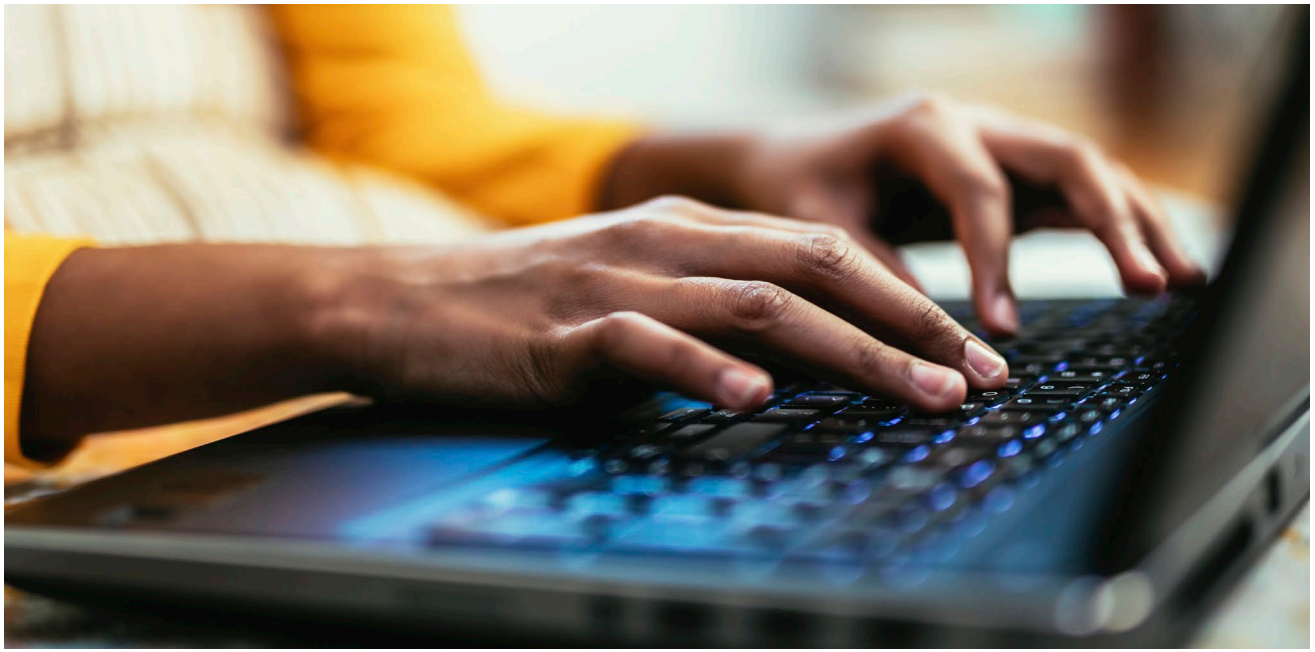
Aligning payer and provider strategies for enhanced member experience

Modern payers are evolving to meet the challenges of the increasingly complex healthcare landscape. Leveraging powerful tools like UpToDate® decision support and Medi-Span® drug data solutions can help organizations adapt their data strategies to break down walls between medical and drug benefit teams and better align with provider organization.

Wolters Kluwer

Section 1:

Payers are evolving to meet the challenges of modern healthcare



The healthcare industry is growing more complex every year, and for health plans, that poses ongoing challenges[1] to remain compliant with evolving regulations, keep current with data security and technology advances, and stay on pace with the changing needs of member care delivery and management.

Within these many demands, payers are discovering opportunities to improve both operational efficiency and member experiences by rethinking their data strategies and strengthening alignment in two key areas:

- **External data alignment between payers and providers.**
- **Internal data alignment between payer benefit teams.**

A survey[2] of health plan executives determined that investing in and aligning data resources was a top priority for payer leadership when addressing business challenges. The reasons for that include:

- **Cost, Consumerism, and Communication.**

Cost

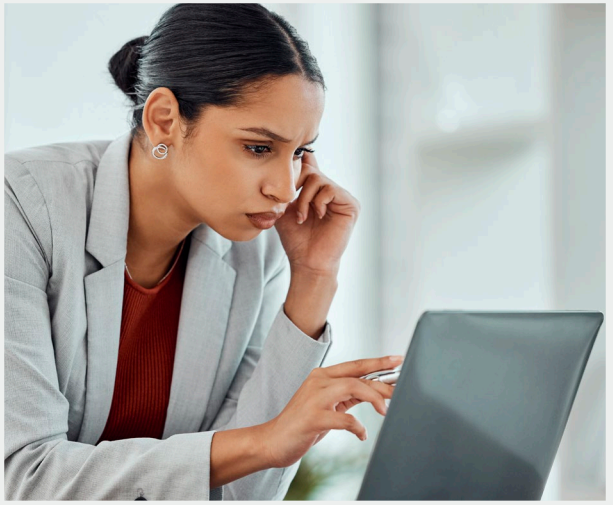
Health plan financials have been under strain in recent years[3]. Many factors contribute to cost pressures, including the proliferation of new medication therapies, the aging population, and more. With each new therapeutic approval comes the added stress of staying on top of evolving guidance and best practices to determine coverage. Many of the most innovative and thus sought-after medication therapies tend to be the most expensive, some in recent years climbing to over $1 million in therapeutic costs.

Consumerism

As more medications and treatments become available – including more complex therapies and specialty medications – demands on health plans evolve. Employers are also challenging payers to come up with more innovative plans and coverage options to suit their members' needs. With more demand from employers, pressure to keep evolving and competing increases. But that pressure doesn't only come from employers, it comes from members as well. The modern plan member is a savvier health consumer and is more likely to be discussing their coverage and how it compares to that of peers.
While that sort of discussion can drive informed research, it can also lead to member confusion and dissatisfaction, as there are many different benefit plans reflecting the different employer, government, and payer requirements.

Communication

Many of the emerging, costly therapies straddle both the drug and the medical sides of health plan coverage, which have typically been more siloed in terms of both payer management and coverage. To better evaluate these therapies, determine their effectiveness, balance costs, and manage member care and satisfaction, payers need to find ways to align traditionally separated teams and improve cross-communication. Additionally, there is often a lack of technology integration between the provider and the payer. When these two parties are working from different or conflicting information, it can create more challenges, including delaying patient care.



"Understanding current data challenges within payer organizations is key to addressing them and building successful strategies. Many payers don't have the right data infrastructure fully in place yet to support these types of cross-benefit therapies."

Allison Combs,
Head of Product, Payer Clinical Effectiveness
Wolters Kluwer, Health

Section 2:

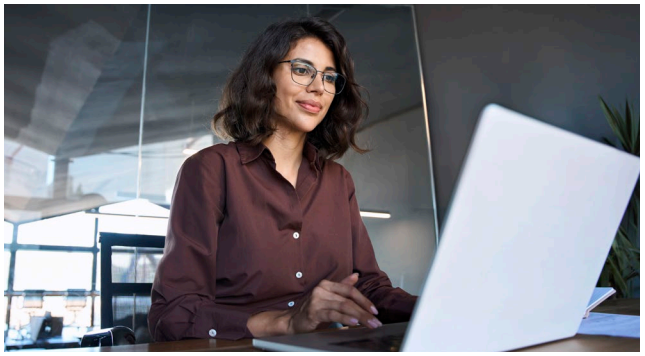
The power of team alignment

According to Gartner, poor data quality costs organizations **$12.9 million annually**[4], and data scientists spend between 50-80% of their time collecting, cleaning, and preparing data before it can be used[5].

"In our industry, whenever there's change, there's opportunity," says Allison Combs, Head of Product – Payer Clinical Effectiveness at Wolters Kluwer, Health. At this moment, for payers that means an opportunity to develop more effective data and team alignment strategies. "We're all trying to work together more closely, especially as providers are taking on more risk and payers are moving more into the care delivery space."

As payer organizations seek to understand and address whole-person health among their members, they may need to adjust operations to meet these new challenges, including internal alignment between medical and drug benefits teams.

With more complete pictures of data, health conditions, and prescriptions, teams can better address member populations and target more effective care interventions and support based on social drivers as well as claims.



Payers and providers: Reducing friction for superior member experience

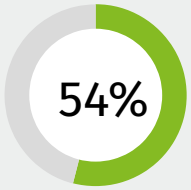
"I think both payers and providers really are looking for a timely answer to find the best possible treatment for a patient or a member. However, they're coming at it from different angles," Combs says. "While they're both taking into account evidence, payers also have to take into account whether or not something is covered or appropriate from a population level. So, while the payers have to weigh the financial costs as well the clinical benefits, they're doing that up front, whereas many providers don't tend to look at the financial pieces until closer to the end of that patient interaction or even after the patient has left the health system."

This difference in decision-making processes and timelines can lead to conflicts in final decisions or in communication between providers and payers, "especially when there's an influx of new evidence in healthcare all the time," she adds.

Why do payers and providers need to align on evidence-based medicine?

Medical knowledge doubles every 73 days.[6]

New FDA drug approvals hit an all-time high in 2023.[7]



54% of claims spending is attributed to **specialty drugs**.[8]

Payer-provider alignment begins with evidence-based medicine, Combs says. When various entities are using the same evidence-based source of medical and drug best-practice knowledge to align therapeutic and coverage decisions, "that trust and that transparency goes a long way in order to bring the parties together. You're never going to 100% agree on everything. But, if you can keep the member at the center with that evidence-based perspective in mind, it goes a long way to help facilitate the decision-making."

Combs explains that when two communicating organizations use disparate electronic systems, including different decision trees, conflicting coding, and sometimes even variable medical evidence or interpretations of that evidence, it leads to inefficiencies as well as potential wasted treatments. "In the world where you have drug shortages and caregiver shortages, we don't want to be wasting our precious resources or causing abrasion between parties," she says. "It's really important that payers and providers do their level best to communicate and align with the evidence first and foremost."

Better alignment can also have a positive impact on member satisfaction.

"Sometimes people are hit with a lot of different information sources and aren't sure even what questions to ask," says Mitch Collier, Technology Product Management Associate Director at Wolters Kluwer, Health. "Transparency and consistency for members is really important. The more members get the same information throughout the process, it helps support their decision-making, their care, and their overall satisfaction."

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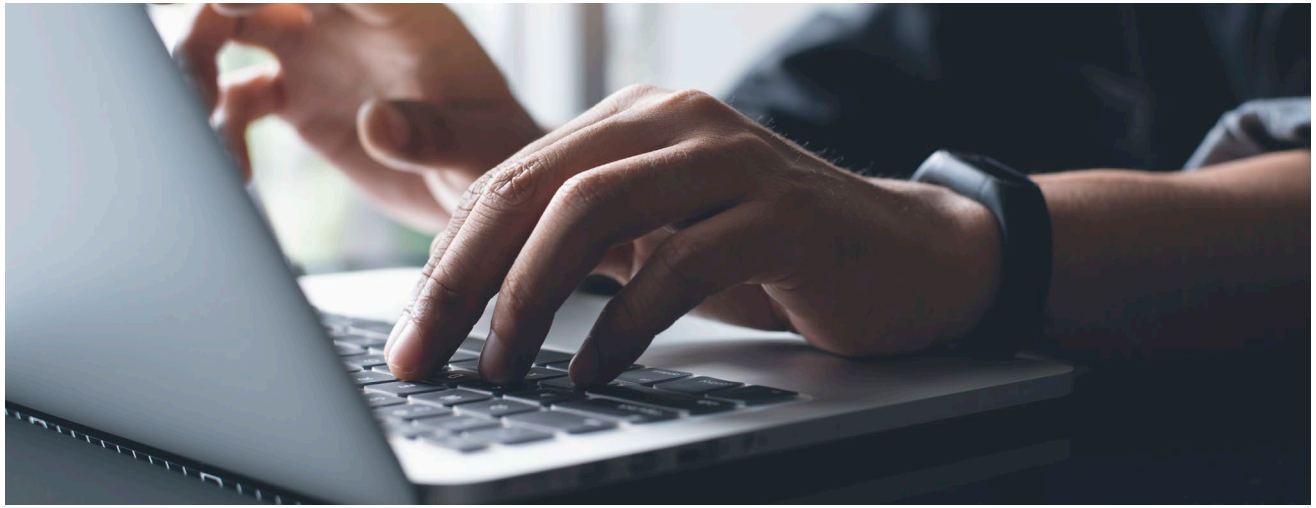


Payer benefit teams: Uniting forces for better outcomes

Historically, medical and drug benefit teams have operated in silos. The system was built to accommodate clear delineations between prescription medication and medical treatments, resulting in distinctly different organizational processes, communications, and operations. This can lead to some inefficiencies and inconsistent decisions — a 2023 study showed that in 14% of instances, medical and pharmacy policies were different for the same drug and could complicate member access to care[9].

With the recent advent of more specialty drugs and complex medical procedures, lines have blurred between medical and drug benefit teams and increased the need for more interoperable processes.

In 2023, specialty drugs accounted for less than 5% of claims volume but accounted for **54% of spending**[8]. Complicating this is that 40% of specialty drugs fall under medical benefits.[10] Inconsistent decisions around these therapies can become very costly for all involved.

When drug and medical benefit teams are aligned with data and proper code mapping, payers can have more insight into their members' health to work toward:

- **Improving operational efficiencies**
- **Addressing whole-person wellness for tailored member experiences**

Efficiency:

When pharmacy and medical benefit teams have better insight between medical indicators and drug prescriptions, it can improve internal efficiencies, actuarial forecasts, and targeted interventions as well as member safety. It can also help reduce costly searches for the proper indications for drug prescriptions, reduce human errors, and mitigate member frustrations.

Member experience:

Aligning medical and drug data can also help payers support the mass personalization of health content and outreach to members. Without the ability to tailor programming and align care management and outreach efforts, Collier warns that plans could run the risk of having one department recommend, for example, a diabetes management or weight loss program that isn't covered or is slightly different than what is available for that particular member. Alignment helps avoid that kind of confusion and frustration, promoting better outcomes and satisfaction for the member.

Section 3:

Technology that drives collaboration and alignment

The right technology tools can help payers support an aligned data strategy across benefit teams and collaborate more effectively with provider organizations and pharmacy benefit managers (PBMs).

Selecting the right technology tools begins with finding vendor organizations payers can trust and with whom they can form an ongoing partnership, advises Combs. “You need to know what you’re getting into, especially in terms of what clinical evidence they’re using to power their solutions, how they’re using it, what are their interpretations, how are they codifying it, and if the evidence is created and curated by true clinical experts.”

Another essential factor is innovation. Vendors who are interested in collaborating with health plans on developing offerings to address emerging industry needs create opportunities for both the vendor and the health plan to grow and discover new ways to differentiate themselves, while also better serving member health.

Ultimately, the right solution will bring together “consistency of evidence, as well as the innovation factor, and the timeliness and awareness,” says Combs. “It’s the application of all that into the current best practices of both the clinical side and the business side, as well as infusing medical and pharmacy knowledge into processes, systems, and infrastructure.”

Questions to ask when evaluating a solution vendor

- Where do you get your clinical evidence?
- Is it created/curated by experts?
- How is the evidence used in your solutions?
- What are your guidelines for interpreting clinical evidence?
- How often is information updated?
- How do you codify data?

UpToDate®

Connecting benefits teams to the latest drug and clinical evidence

Within payer organizations, medical and drug teams need to stay aligned and updated on the latest drug and clinical evidence in the face of continuously changing information and regulations. The UpToDate suite of solutions from Wolters Kluwer – including UpToDate® clinical decision support, UpToDate® Lexidrug™ drug reference, and UpToDate® Member Engagement – provides access to the industry's leading evidence-based resources to inform coverage decisions, support member care, and streamline operations.

UpToDate clinical decision support is trusted by more than 3 million users worldwide, and its expert, evidence-based content is accessed more than 60 million times a month to support or confirm clinical decisions. For payers and PBMs, using UpToDate helps create alignment with the many providers and provider organizations that rely on its content daily.

UpToDate Lexidrug (formerly Lexicomp®) evidence-based drug information is consistent with UpToDate content, and drug insights are also integrated into UpToDate clinical decision support to aid in determining appropriate prescriptions. When the same drug information is used across multiple departments, benefits teams, and organizations, then the whole healthcare ecosystem can make unified, evidence-based drug decisions.

"Using UpToDate for clinical insights and pharmacy, plus our member engagement solutions that are based on those same clinical guidelines and foundations, creates consistency for the member throughout the process," says Collier. "So, whether it's care managers being able to send follow-up materials that align or population health initiatives focusing on things like preventive screenings, member-facing materials and communication is consistent."

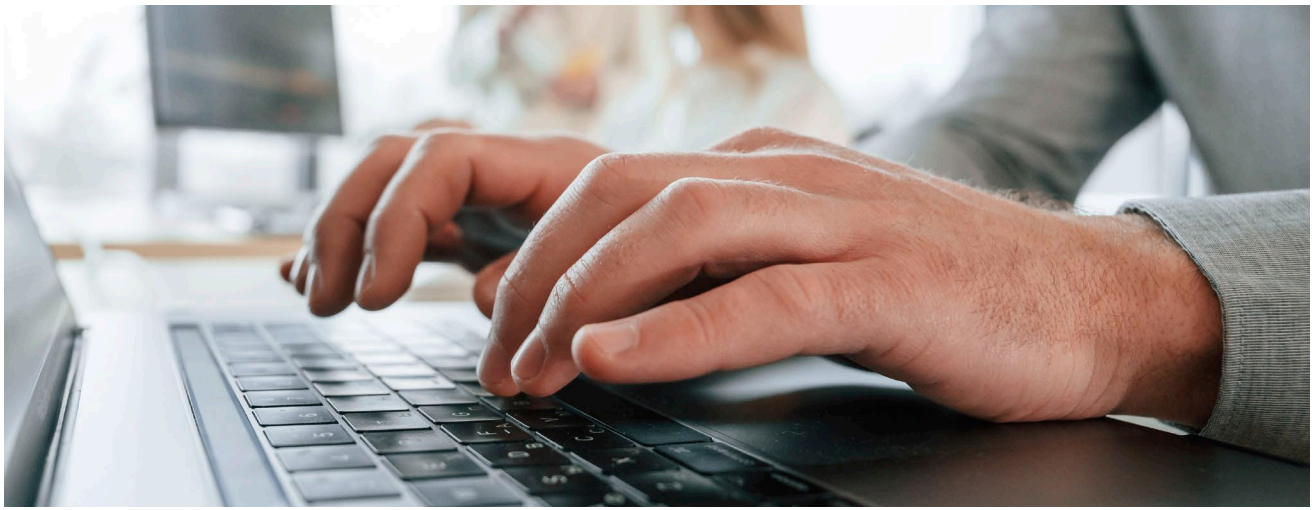
How does the UpToDate suite benefit payers?

Consistent content enables clinical decision-making in-workflow with the same evidence-based information clinicians trust.

Current, continually updated medical information supports benefit designs, claims management, and informed decision-making.

Build member trust by encouraging healthy behaviors that align with clinical care plans.

Strengthen drug decision-making and management – including formulary development, claims adjudication, utilization management, and more – with the depth and breadth of aligned drug information resources.



Medi-Span®

Building foundations of interoperability and therapeutic classification

As part of Wolters Kluwer, Medi-Span® data and content is developed using the same rigorous editorial process as the UpToDate suite of solutions, and they are designed to be consistent and work in concert.

Health plans have **trusted Medi-Span drug data for over 50 years** to help manage claims adjudication, formularies and coverage tiers, prescription reviews, and population health analytics. It is the preferred solution for **17 out of the 20 top-grossing PBMs** and of the **20 top health plans**.

With foundational drug identifiers and attributes such as the Generic Product Identifier (GPI), evidence-based clinical screening data, valuable government and regulatory information, drug pricing data, and more, Medi-Span content and therapeutic classification system can help health plans and PBMs streamline operations, ease staff burdens, analyze claims and population health data, pursue benchmarks, and enhance member safety.

Data analysts often use crosswalks and the proprietary Medi-Span GPI to translate back and forth between medical conditions and code databases and then back into NDC codes. The Medi-Span interoperability suite is valuable in aligning organizations and improving communications.

Section 4:

Creating a data strategy for the future

In a recent Wolters Kluwer webinar poll of health plan leadership[12], when asked what steps they've taken so far to align member data and begin implementing a data strategy, a surprising majority answered "none."

While Combs doubts that any organization has truly done nothing in terms of data strategy, she notes that this answer likely stems from the fact that "in the healthcare space, very few things turn on a dime, with all the systems and processes that we have in place. Everything's moving so quickly that sometimes it feels very easy to forget to take a breath and make a plan. And instead, you just feel like you're running to keep up."

As organizations embark on or revisit their drug and clinical data strategies and opportunities to improve alignment, experts recommend examining **6 potential avenues for enhancing success.**

Keep the human at the center: Any data strategy needs to ultimately be in service of the member, their experience, and guiding them toward better health decision-making.

Strive for 'transparent invisibility': It is worth reworking your data structure to improve user experience. "You can't get those Star Ratings or those CAP scores if you aren't reworking the mechanisms underneath to make sure the benefit coverage is clear but that the claims processing is almost invisible to members so they can stay focused on their health and the resources payers are providing them," Combs advises.

Remove data silos: Creating clear, interoperable data transfers is essential to understanding member populations and their medical and drug expenditures more clearly. This allows payer teams to identify opportunities for efficiencies, optimize formularies and policies, and create smoother experiences for teams.

Implement scalable tools: Having solutions and processes in place to provide the latest information and support coding interoperability is necessary to translate claims and prescriptions between teams. A scalable member engagement and education solution will also leverage data to provide personalized content when claims include ICD-10 codes indicating certain medical cases.

Focus on health equity: With full pictures of data, health conditions, and prescriptions, teams can better address member populations and target care based on social drivers as well as claims. With the Centers for Medicare & Medicaid Services (CMS) implementing new health equity standards in 2027[11], more accessible data will be essential to leverage for success.

Prioritize innovation: With new and complex therapies in particular, keep investigating what needs to grow and evolve to better serve members and maximize business value. Engage with partners who can provide sustainable, innovative solutions.

Ultimately, Combs maintains, a successful data strategy comes back to aligning behind evidence that both healthcare professionals and members can trust.

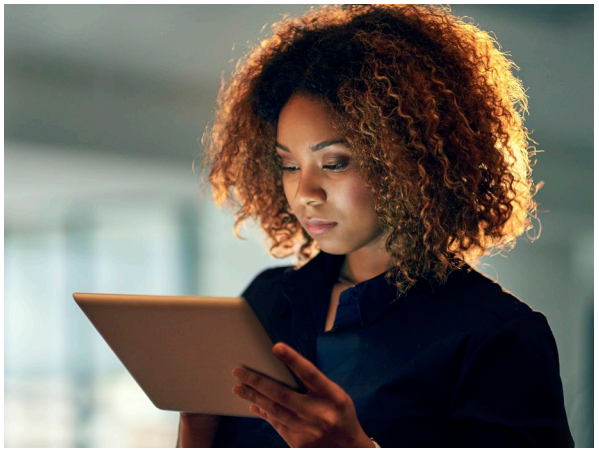
"Informed, consistent decisions on healthcare coverage should align with the evidence that the providers are using at the individual level with members and the discussions they are having on behalf of the members," she says. "Continuing that journey with aligned evidence will not only help the members have a better health experience, but ideally better outcomes."

Combs believes the benefit of evidence and data alignment extends beyond gap closures. "Trying to be more efficient but not losing the human in the process is really critical to helping those care experiences and supporting the choices that everyone is making along the way. It will help create more cost-effective care, and what's the most important, allow us to focus on the health of that person or population."

Ready to transform your operation?

Learn more about evidence-based solutions from UpToDate and Medi-Span to help align your teams.

Wolterskluwer.com/en/solutions/uptodate/contact/sales



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