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Top Challenges Health Plans and Payers are Solving for in 2024

Health plans and payers in 2024 are facing a mix of new and ongoing challenges and opportunities presented by today's rapidly evolving healthcare environment. Some of the top considerations include:

- The continued shift to value-based care models
- The need to enhance quality and improve Star Ratings
- Increased costs and high utilization
- Increasing adoption of health information technology and data exchange standards
- The critical need for collaboration among care partners – just to name a few.

In this trends report, we'll go over:

Top challenges health plans and payers are solving for in 2024.

Recommendations for tech solutions that can complement or enhance current approaches for greater impact.

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Quality management and enhancing visibility of patient needs

Increasingly, value-based care and the importance of quality outcomes mean that health plans need to be able to identify where members may experience gaps in care due to lag times, improper coding, and lack of visibility to members' location and clinical status.

As advances in care collaboration take place between payers and providers, this continues to highlight the importance of real-time collaboration to reduce care and coding gaps.

However the collaboration challenges that exist can lead to disruptions in care, problems with care transitions, and duplications in care delivery. Providers may struggle with the limitations imposed by payers, while payers, focused on streamlining care, may not understand how a common practice or procedure is both necessary and value-based. Payers may also need to educate providers on the benefits and best practices for working through contracts with two-sided risk.

The ability for healthcare partners to work together effectively may also be impeded by outdated IT infrastructure. The use of smarter technology networks that facilitate collaboration, dispatch urgent notifications regarding high-risk members, and deliver crucial information in real time directly to providers can improve coordination, cost savings, and care transitions – all critical for health plans to support the continuum of care. Health plans should also consider their resource allocations for preventive and proactive care and ensure providers are aware of those social support services available to help close care gaps, reduce adverse events, and improve member outcomes and prognoses.

Health plan and payer organizations must have the tools and processes in place to support their current and future collaborative efforts as the paradigm continues to shift to a value-based care environment. For example, technology that pulls together valuable data from disparate care plans, pathways, and healthcare entities into a single integrated system with true interoperability (that's also easy to understand and in a member-centric format) will alleviate many of these challenges.

Performance monitoring based on data reporting requirements

Health plans can expect healthcare rules and regulations to continue to drive patient outcomes, quality of care, and costs in 2024 and beyond, largely centered around transparency and interoperability.

Health plans must be agile in light of changing data reporting requirements like the new HEDIS® (Healthcare Effectiveness Data and Information Set) ECDS (Electronic Clinical Data Systems) Reporting Standard. HEDIS[1] is one of healthcare's most widely used performance improvement tools, and includes quality measures for physicians, PPOs (preferred provider organizations), and other entities.

An opportunity exists to use HEDIS specifications to streamline provider performance monitoring and comprehensive reporting. To do so, health plans need to help their provider network close gaps in care that cause suboptimal HEDIS Measure performance. For example, with real-time data, identifying and managing discharged patients is no longer delayed — as it can be with time consuming manual workflows.

Along with standards such as HEDIS Measures, as more provisions of the 21st Century Cures Act are implemented, health plans and payers have had to keep up with the resulting regulation changes. This has required more agility and interoperable health IT systems.

For example, in April 2021, the CMS Interoperability and Patient Access[2] rule went into effect, launching the official transition of Electronic Health Records (EHR) specifications to the HL7 Fast Healthcare Interoperability Resources (FHIR) standard, which will ease the job of transmitting data to the point of care.

To successfully navigate this dynamic care management landscape, health plans must make investments in quality and coding solutions today while also considering how their needs may progress in the future.

IT infrastructure must be agile and system agnostic to work across platforms used by all care partners. **To support true interoperability, data can't just be accessible – it must also be actionable.** For example, new data reporting standards require information to be properly documented in the medical record — an NCQA HEDIS audit requirement. Supporting providers with both real-time identification of members requiring time-sensitive follow-up care, and with **data exchange and supporting discharge documentation from Continuity of Care Documents (CCDs) will support better quality performance and compliance.**

Connecting fragmented data, systems, and insights

Disparate data silos and fragmented member views lead to care gaps and lost opportunities for coordinated care, impacting reimbursement

Limited care coordination due to lack of visibility into real-time healthcare service utilization poses a major challenge. Health plans and payers need to work towards greater interoperability to prevent gaps in data. These gaps impact care delivery, which is highlighted by Stars Ratings that reflect the quality of care provided by network providers on an annual basis. This in turn directly impacts Medicare reimbursement.

It is not enough to simply exchange data with providers: the data exchange must be secure and bi-directional between payers and providers; the data must be accurate and complete; and, most importantly, the data must be timely and actionable.

Receiving or sharing data that is fragmented, inaccurate, incomplete, or in an unusable format will not help payers or providers manage care effectively. Instead, payers should seek out health information technology solutions that support real-time visibility into member activity throughout the care network to identify care gaps and ensure that case managers coordinate preventive care and proactive interventions.

Enhanced interoperability for streamlined data exchange will help health plans and payers better manage member resources and offer effective engagement at the right time to reduce high ED utilization, support safe transitions in care,[3] and improve member satisfaction.

All provider engagement efforts will depend on payers having a solid foundation of quality data and secure data exchange solutions to send and receive up-to-date, holistic patient health information, including clinical; demographic; social determinants of health (SDOH); and ADT data.

Most importantly, having ADT alerts or data feeds sent directly within provider workflows will support more effective provider engagement than relying only on claims data alone. While claims data can be delayed by days, weeks, or even months, **ADT alerts that notify a member's care team when they are hospitalized, discharged, or transferred to a post-acute care provider in real time can help identify time-sensitive HEDIS care gaps in health information critical to better care coordination** and timely outreach to prevent readmissions and improve outcomes.

Increasing plan member well-being and satisfaction

As the Centers for Medicare & Medicaid Services (CMS) shift the weight of their Medicare Advantage Star rating to focus more heavily on patient experience, health plans face new pressures to engage with their members in an impactful way that drives quality improvement and outcomes.

Members select Medicare Advantage plans based on several factors, but primarily leverage a plan's Star Ratings to decide between otherwise comparable plans. This comparison of costs and benefits can impact a health plan's annual enrollment, both in growth and retention. Additionally, Star Ratings reflect overall plan performance and can impact plan compensation, with top-performing plans (at least four stars) receiving bonus payments, improving a plan's overall bottom line.

Plans must take a proactive role to improve their Stars performance. To improve the quality of care members receive and improve Star Ratings, health plans need to be able to effectively help network providers close quality gaps through improved plan-provider collaboration and enhanced member engagement.

There are a variety of factors which may influence member engagement. For example, some members don't understand or trust their insurance benefits or have had a difficult experience in the past. They may also believe their costs will be higher if they interact more frequently with medical professionals, and may be unaware of the distinction between in-network versus out-of-network providers and the cost differences involved.

Another factor that may affect a member's ability to seek preventive medical care is their current circumstances. They may be struggling with housing stability or may lack reliable transportation options to make it to doctor's appointments. Other factors like behavioral health conditions (e.g., a substance use disorder) or mental health conditions can also impact a member's capacity to utilize proper preventive or medical care services available to them.

Technology can offer solutions here by supporting a more holistic view of the member and by providing actionable data that tracks the member's journey across the healthcare network. Layering other pertinent information, such as a member's health risks, health history, and lab work to point-of-care providers, facilitates a more proactive engagement strategy tailored to the member's unique situation. This also helps to inform meaningful messaging and channels to use for outreach. At the same time, providing curated, standardized ADT and transition of care (TRC) alerts delivered as daily or real-time feeds sent within the provider's workflow identifies the member's movement throughout the network, enabling timely follow-up and support. The right collaborative partnerships among health plans and providers – aided by advanced technology and communications – **can help to reduce hospitalizations, decrease the total cost of care, and achieve better outcomes all while enhancing the patient experience.**

Managing increased utilization and costs

Health plans and payers continue to seek out new strategies and tools that will help them manage unnecessary readmissions, ED utilization, and SNF length of stay, all of which represent major drivers of cost of care.

When reporting for all stakeholders involved across the continuum of care is not streamlined, the resulting gaps in care can increase inappropriate utilization or lead to adverse outcomes post-hospitalization that drive up unnecessary readmissions.

Additionally, the growing complexity of care, especially when managing chronic disease, can lead to higher costs and lower quality outcomes – exactly the opposite of the high-quality, affordable care that value-based models seek to provide.

Gaining deeper insights into specific populations and episodes of care delivery has become increasingly important. Payers are seeking a more holistic view of the risk factors affecting their members. As an example, using real-time data to identify members requiring follow-up care based on HEDIS measures can provide the context needed to drive time-sensitive follow-up. With interoperability, the right IT solution can then leverage this data connected to transitions of care to identify patients who need follow-up care and medication reconciliation and send discharge summaries to network providers to support patient engagement.

Considering the escalating costs associated with gaps in care, payers must leverage better solutions to identify members at higher risk of hospitalization and poor outcomes. To effectively monitor groups or individuals across the care continuum, more data sharing and collaboration is needed between payers and providers. Namely, **payers should seek out technology that pulls together information from multiple data sources** to improve both risk stratification and risk adjustment to capture the insights needed to manage care for an individual within a specific population.

Health plans and payers need a smart admission, discharge, transfer (ADT) notification platform that can synthesize multiple risk factors and dispatch only the most critical notifications to the point of care. This can allow payers and providers to collaborate more effectively to identify, stratify, and adjust risk – which, in turn, can improve engagement, member services and, ultimately, clinical and financial outcomes.

Closing Considerations

Health plans and payers need to ensure their technology platforms are set up to align with these continuing changes in the healthcare landscape.

As the shift to value-based care models accelerates and member satisfaction becomes increasingly important, health plans and payers need to keep pace by supporting effective collaboration with providers in their network. This will only be possible by ensuring that your technology can support streamlined, real-time data exchange and is compliant with interoperability standards and ever-changing regulations in healthcare.

To achieve success in such a complex landscape, health plans and payers looking to address these challenges need a technology partner that can help them optimize care management efforts and support provider collaboration through the use of smart solutions and rich data networks offering real-time insights and communication.

PointClickCare is an industry-leading health IT platform that all major health plans have implemented to help solve these challenges facing payers in 2024.

For more information about how we can partner to help find solutions for your top challenges and goals as a health plan or payer, visit us online to **learn more**.

1. https://www.ncqa.org/hedis/measures/
2. https://www.cms.gov/files/document/cms-9115-f.pdf
3. https://pointclickcare.com/blog/better-clinical-outcomes/pointclickcare-connect-improving-patient-transitions/