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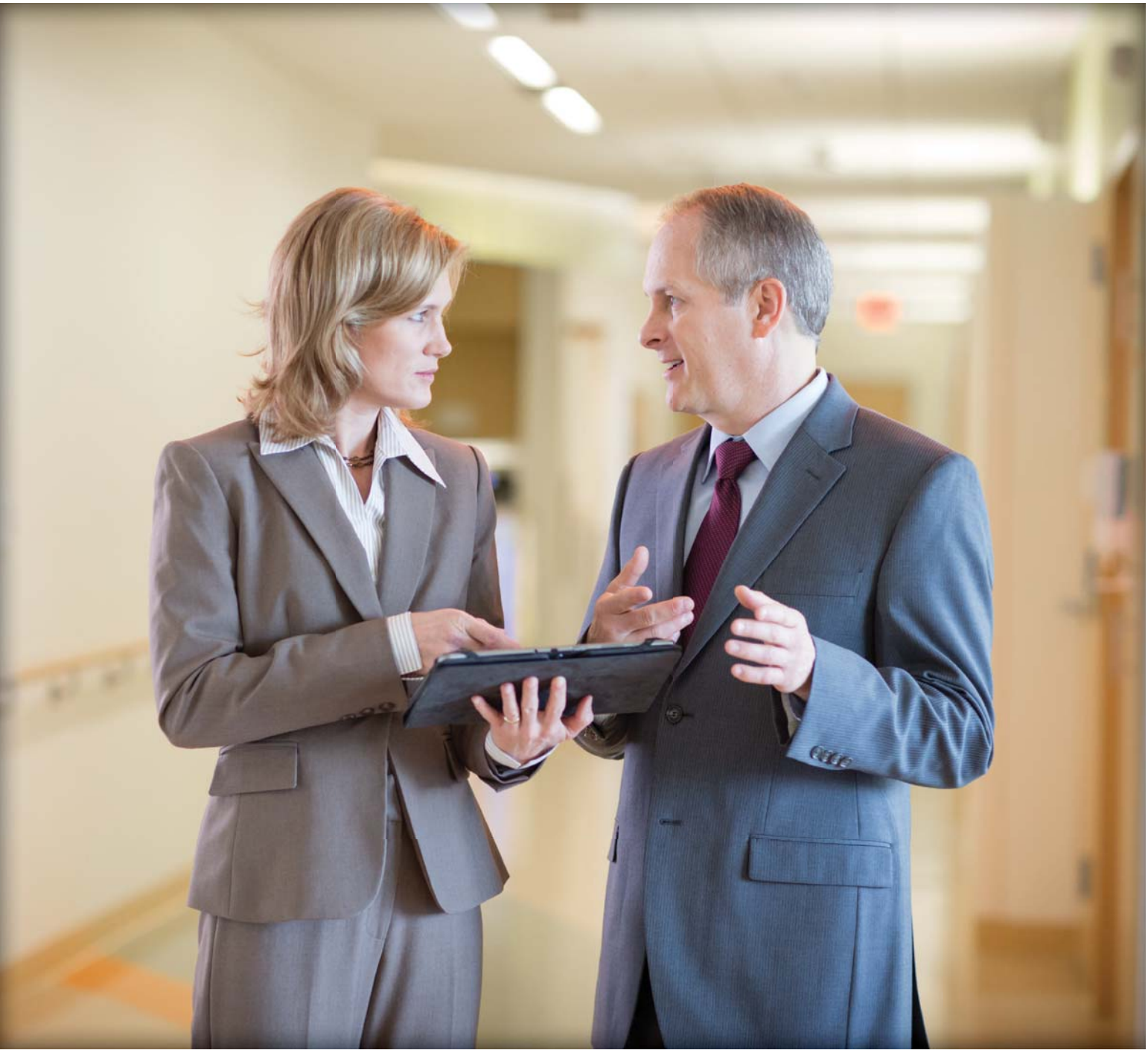


Perspectives

for health plans

FALL 2014

Perspectives

Welcome to the Fall 2014 issue.

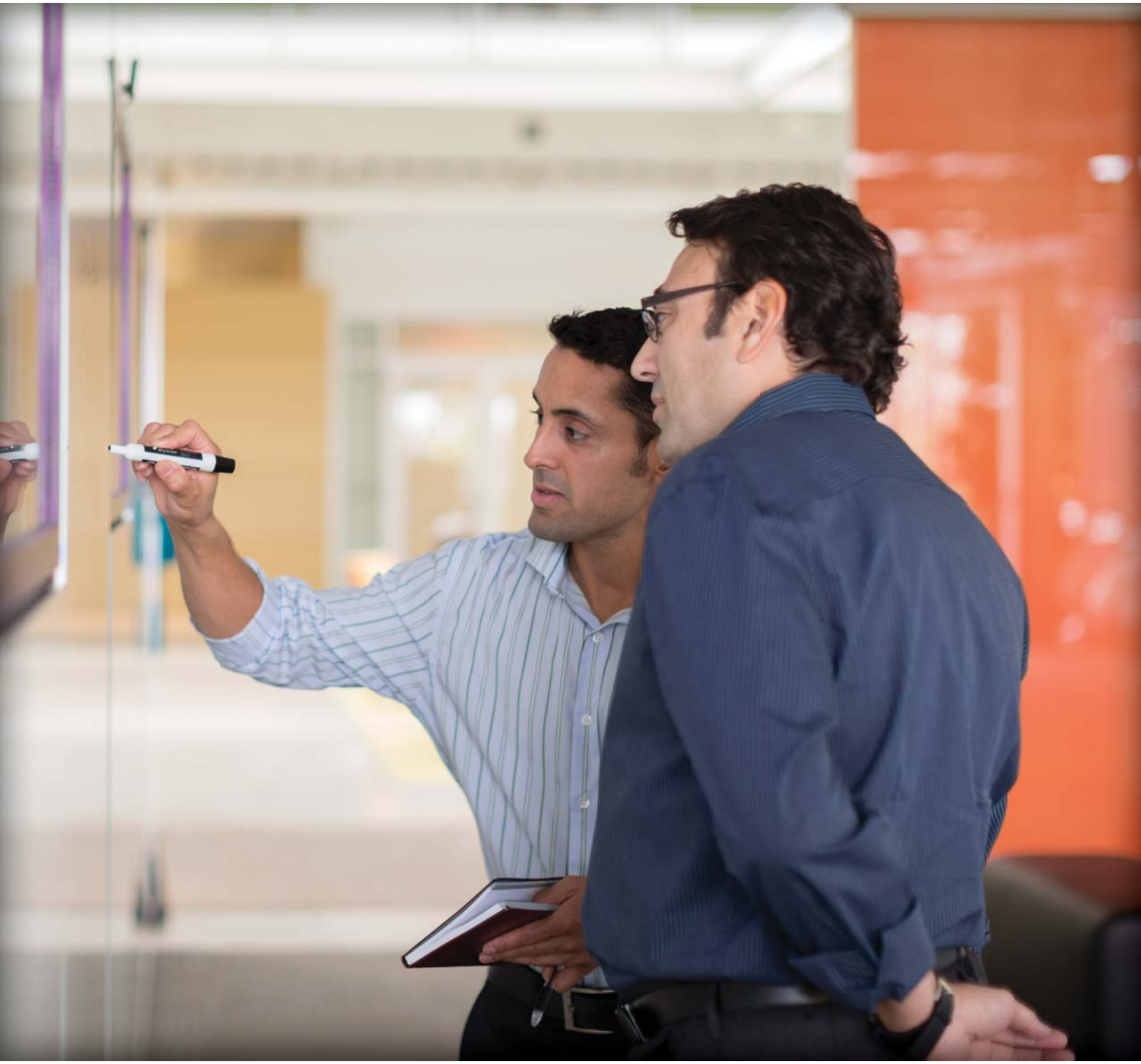
At Optum, we recognize both the challenges and the opportunities health plans have in today's market. We remain committed to understanding the implications of these changes, and bringing together the brightest minds in health care to discuss how to meet these challenges head-on.

This issue of Perspectives features real-world examples and proven strategies health plans are using to navigate the intricacies of designing and implementing a consumer-centric front office, reducing medical expenses through population health management, enhancing engagement with providers and enabling payer provider convergence through analytics and technology.

We hope it serves as a valuable resource to you and your colleagues.

Best regards,

Eric Murphy
President, Payer Solutions, Optum



Benchmarking helps plans identify medical cost management opportunities

Expert presenters

Derek Pederson, Vice President, Medical Informatics Consulting, Optum

Steve Griffiths, PhD, MS
Vice President, Network and Population Health Consulting

There is no question that new regulations are putting pressure on payers (health plans and risk-bearing providers) to explore business models that will allow them to reduce their medical loss ratios (MLRs), strengthen clinical performance and enhance relationships with providers. As part of this process, payers need to consider how benchmarking their performance against local, regional and national norms can help them identify areas of opportunity for harnessing resources, improving care and managing medical costs.

"At the local, state and federal levels, there are lots of new forces — legislation and regulations in progress — that require plans to really rethink their business models and identify new approaches to help them grow and become more effective in how they manage and develop their business," Steve Griffiths, PhD, vice president, medical informatics consulting, Optum, said at a recent Optum Perspectives webinar.

These forces, Griffiths explained, also include new member populations, evolving quality measures and an increasing need for operational and cost efficiencies. "Organizations need to understand how their prevalence rates, cost and utilization profiles, and distribution of services across various categories of care are benchmarked at a population level — and also from a clinical perspective — within episodes of care."

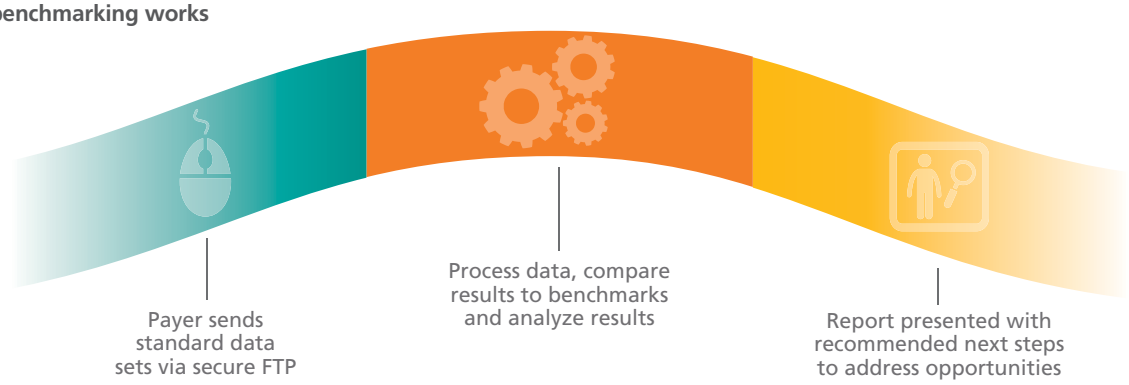
Leverage data to prioritize between multiple opportunities

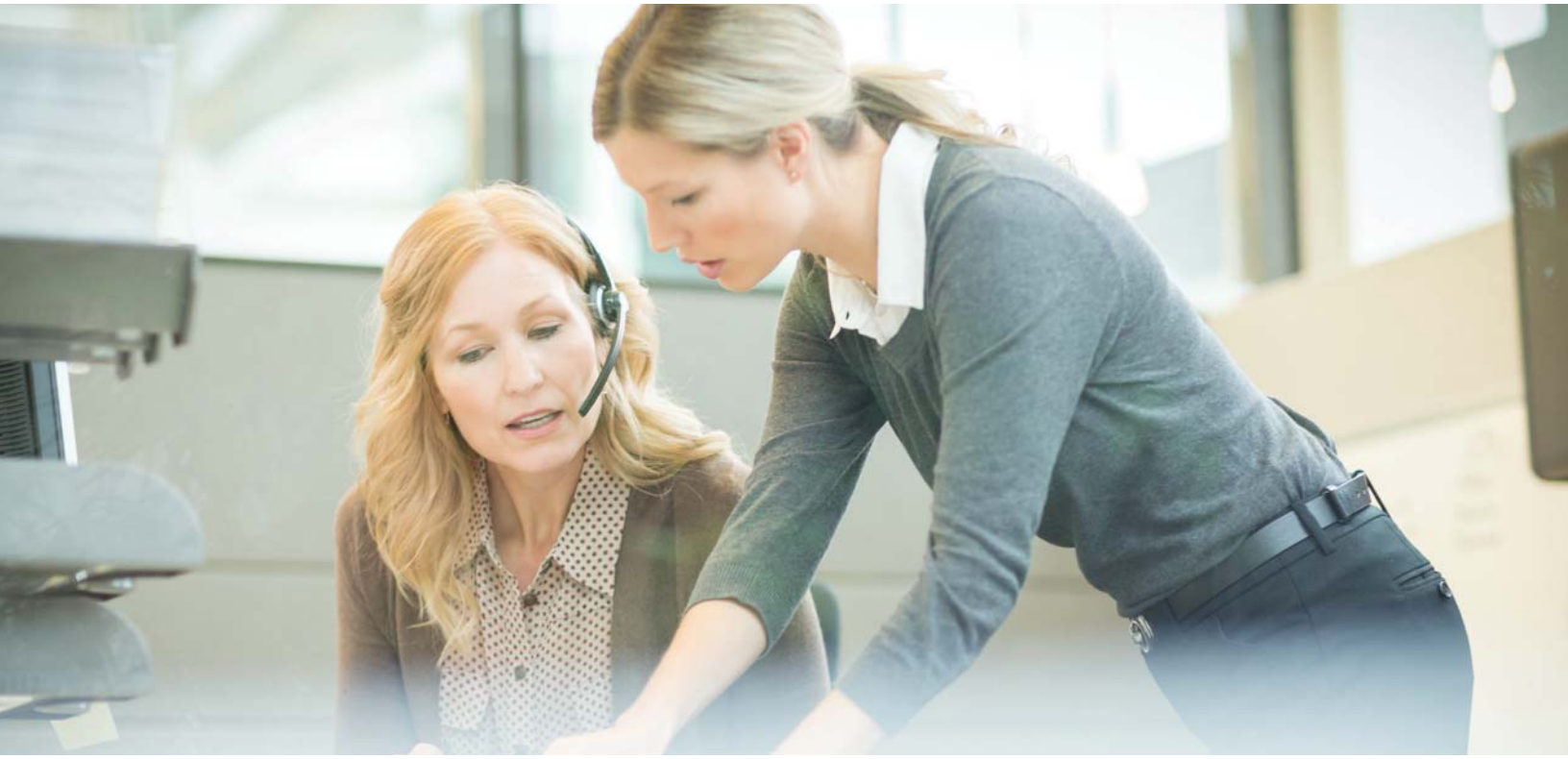
Griffiths told webinar attendees that because plans are working with limited resources, it is crucial to their success that they use the information they have at their disposal "to really prioritize opportunities [for improvement] and have a robust process for remediating those issues." Many plans may not understand that benchmarking can provide a more accurate picture of the plan's current status and help them develop a measured strategy for improving operations and lowering costs.

He described a payer that came to Optum with an MLR that was greater than 95 percent. Plan managers started throwing out ideas that might decrease that rate, such as "we need a transplant program," or "we need a diabetes program," which amounted to little more than "throwing darts at a wall," he said. Instead, before investing in new programs, they first needed to understand what their performance landscape was by using data and comparative information to identify performance issues that should be addressed.

Figure 1

How benchmarking works





Addressing benchmarking challenges head on

Optum conducts benchmarking using simple standard claims along with member and provider data sets "to give us a view of financial, clinical and network performance," according to Griffiths. To reach that high-level view of performance, Optum directly tackles the following benchmarking challenges:

- **Data access** — Optum benchmarks are composed of a multi-payer, multiyear data set of 16 million commercially insured members in all 50 states. It is structured to create a national benchmark, nine regional benchmarks and more than 40 market-specific benchmarks.
- **Common definitions** — Griffiths stated that common, standardized definitions for different types of services are extremely important. As one of its key tools, Optum uses Episode Treatment Groups (ETGs) to help capture all services related to the treatment of diseases and conditions. Age/gender results are then compared to the appropriate benchmark.
- **Opportunity impact** — Benchmark results can only prioritize opportunities if variances are quantified based on a health plan's actual cost information. For example, remediating one area may save $2 million per year but remediating another area could save the plan $30 million per year.

> *Indeed, comparing a payer's results to benchmarks not only will help plans prioritize where to put resources, but also will verify that current payer programs, such as disease management, care management and network initiatives, are producing the intended results.*
>
> *— Derek Pederson*
> *Vice President, Medical Informatics Consulting, Optum*

Using benchmark results to monetize opportunities

Indeed, comparing a payer's results to benchmarks not only will help plans prioritize where to put resources, but also will verify that current payer programs, such as disease management, care management and network initiatives, are producing the intended results, according to Derek Pederson, vice president, medical informatics consulting, Optum. Pederson explained that plans should benchmark data covering inpatient facilities, outpatient facilities, professionals and episodes or conditions.

During the webinar, Pederson described a plan that demonstrated a high level of inpatient/emergency department utilization (73.8/1,000) compared to benchmarks. Optum looked at moving the plan's admit rate per thousand down to the median benchmark in the Mid-Atlantic regional rate (51.7/1,000), which would save the plan between $80 million to $90 million per year.

An additional level of analysis could identify the primary care providers who may be responsible for the patients being admitted for avoidable conditions and identify the hospitals and systems where readmissions are occurring most often. "Our goal is to leverage the data to create that monetization … to focus on those opportunities that will make the biggest difference in MLR or total cost of care," Pederson said.

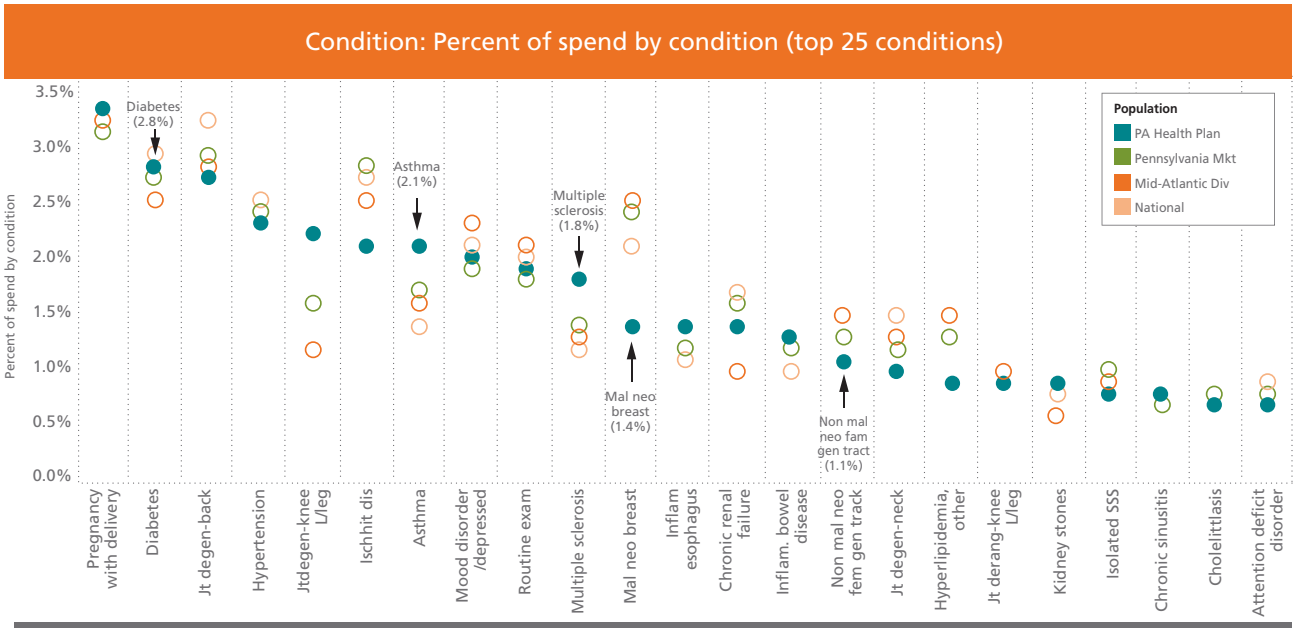
> *Our goal is to leverage the data to create that monetization … to focus on those opportunities that will make the biggest difference in MLR or total cost of care.*
>
> *— Derek Pederson*
> *Vice President, Medical Informatics Consulting, Optum*

By benchmarking the top 25 conditions driving the cost of care, plans can leverage the Episode Treatment Groups that differ from traditional cost and use benchmarks, he continued. For example, if a plan has a gender-adjusted knee replacement rate at the 93rd percentile, moving that rate to the median rate (43rd percentile) would yield a savings between $32 million and $39 million per year.

Further, taking a closer look at specialty pharmacy spend for the plan could help the plan determine "if there are opportunities to partner with the pharmacy benefit manager and the medical care management team to impact the cost trends," Pederson noted.

Figure 2

Top 25 conditions driving total cost of care



As a proportion of overall spend, diabetes, asthma, obesity and multiple sclerosis, are all above benchmark rates. Joint degeneration of the knee and lower leg is substantially above the benchmarks. Note: Percent of spend is not age/gender adjusted.

Developing a plan of action

When considering benchmarking, Griffiths said, plans need to focus on engagement and system change as they move from collecting and analyzing data to taking action. He noted that benchmarks alone will not effect change — instead the payer must organize resources to effect that change and maximize the improvements. The following elements are integral to this change:

- Strategic plan
- Executive support and investment
- Program management
- Measurement and tracking tools
- Contracting evolution/aligned incentives
- Network optimization
- Population health — optimization

Plans also should be aware that "knowing how similar or dissimilar some of these important measures are compared to local, regional and national benchmarks — measured in the same way and viewed from a financial, clinical and network perspective — helps to provide a road map" regarding which areas to remediate, Griffiths said. He concluded by adding that the benchmarking process can be updated on a regular basis to identify ongoing system change and to help refocus priorities in the future.

> *"Benchmarking supports a greater focus on being more effective from an operational perspective as well as being strong around clinical issues."*
>
> *— Steve Griffiths*
> *Vice President, Medical Informatics Consulting, Optum*

"Benchmarking supports a greater focus on being more effective from an operational perspective as well as being strong around clinical issues," he said. "It allows plans to use information in an impactful way to create change."

How Optum can help

Benchmarking can provide a more accurate picture of your health plan's current status and help you develop a measured strategy for improving operations and lowering costs. Optum directly tackles the following benchmarking challenges:

- Data access of 16 million commercially insured members in all 50 states
- Common definitions to help capture all services related to the treatment of diseases and conditions
- Opportunity impact by quantifying variances based on a health plan's actual cost information

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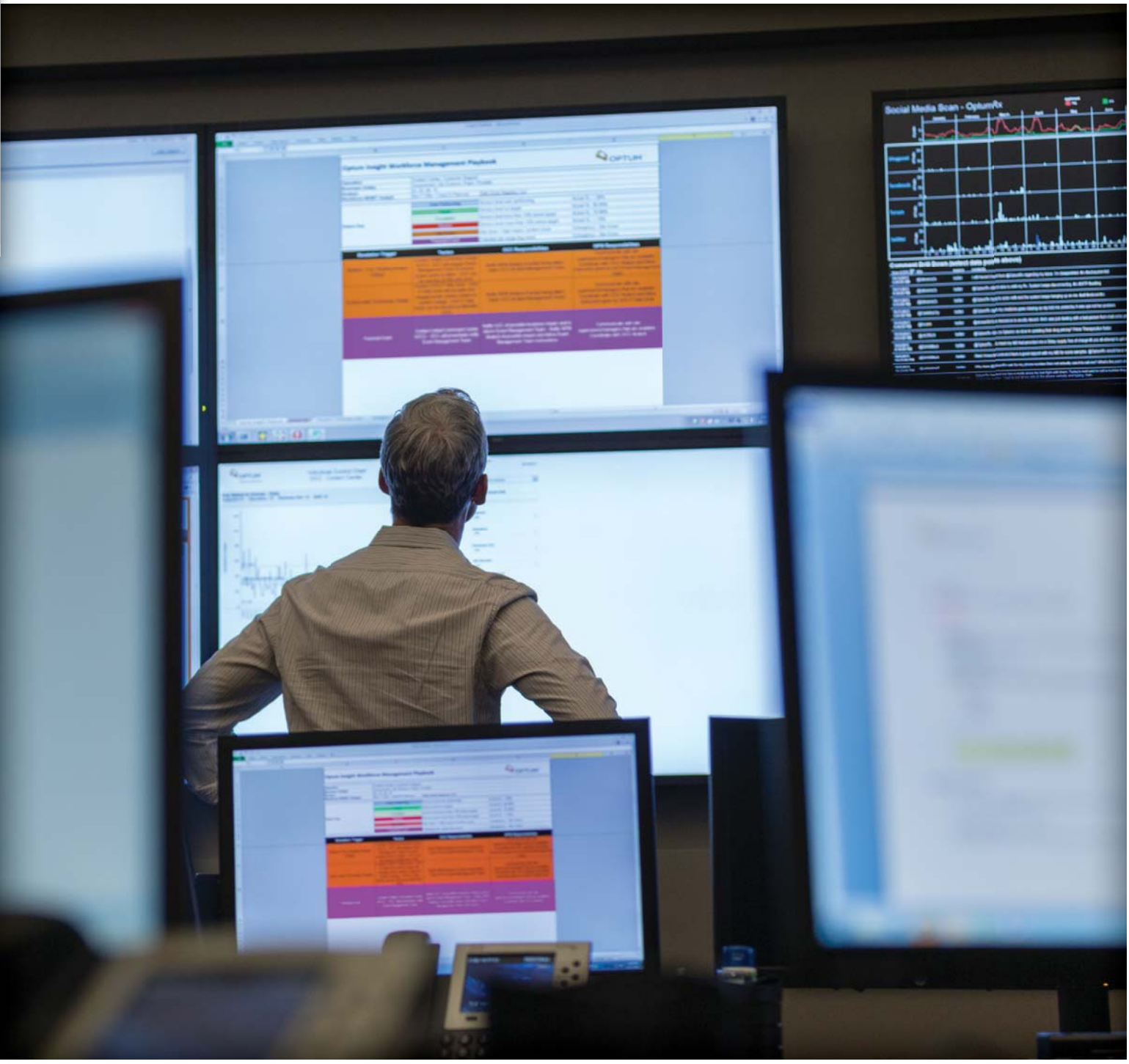


IT strengthens payer-provider partnerships as VBR arrangements take hold

Expert presenters

David Chennisi, Vice President, System Integration, Optum Payer Consulting

Dean Farley, PhD, MPA Vice President of Provider Reimbursement, Optum Payer Consulting

New reimbursement models, changing regulatory dynamics and broad quality initiatives pressure providers and health plans to increase their focus on the value of health care services being delivered for the premium dollar. This shift in focus causes risk to be transferred from payers to providers, blurring the distinction between the two entities. It also drives both entities to forge relationships that maximize mutual resources — experience, tools, technology and data — in order to lower costs and improve the quality of care. IT plays a critical role in this convergence, according to Dean Farley, vice president, provider reimbursement, Optum payer consulting.

"The winners in this process will be the payers and providers who figure out how to collaborate, how to share information and how to use technology to enable higher quality and lower costs," he said. "I think it's safe to say that in this context, technology plays a fundamental role," Farley said at a recent Optum Perspectives webinar, "Payer/provider convergence and IT's critical role as enabler."

Farley explained that providers may need to rely more on payers to help them manage the risks they are assuming in value-based reimbursement (VBR) arrangements, because plans have data and technology assets that providers do not possess. "A provider typically doesn't see all of the care that is being given to a patient," he said. Providers know what they are doing, but unlike health plans which see claims for all services related to a patient, they do not see the patient's big picture, he continued. For risk transfer to be successful, payers and providers will need to work together toward a common goal.

Technology is a powerful tool in VBR realm

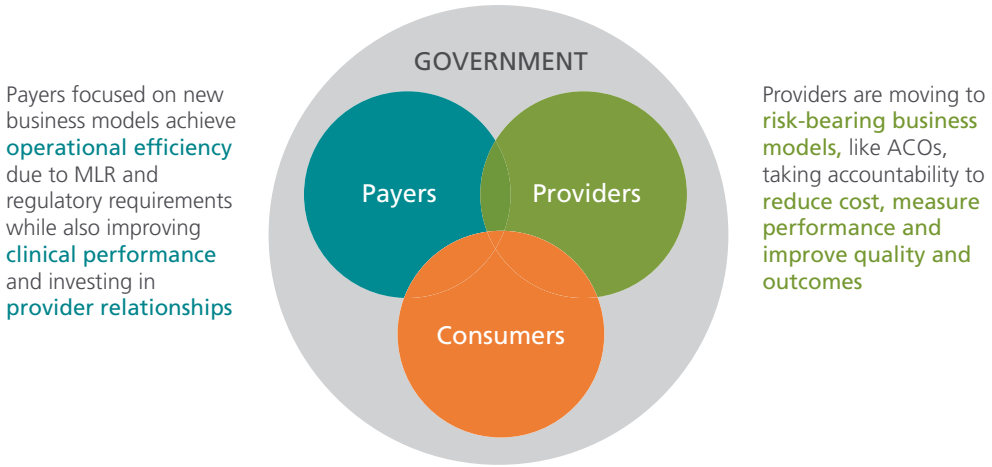
Farley noted that although medical technology continues to make great advances, those advances come at great cost. "The question is how do we begin to evaluate which technologies are worth the cost? And how can we create incentives that encourage providers to adopt cost-saving or at least cost-effective technology?" he asked. "The answer is to place providers at more risk and align incentives between payers and providers."

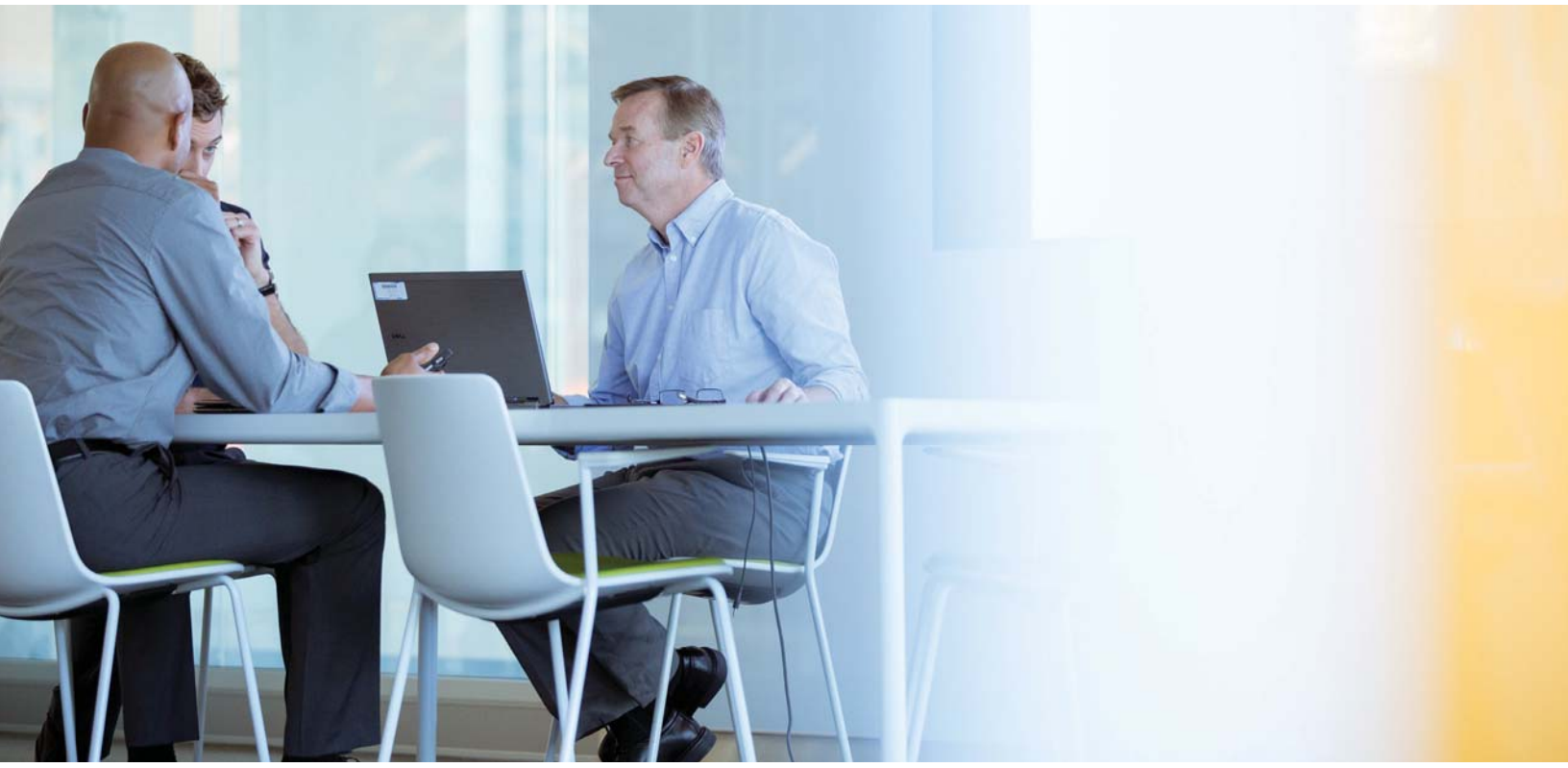
To do this effectively, benefit plans cannot "just dump risk on providers or consumers and wish them luck … they need to view providers and consumers as partners and work with them. Payers have the resources to build the infrastructure that will be needed," Farley explained. He advised plans to consider the following

Figure 1

Emerging relationships and value-based models

The **convergence** of payers and providers requires **new technologies** and **value-based service models** to comply and compete — or even just survive





questions as they assess whether their infrastructure will support these risk-sharing arrangements:

- Can your systems manage risk-based arrangements?
- Are your systems connected in real time to EMRs?
- How will you use integrated member/patient data to drive improved outcomes?
- How can you help providers create their own capabilities and/or support them?

Successful VBR implementation starts with data

Optum believes that data is the foundation of payer/provider relationships. Payers and providers "need to move toward having a common view, or common methodology for data analytics and information in order to make sure that all parties have timely access to appropriate clinical information and are able to perform clinically meaningful risk adjustment," David Chennisi, vice president, system integration, Optum payer consulting, told webinar attendees.

Plans have "an enormous and significant asset" in their existing infrastructure that has been developed over decades to support their own risk management, such as actuarial services, decision support services, data management and claims capabilities, Chennisi said. "There's an opportunity for plans to make available pieces of what they do to provider organizations with whom they are partnered in VBR relationships," he added.

> *"There's an opportunity for plans to make available pieces of what they do today, to provider organizations with whom they are partnered in VBR relationships."*
>
> *— David Chennisi*
> *Vice President, System Integration, Optum Payer Consulting*

"Health plans need to review their capabilities and evaluate how to package themselves. Plans need to understand the segments in the market," Chennisi continued. "It's important to take a look at what combinations of capabilities can be offered to the marketplace." Chennisi suggested that plans ask themselves the following questions:

- Do you have online tools for performance measurement? Paper tools?
- Do you have the ability to integrate with the electronic medical record (EMR) and provide clinical records?
- Can you create a centralized portal for engagement with providers?

Plans do not have "to bite everything off in one fell swoop," Chennisi remarked, and can prepare for a logical progression where the information gets "where it needs to be over time," which "is in the hands of the clinician, right at the point of care. The process can start with passing specific data to an individual's EMR and then move over time to a communitywide view of the patient with appropriate access and collaboration. Finally, data would move into the zone of population health management, supported by real-time data and analytics."

Optimizing information management will improve quality of care

Chennisi walked attendees through a map of information flowing among payers, providers and members. The more advanced functionality of shared data assets results when utilizing the health plan's clinical analytics platform (fueled by claims data collected by the plan), the member/patient engagement interface, the provider engagement interface and, significantly, the real-time health information exchange (HIE) infrastructure.

The HIE "is where things really get exciting, because it lets multiple organizations share important clinical information electronically," according to Chennisi. "This improves the timeliness of data and allows providers to consume and process clinical information using their own systems, not someone else's system," he said.

Farley remarked that as providers are being asked to increasingly participate in or even own specific core management functions, such as medical homes being responsible for case management or care coordination, underlying technologies and functions are the tools through which they can get the job done. "Analytics that are looking at financial, operational and clinical outcomes, trying to understand what is working and what is not working, and figuring out why can be embedded in the corporate strategy," he noted.

In closing, Farley set forth the following takeaways that are critical to understanding where the health care industry is headed:

- Value-based contracting blurs the distinction between benefit plans and provider organizations — indeed there are insurance companies running health clinics and providers running consumer outreach campaigns.
- A commitment to value-based contracting requires far more than new financial arrangements between benefit plans and providers. "This isn't just about incentives," Farley said. "It's about building a shared infrastructure and having a shared commitment to increasing the value that patients are receiving for their money."
- The purpose of value-based contracts is to create mutual interest in managing the health of a population efficiently and effectively.
- Plans must support their network of providers along both clinical and administrative dimensions.

Figure 2

Segmented strategies for effective network management

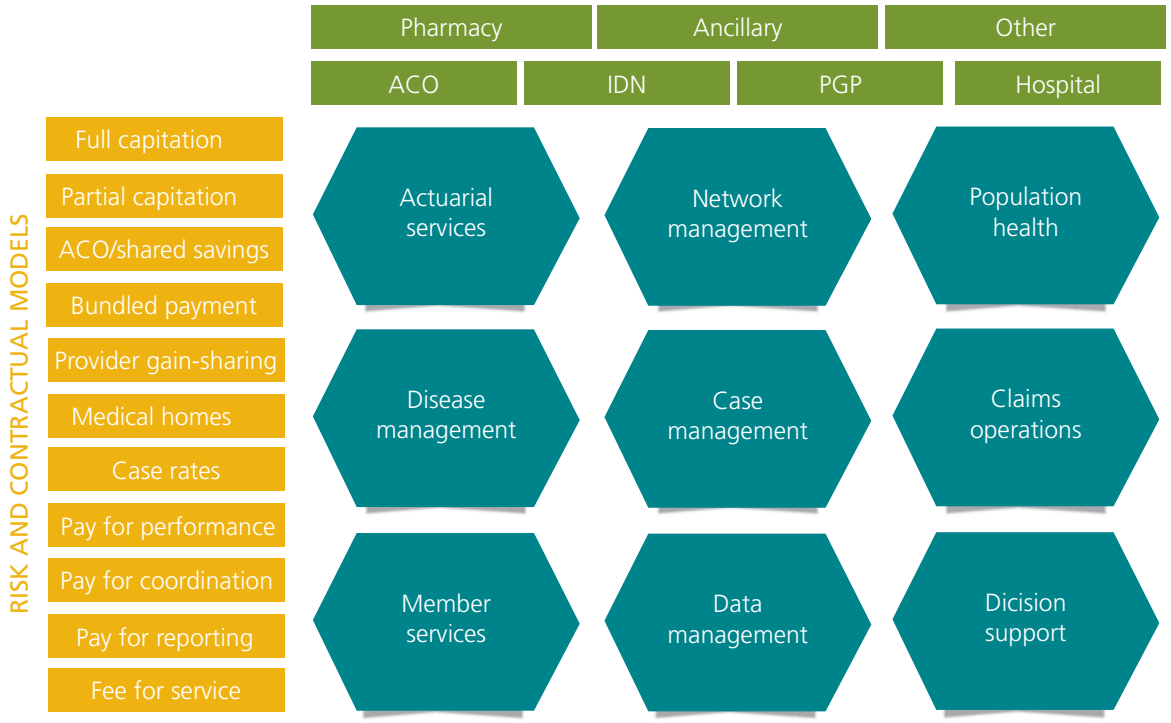
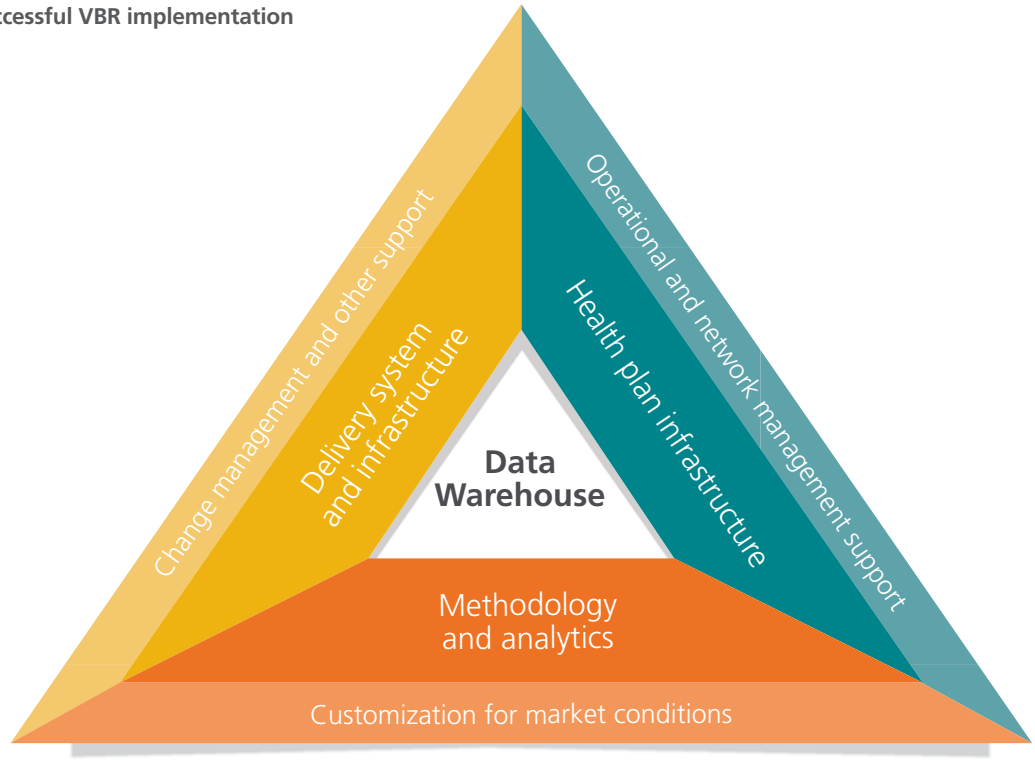


Figure 3

Keys to a successful VBR implementation



- The most effective plans will take time to segment the providers they work with and establish a provider-support framework.
- Provider organizations must lead the way in managing the medical expenses for which they are at risk, with plans as their partners.
- The most successful providers will take advantage of the infrastructure created by benefit plans to use clinical information and new care models effectively.

"When providers are at risk as a result of [VBR] arrangements, they play a leading role in some of the medical management functions," Farley concluded. "The challenge is to leverage technology across organizational boundaries and to enable these functions and drive improvements in care."

How Optum can help

The health care market trend of payer/provider convergence requires flexible, scalable services to plan and implement new risk-based business models that improve the quality of care. Optum can help health plans and other risk-bearing entities integrate their IT and business strategies and position them for growth with:

- Value-based Reimbursement (VBR) strategy development, and technology and operational assessments
- VBR contracts, metric alignment and reporting
- Systems integration, configuration and development, and an analytics data warehouse to provide actionable data

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Provider engagement has a major impact on quality, costs and outcomes

Expert presenters

Stephanie Will, Vice President, Risk Adjustment, Optum

Steven Mueller, Senior Vice President, Business Platforms and Operations, Optum

Because health care market dynamics now impose risk adjustment and quality standards on financial performance across all market segments — Medicare Advantage, Managed Medicaid and commercial plans — in order to balance risks, improve quality and decrease costs, health plans must move beyond retrospective claims analysis and basic assessments. To optimize potential health plans must fully engage those who serve on health care's front lines: providers.

Providers are the linchpin in improving plan performance, according to Stephanie Will, senior vice president Optum, who spoke at a recent Optum Perspectives webinar, "Enhancing Engagement with Providers to Improve Cost, Quality and Revenue Outcomes." She explained that plans are underperforming for a variety of reasons, many of which involve a lack of adequate interaction and engagement with providers.

A changing market presents obstacles

Due to market changes, new obstacles are taking hold, such as member movement, coding variables, physician resistance, and documentation and data accuracy. However, she noted that overcoming obstacles to plan success is not easy. "If it were easy, everyone would be doing it," she said.

In light of these obstacles, plans should focus on the following actions:

- Prioritizing and refreshing a list of members to engage — "Don't treat all members equally," Will said. "Focus on those who can have an impact on the plan."
- Overcoming physician resistance with physician engagement tools and services
- Filling gaps in physician engagement with member engagement tools and services, "so assessments are beneficial to both"
- Establishing an overall performance management infrastructure

Figure 1

Why are plans underperforming?

> *Successful organizations "don't treat risk adjustment and quality as a separate area," Will said. Instead, these organizations make these elements "a core part of their organizational strategy and the foundation of their funding mechanism".*
>
> *— Stephanie Will*
> *Vice President, Risk Adjustment, Optum*

Plans can work toward these goals by using a best practice model that employs multiple steps on a continuum.

Successful organizations "don't treat risk adjustment and quality as a separate area," Will said. Instead, these organizations make these elements "a core part of their organizational strategy and the foundation of their funding mechanism."

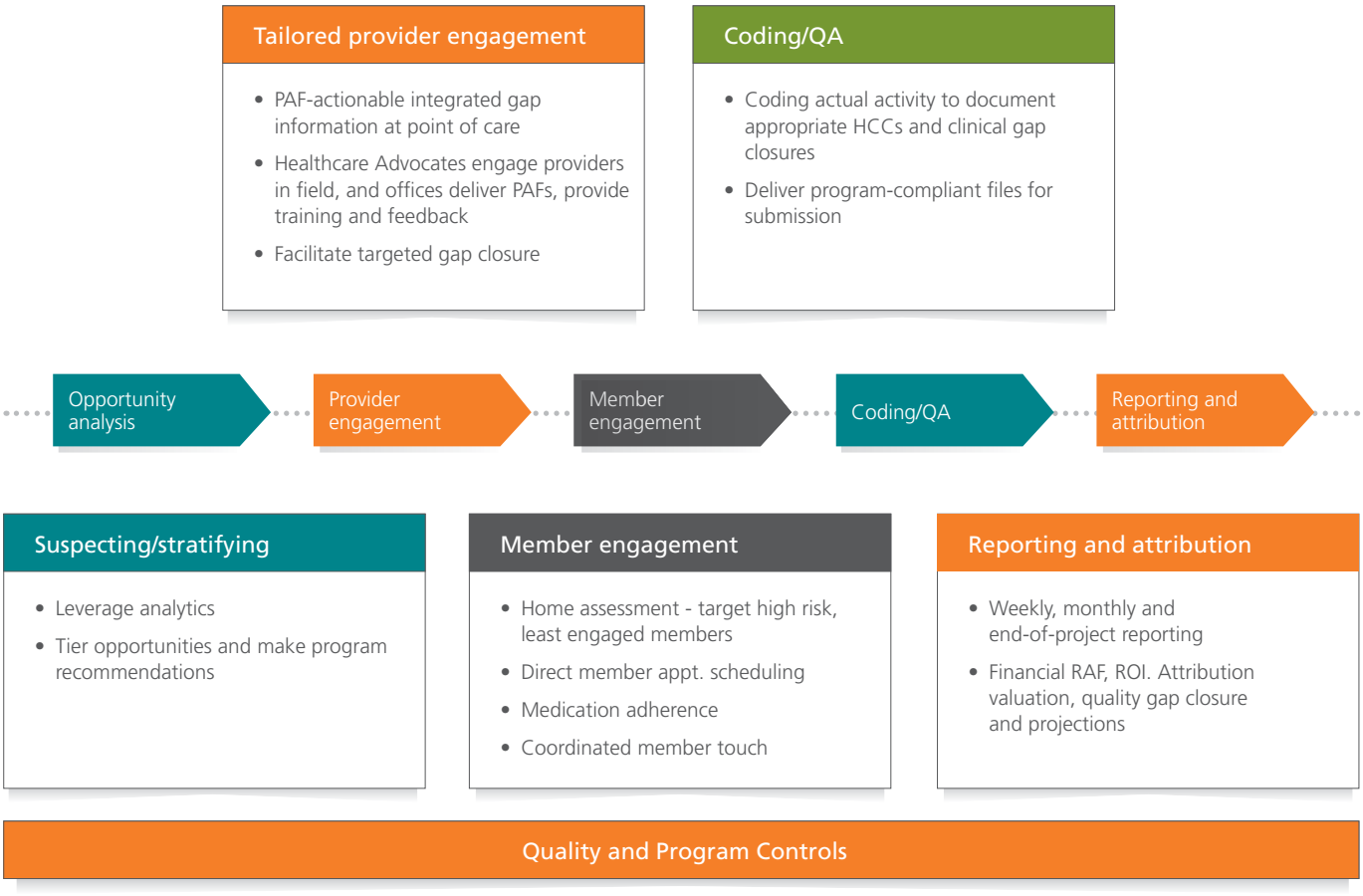
Focus first on top tier opportunities

Steven Mueller, senior vice president, business platforms and operations, Optum, told webinar attendees that although getting started down the path toward better provider engagement may seem daunting, plans should focus first on the top 30 percent of the member population which typically drives "about 90 percent of all of your care gaps." Of course plans also need to provide "foundational support" to the remaining 70 percent of the member population, but honing in on the members who are at greatest risk "puts the right capabilities in place to close care gaps," he said.

For example, plans can support providers serving members in the top tier by recapturing previous hierarchical condition categories (HCCs), embedding clinical extenders or establishing physician champion programs. This support often will yield improved closure of previously identified care gaps, improved comprehensive review of suspect data with patients, and improved verification of suspects, Mueller said.

Figure 2

Best practice model



He also explained that plans have to identify where their providers are on the spectrum of physician engagement and then develop plans to move them along on that continuum, recognizing that there is not a single approach that will work for every provider. "We especially want to move physicians up to the 'engagement continuum' where they have responsibility for the members that have the most significant care gaps," he said.

"This should be a very focused effort," he continued, adding that Optum deploys Coding Educators to work side by side with physicians, and it helps to ask provider relations teams to work with and influence physicians "to really make a difference" by assessing high-risk populations and bridging care gaps.

"It's exciting when you see physicians start to understand how to code better and get through the critical membership faster and more accurately," Mueller stated. Further, with proper engagement, providers "apply better quality standards documentation along with their assessments to make sure that everything passes a quality audit."

Three stage of engagement

Plans generally are at one of three levels in terms of their provider engagement: (1) no foundation/just starting out; (2) foundation exists, but needs enhancement; or (3) foundation is established, but refinement will enhance results.

No foundation. Plans without established risk-adjustment programs need to start with a foundational infrastructure," Will told attendees, adding that capitalizing on engaged physicians will drive results. She said that plans should have at least the following "boxes checked" as they build their foundational programs:

- Opportunity analysis/targeting (identify members to engage to achieve expected value and ROI cut points)
- Retrieval (use basic analytics and retrospective chart review)
- Coding/QA (ICD-driven, possibly CPT®)
- Reporting and attribution (program value and attribution reported by provider and member attributes, and comprehensive weekly, monthly and end-of-project reporting)

Will also stated that establishing a foundational model has been successful in improving the documentation of risk. If plans are not seeing a progression in risk score improvement, they should ask "Is that appropriate? Does that feel right?" she said. "People often want to know what their risk score 'should' be, but there is not a standard answer. Your risk score should reflect the burden of disease in your population … and you may need to employ more tactics or solutions to reduce risk exposure."

Limited foundation. Plans that already have a foundation in place should add suspecting analytics, member outreach and provider engagement to the mix. For example, "plans have to do that recapture or their scores will drop, but they need to move past recapturing," Will said.

Figure 3

Provider participation strategies

Strategy

- Sophisticated management process for supporting provider participation
- Escalation path defined
- Leverage Healthcare Advocates to engage with providers to resolve issues
- Year over year analysis of PNPs and engagement strategies for each chart review project period

Resources

- Strong Client Management team
- Healthcare Advocates leverage previously established relationships with providers and their staff
- Supporting teams clinically trained with subject matter expertise in RA Services; located in provider communities

Reporting

Provider Not Participating Summary

PNP Reason Code	Site ID Count	Total Charts
PNP001: Provider Office Not Responding	70	2304
PNP002: Provider Refused Chart Review	24	1303
PNP007: Requesting Chart Reduction	1	488
PNP009: Requesting Payment	37	368
PNP004: Phone/Address Data Invalid	39	134
PNP016: Requesting Legal Consent	1	96
PNP003: Provider No Longer At Address Given	8	36
PNP012: Provider Data Fails Verification	6	32
PNP010: Member Data Fails Verification	4	8

Health plan value and results

- Increased provider record retrieval participation
- Improved provider satisfaction rates
- Weekly PNP reporting by reason code including days pending to resolution

Established foundation. After plans have a firm foundation in place, they can extend the suspect analytics, along with member and provider engagement. During this stage, Optum typically deploys an "outcome lead" or a "quarterback" to manage in the market and in the field, according to Mueller, "where we have that physician treating the membership and making sure that we iterate on that data from that physician to an annual assessment process. We are constantly bringing that data into our engine and rerunning that engine to stratify the membership to ensure that we are always focused on the highest uncovered recapture or suspect opportunities in a blend that we establish with our clients."

Will then described some provider participation strategies plans can use to assess where they are and what they can do to get to the next level. "I don't believe there is enough you can do to engage with your providers," she told attendees. The message for plans on both the provider and member side "is that you don't want to treat everyone the same," she said. "You have to figure out how to meet the providers where they are and help them to take the next step up the spectrum to be in that effective, engaged quadrant."

Engagement solutions yield results

Mueller then shared a case study covering a physician organization serving 27,000 patients in the Southwest United States. The plan was concerned that it was leaving patient conditions undetected, and it faced challenges with its physician and member engagement. Among several activities, Optum provided people, processes and technology to assist clients in such areas as:

> *"I don't believe there is enough you can do to engage with your providers."*
>
> *— Stephanie Will*
> *Vice President Risk Adjustment, Optum*

- Network assessments
- Analytics to identify high-priority patients on an ongoing basis
- Member outreach
- Meaningful reports for physicians to support patient quality of care
- Capabilities to improve the documentation and coding process

The results, Mueller concluded, were increased Medicare Advantage star ratings, increased patient visits for high-priority patients, improved risk scores and increased awareness of the physician practice by reopening and staffing a clinic location.

"If we can get members onto care pathways early, we will decrease costs over time and accurately reflect the costs of the programs needed to treat that membership and ultimately improve health outcomes," Mueller said. Optum "uses the data analytics that work best across the organization to drive through processes with the most important assessment tool that we have: the relationship between the physician and the member."

How Optum can help

In order to balance risk, improve quality and decrease costs health plans must move beyond retrospective claims analysis and basic assessments. To optimize potential, health plans must fully engage those who serve on health care's front lines: providers. Optum can provide help to people, processes and technology in areas such as:

- Network assessments
- Analytics to identify high-priority patients on an ongoing basis
- Member outreach
- Meaningful reports for physicians to support patient quality of care
- Capabilities to improve the documentation and coding process

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Consumer-centric front office uses data, outreach to engage members

Expert presenters

Lori Stevens, Senior Vice President, Payer Solutions, Optum

Herschel Reich, Vice President, Actuarial Consulting, Optum

Clay Heinz, Vice President, Business Development, Optum

As new requirements wash over our health care marketplace, we are reminded of how far behind we are regarding consumerism when compared to other industries. Under the Affordable Care Act, health plans have been striving for a business model that shifts away from being employer-centered and puts consumers at the center of their organizations. To truly become a "consumer-oriented" organization, payers must design and build effective consumer-centric front-office structures that will help them grow and retain membership, manage costs and improve the member experience, according to Lori Stevens, senior vice president, Payer Solutions, Optum.

"Consumer centricity has an impact on every aspect of a plan — it is a journey and not a destination," Stevens said in a recent Optum Perspectives webinar, "Building a Consumer-centric Front Office." "As we start this journey, one of the interesting concepts is that there is no single application or business process that suddenly makes a plan more consumer-centric."

However, payers can start by placing more emphasis on consumer engagement, knowing that this effort will also help with their plans' other primary front-office priorities of channel optimization and business process transformation. Prioritizing consumer engagement efforts allows plans to:

- Develop and execute against a consumer strategy
- Provide personalized tools and services that drive positive behavior decisions and lead to cost-effective decisions
- Evolve business-to-business infrastructure to support emerging market demands

Stevens noted that to fully realize these goals, plans need better data. "Consumers expect real-time experiences though legacy systems, and disparate data hinder payers' ability to deliver upon these new consumer expectations," she told webinar attendees. "Data is a key capability and aggregation, and use of that data in a consumer-centric world is a key priority of payers moving forward."

"Big data" can help plans with consumer goals

"Big data" is a collection of high-volume, high-velocity and high-variety information assets that demand cost-effective, innovative forms of information processing for enhanced insight and decision-making. If rendered actionable, big data can help plans implement the four key elements of consumer-centric solutions, according to Herschel Reich, vice president, Actuarial Consulting, Optum.

As Reich explained, these elements are:

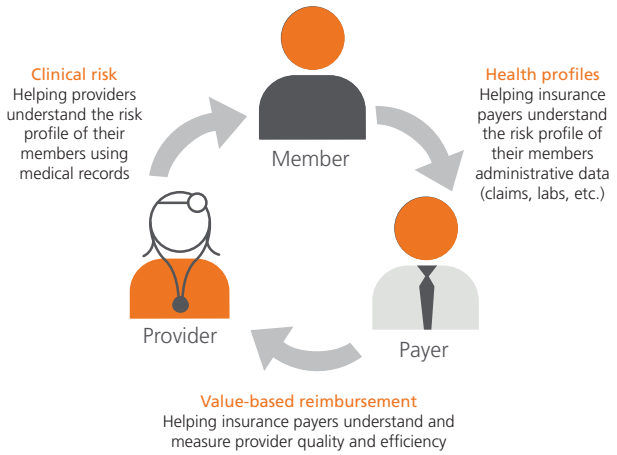
- **Personalization.** Health care is intensely personal. Payers need to close the information gap between buyers and sellers and act more like leading retailers and financial firms in their ability to understand and meet unique customer needs and preferences.
- **Seamlessness.** Payers need to ensure efficient consumer experience — information and access need to be in real time, and care and service needs to be readily available.
- **Simplification.** Ease of use and comprehension are built on the backbone of the data. Payers need to make it easy for consumers to interact with the health care system.
- **Transparency.** Transparency goes beyond making health care costs, quality ratings and other information readily accessible; it involves building consumer trust that plans will be an appropriate shepherd of the data.

Reich illustrated how big data applications can transform the health care space. For example, he stated that by using enhanced data that is available beyond claims, companies can improve their prediction of health care spending. Further, plans can pair their knowledge of who might be more likely to use services in a

> *"Consumers expect real-time experiences though legacy systems, and disparate data hinder payers' ability to deliver upon these new consumer expectations."*
>
> *— Lori Stevens*
> *Senior Vice President, Payer Solutions, Optum*

Figure 1

Use cases in health care



preventative, wellness or care management setting with actionable data. "Using big data is not a far-fetched, futuristic approach," Reich said. "It is being explored today by companies looking at predictive risk factors or markers for chronic disease."

Advanced analytics and sophisticated data tools also can help companies with market segmentation, customer service/staffing models and network analytics. "Companies are using big data applications to create a single point of view or a single source of truth, across platforms and products, to guide all customer interactions," he added.

Consumer centricity prompts more efficient staffing

Shifting the front office's focus to consumers — and the unique staffing demands imposed by the significant seasonality of the consumer sales period — creates great opportunity to drive efficiency in your operations, Clay Heinz, vice president, business development, Optum, told webinar attendees. He remarked that these seasonal demands place more emphasis on operational scalability, as there is little opportunity to accumulate tenure in your front-office organization.

Additionally, supporting multiple business segments has a tendency to create multiple communication "queues". He remarked that with a blended model, a consolidated selling season can reduce staffing requirements by up to 40 percent and better meet member needs. "There is an opportunity to cross-train phone representatives to accommodate both [Medicare and ACA] product lines," he said. "There could be a 40-percent staff reduction if you are willing to invest the time into quality representatives and train them on supporting multiple business segments. Where that becomes really relevant is the slow season," he continued.

Along with seasonal demands comes a slow period. For sales, this is the Q2/Q3 time frame and for service operations, just the opposite. During the off-season, he explained, these well-trained sales staff (who are well-versed in all of the plans) can help consumers

Figure 2

Health care contact center operations

Seasonal requirements demand scalable contact center solutions

Recruitment	Recruiting the right employee for the right form of member engagement • Online profiling tools • Proper licensing
Training	Scalable training solutions to meet seasonal demand • Trainer Certification • Quick curriculum development for real-time adjustments due to regulation updates or communications
Compliance	Constant watch on the changing regulations while still close to operations
Performance	Clear visibility into key performance indicators create a performance-based culture • Changes to the marketplace drive changes in KPIs • Align incentives throughout the operation

navigate their plans' particulars and understand their options, which enhances the consumer experience. "That proactive activity drives retention, reduces inbound inquiries throughout the year and drives loyalty within the membership base," he commented.

One consumer engagement strategy that Optum has had success with this year is training call center representatives to reach out to members who have not paid their premiums. "Using that seasonal workforce to reach out [enabled] the plan to retain membership and drive upwards of a 96-percent retention rate on members who had signed up during the open enrollment period. We blended some educational messaging to create an 'onboarding' concept and also leveraged a dynamic HRA to coarsely asses the risk."

Ensuring that contact center solutions are scalable during all seasons requires a "deep dive into operations," Heinz said. Plans must take a closer look at recruitment, training, compliance and performance indicators in order to operate a successful health care contact center.

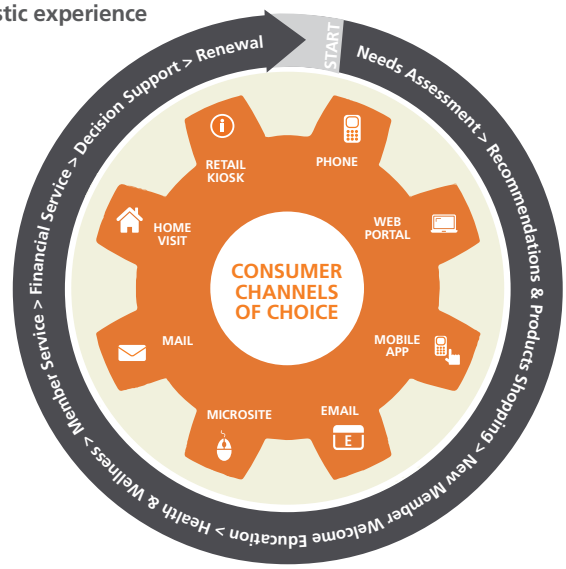
Channel of choice is crucial to engagement success

Plans seeking a consumer-centric front office also should recognize that if they are not using the consumer's "channel of choice" — including web, email, phone, text, click-to-call or click-to-chat channels — to communicate with that member, they are not optimizing their outreach efforts. In other words, Heinz said, "consumers are more likely to buy and more likely to leverage medical management programs" if plans are communicating with them via the channels they prefer. Channel of choice "is becoming table stakes," he said. If you are not able to engage multiple channels in your front office, there is an opportunity to do so either through outsourcing or in upgrading your communication platform."

Heinz concluded that plans need to look at consumers in a holistic manner. "I am amazed by how much time and energy is spent with consumers during the sales process that is rarely parlayed into how you engage those consumers once they've made that purchase. There is an immediate opportunity to parlay pre-sales information into post-sales engagement, leveraging some of the big data applications." He also described the ideal member value chain, which is only possible through a holistic consumer experience.

Figure 3

Holistic experience



"Just as seasonality has impacted our business and places significant demands on our operations, we also find ourselves in a cycle with our members, where they can select a new brand year after year," Heinz said. Stressing that a front-office focus on the consumer is good business, he asserted that engaging consumers, though better analytics, responsive call centers and meaningful, well-placed outreach, is "critical to drive loyalty and retention proactively and reactively throughout that member lifetime."

How Optum can help

Optum assists our clients in effectively targeting, acquiring, retaining and maximizing the right customer relationships through integrated technology platforms, services and consulting solutions. With proven methodologies, customizable tools and experienced professionals, we provide insights in the following areas:

- Analysis and evaluation to optimize new markets and new channels
- Transformation of business processes to drive data integration and improved workflow efficiencies
- Consumer engagement and retention through personalization and member support

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Visit optum.com
or call 1-800-765-6807.

Biographies

David Chennisi, Vice President, System Integration, Optum Payer Consulting

Chennisi has more than 30 years of experience in the health care industry and is a key leader in the Optum Payer Consulting Practice. His teams are responsible for successful systems implementation and integration projects spanning core administrative claims adjudication, medical management, business intelligence/data warehouse, and customer relationship management applications. Prior to Optum, Mr. Chennisi served as CIO at Texas Children's Health Plan.

Clay Heinz, Vice President, Business Development, Optum

Heinz is responsible for developing new business concepts at Optum. As Vice President of Client Practice, he lends his expertise and innovation to payers, providers, employers and government entities in the health care marketplace. Prior to joining Optum, he worked for Extend Health as an innovator in the early years of exchange-based sales.

Steven E. Mueller, Senior Vice President, Business Platforms and Operations, Optum

Mueller is the leader of Physician Transformation and Provider-based RAF Prospective Services activities for Optum. Prior to joining Optum, Steven was the CIO for UnitedHealth Networks Physician and Hospital Contracting as well as led the Network Technology and Integration since 2002. He brings over 20 years of experience in the Operations and Technology industry.

Dean Farley, PhD, MPA, Vice President of Provider Reimbursement, Optum Payer Consulting

Dr. Farley is a health economist with more than 30 years of experience managing and conducting research on health care financing and reimbursement. He currently manages a consulting practice focusing on payment reform and payment analytics within our Networks and Population Health business.

Steve Griffiths, PhD, MS, Vice President, Medical Informatics Consulting, Optum

With over 17 years of experience in the health care industry, Dr. Griffiths oversees the Medical Informatics consulting practice within Optum. His team focuses on provider support and improvement initiatives, care management consulting, and program evaluation. Griffiths has spoken nationally on statistical variation in outcomes measurement and works with other experts in the industry to develop recommendations for addressing small population sizes.

Derek Pederson, MA, MBA, Vice President, Medical Informatics Consulting, Optum

Pederson is an informatics consultant at Optum. He has 19 years of experience in health care reporting and analytics applying episode- and population-based case-mix adjustment methods. He leads a team of informatics consultants that work closely with payer, provider and employer group clients to leverage data to answer complex business questions and improve operations.

Herschel Reich, FSA, Vice President, Actuarial Consulting, Optum

Reich is Vice President, Actuarial Consulting for Optum Payer Consulting. In this role, he manages the Optum New York Office. Reich is currently leading the Optum Actuarial Toolbox and Specialty Benefits consulting practice. He has over 25 years of experience with health plans in actuarial, management and strategy roles, the last 10 with Optum.

Lori A. Stevens, FSA, Senior Vice President, Payer Solutions, Optum

Stevens is Vice President and General Manager for Optum Payer Acquisition and Retention solutions. In this role, She is responsible for the strategy and business development of payer sales solutions supporting modernization, efficiency and growth goals. Stevens joined Optum in 2000 and has over 20 years of experience with health plans in actuarial, management and strategy roles.

Stephanie Will, Vice President Risk Adjustment, Optum

Will leads Market & Client Strategy for the Optum Risk Adjustment and Quality business. She has over 17 years of experience within the health care and managed care industries including, 10 years within the nation's largest Medicare Advantage plan. Will has extensive experience in risk adjustment across all markets.

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