

IT strengthens payer-provider partnerships as VBR arrangements take hold

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ew reimbursement models, changing regulatory dynamics and broad quality initiatives pressure providers and health plans to increase their focus on the value of health care services being delivered for the premium dollar. This shift in focus causes risk to be transferred

from payers to providers, blurring the distinction between the two entities. It also drives both entities to forge relationships that maximize mutual resources — experience, tools, technology and data — in order to lower costs and improve the quality of care. IT plays a critical role in this convergence, according to Dean Farley, vice president, provider reimbursement, Optum payer consulting.

“The winners in this process will be the payers and providers who figure out how to collaborate, how to share information and how to use technology to enable higher quality and lower costs,” he said. “I think it’s safe to say that in this context, technology plays a fundamental role,” Farley said at a recent Optum Perspectives webinar, “Payer/provider convergence and IT’s critical role as enabler.”

Farley explained that providers may need to rely more on payers to help them manage the risks they are assuming in value-based reimbursement (VBR) arrangements, because plans have data and technology assets that providers do not possess. “A provider typically doesn’t see all of the care that is being given to a patient,” he said. Providers know what they are doing, but unlike health plans which see claims for all services related to a patient, they do not see the

patient’s big picture, he continued. For risk transfer to be successful, payers and providers will need to work together toward a common goal.

### Technology is a powerful tool in VBR realm

Farley noted that although medical technology continues to make great advances, those advances come at great cost. “The question is how do we begin to evaluate which technologies are worth the cost? And how can we create incentives that encourage providers to adopt cost-saving or at least cost-effective technology?” he asked. “The answer is to place providers at more risk and align incentives between payers and providers.”

To do this effectively, benefit plans cannot “just dump risk on providers or consumers and wish them luck ... they need to view providers and consumers as partners and work with them. Payers have the resources to build the infrastructure that will be needed,” Farley explained. He advised plans to consider the following

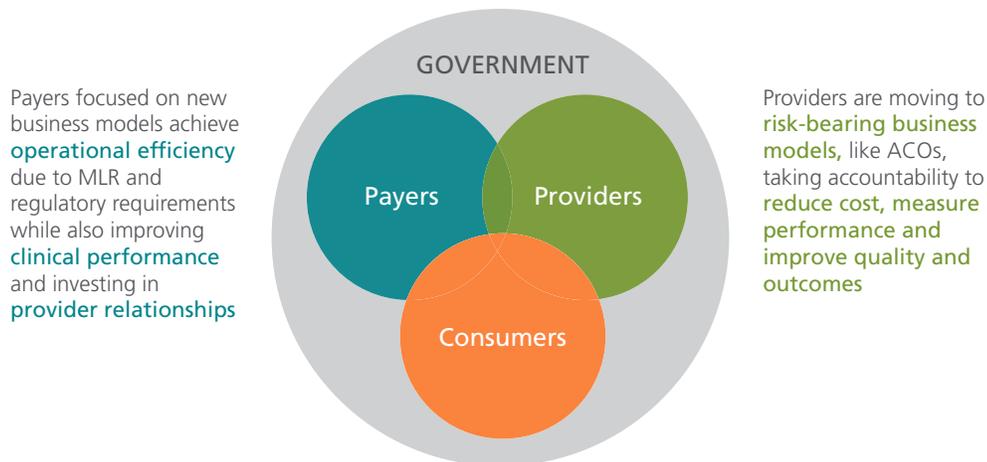
**Expert presenters**

**David Chennisi**, Vice President, System Integration, Optum Payer Consulting

**Dean Farley, PhD, MPA**  
Vice President of Provider Reimbursement, Optum Payer Consulting

**Figure 1**  
**Emerging relationships and value-based models**

The **convergence** of payers and providers requires **new technologies** and **value-based service models** to comply and compete — or even just survive



Consumers are **taking additional decision-making responsibilities** both in selection of plans (public and private exchanges) and in managing costs (e.g., high-deductible plans, HSAs)



questions as they assess whether their infrastructure will support these risk-sharing arrangements:

- Can your systems manage risk-based arrangements?
- Are your systems connected in real time to EMRs?
- How will you use integrated member/patient data to drive improved outcomes?
- How can you help providers create their own capabilities and/or support them?

### Successful VBR implementation starts with data

Optum believes that data is the foundation of payer/provider relationships. Payers and providers “need to move toward having a common view, or common methodology for data analytics and information in order to make sure that all parties have timely access to appropriate clinical information and are able to perform clinically meaningful risk adjustment,” David Chennisi, vice president, system integration, Optum payer consulting, told webinar attendees.

Plans have “an enormous and significant asset” in their existing infrastructure that has been developed over decades to support their own risk management, such as actuarial services, decision support services, data management and claims capabilities, Chennisi said. “There’s an opportunity for plans to make available pieces of what they do to provider organizations with whom they are partnered in VBR relationships,” he added.

*There’s an opportunity for plans to make available pieces of what they do today, to provider organizations with whom they are partnered in VBR relationships.*

— David Chennisi

*Vice President, System Integration, Optum Payer Consulting*

“Health plans need to review their capabilities and evaluate how to package themselves. Plans need to understand the segments in the market,” Chennisi continued. “It’s important to take a look at what combinations of capabilities can be offered to the marketplace.” Chennisi suggested that plans ask themselves the following questions:

- Do you have online tools for performance measurement? Paper tools?
- Do you have the ability to integrate with the electronic medical record (EMR) and provide clinical records?
- Can you create a centralized portal for engagement with providers?

Plans do not have “to bite everything off in one fell swoop,” Chennisi remarked, and can prepare for a logical progression where the information gets “where it needs to be over time,” which “is in the hands of the clinician, right at the point of care. The process can start with passing specific data to an individual’s EMR and then move over time to a communitywide view of the patient with appropriate access and collaboration. Finally, data would move into the zone of population health management, supported by real-time data and analytics.”

### Optimizing information management will improve quality of care

Chennisi walked attendees through a map of information flowing among payers, providers and members. The more advanced functionality of shared data assets results when utilizing the health plan’s clinical analytics platform (fueled by claims data collected by the plan), the member/patient engagement interface, the provider engagement interface and, significantly, the real-time health information exchange (HIE) infrastructure.

The HIE “is where things really get exciting, because it lets multiple organizations share important clinical information electronically,” according to Chennisi. “This improves the timeliness of data and allows providers to consume and process clinical information using their own systems, not someone else’s system,” he said.

Farley remarked that as providers are being asked to increasingly participate in or even own specific core management functions, such as medical homes being responsible for case management or care coordination, underlying technologies and functions are the tools through which they can get the job done. “Analytics that are looking at financial, operational and clinical outcomes, trying to understand what is working and what is not working, and figuring out why can be embedded in the corporate strategy,” he noted.

In closing, Farley set forth the following takeaways that are critical to understanding where the health care industry is headed:

- Value-based contracting blurs the distinction between benefit plans and provider organizations — indeed there are insurance companies running health clinics and providers running consumer outreach campaigns.
- A commitment to value-based contracting requires far more than new financial arrangements between benefit plans and providers. “This isn’t just about incentives,” Farley said. “It’s about building a shared infrastructure and having a shared commitment to increasing the value that patients are receiving for their money.”
- The purpose of value-based contracts is to create mutual interest in managing the health of a population efficiently and effectively.
- Plans must support their network of providers along both clinical and administrative dimensions.

Figure 2  
Segmented strategies for effective network management

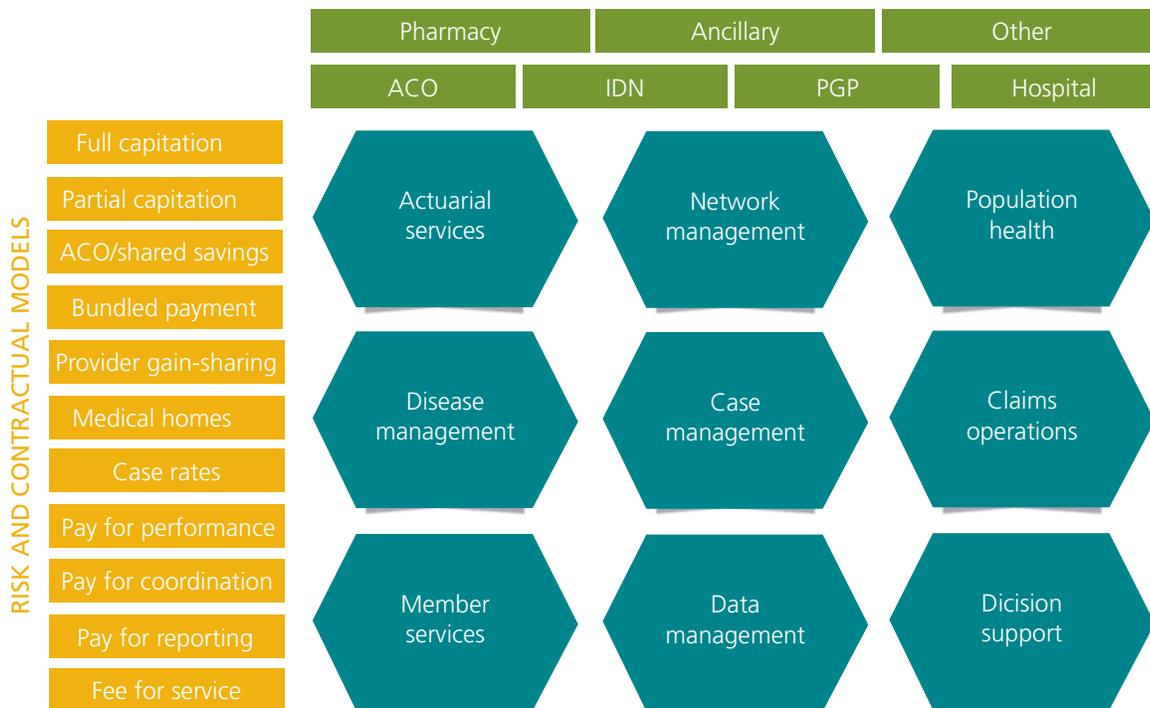
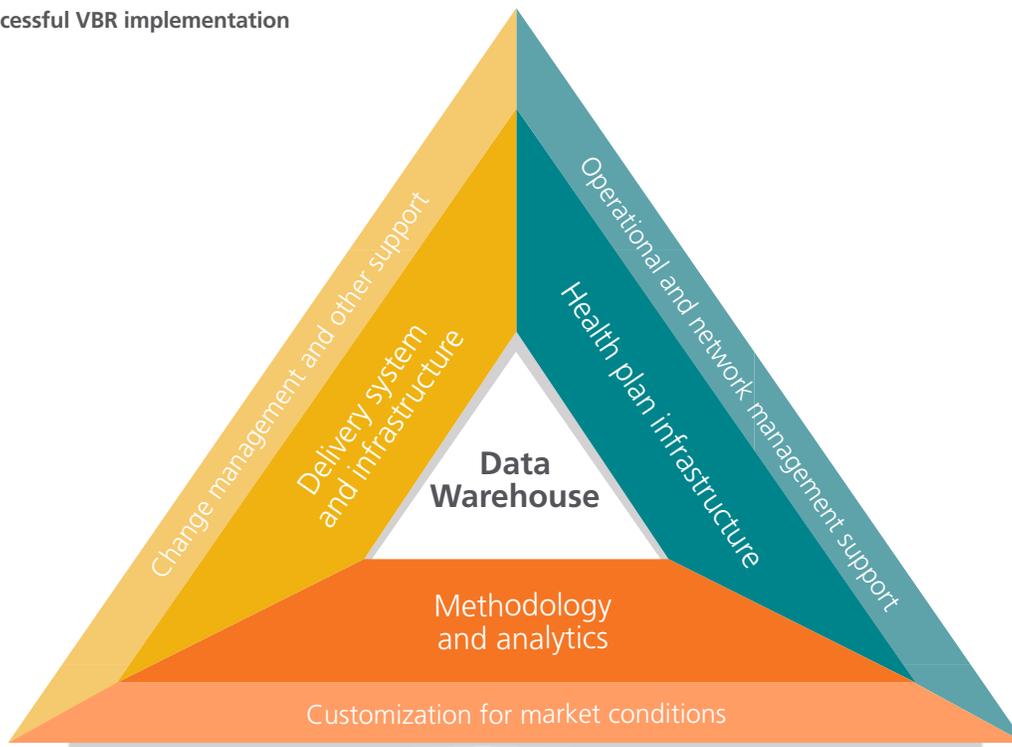


Figure 3

Keys to a successful VBR implementation



- The most effective plans will take time to segment the providers they work with and establish a provider-support framework.
  - Provider organizations must lead the way in managing the medical expenses for which they are at risk, with plans as their partners.
  - The most successful providers will take advantage of the infrastructure created by benefit plans to use clinical information and new care models effectively.
- “When providers are at risk as a result of [VBR] arrangements, they play a leading role in some of the medical management functions,” Farley concluded. “The challenge is to leverage technology across organizational boundaries and to enable these functions and drive improvements in care.”

### How Optum can help

The health care market trend of payer/provider convergence requires flexible, scalable services to plan and implement new risk-based business models that improve the quality of care. Optum can help health plans and other risk-bearing entities integrate their IT and business strategies and position them for growth with:

- Value-based Reimbursement (VBR) strategy development, and technology and operational assessments
- VBR contracts, metric alignment and reporting
- Systems integration, configuration and development, and an analytics data warehouse to provide actionable data

### Want to learn more?

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