Using technology to drive business transformation

Overcoming significant challenges with technology

The concept of business as usual no longer exists as payers strive to achieve their 21st century goals. Unprecedented change is the rule, influenced by ballooning health care costs, an evolving consumer-driven health care market, an aging population and an increase in chronic conditions. These challenges are matched by demands for increased transparency and healthy living. Add to that the ongoing debate regarding defined benefit versus defined contribution. And factor in constantly shifting regulatory requirements, expanding health insurance coverage and payment reform — with shared-risk models like accountable care organizations (ACOs) — and medical loss ratio minimums.

Today's challenges will not be resolved by the old ways of doing business supported by yesterday's technology. Transforming a payer organization so that it can effectively compete and thrive simply cannot be accomplished with outdated legacy platforms, aging ancillary systems and expensive, error-prone manual processes. Payers need next-generation, business-transforming technology to radically innovate and efficiently address the business imperatives of the evolving health care economy.

Five primary challenges facing payers

To effectively compete, payers have to address the following challenges:

1. **Streamline operations:** Drive down administrative costs and streamline operations. Automate everything possible to remove human error and to become as efficient as possible.
2. **Engage members and providers:** Take customer service to new levels where questions can be answered quickly and correctly the first time, every time.
3. **Enhance transparency:** Get the right information to the right stakeholders (whether internal or external) so they can make good decisions. Stakeholders are realizing that if they don't have the information they need to be successful, they won't participate.
4. **Support new business models:** There is no more "one-size-fits-all" health care. Mainstream or secondary — which models will be most prevalent? It doesn't really matter; payers have to be able to adapt and respond as the models evolve.
5. **Comply with regulatory requirements:** With Federal and State standards, ICD-10 and even ICD-11, the concept of "remediate once and then you are done" is not an option. Payers need to be able to adapt repeatedly with reliable approaches.

This white paper explores the essential role technology plays in transforming these challenges into opportunities that will enable payers to thrive in these changing times.

The challenges from one payer's perspective

To help illustrate the challenges and opportunities, we'll describe Alpha Health Plan's situation. (Alpha is a fictional payer based on various clients.) Like many payers, Alpha

wants to streamline, transform and grow its business by:

- Driving down administrative costs
- Improving quality of care
- Supporting new business models
- Eliminating manual processing of claims and other paper-based flows
- Reducing the 30+ satellite systems bolted on around the edges to augment core system functionality
- Complying with new regulatory standards including payment reforms
- Improving customer and provider satisfaction
- Increasing transparency internally and externally to make informed, real-time decisions
- Expanding Medicaid offering
- Participating in an ACO
- Offering products to individuals
- Mitigating the need for multiple calls to answer a single question from a customer or provider

Alpha Health Plan:

- Based in the Midwest
- 600,000 members
- Uses core administrative and care management systems circa 1995

(Alpha is a fictional health plan.)

The following table examines the five primary challenges and how technology can help payers adapt to the changing health care marketplace and make significant improvements.

	Operational transformation	IT-enabled transformation
1 Streamline operations	• Put the emphasis on quality, get a clear understanding of workflows, and identify business rules or values that can be controlled by end users • Build as much efficiency into processes and application configuration as possible	• Improve auto-adjudication, driven by data cleanliness across members, providers and benefit plans • Increase efficiency through automation • Empower business users to make changes easily and quickly
2 Engage members and providers	• Take an "outside-in view" to process design and information flows • Use external measures and perspectives to evaluate performance • Measure performance from a customer perspective to retain loyalty	• Make essential data from the core system available to providers and members • Facilitate consistent, accurate and timely communication via contact centers, portals and mobile applications • Identify at-risk members to enhance medical management and reduce medical spend
3 Increase transparency	• Allow real-time interaction with members and providers • Improve processes for data capture • Enhance access to accurate information and enable members to gain a better understanding of their benefits, related costs and quality of care choices, as well as variations in pricing	• Make integrated, enhanced data available for informed decisions by internal and external stakeholders
4 Support new business models	• Identify core competencies — the products and services that differentiate the payer • Consider outsourcing areas that are not part of a payer's core competencies to drive down costs, improve service performance and free investments for core initiatives	• Create flexible and responsive systems to enable current and future business models (i.e. ACOs, pay-for-performance, health insurance exchanges and value-based reimbursement/value-based benefits)
5 Achieve regulatory compliance	• Leverage modern technology with flexible design to drive more cost-effective response to regulatory changes • Take advantage of regulatory changes and technology investments to enhance business operations, financial management and quality	• Implement modern, agile technology designed to adapt to regulatory changes cost effectively • Extend these technology investments for rapid response to future compliance and regulatory changes • Differentiate Alpha as a progressive, market leader

Alpha and many other health plans like it, have over the course of time added levels of operational and technological complexity. Today's market challenges present an excellent opportunity for payers to improve — from both an operational and IT perspective.

Payment innovation case study: State of Ohio

Many states are applying value-based payment models. Alpha Health Plan is considering expanding its Medicaid business in Ohio. The plan investigated the State of Ohio's payment model and discovered important insights that will help the plan better understand the business implications.

The state of Ohio has established the goal of enrolling 80 to 90 percent of Ohio's population in some form of value-based payment model* (Arkansas and Tennessee are among two other states engaged in similar payment innovation efforts).

That means the state is:

- Shifting rapidly to patient-centered medical homes (PCMH) and an episode-based model in Medicaid fee-for-service
- Requiring Medicaid managed care organizations (MCOs) to participate and implement these payment models
- Incorporating this goal into MCO contracts for the state employee benefit program

	Patient-centered medical homes	Episode-based payments

Year 1	• In 2014, focus on Comprehensive Primary Care initiative
	• Payers agree to participate in a design for elements where standardization and/or alignment is critical
	• Multi-payer group begins enrollment strategy for one additional market
		• The State leads design of five episodes:
		  • Asthma (acute exacerbation)
		  • Perinatal
		  • COPD exacerbation
		  • PCI
		  • Joint replacement
		• Payers agree to participate in the design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year

Year 3	• Model rolled out to all major markets • 50 percent of patients are enrolled	• 20 episodes defined and launched across payers
Year 5	• Scale achieved statewide • 80 percent of patients are enrolled	• 50+ episodes defined and launched across payers

*A combination of episode- and population-based payments

The following payment innovation plan goal is being executed in an aggressive five-year time frame, with 2014 as Year 1. The state continues to define what this looks like. In the meantime, payers — like Alpha — who want to serve Ohio must respond to and be able to support the goal and milestones. This requires an ongoing strategic focus on operations and technology to adapt to new business models.

A pivotal time for data sharing and transparency

Value-based payment models such as those in Ohio are transforming the relationship between the payer and providers. Providers don't have the information they need to be successful in these payment models unless they work with the payer. If Alpha or other payers want to achieve meaningful reform — financially and clinically — it has to figure out how to take the relevant data and expose it to the providers so they understand:

- Why they are being evaluated
- What opportunities exist for meaningful clinical improvement

- What they can do differently to be successful
- How they can use the data to understand – in real time – what they need to do

Without help from the payer, the individual provider has very little opportunity to envision the entire package of services that members receive. Without that information, it is difficult to manage care. The need for transparency becomes evident as payers move toward new business models. The key is to make the data transparent and then engage providers and members to take advantage of the information.

Manage change for long-term success

If a payer is going to make a significant investment in new technology and operations, what is the best way to optimize that investment? There are organizing principles that can improve the likelihood of a successful outcome:

- **Change your frame of reference:** Transaction system changes should energize business process improvements. There should be measureable gains in product cycle time, claim accuracy, customer relationship management and other key performance indicators. Be specific and narrowly focused in how you measure success.
- **Develop a clear strategy:** What is the plan? How will it be communicated consistently? Ensure everyone at every level is engaged and takes responsibility.
- **Embrace change:** Even when the change in the works will ultimately benefit everyone, it is not easy to shift an organization to start thinking differently. Individuals often hang on to past inefficiencies because they remember how hard they worked to get a process or system change implemented to address a need.
- **Know who is in charge:** There should be one individual — or just a few — with clear responsibility and decision-making authority. Otherwise, each key step becomes a time-consuming compromise.
- **Align — and realign — stakeholders around key values:** This includes aligning with the vendor. All partnerships are critical to achieving change together.
- **Overall: Adhere to a discipline.** Stay focused and continue to measure progress to ensure the strategic plan is on track.

By following these steps, payers can optimize their investment in technology and achieve the business transformation they seek.

Technology as a key transformation driver

Many payers realize that their systems and the supporting technology are outdated. The amount of time and money spent adapting to new regulatory requirements, the manual processing currently needed to continue business as usual, and the time and expense of cobbling together solutions for existing 30+ year-old legacy systems are too high a price.

For payers to fundamentally transform their business, they must use next-generation technology to overcome their five biggest challenges: streamline operations to reduce costs, engage members and providers, enhance transparency to improve quality of care and outcomes, support new health care business models, and achieve regulatory compliance.

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