility into patient movement across the continuum of care.

Making strides to reduce readmissions

Over the past twenty years, lowering readmissions has been a longstanding challenge for both payers and providers. The CMS Hospital Readmissions Reduction Program receives the credit for declining readmission rates, however evidence suggests that the reduction has actually been driven by an overall decline in all hospital admissions.

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Value-based care agreements have aligned incentives across stakeholders, and advances in telemedicine, in-home care and real-time data availability have also shown the potential to positively impact readmissions. In conjunction with these advancements driven by value-based care, payers and providers must continue to collaborate around strategies such as discharge planning and post-acute provider network management to drive positive outcomes for patients and reduce readmissions.

Improving member experience

With increasing numbers of older Americans choosing Medicare Advantage plans and more high-quality plan options than ever before, payers must deliver a consistently superior experience for their customers. Stars Ratings and other quality initiatives have delivered strong outcomes in areas like medication adherence and preventive care, however payers have historically struggled to move the needle in member experience and satisfaction. As CAHPS and other patient experience and satisfaction measures become increasingly important to health plan reimbursement, payers' continued focus on improvement in these measures is anticipated in 2020 and beyond. Driving satisfaction scores is complicated and multi-factorial, but there are elements within payer control that can make an impact, including more accurate and efficient prior-authorization, more timely care management and support, and better network management and utilization management to ensure patients receive the appropriate level of care from the right provider at the right time.

Prioritizing emerging focus areas and new technologies

Payers must wade through several evolving healthcare solutions as they consider their strategies, but ultimately the key is for decision makers to remain focused on implementing initiatives that are proven to deliver a high impact across multiple high-priority areas.

For example, social determinants of health has emerged as an area of focus for payers. One potential strategy to achieve more effective care management entails a better understanding of how social determinants drive – or inhibit – continued quality improvement. By leveraging new sources of real-time data that extend beyond what is available in claims data, health plans may gain different perspectives on patient challenges and risks, and better insight into the non-clinical social barriers that may play a role in a patient's frequent hospital readmissions or ED utilization. To establish a more complete picture of patients' health, plans must incorporate new sources of data and intervene more quickly to ensure no patients fall through the cracks.

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Additionally, payers have been barraged with a host of technology solutions that range from telemedicine to patient engagement and remote monitoring. Many of these new solutions highlight the potential of "big data" or "A.I.", both of which have been buzzwords in healthcare for years. Health plans and other organizations have invested significant resources to develop the infrastructure required to collect massive amounts of data from disparate sources, but the data alone will not improve quality or reduce costs. Payers must adopt technology that makes data actionable and contextual – using it to inform clinical decision-making and improve care management. Health plans should seek solutions that can not only provide the data from disparate sources, but that can also surface data and provide alerts in a way that is meaningful and actionable.

Conclusion

Many payers recognize it is critical to prioritize care management, but they must continue to drive initiatives that utilize real-time data to effectively and efficiently track patients within the continuum of care, reduce readmissions and improve member experience. Although still a valuable data source, payers can no longer rely solely on claims data to successfully manage patients – particularly complex and high-risk patient populations. Ultimately, care coordination technologies that provide access to real-time clinical updates and actionable data are essential to help payers address care management challenges in 2020.

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