Everest Group®

May 2024

Revolutionizing Healthcare Operations

Unlocking Transformation with Business Process as a Service

Contents

Introduction

In today's complex healthcare landscape, the demand for efficient, scalable, secure, and cost-effective solutions has never been greater. The recent cybersecurity outage involving Change Healthcare underscores the importance of a future-proof solution with robust information security protocols. Given evolving regulatory requirements, increasing member expectations, and the imperative for better outcomes, healthcare payers and payviders face significant challenges in managing their operations – injecting urgency into the need for a transformative solution. Business Process as a Service (BPaaS) has emerged as a transformative solution that offers a paradigm shift in how administrative and clinical tasks are managed. Through a platform-led approach, extensive healthcare expertise, and cutting-edge technological advances, BPaaS enables enterprises to streamline processes, increase scalability, and drive operational excellence in this rapidly changing environment.

This report is a comprehensive exploration of the vital role of BPaaS solutions within the healthcare payer landscape and an explanation of how BPaaS can help payers achieve the actionable outcomes they need to succeed in this complex and demanding healthcare market. Specifically, the report includes:

- An overview of the challenges in the enterprise market and how BPaaS can help solve these issues
- A thorough analysis of broad-based BPaaS solutions, their key elements, and their operational efficiency benefits
- Insights into specialized BPaaS solutions, highlighting successful use cases and targeted approaches to address specific pain points
- An examination of the unique intersection of BPaaS in payviders including Provider-Sponsored Health Plans (PSHPs), where the convergence of payer and provider presents intriguing opportunities for innovation and collaboration
- An evaluation of the use of BPaaS to navigate the ever-evolving terrain of tomorrow's healthcare landscape

Healthcare enterprises can use this report to assess the core tenets and different types of BPaaS solutions, its benefits to their operations, and key sourcing considerations for leveraging BPaaS as a transformative solution.

Understanding the need for BPaaS solutions in the healthcare payer landscape

The US economy, driven by high healthcare costs, has put significant pressure on the healthcare ecosystem. According to CMS data, US health care spending grew at 4.1% to reach US$4.5 trillion in 2022, faster than the 2021 increase of 3.2%. Moreover, although actual figures are not yet available, growth in national health spending is expected to accelerate to 5.1% in 2023[1]. The rampant increase in healthcare spending is driving up the cost of services for payers, pressuring their margins, despite relatively strong top-line growth. To maintain their margins, they need to significantly reduce operating and administrative expenses; otherwise members, who are already challenged by costly premiums and reduced benefits, will bear the brunt of even higher costs.

However, reducing these administrative costs is easier said than done given myriad challenges – both traditional and emerging – that healthcare payers face, as we explore below.

According to research from the Stanford School of Medicine, US healthcare wastes over US$265 billion annually due to administrative complexities, and despite technology investments, the rate of increase in administrative costs has outpaced that of overall healthcare expenditures.

Notable healthcare payer pain points that require transformative solutions

Incumbent solutions' limited scalability and agility: As the payer landscape evolves, traditional solutions face scalability and compatibility challenges as technologies advance. As member mix shifts toward Medicare Advantage and Affordable Care Act (ACA) exchange plans, systems need to adapt to meet member needs and benefit structures. Notably, Medicare Advantage enrollment alone surged by about 30% to about 31 million from 2020 to 2023[2]. Traditional systems struggle to manage fluctuating demand for different plan and product type benefits, creating resource inefficiencies, fragmented care delivery, and suboptimal outcomes; highlighting the urgency for more agile solutions

1 National Health Expenditures 2022 Highlights | CMS National Health Expenditure Projections 2022-2031 (cms.gov)
2 Monthly Enrollment by Plan | CMS

Demand for interoperability given legacy system challenges: In the era of interconnectedness, legacy systems' disjointed infrastructures impede data-driven insights and seamless information exchange. In fact, the CMS Interoperability and Prior Authorization Final Rule mandates that specific health plans such as Medicare Advantage organizations, state Medicaid and Children's Health Insurance Program, Medicaid managed care plans, and Qualified Health Plan issuers maintain HL7 FHIR APIs for patient access, provider access, and prior authorization, which means interoperability efforts need to accelerate.

Information security amid evolving regulatory compliances: The web of constantly evolving regulations and increasing cybersecurity incidents in the healthcare industry highlights the importance of a compliant system with strong information security measures. The recent cyber-attack on UnitedHealth-owned Change Healthcare that affected its systems across payer, provider, and pharmacy operations, and impacted over 6 TB of sensitive patient data highlights the need for a strong, flexible system with stringent and vigilant cybersecurity measures[3]. According to the HHS report, there has been a 256% increase in large breaches involving hacking and a 264% increase in ransomware over the past five years, underscoring the urgent need for payers to prioritize cybersecurity readiness and invest in network security, social engineering, and application security tools among others[4].

Complexities with value-based care: Health plans continue to find it challenging to implement value-based care due to concerns around financial viability and administrative burden. The complex payment structure tied to specific outcomes and risk-adjusted reimbursements requires accurate tracking of performance and quality metrics. Furthermore, the increasing focus on health equity and social determinants of health accentuates the need for a transformative approach to value-based care through significant systemic changes.

Evolving member expectations: Members expect the same digital benefits from their payers that they experience in other aspects of their lives – personalized, top-notch healthcare experiences – which traditional engagement models struggle to offer. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey shows that Medicaid enrollees' member satisfaction with their health plans is at its lowest in the last couple of years, continuing a downward trend for payers[5]. This decline clearly highlights the need for organizations to invest in innovative tech-enabled solutions with a member-centric mindset, or they risk compromising member satisfaction and loyalty.

Given the increasing complexities of the healthcare landscape, a comprehensive and modular platform-led solution that is scalable and cost-effective – as opposed to rigid and costlier legacy systems – is imperative. While service providers have invested in efforts to support buyers to address this challenge, not all efforts have generated the necessary returns. Buyers have been dissatisfied by issues such as lack of clarity

3 Change Healthcare Confirms Blackcat Ransomware Attack as Systems Brought Back Online (hipaajournal.com)
4 HHS' Office for Civil Rights Settles Second Ever Ransomware Cyber-Attack (hhs.org)
5 2023 CAHPS Health Plan Survey Database Chartbook (ahrq.gov)

around value realization, unmet outcomes, and pricing models with limited client visibility into utilization (such as FTE or input-based models).

This is where the Business Process as a Service (BPaaS) model comes in. The BPaaS model is a platform-first approach that sits at the intersection of people, process, and technology. Backed by four core tenets, platform, operations, deployment, and domain expertise, BPaaS has the potential to resolve burning issues with a cost-effective yet agile and flexible transformation model.

The core tenets of BPaaS

A BPaaS solution comprises of four major tenets – platform, operations, domain expertise, and deployment, as depicted in Exhibit 1 and detailed below.

Exhibit 1: The core tenets of BPaaS

Source: Everest Group (2024)

01

Platform

A BPaaS platform provides significant technology leverage with a centralized technology solution – through either a system of record or a system of engagement. This platform facilitates a range of business processes, applications, and tools, while integrating disparate systems and providing scalability and customization.

Operations

Business and technology operations is the core of the BPaaS solution. Catering to a broad set of healthcare services, the solution achieves process efficiency through consolidated operations, single contractual relationship, and pre-defined workflows that ensure process enhancements, best practices, and robust compliance.

02

03

Domain expertise

A skilled workforce with deep domain knowledge and experience is required to effectively utilize the technology and process expertise that BPaaS offers. The BPaaS model includes domain experts with an in-depth understanding of healthcare-specific processes, regulations, and best practices, as well as comprehensive understanding of the business processes and technology proficiency.

Deployment

BPaaS solutions can be deployed either over the cloud or on-premises, depending on an enterprise's preference/requirement. Cloud deployment provides easier accessibility, enabling collaboration, less dependency on IT resources, and elastic scalability to ramp up or down based on demand, without up-front investment, increasing both autonomy and operational efficiency.

04

BPaaS solutions are evolving to meet a variety of payers' nuanced needs

Multiple types of BPaaS solutions have emerged to meet both – the dynamic nature of the payer market and healthcare organizations' evolving needs. These solutions encompass a range of tailored services to streamline and optimize key business processes, allowing healthcare payers to give their members an exceptional experience while also increasing process-specific efficiency. In general, there are three types of BPaaS solutions: broad-based, function-specific, and Line-of-Business (LoB)-specific.

- **Broad-based / end-to-end BPaaS solutions** offer comprehensive outsourcing of entire business processes, providing a holistic approach to healthcare administration. This option is a one-stop broad-based platform solution with broad/end-to-end coverage of multiple healthcare processes across front-, mid-, and back-office operations. It is built around the Core Administrative Processing System (CAPS).
- **Functional BPaaS solutions** focus on specific healthcare operations areas, such as provider credentialing, network management, or utilization management, thus offering targeted, specialized solutions to address specific challenges.
- **LoB-specific BPaaS solutions** serve the unique needs of specific plan types, such as Medicare, Medicare Advantage, Medicaid, and Managed Medicaid, providing specialized services to meet specific requirements. These targeted in-a-box platform solutions offer comprehensive services tailored to the needs of specific plan types.

Deep dive into broad-based BPaaS solutions for scalable operations

The goal of broad-based BPaaS solutions is to modernize core operations and expedite the shift to value-based healthcare without significant up-front cost commitment, essentially providing a cost-effective alternative to traditional outsourcing. These solutions assist payers in updating core infrastructure and embracing resilient operating models, which is vital given evolving needs and regulatory changes. The challenge is that the modernization costs associated with replacing legacy platforms can be prohibitive given the technology debt accumulated by legacy systems. On the other hand, not modernizing legacy systems leaves payers vulnerable to penalties of up to $US1 million per violation according to the requirements in the 21st Century Cures Act (which has already logged 40 penalties for non-compliance[6]). The core construct of broad-based BPaaS solutions offers an effective solution to these challenges.

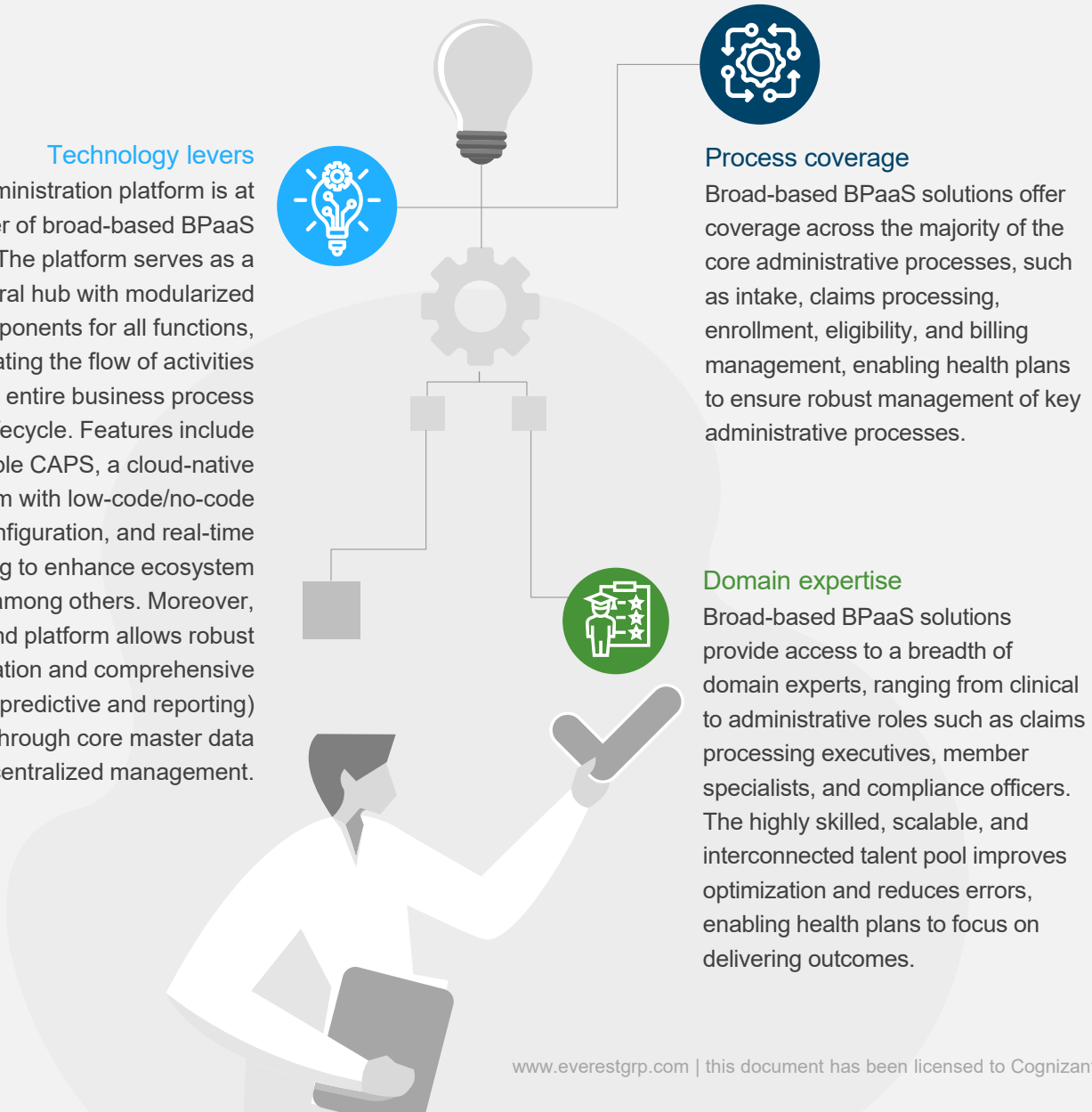
6 Resolution Agreements | HHS.gov

The key elements of a broad-based BPaaS solution

Broad-based/End-to-end BPaaS solutions offer a comprehensive set of components that collectively enable the delivery of holistic healthcare services through the outsourcing of an entire group of business processes. This solution enables payers to offload administrative burden, leverage advanced technologies, and focus resources on delivering high-quality care. Exhibit 2 defines the key elements of an end-to-end BPaaS solution.

Exhibit 2: The key elements of a broad-based BPaaS solution

Source: Everest Group (2024)



Technology levers

A core administration platform is at the center of broad-based BPaaS solutions. The platform serves as a central hub with modularized components for all functions, orchestrating the flow of activities across the entire business process lifecycle. Features include composable CAPS, a cloud-native platform with low-code/no-code configuration, and real-time processing to enhance ecosystem integration, among others. Moreover, an end-to-end platform allows robust automation and comprehensive analytics (predictive and reporting) capabilities through core master data record and centralized management.

Process coverage

Broad-based BPaaS solutions offer coverage across the majority of the core administrative processes, such as intake, claims processing, enrollment, eligibility, and billing management, enabling health plans to ensure robust management of key administrative processes.

Domain expertise

Broad-based BPaaS solutions provide access to a breadth of domain experts, ranging from clinical to administrative roles such as claims processing executives, member specialists, and compliance officers. The highly skilled, scalable, and interconnected talent pool improves optimization and reduces errors, enabling health plans to focus on delivering outcomes.

The key enterprise needs driving adoption of broad-based BPaaS solutions and subsequent benefits for payers

Broad-based BPaaS offers a comprehensive solution to address key enterprise needs while delivering a wide variety of benefits to stakeholders.

- **Unified operations across the payer value chain for seamless integration:** A primary advantage of broad-based BPaaS solution is its ability to unify operations across the major value chain processes, ensuring a holistic approach from front-end member interactions to back-end administrative tasks. It facilitates seamless interoperability between systems, enhancing efficiency and data utilization for decision-making. For example, when a member submits a claim for a medical service, the platform automatically updates the member's profile, sends automated notifications through the member services portal for additional information, and seamlessly updates the data back into the claims processing workflow for adjudication. This process allows members to use a single portal to check claim status, review benefits, and raise concerns, as needed.
- **Preconfigured systems minimize up-front cost:** Broad-based BPaaS solutions eliminate the high up-front capital costs associated with replacing existing systems by using a single platform with preconfigured systems that can integrate with existing internal frameworks. The plug-and-play model streamlines operations and significantly reduces the financial barriers typically associated with system overhauls – and with minimal oversight. A compelling example of the cost effectiveness of broad-based BPaaS is experience of a health plan with three million members that reduced its core administrative expenses by over US$13 million by rebuilding its CAPS into a new services framework that includes membership, provider, and claims management.
- **Accelerated deployment of solutions:** Broad-based BPaaS solutions are distinctively agile and flexible, enabling organizations to accelerate speed to market in today's fast-paced environment, ensuring business continuity and limited downtime. By leveraging BPaaS, organizations can rapidly deploy new products, services, or enhancements to existing offerings such as real-time claims editing and pricing and expediting clearinghouse connectivity through HIPPA EDI transactions through custom workflows, thus ensuring that they stay ahead of the competition and meet evolving customer demands. In comparison to legacy systems – which may have taken years to implement – healthcare organizations have been able to onboard and deploy modernized CAPS in as little as 6-9 months.
- **360-degree member visibility:** With broad-based BPaaS, payers also gain end-to-end member visibility, empowering them with comprehensive insights to make informed decisions. It offers a complete view of members across their lifecycles, including their interactions, preferences, and health histories. This member visibility empowers payers to personalize their services, anticipate member needs, and

proactively address issues, ultimately enabling a superior member experience. Case in point: a Texas-based health plan was able to fully integrate member touchpoints to coordinate all administrative and clinical aspects of its member experience to reduce gaps in care and dissatisfaction with services through a broad-based BPaaS solution.

- **Robust compliance oversight and management:** Organizations can achieve strict compliance oversight and management through broad-based BPaaS solutions by implementing a proactive and systematic approach that integrates risk assessment, contractual agreements, monitoring, training, and continuous improvement practices. By monitoring all processes, systems, and practices within the framework, the system can ensure adherence to relevant laws, regulations, and industry standards such as HIPAA 5010, ICD-10, HL7, FISMA, FedRamp, SOC2, and HITRUST. Some broad-based BPaaS solutions provide dedicated compliance modules as well. Case in point: By leveraging broad-based BPaaS solution, a one million-member health plan met all regulatory compliance levels and positioned itself for success under a value-based care model and mandated interoperability requirements.

Focus on key payer-requested outcomes through broad-based BPaaS adoption

Broad adoption of BPaaS solutions among payers is driven by a clear focus on achieving key measurable outcomes that increase operational efficiency, reduce costs, and accelerate time to market. While the benefits of BPaaS adoption are evident, payers are particularly interested in actionable outcomes that directly impact their bottom lines and operational performance. Some of the key outcomes payers seek through broad-based BPaaS adoption include:

Strategic outcomes

Cost reduction

A key outcome payers seek through broad-based BPaaS implementation is the reduction in Total Cost of Ownership (TCO), which encompasses all expenses related to acquiring, operating, and maintaining the technology infrastructure and operations as well as indirect costs such as downtime, productivity losses, risks from security breaches, and regulatory non-compliance.

Productivity metrics

By automating and optimizing workflows and eliminating manual interventions across the operational value chain through broad-based BPaaS, payers expect significant increases in operational efficiency and productivity, which gives them more time to focus on core and high-impact activities of the business.

Speed to market

Given that extended deployment timelines are extremely detrimental to the business continuity and member experience, quick implementation of systems and operations is vital. Payers prefer BPaaS solutions because they are faster to implement than in-house investments and traditional outsourcing models.

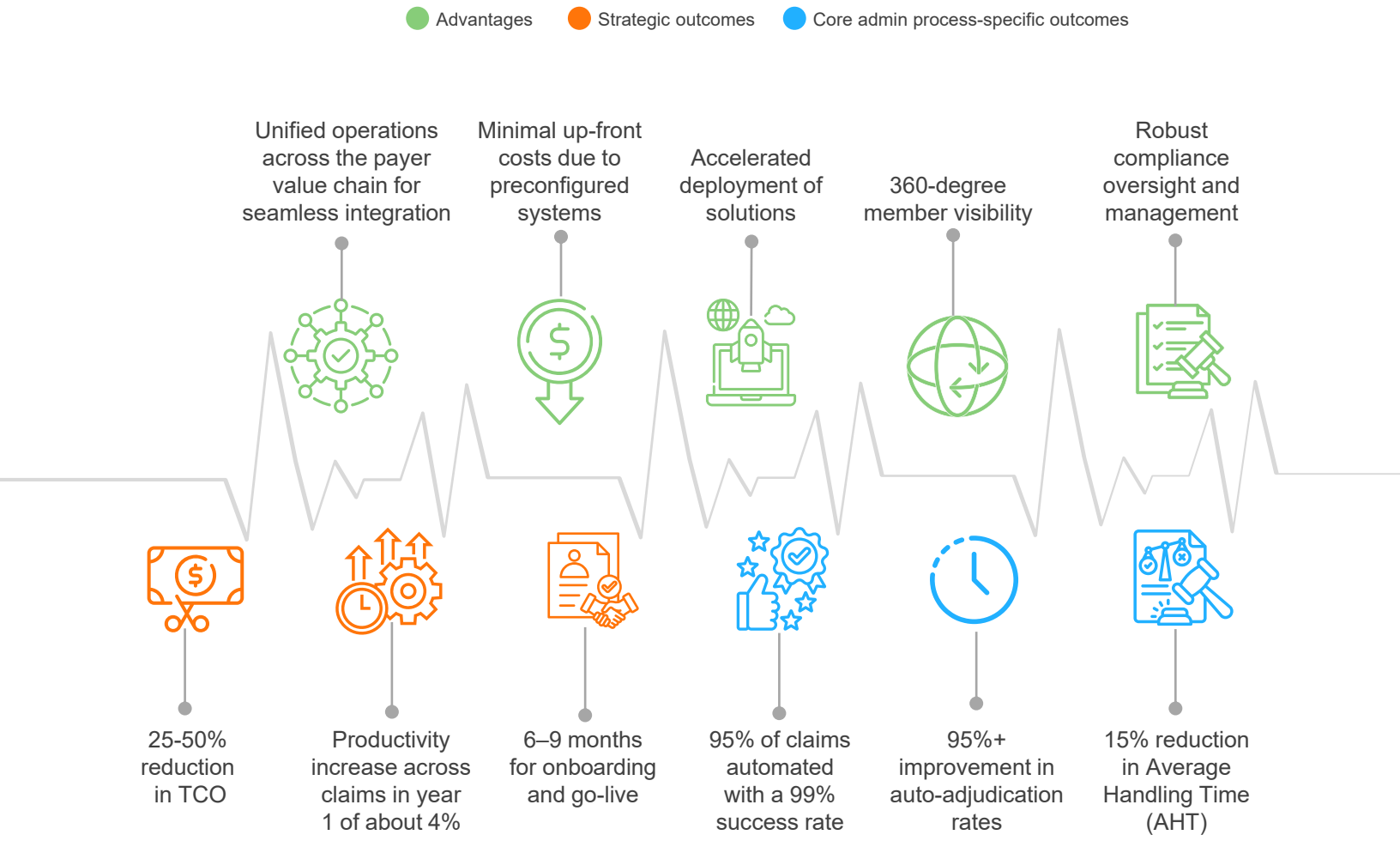
Core process-specific outcomes

Payers want to derive additional value from broad-based BPaaS engagements, moving beyond strategic outcomes to core administrative process improvements. Additionally, end-to-end compliance with regulations and industry standards is a table stakes outcome.

Exhibit 3 shows the benefits and outcomes payers seek from broad-based BPaaS adoption.

Exhibit 3: The advantages and representative outcomes payers expect from broad-based BPaaS implementation

Source: Everest Group (2024)



The emergence of broad-based BPaaS solutions tailored to the nuances of specific plan types and LoBs

Despite broad-based BPaaS solutions' promising benefits, there are some limitations. For example, enhanced process/LoB-specific customization and a preference for a diversified vendor base among some enterprises restrict their ability to implement broad-BPaaS solutions. Moreover, some regulated markets such as Medicaid and Medicare Advantage regularly introduce regulatory changes with which managed health plans must comply, so payers adopt several LoB-specific BPaaS solutions whose modularity enables them to accommodate regulatory changes quickly without disrupting existing operations.

As enrollment increasingly shifts from traditional plans to different plan types, including privately managed government plans such as Medicare Advantage and Managed Medicaid, the need for tailored and efficient solutions has become more urgent. Furthermore, many health plans are increasingly subject to regulatory scrutiny and governance. For example, CMS has made policy and technical adjustments to the Medicare Advantage and Medicare Prescription Drug Benefit Program for 2024. A key component of the rule is the establishment of a new Health Equity Index reward beginning in 2024 for inclusion in the 2027 Star Ratings[7]. These shifts are driving demand for tailored in-a-box BPaaS solutions that can ensure compliance, while managing benefit administration and core services. Exhibit 4 presents the emerging LoB-specific broad-based BPaaS solutions.

Exhibit 4: Emerging LoB-specific broad-based BPaaS solutions

Source: Everest Group (2024)

	Key components	Differentiating factor from prevalent broad-based BPaaS
Use case 1 Medicare/Medicare Advantage-in-a-box	• CMS-compliant claims management and reconciliation, coupled with member services • Encounter data processing and CMS submissions	Given the direct link between quality metrics, such as Star Ratings, and financial components, such as reimbursement and penalties, a dedicated risk and compliance module that includes risk adjustment, STAR rating support, and CMS reporting is a value-add to the broad-based BPaaS.
Use case 2 Medicaid-as-a-Service	• Agile and flexible claims and membership management, compliant across all states • Medicaid fiscal agent services, particularly for denials and appeals support	There is a significant variation in modernization of legacy Medicaid Management Information System (MMIS), according to states. The Medicaid-as-a-Service solution offers capabilities to easily integrate with MMIS systems for seamless collaboration and submissions, despite the variations.

7 2024 Medicare Advantage and Part D Star Ratings | CMS

Adoption trends of broad-based BPaaS among payer enterprises

While a diverse range of broad-based BPaaS solutions has been introduced, uptake of these solutions varies significantly across different payer categories. Trends in broad-based BPaaS adoption show that payers are increasingly realizing the value of BPaaS deployment from a transformation and modernization perspective. Two trends are particularly notable:

Small and mid-sized health plans (less than 500,000 lives) favor broad-based BPaaS solutions due to budget constraints, viewing them as a cost-effective technology solution without hefty up-front IT investments. These solutions enable them to compete with larger entities by focusing on strategic areas such as market expansion and product innovation. Conversely, larger health plans (more than 500,000 lives) are less likely to favor broad-based BPaaS due to existing systems and outsourcing commitments. Yet adoption is increasing among larger plans due to cost pressures, member dissatisfaction, and the need for greater adaptability. See Exhibit 5 for details.

Government plans are major adopters of broad-based BPaaS, particularly for modular MMIS setups. States, encouraged by CMS, are modernizing legacy systems and shifting to as-a-service models, using BPaaS for administrative services such as claims and provider management. On the privately managed side, Medicare Advantage (MA) and Managed Medicaid plans are increasingly adopting BPaaS solutions to address their growing enrollment and operational challenges. These sectors leverage broad-based BPaaS solutions for certain transactional processes such as member enrollment, claims processing, and financial reporting. Furthermore, these solutions also provide access to a skilled talent pool, improving compliance and quality measures such as STAR ratings and HEDIS scores, which are crucial for improving enrollment and financial performance.

Exhibit 5: The growth of broad-based BPaaS by payer size and case study examples

Source: Everest Group (2024)

Growth rate
4-7%

Growth rate
<4%

Small and mid-sized payers (<500,000 lives)

A regional mid-sized payer with Medicare and Medicaid health plans as part of its portfolio leveraged broad-based BPaaS for holistic services for core administration to achieve operational efficiency and encourage whole-person care.

Large payers (>500,000 lives)

A large payer with multiple business lines significantly overhauled its operations, from front-end activities such as member and provider engagement to back-office claims processing, by deploying a broad-based BPaaS solution.

Deep dive into specialized BPaaS solutions

Healthcare payers vary widely in terms of their modernization efforts – some have already extensively digitally and operationally transformed, while others are in the early stages of modernization. Payers that are not yet prepared for full-scale transformation prefer functional or process-specific BPaaS solutions that address specific pain points and segments within their value chains, allowing them to address immediate needs without committing resources to a comprehensive operational overhaul. Payers can implement these targeted solutions in a phased manner, gradually expanding their use of BPaaS as their appetite for modernization increases.

The evolving need for functional/process-specific BPaaS solutions in the payer market

While the internal workings of payer systems and infrastructure might be critical in the decision between broad-based and process-specific BPaaS solutions, the need for functional BPaaS differs based on the plan type's market dynamics and the regulations targeted to specific functions and outcomes.

For example, based on current projections from the Medicare trustees and the Congressional Budget Office, Medicare Advantage Part A spending will exceed Part A revenues each year beginning in 2023, and will be completely depleted by 2030[8], which will make it imperative for MA plans to achieve financial efficiency. In this case, focus on spend reduction will increase the demand for payment integrity solutions that can improve the identification of Fraud Waste and Abuse (FWA).

From a regulatory standpoint, the recently released CMS Interoperability and Prior Authorization Final Rule establishes a requirement for payers in Medicare Advantage (MA), state Medicaid, and Managed Medicaid Care to respond to urgent requests within 72 hours and standard requests within seven days – half the current timelines for MA plans[9]. Meeting this requirement necessitates a significant overhaul of utilization management – prior authorization in particular – which will be a growth driver for utilization management BPaaS solutions with electronic prior authorization functionality. Exhibit 6 highlights the key needs among payers for functional/process-specific BPaaS solutions.

8 Medicare - May 2022 Baseline (cbo.gov)
9 CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS

Exhibit 6: The need for functional/process-specific BPaaS solutions among payers

Source: Everest Group (2024)

Low → High

Challenges creating the need for functional BPaaS	Comments	Degree of impact on adoption of functional BPaaS solutions
Increasing function/segment-specific nuances for different plan types 	Different plan types have segment-specific nuances according to regulatory and market requirements, which has driven the need for targeted solutions	
Budgetary constraints coupled with restrictive technology adoption 	Some payers have notoriously been slow to adopt technology, preferring a phased adoption approach, especially of BPaaS, which does not require a significant budgetary commitment	
Integration issues due to varying stages of investment in payers' modernization journeys 	Payers are in different stages in their modernization journeys, especially related to CAPS legacy systems, and prefer modular process-specific BPaaS solutions for ease of integration with current investments	

Successful use cases for functional BPaaS solutions and their key advantages and outcomes for payers

Functional BPaaS solutions offer payers a variety of benefits – such as streamlined provider network management, improved payment integrity, optimized utilization management, and seamless care coordination – tailored to specific pain points. These solutions help drive process-specific outcomes such as improved provider engagement and clinical decision accuracy for Utilization Management (UM), ultimately improving care outcomes for members. Exhibit 7 offers several use cases of functional BPaaS solutions, their benefits and measurable outcomes derived by payers.

Exhibit 7: Successful use cases, benefits, and actionable outcomes of functional BPaaS solutions

Source: Everest Group (2024)

Solution / use cases	Description	Advantages	Examples of outcomes
Network / provider lifecycle management 	End-to-end provider network management - credentialing, enrollment, contracting, and performance management	• Quick onboarding of providers • Enhance collaboration between payer and providers	• Reduction in credentialling time by 50% • Reduction in provider abrasion
Payment Integrity 	Combination of claims editing platform, real-time data management, and advanced analytics for FWA identification for both pre- and post-pay integrity	• Identification of overpayments and revenue leakages (FWA) • Compliance with No Surprises Act and Price Transparency Rule	• Reduction in inappropriate payments • High acceptance rate of claims-related payment • Lower appeals rate
Utilization management 	Suite of services such as prior authorization intake and processing, medical necessity reviews, and denials and appeals management; informed by clinical guidelines, workflow automation and analytics, and dedicated provider portal	• Ensuring prior authorization approval timelines are met, as per regulations • Accurate evidence-based reviews for reduction in overpayment and improper denials	• Increase in clinical decision accuracy by 3-5% • Reduction in clinical appeals from 22% to 9%
Care coordination 	Care coordination across the care continuum, including case/disease management, nurse triage, remote patient monitoring; integration with utilization management, member engagement, and population health analytics for enhanced care coordination	• Seamless care coordination and case management • Reducing re-admission in the short- to medium-term and hospital admissions in the long-term due to avoidable medical cases	• 20% reduction in medical re-admission rates • Transition-of-care outreach within 24 hours of discharge

Adoption trends for functional BPaaS solutions among payer enterprises

As functional/process-specific BPaaS solutions gain popularity among payers, the current adoption trend highlights payers' increasing affinity to use functional BPaaS solutions for nuanced segment-specific requirements.

Large payers are more likely than small and mid-sized payers to use functional solutions, driven primarily by limited overhaul efforts and past and current investments in multiple solutions. The gradual adoption approach enables payers to carefully assess the impact of BPaaS on their operations and how they align with targeted outcomes achieved before fully adopting. Exhibit 8 shows the growth of functional BPaaS adoption, the variance by payer size, and notable case studies in the payer market.

Exhibit 8: The growth of functional BPaaS solutions among health plans by size and case study examples

Source: Everest Group (2024)

Growth rate
10-13%

Growth rate
7-10%

Small and mid-sized payers (<500,000 lives)

A small payer with Medicare enrollees across multiple states partnered with a care management BPaaS provider for end-to-end case, disease, and utilization management across multiple specialties such as radiology, cardiology, oncology, musculoskeletal, and sleep care

Large payers (>500,000 lives)

A leading health plan with presence in multiple states and product lines used a provider lifecycle management solution to streamline a large volume of new provider onboarding, gain visibility into provider data, and establish a provider onboarding and maintenance system

Given that functional BPaaS adoption is segment-specific, adoption varies significantly based on need. For example, demand for complex care and utilization management is higher in Medicare Advantage plans due to the larger elderly population base, creating higher demand for utilization management BPaaS solutions. On the other hand, given that some common challenges, such as provider abrasion, are plan agnostic, adoption levels are similar across plan types for provider credentialing or lifecycle management BPaaS.

BPaaS in payviders at the confluence of healthcare

Healthcare organizations – both payers and providers – are looking to integrate capabilities to deliver truly end-to-end healthcare services, which has given rise to the payvider model. The rise of value-based care and increasing consumer demand for better services have amplified the importance of payviders. By integrating payer-provider workflows and platforms, payviders bridge gaps in fragmented healthcare systems, allowing for seamless data sharing, benefit administration, and care delivery. This focus on value-based care, cost reduction, and interoperability makes the payvider model increasingly attractive and helps to support newer health models such as Accountable Care Organizations (ACOs), Pay for Performance (PFP) reimbursement, and value-based networks.

Given their presence across the healthcare spectrum, payviders face unique challenges in terms of operational and financial efficiencies, including:

- Multiple siloed systems for different processes such as CAPS for claims management, EHR/EMR for medical records, and function-specific technology for virtual health, utilization management, case/disease management, and risk and compliance, among others.
- The payvider model faces challenges in terms of scalability, which can increase costs because the model requires significant investment in technology and operations to integrate services effectively and achieve economies of scale.

These challenges make payviders a right segment for BPaaS adoption across two primary categories –provider-sponsored health plans (PSHPs) and payers with provider capabilities:

- **Provider-sponsored health plans**
  A PSHP is formed when a health system offers its own health insurance plans. Geisinger Health Plan and UPMC Health Plan are some of the prominent examples in the PSHP ecosystem. Given the competitiveness of the health insurance market, hospital-owned PSHPs require effective, outcomes-based population health management to excel under value-based care reimbursement models. This is where BPaaS solutions come in. The complex task of launching, operating, and scaling a health plan within a provider ecosystem, traditionally slow to embrace advanced digital solutions, presents a prime opportunity for BPaaS deployment. By leveraging BPaaS solutions, PSHPs can explore new markets, launch new LoBs while circumventing specific challenges such as state-specific requirements for Managed Medicaid, and design and launch competitive plans quickly. As a result, PSHPs are able to enhance risk and medical management, improve point of care transition and referrals, and provide a comprehensive member experience across coverage and care delivery.

By leveraging BPaaS solutions, PSHPs can explore new markets, launch new LoBs while circumventing specific challenges such as state-specific requirements for Managed Medicaid, and design and launch competitive plans quickly.

- **Payer with provider capabilities**
  In this model, health plans develop provider capabilities, as seen in Humana's expansion into care delivery with CenterWell and Conviva. This helps payers in cost containment by steering patients to less expensive care settings such as Ambulatory Surgical Centers (ASCs) and improves the quality of care through active management of physician enterprises. Given the vast potential of utilizing provider data, BPaaS plays an instrumental role in integrated transformation for payers with provider capabilities. Modularized BPaaS solutions with CAPS systems enable payers to add care-focused modules and leverage the convergence of claims and clinical data to improve the management of chronic conditions with better health coaching from in-house physicians. Additionally, the BPaaS-led approach supports these payviders in operational efficiency through improved credentialing, fraudulent claims management, and payment coordination.

Leveraging BPaaS in tomorrow's healthcare landscape through third-party support

Already experiencing significant change, the US healthcare ecosystem is likely to see that change accelerate in the near future given the emergence of digital health solutions and technology-led care delivery to serve shifting patient demographics and preferences, as well as efforts to achieve health equity. Among the Center for Medicare and Medicaid Innovation (CMMI)'s strategic objectives is for Medicare and Medicaid fee-for-service beneficiaries to be in a care relationship with accountability for quality and total cost of care by 2030. As a result, BPaaS in healthcare is likely to become more evolved, integrated, and outcome-oriented, which may necessitate third-party support. Payers and payviders need to be cognizant of several emerging requirements when evaluating their BPaaS partnerships.

Digital, AI-led innovation for strategic, outcome-based partnerships: Digital innovations, especially AI chatbots, advanced analytics, and integrated ML-based automation tools, are instrumental in optimizing processes, improving decision-making, and refining strategy. By connecting service delivery directly to measurable outcomes, these innovations ensure transparency and value creation through partnerships. This is particularly crucial in the current trend toward outcome-based, risk-sharing engagements, where incentives are tied to actual engagement goals. Given this shifting landscape, partnering with service providers equipped with AI-enabled BPaaS capabilities that can deliver on outcomes effectively for strategic support is vital.

Flexible BPaaS for emerging LoBs: As enrollment dynamics continue to change, new and emerging plan types and LoBs with differentiated member requirements, benefits administration, and regulatory compliance will emerge. While the growth in Medicare Advantage enrollment is significant, the emerging ACA marketplace is likely to change enrollment dynamics. Enrollment in ACA plans has already increased by about 78% to 21.3 million for the 2024 Open Enrollment Period, according to CMS data[10]. These changes are likely to increase the demand for in-a-box solutions that can be modified based on plan type. Health plans need to carefully evaluate third-party providers' capabilities to handle various operational complexities by plan type.

Care-centric solutions: The US Department of Health and Human Services (HHS)'s Healthy People 2030 initiative includes numerous objectives related to Social Determinants of Health (SDOH) and the importance of upstream factors in reducing health disparities. These objectives require payers to adopt more integrated care management practices that encompass case/disease management, utilization management, and population health analytics that consider SDOH for whole-person care. Consequently, it is crucial for payers to seek third-party providers that prioritize care in their BPaaS solutions to deliver more personalized and effective healthcare outcomes.

Technological modularity such as generative AI: By adding generative AI algorithms, BPaaS platforms have the potential to automate and enhance various processes, such as Natural Language Processing (NLP) generation for clinical documentation, medical chart/EHR data and coding analysis, and efficient claim processing. Generative AI can also facilitate personalized member interactions, such as generating tailored educational materials or recommendations based on individual health data. Payers need to prioritize BPaaS solutions that harness the power of generative AI, ensuring a more streamlined, efficient, and patient-centric approach to healthcare management.

Cloud deployment: While cloud-based BPaaS deployment is already under way, a significant amount of core admin-related infrastructure remains on-premises. Migration to cloud for BPaaS deployment, especially through hybrid cloud strategies by partnering with hyperscalers such as Azure, AWS, and Google Cloud, is likely to rise. Payers should seek support from third-party providers that have demonstrated expertise in cloud migration and strong capabilities to effectively manage process ramp down/up, navigate cloud operations, and ensure seamless interoperability across multiple cloud platforms. Further, it is crucial for payers to prioritize providers that can maintain HIPAA compliance, safeguard data, and mitigate the risk of vendor lock-in.

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Conclusion

To effectively address its many varied challenges, the healthcare industry needs a transformative approach to operations. Many see BPaaS as a pivotal solution, as it offers innovative approaches to streamline administrative and clinical operations. Its technology-driven framework and deep domain expertise empowers payers and payviders to optimize processes, scale efficiently, and achieve operational excellence in a rapidly changing landscape. As enterprise expectations from service provider engagements continue to evolve in tandem with changing market dynamics, BPaaS solutions are uniquely positioned to meet enterprise requirements through continuous refinement to the solution framework and model.

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This study was funded, in part, by Cognizant

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