Paving the Way to Fruitful Payer-Provider Partnerships: Building a Foundation of Trust

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Understanding the Problem

• Payers and providers have historically had tumultuous relationships
• The payer-provider relationship has centered on financially focused contracts
• Both have same end goal—improved patient outcomes—but both take different approaches to reach that goal

"The reality is that payers and providers are working to please the same customer—but they are doing it in different ways... Both the provider and payer perspectives have their merits, which is why we need a better model that creates more alignment to eliminate conflicting incentives."1

- Peter Markell, EVP of Administration and Finance and CFO, Partner HealthCare Systems (Healthcare Financial Management Magazine, March 2016)
The Provider Perspective

Frustration with Payers

• Providers lack trust in payers
  ▪ National payers received an average trust score of 51.8/100 (ReviveHealth Payor Survey, 2015)²

• Providers view payers as a barrier to quality care
  ▪ Don’t cover certain medical procedures
  ▪ Reimbursement process very time-consuming
  ▪ The providers with fee-for-service reimbursement are feeling the pressure to see more patients in shorter amounts of time
  ▪ Payment reductions = Patient volume increases
  ▪ Goal: Revenue neutrality
Frustration with Technology

• Facilitating meaningful data exchange
• “Increasing computerization of practice” cited as one of top 3 factors contributing to physician burnout (*Medscape Lifestyle Report, 2016*)
• Difficulty with EMRs
  ▪ Design facilitates billing/data storage/data exchange, not provider workflow. Provider workflows were designed for paper-based environments.
  ▪ Disrupt bond between provider and patient (e.g., when collecting information, provider must face screen and input data instead of facing patient, making eye contact, etc.)
  ▪ Many providers report feeling like data-entry clerks and are hiring scribes to maintain EMR entries.
  ▪ EMR processes are seen as a major change that providers cannot embrace.

Decreasing Provider Satisfaction

• Increased feelings of burnout:
  ▪ 40% - 55% of physicians report feeling burnout, depending on specialty (*Medscape Lifestyle Report, 2016*)
  ▪ 54.5% of physicians reported feeling at least one symptom of burnout in 2014, compared to 45.5% of physicians in 2011 (*Mayo Clinic Proceedings, Dec. 2015*)

• Factors that most contribute to burnout:
  ▪ Decreasing autonomy
  ▪ Cognitive scarcity
The Payer Perspective

Transition to Value-Based Payments

- Payer infrastructure built around traditional fee-for-service model

- Difficulties getting physicians on-board
  - 100% value-based care is a risk for providers
  - Challenges in defining and measuring Value or Quality - most current measurements are based on transactional measures or proxies based on coding and billing guidelines
  - The movement towards measurement of true Quality metrics has been slow and not universally embraced based on the division of ranks between winners and losers.
  - The perception of metric changes based on revenue impact at the practice level
Difficulty Containing Costs

• Consistent increases in healthcare costs seriously impacting payer revenue

• Rising costs can be attributed to, among other factors:
  ▪ High pharmaceutical costs
  ▪ New treatments and technologies
  ▪ An aging population
  ▪ Care inefficiencies
  ▪ “Try everything” mentality

Complicating Factors
Models to Curb Utilization & Costs

• Three common models:
  ▪ Denials
  ▪ Risk-sharing/bundled payments/capitation
  ▪ Tiers/narrow networks

• Each model has its pros and cons, but the denial model is seen as the most intrusive.

• Problems with denial models:
  ▪ Pit payers against providers
  ▪ Conversations focus on “who is right”

Contract Negotiations

• Payers feel providers seek to offset lower levels of reimbursement from Medicare/Medicaid through commercial contracts

• Providers feel that payers don’t play fair
  ▪ Less than 60% of healthcare executives think that payers are at least “somewhat willing” to work with them on negotiations (Numerof & Associates, 2016)\(^7\)
  ▪ 34% of surveyed providers cite “Negotiations over in-network/out-of-network status” as a source of conflict in their relationships with payers (HealthLeaders, 2015)\(^8\)
Lack of Goal Alignment

• Payers see providers as solely looking to increase revenue.

• Providers see payers as simply looking for reasons to tell them “no”.

• Both parties want better outcomes but don’t agree on what constitutes better outcomes.

Closing the Gap
How to Address the Current Impasse

• Shift question from “Who is right?” to “What is right?”
  ▪ Agree that the patient’s best outcomes are everyone’s goal
  ▪ Rebuild trust by defining mutually beneficial endpoints

• Payers and providers work together to achieve common goals

• All parties (patient, payer, provider) benefit

Collaborative Care: A Case Study

• 56-year-old female with family history of thoracic aneurysm
• No current complaints, no previous diagnostic imaging
• Provider requests CTA of chest and CTA of abdomen and pelvis
• Patient does not meet criteria for these procedures
• Discussion between ordering physician and peer physician focuses on what is a better treatment option and why, using clinical evidence for support
• Procedures changed to chest x-ray and abdominal ultrasound
• Benefits to patient, provider, AND payer
New Pay-for-Performance Models

• Define and agree on quality metrics, the meaning of “better outcomes”.

• Payers and providers can work together to develop pay-for-performance models using quality metrics.

• Any deviation from those metrics does not mean poor metrics.

• Better compensation models are needed to move away from fee-for-service models without creating a threat to financial security.

• Clinical decision support model = A smarter, personalized model

Increase Transparency/Data Sharing

• Payers can implement solutions that make it easy to share all available data to reduce fragmentation of patient care
  - Providers rated “access to risk-adjusted payer data” and “access to aggregate claims data” as the top two payer activities that provide their organizations the most benefit (HealthLeaders, 2015)⁹

• Providers can share clinical data to help manage complete care of patient
Increase Transparency/Data Sharing

- Success Story: Innovation Health (Partnership between Aetna & Inova Health)\(^\text{10}\)
  - Nurses from both payer & provider meet daily to review patient information
  - Aetna shares claims data
  - Inova and affiliates share clinical data from EMRs
  - In first two years of program implementation, 30-day readmissions down 28%

Collaborative Consultative Model as an Alternative to Denial Model

- Collaborative treatment decisions lead to more appropriate, effective care
  - Study by Adam Powell PhD et al., “Reinitiation of Withdrawn or Modified Neuroimaging Requests After Collaborative Consultation” (Academic Radiology, Nov. 2015)

- Collaborative, educational models that don’t deny care still lead to cost savings
  - Study from Rapaport et al., “A Large State Medicaid Outpatient Advanced Imaging Utilization Management Program: Substantial Savings Without the Need for Denials” (Medical Care Research and Review, Sept. 2015)
Collaborative Consultative Model as an Alternative to Denial Model

- Common misconception is non-denial model will lead to more approved procedures
  - Study from Robinson et al., “The Effect of a No-Denial Policy on Imaging Utilization” (Journal of American College of Radiology, July 2013)

Collaborative Consultative Model as an Alternative to Denial Model

- Collaborative models show commitment to patients’ best interests
- Non-denial models reduce abrasion between payers and providers
  - Example: Sleep Medicine Case Study
- More realistic use of evidence-based guidelines
- Focus on improved outcomes through provider education
  - Example: Peer physicians in specialty of requested procedure made available to have a constructive conversation about evidence-based practices
  - Educational resources should align with how physicians learn
Making Collaborative Care a Reality

Collaborative Care: What can payers do?

• Implement programs that work with providers to determine optimal treatment solutions for patients.

• Provide meaningful, accessible resources for providers.

• Incorporate providers into discussions on how to define quality goals and improved patient outcomes.

• Evidence-based practices need to adapt, depending on individual patient circumstances.
Collaborative Care: What can providers do?

• Partner with payers to align quality patient outcomes with revenue goals
• Work with payers to develop mutually beneficial pay-for-performance structures
• Use available resources to enhance patient outcomes

Q & A
Appendix

1. Quote source: https://www.hfma.org/Content.aspx?id=46822