Omega Healthcare®



PLAYBOOK

How-To Guide for Improving Member Engagement

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A New Era of Member Engagement

CMS's evolving focus on member experience, health equity, and measurable outcomes is reshaping the healthcare landscape — not just for Medicare Advantage (MA) plans, but across all lines of business.

Star Ratings and similar programs have become powerful market signals, influencing how payers compete — and how members choose. According to the McKinsey Medicare Shopping Survey, 50 percent of MA members said Star Ratings were among the top features they considered when selecting a plan. Nearly a quarter said ratings were the most important decision driver — up from just 5 percent in 2020.

Maintaining high quality scores and sustaining enrollment growth depend on a health plan's ability to deliver meaningful member engagement and measurable satisfaction. These are no longer soft metrics — they're central to health outcomes and business performance.

But, delivering on those expectations is increasingly complex. As CMS raises the bar — and members demand more personalized, connected care — plans must find new ways to reach members effectively, support provider collaboration, and improve outcomes at scale.

This guide outlines the practical strategies payers can implement to:

- **Improve member satisfaction** and retention through personalized outreach
- **Strengthen collaboration** between payers, providers, and members
- **Close care gaps** with scalable, tech-enabled support models
- **Elevate performance** on key quality and experience measures

With the right strategies — and the right partnerships — payers can transform member engagement into a scalable, sustainable performance advantage without overextending internal resources.

The Star Ratings Ripple Effect: 5 CMS Trends Reshaping Plan Performance (Across the Board)

In 2024, CMS announced several important changes to the Star Ratings system set to take effect in 2025 and beyond. At the center of these updates is a clear message: engage your members, remove barriers to high-quality care, or fall behind.

For all payers, keeping pace means focusing in on five key CMS trends shaping how plans are scored on the Star Ratings scale — and how they improve outcomes across the member journey.

1. **Member experience now drives performance.** CAHPS and HOS measures carry more weight — making satisfaction, access, and communication central to plan success.
2. **Health equity is now a mandate.** The new Health Equity Index (HEI) rewards plans that improve outcomes for members with social risk factors.
3. **Preventive care is a top priority.** New measures emphasize earlier interventions and stronger care team coordination, especially for older adults.
4. **Medication management is expanding.** MTM eligibility will double by 2027, requiring scalable outreach and member support models.
5. **Risk capture standards are rising.** New HCC model updates demand clean documentation, accurate coding, and tighter provider collaboration.

What does this mean for non-MA plans? CMS standards, including the Star Ratings system, serve as both a **model and a motivator** — shaping how *all* health plans define success, measure performance, and engage their members.

Aligning Quality, Experience, and Engagement: A Unified Path to Performance

For many payers, quality, experience, and member engagement are treated as distinct priorities — each with their own teams, metrics, and workflows. In reality, they're deeply interdependent: Improvements in one often depend on coordination across the others.

A missed wellness visit, for example, doesn't just impact HEDIS scores — it may reflect a lack of member understanding or insufficient outreach. Poor service experiences can drive down CAHPS scores and increase churn. Incomplete follow-up on care gaps can negatively impact health outcomes and lead to risk adjustment issues and missed revenue opportunities.

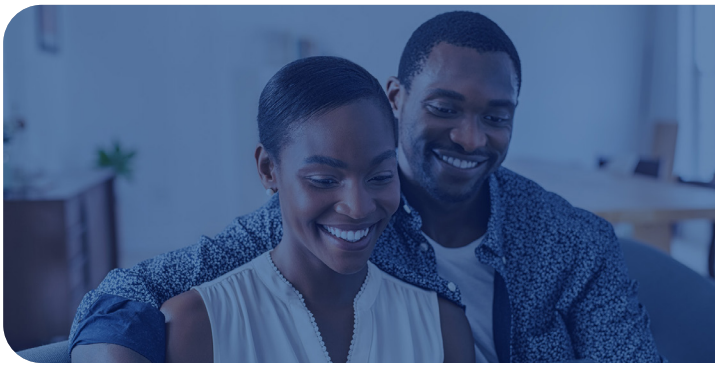
Over 50 percent of insured adults find at least one aspect of how their insurance works difficult to understand, and 65 percent feel that managing their healthcare is "overwhelming."

These disconnects put experience *and* outcomes at risk, underscoring the common barrier and the source of declining payer quality ratings: fragmented engagement strategies.

Leading health plans are addressing the breakdowns by aligning around a unified model — one that treats engagement as a shared strategic driver, not a siloed department. This means:

- **Making engagement foundational** to quality and experience efforts — not a separate initiative.
- **Connecting data and workflows across teams**, so outreach supports clinical and administrative goals.
- **Empowering the care team** — payers, providers, and members — to coordinate around timely, relevant actions and work together toward shared goals.

The following best practices show how payers can put this unified model into action — operationalizing member engagement and turning it into a force multiplier for quality, experience, and performance.



6 Best Practices for Operationalizing Member Engagement

Turning engagement into a performance driver takes more than aligned goals — it takes system-level change.

Below, we outline how payers can translate high-level intent into tangible impact, enabling timely action, smarter workflows, and stronger collaboration across the care team and throughout the member journey.

1 Empower the *Full* Care Team

Most engagement programs are designed in silos — payer-run outreach, provider-led follow-up, disconnected workflows in between. The result? Members get redundant or conflicting messages, gaps stay open, and no one has a complete view of what's been done.

To address these issues at the root cause, payers need to treat engagement as a shared function across the care team — with clearly defined roles, aligned messaging, and coordinated timing.

What to do:

- **Integrate provider context into outreach workflows.** Use practice-level preferences and EHR data (when available) to ensure member messaging aligns with provider protocols.
- **Route key insights back to providers.** Make sure providers know when you've contacted a member, closed a gap, or identified a barrier — especially before a visit.
- **Sync priorities and timing.** Align campaigns and care gap outreach with provider initiatives to avoid conflicting messages and improve the member experience.

When engagement is shared across the care team — not duplicated or delayed — members receive the clear guidance they need, and teams can spend less time cleaning up each other's work.

2 Route Inquiries and Work by Complexity

Payer clinical teams are drowning in tasks that don't require clinical judgment — scheduling questions, benefit clarifications, medication refill help. Every time a nurse is pulled into administrative work, it delays more urgent, high-complexity care and drives burnout.

The solution isn't to work more or even faster — it's to work smarter.

What to do:

- I**mplement tiered triage models**. Route coverage questions, appointment support, and other non-clinical tasks to trained admin or non-licensed teams. Escalate only when clinical input is needed.
- **Match task type to skill level**. Avoid defaulting every member touchpoint to an RN. Reserve licensed staff for care planning, risk stratification, and post-discharge outreach.
- **Extend capacity with external support**. For high-volume or overflow needs, consider partners who can follow protocols, escalate appropriately, and protect internal bandwidth.

This isn't just about saving time — it's about protecting high-value clinical capacity and improving *resolution speed* across the board.

3 Use Data to Enable Timely, Targeted Action

Payers sit on critical signals — missed screenings, recent ED visits, care transitions — but those insights rarely make it to the right person fast enough to act. Too often, data is treated as a reporting tool instead of an operational asset.

If the goal is to close gaps and improve outcomes, data has to move faster — and go further.

What to do:

- **Operationalize priority signals**. Define which data points should immediately trigger outreach — like a discharge without follow-up or a member overdue for a cancer screening.
- **Make data actionable**. Don't just flag gaps — assign ownership, provide context, and connect to next steps within your outreach workflows.
- **Enable feedback loops**. Route member responses and provider updates back into your system. Without two-way flow, gaps stay open longer than they should.

When data is tied to action — not just analysis — plans can intervene earlier, support smarter outreach, and reduce the risk of delayed or missed care.



4 Co-Brand or White-Label Strategically

Even the best outreach strategies fall flat if members don't trust the source. Members are more likely to act on information that appears to come from their provider — even when the effort is funded or coordinated by the health plan. That's not a branding issue — it's a trust issue.

To improve engagement, communications should reflect the clinical relationships members already know and value.

What to do:

- **Use "on behalf of" messaging**. When appropriate, position outreach as coming from the provider or care team. This strengthens credibility and increases response.
- **Segment branding by channel**. A letter might carry the provider's name, while follow-up texts or calls reference the plan. Use each channel to reinforce coordination, not confusion.
- **Align tone and content with provider conversations**. Work directly with provider teams to ensure outreach supports — not conflicts with — what's happening in the exam room.

The goal isn't to obscure the payer's role — it's to build trust and continuity across the entire care experience.

5 Enable Action Without Adding Burden

Every plan wants to improve engagement — but few have the internal capacity to scale outreach, triage, and follow-up without pulling resources away from clinical or strategic priorities. Asking internal teams to do more without adjusting the model leads to bottlenecks, burnout, and missed opportunities.

To succeed, plans need scalable engagement support that drives action without overloading existing teams.

What to do:

- **Identify where internal teams are stretched**. Start with high-volume tasks like wellness outreach, risk adjustment support, or gap closure reminders — and map what's falling through.
- **Extend the team with purpose-built support**. Whether internal or external, build capacity around tasks like outbound calls, SDOH screenings, or documentation follow-up — so licensed staff can focus on complex care.
- **Define ownership and escalation clearly**. Delegating doesn't mean losing visibility. Structure workflows so that every task has a clear owner, next step, and escalation path.

Engagement should create momentum — not more and more work. The right support model lets teams do what they do best, while still moving the needle on quality, satisfaction, and outcomes.

6 Design Around Member Outcomes, Not Internal Silos

Engagement efforts often mirror org charts — carved up by department, delegated based on funding, and disconnected across programs. But, members don't experience care that way. They don't care who "owns" the outreach. They care whether they get the right information, at the right time, in a way that helps them get the care they need.

When internal silos shape engagement strategy, members get a fragmented experience — and plans lose opportunities to improve outcomes.

What to do:

- **Start with the member's perspective**. Map common outreach scenarios across teams (e.g., wellness, chronic condition follow-up, post-discharge) and identify where gaps or duplication occur.
- **Align around shared goals**. Bring clinical, quality, and engagement teams together around measures that matter — like retention, gap closure, satisfaction, and risk accuracy.
- **Build workflows that prioritize clarity and continuity**. Engagement should feel like a single conversation across time — not three separate calls from three disconnected teams.

Reframe your engagement strategy around outcomes, not org charts. When plans organize around the member journey, they unlock better results — and a more seamless experience across every touchpoint.

Scaling Impact Through Smarter Support Models

Payers don't need more complexity — they need flexible support that extends capacity without adding burden. That's where we come in.

Omega Healthcare helps health plans operationalize member engagement by filling critical gaps across the care team — supporting both clinical functions behind the scenes. From triaging inquiries to coordinating provider-aligned outreach, Omega Healthcare ensures the right team member steps in at the right time — so every interaction moves the needle.

Bringing It All Together: Turning Member Engagement into a Scalable Advantage

Member engagement isn't just a compliance requirement — it's a core lever for improving quality, satisfaction, and long-term performance. But, reaching the right members at the right time with the right message takes more than good intentions. It requires shared ownership, aligned infrastructure, and the capacity to act.

Health plans that treat engagement as a cross-functional strategy — not a siloed initiative — are better positioned to meet rising expectations, close critical care gaps, and deliver stronger outcomes across the board.

Learn More

Discover how Omega Healthcare's flexible portfolio of platform-based services improved risk adjustment coding productivity and accuracy for one of America's largest Blue Cross Blue Shield insurers.



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