Illuminating the path to value-based partnerships

An executive’s guide to data-driven alignment

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Data and value-based partnerships

Meeting the challenge of value-based care

Health organizations are striving to compete and thrive. They work hard to gain a deeper understanding of market dynamics, partnership choices and growth opportunities.

Lowering costs while improving health outcomes is a tricky task. Managing the cost, billing and payment of care services requires a sophisticated system and staff. And just meeting industry benchmarks requires that health plans and providers work together in new ways.

The challenge of value-based care entails meeting consumer health needs before, during and after a care event. This is an undertaking that no one can handle alone. But how can leadership feel confident about the recommended action plans? To succeed as partners, organizations need a complete data-driven view of their market and their place within it.

Align with champions and partners

Achieving partner alignment is the key to unlocking market growth. But such partnerships don’t happen by accident. They’re built by strategic, clinical, financial and IT leaders who see the value of sharing data. The partnership process starts with data-driven conversations about markets, populations, performance and pricing.

With the clarity of rich data, health plans and providers can identify common objectives and meet market demands together. Deploying this data can fuel better system performance, greater consumer loyalty, and surer financial growth.

This e-book illustrates how health care leaders can use data to build strategic relationships that deliver value and drive growth. It offers a data-driven roadmap for achieving benchmark performance, lowering care costs and building consumer loyalty.

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Health care partnerships are on the rise. And they are coming from all sectors. Vertical integrations are looking to build economies of scale. Employers are creating new arrangements to secure control of the supply chain. Retailers are making new connections to leverage their consumer expertise. Other non-health industries — tech being a leader among them — are edging into the market as well.

But the most common health care partnerships are found at the market level between health plans and providers. In a recent survey from Optum, over half of health care leaders said value-based partnerships are essential for reducing the total cost of care. Meanwhile, half of respondents indicated there is more work to be done through greater collaboration.¹ These players come in all sizes, and all are looking for smart ways to compete. Many are discovering how data analytics can help forge and fuel strategic relationships.
Where are you on the path to partnership?

PHASE 1 Preparing to partner

Before you engage any risk associated with value-based arrangements, you want to know that you’re partner-ready. Here are four steps to partnership and data readiness:
1. Create a market diagnostic blueprint
2. Conduct an organizational self-assessment
3. Assess potential partners
4. Quantify the high-impact opportunities

PHASE 2 Building the foundation

Claim and payment transactions have long been challenging for health plans and providers. If there’s friction here, creating a closer strategic partnership will be difficult. Centralizing data and perfecting its exchange can build transparency and understanding. This builds the trust at the financial core of the relationship.
PHASE 3 Collaborating for quality

Leaders must evaluate their market opportunities and identify shared objectives. Then they can use data analytics to design their first alternative care and payment models.

PHASE 4 Forging strategic partnerships

Value-based partnerships use data and analytics to expand their footprint and respond with effective interventions. When stakeholders share, they can work together to save costs and deliver high-quality outcomes.
1. Create a market diagnostic blueprint

Health leaders know their competition. But many haven’t gathered the right data to size up gaps, pricing opportunities and network leakage.

The process should begin with publicly available data, amending with richer data if desired. Then, partners can develop a market diagnostic blueprint to determine:

- Consumer populations, their full scope of needs, their geographic footprint and their social determinants of health
- All health plans and provider systems available to the community
- The mix of government-sponsored and commercial health plans
- Who is offering what products and how they are priced
- The size of providers and the types of care their network delivers
- New entrants who may disrupt the market

Gathering this data and the associated insights can help you spot unmet needs and unseen opportunities.

2. Conduct an organizational self-assessment

Before investing time and resources in a partnership, it’s wise for organizations to check their own readiness. Executives must be ready to respond to the requirements and contractual obligations they will create.

Among the matters they should consider:

**Clinical competencies**

Clinical leaders must uncover where leakage is occurring. To do that, they can assess the scope and cost of their populations’ care needs and map referrals by procedure. Comparing service channels to patient locations will reveal gaps. These can be closed by partnering with providers in that area who can best manage quality outcomes for these conditions and populations. An assessment of network performance and readiness can help identify partnership goals and incentive requirements.

**Strategic readiness**

Strong governance ability, past partnership experience and durable current relationships are good early indicators of likely partnership success. Brand awareness and affinity levels are other values you can bring to the negotiating table. Moving forward, executives should be confident that their teams are data-ready to meet long-term requirements.

**Financial valuations**

Finance teams need valuations of the current network, infrastructure, footprint and population care needs. Then they can rationalize or negotiate any partnership. These inputs can balance partner strengths, identify gaps, define opportunities and help structure the contracts.

**IT requirements**

Organizations moving toward high-performance health care must be data-ready. They should have the capabilities for secure and discreet data-sharing. Financial and clinical infrastructure is a valuable asset to bring to a partnership.
3. Assess potential partners

The first step in evaluating partners is defining your own growth objectives and market opportunities. Then, use analysis from your market blueprint to identify which partners share your population and growth goals. Also ensure they have an equivalent ability to manage high-quality care and outcomes. Mapping how well others are already doing at bearing risk can also help inform your decision.

Thoughtful leaders will ask a great many questions before deciding whether to move ahead with a partnership venture. Here’s a short list of questions to get started:

**Strategic**
- Based on your market analysis, which prospective partners align with you?
- Where are you “sharing” patients or members today?
- Does the potential partner have leadership in place to support the partnership?
- Do they share your growth objectives by product and populations?
- Are the two cultures compatible?

**Financial**
- Who will determine contract obligations?
- How will metrics be shared?
- Will capital be contributed to the partnership? How will it be used?
- How will billing be processed?
- Will human resources and real estate be included in the relationship?

**Clinical**
- How challenging will it be to align programs and quality standards?
- How will you share utilization management and care Coordination responsibilities?
- Does their infrastructure support the care management required for growth?
- What physician leadership can they bring to the venture?

**Information technology**
- What technology will be involved?
- How will you share clinical and financial data?
- Is your partner data-ready?

4. Quantify the high-impact opportunities

Determining the financial potential of these arrangements requires actuarial modeling of available premium dollars and their current distribution.

Selecting the right care opportunity hinges on consumer data. This information identifies what consumers need, where and how they engage, and when they leave your network.

Combining these data sets pinpoints where you might focus resources. These opportunities should improve care within your population and generate a benefit from the partnership investment. Data analytics can help you look further to identify the care and payment model you wish to pilot.

According to Jay P. Hazelrigs, Vice President of Optum Advisory Services, sharing is the foundation of value-based partnerships. “Prospective partners should make sure they’re contractually aligned,” he said. “Do you have an equivalent ability to manage high-quality care and outcomes, and are you willing to share data to achieve this goal? Alignment in these areas goes a long way in enabling the necessary collaboration.” This sharing includes:

1. Data
2. Growth and quality objectives
3. Populations
4. Infrastructure
5. Culture
6. Capital
7. Allocation of responsibilities
8. Key asset contributions
Building the foundation

Building trust at the financial center

By automating claim and payment workflows, health plans and providers become better prepared to engage partners and alternative payment models. They can accomplish this by automating accurate claim and payment workflows.

Many health plans are still operating on incremental controls and audit process to prevent leakage and improve accuracy. But when they move toward streamlined data sharing and workflows, they are shifting toward holistic big-data management. This is foundational to value-based contracts.

For providers, data-driven claim payment conversations happen throughout the care event. They determine prepayments, copayments and the final adjudicated claim balance. Data improvements at the front-end of the revenue cycle reduce denials. They can also help build a more holistic picture of the patient early in their encounter.

A well-functioning payment process builds trust in the health plan-provider relationship. It has a profoundly positive impact on consumer satisfaction levels. And health care leaders are well aware of the issue. 61% of health plans and providers said their organizations aren’t yet prepared to boost consumer engagement under value-based contracts.

Finding agreement and benefits in the claim process

By centralizing their payment system, health plans strengthen their business. Savings can be as high as 4% in medical costs and 10%–20% in administrative expenses. And these savings can help fund technology investment. Eliminating fraudulent and improper payments can lift a health plan’s NPS scores and make them more attractive to potential partners.

Providers also need a collaborative environment across their clinical, operational and administrative staff. Denials can be resolved before submission with accurate clinical documentation, historical claims data, denial trend analytics, and intelligent claims editing. Without a modernized revenue cycle, value-based contracts will be harder to reconcile.

Supporting data and technology

For health plans, payment accuracy brings together operations, product management, analytics, claims and member administration teams. Only then can they resolve data issues associated with denials. They can also shift their infrastructure to a cloud-based data sharing platform.

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Financial data is the keystone of the health plan-provider relationship.

An early step in value-based partnerships is to overcome decades of tension around rates and denials. Health care denial rates remain high with an average in-network claims denial rate of 18%. These represent unnecessary administrative costs and aggravate everyone involved. Health plans, providers and consumers feel this friction daily. When stakeholders lack trust in the process, they won’t trust anything else.

Find more resources on simplifying payment systems at Optum.com/simplify
### Ensure accurate, data-driven decision-making early in the partnership

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<th><strong>Health plan action steps</strong></th>
<th><strong>Provider action steps</strong></th>
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<tr>
<td>□ Assess existing payment process</td>
<td>□ Analyze queries, denials and rejection reports</td>
<td>□ Identify internal executive sponsors</td>
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<td>□ Implement well-defined, integrated analytics</td>
<td>□ Maintain a knowledge base of health plan rules and guidelines</td>
<td>□ Infuse predictive models into your claim payment process</td>
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<td>□ Bring activities into one office</td>
<td>□ Infuse analytics within existing EDI workflows</td>
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<td>□ Determine metrics</td>
<td>□ Feed intelligence upstream</td>
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<td>□ Identify problem claims before payment</td>
<td>□ Resolve claims before submission</td>
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### What you carry forward

By shifting internal data out of silos, health plans can begin to operate in a big-data environment. A claim payment system with low denial rates builds trust in the health plan-provider relationship. Adding automation and analytics allows for better internal decision-making. Best of all, it’s a profitable gateway to modernization.
Collaborating for quality

Data lets you analyze cost and impact care management.

Ensuring optimal quality at the lowest price starts with a complete view of the patient. Getting that view involves commitment within the health plan-provider partnership to share clinical and claims data. Only then can they confirm care gaps, understand leakage or identify why service performance fell below benchmarks. Only then will they know if their services and their partnerships are competitive.

Create patient views by combining data
For organizations building their value-based strategies, gathering complete historical views is a swift way to start. Sharing this data with your primary care network allows them to close care gaps and add more data to the profile.

Identify high-risk patients by amending data
Patients often enter the system with unrecognized health concerns. High-risk patients can be spotted early by amending patient data with longitudinal data and predictive intelligence. That enables them to receive the interventions they need in a low-cost, ambulatory setting.

Reduce readmissions by sharing rich data
Care decisions made outside of the hospital determine if a patient stays well or if the treatment has collapsed. Transition teams, specialists and ambulatory facilities need to share the same data-rich patient view. They need access to the same evidence-based care protocols that health plans and providers agree give rise to success.

Eliminate care variation through data analysis
Using cost accounting data can help health plans and providers identify care variations within verticals that represent the most risk in their population. This can focus efforts to eliminate care variation for the most costly and complex conditions.

Test alternative model pilots
Population health modeling can evaluate suggested care models and the impact they could have on health and costs. The best outcomes are a result of complete patient views that are shared across the model’s care continuum for outreach, diverting utilization and managing transitions well.

Read more about how Wilmington Health achieved 44% less ER visits than the national ACO benchmark.

Read more about how UMass Memorial Health Care utilized data and analytics to achieve a 2.7% increase in breast cancer screenings.
Value-based partnerships at this phase have mastered their internal data — both clinical and financial. They can now make informed strategic decisions to strengthen their market share and their market position. See how advances in data and analytics are improving outcomes, reducing costs and enhancing the patient experience.

Connecting the data to coordinate care

In these types of relationships, health plans can begin to contribute to cost-effective, quality care. Providers start to gain a line of sight into the complexities of managing risk.

Value-based partnerships can align their strengths and innovate their services to match the market need. Collaborating around data and a shared view of market opportunities can accomplish this. As each organization transitions to value, they must coordinate across clinical, financial and operational systems.

And the benefits are real. Through a market analysis and combined approach to data, health plan and provider partnerships can:

**Be more strategic**
- Confirm where you are most competitive
- Figure out when consumers are leaving the network
- Gain a more predictive view of risk
- Measure the business value of potential interventions

**Act with foresight**
- Leverage analytics for patient views
- Evaluate which physicians are achieving benchmarks
- Test value-based models

**Gain more rewards**
- Improve care protocols
- Reduce readmissions
- Improve utilization
- Meet CMS requirements
- Increase quality metrics and rankings

What you carry forward

Value-based partnerships at this phase have mastered their internal data — both clinical and financial. They can now make informed strategic decisions to strengthen their market share and their market position. See how advances in data and analytics are improving outcomes, reducing costs and enhancing the patient experience.
Forging strategic partnerships

High-performing, value-based partnerships use analytics at every turn. They map their markets, understand their populations and evaluate their strengths. They also identify competitive threats and use predictive modeling to design care models that will improve specific outcomes and impact the total cost of care.

They also use data analytics to track quality at each phase of the patient experience. Data can guide caregivers toward cost-effective quality outcomes — from preventive intervention through in-patient analysis and post-care transitions.

To stay attuned to protocols and benchmarks, physicians use real-time performance reports to monitor quality along the way. Health plans can help providers meet this new demand for data infrastructure.

But leaders on either side need clarity. Actuarial analysis can determine which value-based models offer the greatest opportunity, and what level of risk they are equipped to manage. Let’s look at three that are gaining momentum.

**Specialty models**
These manage specific conditions such as cancer, diabetes and heart disease by connecting primary and specialized care. They generally focus on government-sponsored programs. These arrangements share savings achieved by lower utilization. Contracts are based on the ability to provide cost-effective, quality care across the life cycle of the disease.

**Bundled payments**
These frameworks focus on specific care episodes, such as cardiovascular procedures, orthopedic surgeries and perinatal care. They focus on reduced care variations and reduce medical expenses for the surgeries and follow-up care.

**Patient-centered medical home**
These structures concentrate on long-term engagement with the patient for conditions such as heart failure or behavioral health. Contracts often determine a fixed price for care on a per-month, per-member basis.
Responding to market dynamics with actionable data

Successful health plans and providers have established high-performing networks and can sustain competitive pricing. With this advantage, they can aim to dominate the market for specific services or populations.

And since prevention and utilization strategies guide patients outside of the hospital, these value-based arrangements can also generate new revenue streams.

Determining the market opportunity and designing the products takes data. Aligning care pathways with financial and quality models takes data. Building new work streams and performance reports takes data. Supporting care coordinating and consumer engagement takes data. Data analytics enables the insight you need to focus resources and improve outcomes.

What you carry forward

The ability to share and coordinate intelligence gives value-based partnerships the insight they need. It helps all parties maintain relevance, respond to market dynamics and build consumer loyalty. Read more about how data-driven insights will change health care.
Where are you on the path to value-based partnerships?

Review the checklist at each phase to assess your level of readiness.

PHASE 1
Preparing to partner

- Completing a market blueprint
- Conducting organizational assessment
- Evaluating potential partners
- Defining relationship opportunities

PHASE 2
Building the foundation

- Removing friction from the claim payment system
- Pulling internal data out of traditional silos
- Infusing predictive models into the claims process

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Having the infrastructure to share data
Amending data with longitudinal insights
Utilizing data to assess care variation
Conducting population health modeling

PHASE 3 Collaborating for quality

- Having the infrastructure to share data
- Amending data with longitudinal insights
- Utilizing data to assess care variation
- Conducting population health modeling

Review the checklist at each phase to assess your level of readiness.

PHASE 4 Forging strategic partnerships

- Sharing performance metrics with clinicians
- Tracking quality across the consumer experience
- Refining care protocol to match evidence-based guidelines
- Meeting utilization goals and CMS benchmarks

Value-based readiness checklist
Achieve collaborative, value-based partnerships using data analytics

Health care intelligence empowers collaborative decisions to ensure efficient care and sustainable growth. It provides the transparency needed for honest, strategic conversations. Of course, this growth doesn’t happen right away. It takes three to five years for strategies to generate results. But by taking a data-driven, collaborative approach, health systems and providers can realize positive change.

With a thoughtful, phased approach to partnership you can:

• Balance modernization with opportunity
• Engage appropriate levels of risk
• Strengthen your relevance in the market

Learn more about how your organization can use data analytics to create value-based partnerships.

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optum.com/partnersinvalue

Sources

https://www.modernhealthcare.com/assets/pdf/CH118754212.pdf


3 Choffin M, Durham J. CIOs will chart the course to the cloud, beginning with payment accuracy. Insights page. Optum website. 

About Optum

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. We deliver integrated solutions infused with OptumIQ™, our unique combination of data, analytics and health care expertise, to help modernize the health system and improve overall population health.