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Increased Automation, Communication Drive Improvements in Back-Office Results

In the midst of an industrywide shift toward value-based care and big data analytics, insurers are doubling down on efforts to streamline their back-office operations, turning to old-fashioned communication and new-wave automation to improve claims processing across the delivery system.

Last month electronic medical records (EMR) provider athenahealth, Inc. issued its annual PayerView, a report ranking more than 200 payers in areas such as how quickly claims are paid and how often they are denied. Cigna Corp. took the No. 1 spot, unseating Humana Inc. — which claimed the highest ranking the past four years running — but a mix of regional plans, Medicare Part B payers and Blues plans rounded out the rest of the top 10. (Humana came in fifth.)

The major insurers excelled in enrollment efficiency, while Blues plans logged the lowest number of days a claim spent in accounts receivable — the report's "most important metric," Kim Green, senior payer intelligence manager, wrote on athenahealth's blog. Medicare Part B payers had the highest rate of resolving claims on their first submission.

Capital BlueCross, which was ranked second in the report, says it is continually looking for improvement opportunities both in the company's current IT capabilities and from other vendor offerings, as well as looking at ways they can build solutions in-house, according to Vice President of Operations Shawn Scott. The insurer sees its second-place PayerView ranking as a testament to those efforts, she says.

"I think a lot of the impact on the athenahealth survey is what the providers, the hospitals and the providers think of us, and we work hard," she says. "Once we get that claim in from our providers, that we turn around quickly and accurately."

Keith Vargo, executive vice president of sales, marketing and strategic relationships for Oregon-based PLEXIS Healthcare Systems, says value-based care has changed the game when it comes to how administrative operations function.

"A decade or so ago when you talked to a potential customer, it was about your functional requirements or the functionality that your system brought to bear," he tells *HPW*. "That's still important but it seems the conversation nowadays is more on, 'Tell me about your technology and your architecture. Tell me about how I can extend your platform to communicate with a care coordination system to coordinate with this much longer ecosystem of solutions.'"

Staff analysts look for points along the operational process where there is a high chance of error or a potential for automation. Removing the human element is another crucial component of streamlining claims and other administrative services, which Anita Anita Nair-Hartman, vice president of strategy and business operations for payer business at Truven Health Analytics, tells *HPW* is becoming more and more prevalent. Increased regulatory requirements are pressuring insurers to improve their data systems, but at the same time giving them the opportunity to increase quality.

"I think there's much more, not that they didn't have it before, but there's a much quicker ability to see what the impact of their processing is in real-world terms because of these reports and regulatory requirements. They don't have a choice; they have to improve it," she says. "You can't survive otherwise. You really can't."

Anita Nair-Hartman contends that the industry still has "a lot of work to do" in devising systems that pay one rate for an entire group of patients, while still making sure they received individualized services.

"It's still a fairly burdensome process from service to payment," Anita Nair-Hartman says. "EMR is one way of capturing what happens with providers at the point of care, but it doesn't go all the way through to connecting to the financials. With value-based care — things like bundled payments — we are going to get to this interesting point where the financial part and the transactional part are going to have to change, but everyone is really still testing the waters."

'Feedback Loop' Led to Major Tweaks

Capital BlueCross relies on what it calls a "feedback loop" that queries front-line staff on ways to improve the customer service experience for providers as well as members. For the past 18 months, the feedback loop has

revealed ways to improve and simplify processes, Scott says.

"We talk to the front-line staff — these are the people doing the work day in and day out — we have a consistent dialogue going on about how we can help them do their job more accurately and more efficiently," she says. "We take that information along with the information we get from our in-line quality assurance processes, and we factor that back into our training and online documentation that assists the staff with their jobs, and we feed this to the process improvement area where there's an opportunity for reducing manual effort on our part. We find the feedback loop very effective, and I think that's the big difference, is that we include the front-line staff in those discussions."

Capital BlueCross declined to provide data surrounding its administrative processes, but Scott did say that one extreme instance in which the feedback loop proved effective was in reducing the number of steps it took for HMO members to select a primary care physician. Customer service representatives said members were struggling with the process, and a review was able to reduce the number of steps involved from around 15 to just two.

User-friendly interfaces are also an "expectation," and have been driven by the era of social media. "The folks who are using a claims system, or operating a claims system, are on social media, so they are used to those types of user experiences — being able to navigate via a phone or log into a portal and have a user experience that's comparable to what they're seeing in other aspects of their lives," Vargo says.

Cigna in a statement said it was "thrilled" to earn the No. 1 ranking in the PayerView report, but added that there is still room for improvement, and that the company has invested a "significant" amount in people and technology dedicated to improving the provider and consumer experience.

"Nevertheless, we recognize that our work is not finished," Julie Vayer, vice president of total health and network operations, said. "We remained focused on continuous improvement through collaboration with athenahealth and other organizations so that we can earn the trust of health care providers every day."

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