Payer/Provider Partnerships Enable Value-Based Reimbursement
by Jay Sultan

Historically there have been huge challenges between payers and providers trusting one another and sharing valuable financial and clinical information. These have been caused by incentives of the “zero-sum, I win you lose” contracting reality of the fee-for-service world and technology barriers created by the almost exclusive use of claims and encounters as an information exchange medium. However, value-based reimbursement methodologies, such as bundled payments and shared savings, are taking a firm hold on the managed care, commercial and government markets. New types of partnerships must evolve between health plans and providers for these initiatives to work and deliver on the “increased quality with lower costs” promise.

Value-based reimbursement (VBR) describes new methods of delivering and paying for healthcare that reimburse for the value of services, not just volume. While people criticize the waste, poor quality and perverse incentives laden in our fee-for-service world, the reality is that the current system works exactly as designed—only rewarding volume. VBR, or payment reform, changes how providers are paid, making them accountable for the value of services delivered and sometimes transferring a portion of the financial risk held by payers to providers.

The word “partnership” has been abused in describing past and present payer/provider relationships, but it is the right word and concept as the industry proceeds with VBR. A new partnership dynamic is necessary for any type of VBR methodology or new care delivery model to be successful.

Accountable Care Organizations (ACOs) can’t be established with the expectation that they will generate savings and improve the health of their membership without changes to the way payers interact with providers.

Payers cannot simply contract for VBR; they must enable it through changes in how information and knowledge are shared, which requires breaking administrative, IT and legal barriers within a payer organization.

Getting There
Collaborative innovation among partners is essential to ensuring new care models successfully result from changes to payment methodology. Establishing trust and transparency, while it may seem rudimentary, is probably the greatest challenge in a partnership. A major area of trust and transparency is data sharing prior to a contract. This is critical because each party needs to have information from the other to help make the decision to enter into an agreement and potentially share risk. In particular, providers must understand the complete and actual costs of the patients they are agreeing to manage and are often unaware of the flaws that exist in their own data.

Only a payer knows two vital elements:

- The full longitudinal care the patient receives, including care outside of the provider organization’s data footprint. Identifying the provider who is rendering care needs to be included as much as possible, especially if that provider is not part of the partner’s organization. Having knowledge of visits to urgent care, the emergency room and uncoordinated self-referrals to specialists offer some of the greatest opportunities for improvement.

- The actual cost of the historical care, measured in “allowed amount.” Billed amounts are not useful and never the unit used in the execution of a VBR agreement. Even if providers have all the relevant claim data, it is almost impossible for them to match their incoming payments to their outgoing claims in a way that allows them to measure actual payer cost.

Most payers are aware of the specific legal considerations and IT challenges associated with sharing data in this way. In addition to legal and IT barriers, it requires a great deal of trust by the provider to offer this type of transparency. Outside of the partnership, in the fee-for-service world, a payer will be at a great disadvantage when negotiating with a provider that has received these data. So if payers think they can be successful forever operating in a fee-for-service world, they might not be willing to share such data. But the willingness to offer this level of transparency is a significant way a payer can establish trust with a provider. In addition, providers no longer want reports only from payers, but the raw data that they can manipulate themselves.

A second major area of trust and transparency is the role of the payer in monitoring and sharing the progress (financial and quality) of the provider during the execution of the VBR contract.

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During the term of the agreement, and with the right level of transparency, a payer will continuously monitor providers’ performance and share this information with them in ways they can comprehend and apply.

Dashboards showing cost and utilization, current attribution, the use of key performance indicators and interim quality results are all extremely valuable to a payer and necessary for success.

This type of ongoing transparency is vital to assist the financial management of the provider under risk; however, alone, it is not sufficient. A provider also needs clinical data and derived knowledge to enable its clinical interventions, care management and other proactive changes.

While provider systems, such as electronic medical records (EMRs) and decision support systems, are useful here, a provider is still hampered by a lack of longitudinal data. Providers do not know what they do not know.

This is one reason why it makes financial sense for payers to provide health information exchange and population health management capabilities to providers. These will not only enable claims data to be shared, but also make it possible for payers to accept clinical transactions from provider systems. With this technology, providers can have a complete view of all care being delivered to the attributed patients, along with knowledge (analytics) to help them identify risk, stratify the population and identify opportunities to intervene, especially in care transitions. In addition, clinical transparency offered by a provider can assist payers in medical policy and plan-based care management.

In addition to trust and transparency, there are other important partnership goals. Payers should enable lightweight innovation strategies by finding ways to start small initiatives quickly yet scale to size based upon success. For example, a hospital-based ACO might quickly launch an innovation using the employees of the hospital as the initial membership, thus leveraging the rich knowledge they have about their own employees. This typically requires IT investment in flexible capabilities and dedicated staff with an entrepreneurial approach and power to address organizational barriers.

For most organizations, the best way to meet new IT requirements is to work at the edge of the IT enterprise, where technology is easier and faster to interpret. Purposely designed products and services that can meet the partnership’s needs by using data as it enters and exits the organization, while leaving the core IT capabilities unaffected, can help achieve this goal. Core claim systems and EMR systems are difficult to change rapidly and are poorly suited to support innovation.

Finally, consider the age of the data being shared. If it takes months for data to flow in and out of a warehouse and into a provider’s view, it has far less value for a partnership. While true real time is unnecessary, getting data in “near time” (days, maybe a week) from the event occurring is the most useful so that providers have the opportunity to react to a case in progress.

Common themes reported by successful programs include:

- While an agreement might be with a hospital, integrated delivery network or a practice lead, it is the front line physicians who must change their behavior to be successful. Most physicians are still rewarded for volume, even if their parent organization has contracted for value. Frequent and accurate communication with physicians and having physician champions is essential.
- Understand and plan for the administrative changes within a payer organization that result from VBR. Outside the new requirements discussed above, there is often significant impact to the payer’s existing workflows and capabilities. For example, if a shared savings arrangement is successful and a large bonus check is written, how can they be allocated back to self-funded employers whose patients benefited? How can bonus payments be reflected in medical spend, underwriting and finance operations if that check is not created out of the claim system? How should benefit design, clinical edits and pre-authorization be changed given the goals of the VBR program?
- Partnerships do not exist in a vacuum. Most providers partner with other payers, as well as with the government, and they want similar, yet different things in VBR. Consider how to foster a community approach to VBR by creating or supporting multi-stakeholder programs and agreeing upon common use of quality data.

Assessing Readiness

These changes and partnerships require collaboration and time. Administrative challenges will also arise. Before embarking on this initiative, payer and provider organizations should decide if they are prepared to:

- Understand and measure the risk a provider organization is accepting in quantitative terms.
- Start quickly and small, with a low cost of experimentation, yet able to scale quickly around success.
- Enable provider-based care management to identify and proactively intervene on high-risk patients to reduce the cost and acuity of their condition.
- Share data between payers and providers and among providers.
- Support care transitions and longitudinal views of all care.
- Provide knowledge that providers can use to intervene.
- Measure progress quantitatively while the program is in operation.
- Support a rapid cycle of intervention and measurement.
- Change workflows and administrative processes to be successful under new VBR models.

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