Listening to America's Health Plan Operations Executives

Our top 9 innovation "prescriptions"

Contents

Most health plan operations are under tremendous pressure. They must reduce expenses and improve quality while maintaining compliance and retaining their members through positive experiences and healthier outcomes. Most would agree that a healthier tomorrow requires progressive and innovative steps forward.

In the course of interacting with dozens of health plan operations executives, we have listened to and discussed many of their most pressing challenges and their visions for building a sustainable health plan operating model that delivers improved business outcomes and grows membership.

What did we find? Health plan leaders understand that they have a vital mission to create satisfied and healthier members through provider collaboration supporting coordinated, evidence-based care and wellness-promotion activities. At the same time, they must achieve operational excellence to reduce the costs and improve the quality of their operations to foster health and wellness. Underpinning both thoughts is a view that some of the fundamentals of today's business model must change to be sustainable in the future. Most health plans have taken steps, shifting into the hospital and physician practice arena through acquisitions, demonstrating a forward integration strategy into care delivery practices. And some have started shifting to evidence-based care and quality metrics, and pay-for outcomes or performance.

Overall, health plan operations executives consistently voiced a need for ongoing examination and diagnoses of critical areas for continuous improvements as well as end to end innovation. One of the key areas of focus is an operating model that can deliver improved member experience and satisfaction while simultaneously reducing operating and medical expenses and maintaining regulatory compliance. It's a tall order and no one has cracked the code on it.

Rapid insight into operating and plan metrics for decision-making was seen as key, and influenced everything from the fundamentals of business model design, to member segmentation and targeting decisions, to making operations more efficient.

Although leaders are consistently excited to discuss the future of their organizations, they also value many of the successes of the past, including managing costs and being pragmatic in balancing considerations involving people, process, and technology. As they look ahead, business services partnerships are expected to play an increasingly important role in achieving future business goals, as well as managing risk through diversified sourcing.

Listed below are Concentrix's top 9 innovation "prescriptions" for a successful health plan operation. There is one section for member health and satisfaction and one for operational excellence. However, a fundamental connection should be recognized in that member satisfaction improves as operational excellence improves. Taken from our interactions and evaluations of many health plan organizations, these are the topics that are shaping the business conversations today.

Rapid insight into **operating** and **plan metrics** for decision-making was **seen as key**...

1. The heart of your business: Improve member experience and retention.

Many health plan executives are starting to realize they need a 360-degree view of members to help design the optimal experience that can shift and meet changing consumer needs and requirements, all at better costs. Keeping members satisfied and loyal supports profitability within the base, while reducing acquisition costs.

To enable a holistic view of their members, plans should consider end to end member management models. Focus on proactive member outreach, prioritizing member interactions, will be important. The consumer "member" will continue to evolve and shape the services required of health plans.

Health plans that anticipate and meet consumer demands can gain a significant advantage, particularly as the individual market membership stands to triple in the next three years. Health plans will need to enable consumer capabilities from contact through payments. Unstructured analytics is empowering companies to analyze their vast stores of unstructured information, such as voice data, emails, social media and other information sources previously not tapped, to make new discoveries and better understand and anticipate member needs.

2. Change your mind set on individual customization.

Many health plan executives have realized shifts in the fundamentals of engaging their membership base. With the increase in individual memberships, and the decline in employer-sponsored insurance programs, they recognize that the future must focus on affordable individual patient- or member-coordinated care management and move toward a business where healthy outcomes are the focus, instead of simply paying for care and acute interventions after the fact. Medical practice quality, payments reform and collaboration between the health plan and the provider are the three legs of the stool that need to be balanced going forward. Central to this shift will be a focus on understanding members' needs, providing advice, and changing behaviors and health-related decisions. Better tools and access to information are needed. They can empower the member with information at the point of service regarding treatment costs and outcomes, which can help reduce waste and give the member control over their healthcare.

3. Care management is a "team sport."

As health plan business models evolve, the value proposition to members, employers and provider networks must also shift. Health plan executives continue to improve brand value through a spectrum of wellness, disease prevention, and chronic care management programs. These are designed, developed, and marketed to capture and satisfy empowered healthcare consumers. Health plans wish to be viewed as proactive, collaborative, positive team players aligned with providers to keep members healthy—and not as mere financial gatekeepers.

Monitoring and measuring the "team" progress calls for a new approach, creating end to end member/patient management models with care delivery outcomes. The role of analytics becomes central to gaining visibility to this activity as it happens. Analytics can also help predict ways to improve member satisfaction and deliver savings as well as clarify the impact of the "outliers" that differ from typical members. Advances in data analytics now reach further than ever before, including predictive modeling for treatment outcomes and care management and more holistic payment integrity detection. Combined with automation, the results are expected to speak for themselves in terms of reimbursement and payments based on performance and business model sustainability.

4. Look to lessons from the retail world to change member acquisition activities.

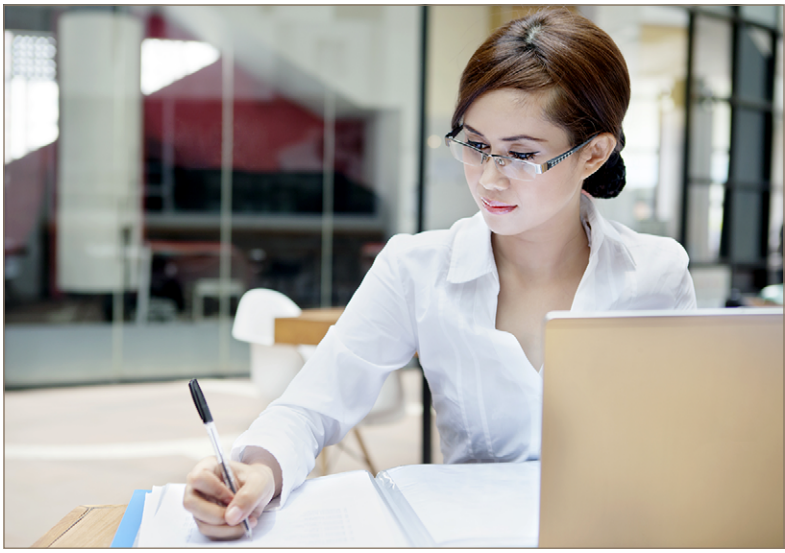
As the traditional health plan business-to-business (B2B) sales and revenue recognition model declines, health plan executives are starting to develop new models similar to the retail and consumer products industries: business-to-consumer (B2C). Banks and telecommunications companies have learned over the last decade that acquiring new business means securing access to the right data to gain a deeper understanding of consumer segments and attendant buying behaviors. In a similar way, health plans need to redouble efforts to focus on and understand member-segment characteristics that provide clarity to target markets and an understanding of appropriate acquisition programs, costs of managing multiple communication channels and member-segment profit potential. Member insight and data will be keys in these endeavors as more customized benefit options, pricing, and delivery features will need to be matched to individual member demographics. By leveraging analytics, such as lifetime value, health plan leaders can even decrease business risk by better understanding the evolution of consumers and markets.

5. Prepare for future examinations.

ICD-10, HIPAA and regulatory compliance with changes in government reform programs top the current list of regulatory concerns impacting health plans. Health plan executives discussed their desire to reduce fixed costs in achieving and managing compliance and establishing predictable variable costs to help manage compliance requirements in the future. Although the move to ICD-10 (scheduled to take effect Oct. 1, 2015) promises strategic transformation and, to a great extent, improved transparency, the cost and compliance burdens are substantial. Improved utilization management can be achieved through the efficient use of ICD-10 diagnosis and procedure codes by plans and providers and the exchange of patients' profile information. This can signal variations in treatments across the care process. In light of constantly changing regulatory demands and new levels of scrutiny, successful health plan organizations must manage regulatory mandates, risks, and internal governance policies and protocols. This will help them meet the needs of members, employers, and providers, more securely and more cost-effectively.

6. Balancing profits, ratios and ratings.

As accountable care organizations (ACOs) grow, the basis of competition also shifts in lockstep. Health plan leaders need to optimize their operations towards profitability with the goal of effectively managing costs and simultaneously improving member satisfaction and managing compliance with a host of performance metrics. These include service levels, medical loss ratios (MLR), NPS scores and STAR ratings. Continuously meeting or exceeding the myriad of metrics requires an investment in time, resources, and technology to fully understand the involved processes, the barriers to achievement, as well as the steps to achieving greater visibility to performance levels. Prioritizing member based metrics and operating a holistic member management model through deployment of real-time monitoring, process optimization, advanced tools, analytics and automations can help achieve objectives and address the performance measurements puzzle.



7. Reduce redundancies and rework.

In an ideal health plan world, rework, pends, denials and appeals would be eliminated and enrollment, claims and contracting throughput and cycle times would be rapid. Although health plan executives understand the issues, people, process and technology limitations prevent this panacea and hamper process maturity and efficiency. One of the first steps to reducing redundancies and rework is to identify wasteful redundancies and inefficient processes and then redesign operations to meet operational efficiency goals. Health plan leaders are interested in new, simplified approaches to process redesign that utilize new techniques and wrap around technology that can be enabled with analytics and automations. By improving process efficiency, plans can do more with less, providing a win-win for members and the organization's bottom line. Payer and provider interoperability also need to be considered when health plans take the lead in addressing their workflow, data, and administrative requirements. Streamlining and automating steps within the process of enrolling a member or paying a claim need to be confronted holistically and in coordination with providers and other parties. Rework has a negative impact on health plans, providers and members, driving up unnecessary cost and impacting satisfaction. Analytics is key to identifying root cause drivers for reworks so health plans can address and prevent recurrences.

8. Seek process automation opportunities.

Many health plan organizations speak to simplification and standardization as hallmarks toward a more efficient operation. Business process automation is an effective approach to providing quality and efficiency. Although not every process is a candidate, automating routine tasks is a lever companies can use to simplify, standardize, and improve performance and profitability. With limited dollars for enterprise technology infrastructure improvements, leaders are looking to new ways of automating key functions, deploying new process modeling technology and techniques for automation at the desktop level.

Today, in processes like enrollment or claims validation, it is possible to reduce or even eliminate manual data-entry errors. This is accomplished through automatic provisioning of the appropriate desktop views, corresponding information, and process step options at the right time. All too often, agents or processors spend valuable time checking or cutting and pasting data from multiple applications. Automations can also effectively improve process and financial accuracy. By automating claims auditing prior to payment, significant mis-payment savings can be realized.

9. Analyzing your results: Did we mention analytics?

Health plan executives are seeking to improve business processes and care delivery outcomes by leveraging enterprise data. Using operations data and analytics, they can integrate, manage and analyze information at rest, in motion and on demand to gain visibility to care delivery outcomes, provide transparency and deliver business insights across the health plan value chain. Operational analytics can turn the transformation and improvement discussion on its head, providing a real-time, quantitative dashboard to opportunities and priorities for continuously improving business operations and driving improved member experience and satisfaction.

The future of business services partnerships at health plan companies

Business services partnerships remain a powerful lever for health plan executives who want their current business model to focus more on care, offer best-in-class member experiences, and simultaneously demonstrate operational excellence. Health plans can use these partnerships to more quickly adopt new leading practices, trial and scale alternative business operations, and focus their energies on devising new business strategies.

Health plans are in prime position to improve member experience by developing a 360-view of their members. This requires horizontal, progressive thinking and management. Most health plans are structured by function or line of business, with different data sources and different services partners yielding fragmented member views. Focus on reducing operating expenses and improving quality is usually managed at line of business level, sub-optimizing at the member or end to end level. Prioritizing focus on member satisfaction drives end-to-end optimization horizontally, across health plan processes and their provider network. Indeed, member satisfaction inherently drives quality and reduces cost. Health plans can utilize a business services partnership to test and prove value of an end to end member-centric model, through multiple phases or approaches. This requires a business services partner with strong back and front (customer care) office competencies.

Not all business services partners or vendors are equal. When considering business services partners, health plan executives need to evaluate the maturity of the operation and make certain the new arrangement delivers much more than just reduced-cost processing. Member experience, end to end process and innovation capabilities as well as data and physical security and outcomes based performance parameters, should weigh heavily in the decision-making process. Teaming with the right company that provides end to end services, combined with analytics, automation and technology, can be the genesis for enabling a new member-centric operating model.

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For more information

If you'd like more information on adding value to your health plan operations, please contact your Concentrix representative or visit the following website: **www.concentrix.com**.

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