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White Paper

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How to Engage Providers Differently to Satisfy the New Healthcare Consumer

Transforming provider relationships can be the key to engaging consumers

U.S. health plans today operate in a world of rising expectations. They must work to contain increasing healthcare costs, while at the same time cater more to consumers. Members are the ultimate users of healthcare and health plans can no longer seek to solely satisfy the demands of employers. Health plans are redesigning their networks in search of value—finding the providers who deliver the best quality care, preventing health problems before they occur, and doing so efficiently and cost-effectively.

In addition to the economic and regulatory pressures forcing change, health plans are subject to the same digital business trends impacting every other industry. Health plans are becoming digital products. Consumers increasingly pick their plan online, whether through a government-run exchange or a portal operated by their employer. They expect that online experience to be a good one, and will be sorely disappointed if it's not. The same is true for providers. They are looking for a good digital experience when they interact with the health plan.

This is something consumers and providers have in common—a demand not only for a better digital experience, but a good overall experience. That means providing accurate, up-to-date information, and making it as convenient as possible to enroll and use one's coverage. The health plans that do the best job of seizing the opportunity to engage with providers and consumers in a positive way will be the ones that thrive in the new healthcare economy.

Already **20 major health plans** have pledged to convert 75% of their business to value-based arrangements

Consumer satisfaction; and designing high-quality, cost-effective networks are interrelated goals. Transforming provider relationships can be the key to meeting all of them.

Recognizing this, Florida Blue and McKesson are working together to break down the silos between the organizations and information systems that serve providers and consumers. Our goal is to provide better service and strengthen loyalty from both constituencies.

By engaging providers differently, with streamlined tools and business processes, we believe we can reduce administrative and medical costs, improve member health outcomes, and make Florida Blue the plan of choice for providers as well as members.

Analysis of four current trends:

1. **Value-Based Reimbursement**
   By the end of 2016, the federal government plans to shift 30% of Medicare payments to alternative payment models, such as Accountable Care Organizations or bundled payment arrangements. By the end of 2018, that will go to 50%[1]. Already 20 major health plans have pledged to convert 75% of their business to value-based arrangements[2]. Half of the commercial business for Blue Cross and Blue Shield of Massachusetts is tied to these new models. Aetna is up to 28% for its business as a whole[3]. Overall, a McKesson study found that two-thirds of payments will be tied to value-based measures by 2020[4].
2. **Consumerization**
   Consumers are playing an ever-bigger role in the U.S. healthcare system. For starters, 16.4 million people gained health insurance coverage through the Affordable Care Act[5], which means they shopped for and picked their own plan. Even in the context of employer-provided plans, more responsibility is being shifted onto employees. Overall, patients now pay almost 25% of medical bills and 37% of the cost of health benefit premiums[6]. In part, this reflects a deliberate strategy of exposing consumers to more of the true cost of healthcare and health insurance, so they are motivated to be part of the solution for controlling costs. They are feeling the change: 40% of consumers say healthcare costs strain their family budgets[7]. In 2014, roughly 50% of the products sold on exchanges were narrow-network plans[8], where consumer bargained away a degree of provider choice in return for lower premiums.

During the average month up to **3% of provider data** becomes outdated

3. **Healthcare Cost Management**
   U.S. healthcare spending has reached $2.9 trillion annually[9], and one of the biggest complaints about it is that too much of that goes to administrative overhead. Claims processing is estimated as a $400 billion expense[10]. Providers spend $31 billion annually interacting with payers[11]. Excess administrative costs—those we ought to be able to eliminate—are pegged at $190 billion annually[12].
4. **Regulatory Compliance**
   Regulatory change is occurring on multiple dimensions as a result of the Affordable Care Act and The Centers for Medicare and Medicaid Services (CMS) initiatives. One aspect that deserves more attention: As consumers are increasingly tasked with choosing the provider network that's right for them, they need accurate and useful information about whether providers and services (such as pharmacies they use or want to use) are included in the plan. State and federal regulators are taking note of situations where that's not the case—where, for example, too many of the providers listed are not, in fact, taking new patients and therefore are not realistic options for new members. CMS is setting minimal requirements for "network adequacy.[13]" Meanwhile, 29 states have set price transparency standards (and eight states have made them particularly stringent) so consumers can get a better picture of the bottom line when considering a given network and a given premium[14].

How can we focus on each of these trends?

1. **Value-Based Reimbursement**
   Design provider networks to steer consumers toward the providers with the best value measures; i.e., the best health outcomes in proportion to cost. While new care models elevate the role of the consumer—by encouraging them to demand less expensive early interventions over more expensive hospitalizations—we also need to ensure the economic and contractual incentives for providers are aligned in the same direction. Providers must be incentivized to encourage healthy behaviors and order preventative tests, such as cholesterol screenings and mammograms.
2. **Consumerization**
   Design custom networks for targeted populations. Give consumers the current and accurate information they need to choose a plan and providers within the network. We're expecting consumers to take on more financial and decision-making responsibility in this new era of healthcare, but we can't expect them to become economists or legal experts. We need to explain their options in plain language and provide tools for calculating the costs of alternative plans. One of the most important considerations for consumer plan choice is which providers are included in a given network. It is crucial to ensure that provider directory data is accurate and up to date. The worst thing we can do is encourage consumers to choose a plan they believe includes a favorite primary care physician, only to find out later the provider has dropped out of the network or had their practice acquired by a non-participating organization.

Excess administrative costs are pegged at **$190 billion** annually

CMS is setting minimal requirements for "network adequacy"

3. **Healthcare Cost Management**
   Streamline processes to reduce the cost of claims and other administrative overhead, keeping expenditures focused on actual care. Our dialog with providers should revolve around quality care and positive outcomes rather than administrative functions and transactions. We can do this by eliminating unnecessary rework, resubmission of claims, and appeals; by allowing providers to see their claims processing status online; and by paying them right the first time. In a similar way, when a customer calls, we want to provide them with the right answer on the first call as often as possible. This needs to start with streamlined provider enrollment, during which we clearly communicate to providers how they will be paid for participation in the network and then promptly update the network provider directory. Delays and errors in this process have a ripple effect, presenting consumers with a false view of what services will be covered, frustrating consumers and payers with unpaid claims, and wasting time and effort trying to reconcile inconsistencies. Bureaucracy doesn't make anyone healthier or happier.
4. **Regulatory Compliance**
   Stay ahead of government requirements. For example, provider directories are expected to be accessible to the public and machine readable, so they can be consumed by other healthcare apps. Directories must also be updated regularly. The exact time limit might change according to rules either pending or in force, but we expect the time window to shrink to a matter of days before long.

Several of these points touch on the importance of the provider directory. Keeping the directory current might not sound like a big deal, but it is. A single payer may be supporting hundreds of provider networks, each targeted at a different demographic and with different providers enrolled. Simply keeping all of them straight becomes a challenge.

In our experience, during the average month up to 3% of provider data becomes outdated. Providers move, stop taking new patients, drop out of the plan, or have their practices acquired by hospitals or larger practice management groups. Without continual updates to an online directory, those discrepancies accumulate rapidly.

The threat of fines and other regulatory action related to inadequate networks and inaccurate provider directories should get your attention. For now, the crackdown on inaccurate directory data has been limited to a few egregious examples. We expect to see more of this if payers fail to take these new regulations seriously. Consumers who feel they've been misled about the scope and quality of a network will make sure their legislators hear about it.

But that's not the biggest reason to change how we do business. This is an opportunity to ask, "What if we're thinking and going about this all wrong?" Instead of lamenting the consequences of failing to act, why not celebrate this transition as an opportunity to excel? Instead of focusing narrowly on the regulatory or technical challenges associated with providing accurate provider directories, consider making that more accurate information part of a broader redesign of your relationship with providers.

By definition, a good relationship is not an adversarial one. Too many providers have been trained by negative experiences with payers to treat them as the enemy. When providers are dissatisfied, they're not shy about sharing their opinions with patients. And more so than ever before, those patients are the consumers we need to impress if we are to win and keep their business.

Consumer and provider satisfaction, and the design of a high-quality and cost-effective provider network are all interrelated goals. Providers who have the right quality characteristics and know they're in demand will sign up and stay with payers who are easy to do business with.

The presence of those quality providers will make a network more attractive to consumers.

Patients now pay almost **25% of medical bills** and **37% of the cost** of health benefit premiums

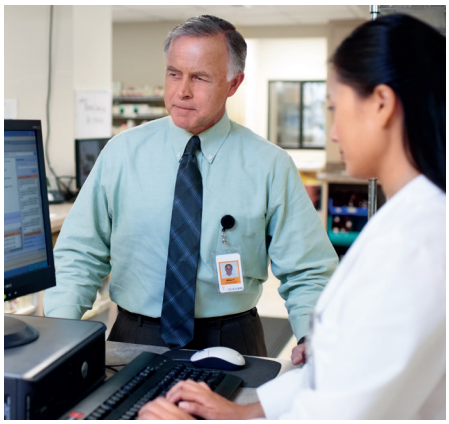
Transforming your provider relationships can be the key to:

- Engaging consumers
- Reducing friction with providers
- Aligning your network with value-based reimbursement
- Containing costs
- Mitigating regulatory risk

This is the strategy being pursued by Florida Blue, which believes the provider relationship with the payer is core to the entire provider and member experience. As a result, Florida Blue is breaking down silos in their organization and technology infrastructure to make certain data can flow between internal systems and both consumer and provider portals. To present accurate information to consumers, Florida Blue is striving to make it as easy as possible for providers to update their information.

In fact, Florida Blue understands it must be easy to do business with in general by providing accurate and up-to-date information on fee schedules and credentialing information as well. New providers should be able to enroll and self-create a profile the same way.

Florida Blue's goal is an easy self-service experience that rivals online banking, another consumer experience that has set high expectations for what people expect from a digital business. Think about that for a minute: How many of us physically go to a bank branch and fill out a deposit slip anymore? We expect up-to-the-minute, accurate information about our bank balances, which checks have cleared, auto-payments, and so on. Why should healthcare be different?



Florida Blue has its share of high-cost, inflexible legacy systems standing in the way of this vision, and anticipates a three- to five-year migration to a new platform. Still, the goal is clear, and the plan is in motion.

So as you think about your network design and provider relationships, we encourage you to think big about what's possible. How do you compete differently and attract consumers to the network that's right for them? How do you steer them to the right providers who will provide high quality, high value care?

The initial concern we're hearing is about making sure consumers understand who is in the network. Long term, that needs to evolve to helping them understand the pricing, quality, and value associated with each provider. That, in turn, will make it even more important to court the providers who shine by those measures.

Fortunately, as you improve cost and quality transparency, you also make it easier for the highest-value providers to benefit from membership in your network. Handled properly, this transition should benefit payers, providers, and consumers, too.

About McKesson

McKesson Corporation, currently ranked 11th on the FORTUNE 500, is a healthcare services and information technology company dedicated to making the business of healthcare run better. McKesson partners with payers, hospitals, physician offices, pharmacies, pharmaceutical companies and others across the spectrum of care to build healthier organizations that deliver better care to patients in every setting. McKesson helps its customers improve their financial, operational, and clinical performance with solutions that include pharmaceutical and medical-surgical supply management, healthcare information technology, and business and clinical services. For more information, visit www.mckesson.com.

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