ELENA J. MCFANN

Marco Island, FL
(952) 221-5130
elenamcfann@yahoo.com
https://www.linkedin.com/in/elena-mcfann/

HEALTHCARE EXECUTIVE MANAGEMENT

C-SUITE | MANAGED CARE | GOVERNMENT PROGRAMS | INNOVATION

Dynamic healthcare executive with a career of expertise in managed care. Demonstrated ability to build strong cross-functional teams to provide consumers access to high quality, affordable healthcare, drive strategic growth, and foster practical innovation. Expert presenter and negotiator. Adept at forging relationships with customers, providers, agents, brokers, policy makers, and regulators, and building consensus across multiple organizational levels.

AREAS OF EXPERTISE

- Medicare Advantage
- Growth and Retention
- Sales and Marketing Integration
- Quality and CMS Stars
- Public Policy Advocacy
- Strategic Planning and Execution
- Network Strategy and Negotiations
- Value-Based Care
- Healthcare Cost Improvement
- Financial Turnarounds
- Mergers, Acquisitions and Integration
- Organizational Alignment
- Team Development, Mentoring
- Innovative Solutions

PROFESSIONAL EXPERIENCE

ELEVANCE HEALTH, Indianapolis, Indiana **2020 - Present**

Fortune 21 company, a $155 million (calendar year 2022) company serving over 117 million people.

President, Medicare 2021 - Present

Responsible for strategy; quality and CMS Star ratings; financial performance; and operational execution of Elevance Health's $31+ billion Medicare business serving over 2.6 million Medicare eligibles in 24 states across Individual Medicare Advantage plans, Group Retiree programs, Medicare Supplement plans, and stand-alone Part D offerings.

- Revamped Medicare Advantage product portfolio nationwide to tailor to local market conditions; promote consumer choice and a simplified experience; and deliver profitable, sustainable growth and quality outcomes.
- Expanded Individual Medicare Advantage membership by over 17% and people served through Dual Special Need Plans (DSNPs), in particular, by 59%. Turned around financial performance of business, increasing top line annual revenue by 40% and bottom-line operating gain by over 6X.
- Led execution of comprehensive plan to improve voluntary lapse rates. Optimized distribution channel mix between direct sales and external producers while balancing consumer shopping preferences. Expanded Loyalty Team capacity, adopted Artificial Intelligence (AI) and Large Language Modeling (LLM) for proactive member engagement via text, and redesigned welcome / on-boarding processes. Delivered double digit reduction in rapid disenrollment rates; reversed multi-year degradation in retention; and significantly improved lifetime value.
- Championed expansion of innovative Health Advocate customer service model to Medicare Advantage members to deliver a more personalized experience and a single point-of-contact for all needs in order to improve CAHPS scores. Delivered significantly improved first call resolution and reduced customer service associate turnover.
- Pioneered multilingual communications with associates, established monthly listening forums with front-line staff, and delivered best in class associate engagement and satisfaction results.

President, Medicaid, West Region 2020 - 2021

Responsible for all aspects of business and financial operations of Elevance Health's $11 billion Medicaid business serving nearly 2.8 million beneficiaries in California, Colorado, Nebraska, Nevada, Texas and Washington.

- Successfully advocated for actuarially sound rates from State partners across the region, launched new locally focused healthcare cost improvement programs, and expanded membership assigned to high performing providers from 47% to 60%.
- Collaborated with Enterprise Operations to launch a new customer service model which boosted post-call satisfaction by 400 basis points to nearly 94% in less than four months with no increase in average handle time.

- Championed telephonic outreach to 120,000 of the most vulnerable West region members during the first three weeks of the COVID pandemic to address their social drivers of health. Successfully connected members to resources for telehealth, food, medication, medical attention, and loneliness and social isolation.
- Co-led end-to-end redesign of Medicaid business to take advantage of national scale deployed locally. Drove significant administrative efficiencies, delivered best-in-class value-based quality outcomes, enhanced local ground game for RFP wins, and upgraded key talent to accelerate decision-making in the markets while keeping high performing talent turnover at less than 2%.
- Served on Enterprise Culture Council, providing strategic oversight to Enterprise Culture Action Team, advocating for cultural change throughout the organization, mentoring Culture Coaches, and celebrating demonstration of values and expected behaviors.

UNITEDHEALTHCARE, Minnetonka, Minnesota **2003 - 2019**

Segment of UnitedHealth Group, a $226 billion (calendar year 2018) diversified healthcare company.

Chief Executive Officer, Central Region, UnitedHealthcare Medicare & Retirement 2013 - 2019

Managed end-to-end performance of UnitedHealthcare's $14+ billion Medicare Advantage business in Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, Texas, and Wisconsin. Accountable for profit and loss; growth; product strategy and development; quality and CMS Star ratings; and network performance.

- Expanded membership by 60% in five years to 1.2 million seniors, propelling UnitedHealthcare into #1 market share in region with over 25% market share. Increased annual revenue by 80% and earnings by 90%.
- Led execution on comprehensive CMS Star ratings improvement plans, delivering 87% of members in 4+ Stars rated plans for 2020 and the largest 5 Star plan in the history of the enterprise with over 250,000 members.
- Redesigned network strategy across the region. Achieved 81% of medical spend in value-based agreements with over 50% in capitation / risk share arrangements.
- Drove end-to-end restructure of clinical model, tailored to the unique needs of seniors, resulting in significantly improved inpatient and post-acute results.
- Hired key leadership, upgraded talent, and stabilized team. Maintained best in class employee engagement levels.

Chief of Staff, UnitedHealthcare 2011 - 2013

Served as senior advisor to Chief Executive Officer and key member of Executive Leadership Team providing health benefits to 44 million consumers. Led development of strategic plan, long range plan and annual business plan in conjunction with leadership from Finance, businesses and shared services functions. Prepared and coordinated all relevant materials for business reviews, quarterly earnings releases, rating agencies, investor conferences and Board of Directors meetings. Ensured aligned, unified approach to the market with business partners across UnitedHealth Group.

- Led development of first strategic plan for UnitedHealthcare post-integration of all benefits businesses, providing durable foundation for multi-year business plans. Coordinated rigorous annual long-range plan update process.
- Evolved Board of Directors and investor conference materials into crisp, concise summaries – used as models for external communications for key constituents such as major clients, Federal agencies and State regulators.
- Restructured semi-annual leadership meetings, broadened participation, improved effectiveness of messaging platform and introduced LiveStream technology. Drove 70+% cost reduction and achieved 90+% satisfaction.

Vice President, Network Strategy & Innovation 2008 - 2011

Led network strategy for nationwide network comprising over $125 billion spend across 650,000 physicians and 5,200 hospitals serving 25 million commercial members and 8 million government programs members. Spearheaded 5-year network strategy plan to reinvigorate and innovate network offerings for commercial, Medicare and Medicaid lines of business. Partnered with Sales, Product, Health Care Economics, Health Services, Legal and Regulatory leadership to drive successful execution on business plans to dramatically improve healthcare affordability.

- Innovated UnitedHealthcare's pay for performance program through new value-based contracting methodologies, including accountable care, episodes of care / bundled payment, gain-share, and full risk.
- Led development and implementation of tiered network structures and narrow networks in pilot markets.
- Directed comprehensive $133 million unit cost improvement plan.

Vice President, Network Management & Integration, Pacific Region 2006 - 2008
Spearheaded integration of PacifiCare and UnitedHealthcare physician, hospital, and ancillary care provider networks across California, Oregon, Washington and Alaska – $12 billion spend across 81,000 care providers and 466 hospitals serving over 3 million commercial and senior consumers. Led hospital, medical group, physician and ancillary provider negotiations across the region. Partnered with Sales on broker, consultant and customer finalist presentations.

- Successfully drove California network transition for 1.1 million members in less than 180 days, adding 21 hospitals and 9,000 physicians, delivering 9% improved network access and superior economics versus incumbent leased network.
- Directed comprehensive $80 million medical cost improvement plan.
- Championed largest single deployment of claims pricing engine to effect smooth network integration and consistent care provider claims experience across the region.

Vice President, Network Management 2003 - 2006
Designed and deployed strategic tools, processes, and standards across network of over 500,000 physicians with 617,000 office locations coast to coast and $18 billion in spend. Developed UnitedHealthcare's first pay for performance program. Led due diligence activities for Network Management for health plan acquisitions and drove physician network integration for acquired entities.

- Deployed innovative, simplified contract templates and fee schedules for physician network, driving to 69% adoption of contract templates and 84% of reimbursement methodologies across the country in 2 years.
- Implemented fee schedule methodologies resulting in 99+% fixed pricing and low single digit unit cost trends.
- Spearheaded all Network Management activities for Center for Medicare and Medicaid Services (CMS) audit.
- Championed system and process improvements to dramatically improve physician office readiness for Consumer Directed Health Plans.

PACIFICARE HEALTH SYSTEMS, Cypress, California **2000 - 2002**
Fortune 500 healthcare company with 3 million health plan members.

Director, PPO Management 2002
Managed preferred provider organization (PPO) network nationwide, including proprietary network in 8 States and affiliate network relationship in 42 other States. Created and launched network architecture and strategy across PacifiCare, including migration away from leased networks to 100% proprietary network. Designed provider manual and physician office training program. Improved premium pricing models to incorporate accurate network costs through coordination with Pricing and Underwriting, Finance, Network Management, Medical Management and Sales.

- Constructed and implemented new physician fee schedules to optimize network cost position and product pricing and achieve operational efficiencies.
- Designed, launched and completed recontracting of 22,000 physicians in less than 6 months.
- Championed process improvements resulting in 77% in-network claims paid rate.
- Developed and built company-wide processes and policies for Network Management and Operations.

Director, Fee for Service Contracting 2000 - 2002
Built and managed network of ancillary service care providers delivering healthcare to more than 810,000 shared risk and fee for service members in 170 shared risk capitated medical groups, IPAs and directly contracted physician networks in California. Developed 19 direct physician networks throughout California. Negotiated contracts with organ transplant facilities serving PacifiCare Health Systems' membership nationwide. Coordinated with Medical Management, Network Management and Claims Departments to monitor clinical quality, service quality and cost of care.

- Partnered with delegated medical groups to achieve optimal referral patterns.
- Developed and implemented plan which achieved over $11 million annualized unit cost reduction.
- Spearheaded plan resulting in $12.6 million in additional annualized savings from capitation, contract renegotiation and referral pattern redirection.
- Designed and implemented contract management and cost containment tools infrastructure which delivered $9 million in incremental annualized savings.

ADDITIONAL RELEVANT EXPERIENCE

CORVEL CORPORATION, Irvine, CA
National PPO Director

MEDPARTNERS, INC., Long Beach, CA
Vice President, Network Management, Southern California
Director of Provider Contracts, Greater Los Angeles Region

ERNST & YOUNG LLP, Los Angeles, CA
Senior Consultant, Health Care Consulting Practice

EDUCATION

Master of Health Care Delivery Science
Dartmouth College, Hanover, New Hampshire

Master of Business Administration
Southern Methodist University, Dallas, Texas

Bachelor of Science, Civil Engineering
Massachusetts Institute of Technology, Cambridge, Massachusetts

COMMUNITY SERVICE AND MEMBERSHIP

Leadership Council, MIT Priscilla King Gray Public Service Center
MIT Educational Counselor
Member, Uplift Education Board of Directors
Alumni Advisory Panel, Dartmouth College, Master of Health Care Delivery Science Program