Payer-Provider Collaboration: It's a Whole New World

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The traditional lines between payers and providers are shifting, as more and more providers enter alternative payment models (APMs) and take on population health management and care management as core functions. How do you see the relationships between payer and provider organizations shifting in the next couple of years?

While historically the payer/provider relationship has at times been adversarial, with the availability of copious amounts of healthcare data, there is the opportunity for payers and providers to collaborate to improve the health of the patient of the patient now more than ever. Both organizations should be focusing on modern methods of capturing, codifying and analyzing data collected on patients so that information can be utilized to provide better outcomes.

The level of cooperation between payers and providers is changing as well. Where do you see the main areas of potential cooperation?

From my perspective, there are two main areas where payers and providers can collaborate - better outcomes and lower cost. From an outcomes perspective, the healthcare industry has established a set of evidence-based medicine guidelines, which can stand as the basis for a patient's care in the majority of cases. By understanding where the patient has received this care and collecting the information from providers around the provision of this care, payers can work collaboratively with the providers to determine gaps in the overall treatment of the patient. Claims payment data from a variety of providers can set the basis for evaluating necessary clinical interventions and determining ongoing care. Identifying a diagnosis based on claims payment data can enable the payer to collaborate with their providers to ensure that a clinically appropriate treatment plan is created and deployed for each payment. If these clinical indicators can be identified at the beginning of care, both the payer and provider can avoid costly ongoing treatment for the patients, resulting in lower costs for the payer, provider and patient.

Which alternative payment models and organizational structures do you see as the most successful so far? ACOs? Bundled payments? Clinically integrated networks? Narrow networks?

The struggle with any alternate payment model is the ability to assess where a provider stands within the model. Providers struggle to get a birds-eye-view of where they are with their patient population and where they need to make changes in their case management of high-risk patients. From a hospital consolidation perspective, a singular EMR with comprehensive charge capture can enable an organization to collect the data they need to analyze where they are with their patients. However, with patient leakage, especially in rural areas or with snowbird patients who receive care in two different states, an organization can still lack all the data they need to make these decisions. As payers, the data is collected from wherever the patient is seen and can give a more comprehensive view of a patient's care. In order to assess their financial standing in their at risk contracts, providers need to push payers to provide them with access this data on an ongoing basis so it can be analyzed with their available data to allow providers to more effectively negotiate and manage their at risk contracts.

What are some of the key lessons that the leaders of hospitals, medical groups, and health systems are learning right now that will provide templates and lessons learned for others going forward?

One of the emerging trends in the market is the advent of "payviders" - a business collaboration between the care provider and the insurer. Providers see opportunities to grow revenue by accepting risk and growing their patient population. Payers see opportunities to partner with providers to expand value-based contracting. Since the passage of the ACA, the number of ACOs has grown dramatically. Many of those include partnerships between payers and providers.

How quickly will the collaboration accelerate in the next few years? Will the landscape around APMs and payer-provider collaboration be very different three years from now?

As with everything in healthcare, it is almost impossible to predict where the future will take us. As one of the only industries that is dramatically affected not only by government legislation, but also by consumer choice and preferences, the landscape is constantly changing. The advent of price transparency and public data that reports on outcomes and cost will most likely drive consumers to take charge of their care in a way that we have not seen in the past. With the ever-rising cost of healthcare and high deductible plans, consumers will be the driving force behind the success of not only the providers, but also payers who are supporting their care. The claims payment transparency that consumers have now is unparalleled and as healthcare continues to hit consumers in their pockets, they will demand more efficient care with better outcomes. Payers, in an effort so lower costs, will demand the same type of outcome related data from their providers in order to provide better customer service for their members.