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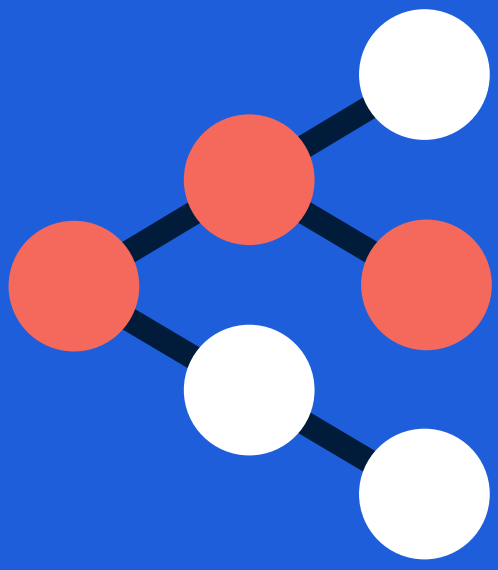
How to Differentiate Yourself in an Increasingly Value-Focused Ecosystem

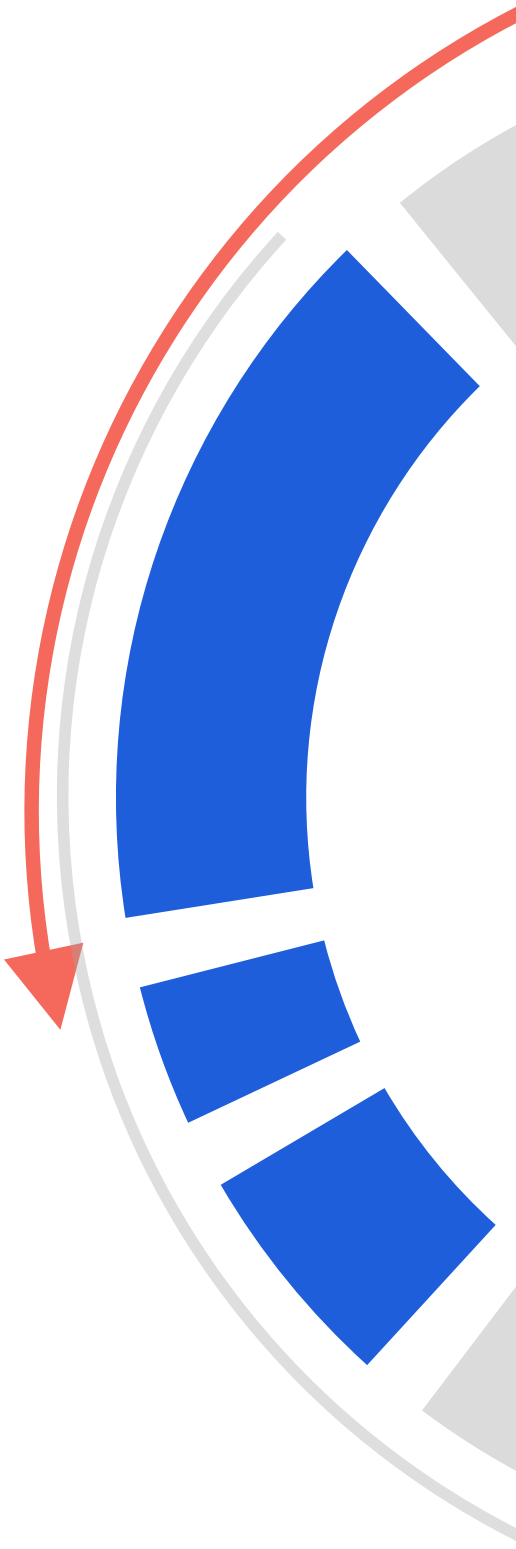
Start focusing on prospective opportunity over retrospective cost



Things used to be so simple. The recipe for a differentiated ASO value proposition included a wide provider network, competitive provider discounts, and a smorgasbord of clinical programs.

Today, the reality is much different. The standalone value of discounts is deteriorating, and health plans are being asked to assume new and more complex forms of risk tied to total healthcare costs. So how do you stand out? And, as employers expect more from their health plans and PBMs, how can you create, quantify, and communicate a unique value proposition to support your growth and retention objectives?

The answers to these questions are not simple. Having experience with a number of health plans that have executed on their transformational objectives, however, has provided insight on a number of "Best Practices" that should be considered when generating new strategies. All of these start with technologies that enable data-driven decisions around both member and provider engagement, with the ultimate goal of improving health, managing total costs, and measuring outcomes.



6 **proven** best practices for forward-thinking health plans

1. **Risk must be evaluated across benefits.** The importance of cross-benefit health management has become more significant due to the substantial increase in pharmacy spend as a proportion of total healthcare costs. Payers are being asked to manage a member's total health — not just medical utilization or drug compliance. The challenge, however, is understanding how impacting utilization of one benefit (e.g., drug compliance) affects utilization on the other (e.g., reduced ER visits) and accurately assessing the value these whole person health management strategies will generate when implementing (and selling) programs with risk-based pricing mechanisms.

2. **Retrospective utilization must be balanced against forecasted opportunity.** When deciding who to prioritize for clinical intervention, it's tempting to focus on the members with the highest utilization rates. After all, these members have a history of driving a disproportionate amount of your spend.

   But in order to bend the cost curve, it's just as important that you understand your emerging risk and impact members before they incur exorbitant costs. The right models (and technologies) don't just look backward at a member's utilization — they also forecast how likely each member is to utilize healthcare services in the future. This includes predicting members who will develop chronic conditions, or who already have a condition that hasn't yet been diagnosed — enabling earlier interventions to prevent or better manage these conditions. Your value is determined by how well you manage future outcomes, not how well you report upon what's happened in the past.

3. **The individual (and, historically, siloed) components of your health management strategy must be aligned with each other — and with your larger financial goals.** Every clinician's top priority is improving member health outcomes—and rightfully so. However, many of the risk stratification tools traditionally used by clinicians differ from the tools used by actuaries and underwriters in their evaluation of risk. As payers take on new forms of risk based on the way their organizations manage total healthcare costs, it's important that their clinical and financial constituencies are aligned so they receive credit (i.e., are reimbursed) for their activity.

   To achieve this more holistic alignment, health plans need a framework that directly and transparently ties clinical outcomes to financial opportunities. The right (translation: transparent and intuitive) model attaches financial value to the mitigation of negative outcomes so that all stakeholders understand the value of steering members toward high value providers, closing gaps in care, enabling earlier interventions for those with emerging chronic conditions, and avoiding high-cost events.

4 **Member behavior must be maximized through multi-modal outreach.** A risk stratification tool that perfectly identifies the riskiest members is worthless unless a health manager can connect with members and get them to take action. In our experience, the most successful organizations employ a multi-modal approach to outreach — telephonic, digital, and provider-centric. Whatever risk stratification tool you use, make sure it can inform outreach through a variety of modalities.

Health plans need clear answers on which modalities are most effective (something that could differ depending on subpopulation), and which members are most likely to engage with a care management plan. Done right, incorporating these insights into the development of care-outreach programs delivers results that far exceed the incremental. One national insurer found that, after implementing technology that provided full reporting on multi-model program performance, members identified as highly likely to engage were 2.6 times likelier to change their behaviors as a result of clinical outreach.

5 **Your reporting tools must give providers the information they need to be successful.** Providers can be a force multiplier for any health management strategy. But your analytics and risk-sharing strategies must be designed to incentivize providers to move from a fee-for-service mindset to a value mindset. Reporting tools that identify treatment patterns and can tie them back to individual providers can be a powerful tool for motivating a shift toward whole-person health.

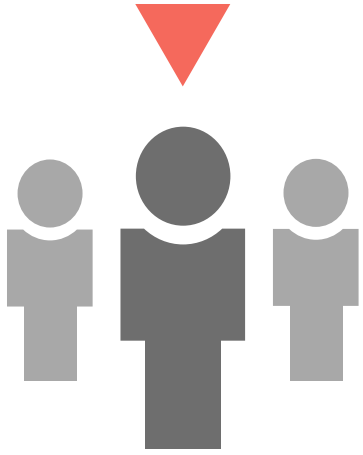
6 **Proactive, transparent, and timely performance reconciliation is critical.**
Discerning the retrospective value of any clinical program is hard — especially when evaluating savings across benefits. The truth is, few organizations do this well. That's why it's important for health plans to have a transparent and timely method for tracking program performance — for their own reference *and* for conversations with current and potential clients. Indeed, when multiple parties are vying to take credit for affecting positive outcomes, the vendor with the most timely and understandable performance reporting will win.

Case Study

How we helped one national insurer differentiate on *value,* achieve **$200 PMPY** in plan savings

Challenge

A large national health plan was seeking to transform its value proposition for winning and retaining ASO business by replacing standard industry pricing with a shared-risk arrangement where compensation would be based on member health and cost outcomes.



Underlying Problem

The insurer lacked a data and analytics hub capable of supporting this new value-based approach. It needed a vendor that could:

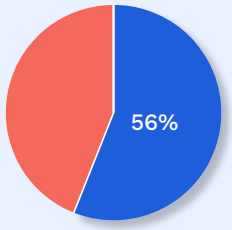
- Integrate and unify data from 18+ traditional and non-traditional sources
- Accelerate its AI/ML capabilities
- Align financial and clinical incentives with insights that could be quickly disseminated to key stakeholders
- Provide a transparent mechanism for measuring, tracking, and reconciling results with customers

Solution

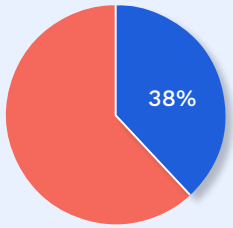
The national health plan worked with Certilytics to transform its value proposition from a focus on retrospective cost to prospective opportunity. This enabled a "whole person" health management model that received a positive reception in the market and was successfully implemented with dozens of new customers representing millions of members.

Results

- The new model generated **$200 PMPY** in plan savings across benefits.
- As a percentage of total cost per member, **inpatient admissions dropped from 56% to 38% after just one year.**
- For high-risk members in particular, **the health plan increased actionable savings opportunities by nearly 3x.**
- In addition, **members identified through propensity for engagement modeling were 2.6 times likelier to change their behaviors** as a result of clinical outreach.



Year 1



Year 2

Saving money, improving utilization patterns—and understanding why

The challenges health plans must overcome to succeed in value-based care are myriad, multifaceted, and diverse. Some involve drivers that are outside of any one entity's control — such as SDoH, the rise of specialty drugs, or, say, a global pandemic — but the solutions needed to successfully confront the challenges are all connected by common threads.

The most successful health plans will continue to prioritize flexible, modern technologies that allow maximum scalability and adoption without costly technology dependencies. They'll align their financial decision-making process with their clinical and utilization management strategies — across all population health programs and stakeholders. And they'll focus on turning their data into opportunity by leveraging it to uncover prospective opportunities — across medical and pharmacy benefits, for populations with known and emerging clinical risks, and under shared and full-risk models that providers recognize require a new spirit of collaboration and open communication.

Ready To Learn More?

For a free consultation with our team of experts, contact us here:
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