EXAFLUENCE
Data Driven Influence

Unlocking Success with Payer Executive Decision Boards – Part 2

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Part 1 of this blog series dealt with how in the dynamic healthcare landscape, payer organizations face multiple challenges of competitiveness, cost management, operational optimization etc. and how real-time insights from payer executive dashboards can help overcome these challenges. We also discussed that how organizations can embark on this analytical maturity journey and the various tools and frameworks available to help in this process. This part 2 of the blog series introduces the KPI framework in detail and talks about the metrics and dimensions across multiple assessment areas.

Payer Decision Boards - Part 1

How does Exafluence's Payer KPI Framework contribute to effective decision-making for payers, and what key sections does it encompass?

Exafluence's Payer KPI Framework significantly enhances decision-making for payers by offering a comprehensive analysis of key performance indicators. Encompassing nine sections, including Utilization, Financial, Provider, Member, Care Quality, System, TPL (Third Party Liability), Managed Care, and Operations, the framework provides a holistic view of payer operations.

Measure Category	Measure Count
Care Quality	7
HEDIS	6
Patient Satisfaction CAHPS	1
Financial	15
Payments	6
Cost	3
Adjustments & Denials	6
Member	2
Member	2
Provider	6
Enrollment	3
Provider Network Adequacy	3
Systems	1
Systems	1
TPL/COB	2
TPL/COB	2
Utilization	14
Super Utlizers	5
Top N Board	7
Service Utilization	2
Operations	13
Prioir Authorization	2
Claims	3
SLA/Timely Filling	4
Appeals / Grievances	4
Managed Care	7
Managed Care	7
Grand Total	67

How does the Utilization Dashboard contribute to effective decision-making for payers, and what specific insights does it offer?

The Utilization Dashboard is a cornerstone of effective decision-making for payers, offering invaluable insights into Super Utilizers, Service Utilization, and General Utilization. It serves as a comprehensive tool, enabling the identification of patterns, negotiation of contracts, and strategic optimization of resources.

In the Super Utilizers section, the dashboard facilitates the identification of high-dollar spenders, allowing payers to implement targeted measures for cost mitigation and fraud detection. Analyzing claim-based and provider-based super utilizers provides a nuanced understanding of utilization patterns across various providers and members.

The Service Utilization component offers a granular view of service usage, aiding in negotiations and capacity planning. From KPI cards providing a quick snapshot to detailed analyses covering discharges, OP visits, stays, ER visits, Telehealth sessions, and day care procedures, the dashboard ensures a thorough understanding of the demand for services.

The General Utilization section provides a quick pulse check of member utilization across dimensions, utilizing top N charts for insights into key provider partnerships, prevalent member diagnoses, and procedures performed. This holistic approach empowers payer executives to make informed decisions, proactively address emerging trends, and optimize resources effectively in the dynamic healthcare landscape.

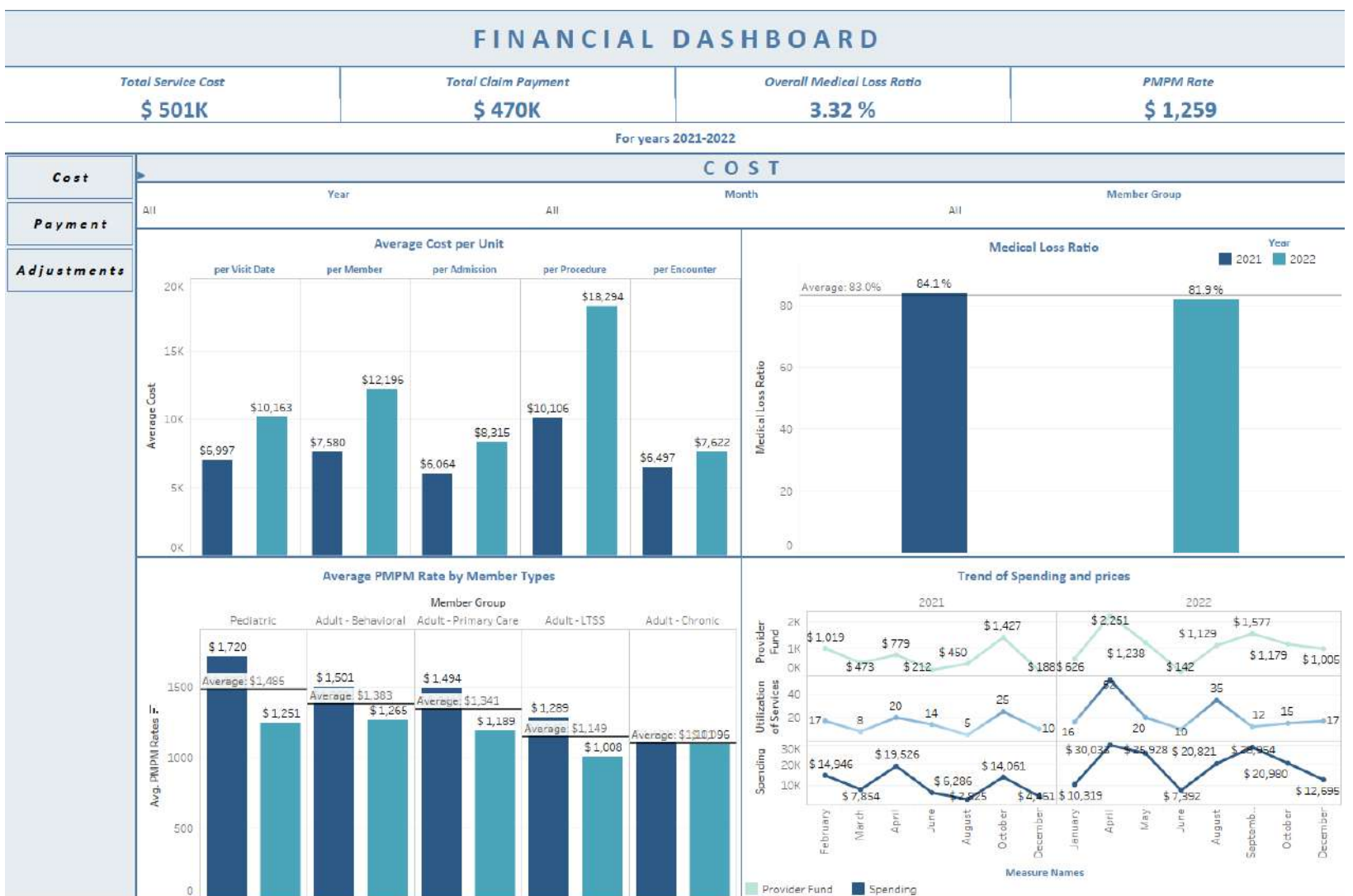## Member based Super Utilizers by Providers
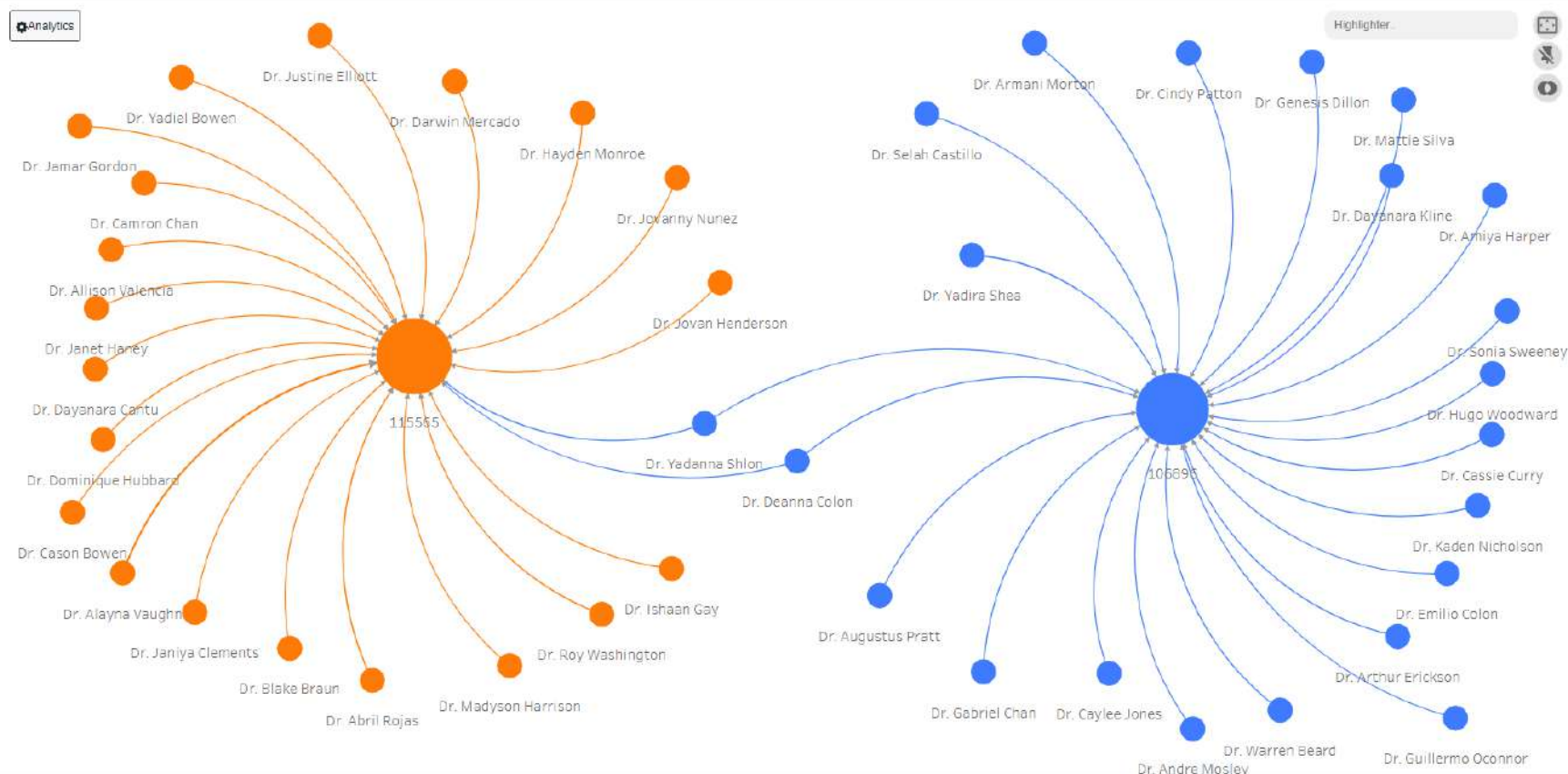
How does the Financial Measures Dashboard contribute to effective payer operations, and what specific insights does it offer regarding costs, payments, and adjustments?

The Financial Measures Dashboard is instrumental in ensuring the effective functioning of payer operations, offering detailed insights into Costs, Payments, and Adjustments. In the Costs Section, it analyzes costs at various unit levels, including per member, per visit, and per encounter. This includes tracking the medical loss ratio, PMPM rate, and overall spending, enabling payers to maintain a balance and intervene early for unexpected changes.

Moving to the Payments Section, the dashboard dissects member claims payments across dimensions, utilizing trend line charts to track payments based on claim and facility types. Additionally, it provides insights into payments received from Medicare, highlighting areas where performance changes positively impact incoming payments.

Simultaneously, the Adjustments and Denials Section tracks denial categories and reasons, along with adjustments made to past claims. Using a sunburst chart, it allows for easy drilling down into denial categories and reasons, ensuring a clear understanding of payer operations. This holistic approach empowers payers to make informed decisions, address financial imbalances, and maintain effective operational functioning.

FINANCIAL DASHBOARD

Total Service Cost	Total Claim Payment	Overall Medical Loss Ratio	PMPM Rate
$ 501K	$ 470K	3.32 %	$ 1,259

For years 2021-2022

COST

Cost | **Payment** | **Adjustments**

Year	Month	Member Group
All	All	All

Average Cost per Unit

per Visit Date	per Member	per Admission	per Procedure	per Encounter
$6,997 / $10,163	$7,580 / $12,196	$6,064 / $8,315	$10,106 / $18,294	$6,497 / $7,622

Medical Loss Ratio — Year: 2021, 2022
Average: 83.0% — 84.1% (2021), 81.9% (2022)

Average PMPM Rate by Member Types

Member Group: Pediatric, Adult - Behavioral, Adult - Primary Care, Adult - LTSS, Adult - Chronic

$1,720 / $1,251 — Average: $1,485
$1,501 / $1,265 — Average: $1,383
$1,494 / $1,189 — Average: $1,341
$1,289 / $1,008 — Average: $1,149
Average: $1,096

Trend of Spending and prices
2021 / 2022

Provider Fund: $1,019, $473, $779, $212, $450, $1,427, $188, $626, $2,251, $1,238, $142, $1,129, $1,179, $1,577, $1,006

Utilization of Services: 17, 8, 20, 14, 5, 25, 10, 16, 20, 10, 35, 12, 15, 17

Spending: $14,946, $7,854, $19,526, $2,625, $6,286, $14,061, $4,251, $10,319, $30,032, $25,928, $20,821, $7,392, $20,980, $12,695

February, March, April, June, August, October, December, January, April, May, June, August, Septemb., October, December

Measure Names: Provider Fund, Spending

What are the essential metrics for evaluating provider performance and ensuring enhanced healthcare quality?

Essential metrics include tracking Provider Status Change measures, understanding the distribution of enrolled providers across specialties using visualized data, utilizing geographical insights to assess network adequacy, and incorporating Time and Distance Compliance through geo maps to guarantee reasonable provider reach. Additionally, monitoring Appointment Wait Time Performance by Provider Type is crucial for evaluating healthcare delivery efficiency and enhancing network adequacy and patient satisfaction. Overall, a holistic approach involves assessing status changes, enrolment dynamics, specialty distribution, and network adequacy through geographical and time-related analyses.

What methodologies or tools are recommended for effectively tracking member related measures?

Emphasizing the importance of metrics like Member Enrolment Trend, Member Count by Race/Ethnicity, and Member Support by Type and Channels. Tracking these trends weekly and monthly, with visualizations for gender and age-group-wise enrolment, provides vital insights for healthcare planning. Diversity takes centre stage with a focus on Member Count by Race/ Ethnicity, ensuring healthcare policies are culturally sensitive and inclusive. The roadmap for the future includes plans to incorporate Member Status and Support Channels, enhancing our ability to understand member engagement. The "Appeals / Grievances" section uncovers nuanced interactions between members and providers. Measures like Member Grievances, Provider Grievances, Member Appeal Trend, and Provider Appeal Trend delve into grievances and appeals, categorizing them by type and outcome trends. While specific visualizations aren't detailed, the emphasis on outcome analysis provides a strategic approach to refining healthcare strategies. In conclusion, this blog underscores the significance of data-driven decision-making, guiding healthcare providers toward proactive and patient-centric strategies.

What does the Care Quality Measures Dashboard provide in terms of summarizing healthcare effectiveness data and information?

The Care Quality Measures Dashboard is a crucial tool for healthcare assessment, offering a comprehensive summary through a detailed scorecard. This includes aggregated scores at the category level, providing an overview of healthcare effectiveness data and information. A notable feature is the Measure Level Drilldown option, empowering users to conduct in-depth analyses of specific measures, facilitating the identification of strengths or areas for improvement within healthcare

practices. Within the dashboard, the HEDIS Aggregated Quality Factor Score (AQFS) Visualization plays a central role. It presents a scorecard with a weighted average score at the group level compared to weighted benchmarks, allowing for a holistic assessment of healthcare service quality. The Scorecards cover Effectiveness of Care, Access/Availability to Care, Use of Services, Risk Utilization, and E Clinical

Data, offering insights into performance in these critical domains. Furthermore, future versions are planned to incorporate additional measures, showcasing a commitment to continuous improvement and adaptability to evolving healthcare needs. This feature-rich approach ensures stakeholders can derive actionable insights, promoting a proactive and data-driven approach to enhancing healthcare quality.

As decision-makers in healthcare payer organizations, navigate the complex landscape of healthcare to ensure effective operations, financial sustainability, and, most importantly, the delivery of high-quality care to members, it is imperative that they have the right tools providing them the right information at the right granularity to make the key decisions. In this dynamic and evolving field, strategic decisions are crucial and impactful, and leveraging tools like Exafluence's Payer KPI Framework becomes instrumental in unlocking success for organizations.

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