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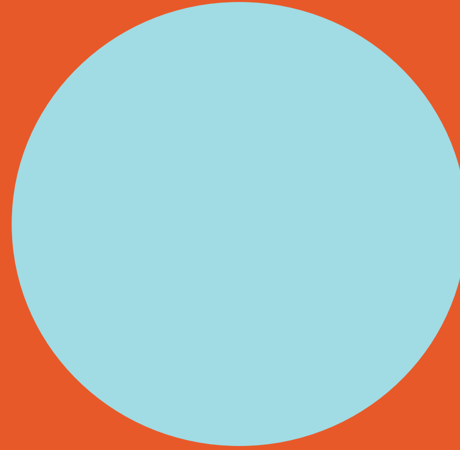

The Road to Greater Payer-Provider Collaboration Has But One Path

By
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Synopsis

For U.S. healthcare to realize its goals of better health outcomes at lower care costs, enhanced payer-provider collaboration is critical. Value-based care and corresponding payment models are the key enabler of that collaboration. More than a decade after the Affordable Care Act set value-based care in motion, most health systems and physician groups engage in some collaboration with health plans. Today some have significant programs, but a significant number have superficial efforts.

Why has meaningful payer-provider collaboration lagged? There is likely not one answer to a complex problem. The organizations that deliver value well generally focus only on value as their systems and processes are set up for this model of care. It's challenging to try to get value outcomes with a system that's set up for volume. The persistence of fee-for-service (FFS) medicine, the lack of energy for change management, and the challenges of meeting performance goals in value-based contracts are all contributing factors. **To shift to value and enhance collaboration with payers, health systems will need to fully commit to value-based care.** Half measures won't work.

The COVID-19 pandemic exposed many fault-lines in U.S. healthcare, including the fragility of FFS medicine and the power imbalance between payers and providers. When hospitals paused elective surgeries and physician clinics temporarily closed, claims volumes fell and the fortunes of payers and providers diverged dramatically.

Providers, already operating under razor thin margins, struggled to stay afloat. Many would have collapsed without rescue funding from the CARES Act. In contrast, payer revenues soared. Even with MLR stipulations, UnitedHealth Group achieved record profits and continues to thrive. Of course, this could be transient, as volumes return to or exceed pre-pandemic levels. The point, though, is that risk is a hedge to volume.

The "Great Divergence" has everything to do with the contradictions of FFS medicine. Providers get paid for the volume of procedures they perform; payers get paid per member per month. Effectively, this makes them financial adversaries in a zero-sum game. And since contracts are only for a year, investments in improvements in health don't have enough time to mature and pay off for either party.

When the Affordable Care Act initiated value-based care models over a decade ago, payer-provider collaboration was considered fundamental to improving health outcomes and lowering care costs. Today, while most health systems and physician groups engage in some collaboration with health plans, real value-based arrangements are rare and FFS medicine still rules. Accordingly, there's little need for financial transparency or data sharing between those providers and payers.

In contrast, a number of innovative and nimble provider organizations have configured their business models to thrive in value-based contracts, and have secured greater collaboration with payers as a result. Their success may threaten health system market share in the future. Traditional health systems will need to follow the lead of those nimble providers or find ways to partner with them if they want to embrace value-based care.

Through the FFS Looking Glass

Despite tremendous industry focus on the shift to value-based care, the majority of a health plan's book of business still operates under FFS contracts. This creates little incentive or motivation for providers to shift to value or for payers and providers to collaborate.

The incentives are different where health plans manage populations in risk-based programs like small group exchange products and Medicare Advantage. While that's typically a smaller component of their overall business, plans can make significant profits managing these populations by reducing the volume of care those beneficiaries receive while achieving quality health outcomes. Sometimes it takes years for programs to be effective, however, and typical contract cycles are annual.

Few traditional providers have the data analytics and care delivery infrastructure in place to engage in the kind of holistic and continuous care services needed to achieve better health outcomes at lower costs. Ironically, providers haven't made those investments because FFS arrangements remain so profitable, and it's impossible to operate under both business models at once.

In place of such collaboration, health plans engage in basic care management. They keep providers in line with gatekeeper functions (like pre-authorization procedures) or through limited (upside-only) risk arrangements that offer providers some financial reward for hitting specific measures but leave payers in control of the premium dollar where profit is made.

This is managed care 101—the basic ways to tamp down utilization. They work, but are painful to implement and are short-sighted measures. Payers have little incentive to share data or align strategy with providers within such limited partnerships. And providers bring little to the table in turn.

Committed to Value

In contrast, a new breed of providers has flipped that equation. Their business models are designed to succeed in value-based markets, and the majority of their patients are enrolled in at-risk contracts through Medicare Advantage, Managed Medicare or Direct Contracting.

Providers like One Medical, Oak Street Health, ChenMed, Absolute Health, VillageMD, Heritage Medical Group, among others, think and operate differently than traditional physician groups and health systems. They are primarily risk-based, and see patients as consumers, and understand the importance of location, brand, and engagement like the best retail businesses. Backed by robust data and analytics capabilities, they understand their local markets and the needs of their patient populations often better than the health plan.

Accordingly, they provide holistic care services through multi-functional care teams and an array of social service provider partners. This helps them manage chronic illnesses, address social determinants of health like transportation, housing, nutrition, etc., and reduce acuity and costs. In addition to their convenient retail locations and hours, they also incorporate digital technologies like virtual care and remote monitoring to treat patients when and where their care is needed.

As businesses, these providers thrive by taking full-risk capitation for their patients, developing effective treatment plans, and profiting on achieving quality health outcomes at a lower total cost of care. Recently, a number of such companies have gone public with valuations (predicated on scaling and growth) that eclipse most health systems, despite their smaller size. The markets recognize that their model, which is supported by a scalable digital infrastructure, represents the likely future of U.S. healthcare.

Like payers, these providers were not overly hurt by COVID because their care utilization costs dropped. Instead, they were able to pour these "extra" resources into new services that followed social distancing guidelines and still met patient needs. That's one of the major advantages of value-based care models.

All-in on Collaboration

These non-traditional, risk-capable provider organizations may be small compared to major health systems, but their clout and reach is growing. Walgreens' acquisition of VillageMD, for instance, positions VillageMD to scale quickly.

Payers engage in greater collaboration with these organizations because they bring so much to the table. In contrast, what distinct selling points do traditional providers offer? Are they the most efficient operator? Are they better at delivering quality care than any other provider? Do they have more hold or sway over their patients? Do they know those patients better than any other stakeholder? Few health systems or physician groups bring anything close to that level of added value.

If providers decide that value-based care is their future, they must determine how to go forward. Straddling both models won't work. Should they become part of a health plan's vertically integrated strategy? Should they partner with the new breed of value-based provider to engage in risk-based contracts by proxy? Should they build the necessary risk-taking capabilities internally?

For those that choose the latter course, there has never been a more cost-effective time to adopt next-generation data-sharing, data analytics, and digital technologies. Building out a platform that engages and serves patients better is a bold commitment that requires a clear strategic vision.

With such capabilities in hand, providers will find payers more eager to collaborate. Real collaboration is based on mutual benefit, not wishful thinking.

Innovaccer Inc., the Health Cloud company, is a leading San Francisco-based healthcare technology company committed to accelerating innovation in healthcare. The Innovaccer® Health Cloud unifies patient data across systems and settings, and empowers healthcare organizations to rapidly develop scalable, modern applications that improve clinical, operational, and financial outcomes. Innovaccer's solutions have been deployed across more than 1,000 care settings in the U.S., enabling more than 37,000 providers to transform care delivery and work collaboratively with payers and life sciences companies. Innovaccer has helped organizations unify health records for more than 24 million people and generate more than $600 million in savings. Innovaccer is the #1 rated Data and Analytics Platform by KLAS, and the #1 rated population health technology platform by Black Book.

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