Mede/Analytics®

A MEDEANALYTICS WHITE PAPER

Enabling Payer and Provider Collaboration in the Journey Toward Quality Care

Scalable Quality Management Analytics Boosts Health Value

Today's healthcare landscape is changing. Whether that change comes from new reimbursement models, provider consolidation, or consumerism, all players in the healthcare ecosystem must focus on delivering a satisfying healthcare experience at a reasonable cost. With a new healthcare economy defined by value over volume, payers and providers must work together to improve quality for the patient populations they serve.

"This ecosystem approach, and the associated network effect, allows you to deliver value that is greater than the sum of the parts you orchestrate."
– Gartner

This white paper describes this new healthcare economy and outlines ways in which payers and providers can work together to achieve their quality goals. We'll discuss the role of data-driven, scalable quality management analytics in closing gaps in care, avoiding duplicative care, achieving high quality scores, and improving patient care. We'll show how the technology enables payers and providers to collaborate toward a holistic, data-driven approach to population-based quality care—ultimately to aid in the journey to value-based care.

In a report titled *Introducing Provider/Partner Alignment: U.S. Healthcare Payer CIOs' Transformative Relationship Model*, Gartner agrees that collaboration is critical to improving quality. "A core tenet to orchestrating health value is your ability to work in collaboration with suppliers, partners and customers across platforms, leveraging the capabilities, connections and digital moments of other organizations to enhance and maximize the reach and impact of your own capabilities and expertise. This ecosystem approach, and the associated network effect, allows you to deliver value that is greater than the sum of the parts you orchestrate."[1]

[1] Gartner, *Introducing Provider/Partner Alignment: U.S. Healthcare Payer CIOs' Transformataive Relationship Model*, February 2017

"The result is a never-ending cycle of payers and providers in opposition, both wasting resources in an effort to counter each other's perceived advantages."
– Gartner

Quality management analytics plays a key role in this endeavor. With shared information and tools, payers and providers can collaboratively meet quality objectives. The technology offers an efficient, sustainable way to measure and monitor quality and can be updated and managed in partnership with providers.

IDC Health Insights sums it up nicely: "Payer and provider organizations need to think outside of traditional business relationships and reimbursement paradigms in order to deliver effective and efficient health management programs. Forward-thinking leaders are realizing that a post-reform environment, combined with unsustainable costs of care, demands a more population-based approach to health management programs. These programs need to be supported by innovative IT applications that are meaningful and accessible to all related stakeholder groups."

The Journey Toward Value

Healthcare spending in the United States has reached $3 trillion a year, and the outlook is not improving. Specialty drug spending is expected to reach nearly $402 billion by 2020, a 109% increase over 2016. And chronic diseases account for 86 cents of every dollar spent. Care for heart disease and stroke alone costs $315 billion.[3]

As healthcare costs continue to rise at astounding rates, reimbursement dollars are being restructured to give greater weight to value over volume. As a result, all payers in the healthcare ecosystem are being called upon to collaborate in an effort to improve quality and outcomes for their patient populations. However, reimbursement models that have existed for the past several decades have created a disconnect between payers and providers that makes such collaboration difficult.

Until now, under fee-for-service reimbursement models, payers and providers have operated in a relationship that is misaligned at best and adversarial at worst. On the one hand, payers work to assert raw purchasing power. On the other, providers strive to extract higher rates from payers in contract negotiations. "The result is a never-ending cycle of payers and providers in opposition, both wasting resources in an effort to counter each other's perceived advantages," says Gartner.[4]

If the U.S. healthcare system is to succeed in reducing costs and improving quality, this relationship must change. For payers and providers alike, the journey to value-based care requires a shift in mindset and new approaches to sharing information to enable quality improvements.

The Shift to Quality Under MACRA

Despite any uncertainty about the future of healthcare in our current political environment, value-based care is here to stay. In fact, the focus on quality is becoming more deeply ingrained by MACRA which holds overwhelming bi-partisan support and will drive cost and quality improvements for healthcare providers and payers alike. MACRA establishes incentives and penalties for providers who adopt programs to reduce costs and improve quality and efficiency. With the potential to influence Medicare reform in the future, MACRA requires that payers and providers work together to collaboratively meet quality objectives.

[2] IDC Health Insights, *Best Practices: Payer Health Management Programs — The Evolution of Quality and Payment Models,* October 2014
[3] Blue Cross Blue Shield, *Why does healthcare cost so much?,* accessed February 15, 2017, www.bcbs.com/issues-indepth/why-does-health-care-cost-so-much
[4] Gartner, *Introducing Provider/Partner Alignment: U.S. Healthcare Payer CIOs' Transformataive Relationship Model,* February 2017

"MACRA'S approaches will become more widespread, standardized, and nuanced than other value-based methodologies currently in place at healthcare payers."
– Gartner

In a report titled *MACRA's Downstream Effects Change Healthcare Payer CIO Spending Priorities*, Gartner offers its position on MACRA's influence on quality. "MACRA affects more than just provider compliance and contracting. It will force changes in healthcare payer spending priorities.... Payers can think of MACRA as one more step in a longer Medicare evolution toward value-based reimbursement."[5]

To qualify for incentives and avoid penalties under MACRA, providers can choose from two payment models: MIPS and APMs. MIPS, or the Merit-Based Incentive Payments System, establishes four key categories of differing weights that combine to create a composite score. The higher the score the provider receives, the greater their adjusted payment. With reporting beginning in 2017 for payments in 2019, MIPS allows for a 4% increase in payments. By 2022, this will increase to 9%.

For APMs, or Alternative Payment Models, MACRA incentivizes providers farther along in the journey toward value-based care. The APM model provides bonus payments for participation in patient-centered medical home (PCMH), Medicare Shared Savings Program, bundled payments, or other qualifying advanced payment models.

While MACRA is specific to Medicare, many commercial and state government payers are beginning to embrace MACRA concepts as they adapt to value-based care. Often seen as a crucial component in the evolution toward value-based reimbursement, MACRA promises to significantly alter healthcare reimbursement.

According to Gartner, "MACRA's approaches will become more widespread, standardized, and nuanced than other value-based methodologies currently in place at healthcare payers."[6]

Payer and Provider Collaboration Toward Quality

To improve cost and quality, providers must work toward positive patient outcomes that address gaps in care and reduce duplicative care. However, in today's disconnected provider environment, many providers operate in silos and do not have insight into care performed by other providers. The only way to achieve their quality objectives is to work with payers, which are typically the only entity in the healthcare ecosystem that has the data required to create a holistic patient record. With this in mind, the shift to value-based care requires that payers and providers work together to improve quality and use that holistic patient data to their advantage.

The shift to value-based care requires that payers and providers work together to improve quality and use that holistic patient data to their advantage.

To improve and accelerate collaboration with payers, many providers expect MACRA-based concepts in payer contracts, much like the shift to DRG-based inpatient payments. As provider consolidation continues to accelerate under MACRA, these large provider organizations will hold great sway over the use of data currently in the coffers of the payer's data warehouse.

While a collaborative spirit will help meet the requirements of MACRA, it will most certainly benefit patients. "When physicians, health systems, and health plans work together to align efforts and incentives, patient outcomes improve," said Niyum Ganhi, chief population health officer for Mount Sinai Health System.[7]

[5] Gartner, *MACRA's Downstream Effects Change Healthcare Payer CIO Spending Priorities*, November 17, 2016
[6] Ibid.
[7] *Health Payer Intelligence*, "Why HEDIS Quality Measures Matter for Value-Based Care," July 5, 2016

Analytics Technologies for Payers and Providers

As payers and providers increasingly collaborate to harness patient data, it's important to work with technology vendors who have experience working with both entities. To this end, Soyal Momin, VP of Analytics for Presbyterian Healthcare Services, said, "MedeAnalytics' deep analytics expertise with both payer and provider organizations was critical for us as we needed a partner that could provide insights for our entire enterprise: the health plan, health system and medical group."

The Changing Role of the Payer

Data is growing at explosive rates in every industry across the globe. In healthcare specifically, Meaningful Use and now Advancing Care Information under MACRA are deepening a digital transformation that enables data to be used to improve quality. As payers foster collaboration with providers in the effort to improve quality, they must harness clinical data and turn it into actionable insights. It is not enough to simply process and collect data or merely send providers copies of the claims they submitted previously. It requires a technology shift and a new mindset that enables payers and providers to collaboratively share the information that will actively drive clinical decision-making.

For the payer organization, the need for actionable clinical insights has the potential to fundamentally alter payer operations. The data must be viewed not as a liability to manage and store but as an asset that can improve outcomes and ensure financial viability for payers and providers in uncertain times.

According to Gartner, "Healthcare payers must play a new role as partner, sitting as a data and relationship aggregator that ties together information from purchasers, regulators, providers, and patients."[8]

Payers must collect information on everything from claims and demographics to clinical data generated by the electronic health records of multiple providers. The goal is not to create a portal to merely manage utilization, but to use clinical information to eliminate gaps in care and drive positive patient outcomes and therefore healthcare value.

> "Healthcare payers must play a new role as partner, sitting as data and relationship aggregator that ties together information from purchasers, regulators, providers, and patients."
> **– Gartner**

The Power of Data in Quality Management

As payers and providers adopt technologies that enable population-based care, forward-thinking organizations are collaborating on quality management programs that serve as the basis of their efforts. These programs must be designed to not only measure and monitor quality measures but also lead data-driven conversations so payers and providers can collaboratively improve clinical outcomes for their patient populations.

Building an effective quality management program requires measuring and monitoring an organization's performance on a host of quality measures including HEDIS,® CMS Star Ratings, QRS, AHRQ, PQRS, NQF, and custom quality measures. Among these quality measures, HEDIS and CMS Star Ratings potentially have the greatest impact as value-based care unfolds.

Used by more than 90% of the nation's payers, HEDIS allows payers to compare year-to-year performance and determine improvement opportunities. According to NCQA, HEDIS has evolved to become "the gold standard in managed care performance measurement" since its introduction in 1993.

> Building an effective quality management program requires measuring and monitoring an organization's performance on a host of quality measures.

[8] Gartner, *MACRA's Downstream Effects Change Healthcare Payer CIO Spending Priorities*, November 17, 2016

Complete with data algorithms and predictive analytics, payers and providers can identify high-risk and high-spend members in a scalable way.

In addition, the CMS Star Ratings offer a snapshot of payers' overall performance and are used by CMS to determine financial rewards and penalties. The ratings are publicly available and potentially influence consumers, directly affecting payers' bottom lines. The challenge for payers is that the ratings are based on two-year-old data, and their criteria tend to change frequently. Predictive analytics are important to course correcting throughout the year while also staying ahead of shifting criteria in the years ahead.

As a whole, these quality measures focus on reducing gaps in care, avoiding duplicative care, improving chronic disease management, increasing patient engagement and satisfaction, and expanding preventive services. With these measures as their guide, payers and providers can align efforts and incentives to design effective quality management programs. And with accurate, comprehensive data at their core, these programs hold great promise in not only meeting or exceeding quality measures but also improving patient outcomes and a population's overall health and long-term well-being.

Monitoring Value with Scalable Quality Management Analytics

To begin to improve efficiency in quality management, providers and payers must work together to identify high-risk patients and those with gaps in care. Implementing a scalable, shared quality management program with data analytics offers the tools that payers and providers need to create personalized, automated interventions, prevent unnecessary readmissions, and measure an organization's effectiveness in its quality improvement initiatives.

Complete with data algorithms and predictive analytics, payers and providers can identify high-risk and high-spend members without waiting as long as three months for data that does little more than report back on care already provided. As patient populations grow and as value-based care reimbursement models take hold, manual tracking with inaccurate or incomplete data is ineffective and unsustainable. An important aspect of this scalability is the ability to align multiple payers with multiple providers across multiple chronic conditions. This flexibility is a critical component of a sophisticated analytics platform that measures effectiveness in quality improvement initiatives.

To ensure complete clinical documentation, quality management analytics must be able to extract data directly from the electronic medical record. This simplifies administration for providers. By pulling data formerly only available through manual chart review, the system is updated immediately and can include data not limited to claims like blood pressure, height, weight, BMI, smoking status, and more.

Integrating information from all organizations involved in patient care is crucial to maintaining the scalability of quality data analytics. For example, if a child receives an immunization at school or an adult receives one at a local drug store, immunization data can be retrieved from state records. By the same token, lab results can be imported directly from labs. In this way, any care provided outside of the purview of the primary care manager is completely accessible and accounted for in quality measures.

Rather than gathering data and reporting on quality measures at the end of the year when they're due, quality compliance can be managed throughout the year.

Another important characteristic of quality management analytics is timeliness. Rather than gathering data and generating a report on quality measures at the end of the year when they are due, quality compliance can be managed throughout the year. Providers should be able to go into the system at any time of year to update data and indicate to the payer that a gap in care has been closed, creating an immediate change to their quality scores. All supplemental and EMR data must be auditable and provided to the payer to support yearly HEDIS audits and to help accurately reflect the payer's HEDIS and Star Ratings.

To ensure that all records are comprehensive and accurate, sophisticated data matching is an important facet of quality management analytics. The system should create a unique patient identifier for every patient, eliminating duplicate records and creating a holistic patient view. For example, the system should recognize that Daniel West and Dan West are likely the same person, especially when the date of birth and other demographic data is the same. With complete and current demographic and clinical data, the system's matching algorithms should ensure that all patients are represented only once across all state and commercial health plans.

Payers often offer quality management analytics to their providers at no cost to increase collaboration and encourage their providers to close gaps in care and improve quality scores. This is also often accompanied by financial incentives for providers who participate in value-based care and alternative payment models.

Designing Population Health Registries for Tomorrow's Healthcare Economy

As healthcare's payment models continue to evolve, payers and providers must look toward a future defined by positive outcomes for their patient populations. The focus on quality and value will become more deeply ingrained, and MACRA will continue to influence the reform of the future. To meet their objectives, payers and providers must collaboratively design quality management programs that enable them to meet or exceed quality measures and pay-for-performance expectations—today and for years to come.

For more information about improving quality management, please email Elizabeth Stevens (elizabeth.stevens@medeanalytics.com) or visit MedeAnalytics.com/Solutions/Quality-Management.

About MedeAnalytics

MedeAnalytics provides evidence-based insights to solve a real problem that plagues healthcare – how to use the immense amount of patient data collected along the care continuum to deliver cost-effective care and promote a healthier population. Its analytics platform delivers intelligence that helps healthcare organizations detect their greatest areas of risk and identify opportunities to improve their financial health. It empowers providers and payers to collaborate and use data to strengthen their operations and improve the quality of care. MedeAnalytics' cloud-based tools have been used to uncover business insights for over 1,500 healthcare organizations across the United States and United Kingdom. The company has also been named one of *Modern Healthcare's* top 100 Best Places to Work in Healthcare for 2014, 2015 and 2016. For more information, visit **www.medeanalytics.com**.

Mede/Analytics®

5858 Horton Street, Suite 170 / Emeryville, CA 94608
T 510 379 3300 / www.medeanalytics.com

MEDE-QM-WP-0217