COPE HEALTH SOLUTIONS

Payer-Provider Partnerships are the Cornerstone of Improved Health Plan Quality Scores

Employers, the Centers for Medicare and Medicaid (CMS) and state departments of health are increasingly holding health plans accountable for moving the health care delivery and payment system from the horse and buggy era to a "transportation network" for entire populations. CMS, states and employers have all heightened expectations for health plans to do more to achieve specific and complex quality outcomes.

Quality performance is now a key differentiator in Medicare, Medicaid and commercial plan programs to distinguish high performing health plans, health systems and medical practitioners. Furthermore, as more payments are shifting to value-based payment (VBP) arrangements, integrated delivery systems and health plans have significant revenue and membership tied to quality performance on key metrics – necessitating specialized resources and coordination to manage effectively. Achieving high quality ratings in HEDIS, CAHPS and STAR programs requires an integrated approach across care delivery "enterprises" that focuses on clinical outcomes, patient/member experience and accessibility of services.

Health plans traditionally have not been able to do much directly to actually impact quality, aside from mining, collecting and reporting data. The role of a health plan is to outline requirements, promote high quality behaviors, share information and data with providers to identify barriers, resource the infrastructure to build properly and remove barriers to improved practitioner performance. Health systems and physician practices thrive when there are strong and clearly defined collaborative partnerships with the health plans to improve operational processes and workflows. This collaboration supports providers in revamping care delivery models to strengthen their organization's value proposition to their payers.

The following questions can help payers and providers to understand and support the health plan and providers' roles in enabling quality improvement:

- **Do providers understand the standards and requirements to perform well?** Physicians must assess and modify current processes to fulfill legal, contractual and compliance requirements. Ensuring a cohesive quality improvement program across the enterprise decreases variations in practice and performance; this increases the likelihood of improved performance and consistent quality ratings. However, it is extremely complicated for practices to handle process flow on behalf of multiple lines of business and conflicting payer programs.

- **Have measures been coordinated and prioritized?** Providers hold accountability for a multitude of quality measures from many payers and programs. Without alignment and coordination, the burden of tracking and monitoring conflicting guarantees lowers performance. Providers and payers should work together to develop a consolidated list of metrics to determine conflict and alignment, as well as a better understanding of the most meaningful performance metrics.

- **Do physician practices have embedded care coordinators linked to a standardized and centrally managed care team?** Bridging quality performance across the practice or enterprise increases the likelihood of successful performance. Administration of quality programs

Evan King
Principal & COO

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is often in silos across enterprises. Operations cannot succeed if they are uncoordinated and have varied levels of infrastructure. Further, lack of central care models/workflows/systems and communications create inefficiencies. Medical management involves heavy coordination across multiple domains, including data analytics, workflows and information systems to manage member outcomes. Improvement relies on identification of process bottlenecks, variances and contributing factors creating inefficiency and inconsistency in patient management and unnecessary hospitalizations and emergency department visits.

- **Are care teams optimized and right sized in composition and caseloads?**
  Effective care teams (including nurses, other health professionals and practice support staff) enable the practice to provide a greater scope of comprehensive care services, increased patient visits, larger caseloads and better management of administrative and clinical work. Delegating responsibilities to the most appropriate health care professional ensures top of license practices and targets skill mix by patient acuity and drivers of risk.

- **Are business requirements aligned across information systems and coordinate with operations and workflow processes across the enterprise?**
  The practice or system must establish governance and workgroup structures with agreed upon pace of change, charters, roles and responsibilities. Clear communication channels are essential for consistent and effective messaging throughout the integrated delivery network.

- **Do practitioners have the data they need to identify proactively those members receptive to changed care to improve quality and reduce high cost care?**
  Real-time claims data is essential to identify patterns in member and provider utilization of services for rapid intervention. Data requirements must outline dependencies among claims data (including pharmacy claims), member services, medical management infrastructure and health information exchanges (HIE) to coordinate efficient tracking and reporting. Practitioners must be able to document evidence-based care interventions in a single-source, skip-logic enabled care plan that is accessible across care settings.

- **Do they have actionable analytics to ensure timely reports and improvement interventions?**
  Health plan real-time data on current measures is often non-existent or delayed. Yet, health plan level claims information, performance reports and early warning signals are key for timely and actionable behavior changes at the individual physician level.

- **Does the customer service starting at the hospital registration desk create a defining and lasting moment in the patient's mind?**
  Patient and member expectations have become a pivotal factor in overall quality ratings. Customer service can be the "make it or break it" for the overall experience a member has with a health plan. Regularly surveying member/patient needs and wants keeps a pulse on the population and can provide early warning signs for needed improvement. This puts additional pressure on a payer-provider value collaborative to engage consumers and enhance the consumer experience.

- **Is patient experience measured and is it improving?**
  Patients must move from the back seat to the driver's seat in managing their health. Patient engagement requires active collaboration among patients/members, their health plans and their providers to achieve positive health outcomes. Seamless, data-enriched workflows within and across the health care ecosystem benefit the consumer by fostering financial transparency and the ability to navigate and access care. Patient engagement measures are fundamental to designing customized care pathways that reflect the patient's unique needs, commitment and support milieu.

Developing comprehensive population health capabilities will provide practitioners with the technology, services and strategy to first identify members in need of alternative or heightened care options. From there, whole-person, data driven interventions can be designed and delivered to improve outcomes and reduce unnecessary acute care utilization.

The framework for high performance consists of:

- Identification of these impactable members/patients
- Determining who is responsible for care management interventions
- Ensuring appropriate staffing of care management delivery
- Program evaluation and report

- **Are practices optimized to deliver care through telemedicine?**
  Telemedicine facilitates access to quality health care encounters and improved remote monitoring of at-risk patients. As well, telemedicine can help shift appropriate encounters to the lowest-cost settings and provide a foundation for accountable care.

Health plans must continue to step up to become strategic advisors and collaborative partners to enable providers to succeed under quality and value-based contracts. Health care practitioners and health plans should share seats at the table for discussion around consolidating resources and support that will help both entities improve on all quality dimensions. This "co-opetition" is crucial for sustainable results and lasting impact.

Endnotes

[1] HEDIS stands for Healthcare Effectiveness Data and Information Set. Employers and individuals use HEDIS to measure the quality of health plans. HEDIS measures how well health plans give service and care to their members. Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a series of patient surveys rating health care experiences in the United States. STAR Ratings give an overall rating of the plan's quality and performance.

For more information, please contact Carla D'Angelo, VIce President, COPE Health Solutions at cdangelo@copehealthsolutions.com or Evan King, Principal & COO at eking@copehealthsolutions.com or call 213-259-0245.