Payer forward

How a digital mindset optimizes care delivery, reduces inefficiencies, and enhances relationships across the healthcare continuum

athenahealth

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Why digitization will help health plans better collaborate with providers, and enhance outcomes

Curbing costs and improving care are among the top priorities identified by most health plans.[1] Providers are trying to do the same. The average provider spends 15 hours per week trying to manually close quality care gaps and about $40,000 per year satisfying quality initiatives.[2] Even when the two work in tandem, there can be inefficiency – and potentially, friction.

New needs and opportunities surfaced during the COVID-19 pandemic have thrust the urgency for a digital approach into the spotlight (see sidebar). With millions of missed routine screenings and appointments due to the temporary hiatus of in-person visits, health plans and providers are now faced with the mutual challenge of closing care gaps. But it's not all for naught. In its report on a shocked system emerging stronger, PricewaterhouseCoopers writes that "Healthcare organizations can achieve efficiency with better digital relationships."

"The pandemic may have accelerated payers' efforts to reduce physicians' administrative burdens," the PwC Health Research Institute found in its research across a wide swath of consumers and executives from health plans, provider groups, and pharmaceutical companies. "Health systems are expected to make the shift in automation from the back office of finance and human resources to the doctor's office in 2021."[3]

The indelible challenges and opportunities surfaced by COVID-19

Appointment volumes dropped dramatically during the onset of the COVID-19 pandemic, with millions of Americans delaying or foregoing preventative care due to fears of in-person exposure at medical facilities. While the adoption of virtual care across the healthcare continuum has been an unexpected silver lining that's thrust into the spotlight the importance of a digital mindset, the temporary lag in routine checkups and screenings put additional strain on a medical system already facing myriad challenges. That strain is compounded when gaps in care can't be automatically surfaced.

Colonoscopies declined almost 90 percent in April 2020 and were still down 30 percent in June as compared to 2019. Mammograms declined over 75 percent and were also down 30 percent during that same timeframe.[4] The Journal of the American Medical Association found that during the pandemic, the weekly average number of people diagnosed with one of the most common six cancers – breast, colorectal, pancreatic, gastric, esophageal, and lung – dropped by 46.4 percent. Breast cancer diagnoses dropped by more than half.[5]

"While residents have taken to social distancing, cancer does not pause," researchers wrote. "The delay in diagnosis will likely lead to presentation at more advanced stages and poorer clinical outcomes. One study suggests a potential increase of 33,890 excessive cancer deaths in the United States."

Dramatic declines[6] in the volume of childhood immunizations and other routine care have created a backlog of patients who need to be screened and/or seen in person. The more automated the process is to surface and notify those who need care first, the less strain the medical system will face. With telehealth being the impetus that's gotten patients more digitally engaged in their care than ever before, patient outreach campaigns via email, text messages, or portal notifications should go a long way to reinforcing the relationships between payer, provider, and patient.

A solution to enhance the business of healthcare — and outcomes

Today's opportunity is to phase out largely manual processes that can save time and money and lead to better care outcomes. The effort and cost of manual chart pulls, for instance, is massive. So-called "chart chasing" can cost health plans $40 or more per member per year – that's $4 million annually for every 100,000 patients.[7] That figure doesn't take into account the financial weight of staffing full-time employees to perform manual care-gap review, either. Using skilled professionals to manually cull paperwork is just one reason the U.S. faces staggering administrative costs that make up about 34 percent of total healthcare system expenditures.[8]

At athenahealth, we believe health plans are partners, and an essential part of our vision of creating a thriving ecosystem that delivers accessible, high-quality, and sustainable healthcare for all. athenahealth's cloud-based Health Plan Data Exchange provides health plans with 360-degree access to member clinical data at scale, without the traditional cost and effort of chart pulls. Once a health plan is connected to our network, member data is automatically sent each time an encounter is closed, in a standardized, electronic C-CDA (Consolidated Clinical Document Architecture) format that's easy to use and act on.

Health Plan Data Exchange delivers valuable insights into a member's continuum of care — insights that might not otherwise surface — in a way that is faster ***and*** more cost-effective. Health plans get the robust data they need to meet quality reporting needs including the Healthcare Effectiveness Data and Information Set (HEDIS), and the Centers for Medicare & Medicaid Services Medicare Advantage risk adjustment payment models.

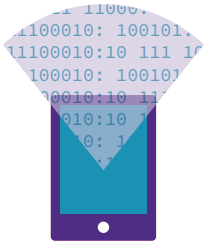
Our national network makes it easy for health plans to join our ecosystem and connect directly with our providers to increase collaboration and improve health outcomes, lower costs, and leave members happier and more engaged.

> CMS awards a **5%** bonus payment to health plans that have a rating four stars or higher out of five.

When athenahealth surfaces a health plan's insights, such as claims-based care gaps and existing conditions, in its members' clinical charts, providers are able to use these insights immediately to create notifications about upcoming preventative services; close quality and care gaps; help inform proper treatment through the EHR at point of care; and help patients stay on track with their health. Not only can members stay healthier, but plans can control their costs, too. This partnership also makes it easier for providers to meet quality program goals and incorporate more value-based programs.

A partnership with athenahealth has effects that ripple across the healthcare continuum

Here are the 3 key outcomes enabled by embracing a digital mindset:



1

Faster and more seamless data access:
Spend less time — and money — acquiring clinical data on your members. Administrators can use their time more efficiently to enhance their contributions to their organizations.

2

Improved relationships with providers:
You'll be able to identify key areas to collaborate with those providing care. Empower them to make more meaningful decisions, faster, thanks to the infusion of analytics into provider workflows at the point of care.

3

Enhanced engagement:
Artificial intelligence continues to broaden the scope of possibilities for members to become engaged in their own care, especially those who are high-risk. Artificial intelligence can also help provide insurance company care specialists with more insights to tailor their approach to member communication.

How health plans are shifting strategy

The Health Research Institute finds that for the first time since 2017, health executives across provider groups, health plans, and life sciences are likely to reprioritize the focus of their 2021 operating models. That means honing in more on the physician-patient relationship versus focusing on members directly. Ninety-one percent of health plan executives cite improving the clinician experience as their primary goal.

CMS final interoperability rules, which were finalized in March 2020 just as the pandemic hit, may fast-forward plans for providers and allow them more ways to provide data to help physicians and hospitals succeed in value-based care models.

The rules lay the groundwork and outline the infrastructure for a more dynamic system in which consumers can use third-party apps on their smartphone to access personal health data that is traditionally housed by insurers and providers. Encounter and clinical information, and claims, will follow members as they transition from health plan to health plan. Provider groups will have to electronically alert other groups when a patient is admitted, discharged, or transferred. "A comprehensive strategy that considers how the rules can lead to a more effective healthcare system that puts the consumer in the center would put the organization on offense in this new data-sharing environment," writes HRI.[9]

Where do you fit in?

To understand how athenahealth supports health plans in their individual journeys toward digitization and its associated innovation – and organizational practices that sustain it – consider three hypothetical insurers:

THE TRADITIONALIST

Sisyphus Healthcare

THE DIGITALLY MINDED

Atlas Healthcare

THE TRAILBLAZER

Heracles Healthcare

THE TRADITIONALIST

Meet Sisyphus Healthcare

It's paper aplenty for Sisyphus Healthcare, which contracts with medical records collection professionals to manually obtain clinical data in-person at a rate of $40 per member per year. That's $4 million annually for every 100,000 members, but the cost isn't the burden of Sisyphus alone. Provider groups must schedule an employee to pull charts, copy and print them, and then set aside stacks of paperwork that are often several feet high — often just for one lab result — in a designated area that could be used for patient care. This has been especially troublesome during the COVID-19 pandemic, as provider groups tried to maintain centralized offices with mostly remote staff.

Once paperwork is obtained by the provider group, results must be manually entered into a payer's system, or scanned in. This requires extra staff, who often can't input clinical data as soon as it's received based on the large volume of paperwork arriving during peak times.

Compounding the issue is massive eligibility files required for enrolled patients between Sisyphus and some providers' clinical records vendor. The back-and-forth reporting means a delay in access to data, which in turn means a delay in payment. The delay also can lead to addressing care gaps with patients more slowly. That's especially irksome as the healthcare continuum deals with the reverberations of the COVID-19 pandemic and missed preventative appointments and screenings.

Sisyphus knows they are leaving money on the table, due to the higher cost for repeated manual tasks and greater chances for mistakes due to the manual nature of the work. Their rating with the Centers for Medicare & Medicaid Services is just 2 out of 5 stars. They need an additional two stars to qualify for a bonus payment of 5 percent.

Sisyphus Healthcare at a glance

Efficiency rating

- Lower revenue
- Fewer opportunities realized for addressing patient care

Revenue opportunity

- **High:** Maximum potential to increase profitability

Outcomes

- Lower visibility into care gaps
- Long delays in addressing patient care gaps once surfaced
- Provider relations often strained

THE DIGITALLY MINDED

Meet Atlas Healthcare

Atlas Healthcare prides itself on delivering excellent member care while keeping costs low for its organization and patients. The payer already uses athenahealth's Prescription Real-Time Benefits Check to determine a patient's prescription benefit coverage, provide accurate costs for their prescriptions at the time of prescribing, and choose more economical treatment options when available.

But a lack of visibility into services delivered out of its provider network meant that Atlas was likely covering duplicative care.

Six months ago, they implemented an automated data extraction program, and have already tracked great results thanks to having data in a standardized, electronic C-CDA (Consolidated Clinical Document Architecture) format that can be scaled for multiple needs across the business. Atlas is also pleased with the positive feedback they've received from their contracted provider groups, who no longer have to engage a full-time employee to manually pull and copy patient charts (nor do those providers have to set aside space for document storage that could be used more efficiently).

Atlas' next goal is reducing friction across the healthcare continuum by supporting providers' efforts to transition to value-based care programs, and supporting quality program performance goals. Atlas anticipates using insights from health plan data and member medical record data to give providers real-time insights and spot potential gaps in care. As patients with diabetes often have several appointments for blood pressure, blood sugar tests, medication reviews, and eye exams, automatic alerts for their providers generated by Atlas' data can help improve the experience for those patients.

But Atlas still knows it has further to go in addressing care gaps across the entire spectrum of their patients, particularly after COVID-19. Increasing the volume of patient engagement campaigns triggered by analyzing exchange data is just one goal for this year. The other is enhancing Atlas' CMS star rating from 3 to 4; the organization is already well on its way to doing so.

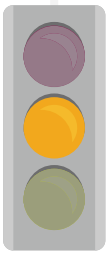
Atlas Healthcare at a glance

Efficiency rating

- Average
- They have more quality data than ever before
- Organization needs a strategic approach in regard to updating operations and rolling out new programs

Revenue opportunity

- **Realized incrementally**



Outcomes

- Marked progress improving provider relations
- Members with chronic conditions report satisfaction with enhanced care
- On track to earn CMS bonus payment

THE TRAILBLAZER

Meet Heracles Healthcare

Heracles Healthcare prides itself on a proactive approach to investigating new technologies that will enhance profitability, operations, and patient outcomes across the healthcare continuum. Reducing manual tasks for its employees is one of Heracles's hallmarks. The payer uses natural language processing and artificial intelligence (AI) whenever possible to enhance processes, and has even implemented the use of bots across the organization for tasks that can often be automated. Voice recognition software that analyzes calls and generates informed prompts for agents has reduced hold times and repeat calls from members.[13]

To maintain efficient and productive relationships with providers, Heracles is piloting a process automation program for contracting. An enhanced portal means providers can more easily check in on different claims, and Heracles will also be involved in developing straight-through processing in order to automate handoffs between varying systems.

Providers note greater satisfaction because they can keep staff focused on patient care, as opposed to dedicating time to pulling charts for in-person pickups. Patient care gaps are surfaced most quickly at Heracles, meaning addressing those issues is faster for providers and patients. Practice staff have visibility into gaps prior to patient appointments to prepare in advance for the most seamless experience at the point of care. Practices can also generate reports and address gaps via virtual engagement campaigns.

Heracles estimates that its investment in data exchange processes will ultimately reduce costs for members because they are notified earlier about scheduling the care that they need. With the most visibility into out-of-network procedures and care, Heracles is also able to save on duplicative member services. Heracles has also noted better patient and provider satisfaction after implementing new technology to track prescription drug coverage and costs, and select lower-cost options when available. As a trailblazer, Heracles has put together a specialty internal team working on implementing how to best use data from member wearables to address member care and reduce costs.

A pilot program to engage patients with an avatar that is half A/I-driven and half agent-controlled should enable 24/7 care management for members with chronic conditions.

Employees are grateful that there is no further monthly sending of member eligibility files required; eliminating that extra step means Heracles gets the data it needs faster – and, in turn, is more profitable. Data is structured uniformly across the organization, so different departments have visibility and access for various use cases. Because of implementing a data exchange program, Heracles has earned 5 out of 5 stars from CMS and is eligible for the maximum 5 percent bonus payment.

Heracles Healthcare at a glance

Efficiency rating

- Above average

Revenue opportunity

- **Maximized**

Outcomes

- Most productive relationships with providers
- Potential for healthiest members
- Most potential for financial impact

The path forward starts here

Wherever you are when it comes to your digital strategy journey, recognition of its importance is the first step. Those who are succeeding in addressing care gaps and improving their quality scores didn't get there overnight. But every organization, no matter what its scale or geography, should have the same guiding principles as their North Star: enhancing efficiency, outcomes, and revenue.

Which of the health plans did you identify with most? Have you seen marked success, like Heracles Healthcare? In the middle making slow but steady progress like Atlas?

Or are you in the high opportunity category like Sisyphus, and will realize the most from a transformation?

No matter what your profile is, affecting change will always be about more than "just" data. People matter. That's why a partnership with athenahealth is more than just important, it's imperative. Because we care just as much as you do about your members, providers, and improving the healthcare continuum now – and in the future.

"athenahealth's passion for data and data-driven performance optimization inspired us to modify our metric reporting process for our business partners, fostering a culture of performance management that will help drive needed innovations in healthcare."

Florida Blue, athenahealth partner since 2018

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