
# Bridging the Communication Gap between Health Plans and Providers

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Effective communication and trust are the essential keys to any relationship. The plan-provider relationship is no different. Health plans and providers often have problems communicating with each other. A shift towards value-based coordinated accountable care has urged health plans and providers to collaborate to improve population health and patient experience while lowering costs. Most plan-provider communication revolves around rate negotiations. Providers express little trust in health plans stemming from confusing contractual language and expectations. Traditionally, providers focus on service delivery while health plans focus on factors such as quality, cost and service. An open, honest relationship with transparent communication and cooperation is needed to bridge the communication gap and create mutually bene cial partnerships. There are methods that health plans and providers can take now to start closing the communication gap. Sharing data, creating health plan-provider networks, utilizing audits and bi-partisan education are all methods health plans and providers could use to help foster collaboration and bridge communication.

### Data Sharing Across the Care Continuum

To foster collaboration, data sharing should be implemented and incentives should be aligned across the care continuum so that both parties are motivated to improve outcomes and lower costs. Data sharing is one of the key bene ts of bridging the communication gap between health plans and providers.

According to a 2012 PricewaterhouseCoopers (PwC) Health report, health plans and providers can improve collaboration by sharing and integrating clinical data. Health plans hold the bulk of useful data and when combined with the providers' clinical expertise, the result is better patient outcomes. Sharing data gives providers access to claims information that provides with them a patient's entire medical history. This information is useful in helping educate patients about their health risks and to boost transparency in plan-provider communication. The report highlights examples where health plans share information that becomes actionable for providers and helps foster a partnership that is also tied to incentives and payment structures from the Centers for Medicare and Medicaid Services (CMS) (See Figure 1 on page 2).[1]

Health plans and providers have a vast amount of patient information. Health plans have historical claims data while providers have clinical data. Both parties use their data for checks and balances, but there is a lack of collaboration whereas both data types are used and shared to identify the best treatment for patients and mutually determine the appropriate care. The reason for the lack of collaboration and alignment is trust. Neither party trusts the other with the use of their data.

Health plans and providers must have upfront discussions on what information will be shared, and each party must share data that is useful to the other. Both parties must be transparent in their communication. Health plans must clearly communicate to providers the rules that govern what they are paid. This information will help providers understand how reimbursement is determined, the factors that influence the payments they receive and how they are reimbursed based on clinical outcomes

**Figure 1: Insurer strengths address provider needs to create value**

| Insurer strengths | Solutions | Value to provider |
|---|---|---|
| Disease management/ care plan adherence | • Can bridge gaps in care using medical claims, health assessments and wellness programs. | • Provides opportunity to address gaps in care plans. Enhances quality and outcome of care.<br>• Reduces unneccessary emergency department hospital visits. |
| Technology & advanced analytics | • Enables real-time consumer information exchange and engagement using portals and consumer health profiles.<br>• Can provide variation in medical care reporting. | • Enables higher quality of care to be performed at the point a consumer is accessing care services.<br>• Gives opportunities to review procedures and protocols at different locations and prices, to reduce cost and increase quality in patient care.<br>• Allows consumers to take more ownership and play a bigger role in managing their own healthcare. |
| Actuarial – informatics capabilities | • Aggregates, prioritizes, and predicts financial risk and implements risk mitigation solutions.<br>• Enables population health management strati cation. | • Supports outcomes-based reimbursement requirements.<br>• Ablility to perform predictive modeling of patient condition for strati cation and risk mitigation assessment (improved quality reporting). |
| Prescription drug coordination | • Provides history of presciption drug utilization. | • Gives insight into patient prescription history and the opportunity to have one-on-one patient consultations about adverse combination of drugs, adherence, etc. |
| Consumer engagement | • Indentifies opportunities to perform consumer outreach for health engagement and education. | • Supports physician and patient engagement/relationship. |

*Source: "Advancing Healthcare Informatics: The Power of Partnerships", PricewaterhouseCoopers. September 12, 2012. Available online at: http://pwchealth.com/cgi-local/hregister.cgi/reg/advancing-healthcare-informatics.pdf*

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rather than interventions delivered. In turn, providers must clearly communicate the clinical outcomes health plans are or are not achieving. Outcome measures must re ect the goals that providers or ACOs (accountable care organizations) are being incentivized to achieve based on an accreditation process established by the National Committee for Quality Assurance. These measures should improve population health, patient experience and satisfaction with access to care, how it is managed and transitioned, include preventive care, and lower per capita cost. Providers implement a strategic quality management approach to deliver high-quality, valued-based care and achieve better clinical outcomes.

The end result is effective communication and trust that helps providers receive appropriate compensation, health plans identify patients needing greater efforts to reach them, and both parties improve population health in a cost-effective manner resulting in economic rewards.[2]

### Health plan-provider Networks

Plan-provider communication networks are needed to ef ciently and effectively harness data from both parties and enable rapid innovation and the sharing of real-time data for immediate response. Health plan-provider networks utilize care management, electronic health records (EHRs), and analytics to seek to resolve communication and collaboration challenges between health plans and providers. In keeping with HIPAA regulations, communication between health plans and providers must be customized to include only information that is relevant to specific attributed patient populations, physicians, reimbursement and care delivery models. The goal of plan-provider networks is to present both parties with transparent, high-quality data to improve trust and increase health plan-provider engagement in the improvement of communication and ultimately, population health.[3]

### Using Audits to Bridge Communication

The rise of audit requests has posed a problem in the plan- provider relationship. Providers see an increase in patient load and chart requests due to the Affordable Care Act. Health plans must review their new member records to accurately identify and assign comorbidity risk. Both health plans and providers must work towards greater compliance. Auditing medical records is a crucial step in the process.

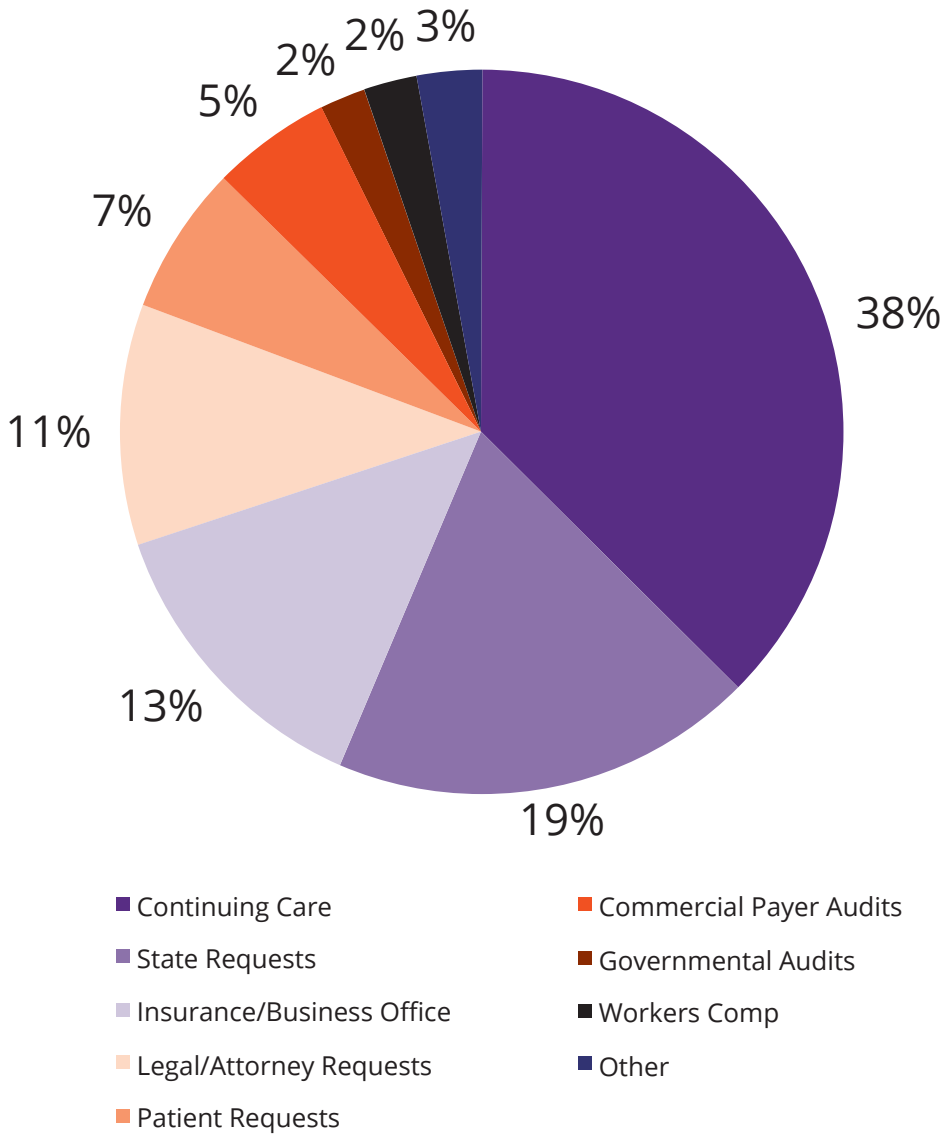
Providers struggle with numerous types of information requests from various third-party health plans, governmental agencies and national health plans—requester deadlines differ and vernaculars vary. Consequently, health plans are forced to repeatedly call health information management (HIM) and audit departments when claim data inaccurately identifies place of service, provider or other patient information. An upsurge in audit requests from commercial health plans and health plans threatens to exacerbate these problems.

The audit process can change the plan-provider relationship from adversarial to advantageous through improving communication. Bridging communication gaps and language barriers through clearer record requests would take the burden off the providers and alleviate plan problems by helping to answer the following questions:

- What exactly does the health plan want?
- What am I required to gather and send?
- If health plans come on site, HIM will inevitably ask, “Who are they?”
- Are they authorized to review our records?

Chart requests that come from commercial health plan audits represent just five percent of all requests that providers receive. Hospitals also receive high volumes of medical record requests from other hospitals, physicians, attorneys, patients and more (See Table 1). The problem is that commercial plans often assume they are the only requestor. Education is required on both sides of the audit equation to improve processes and reduce plan-provider friction. It is in the best interest of both parties to fully understand the types of audits being conducted by health plans and the rationale for each. Many commercial plan audits mirror internal and external audits being simultaneously conducted by the provider.

**Table 1: Where Do Requests Come From?**
**Total medical record requests by requester**



*The definitive benefactor in improving communication between health plans and providers is the patient.*

As record requests increase, so do the chances they'll get confused. This is especially true when audit and HIM teams receiving requests are decentralized across multiple locations. It is important for providers to understand why records are being requested. In a best case scenario, health plans would also standardize the specific documents they need and verbiage they use in request letters.

Plans could smooth the process by stating more clearly in the request letter: what, why, when and how. Vague requests take much longer to analyze, navigate and fufill. At a minimum, the following five questions should be included within the record request:

1. What service?
2. Which encounter?
3. What location?
4. What is this request for?
5. Has the same chart been requested previously?

Also needed in the release are: health plan name, type of audit, HIPAA BAA (business associate agreement), patient information, date of service, and any other specific information required for that measure or review.

For providers, all data from each request and submission should be entered in a centralized audit management software application for the organization. This helps providers track audit activity by health plan and type of audit, maintain a record of all documents sent, better manage requests, and stay abreast of audit trends.

Patient access, clinical coders, billers and collectors perform unique functions and speak different languages across the hospital revenue cycle. Similarly, commercial health plans have multiple departments and terminology involved in audit processing. In many cases, inter-departmental communication and language barriers are the main problem to overcome. Breaking down language barriers helps to streamline audit processes and reduce costs. Better interdepartmental communications also help reduce rework and wasted time. For example, within one organization, medical record requests may be referred to as a "chase file," a "pull list," a "retrieval file," a "request letter," etc. Each of these terms is simply what health plans call the records they need—the actual requests from plans to providers. Providers simply call these "request lists".

### Bi-Partisan Education

Health plans and providers should begin speaking the same language in documentation and face-to-face discussions. Education is needed on what pieces of information are required for each type of record request, how the information will be used by the health plan and guidance for HIM professionals on a case- by-case basis. The requests should be evaluated for trends in data to utilize during internal provider education. Processes should be aligned to improve outcomes and discuss areas for collaboration. Ultimately, bi-partisan education will help bridge the plan-provider communication gap and foster a more collaborative relationship to improve population health.

### Time Will Tell

Bridging the communication gap will not happen overnight. It will take time and effort from all parties involved; however these methods are a good starting point. The definitive benefactor in improved communication between health plans and providers is the patient. Both health plans and providers are ultimately focused on providing the patient with the best healthcare experience possible.

## Audit Definitions

**Risk Adjustment - Medicare Advantage, Medicaid, and Commercial Audits**

- Health plans conduct these audits to verify that claims data received is validated by medical record documentation, and further determine if other chronic conditions exist that may not have been submitted with the claim.
- Similar to the quality improvement audits conducted by providers.
- HEDIS – Healthcare Effectiveness Data and Information Set
- Occurs from January through May of every year.
- Medicare uses HEDIS data to measure and rank health plan performance.

**DRG – Diagnosis Related Group**

- Ensures cases are coded and sequenced properly and that the information billed correctly matches what is in the patient's medical record.
- A review of hospital claims that have been submitted to a health plan for payment.

**Care and Quality Improvement Plan**

- Targets records of patients at a high risk for certain diseases.
- Goal is to use findings from the review to get members into physician offices and clinics for preventive care before their condition progresses and requires hospital admission.

**Outcomes Measures - Five Star Program – Medicare Advantage**

- CMS and NCQA measure the quality of health plans.
- Health plans that demonstrate year-after-year improvement in patient experience, reduction in patient complaints, and sustained achievement of quality measures receive a better performance score.

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*[1]Perna, Gabriel. "PwC Report: With Population Health, Health plans and Providers Have to Play Nice." Healthcare Informatics. September 28, 2012. Available online at: http://www.healthcare-informatics.com/article/pwc-report-population-health-healthplans-and-providers-have-play-nice*

*[2]Rizk, MD, Emad. "Three Types of Alignment for Better Health plan-provider Relations.". HealthLeaders Media Available online at: http://www.healthleadersmedia.com/HOM-233186-4625/Three-types-of-alignment-for-better-healthplanprovider-relations*

*[3]Ingari, Frank. "The Health plan-provider Network: This system will bring the power of big data to collaboration." Executive Insight. Available online at: http://healthcare-executive-insight.advanceweb.com/Features/Articles/The-Health plan-provider-Network.aspx*

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