WHITE PAPER

Why your organization should prioritize data sharing in value-based payments

By Ben Carroll

INTRODUCTION

Value-based care moves from a nice-to-have model to a healthcare imperative

By Kelly Tsaur and Vikas Garg

As healthcare continues to move from fee-for-service (FFS) to value-based care (VBC) models, health plans should continue to be at the forefront. Costs aren't sustainable, and healthcare consumers say they're not satisfied with treatment experiences or outcomes. They want true payer-provider collaboration to help them move from sick care to personal, preventive care.

In his analysis of how to accelerate value-based payments, our industry colleague Ben Carroll lays out the logistical complexities and common administrative processes that confront health plans and healthcare providers. Ben is a healthcare industry expert and former chief data officer at the largest nonprofit health plan in the mid-Atlantic region. He encourages both sides to embrace greater collaboration and coordination of care by:

- Aligning incentives through refined risk-sharing models and defined step-change behaviors
- Closing information gaps via advanced, real-time data-sharing platforms
- Leveraging predictive analytics to increase patient engagement and decrease medical costs

As Ben writes, “Any discontinuity between payer and provider IT programs is an opportunity to achieve better customer health and satisfaction.”

Why your organization should prioritize data sharing in value-based payments

By Ben Carroll

Across the U.S., chief information officers (CIOs) and chief data officers (CDOs) on both the payer side and the provider side struggle with the logistical complexities of enabling value-based payments. Technology solutions that bridge the biggest gaps in effectiveness and interaction between these main partners are necessary to facilitate this market transformation, and the challenge for leaders on both sides is to define what those solutions look like. You must have a solid shared data ecosystem to succeed.

By working together through common administrative processes and technology, U.S. payers and providers can make the experience of finding and paying for treatment much easier for customers than it is today. Improvements in the cost and quality of healthcare are feasible but only with substantial investment in administrative technology. Any discontinuity between payer and provider IT programs is an opportunity to achieve better customer health and satisfaction.

Organizations need to promote knowledge sharing between payers and providers and streamline workflows. Tools such as the Healthcare Effectiveness Data and Information Set that measure care don't assess the actual achievement of an improved health status for a patient. Chief medical officers (CMOs) will have the information needed to help orchestrate the end goal of enhanced patient well-being from the CIOs aligning the public health, care management and strategic IT structures for both payers and providers.

This white paper explores how the right partnership model, incentivization and team and process alignment are paramount to a successful payer-provider partnership model. The following analysis details research-based issues within the healthcare industry between payers, providers and peripheral entities. Real-time ecosystem models enable healthcare providers and payers to collaborate to improve on and deliver efficient business and consumer outcomes.

Solving the data-sharing challenge in value-based payments

Payers and providers face related but differing challenges in implementing value-based deals, slowing value-based payment expansion and, thus, delaying any associated medical cost savings. Payer and provider challenges boil down to a provider's ability to maintain profitability under value-based payments. Providers are generally challenged to model, gauge and manage the financial effects of value-based contracts from payers and government entities. As a result, the market for analytic vendors to help providers determine value-based payment improvement opportunities is robust.

More-advanced value-based payment models require significantly more technology, data, shared business processes and integrated workflows than early-stage models. Advanced risk-sharing models are also not mutually exclusive; business leaders on both the payer and provider side can agree to apply multiple models in the same relationship. For example, a payer's provider contracting leader might propose to reward a change in a provider's care delivery behavior and outcomes by using episode bundles as bases for shared-risk payments.

Baseline assessment payments readiness is critical in shared-risk payments implementation. Payers can use this assessment as an earnest from-the-ground-up review of applications, operations, business processes, staff needs and workflow discontinuities. For a payer CIO, the IT systems must address new needs under value-based care by interfacing with a partner's electronic health record (EHR), revenue cycle management, care management and value-based analytic applications. For example, let's say a payer has arranged to base its payment of a care management fee on a consumer's election of a primary care physician. That payer must then give the provider a real-time electronic connection between the provider's EHR and the payer's core administrative system so that the consumer can seamlessly change their primary care physician selection.

Getting providers onboard through greater risks and rewards

To address risk payments implementation holistically, you need to consider involving greater levels of provider risk and reward. For example, the director of the Altarum Institute's Center for Value in Healthcare estimates 90% of pay-for-performance contracts are "upside only" in that they do not penalize providers for underperformance. Payer and provider CEOs, boards of directors and CIOs must do more to help their organizations reach higher levels of risk sharing and better health outcomes that are aligned with financial rewards. Higher levels of risk sharing, like moving from pay-for-performance bonuses to shared-risk models, are implicitly tied to better quality and higher rewards. Your assessment must take all aspects of healthcare contractual and operational relationships into account to be complete.

FIGURE 1:

Payer-provider life cycle interaction phases

From an information technology perspective, health plans have invested in web-based portals and other tools to ease providers' patient eligibility look-up and registration processes. Providers have largely not integrated these tools into their EHR systems and are overwhelmed by the burden of using a variety of payer tools. As such, many providers only periodically establish patient eligibility instead of checking for payer site and service coverage at every visit. The result is denied claims when, for instance, a patient changes from managed Medicaid to an ACA exchange individual product—an event that might happen after a patient's income eligibility changes. The solution is not for payers to enhance their web portals to solve a service event but rather for payers to invest in technology that serves and engages providers at all stages of the relationship life cycle and that integrates directly with provider EHRs.

Coordinated action to optimize patient care

Coordinated actions between payers and providers are more often the exception than the rule. For example, provider population health management tools should work hand in hand with payer care management workflow applications. Both strive to optimize member patient health outcomes and quality performance. These applications should continually pass data to one another that helps coordinate the actions of nursing teams in provider settings and at payer worksites based on their respective collaborative roles and expertise. In this model, a payer might pass next best action for quality improvement to a provider that is seeing a member patient that day, while the provider might hand off recommendations for follow-up care scheduling to the payer.

To meet your CEO's value-based payment goals, allocate IT staff and budget resources on areas of misalignment today. Focus on true real-time execution of payment and administrative transactions to make it as easy for your people to coordinate with your partners as possible.

Addressing friction in advanced partnership models

Payer and provider organizations often have different operating models and talent strengths. Organizational change management activities will be required in both organizations to make value-based payment work, on top of technology and process improvement investment. The reward for this investment is a synthesis of experience from both sides. Historically, there has been little data exchange across the continuum of healthcare, but data sharing is critical to support shared processes and decision-making. Data allows identification of the appropriate stakeholders and roles who will achieve alignment on economic incentives.

Providers will need to overcome the fear that payment rates will be adversely affected as they exchange data with insurers, and payers will have to overcome the hesitation that exchanging data with suppliers will make it difficult for those suppliers to recognize and then work around the reimbursement algorithms. There are several approaches payer-provider partnerships can adopt to move toward a trusted health data network:

- Create a framework for exchanging data among all parties participating in the member or patient care cycle.
- Adopt the use of emerging technologies such as data hubs.
- Use electronic medical records (EMRs) as the shared data tool in use by the supplier system.
- Push attributed claims from payers to providers in as near real time as possible. Leverage the shared data network and the claims adjudication system.
- Work with emerging SAS vendors to shortcut cloud, toolchain and certain data management problems, an approach that would also involve improving process maturity and the quality of data.

Ideally, a hybrid approach would leverage several of the above items. With these foundations in place, we still need to develop decision support and predictive models that facilitate proactivity. This will minimize risk while improving costs or economic incentives. Note, however, that even platforms with both an EMR and claims module, like Epic's Tapestry, aren't designed to deliver insights required for value-based contract management and clinical intervention. Leveraging some degree of a data hub approach on both sides supports the capability to share data effectively while preparing for the future in an agile manner.

A new administrative and payment model

A modern data hub approach provides several benefits—including providing a forum for advanced analytics, machine learning, predictive modeling and other types of artificial intelligence. Providing a platform that utilizes these elements helps drive the next best action for patients and caregivers. This decision support can be integrated into patient and provider engagement portals and will help inform both of those core strategies.

Granularity and refinement of these data stories will be enhanced by nonclinical external data, such as race, ethnicity and language data and social drivers of health. Once the objectives of lowering financial risk, growing sustainability, delivering better quality medical services and enhancing patient outcomes are met, health plans and providers who do not accept entering a payer-provider partnership would have difficulty competing in the healthcare industry.

Prioritizing new infrastructure and operating system changes within the business and receiving life cycle stages depends on the priorities of the company and its current investments in technology. Use your evaluation in combination with the strategic plan of your executive team to clarify the rationale for your IT investment and the roadmap for legacy modernization. Have clear criteria and incentives for all parties to use common or interoperable technologies to enhance the customer health outcomes in the next round of value-based contracts at your company. For payers and providers, this is a fundamentally different administrative and payment model emphasizing cooperation and collaboration.

Find ways to improve collaborative workflows and work with the business partners to lobby for them. Help your CEO, CFO and contracting leader identify joint workflow success measures that capture operational efficiency gains and align efficiency gains with financial rewards. For instance, a value-based contract may include a clause that a payer shares a portion of financial benefits from an increased auto-adjudication rate of claims with providers that electronically pre-check patient eligibility at a certain patient visit threshold. All those approaches will help the alignment of providers and health plan platforms.

CONCLUSION

Payer-provider relationships becoming more deliberate

By Kelly Tsaur and Vikas Garg

Across the country, we see VBC initiatives reaching a pivotal point. Payers are gaining traction with their investments, and they’re building trust with certain provider segments that can set aside traditional FFS arrangements in favor of innovative VBC models. Ben rightly observes that chief information and chief data officers are well-positioned to help define and shine a light on the real opportunities. While they might not lead the actual changes in business process, mindset and adoption, they can improve the relevance and trustworthiness of the insights they provide. These leaders have the greatest opportunity, and therefore responsibility, to unlock the business’s ability in making the collaboration happen.

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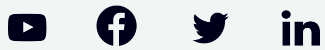

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