Considerations for Benefit Vendors and Providers in Demonstrating Their Value Proposition to Health Plans

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Background

In recent years, health insurers find themselves facing increasing pressures –from a competitive outlook and also from a financial standpoint – to create tangible improvements in health outcomes within the United States. It's within this dynamic backdrop that a myriad of provider and benefit vendors are stepping forward to unveil innovative and previously unexplored solutions to the complex challenges in the healthcare sector. A key challenge that these companies frequently face is in demonstrating their value proposition to health plans so that their services can be included as covered benefits or as care management programs. Often, the providers and benefit vendors offer a compelling solution but are unable to support the effectiveness of their programs due to the newness of the solution. This whitepaper explores the value proposition that these solutions can bring to the healthcare market, analyses that can be conducted to support the value proposition claims, and strategies to get data in order to conduct a retrospective study on the solutions.

Value Proposition

As mentioned above, providers and vendors are offering new and innovative solutions to improve healthcare for patients. The solutions offered vary in how they impact member health care. Below we explore some of the typical ways that these innovations influence healthcare.

Medical Cost Savings

Medical cost savings refer to the reduction of expenses associated with healthcare services and treatments while maintaining or improving the quality of care provided to patients. In the context of healthcare, costs can include a wide range of expenditures, such as medical procedures, hospital stays, medications, diagnostic tests, consultations, and administrative expenses. Medical cost savings are often sought by healthcare providers, insurance companies, employers, and individuals in order to make healthcare more affordable and sustainable.

Efforts to achieve medical cost savings can involve various strategies, such as implementing more efficient processes, promoting preventive care, using technology to streamline operations, etc. These strategies aim to ensure that healthcare services are delivered in a cost-effective manner without compromising the quality of care or patient outcomes. The following is a more detailed, yet non-exhaustive list of the most common ways that providers and benefit vendors can help to generate medical cost savings.

1. Telemedicine and Virtual Care: Utilizing telemedicine and virtual care options can reduce the need for in-person visits, leading to lower overhead costs for providers and fewer expenses for patients.
2. Preventive Care and Wellness Programs: Encouraging patients to adopt healthier lifestyles through wellness programs and preventive care can lead to fewer serious health issues down the line, reducing the need for costly treatments.
3. Chronic Disease Management: Effectively managing chronic conditions through regular check-ins, medication management, and lifestyle counseling can prevent costly hospitalizations and emergency room visits.
4. Population Health Management: Identifying and addressing the unique health needs of specific patient populations can lead to more targeted and effective interventions, reducing costs associated with uncontrolled health conditions.
5. Health Education and Patient Engagement: Educating patients about their conditions, treatment options, and the importance of adherence can lead to better health outcomes and reduced healthcare costs over time.
6. Care Coordination: Improved communication and coordination among different healthcare providers involved in a patient's care can lead to fewer duplicate tests, better treatment plans, and reduced costs.
7. Generic and Formulary Medications: Promoting the use of generic medications and adhering to formulary guidelines can significantly lower medication costs for both patients and healthcare plans.
8. Value-Based Care: Shifting from fee-for-service to value-based care models incentivizes providers to focus on patient outcomes, which can lead to more efficient care and cost savings.
9. Employee Health and Wellness Incentives: Benefit vendors can work with employers to offer health and wellness incentives to employees, encouraging them to adopt healthier behaviors and lifestyles.

It's important to note that the effectiveness of these strategies can vary based on the healthcare system, local regulations, and the specific needs of the population being served. Collaborative efforts between providers, benefit vendors, patients, and health insurers are often necessary to achieve significant and sustainable medical cost savings.

Member Retention

Member retention is a strong driver of profitability for risk-bearing entities. A high member retention rate can mean a more stable revenue stream, lower acquisition costs, lower claims costs from ongoing care management, and steady improvement of risk scores over time. As such, any efforts that support member retention should be considered as part of the value proposition. Provider and benefit vendor solutions frequently contribute to increased member satisfaction and engagement which are strong drivers in whether a member chooses to stay with a health plan. The solutions offered by providers and benefit vendors often serve to enhance member retention, which is crucial for maintaining a stable and satisfied member base. Member retention is essential for the long-term success of health plans. Here are typical ways they work together to achieve this goal:

Providers and benefit vendors play pivotal roles in enhancing member retention by working collaboratively to deliver exceptional care and services. Providers contribute by offering quality clinical care, personalized treatment plans, and effective communication that engenders member satisfaction and encourages members to stay within the plan. Coordinated care, patient education, and ongoing follow-ups establish a sense of trust and reliability, which are crucial for members' decisions to remain with the plan.

Benefit vendors, on the other hand, support retention through comprehensive member engagement strategies. They provide resources for health and wellness programs, facilitate access to value-added services, and offer responsive customer support that addresses members' concerns promptly and effectively. Additionally, benefit vendors help simplify the healthcare experience by guiding members through the complexities of plan benefits, services, and network providers. This level of support and guidance reinforces the value proposition of the health plan, contributing to member loyalty and long-term retention.

Risk Score Improvement

In both Medicare Advantage (MA) and the individual/small group marketplaces, risk scores play a crucial role in determining payment rates and reimbursements. Risk scores are used to estimate the expected healthcare costs of enrollees based on their health conditions. It is imperative that health insurers collect accurate diagnosis coding for their members to ensure accurate compensation for the care their members receive. Here are some typical ways that providers and benefit vendors offer solutions to help with coding efforts.

1. Accurate Documentation and Coding: Ensuring that medical records accurately reflect the health conditions and diagnoses of patients is essential. Accurate coding and documentation can lead to higher risk scores that reflect the complexity of patient care.
2. Chronic Disease Management: Effectively managing and treating chronic diseases can lead to improved health outcomes and higher risk scores. Regular follow-ups, medication management, and preventive care are key components.
3. Annual Wellness Visits: Encouraging patients to participate in annual wellness visits can lead to better identification and documentation of health conditions, ultimately contributing to more accurate risk scores.
4. Specialized Care for Complex Cases: Providing specialized care for patients with complex and high-risk conditions can lead to more accurate risk scores that reflect the resources required to manage these cases.
5. Care Coordination: Coordinating care among various specialists and healthcare providers can help ensure that all relevant diagnoses and conditions are properly documented, leading to more accurate risk scores.
6. Member Education: Educating beneficiaries about the importance of regular check-ups, screenings, and preventive care can lead to early detection and proper documentation of health conditions, ultimately improving risk scores.

7. Risk Stratification: Using data analytics and predictive modeling, benefit vendors can identify high-risk individuals who may need additional care and attention to improve their health outcomes and risk scores.
8. Care Management Programs: Implementing care management programs for high-risk individuals can help improve their health status and documentation of their conditions, resulting in higher risk scores.
9. Social Determinants of Health: Addressing social determinants of health, such as housing and access to healthy food, can lead to enhanced member engagement and consequently improved health outcomes and risk scores for beneficiaries.

Both providers and benefit vendors need to operate within regulatory guidelines and ethical considerations when working to improve risk scores. The goal is to accurately represent the health status of beneficiaries while providing them with quality care and support.

Stars Improvement (Quality of Care)

While the below discussion is primarily in the context of the Star Rating program under Medicare Advantage, it should be noted that the principles here apply to other quality rating programs. The Medicare Advantage Star Rating program is a quality rating system developed by the Centers for Medicare & Medicaid Services (CMS) to assess the performance and quality of Medicare Advantage plans. In addition to being a measure of quality for a health plan, the star rating is also used to reward health plans that are excelling in quality with higher revenues and the potential to offer richer benefits to members. A health plan's star rating is updated annually and ranges from 1 to 5 stars, with 5 stars representing the highest level of quality. There are three major categories of the stars program which further breakdown into multiple measures within each one.

1. Process and Clinical Outcomes: These are measures related to health outcomes, chronic disease management, and preventive care. Examples of measures include plan all-cause readmissions, breast cancer screenings, and controlling blood pressure.
2. Patient Experience: Measures that assess beneficiaries' experiences with their healthcare and services. Examples of measures include care coordination, getting needed care, and customer service.
3. Access to Care: Measures related to beneficiaries' access to needed care and services. Examples of measures include the call center availability and review of appeals decisions

Providers and benefit vendors are uniquely situated to provide support to health plans in improving the quality of care since they are often directly engaged with members. Quality measures should be reviewed to evaluate which measures are most likely to be impacted by the solution offered.

Operations Enhancements

First and foremost, payers, providers, and benefit vendors generally think about the value proposition for their members and the resulting impact of those solutions for their members as demonstrated in the

subsections above. In addition though, providers and benefit vendors should be prepared to discuss how they support the operations and business side of things. Considerations include:

1. Implementation: Having a smooth implementation process for both the payer and the member
2. Continuity of Care: When switching vendors/providers, it's important for the health plan and members to know how members will receive their care in the transition with a goal for the impact to be as minimal as possible.
3. Collaboration on Marketing Materials: The vendor/provider can assist the health plan in preparing marketing materials to go out to members
4. Coordination of Member Outreach and Engagement: It's important to have a clearly defined process for how providers/vendors will engage with members and where appropriate to include the health plan's care management teams.
5. Technology Integration: Providers and benefit vendors should work with the health plan to integrate the solution into their platforms/APIs.

This list is hardly exhaustive but the purpose remains the same. The goal is to make integration with the health plan's benefit structure as seamless as possible for both the health plan and for the member.

Value Proposition Analyses

With the value propositions identified, benefit vendors and providers now must determine how they can demonstrate these value propositions to health plans. We typically find that these programs offer a compelling story that resounds with health plan leadership, but the story falls flat when the actuaries and finance teams get involved. This is because a proper analysis hasn't yet been completed that shows the math behind how these programs are expected to generate a return for health plans. Performing this mathematical demonstration may be challenging, particularly when the program is new or data are unavailable, but it's important to overcome these obstacles in order to get full support from the health plans. Below we consider two primary types of analyses to support the value proposition. Which one(s) are used will depend on availability of data and the individual situation of the benefit vendor/provider.

Prospective Benchmark Analysis

The first analysis that we consider here is a prospective analysis. This is used in cases where the vendor or provider either has a new program or the program that has not collected sufficient data to conduct a proper evaluation of the impact. We refer to this as a prospective analysis because we're attempting to answer the question "If the health plan partners with us, what impact might we expect to see?" The way that we propose to conduct these analyses is to use benchmark data that's as similar as possible to the target population of the intervention with applicable adjustments. We discuss selection of the manual data used for benchmarking in the following section.

Once the manual source data has been selected and adjusted to more closely match the target population, the data can be summarized into meaningful ways based on the chosen intervention. Using fall prevention programs as an example, we would anticipate that there would be medical cost savings in inpatient utilization. Therefore, it's important to make sure that inpatient utilization is split out. Savings may be realized for other service categories as well and these should also be split out.

The last phase of this analysis is to apply the impact of the intervention to the benchmarks. In the fall prevention example, this may involve doing a comparison between the at-risk population who have had a fall versus those who hadn't in order to understand the savings potential for an individual member and then applying some assumption on the percentage of members impacted. Alternatively, this could be where a cache of relevant research can be useful to apply. There are research studies that evaluate the impact of various care management programs that on their own can't really inform a value proposition but can be paired with the benchmark results to produce a dollar figure.

Retrospective Program Impact Analysis

A retrospective analysis can help determine if the care management program is achieving its goals. It can provide insights into the program's impact on patient outcomes, healthcare costs, and other important metrics. The methodology for these analyses is not a one-size fits all approach. There are multiple measurement methods than can be used to identify the impact of a care management program and which one is selected depends on a variety of factors including availability of data, type of intervention, type of population, etc. We will provide a brief overview of the methods and discuss pros and cons associated with each.

Pre/Post Program Analysis - A pre-post program analysis is a type of evaluation that compares data collected before a care management program is implemented to data collected after the program has been in place for some time. As with all the analyses discussed here, the purpose of the analysis is to determine if the program has had a significant impact on the outcomes being measured. Generally, this analysis is conducted by 1) collecting pre-program data, 2) implementing the program, 3) collecting post-program data, and 4) comparing the before and after results to determine if the variance is statistically significant.

Participating/Nonparticipating Analysis - Participating/non-participating analyses are a type of analysis used to compare the outcomes of patients who participate in care management programs versus those who do not. In this type of analysis, patients who opt to participate in the care management program are designated as the participating group, while those who do not participate are designated as the non-participating group. The outcomes of the two groups are then compared to assess the impact of the care management program.

This type of analysis requires a methodology for matching participating members to the non-participating cohort. One such method is propensity score matching. This method summarizes multiple characteristics into a single value, which allows matching on the score rather than across certain characteristics. This could only be based on observable variables and would have to determine which propensity scores are close enough to allow for a match. The second matching methodology is a matched cohort analysis. Under this method cohorts with similar risk characteristics, such as age, gender, or disease severity, would be chosen from both the participating and nonparticipating groups. Rather than being limited on matching members one to one, a cohort is chosen from each group to be used for comparison. This allows for more inference of conclusions since it reduces the potential for selection bias than if an individual matching methodology were used.

Regression/Trend Line Analysis - Regression/trend line analysis is a statistical technique used to analyze the relationship between two variables. The goal is to identify whether a significant relationship exists between the two variables and, if so, to quantify the strength and direction of the relationship. In this type of analysis, one variable is considered the dependent variable, most likely costs, while the others are considered independent variables, such as demographic/condition variables. A regression line is then drawn through the data points, which represents the best-fit line for the data. The regression line represents the average relationship between the variables, and it can be used to make predictions about the dependent variable based on the value of the independent variables.

Data for Analyses

As stated above, what data are used to prepare an analysis will depend on the situation of the vendor/provider and the availability of data.

Experience Data

Generally, the best source of data would be the health plan's data for the given population. Conducting a retrospective analysis for a population engaged with the care management program can be extremely powerful in proving out the value proposition and impact of the program. We touched on some of these analyses above.

That said, some reasons why experience data may not be the best data source include:

- Completeness of data – Data provided by the health plan may be sufficient for the benefit vendor or provider to perform the care management duties but may not be sufficient to conduct an analysis on the impact of their program on cost of care or health outcomes.
- Insufficient experience – The care management program may not have been in place long enough to conduct a proper analysis. Some programs require a year or longer to see meaningful results. Similarly, the engaged membership may not be sufficient enough to draw meaningful conclusions.
- Changing population – The program may have been targeted to one population for one health plan but is being implemented for an entirely different population with a separate health plan.

Data that is typically used for experience analyses frequently utilize some version of member claim data. Full member claim detail provides the most amount of flexibility to conduct an analysis, however, depending on the parameters of the study it may be possible to perform the analysis with some degree of summarization. In some circumstances, it may be appropriate to use other forms of data such as survey results such as member satisfaction or level of pain assessment. This information would not be available in claims data but can be useful in evaluating the impacts of the intervention before sufficient claims detail is readily available.

Manual Data

As stated above, the best source of data is generally the health plan's data for the given population. If possible, it would be best to acquire this but health plans are generally reluctant to sharing data, especially before a contract has been signed. Therefore, benchmarks will have to be made with an alternative data source. The next best data would be some form of a manual or benchmark dataset. There are various datasets available across the markets which can be utilized for these analyses. Wakely and HMA together have access to numerous datasets that can be used as benchmarks for a variety of care management program analyses. Below are some of the primary resources that we have available for analytical use:

- CMS Virtual Research Data Center (VRDC) – This is a virtual research environment on the Centers for Medicare & Medicaid Services (CMS) website which allows seat holders to access and query program data on the CMS servers. This access requires special approval from CMS and HMA/Wakely have a relationship with CMS that allows us access both Medicare Advantage encounter data and 100% Medicare FFS data. Utilizing these resources, we can prepare benchmarks for both MA and FFS populations in Medicare.
- Transformed Medicaid Statistical Information System (T-MSIS) - T-MSIS is the largest, comprehensive dataset of Medicaid program data throughout the United States. Similar to the VRDC, HMA and Wakely has special access to this data set in order to conduct research and analyses.
- Medicare Limited Data Set (FFS 5% Sample) – CMS offers the LDS dataset for purchase on their website for research use. Released annually, this data represents a 5% sample of Medicare FFS members. The advantage to this dataset is that unlike the VRDC the data can be stored on local servers for ease of access which allows for more quick turnaround time on analyses.
- Merative™ MarketScan® Commercial Database – This represents mostly commercial large group data across the United States with over 16 million members included in the dataset. These data are available for a fee from Merative.
- Wakely ACA Database (WACA) - Wakely's ACA Database, named "WACA" contains detailed claims, eligibility and premium data from Edge Servers for over 4.6 million individual and small group market lives in 2021, 3.4 million lives in 2020, and over 4 million lives for 2019. This database is proprietary and unique to Wakely.
- Wakely Medicare Deidentified Dataset – This represents a national dataset of Medicare Advantage plans that participate in Wakely's national risk insights study and includes over 11 million Medicare Advantage member months across 31 distinct Medicare Advantage Organizations.

What manual dataset is used for analysis will dictate what types of adjustments might need to be made in order to model the target population. For example, if we're using the LDS data to model a Medicare Advantage population, then potential adjustments include but are not limited to the following:

- Program Intervention Focus – FFS data are generally robust enough to support drill-down into targeted populations. The analysis should likely only consider beneficiaries who have a comparable condition profile as those who are in the target population. This can consider

particular conditions (e.g. diabetes) or demographics (e.g. gender) or social determinants (e.g. low-income)

- Care Management – Medicare FFS represents an unmanaged population. Therefore, in order to model the health plan's population, it's necessary to consider and adjust for the levels of care management relative to FFS.

- Trend – Often FFS data are older than other data sources and trending to the proposed contract period is likely appropriate.

Considerations For Acquiring Experience data

It may be challenging for some vendors and providers to get data for the populations that they're serving so they can conduct a proper impact analysis. Here are some high-level considerations that these organizations can consider when requesting data.

- Build the contract up front to include data collection and sharing. It's easier to do this in the beginning than to request appropriate data for analysis on the back end.
- Demonstrate in the agreement a contractual need to possess the data. Health plans are not likely to share data just because it is asked for in the contract. If the financial arrangement includes performance guarantees or goals and savings targets, then the data to support the evaluation of those goals needs to be shared as part of the contract so that both parties can agree on the results.
- Health plans may be unwilling to share data for security reasons. In these cases it may be useful to offer to share the data directly with a consulting firm who can act as an unbiased third party to analyze the data on behalf of both organizations. This is also helpful because frequently payors are interested in the results but do not have the resources to do the analysis themselves.
- Explain that data are needed in order to determine member eligibility or member targeting. Typically, member targeting and eligibility are defined based on a set of criteria (e.g. diabetic diagnosis codes or demographics) but if this can be shaped to be based on criteria that involves detailed claims data (e.g. certain diagnoses plus overall medical spend) then this can help the case to acquire more complete data that can be used for analysis.

Conclusion

Health plans need to generate increasing medical savings on their populations in order to remain both competitive and financially stable. There are many new and creative innovations hitting the health care marketplace each year that offer solutions to these health plans. Being prepared to demonstrate how health plans can realize these savings is important in order for these programs to succeed in the market and improve health care and outcomes in the United States.

Wakely can support vendors and providers with any of these topics and more discussed in this paper. Please refer to our care management page for more details. https://www.wakely.com/services/consulting/care-management-analyses

The authors may be reached at the following emails for any questions or to discuss any of the concepts presented here:

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Wakely's STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com