Payers Insights Report

2024 HLTH Conference | October 20 – 24, 2024

Sponsored By

CERIS
A CORVEL COMPANY

EVERNORTH
HEALTH SERVICES

PurpleLab
HEALTHCARE ANALYTICS

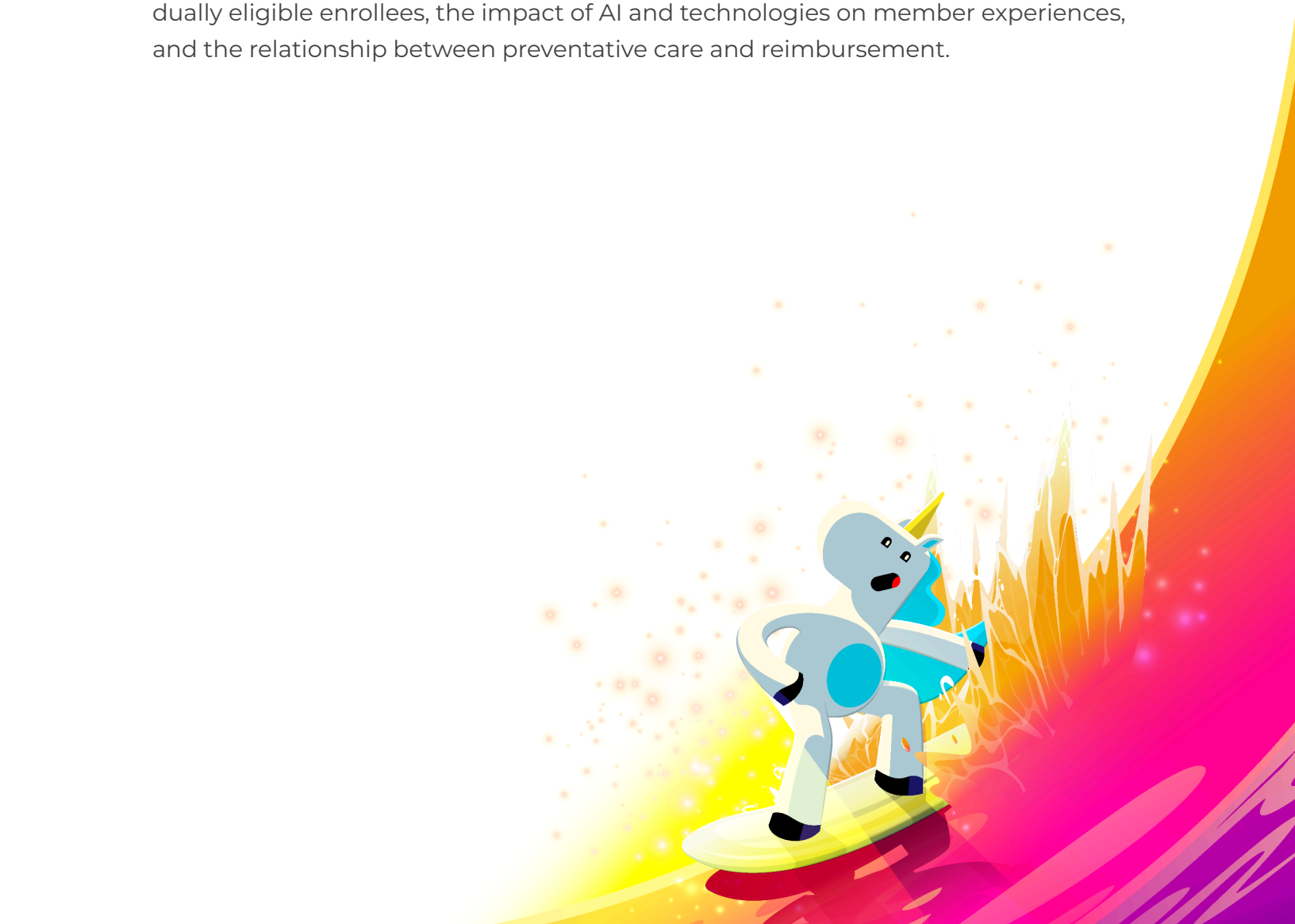
hlth.

Contents

Introduction

There's an ongoing shift occurring within the healthcare payments systems that is reflecting the push to establish more consumer-center initiatives including value-based models, while addressing ways to mitigate the high costs of medical care.

In 2024, at the HLTH Payer Insights Program, leaders from payer organizations explored the many issues facing the payer landscape today – including evaluating dually eligible enrollees, the impact of AI and technologies on member experiences, and the relationship between preventative care and reimbursement.



Reimbursement & Preventive Care

Most payers today believe that prevention is a worthwhile investment that leads to a reduction in future health care costs, especially in a Medicare Advantage setting. Likewise, healthcare professionals play a crucial role in advancing preventive care, but their behaviors are often influenced by incentives related to reimbursement and payment for these services. Most payers want to encourage members to see their primary care physician, have their care gaps addressed, have their diagnoses updated and adjusted as necessary, as it's beneficial for the plan in the long run.

“Payers want to engage their members in wellness by getting them involved in programs, educating them on their benefits, and helping providers understand the importance of these initiatives.” says Russell Robbins, chief medical information officer, Purple Lab, a healthtech company with a mission to make healthcare speak a single unified language to drive better outcomes. In addition, today’s payers are expanding their focus beyond traditional populations to better support underserved communities.

That said, when talking about prevention in America, for many we are still talking about secondary prevention, as true, primary prevention happens in childhood. For example, if a patient has a heart attack, the wellness and prevention techniques employed will be focused on putting that person on a better diet with more exercise.

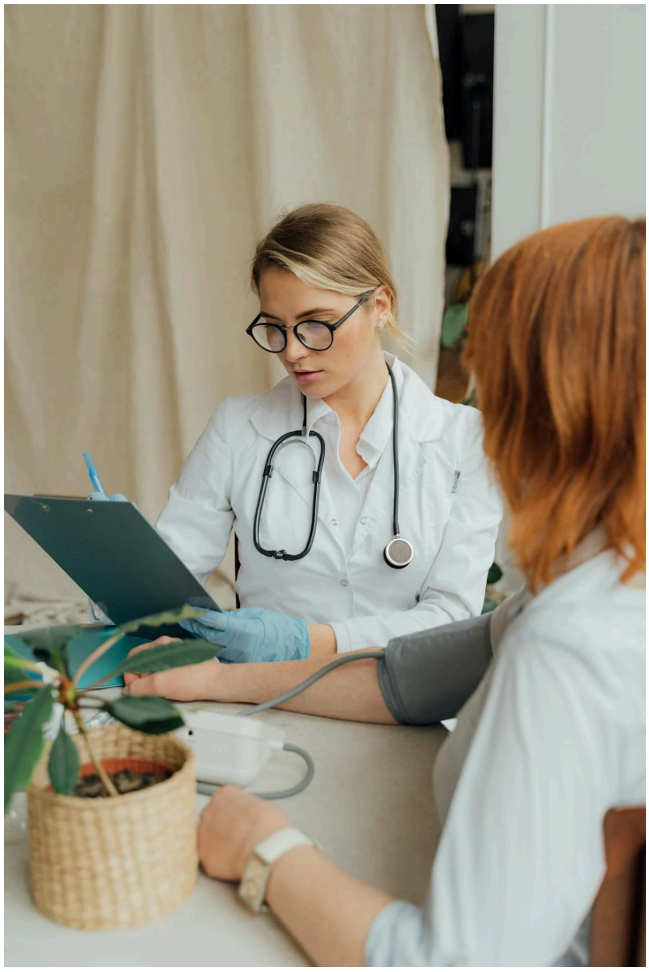
We now have more metrics than ever before.

Pankhuri Sharma / Strategy and Operations Leader at Humana

Darren Wethers, strategic advisor at Managed Care Resource Alliance, points out that when HMOs came into vogue in the 1970s and 1980s, they truly were “health maintenance organizations.”

“They were organized around getting the patient to see the PCP, having nutritional counseling, having lifestyle enhancement discussions,” Wethers says. “What we’re hearing from our members is that they’d rather go back to that former way, where the entirety of their health is being addressed, rather than just a transactional scenario.”

So what is the best way to define value when it comes to reimbursing preventive care? For Pankhuri Sharma, strategy and operations leader at Humana, the healthcare industry has become more mature about ensuring that preventative services have conceptual value.



"Now we have more metrics than ever before, like the reduction in ED utilization, or the reduction in readmissions, or if there is a member who's suffering from a chronic disease – then ensuring that the disease does not advance to further stages," Sharma says. "Of course, member turnover is a reality. As much as we want to improve our members' health, we also want to ensure that whatever costs we put forth ensures that the disease does not advance and we can see those advantages before the member moves on."

Today, we also have many wellness programs and chronic care programs where we put healthy members, as well as those suffering from chronic diseases, on clinical pathways depending on their needs.

"Most of the health care plans that I know are investing into predictive analytics to understand the risk that their members are facing, and depending on the kind of risk tiers the members fall under, the idea is not only to address the high risk members, but also to provide care to the low risk members so that they do not advance on the high risk path," Sharma says.

Social determinants of health also play a role in reimbursement and preventive care. In addition to tagging people based on demographics, payers also evaluate healthcare access and housing instability.

"We're looking primarily at race, ethnicity, marital status, education, and income but we also look at rural versus suburban versus urban," Robbins says. "We're always looking for additional information such as transportation or food deserts, and other types of social determinant factors."

We’re always looking for additional information such as transportation or food deserts, and other types of social determinant factors.

Russel Robins / Chief Medical Officer, Purple Labs

Looking ahead, there are some key strategic priorities when it comes to investing in prevention in the near future. For Sharma, it involves helping members have awareness that preventative care is something that has value, rather than having a symptomatic or reactive approach to it.

“Partnerships with community orgs or ensuring that members get their messaging from their providers is on our radar,” Sharma says. “Many members also live in rural areas or have transportation issues, so focusing on mobile clinics and providing telehealth services is another area of focus. Availability of primary care providers, especially in the U.S. where we have a shortage due to PCPs being overworked is an area of concern as well. This would entail moving toward team-based care, where a member could be taken care of by a team instead of having to anchor the whole preventative care on a PCP.”

Wethers advocates for the whole-person care approach. However, in today's health systems, the data is too fragmented, and it’s often unclear who is leading what. “Where I’ve seen it work well is where you have a single care coordinator who can get the member through all the different sites of care. The patients who had the single care coordinator had few ER visits, more adherence with their medication regimen, more adherence with their appointments. The model is really clear – implementing it is more difficult,” says Wethers.

AI & Emerging Technologies Equals Better Member Experiences

A recent study by the Kaiser Family Foundation highlights the rising and high cost of employer-sponsored family healthcare coverage, which averages over $25,000 per year. Which is why the industry – including payers, providers and consumers – are exploring innovative strategies and solutions to reduce costs. This includes value-based care, digital health tools, and data analytics - which are not only aimed at improving health equity, streamlining care, and enhancing the consumer experience but also at reducing unnecessary spending and improving cost efficiency.

AI is now seen as a powerful tool to drive better outcomes and patient experiences while driving out waste and keeping costs down for employers, purchasers and consumers.

“Twenty-five percent of healthcare spend is due to administrative workloads,” says Samta Shukla, director of AI and data science at Blue Cross Blue Shield Minnesota. “We are trying to come up with strategies and algorithms to reduce the administrative burden and drive administrative efficiencies.” Currently, Blue Cross Blue Shield Minnesota has member experienced advocates receiving calls and they have access to an AI-enabled chat bot that can help answer questions in real time. This is driving member satisfaction as well as reduction in workload for customer center employees, who no longer have to pull up various documents where the knowledge is stored and can give more comprehensive and compliant answers.

“From my perspective, working on the payer and payment integrity side, there are numerous strong use cases for claim adjudication—streamlining and automating the process to enhance efficiency, accelerate claims processing, and ensure faster payments.,” says Steve Sutherland, senior vice president of information systems at CERIS, a company that provides prospective and retrospective claims review and repricing, combining clinical expertise and cost containment solutions to ensure the accuracy and transparency in healthcare payments.

Physicians are increasingly leveraging AI scribes to streamline documentation and ensure compliance with standards that fully capture the value of their work. For example, at HCA

Healthcare, physicians can use a phone to record patient conversations. Within minutes, an AI-generated note is created, requiring only review and a signature from the physician.

AI actually helps me to keep track of an accurate story. It helps me realize what I said in the room would be the assessment and plan of that patient.

Vikesh Tahiliani / Vice President Care Transformation and Innovation, HCA Healthcare

"What the physicians are telling us is, 'My life is really busy. I'm going from room to room to room. I remember that the patient in bed one had chest pain while mowing their yard, but I don't remember some of the other details," Tahiliani says. "AI actually helps me to keep track of an accurate story. It helps me realize what I said in the room would be the assessment and plan of that patient. So there's a lot of cognitive burden that's reduced using these systems."

From a health insurance carrier standpoint, they are often leveraging large language AI models to get record summaries to allow for auditing and reviewing of those records by a human being (rather than an automated review). If you only have AI-generated recommendations without any human oversight, you may fall into the trap of automation bias because AI systems tend to exaggerate the inherent bias in the data.

"When you start using technologies that use AI, it's a huge change management exercise," says Tahiliani. "You have providers that have been practicing the same way for years, if not decades. Now you're asking them to leverage a tool that, in the grand scheme of things, is relatively new. In our change management exercises, in our education, we emphasize that you are the human in the loop. None of this is official until you read it, edit it, and sign it. We emphasize that this is a tool to help you, it is not going to do the work for you."

While AI is streamlining processes throughout the healthcare system, there are key data security concerns emerging with these efficiencies. Players in this space are honed in on regulatory requirements, contractual requirements, and data use agreements to make sure they are protecting the data and using it as it was meant to be used.

"At HCA, we have the largest data repository in the world," says Vikesh Tahiliani, vice president care transformation and innovation, HCA Healthcare. "What we've learned is that if we give access to a certain portion of data, and a vendor or someone else tries to access more than

that, we have audit systems in place that we can track. But once that data's released, it's honestly the honor system after that, because we really can't control what someone does with that data once it's in their hands."

Blue Cross Blue Shield also employs a very rigorous AI governance framework and they are working to develop a similar AI governance framework for vendor vetting. This will entail assessing all vendor vulnerabilities related to the user data.

"We want to make sure we are working with vendors who are trusted and compliant to our practices," Shukla says. "When I am using their solution, what kind of autonomy does it give me? Is it deployed in the right environment? Is it secure? We are seeing if we can reduce some of those vendor black boxes and make the experience a little bit better for the people who are using these technologies day to day."

How do experts envision AI-driven predictions for medical events shaping payers' strategies for funding preventive care? Additionally, what steps are being taken to align reimbursement models with emerging technologies to improve member experiences?

AI has the potential to revolutionize a lot in the member experience preventative care space in the next three or four years.

Samta Shukla / Director of AI and Data Science, Blue Cross Blue Shield Minnesota

"AI has the potential to revolutionize a lot in the member experience preventative care space in the next three or four years," says Shukla. "We are building specific models for the top five commodities that drive most of the cost in healthcare. Quantifying the risk is one model; adherence is another model; compliance is another model. Then we try to piece them all together to infer cost."

It's important for providers and payers to embrace the role that AI will play in the future of healthcare. Many are establishing a responsible AI committee that makes sure your organization is using AI responsibly. Change management also plays a key role as not everyone is going to understand or embrace it immediately. And lastly, it is critical to establish security protocols, data governance and build proof of concepts.

The Future of Care for Dually Eligible Enrollers

Dually eligible Medicare-Medicaid enrollees often have complex healthcare needs, making it challenging to determine the most effective ways to address them. A significant consideration is their preference to remain in their homes, despite facing barriers such as limited access to the internet, required technology, or providers, particularly in rural areas. Moreover, the nearly one million dual-eligible individuals residing in long-term skilled nursing facilities underscores the urgent need for improved technology integration and its potential to enhance patient outcomes.

Melissa Steffan, president of home-based care at Evernorth says it's important to look at dual eligible patients and the intricacies of putting together a care plan that can actually be provided for complex needs.

"When we talk about dual eligible and we think about the social determinants of health, it becomes very apparent if there are financial, food or transportation insecurities," Steffan says. "[If they are at home], you look around their room and you can see why there's a fall risk, why they're having multiple admissions. We're providing care that is needed, in a new and innovative way, although the roots are tied to traditional medicine. The challenge is making sure that the benefits align, that the system itself knows how to transfer the care to the home."

The challenge is making sure that the benefits align, that the system itself knows how to transfer the care to the home.

Melissa Steffan / President of Home-Based Care, Evernorth

It is equally important to provide comprehensive training for community health workers and non-skilled caregivers, enabling them to effectively assess what is working, what is not, and the individual's goals. This training ensures they can develop care plans that align with the

person's needs and adapt as those needs evolve throughout their journey in home and community-based care.

"Before we start talking about disease management goals or preventative care, we need to make sure the person feels safe in their home, that they have access to food, and that they can keep the lights on," says Jennifer Rogers, vice president of long-term services, Highmark Wholecare. "We need to be integrating those goals or services into the person's care plan and then sharing that care plan…so that it cascades throughout the system…to keep them safe and thriving in the community setting of their choosing."

From a payer perspective, it is also important to ensure that the dual eligible beneficiaries can receive care and support that is reimbursed. As Ginny Whitman, associate director of public policy, Alliance of Community Health Plans (ACHP) explains, a Dual Special Needs Plan (D-SNPs) is a type of Medicare Advantage Plan that provides coordinated benefits that address the unique needs of this population, including medical, behavioral health, and long-term services. These plans often include additional benefits not covered by Original Medicare, such as vision, dental, and transportation, and they work to align Medicare and Medicaid coverage for better care coordination.

"When you're thinking about federal regulation and state policy, there's a state-level component to this when you're thinking about innovation waivers with the state Medicaid agencies," Whitman says. "But there's also a fundamental hospital at home program through Medicare. It is really crucial to make sure we get some program-wide consistency, ensuring that this population has the ability to continue receiving this type of care because this population is growing."

There has been a shift over the last several years of more enrollees that are dually eligible moving into Medicare Advantage plans. On a fundamental level, there is a state level trend that is pushing private insurers, specifically Medicare Advantage plans, within the state to adopt fully integrated dual special needs plans.

"The private payer is coordinated with the state so that the health plan is responsible for both the Medicare Advantage portion of the dual's coverage and the Medicaid portion of the dual's coverage," Whitman says. "That offers a higher quality of integration and care coordination and coverage for that individual."

Steffan emphasizes the importance of relieving patients from the burden of navigating complex plans and empowering providers by reducing the need to navigate numerous care management and coordination obstacles.

“Most benefits go unused to the fullest extent because of the navigation and complexity, so as we get better at designing coverage, we need to partner with providers who are providing the care to streamline the execution of that, to get the results that we’re all hoping to see,” Steffan says. “Otherwise, we’re not going to actually move the ball forward.”

The technological infrastructure surrounding the dual eligible program is paramount – specifically as it relates to chronic care management or remote patient monitoring being utilized with duals.

“Remote patient monitoring can do some really great things when connected to the care team,” Steffan says. “It’s designed to be the eyes and ears when somebody is not in the home – whether it is fall protection, diabetes management, etc.”

Rogers highlights that technological tools can capture valuable care insights from providers who interact daily with dually eligible individuals in their homes. “We have the opportunity to enable proactive care and avoid unnecessary hospitalization by using real-time information and early warning systems. We’re empowering our providers by giving them the tools they need.”

Program Contact:

Amy Eckenroth

VP, Strategic Partnerships, *HLTH*

amy@hlth.com