QUALITY MANAGEMENT:

EMPOWERING PAYERS, HEALTH SYSTEMS AND PROVIDERS TO ACHIEVE OPTIMAL CLINICAL OUTCOMES

With the proliferation of value-based contracting initiatives such as government-led Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), Medicare Advantage, and commercial programs, it is evident that delivering high quality care is essential to succeeding in today's evolving market. Well-chosen quality metrics and effective incentives in value-based contracts can lead to healthier populations by generating better clinical, operational and patient outcomes. However, high-quality ratings are difficult to achieve and maintain over time for health plans, health systems and physician practices.

Organizations need a strategic and tactical approach to quality management if they are to achieve remarkably improved clinical outcomes and publicize the benefits of being a high-quality health system or provider group. Started by physicians and the operator of a consistently high-rated Medicare Advantage Prescription Drug (MAPD) plan three years in a row, Lumeris offers the following five lessons from its expertise in managing access and availability, effectiveness and experience of care:

LESSON 1 **Recognize the strategic impact of quality.** Effective quality management transcends both business and care delivery and supports an organization's overall value-based strategy. Ensure that your quality management approach includes both a strategic and tactical focus on achieving clinical quality.

LESSON 2 **Align your provider management strategy with your quality management goals.** Focus on high-impact areas by choosing a meaningful—but limited—number of quality measures. Offer ongoing support to providers and their care teams to help them meet quality measures.

LESSON 3 **Make incentives meaningful.** Aligning incentives across the care continuum is crucial for enabling sustainable behavior change. Worthwhile incentives for physicians encourage performance on quality measures.

LESSON 4 **Remove barriers to care.** Manage the effectiveness and experience of care by making it easier for patients to access care. Improve availability of care by removing financial, transportation and other barriers. For example, offer zero dollar co-pays for lab visits that support achievement of key clinical metrics.

LESSON 5 **Create data transparency with the right tools and information.** Equip payers and providers with powerful tools and actionable insights that offer a complete view of patients and populations based on EMR, claims, lab, and pharmacy data, as well as enhanced analytics. Provide the ability to stratify populations for quality campaigns and to utilize tailored patient outreach methodologies. With complete data transparency, providers are able to manage the effectiveness of care, including recommending necessary screenings and tests to close any gaps.

Our proven approach fosters greater collaboration between payers and providers, engages physicians and patients in healthy behavior change, and drives optimization of quality metrics in any value-based care model—government-led ACOs, PCMH, Medicare Advantage, or commercial. Success in quality management depends on having a plan—and an experienced partner—for navigating your journey to care delivery and business transformation.

INTEGRATING A QUALITY MANAGEMENT PROGRAM IN DIFFERENT VALUE-BASED CONTRACTS

Our approach to quality management supports a variety of different value-based programs, as shown in Chart 1 (on back). From government-led ACOs to commercial contracts, the strategy for quality management begins with strategic assessments that pinpoint where to focus improvement efforts.

Our approach starts with a qualitative readiness assessment to understand payer and provider capabilities, and follows with a quantitative opportunity analysis to identify areas to improve quality. With this information, we guide payers, health systems and providers in designing their overall strategy. Depending on the program type and provider readiness, we translate your strategy into the appropriate tactics within provider value-based contracts. We ensure that physician incentives are balanced, meaningful, drive adoption of appropriate technology, and aid the provider in evolving to the next level of population health management. Aligning incentives is crucial for enabling behavior change. We also recommend aligning patient incentives in order to remove financial barriers to care, educate patients about the importance of primary care and prevention, and align benefits with overall accountable delivery system goals.

Furthermore, we train providers to utilize actionable information in support of value-based contracts. As a result, they are empowered to use a complete and accurate picture at both the patient and population levels, and at the critical point of decision making. Utilizing this actionable information, they can achieve better quality outcomes. Finally, we reinforce provider engagement and behavior change by encouraging open communication to share best practices and foster a culture of continuous improvement around quality management.

NAVIGATING THE ROUTE TO QUALITY IMPROVEMENT

Our powerful technology and services provide differentiation for payers and providers, especially in equipping them with the ability to stratify patients for outreach. With access to data to close gaps in care and data transparency to benchmark their performance against their provider group and national peers, providers can become true managers of quality and earn bonuses as part of value-based contracts.

“In short, we simplify quality management for health plans, health systems and providers,” said John Khoury, Lumeris’ director of clinical solutions and strategy. “Lumeris meets providers where they are on their journey to value-based care, utilizing readiness assessments that pinpoint opportunities to close gaps in care and manage chronic conditions specific to their population. We then work with the actors in the care continuum to plot a course that prioritizes their goals, and help guide them to achieve quality improvement using our technology and services.”

CASE STUDY: POWERING QUALITY MANAGEMENT TO DRIVE PATIENT AND PHYSICIAN SATISFACTION

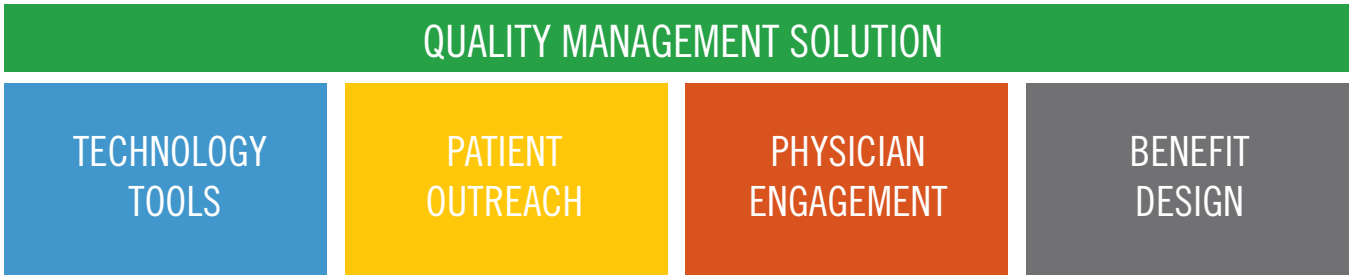
Clients benefit from Lumeris’ years of experience operating a consistently high-rated Medicare Advantage Prescription Drug (MAPD) health plan. Our clinicians and technologists excel in quality ratings improvement, patient-centered decision support and value-based contract management.

For the past three years in a row (2012, 2013 and 2014), Essence Healthcare achieved a CMS quality rating of 4.5 Stars (based on 2011, 2012 and 2013 HEDIS, CAHPS, CMS, HOS, and other data). The plan earned ratings above the national average for “getting needed care” and “quality of care” metrics. Over 95 percent of Essence Healthcare patients are seen annually, and more than 80 percent of networked providers consistently rate that they are satisfied with their collaborative payer partner.

CASE STUDY: IMPROVING PREVENTIVE HEALTH MEASURES THROUGH MEMBER OUTREACH

Lumeris serves as a cost-effective extension of care managers and a catalyst of behavior change and success across a range of quality measures. For a large regional commercial health plan that wanted to improve quality of care related to preventive health measures, Lumeris managed outreach to more than 20,000 members who were due for recommended breast, cervical or colorectal cancer screenings. Results included higher screening rates of 30 percent, 35 percent, and 35 percent, respectively, when compared to a control group. The positive impact on preventive health rates earned the plan the URAC Best Practices in Health Care Consumer Empowerment and Protection Award.

LUMERIS' QUALITY MANAGEMENT SOLUTION



Health systems and payers utilize Lumeris' Quality Management Solution to enable performance on quality measures and perform successful outreach to improve outcomes. Lumeris supports more than 150 national standard quality-related measures in the Accountable Delivery System Platform (ADSP)®, including HEDIS, Star, ACO, PCMH, and Physician Quality Reporting System (PQRS) measures. The solution also features ADSP tools (including the Patient Worklist, Patient Care Profile, Measure Summary Table, and Content Library), reports, and dashboards (such as Members/Patients Not Seen) that help payers and providers manage their populations as well as address gaps in care with each individual patient. Moreover, consulting and delivery services within the solution offer payers, health systems and providers analysis of historic quality performance and help identify target measures for improvement.

We guide clients in deploying their quality management initiatives through use of our:

- Qualitative and quantitative analyses to develop an overarching strategy to address quality opportunities
- Proven methodologies for effective value-based physician contract design
- Proprietary and unique predictive modeling tools and simulators
- Technology tools that provide actionable insight
- Training programs to increase physician engagement and satisfaction
- Expertise in benefit design to enhance access to care
- Best practices for patient outreach campaigns to close gaps in care and improve contact and intervention rates

Founded by physicians, Lumeris combines deep clinical experience and a patient-centered focus to manage overall quality improvement. The Lumeris Quality Management solution helps payers, health systems and providers optimize performance on quality measures and deliver on the goals of the Triple Aim *Plus One*: better health outcomes, lower costs and improved patient *plus* physician satisfaction.

Chart 1: Lumeris guides a variety of value-based programs to success in quality management, beginning with strategic assessments that pinpoint where to focus improvement efforts.

SAMPLE PROGRAMS	GOVERNMENT-LED	PCMH	MEDICARE ADVANTAGE	COMMERCIAL
	• Accountable Care Organizations (ACOs) • Pioneer ACO • Medicare Shared Savings Program (MSSP) ACO • Advance Payment Initiative			
IMPORTANCE	Reporting and performance on quality metrics required for shared savings	Quality measures essential for achieving accreditation	Star ratings impact bonus revenue, enrollment and ability to market	Quality metrics tied to revenue/ value-based contracts; ratings required for accreditation and support marketing efforts and recognition
AREAS OF FOCUS	• Patient Experience • Care Coordination • Preventive Health • At-Risk Populations • Patient Satisfaction	• Access • Population Management • Care Management • Self-Care Process • Referral Tracking & Follow-Up • Continuous Quality Improvement	• Outcomes • Patient Experience • Access • Process	• Outcomes • Patient Experience
SAMPLE MEASURE SOURCES	• AHRQ • CMS • AMA and PCPI • NCQA • MN Community Measurement	• NCQA • Accreditation Association for Ambulatory Health Care (AAAHC) • The Joint Commission • URAC	• CMS Star ratings • HEDIS • CAHPS • Health Outcomes Survey • Operational Measures	• NCQA Quality Compass • URAC • AAAHC • Patient Surveys