WHITE PAPER

The Right Information at the Right Time

Enable Payer/Provider Alignment and Improve Service to Your Members

As a payer, you have a plethora of information at your fingertips, including a significant amount of claims data. In fact, you may find that your claims data — and the information it provides when analyzed — is one of your most valuable assets, especially as you transition to a Value-Based Reimbursement (VBR) model.

Sharing this data with the right internal and external constituents enables you to accomplish three key goals:

> Improved alignment and collaboration with your providers

> Improved service to members

> Better coordination internally with all staff accessing the same information in real-time

Payers and providers must work together to transition to value-based care, but traditionally the parties have been at odds with one other. While the payer needs to minimize expenses and improve margins, providers want to be paid fairly. Most times, it is difficult to achieve both parties' objectives but in today's healthcare world, payers have the power to create alignment and improve collaboration with providers by sharing that one important asset: consumable and relevant data.

Likewise, by making claims data available in real-time to all the constituents in the "patient lifecycle" — providers, members, and your internal staff — you can help ensure that your members receive accurate information regardless of the source, helping to improve the service you provide to them.

This white paper discusses how making the right information available at the right time to the right constituents can fuel your organization's transition to value-based care.

Achieving Payer/ Provider Alignment

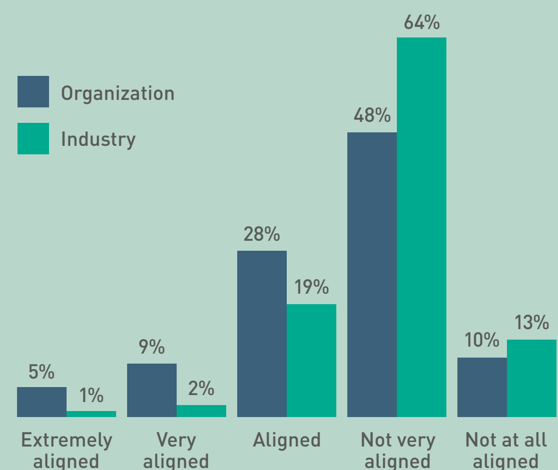
TODAY, PAYERS AND PROVIDERS STRUGGLE TO BECOME ALIGNED

According to NEJM Catalyst, most analysts of the U.S. healthcare system agree that poor integration of care and services is one of the top two drivers of high healthcare spending, second to price levels. Furthermore, respondents of a recent survey on payer-provider integration, conducted by the NEJM Catalyst Insights Council, indicate that a lack of alignment between payers and providers

FIGURE 1

THERE IS MUCH WORK AHEAD TO ACHIEVE ALIGNMENT OF PAYERS AND PROVIDERS

How aligned are payers and providers in working together toward achieving value-based care at your organization? In the health care industry overall?



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inhibits that integration and that this is the reason that "the industry continues to struggle to deliver the highest quality of care at the highest value to patients."

The same survey states that "there is much work ahead to achieve alignment of payers and providers." And, the results are surprising: 77 percent of respondents do not consider payers and providers aligned toward realizing improved value in care delivery. And, 58 percent feel their own organizations are not aligned.

The bottom line: Only three percent of respondents said payers and providers are extremely or very aligned at the industry level (see Figure 1).

How Payers Can Improve Alignment with Providers

Healthcare executives agree that payer/provider alignment can only be achieved through the development and execution of on-going collaboration efforts. According to a recent HealthPayer Intelligence article, "The progression of value-based care among healthcare organizations indicates a shift towards streamlined data sharing, collaborative care models, and the potential for aligned healthcare goals between payers and providers." Jeff Hulburt, the CEO of Beth Israel Deaconess Care Organization (BIDCO) and a previous executive at Tufts Health Plan and Harvard Pilgrim Health Care, also comments, "Health plans also have advantages to assist in the integration of clinical and financial information and claims information."

Jeffrey Conklin, President and CEO of Adventist Health Plan, and Payer & Network Strategies Executive for Adventist Health suggests that, "when it comes to data in a payer-provider collaboration, everything should be on the table. For one, there needs to be enough shared information to make decisions from the 'same source of truth.' Further, the more data shared, the more trust is built between the two partners — and vice versa."

Your health plan sits on mountains of data. The claims your organization processes can provide deep insight about patient health. By sharing this data — and the analysis of this data — with providers, you can create a trust environment with your providers, improve collaboration and alignment — all with an eye to gain consensus on the most important goal: improving patient outcomes.

Successful Alignment Improves Patient Outcomes

Both payers and providers can get critical information from claims data, well above and beyond the information needed to merely pay claims. The data provides information related to diagnoses, procedures, and utilization and payers can analyze the data to get information to improve decision making and effectively manage population health. With claims data, a provider can ascertain whether patients are refilling prescriptions, seeking second opinions, and receiving preventative tests. Claims data can also be used to compare services and the price of services by provider, diagnostic code, geography, etc., and to determine patient outcomes by DRG, evaluate the quality of care provided, whether a provider followed proper medical protocols, and so on. The sharing of data can provide quality metrics on how a provider is performing and how well he/she is doing to keep the population healthy.

As a payer, your organization has the capability to bridge the gap and work closely with your providers. Your organization can improve alignment and collaboration by sharing data, which will ultimately reduce costs, improve efficiencies, and optimize margins. At the same

time, providers get the information they need to continually improve care delivery and receive fair payment for services delivered. In this environment, everyone wins.

A Case Study: Successful Payer/Physician Alignment

Independent Health, a not-for-profit health plan headquartered in Buffalo, New York, has partnered with the primary care physicians in their network, supplying them with critical data to help the providers improve their performance as both parties evolve to value-based reimbursement (VBR). Dave Mika, Vice President, Enterprise Core System Operations, states that "achieving VBR requires us to provide real time, extremely accurate, and readily available data to our providers, including provider scorecards to identify gaps in care and the ability to drill down at the member level." Independent Health, with 375,000 members uses the HealthRules platform for multiple lines of business. Independent Health prides itself in its involvement with and commitment to the greater Buffalo and western New York area and works closely with its provider network for the benefit of its members.

Independent Health continuously shares up-to-date information about a provider's compliance around standards of care based on the unique demographics of their specific population. The data tells those providers how they are performing based on industry-standard recommendations and protocols. Each provider can drill-down to member-level data to see which patient needs which services. As examples, providers can view the results of data analysis on emergency room and urgent care utilization, specialty care, the percent of generic versus brand prescriptions, even the ability to track extended office hours relative to their peers.

"Our providers consistently tell us that that receiving this level of data has been invaluable; it helps the providers transform their practices and ensure their own viability in this changing landscape." - Dave Mika, Vice President, Enterprise Core System Operations.

While payer/provider alignment and collaboration are top of mind topics in today's environment, payers are also focused on improving member satisfaction — another benefit of "right information, right time."

Improve Member Satisfaction

MEMBER SATISFACTION IS THE #1 GOAL

In a recent survey report sponsored by HealthEdge and conducted by Survata, an independent research firm, health plan executives cited member satisfaction as their top organizational goal for 2018 (see Figure 2). This shift in goals from the age-old focus on lowering costs to a modern focus on customers and members represents a significant evolution.

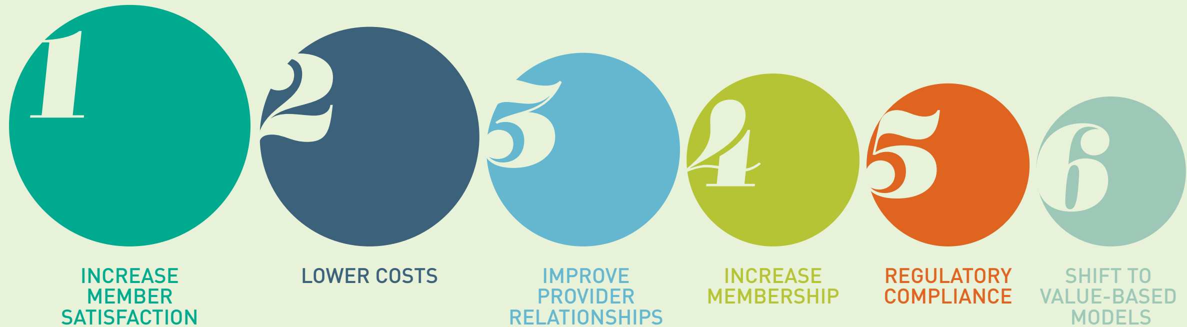
Today's savvy consumer does not want to do business with any company — whether it's a retail store, bank, or insurance company — that doesn't value customer service. But as a health plan, your customers demand even more — the best health coverage at the best price. And, there is no room for mistakes, misinformation, or communication delays.

To deliver a positive member experience, your health plan must have accurate information available to customer service representatives, providers, and members in real-time.

HOW PAYERS CAN IMPROVE MEMBER EXPERIENCE

It is not at all unusual for one of your members to call your plan to ask for information and get different answers from different people. This makes for an unhappy member.

What is the most important organizational goal you have for 2018? Please rank in priority order from most to least important.



Alternatively, if your plan has customer service representatives that have the right information available in real-time to field member inquires, you have a much better chance of having highly satisfied members.

Niyum Gandhi, Executive Vice President and Chief Population Health Officer at Mount Sinai Health System in New York, spoke on a panel about "payer-provider convergence" at the Future of Healthcare (HLTH) 2018 conference. With reference to payer-provider methods that can fuel an improved patient experience, Gandhi comments, "...today, it's common for a patient to call a physician's office about a billing question only to be told, 'You need to call your health plan.' That type of runaround demoralizes patients, but it could be more seamless if providers and health insurers worked off the same set of data."

A CASE STUDY: IMPROVED SERVICE TO CUSTOMERS

Medica, a health plan based in Minnetonka, Minnesota, found that by using the award-winning HealthRules platform from HealthEdge, training time for Customer Service Reps (CSRs) was significantly reduced. Furthermore, CSR's could be put on the phones with members during training, which allowed faster ramp-up time, on the job training to break up classroom time, and resulted in more satisfied customers.

Having patient data available at the moment it is needed can accomplish even more when you consider that the right information at the right time can also improve treatment and outcomes. In a recent article in Healthcare Financial News entitled Health Plans Look to Collaborations to Gain Data, Interoperability and Efficiencies, Anton Berisha, MD, Senior Director of Clinical Analytics and Innovation, Healthcare LexisNexis Risk Solutions states, "The sharing of information will automatically reduce or eliminate unnecessary and duplicative diagnostic workups, improve medication reconciliation, synchronize the use of drugs, reduce chances for adverse drug reactions, reduce or eliminate fraud and waste and decrease abuse trends.... This directly translates into extra revenue, better reputation, and increased patient satisfaction because of less financial burden and better clinical outcomes."

Final Thoughts

It is an age-old conflict — doctors want more money and the health plans want to cut costs and reimbursements. However, the two camps are now finding ways to come together by sharing data for the benefit of all stakeholders — health plans, providers, and the patients/members.

As a payer, you can share claims data with all your providers and improve payer/provider alignment and collaboration. Ultimately, this can help your organization reduce costs and improve efficiencies and margins and ensure the providers have the clinical information they need to improve the quality of care and receive fair payment for services. At a macro level, sharing claims data also helps improve population health.

By sharing data in real time with your internal constituents, you can ensure that your members get the right information every time, all the time, improving member services and member satisfaction.

The bottom line: sharing your claims data can power your organization to achieve success on many fronts. To stay competitive in today's market, your organization must start taking the first steps.

About HealthEdge

HealthEdge® provides modern, disruptive healthcare IT solutions for core administration and care coordination that health insurers use to leverage new business models, improve outcomes, drastically reduce administrative costs and connect everyone in the healthcare delivery cycle. Our next-generation enterprise solution suite, HealthRules, is built on modern, patented technology and is delivered to customers via the HealthEdge Cloud or onsite deployment. An award-winning company, HealthEdge empowers health insurers to capitalize on the innovations, challenges and opportunities that await in the new healthcare economy.

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