Providers and payers partner up

By Joe Cantlupe | August 24, 2017

Healthcare payers and providers have long had an adversarial relationship, thanks to a fee-for-service incentive structure that put their business goals at odds.

But that is beginning to change.

Now, more payers and providers are working together, driven by rising healthcare costs and the value-based payments and population-level health initiatives designed to address them. The partnerships range from data sharing to bundled packages — and in some cases, even collective efforts to save health system infrastructure.

"Our goal is not to be uniquely successful in the old model of care," says Keith Fernandez, M.D., senior physician executive at Privia Health, a physician network of 2,000 providers in four states and the District of Columbia. "We're very intent on working with payers to bring value to the equation, to find ways to collaborate, and to improve outcomes."

Engaging patients in their healthcare is a critical component of improving those outcomes, Fernandez says. Some of Privia's payer-provider initiatives have been simple, such as reducing premiums for nonsmokers or eliminating copays and deductibles for patients who keep their diabetic appointments.

But the group has also embraced some broader-scale programs, Fernandez says. Privia actively pursues bundled payments from payers, including a recent bundle for gynecologic surgery and at-risk contracts for sicker populations of people. In one market, Privia is exploring an episode of care for managing pregnancy, aimed at improving access to care, reducing unnecessary C-sections, and lowering costs.

"There's money to be saved anywhere you have a big cost differential in procedures performed by doctors and the facilities they work in," Fernandez says. "Gynecologic surgery doesn't seem like a typical high-cost surgery, but the variation in the market may be $10,000 – $15,000. And it is a very common surgery, so the savings can really add up."

Partnerships at work

Privia's experience mirrors the market as a whole: Payer-provider partnerships are not only increasing, but changing in form, says Tom Robinson, a partner in the health and sciences practice of Oliver

Wyman, a Washington-based global management consulting firm.

While narrow networks — such as the successful Kaiser Permanente integrated system in California — were predominant in the past, Robinson says, there is now an expanding array of options to work together for a common goal. They include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and pay-for-performance programs.

Many of these new partnerships were initiated following passage of the Affordable Care Act, with its focus on improved cost savings, quality and efficiency, Robinson says. The partnerships are also linked to more demands for consumer choice and a growing Medicare population.

Aetna has been one of the most active payers when it comes to forming joint ventures. The insurer has forged alliances with Banner Health, Allina Health, and Texas Health Resources, and also has a longstanding relationship with Inova Health in Virginia.

Aetna's partnership with Phoenix-based Banner Health was built on a previously formed ACO that had led to an 11.5 percent decline in overall medical costs and a 24 percent decrease in avoidable surgical admissions, Aetna said in a statement. Its new initiative is designed to create more services for patients, such as a single site for tracking healthcare and insurance information, and access to customized health services within the Banner network.

The joint ventures are designed "to extend that farther into the community so that community resources are also at the fingertips of consumers we jointly serve," Brigitte Nettesheim, Aetna's president of Transformative Markets, said in a podcast with Robinson.

"We still have a lot of work to do to start to break down artificial walls and barriers so that we're all more knowledgeable about the consumer," Nettesheim said.

Other collaborations have come on different levels and for different reasons. Approximately a year ago, Axia Physician Solutions, a Management Service Organization under Novant Health in North Carolina, helped stabalize a small community hospital, Ashe Memorial Hospital, with their employed physician network investment in which one of the practies was at risk with losing its Patient Centered Medical Home (PCMH) level one status.

"Connected to their Patient Centered Medical Home status was enhanced reimbursement with a significant payer," says Patrick Easterling, president of Axia Physician Services and senior vice president of Consumer Operations for Novant Health. "If Ashe's medical group lost their PCMH status, the consequential impact would have jeopardized much needed access to primary care physicians."

Novant's relationship with Blue Cross Blue Shield allowed both organizations to come to the table and work out a 90-day plan, Easterling says. In the end, the plan protected Ashe's PCMH status and offered more favorable fee schedules.

All the organizations were able to come to the table and work out a 90-day recovery plan, which the payer was willing to accept, Easterling says. In the end, that collaborative effort not only salvaged Ashe's level one PCMH status, but increased its PCMH designation to level two.

"It is a well-known fact that healthcare reform and other disrupters within the industry are taking its toll on small to mid-sized hospitals across the U.S.," Easterling says. "There is a true sense of accomplishment knowing that collaborative models play a key role in ensuring patients can continue to see their doctor."

Integration leads to better outcomes

Sometimes the collaboration is a matter of better integration. When the Carle Foundation Hospital in Urbana, Ill., planned a now-successful merger with the Carle Clinic Association in 2010, it also came with a 250,000 member health plan, The Health Alliance. At first, that health plan wasn't integrated into the health system.

"It was always a business line that was left alone," said John M. Snyder, executive vice president and system chief operating officer at Carle and now

chief administration officer at the Health Alliance. "But strategically we see the integration of the health plan into the health system as a way to prepare us for value-based reimbursements."

Snyder believes the organizational muscles built from the integration — such as combined medical management, case management, common technology, data sharing, and patient outreach — will help Carle succeed at managing high-risk patient populations.

And the integration between the provider group and the health plan has opened Carle leadership up to "different things we wouldn't have thought of before" in service to its patients, he says.

Barriers to partnerships

While more health systems are working toward partnerships, not every organization wants to go in that direction or is successful at it. Some health systems are doing well financially and intend to stay in fee-for-service; others are getting bogged down because they've embraced too many partners at once and "stumbled out of the gate," Robinson says.

And payers' interest in partnerships often varies by payer and by market, says Fernandez of Privia.

"There are areas in the country where those payers are very interested in value-based care and willing to contract differently to take a few risks with a physician organization," he says. "But the same payer in a different part of the country may be completely uninterested. That's probably because the urgency to change is different in different areas."

The misalignment of incentives can also be a drag on partnerships. Historically, one of the reasons that Disease Management and early PCMHs were not successful was that incentives were not properly aligned for either government or private payers, notes Peter Aran, M.D., former chief medical officer at Saint Francis Health System in Tulsa.

In the last 5 – 10 years, there has been better alignment of incentives, Aran says. He cites the CMS multi-payer initiatives Comprehensive Primary Care Classic, Comprehensive Primary Care Plus, and the Oncology Care Model as initiatives where care delivery improvements were agreed upon by providers, CMS, and private payers.

Fernandez and other industry insiders say the adoption of value-based reimbursements – whether in bundles, ACOs, or other initiatives – will lead to better communication, shared patient touches, efficiencies in operations, and shared accountability.

"[Providers] are not going to transform healthcare delivery if they don't have the payers on the same page," says Aran. "If the payers won't pay for it, care transformation is unlikely to be successful."

At the end of the day, Aran says, providers and payers share the same goal – to deliver appropriate care to engaged patients and families who understand their plan of care. "If we're on the same page," he says, "patient care isn't slipping through the cracks, we're sharing patient touches, and patients are healthier at a lower cost."

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