DRIVING HEALTHCARE TRANSFORMATION:

Top 3 Action Items for 2023

Valenz HEALTH

i thrive customer COUNCIL

INTRODUCTION

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As the healthcare environment continues to rapidly evolve, numerous market forces are converging to create greater challenges for the self-insured industry. These include inflation, growing medical debt, healthcare staffing shortages, unsustainable losses for health systems, rising health premiums, and the intensifying impact of delayed care and screenings.

By working collaboratively and embracing the highest level of transparency, Vālenz® Health and its iThrive Council of customer partners are "skating to the puck" to solve for the issues of today and lean into what's next for our industry.

We've identified three key priorities for 2023 in working toward our shared goal — achieving real transformation in healthcare as we overcome the barriers created by these market forces. Our foundational commitment to the Valenz culture of innovation keeps us grounded as we balance costs, utilization and outcomes while keeping all parties in the health journey aligned for maximized savings.

Adopting greater transparency across everything we do and simplifying the complexity of self-insurance will help us drive the changes that healthcare needs. We invite true collaboration, commitment and community across the industry in our journey to uncovering the right solutions for 2023 and beyond. Together, we can all thrive in the face of change.

Vālenz® Health simplifies the complexities of self-insurance for employers through a steadfast commitment to data transparency and decision enablement powered by its Healthcare Ecosystem Optimization Platform. Offering a strong foundation with deep roots in clinical and member advocacy, alongside decades of expertise in the validation, integrity and accuracy of claims, and a suite of risk affinity solutions, Valenz optimizes healthcare for the provider, payer, plan and member. By leveraging data transparency and delivering an omnichannel approach across the healthcare journey, Valenz improves cost, quality and outcomes for employers and their members – engaging early and often for smarter, better, faster healthcare.

1 ACCELERATE THOUGHTFUL PLAN DESIGN

Thoughtful and accurate plan design is emerging as the front-runner in solving for the future. An optimal plan design that improves the overall healthcare journey for all parties starts with a commitment to transparency in the data. Then, it's about how we use that data to take the actions necessary to improve the member experience.

By engaging early to identify high-cost drivers, risks, care needs, and opportunities to minimize catastrophic expense, we effectively navigate the member to take charge of their health in a way that is cost-effective and drives positive outcomes – without crippling the employer financially.

Robust data engagement provides insight into the right decisions for the plan, including where to leverage charity care 501(r), care bundles, and centers of excellence to benefit the member and the employer. Data also allow us to pinpoint better access points for the future.

The health plan of the future will truly manage the member end to end through the healthcare journey – prospectively, concurrently and retrospectively across the Claim Cost Arc℠ – to remove waste, reduce overall spend, and increase the probability of a better outcome in an earlier stage of care or treatment.

2 SPUR NEW NETWORK DESIGN

We will see continued growth around high-performance networks and clinically integrated networks, which is central to taking control of the 40-50 percent of spend that occurs at the provider level. We already are seeing the market push toward capitated and risk-based plans to improve cost savings and health outcomes for members through value-based care.

To prepare for that shift, Valenz has aligned our Care Value Optimizer solution with a transformative direction of care model. It is supported by a blend of contracted and non-contracted providers, surgical care bundles, and integrated population health-focused care management solutions.

Such expanded network options enable us to facilitate better provider matches for members based on the individual's financial status, health needs, location, and other key indicators. The result: minimizing out-of-pocket expenses for members, generating greater savings for the employer, and optimizing health outcomes.

While enhancing omnichannel member relationships, well-designed networks will focus on top spend conditions with specialty networks and care management options. Financial transparency will prove foundational to assisting members with identifying and selecting high-value provider networks.

3 DESIGN SYSTEMS TO TRACK THE RIGHT KPIS

Together with our iThrive Council members, we are eager to measure the right things so we can determine and report our effectiveness, both internally and externally. We easily report on cost savings, plan spend and ROI, but just as important, we need to measure the quality and overall impact of the program.

In healthcare, quality is only as good as what the member considers a positive outcome. When we say we're balancing an equation of quality, utilization and costs, "quality" really translates to "outcomes," and that's what we're looking to improve.

Along those same lines, the impact we make may be prevention of a poor health outcome years down the road. We need to agree to measure and define various levels of care/treatment avoidance.

Clearly, the definition of KPIs is a work in progress industry-wide. As we develop metrics, we are keenly focused on KPIs for spend per employee per year, savings beyond network discounts, engagement in clinical outreach/management programs, re-hospitalization and other inpatient quality measures, member satisfaction, provider relations, and others.

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