Jefferson Health Plans

JEFFERSON 200

Jefferson Health Plans and You: Enhancing Patient Experience

Presented by ProspHire

Objectives

Introductions

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Why Are We Here?

Medicare Stars | Importance and Impacts

Benefits of a High Performing Plan

Potential Revenue Impact

Reinvestment into the Plan

Pertinent Measures for our Members

IMPACTS

- Potential Autoenrollment in D-SNP
- Stars Bonus and rebate dollars
- CMS 'High Performer' Icon on CMS Plan Finder
- Extended enrollment periods all year

- Quality Bonus Payments (QBPs) which are additional bonus payments MAOs and Rebate Revenue can provide a consistent income stream for health plans
- Better ratings boost both patient care and the financial health of their plans

- Reinvestment in Member Benefits
- Over the Counter (OTC)
- Flexible Spending card
- Rent/Utility Assistance
- Lower Part D; Rx Drugs
- Enhanced Services with Higher Ratings - CX

- Star Measures are not arbitrary. They are common health concerns that most people frequently encounter
- The measures directly impact daily lives of our members

Medicare Stars Overview

The Centers for Medicare & Medicaid Services (CMS) uses a Star Rating Program to evaluate the experiences of Medicare beneficiaries with their health plan and healthcare system. Health plans are rated on a scale from 1 to 5 stars, with 5 stars being the best. To determine these ratings, CMS uses data from various sources and measures a wide range of factors.

HEDIS Measures

Represents both a measure type and data set. HEDIS measures are developed and maintained by NCQA and are largely focused on the processes and outcomes related to clinical quality and preventive care. Data is sourced from claims, chart reviews, and various supplemental data sets, all requiring auditor review and approval

CAHPS Survey

This annual survey focuses on customer satisfaction with the health plan and beneficiary health care. The survey is conducted anonymously. Plans never see member-level responses. The questions ask beneficiaries to rate various health plan and health care elements on a scale of 1 (bad) to 10 (good) and are based on member perception, memory recall, and general satisfaction

HOS Survey

Another survey of anonymous members focused on health care processes and health status. This is distributed annually to members and involves a two-part survey. The assessment and re-assessment is meant to measure whether members health has improved in specific areas year over year.

Pharmacy Measures

The Pharmacy measure set spans a variety of sources from Prescription Drug Events (PDE) to administrative data. Measures are all focused on the utilization of the pharmacy (or Part D) benefit and range from Adherence to prescriptions to participation in standardized programs such as Medication Therapy Management.

Operations Measures

A conglomerate of various administrative data sources including disenrollment, complaints, appeals, call center and language interpretation, and audit functions designed to measure the “back-office” functions designed to ensure an optimal member experience.

Medicare Stars | Our Collective Partnership

To find success in Stars, this cannot be done alone. Providers play a crucial role in supporting the success of a health plans Star Rating. It is imperative that health plans and providers have a coordinated approach to how we can support our members.

Positive Experience Benefits

- **Patient Loyalty and Trust** – patients who consistently receive high quality coordinated care, are more likely to develop a sense of loyalty and trust with their providers
- **Improved Health Outcomes** – communication is key; providing patients with the right information at the right time allows for streamlined coordination of care and over time improved health outcomes
- **Potential for New Patients** – providers hold a strong presence within the communities that we serve, when high quality coordinated care is delivered continuously it will lead to strong member retention and opportunities to attract new members and/or expand into new markets

Payer-Provider Relationship

Acknowledging Challenges

Execution challenges are prominent across the organization due to undefined responsibilities and numerous competing priorities. Priority alignment and education are pertinent in driving performance in Medicare Stars and Medicare overall.

Supporting Relationships

We understand the trust and loyalty patients have in their providers. We strive to support this relationship by facilitating better communication and cooperation between the plan and our provider partners.

Health Plan as Support System

As a health plan, we see our role as a support system for providers, helping to provide the best possible care for our members. We are here to assist and support, not to add to the burden.

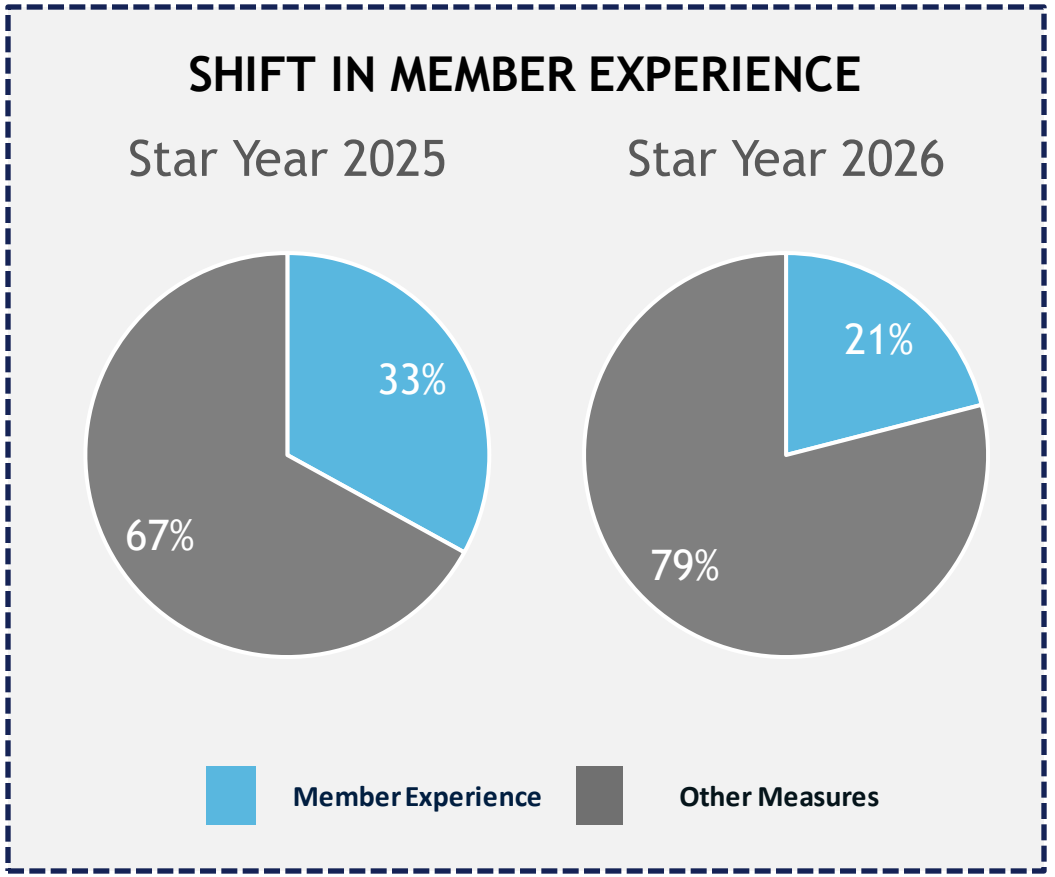
CAHPS Current State

CAHPS Overview

It is critical that us as a health plan and providers consistently have insights into the voice of our members; below details the importance of the CAHPS survey.

What is CAHPS? Why is it Important?

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that focuses on customer satisfaction with the health plan, providers, and beneficiary health care.
- The survey is conducted **anonymously**. All results are at the contract level (not member-level).
- The questions ask members to rate various health plan and health care elements on a scale of **1** (bad) to **10** (best) or never, sometimes, usually, and always.
- To achieve a high Star rating- and more broadly drive growth- we, as a collective, need to ensure that we focus on the member's experience with every possible interaction.



CAHPS Background

Below displays critical information on the mechanics of the CAHPS survey and the season breakdown in terms of timing. We also included some key changes to the survey made recently and basic survey information.

Example Regulatory CAHPS Timeline

- **March 1st** - Mail out web invite letter to members without an email address
- **March 4th** - Email web invitation
- **March 12th** - Mail out first survey
- **April 1st** - Second survey mailed to nonrespondents
- **April 24th** - Telephonic follow-up for nonrespondents
- **May 5th** - Conduct additional telephonic attempts
- **May 7th** - Vendor submits interim data files to CMS
- **May 13th** Vendor submits second vendor report
- **June 1st** - Cutoff date to complete surveys
- **June 11th** - Submit final data files to CMS

Key Insights

CAHPS:

- Surveys are based on members perception, memory recall, and general satisfaction with the health plan, drug plan, and providers
- Approximately **700 members sampled on average each year**
- Implemented in different modes (Mail, Telephone, and IVR)
- Requirements: at least 18 years of age, currently enrolled in a Medicare Advantage contract for six months or longer, and who live in the United States.

Key Changes:

- Members will have the option to the take the **survey online compared to previous years of phone and mail options only**
- 15-minute in office wait question will not be included for the Getting Appointments and Care Quickly measure

What's in the Survey

The CAHPS survey is made up of 64 questions within the entire survey. Of those questions, 21 questions combine to make up 9 CAHPS Measures.

Medicare CAHPS Measures		
Customer Service	Annual Flu Vaccine	Getting Needed Care ★
Getting Appointments and Care Quickly ★	Rating of the Health Care Quality	Rating of the Drug Plan
Rating of the Health Plan	Care Coordination ★	Getting Needed Prescription Drugs

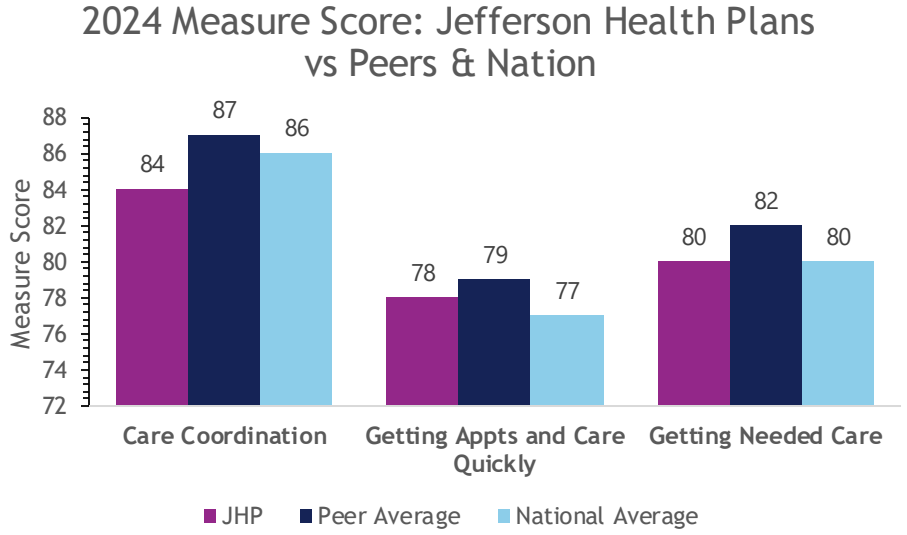
Measure Breakdown

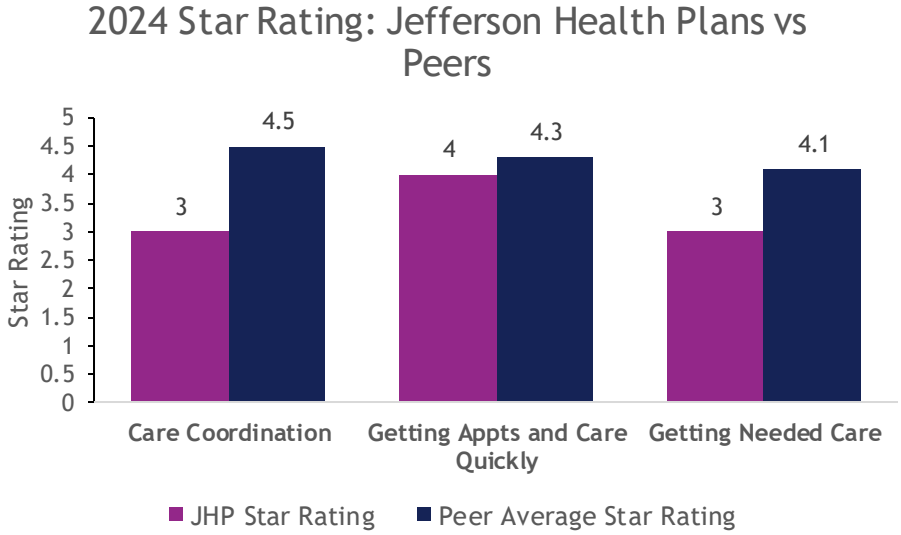
- Drug Plan Related Measures
- Provider Related Measures
- Health Plan Related Measures
- Impacted by all areas
- ★ Focus Measures

CAHPS Industry Insights

CAHPS Performance vs the Industry

The data below is a comparative analysis between Jefferson Health Plans, other local competitors, and the broader industry.





TAKEAWAYS

- ✓ The graphs indicates potential for enhancement across all focus measures
- ✓ The most significant opportunity for improvement lies within the Care Coordination measure.
- ✓ In all 3 measures, Jefferson Health Plans ranks lower than their peers.

Areas of Focus and Best Practices

Getting Needed Care | Measure Summary

Here are the specific questions members answer in relation to Getting Needed Care

Measure Related Questions

1. In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
2. In the last 6 months, how often did you get an appointment to see a specialist as you needed?

Getting Needed Care | Best Practices

Key strategies related to Getting our members the care that is needed are detailed below:

- ✓ Work closely with relevant offices to schedule **urgent appointments** efficiently. This ensures that patients receive timely care when they need it most.
- ✓ Partnering with the health plan to work toward **same day appointment scheduling** and identifying alternative care options including telemedicine and other wraparound services.
- ✓ Promote the use of the **patient portal**, if available. Encourage patients to register and use the portal to view their results. This can enhance patient engagement and improve their access to healthcare information.

Care Coordination | Measure Summary

Here are the specific questions members answer in relation to Care Coordination:

Measure Related Questions

1. In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
2. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
3. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you how often did you get those results as soon as you needed them?
4. In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
5. In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
6. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Care Coordination | Best Practices

Coordinating Care is a whole team effort across the healthcare spectrum where strong communication and technology have proven to be successful. Key strategies include:

- ✓ Prioritize appointments for patients who have **recently been discharged** from a hospital or facility
- ✓ Ask all **pertinent questions** to ensure awareness and **obtain and review records** from hospitals/other providers
- ✓ Request that patients bring in a **list of their medications** for each visit
- ✓ Allow plans **EMR access** to allow for timely coordination of care
- ✓ **On-demand education materials and checklists** for members to allow for improved coordination of care

Getting Appointments and Care Quickly | Measure Summary

Here are the specific questions Members answer in relation to Getting Appointments and Care Quickly

Measure Related Questions

1. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
2. In the last 6 months, how often did you get an appointment for a checkup or routine care as soon as you needed?
3. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Getting Appointments and Care Quickly | Best Practices

Flexibility, responsiveness and utilizing communication channels are key methods to a successful patient experience. Key strategies are detailed below:

- ✓ **Triage System:** Prioritize patients by health risks, reserve daily slots for high-risk members, consider phone consultations, and/or urgent care referrals.
- ✓ **Alternate Care Providers:** For urgent cases with unavailable doctors, consider referrals with nurse practitioners or physician assistants.
- ✓ **Managing Wait Times:** If there's a long wait time, keep patients informed. If necessary, offer them the chance to reschedule.
- ✓ **Decrease No-Show Rates:** Leverage systems to automate appointment reminders through phone, SMS and/or email.
- ✓ **High Cancelation Rates:** Repurpose canceled appointments for urgent cases.

Tools and Resources

Provider Resources

Jefferson Health Plans has developed tools, guides and webinars that highlight our quality initiatives and goals. These resources are available on our website.

RESOURCES

Quality Webpage:
- Improving Patient Experience - A Guidebook to CAHPS, HOS and Quality Resources
- Annual Wellness Visits fact sheet
- HEDIS Hints presentations
- Medicare Management for Medicare members guide

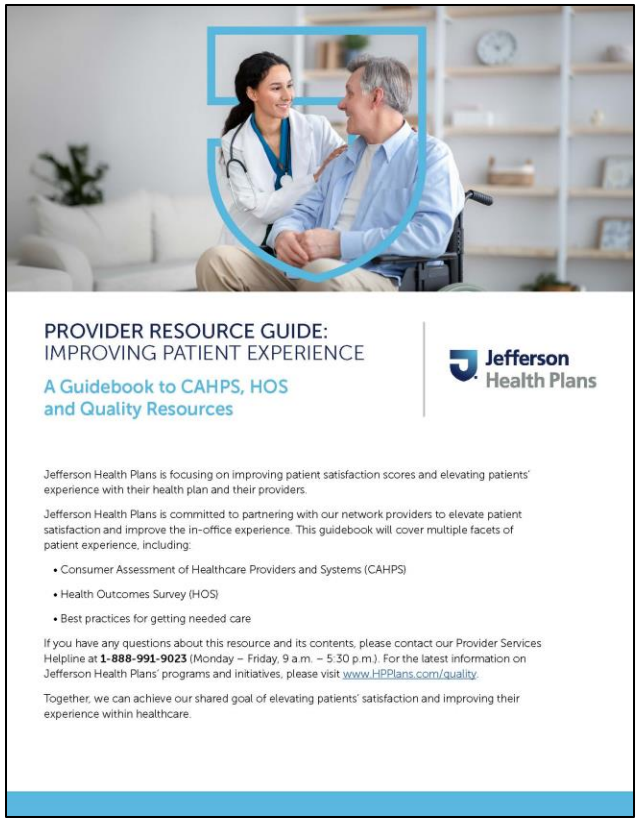
https://www.healthpartnersplans.com/quality

Member Satisfaction and Customer Service Learning Webinar Series:
- Rethinking Access
- Professionalizing Customer Service
- Leveraging QI and Health Literacy to Drive Experience

https://www.healthpartnersplans.com/webinars

Provider Webpage:
https://www.healthpartnersplans.com/providers

For specific resource-related questions, please email us:
providercommunications@jeffersonhealthplans.com



PROVIDER RESOURCE GUIDE:
IMPROVING PATIENT EXPERIENCE

A Guidebook to CAHPS, HOS and Quality Resources

Jefferson Health Plans

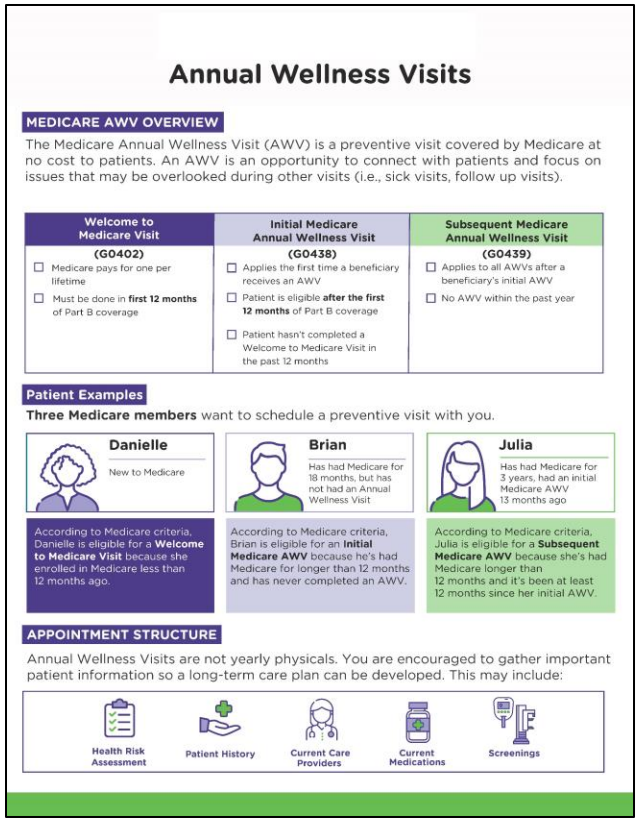
Jefferson Health Plans is focusing on improving patient satisfaction scores and elevating patients' experience with their health plan and their providers.

Jefferson Health Plans is committed to partnering with our network providers to elevate patient satisfaction and improve the in-office experience. This guidebook will cover multiple facets of patient experience, including:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)
- Best practices for getting needed care

If you have any questions about this resource and its contents, please contact our Provider Services Helpline at **1-888-991-9023** (Monday – Friday, 9 a.m. – 5:30 p.m.). For the latest information on Jefferson Health Plans' programs and initiatives, please visit www.HPPlans.com/quality.

Together, we can achieve our shared goal of elevating patients' satisfaction and improving their experience within healthcare.



Annual Wellness Visits

MEDICARE AWV OVERVIEW

The Medicare Annual Wellness Visit (AWV) is a preventive visit covered by Medicare at no cost to patients. An AWV is an opportunity to connect with patients and focus on issues that may be overlooked during other visits (i.e., sick visits, follow up visits).

Welcome to Medicare Visit	Initial Medicare Annual Wellness Visit	Subsequent Medicare Annual Wellness Visit
(G0402)	(G0438)	(G0439)
☐ Medicare pays for one per lifetime	☐ Applies the first time a beneficiary receives an AWV	☐ Applies to all AWVs after a beneficiary's initial AWV
☐ Must be done in **first 12 months** of Part B coverage	☐ Patient is eligible **after the first 12 months** of Part B coverage	☐ No AWV within the past year
	☐ Patient hasn't completed a Welcome to Medicare Visit in the past 12 months	

Patient Examples

Three Medicare members want to schedule a preventive visit with you.

Danielle	Brian	Julia
New to Medicare	Has had Medicare for 18 months, but has not had an Annual Wellness Visit	Has had Medicare for 3 years, had an initial Medicare AWV 13 months ago
According to Medicare criteria, Danielle is eligible for a **Welcome to Medicare Visit** because she enrolled in Medicare less than 12 months ago.	According to Medicare criteria, Brian is eligible for an **Initial Medicare AWV** because he's had Medicare for longer than 12 months and has never completed an AWV.	According to Medicare criteria, Julia is eligible for a **Subsequent Medicare AWV** because she's had Medicare longer than 12 months and it's been at least 12 months since her initial AWV.

APPOINTMENT STRUCTURE

Annual Wellness Visits are not yearly physicals. You are encouraged to gather important patient information so a long-term care plan can be developed. This may include:

Health Risk Assessment | Patient History | Current Care Providers | Current Medications | Screenings

Question and Answer

Closing

Key Takeaways

- Improved CAHPS/Stars results enable plans to invest in patients and patient care
- If you have ideas or experiences of how we can improve, please let us know

Thank you for your participation!
We will send a brief survey about today's event

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