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*Healthcare for  
complex  
populations*

**&**

**The power of  
whole-person  
care models**



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# Executive summary



**Government-financed healthcare** has experienced explosive growth over the last few years. An aging demographic has fueled Medicare enrollment growth, and provisions of the Affordable Care Act — expansions in Medicaid eligibility and subsidies on health insurance exchanges — have further extended the reach of government-financed healthcare.

Due to healthcare reform, there is an emerging opportunity for private payors to serve as intermediaries between a budget-constrained federal government and these government-financed patient populations. These generally older, poorer, and more vulnerable populations place high demands on the healthcare system because they often require not only medical care but also behavioral care, long-term-care assistance, and social support. These members have historically bounced across a fragmented provider system with minimal care coordination and suboptimal outcomes.

This is a challenging problem, yet there are clear rewards for the payor that solves it. We conducted an in-depth study on the care of complex populations, and believe the solution is next-generation whole-person care models. Based on our research, successful models must include five elements: (1) *a care coordinator*, who serves as a quarterback in overseeing the patient's care; (2) *a multidisciplinary healthcare team*, with medical, behavioral, and long-term-care experts; (3) *care collaborators*, such as government agencies, faith-based groups, and the patient's family and friends; (4) *informatics*, such as digital tools for more effective patient monitoring and engagement; and (5) *the right incentive structures*, in which all team members are rewarded for better health outcomes.

Success with whole-person care models requires that payors develop a set of foundational capabilities that apply across all models, along with tailored capabilities required to manage care for specific subgroups (such as homebound elderly or the mentally ill). Critically, digitization is a core aspect of these capabilities, in that it fosters a more coordinated, real-time, and holistic approach to care while optimizing the “level of touch” involved.

# *An opportunity — and a challenge*

In the United States, the Affordable Care Act (ACA) has presented payors with a compelling opportunity. On one hand, there is explosive growth in enrollment for government-financed healthcare programs. On the other, states and federal government agencies are becoming increasingly budget-constrained. The result is that some government programs that were minimally coordinated in the past are now being moved to a managed-care model.

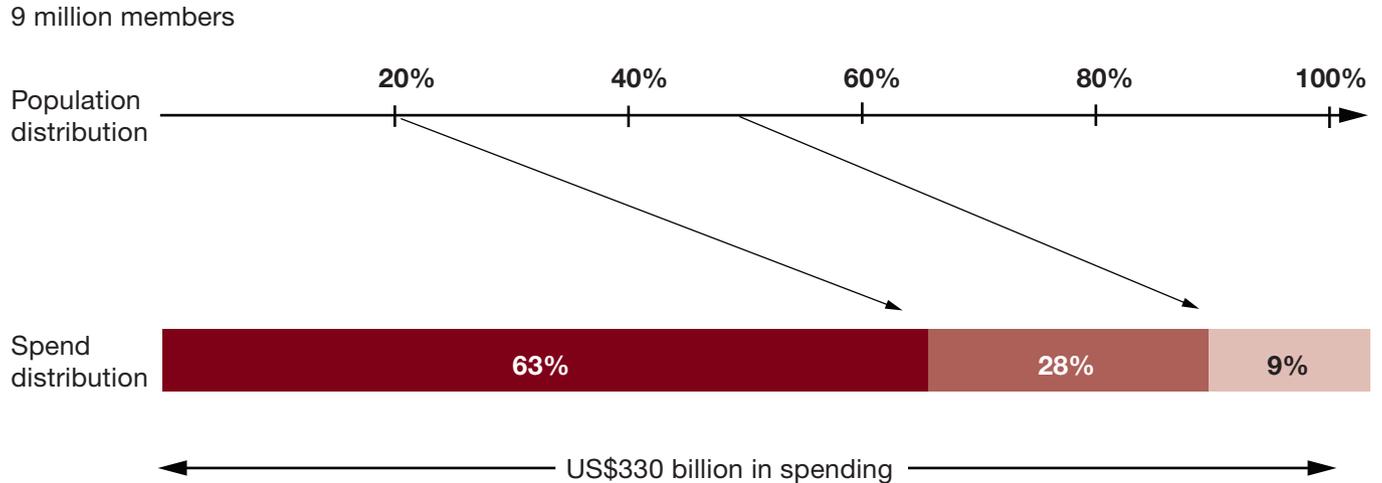
Under the dual demonstration pilot program, for example, healthcare system players have the chance to manage care for complex populations under a potentially profitable demonstration model — one that envisions a three-way contract among states, the Centers for Medicare & Medicaid Services (CMS), and payors. (Accountable care organizations and primary-care case management organizations can also participate.) The program aims to lower healthcare costs, improve outcomes, and introduce market-based reforms by semi-privatizing the care for this market. The government provides a set, risk-adjusted amount of funding per patient, and payors that can manage these patients' care within that budget (while adhering to quality criteria) will be able to keep the difference.

Yet the opportunity comes with challenges, because complex populations are inherently difficult to treat and payors often lack the experience to properly oversee their care. Such individuals may be frail and homebound, living in long-term-care facilities, struggling with serious mental illnesses, or facing other complex chronic medical challenges. In general, complex populations are heavy users of medical care and account for a disproportionate share of costs. For example, just 5 percent of Medicaid beneficiaries account for 54 percent of all Medicaid expenditures.<sup>1</sup> Dual-eligible populations alone — people who qualify for both Medicare and Medicaid — incur more than US\$330 billion in annual costs through Medicare and Medicaid, and the most complex 20 percent of duals account for almost two-thirds of the costs (*see Exhibit 1, page 5*).

*The dual demonstration pilot program aims to lower costs and improve outcomes.*

Exhibit 1

**Roughly 20 percent of dual-eligible patients consume two-thirds of spending for the entire population: Duals population and spending (2008)**



Source: "Health Care Spending and the Medicare Program," Medicare Payment Advisory Commission, June 2012

In addition, patients from complex populations need help with more than just their medical needs. Many also require assistance with behavioral health issues, such as depression, that complicate their chronic conditions. And they need assistance with social needs, including being connected with government services (such as subsidized housing and home heating credits) as well as community resources (for example, Meals on Wheels or faith-based charity programs).

Yet today, the healthcare landscape is so fragmented that serving such patients' medical, behavioral, and social needs is difficult. Patients from complex populations may bounce from emergency room to primary-care specialist to retail clinic to urgent-care center — with nobody helping them navigate the system and no one knowing what all the other players

in the system are doing for a particular patient. As a consequence, costly errors are committed, such as prescriptions for medicines that interact badly with other medications a patient is taking, or unnecessary duplication of tests. Moreover, in the United States, physical and behavioral healthcare systems currently operate separately; providers from each system rarely talk with one another. Thus, for example, a doctor may not be aware that a patient with severe diabetes has been struggling with depression and therefore lacks the will to follow the daily exercise regimen or blood-sugar monitoring the doctor has suggested. Finally, the incentives in the system aren't always aligned — for example, a nursing home may not have the financial incentive to proactively prevent the deterioration of a patient's health in order to avoid hospitalization.

All of these issues raise the degree of difficulty for payors that wish to enter the market for complex populations. Most have little experience dealing with these patients, and poor care management could spell significant financial losses if they don't carefully monitor care for complex patients and if the government doesn't introduce proper risk-adjusted reimbursements. Moreover, owing to these patients' relatively low socioeconomic status, numerous advocacy organizations have arisen to champion their cause. Any missteps on the part of a health plan in serving these patients could spawn tremendous negative publicity for the plan — including charges of skimping on care to turn a quick profit.

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# ***Whole-person care model***

Our view is that integrating the healthcare system to adequately meet these patients' needs and turning a profit are not mutually exclusive goals for payors. To do so, however, they must apply what we call next-generation whole-person care models (WPCMs), meaning a coordinated approach that addresses medical, behavioral, and other needs of complex populations, tailored to specific subpopulations within the patient universe.

The concept for WPCMs derives from a recent Strategy& research effort (see *"About Our Research,"* page 19). We observed that by deploying these models effectively, health plans can reduce costs while boosting quality of care and patient satisfaction.

Our analysis shows that successful WPCMs must comprise five building blocks if payors are to deliver the best care and do so profitably (see *Exhibit 2, page 8*). Optimizing the model requires integrating all five blocks. To be sure, some portions of this model are being applied in small pockets today, but the concept needs to be scaled up broadly in a sustainable and cost-effective way.

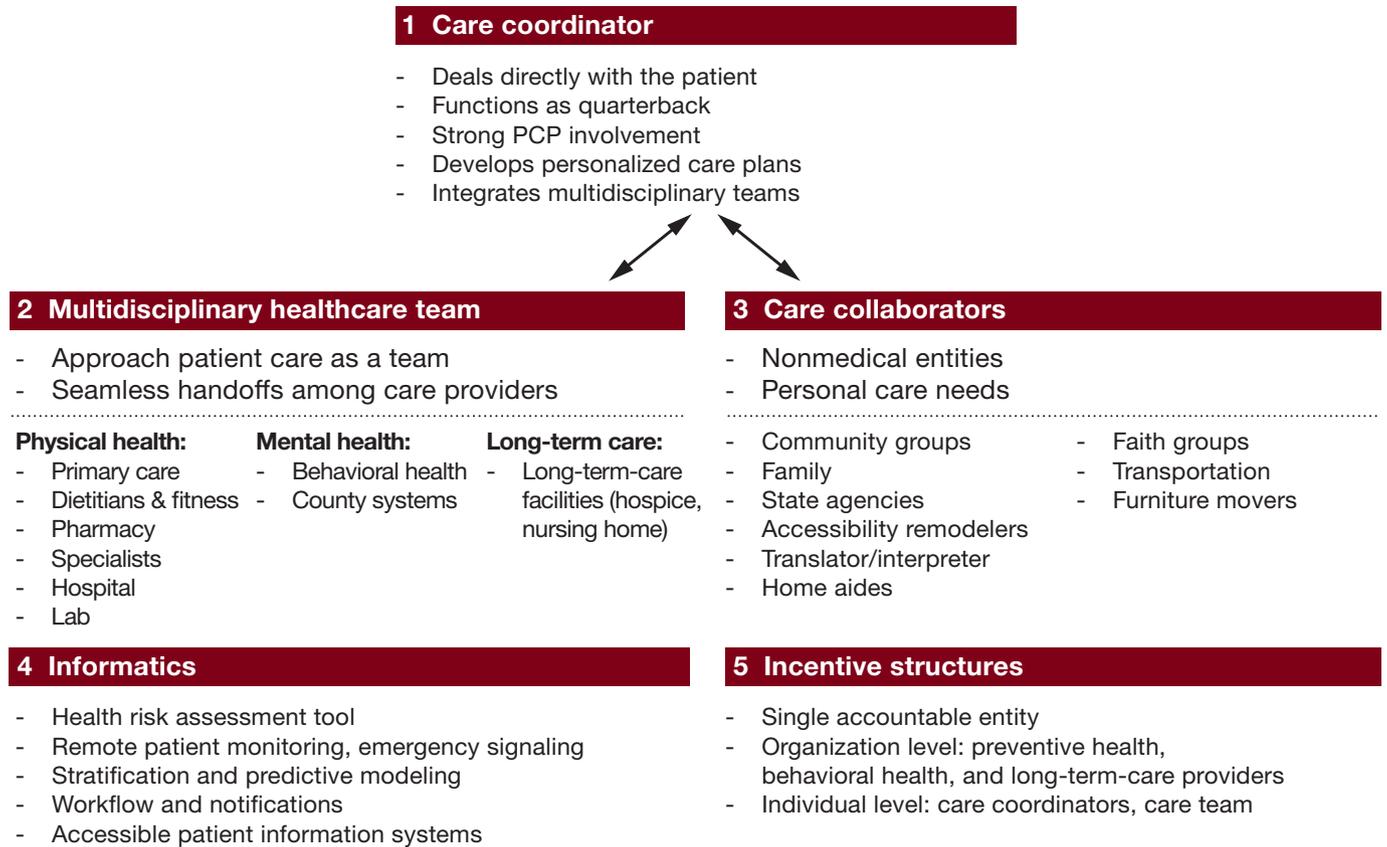
## ***1. Care coordinator***

This individual is the "quarterback" — a central figure in the WPCM who can coordinate information and action among the multiple healthcare providers working with the members he or she is responsible for. This person also works with informal caregivers such as family members, friends, neighbors, and local charities.

The care coordinator may be an employee of the payor, a doctor or registered nurse from a healthcare provider organization, a counselor from a social-work agency, or an individual from another type of organization in a patient's community — depending on the patient's needs. Regardless of their organizational affiliation, care coordinators stay in regular touch with their patients. They perform a range of

Exhibit 2

A whole-person care model for complex populations includes five elements



Source: Strategy& analysis

activities: remind the patient to take prescribed pills, contact family members or neighbors in emergencies, coordinate healthcare providers, help the patient find needed resources, and ensure that medications are reconciled. The best care coordinators are often from the same local region and share cultural similarities or even life experiences with their patient panel. (For example, former alcoholics are often effective care coordinators for current patients with drinking problems; some pilots suggest that mental health patients have stronger bonds of trust with care managers from the behavioral health system.)

## **2. Multidisciplinary healthcare team**

This team consists of the medical providers (including primary-care physicians and specialists), behavioral care providers (such as psychotherapists), and long-term-care facility providers who work closely together to serve patients. Providers may deliver care in a wide range of settings in addition to hospitals, clinics, and nursing homes. For instance, visiting primary-care physicians (PCPs) may see patients at an adult day-care center in the local community, backed by on-site care coordinators who provide services such as fall-prevention counseling and blood pressure checks. Similarly, email mentoring relationships may be set up between PCPs and psychiatrists to collaborate on depression screenings.

## **3. Care collaborators**

These are external entities: government agencies, faith-based community groups, patients' families and friends, and social workers. The value of the informal caregiver network cannot be overemphasized, as collaborators perform a wide range of critical (and often nonmedical) tasks. Examples include volunteers who drive patients to doctors' appointments and adult day-care centers; social workers who visit patients at home or in the hospital to help them learn about and gain access to government services; home aides who provide daily living assistance; and even remodelers and furniture movers who help ensure a safe living space. Care collaborators also include family members who provide backup assistance as needed, such as caring for an aging parent if a snowstorm has led to the closing of an adult day-care facility that the patient typically attends.

## **4. Informatics**

Savvy use of informatics enables all players in the system to gather, generate, and respond to data, such as real-time alerts of unfilled prescriptions. Informatics also supports patient profiling and segmentation, such as identifying people at risk for depression, social isolation, or difficulty gaining access to adequate nutrition.

Innovations in remote monitoring, such as wireless blood-pressure monitors and scales that transmit real-time data to the care coordinator, streamline the monitoring of the patient's condition. Electronically programmed pillboxes "beep" to remind the patient to

take medications. Video and tele-health systems set up in patients' homes reassure them that help is at hand and make them feel less isolated. And analytics on emergency room visits for specific city blocks enable payors to set up primary-care interventions in the field that triage patients before they end up in the ER. Prudent use of informatics can significantly optimize the productivity of the care team and make interventions more cost-effective.

## **5. Incentive structures**

Designed by the health plan (or risk-bearing entity), the right incentives encourage effective behaviors on the part of care coordinators, care collaborators, and healthcare providers. Examples include performance bonuses for care teams that reduce the number of amputations, infections, and hospital admissions for people with diabetes, and referral fees for social workers who connect diabetics to treatment teams or who locate seriously mentally ill individuals who have gone missing. In situations where the health plan contracts with a provider that is fairly integrated in its ability to provide many of the WPCM services, the health plan would need to assess the provider's ability to distribute the incentives in a fair way internally, as that would have implications on the effectiveness of the WPCM.

Forward-thinking payors will design compensation for all providers — care coordinators, physicians, home health aides, adult day-care staff, tele-health professionals — based on the patient's overall set of outcomes, both clinical and financial. This can be assessed by a combination of *outcome metrics*, such as the number of ER visits or hospital admissions, and *process metrics*, such as prescription refills and medication reconciliation within a few days of discharge.

*Informatics  
can optimize  
productivity.*

# Tailoring WPCMs to subpopulations

Member segmentation plays a key role in the application of WPCMs. Subpopulations within the overall complex-population market have decidedly different needs, so health plans need to tailor their WPCMs accordingly. Based on our analysis of dual eligibles, we found that four subsegments drove most of the costs among that population: patients with serious mental illness; those in long-term-care facilities; patients that are frail, elderly, and homebound; and those with chronic co-morbidities (such as diabetes and heart disease). Very often, patients span multiple categories, which further complicates their healthcare needs and amplifies the care management needed (*see Exhibit 3*).

## Exhibit 3

Among dual-eligibles, four population subsegments require the most complex care and thus need tailored versions of the WPCM

The mentally ill	People in long-term care	The frail, elderly, and homebound	People with chronic co-morbidities
<p><b>Criteria:</b> schizophrenia, bipolar disorder, OCD</p>	<p><b>Criteria:</b> admitted to a nursing home</p>	<p><b>Criteria:</b> age 65 or older, have limited mobility and/or functional impairments</p>	<p><b>Criteria:</b> congestive heart failure, diabetes, depression, Alzheimer's</p>
<p><b>Considerations:</b></p> <ul style="list-style-type: none"> <li>- Psychiatric hospitalization</li> <li>- Readmissions</li> <li>- ER visits</li> <li>- Institutionalization</li> <li>- Medication management</li> </ul>	<p><b>Considerations:</b></p> <ul style="list-style-type: none"> <li>- Institutionalization costs</li> <li>- Hospitalization</li> </ul>	<p><b>Considerations:</b></p> <ul style="list-style-type: none"> <li>- Home aides (for bathing, paying bills, cooking)</li> <li>- Hospitalization from falls</li> <li>- Adult day care</li> </ul>	<p><b>Considerations:</b></p> <ul style="list-style-type: none"> <li>- Hospitalization</li> <li>- ER visits</li> <li>- Readmissions</li> </ul>

Various combinations of the factors above further exacerbate the effect on the healthcare cost of the dual-eligible member

Source: Strategy& analysis

Consider patients with serious mental illness. For them, preventable hospitalizations stem primarily from nonadherence to antipsychotic and mood-stabilizing medications. Causes of nonadherence include patients' belief that they are not sick, concurrent substance abuse, and poor relationships with psychiatric staff members. Moreover, many patients who have serious mental illnesses aren't aware of alternative care settings such as charities, shelters, detox centers, and other organizations that provide meals, job-search assistance, and help with receiving Social Security disability insurance. As a result, such patients often end up in emergency rooms. Finally, within this subpopulation are smaller segments with their own unique needs. Examples include foster children who have developed serious mental problems owing to neglect or abuse and who are constantly being uprooted as they shuffle between foster homes.

To effectively and profitably serve severely mentally ill patients, payors need to customize their WPCM to the unique challenges facing these patients. For example, care coordinators who are particularly adroit at motivational interviewing and educating patients on available and appropriate care settings can earn their trust. A coordinator with personal experience — such as a recovering alcoholic or someone who has learned to manage bipolar disease — can further gain the patient's trust and inspire hope that life can be better.

Relatedly, the needs of frail, elderly, and homebound individuals differ substantively from those of people with serious mental illnesses. Within this subpopulation, falls are the number one cause of emergency room visits and hospital admissions for trauma. Patients in this group are at especially high risk of hospitalization if they have unmanaged chronic conditions or live in homes that are unsafe or unhygienic or that lack adequate heating or air-conditioning systems. Thus a WPCM adapted to them should emphasize attention to safety concerns in their living situation and alleviate feelings of isolation. Care coordinators may set up and track readings from remote monitoring devices, such as blood-pressure monitors, and coordinate home interventions such as toenail clipping, shag-carpet removal to prevent falls, and construction of wheelchair ramps.

Similarly, nursing home residents have unique needs as they are generally less healthy and do not live with family. Many suffer from dementia and are disoriented, which requires a higher degree of touch. Some physicians prefer to treat these residents in a hospital setting, which can drive up admissions, as can the lack of medical skills among night-shift care providers. In this demographic, transitions between a hospital and a nursing home, medication interruptions, and depression can all exacerbate health problems.

*A WPCM adapted to the frail, elderly, and homebound should emphasize safety concerns in their living situation.*

Accordingly, the nursing home variant of WPCM should recognize that the care coordinator should be a nurse practitioner — capable of prescribing medication, ordering on-site lab tests, administering IVs, and performing related functions, while also proactively screening for issues with vision, hearing, and depression. The care coordinator should be familiar with end-of-life considerations and organize family conferences to discuss options. Collaborators in this case could also include faith-based groups that provide spiritual services. Clearly, the incentives should be aligned between nursing home and hospice, and conform with complex regulations and reimbursement differentials between the Medicare skilled nursing facility program and Medicaid.

Among the health models we studied, several plans have already achieved impressive results by adapting the WPCM to subpopulations. For example, the Westchester Cares Action Program in New York observed a 46 percent decrease in hospital admissions and a 15 percent reduction in emergency visits for chronic patients.<sup>2</sup> Connected Care in southwest Pennsylvania saw reductions of 12 percent in emergency visits, 12 percent in mental health hospitalizations, and 20 percent in readmissions for patients with serious mental illness.<sup>3</sup> Mid Rogue health plan in Oregon ensured that 100 percent of foster kids in a pilot program were not only assigned to a primary-care physician within 14 days of placement in a foster home but also received a health screening in the first month.<sup>4</sup> CareMore members in California and Arizona cost 15 percent less than the overall Medicare population, in part due to lower acute-care expenses and shorter lengths of stay in skilled nursing facilities — while the system maintained 97 percent member satisfaction.<sup>5</sup> And Optum's Evercare, a nationwide program, has been demonstrating 45 to 50 percent cuts in hospitalizations and emergency visits for nursing home residents.<sup>6</sup> Finally, in Maine, Aetna and NovaHealth experienced 45 percent fewer hospital admissions, 50 percent fewer hospital days, and 56 percent fewer readmissions than statewide unmanaged Medicare populations. That led to cost reductions of 16.5 to 33 percent.<sup>7</sup>

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# ***Digitization: The key to integrating the building blocks***

MCOs stand the best possible chance of adequately and profitably managing the care of complex populations if they take responsibility for not only putting the five building blocks in place but also fostering their integration. Indeed, integration is critical for making the model work holistically and for addressing the lack of coordination currently characterizing the healthcare system. Digitization can play a central role in achieving this integration. Because it optimizes the high level of touch required to effectively and profitably cover care for complex populations, it helps make the programs cost-effective to administer and adds a degree of real-time care coordination (*see Exhibit 4, page 15*).

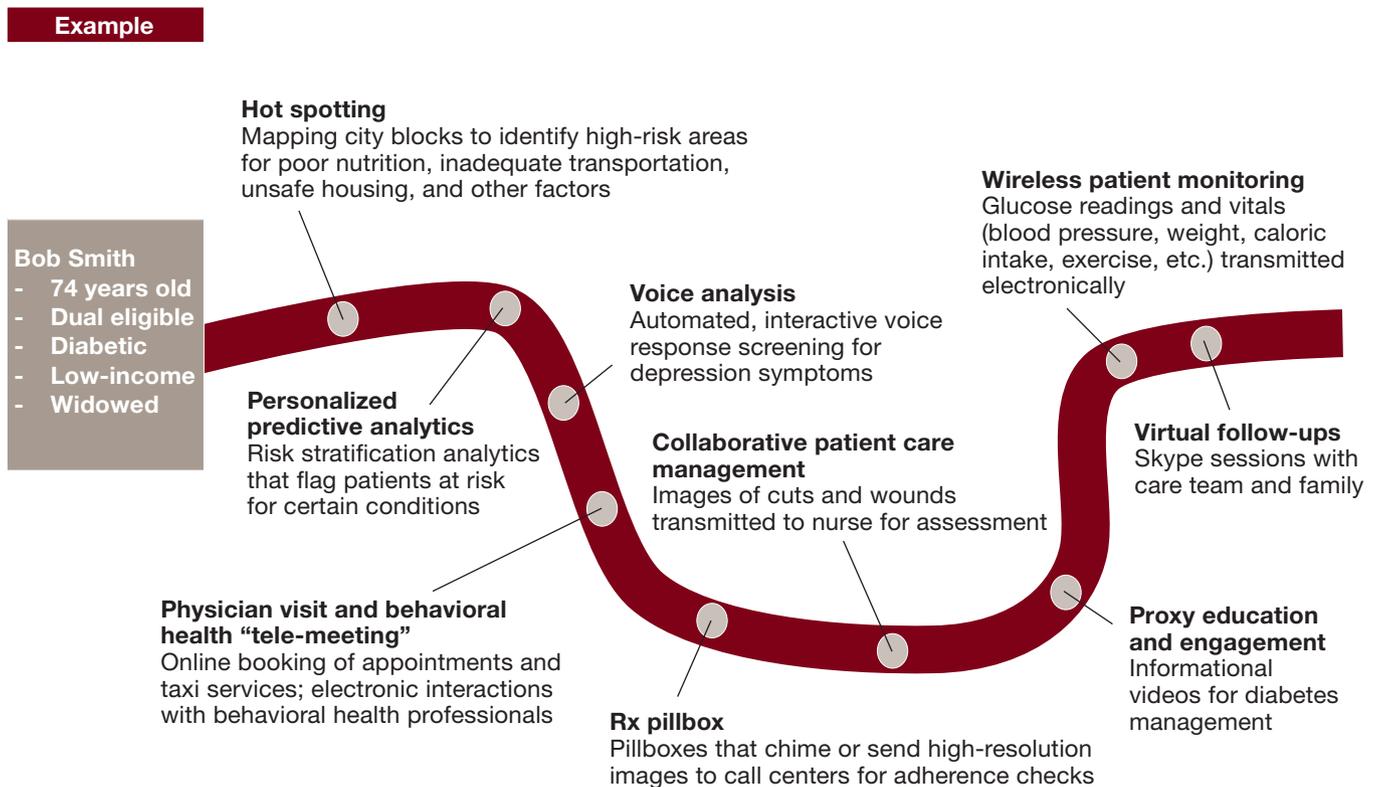
Consider Bob Smith, a hypothetical 74-year-old widower with diabetes who is on Medicare and Medicaid. City-block mapping technology, combined with ER-visit data, has identified Bob as living in a “hot spot” in the city. This places him in danger of poor nutrition, inadequate transportation, and unsafe housing. Moreover, data on the recent death of Bob’s spouse, captured electronically from hospital records, further flags him as being at risk for depression.

Cheryl, Bob’s care coordinator, calls him to see how he’s feeling. During the call, computer-aided voice analysis assists the coordinator in detecting shortness of breath and symptoms of depression. Cheryl immediately sets up an appointment for Bob with his primary-care physician and books a taxi for him on the Web to take him to the appointment. The PCP prescribes an antidepressant, and Bob fills the script on his way home by taxi. His pillbox has technology that scans medications and sends high-resolution images to the payor to ensure that the box has been filled correctly. The box also sends alerts to care team members if it remains filled with pills — suggesting that Bob isn’t taking his medicine.

In the next few weeks, Cheryl visits Bob and notices a small wound on his foot that's at risk of infection. She schedules a home visit from a nurse to treat the wound. Following treatment, Bob sends images of the wound to the nurse's iPad so she can see how it's healing. Meanwhile, Bob's smartphone (one he owns or one the plan provides for him) has an app that lets him transmit his blood-sugar readings to his electronic health record along with vitals such as blood pressure, weight, caloric intake, and exercise sessions. He gets a follow-up call from his PCP if thresholds on any of these are violated. Additional digital technologies — such as a Skype account that lets Bob communicate with his daughter and with Cheryl from a computer in his living room — help ease Bob's isolation and ensure that he adheres to his healthcare regimens.

*Exhibit 4*

**Digitization of the care model optimizes the “level of touch” in caring for complex populations**



Source: Strategy& analysis

# *Building the right capabilities*

To operationalize the new care model, payors must develop capabilities that are foundational across user segments, while ensuring that they can still tailor the model to the needs of specific patient groups (*see Exhibit 5, page 17*). Foundational capabilities include elements that support coordinated care, such as remote patient monitoring, tele-health solutions, and tools to support caregivers. Plans can also drive patient engagement through capabilities such as alerts when specific health conditions escalate, and they can improve patient outreach by coordinating with physicians through, for example, mobile diagnosis and treatment solutions. Informatics is critical as well; capabilities such as geo-demographic analytics will allow plans to assess populations, segment patients, more effectively predict diseases, and better manage cases.

In addition to establishing these foundational capabilities, organizations should build on this infrastructure and improve capabilities that support specific user subsegments. For example, a care model focused on the frail, elderly, and homebound segment could emphasize areas such as wireless monitoring of patient conditions and assessing the effectiveness of providers like home care coordinators and adult day-care staff. It could also develop advanced analytics to track patient patterns such as moods and symptoms, and specialized case management to care for chronic conditions and co-morbidities, among others.

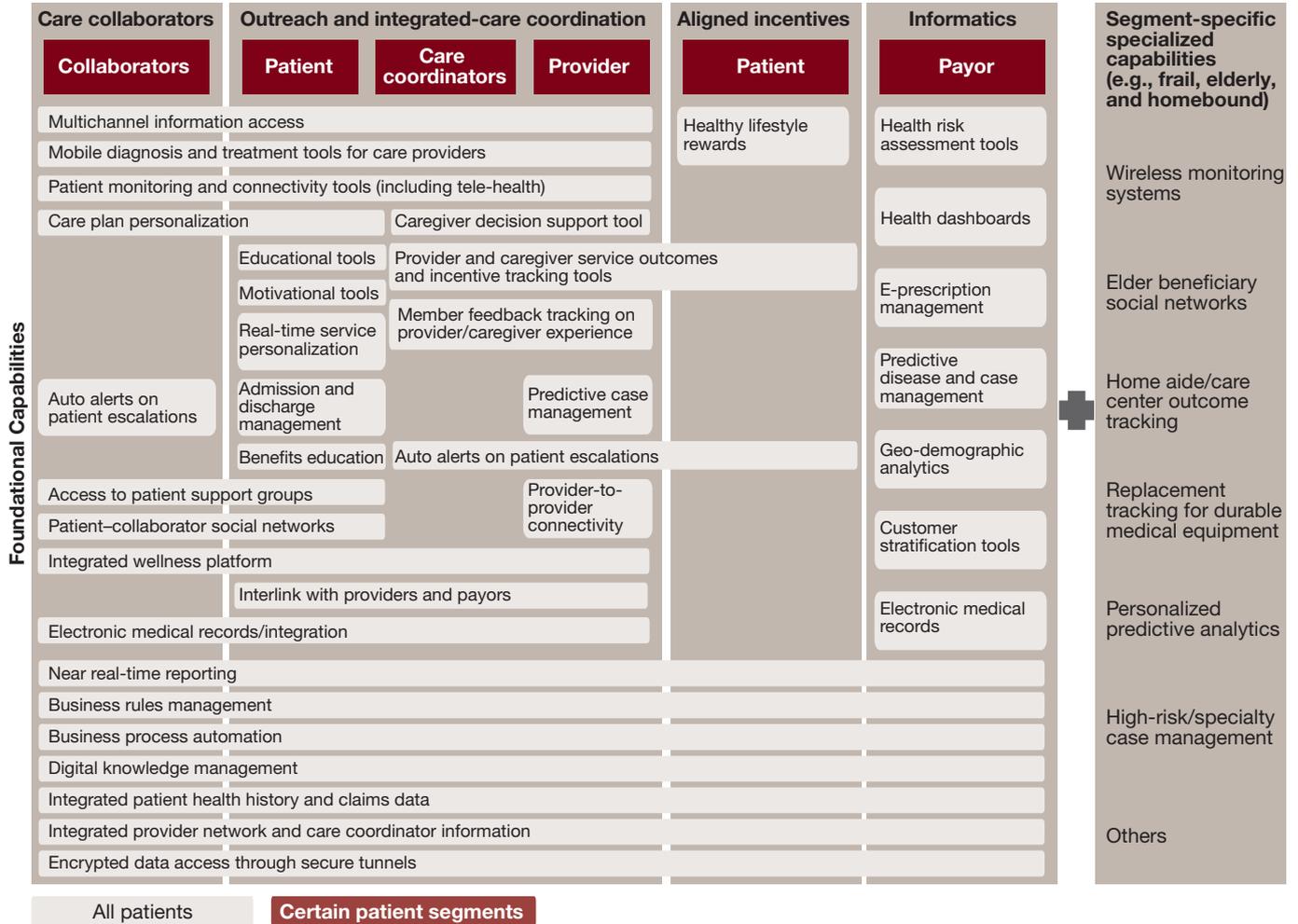
To implement these capabilities — and their supporting technologies — organizations need to adopt a structured approach. They should aim to achieve quick, early wins while ensuring progress toward the long-term vision. Specifically, organizations need to do the following:

- Define business imperatives and the right care model strategy across relevant stakeholders.
- Identify supporting capabilities required to deliver the new care model.
- Prioritize capabilities that need to be built or enhanced, while factoring in the maturity of the organization, how complex the capabilities are to implement, the ROI of specific capabilities, the implication of

*Organizations need to adopt a structured approach.*

Exhibit 5

Sample foundational capabilities for WPCM, with segment-specific specialized capabilities (not exhaustive)



Source: Strategy& analysis

upcoming regulations and healthcare reform changes, and interrelationships among capabilities.

- Develop target-state operating models, which includes defining the right organizational structure, supporting business processes, and technology architecture.
- Develop a business case and define a road map for implementation.

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# Conclusion

In the past, the care for complex populations has been unmanaged and, in many cases, insufficient. Over the coming years, more populations with complex care needs are going to shift to managed care, and private plans have tremendous incentives to start coordinating care and managing these populations more effectively.

Based on our extensive research of 23 care models — including health plans, state-sponsored programs, and other entities — we believe plans that adopt a whole-person care model will win in this environment. To succeed, they will need to systematically build foundational capabilities that apply across all complex populations and also build capabilities that are tailored to meet the unique requirements of specific subsegments. Many plans are already racing to develop such capabilities, and their efforts thus far will give them a head start — and raise the bar for all payors. Those that try to merely tiptoe into these markets, without a clear, well-defined vision and plan for which subsegment they are treating, how their approach will give them an advantage, and how they can strengthen their capabilities to increase their edge over time, could face severe financial losses.

But for those that get it right, the result is a scenario in which everyone benefits: The neediest Americans receive better treatment, government agencies operate more efficiently, U.S. society provides better care for some of its most vulnerable citizens — and payors improve their financial performance.

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# Endnotes

<sup>1</sup> “Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality,” CMCS Informational Bulletin, July 24, 2013, [www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf](http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf).

<sup>2</sup> “Hudson Demonstrates That a Medicaid ‘Health Home’ Model of Integrated Care Works,” Hudson Health Plan press release, March 27, 2012, [www.hudsonhealthplan.org/newsroom/press-releases/2012/distinguished-public-health-service-award](http://www.hudsonhealthplan.org/newsroom/press-releases/2012/distinguished-public-health-service-award).

<sup>3</sup> “Integrating Physical and Behavioral Health Services: Lessons from Pennsylvania,” Center for Health Care Strategies Webinar, Oct. 1, 2012, [chcs.org/usr\\_doc/100112WebinarSlidesFINAL.pdf](http://chcs.org/usr_doc/100112WebinarSlidesFINAL.pdf).

<sup>4</sup> “Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit,” Center for Health Care Strategies, February 2012, [chcs.org/usr\\_doc/Child\\_Welfare\\_Quality\\_Improvement\\_Collaborative\\_Toolkit.pdf](http://chcs.org/usr_doc/Child_Welfare_Quality_Improvement_Collaborative_Toolkit.pdf).

<sup>5</sup> “Care Models for Complex (and Costly) Populations,” California Improvement Network Quarterly Partner Report, June 2012, [chcf.org/~/.media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CINQtrMtngReportJun2012.pdf](http://chcf.org/~/.media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CINQtrMtngReportJun2012.pdf).

<sup>6</sup> Barbara Balik, Amy Boutwell, Gail Nielsen, and Marie Schall, “Reducing Re-Hospitalizations in a State or Region,” Institute for Healthcare Improvement, March 2009.

<sup>7</sup> “Payor-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan,” *Health Affairs*, September 2012, [content.healthaffairs.org/content/31/9/2074.abstract](http://content.healthaffairs.org/content/31/9/2074.abstract).

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## About our research

To develop our WPCM concept, we conducted a study from May 2012 through February 2013 in which we examined the total spend on patients who qualify for both Medicare and Medicaid. We wanted to know how those dollars are distributed across the estimated 9 million “duals” currently in the United States. We found that 20 percent of them account for almost two-thirds of the cost, whereas the healthiest 50 percent consume just 9 or 10 cents per dollar of total healthcare costs. Clearly, patients in the 20 percent represent the focus area with the greatest cost-cutting potential. These are the complex populations where a well-deployed WPCM can help.

We also evaluated care models currently in use at 23 health plans and other organizations that bore the risk for patient care for complex populations, including those for specific groups such as the mentally ill and elderly. We identified the most successful models — those that generated results in the form of both lower costs and better outcomes — and assessed the innovative methods they deployed. We collected the innovations or best practices across these models and synthesized the key themes. Finally, we determined the drivers needed to deploy these care models in a sustainable, cost-effective manner.

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