Gray Matter Analytics Whitepaper

From Antagonists to Allies: Payers and Providers Come Together in the Name of Value-Based Care

Talk of value-based care has run rampant in the healthcare industry for quite some time now. However, the concept – where healthcare providers are reimbursed based on the quality of care achieved not merely the quantity of services delivered – has existed more as an academic thought than a working everyday delivery model. That's finally changing, though, as the healthcare industry is now approaching the value-based care tipping point.

The upshot? Healthcare payers and providers need to move beyond the talk, and start walking the walk. What does that mean? For payers and providers, it necessitates substantial change. After years of working in adversarial relationships, these healthcare organizations now need to pull together and work together toward shared goals. As a result, collaboration is the emerging mantra, according to Sheila Talton, CEO of Gray Matter Analytics, a data analytics advisory and solutions company based in Chicago

"Payers and providers need to start to work with a different mind-set," Talton said. "In order to succeed under value-based care, you need to have both the payer and the provider committed to improving quality."

Beyond the cusp of change

Payers and providers can no longer procrastinate and must start to deal with the realities of new value based models. Indeed, they must change, as a variety of studies indicate that value-based care is about to become the dominant mode of care delivery and reimbursement in the healthcare industry.

Consider the following: Half of healthcare systems are getting some or most of their reimbursement as part of value-based payments that put providers at risk for the cost and quality of care, according to a survey of healthcare payer and provider leaders conducted by KPMG, a global consulting firm. Based on the responses of 86 participants, 36% said they receive some and 14% said they receive most of their reimbursement from value-based contracts.[1] Similarly, *Journey to Value: The State of Value-Based Reimbursement in 2016*, a national study of 465 payers and hospitals conducted by ORC International and commissioned by McKesson, shows that value-based care is becoming a more commonly used model than fee-for-service as payers reported they are 58% along the continuum towards full value-based reimbursement, a 10% leap since 2014 and hospitals reported they're now 50%(?) along the value continuum, up 4% in the past two years.[2]

The call to collaborate

With the realities of value-based care pressing down on them, payers and providers are realizing that – after years of working under less-than-congenial terms -- new care and payment models now require them to work together toward common goals. "They can no longer view their relationship in terms of who wins and who loses. Instead, they need to see themselves in more of a partnership where the payers and providers are aligned around the patients," Talton said.

The change, however, is not necessarily an easy one – as it requires payers and providers to sing from the same hymnal, something that many are not yet accustomed to. In fact, just 47% of physicians reported advancement in payer-provider alignment under value-based contracts in the past year, according to a recent Quest Diagnostics and Inovalon survey.[3]

The good news? Incentives for increased cooperation abound, as payers and providers have much to gain by joining forces. In fact, both parties are bringing some value to the table – which is a prerequisite of any potential partnership. "Payers have part of the data that can drive value and providers have part of the data that can drive value. That's why the two have to come together," said Michael Mathias, CIO and Senior Vice President at Blue Shield of California, San Francisco.

Talton agrees that both payers and providers bring some value to the shared data equation. However, she pointed out that payers typically have more robust data and advanced data analysis capabilities. "Providers often don't have adequate data to understand where their vulnerabilities are in certain services that they deliver to patients. Payers are often in much better situations because they have more mature data analytics platforms," Talton said.

While payers might have a leg up on providers when it comes to data, providers are in possession of something that payers are sorely lacking: namely, clinical data and the relationship with the patients. "Payers need to be improving their relationships with providers and the patients because they simply have to start to provide more value to members. In the value-based care world, they need to do so much more than simply process and pay large volumes of claims," Talton said. "My educated guess is that if you were to take a survey of who a consumer trusts most around giving them advice and caring about the quality of healthcare that they receive, I'll bet you that the providers score much higher than the payers."

New focus, new financial models

When payers and providers join forces and work as a team, they can jointly tackle some of the new realities present in value-based care models. Perhaps most important, these healthcare organizations can work together to succeed under emerging value-based models that define financial success based on the quality of clinical outcomes and the level of patient satisfaction achieved. And, that requires adopting a new tact as providers can no longer simply try to deliver more care and services in an effort to collect more dollars – and payers can no longer simply try to manage and possibly limit payments to providers and ultimately to patients.

Instead, these healthcare organizations must work together to improve overall clinical care outcomes and patient satisfaction, and then accordingly reap the financial rewards of value-based care.

New priorities are apt to come into play as healthcare organizations move in this direction. For example, payers and providers are likely to find that they have a greater impact on outcomes if they work together to improve the health of various populations. Indeed, developing and implementing best practices for large, defined groups – such as diabetic or chronic obstructive pulmonary disease (COPD) patients – is likely to boost clinical outcomes and quality en masse. Indeed, many organizations already are embracing population health. According to the *HIMSS Analytics 2016 Essentials Brief: Population Health Study*, 76% of healthcare organizations had a population health program in place in 2016, compared to just 67% in 2015. Among survey respondents, nearly half reported that their organizations have up to three population health initiatives in place.[4]

In addition, as outcomes and patient satisfaction become more important, healthcare organizations will discover that they need to form close ties with patients. As such, patient engagement will take on increased importance as payers and providers team up with consumers to encourage them to adopt the behaviors that will lead to quicker recoveries and improved overall wellness.

Sampling of strategies

To support population health, patient engagement and other programs that are designed to achieve success under value-based care, payers and providers need to come together to:

Integrate data from disparate sources. Payers and providers need to integrate data – both within and across their organizations – in an effort to reach goals. Such integration is likely to require the adoption of innovative technologies. "Unfortunately, healthcare organizations today have siloed applications. They have electronic medical records, they have lab systems, they have human resources systems, they have claims systems. None of these systems speak to each other – so they need to figure out a data integration strategy to ensure that they can come to the table with more valuable intelligence drawn from their data. To move in this direction, providers and payers need to try to implement some of the newer cloud-based solutions that will enable them to aggregate and integrate data across the enterprise," Talton advised.

Use shared data to manage care across the continuum. When providers and payers can access comprehensive patient data, they are empowered to better manage care. "Providers have no idea how many emergency rooms that a certain patient has been in if they don't have the claims data. They have no idea if the patient was treated and what the patient was treated for in another emergency department," Talton said.

Leverage data to identify population health opportunities. To successfully support population health programs, healthcare organizations need to rely on population health management systems that can identify "a plethora of patient groups and predict where, when and how to best engage them. In addition, they should have the ability to coordinate care across the entire healthcare continuum, support care team collaboration and measure the activities, outcomes and overall performance of providers within the network," according to a Black Book research report based on a survey of 140 CIOs, 159 CFOs and 448 hospital managers.[5]

Use social data to identify population needs. In addition to medical information, socio-economic data can help healthcare organizations determine what is needed to support various populations – and what they should do. "If patients are from a poor community, that tells me they might live in a food desert and not have access to affordable, healthy food choices. Or if a patient lives alone, they might be more susceptible to depression or other emotional issues," Talton said.

Bolster care management efforts. With data aggregated from both payer and provider systems, healthcare organizations can gain better insight into diagnoses, treatments and outcomes. And, this could enable payers and providers to gain more insight that could help with care management initiatives designed to keep members or patients well – and out of the emergency department or hospital.

The information, for example, could help with medication adherence. "The data will tell you whether or not people are taking their medications," Mathias said. "Many times, people are not even filling their prescriptions or they are taking quite a while to fill their prescriptions."

Complete data also can help to direct more aggressive care management efforts. "The data can give us profiles of individuals or cohorts of people who may need more active care. So, it is important to have that data and analyze it. There are indicators that can point to who will eventually become a chronically ill individual. So, healthcare organizations can then reach out to those people proactively," Mathias added.

Coordinate superior customer service. While leveraging data is important, payers and providers can join forces to implement better customer service strategies. "For example, instead of sending a member a letter saying that they are not paying a claim or only paying a portion of a claim, payers can send members a detailed email and follow up with a phone call to ensure that the member understands their choices if they wanted to have a higher portion of the claim paid," Talton said. During this interaction, the payer could explain what effects on payment might have arisen from seeing a physician within the network or getting a second opinion or receiving their physical examination. In addition, if payers and providers work together and have access to each other's applications where the data resides, payers could offer to actually schedule an appointment with a provider – making the whole experience a seamless and convenient one for the consumer.

Cooperation and its copious challenges

While there are many actions that payers and providers can take to succeed under value-based initiatives, challenges abound. Perhaps the most glaring challenge, according to Mathias, revolves around coming to terms with defining the outcomes that will constitute "value."

"There are too many quality measures with government and regulatory organizations offering hundreds of measures. Payers and providers should find a way to break through that. To do so, payers and providers need to have to come together to clearly define what is value and what the goals are," Mathias said.

What's more, providers often deal with many payers – each of which espouse their own quality measures. "The challenge then becomes determining how to reach a true quality goal, when you are dealing with four, five, six or seven payers," Mathias said.

Instead of trying to grapple with hundreds of measures, providers need to work with payers to drive "toward a set of standards that produce true value. So, they need to maybe concentrate on 20 or 30 measures that can truly have a positive impact on clinical outcomes," Mathias said. "Fewer measures would make it make it much easier for payers and providers to come to an alignment around a true value program."

In addition to coming to terms on quality measures, providers and payers also need to work jointly to make the most of their pooled data resources. To this end, Blue Cross Blue Shield of California has Gray Matter Analytics to support value based programs that are being implemented by its accountable care organizations (ACOs).

"Gray Matter Analytics has helped us to re-engineer our data environment so that we can do the high level of analytics and data since around our members and populations," Mathias said. "They help us with everything from data governance to taking different approaches to establishing our data lake and implementing best practices."

Gray Matter Analytics, in fact, provides the ability to aggregate data from multiple payer and provider sources onto its analytics platform. Then, with its machine learning capability, Gray Matter automates the data governance, data collection and data analysis processes.

"When organizations work with our sophisticated data platform, they are able to perform sophisticated data analysis in a very quick timeframe. In fact, within 90 days, we can empower provider and payer organizations with the intelligence needed to work together and implement the many strategies that will result in success under value based care. Trying to perform such data analytics on their own takes years – and that's time that these organizations no longer have as value based care is no longer a futuristic vision but a reality that must be dealt with in the here and now," Talton concluded.

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