



Spectra MEDIX

**THREE KEYS TO PROVIDER
ENGAGEMENT: ALIGNMENT,
CLARITY, & TRANSPARENCY**

Introduction

As health plans transition to value-based payment models, the payer-provider relationship continues to evolve. More than ever it's become important to engage and encourage providers to participate in cost-savings.

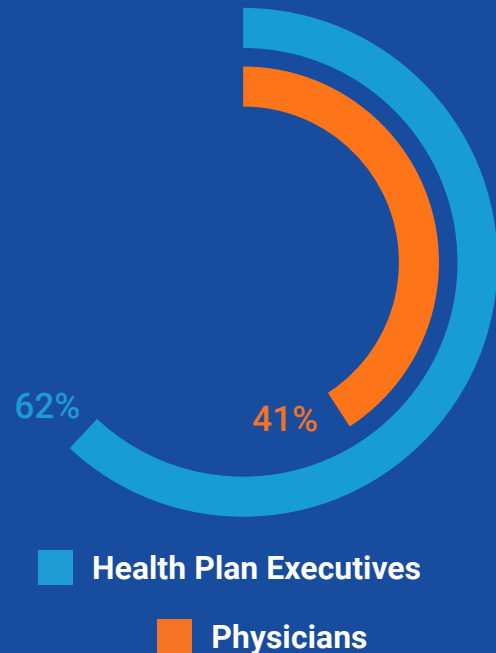
In fact, the majority of your providers are ready to participate. According to a 2019 HFMA survey, 64% of providers plan to assume additional risk within commercial payer contracting models within the next 1-3 years¹. The want is there, but years of tension fuels provider hesitation. According to Kai Tsai, Managing Director of Navigant, a health plan consulting firm: "Sharing risk must be a collaborative pursuit between payers and providers. Both entities need to partner more closely to lessen the gap between the supply of and the demand for risk arrangements in markets nationwide."¹

So how can you partner more closely and encourage provider participation? This eBook explores three key components to successful VBP payer-provider relationships and how to implement them.



01 Alignment

Percentage of professionals who feel as though payers have made progress aligning with providers



Healthcare systems nationwide have had value-based payment on their to-do list for some time, but a recent study shows that the shift from pay-per-service to value-based payments has been stifled due to misalignment between payers and providers. In fact, 62% of health plan executives note feeling as though payers have made progress in aligning with providers, but only 41% of physicians are in agreement.²

To address this misalignment, work with experts from outside of your organization to assess your market and provide data on their healthcare needs. This lays the foundation for discussions around value-based payment and ultimately starts everyone off on the same foot.

The incentives and goals of both payer and provider have to be well-defined prior to contracting in order to facilitate the development of unified objectives. You want to make clear what you're both hoping to accomplish so that you are able to draw out incentives and designate the appropriate metrics and measurements to gauge success.

02 Clarity

Once your goals are clear and your motivations are aligned, you can begin to bring clarity to the specific metrics that will measure provider success both clinically and financially.

According to recommendations by the National Quality Forum (NQF), the easiest place to begin is where providers have data clearly showing improvement. Then branch out into other areas of care where improvement or course correction to reduce care gaps are possible.

Beyond reporting, quality measures need to be surrounded by the data necessary to identify care gaps and foster improvement. According to Jason Goldwater, NCQ Director, “That’s how you continue to evolve. It doesn’t come down to just choosing the measures you think are the most appropriate – it comes down to having the reliable data for these measures to give a better indication of quality.”³

Once you agree on which measures accurately reflect your shared goals, be sure to have in place the measure reporting and analytics capabilities needed to interpret if the goals are being met.

“It comes down to having the reliable data for these measures to give a better indication of quality”

Transparency

Both payers and providers amass a large amount of data that can be useful to one another and can be used in adopting a holistic patient approach. Payers have access to a swathe of claims data while providers have clinical data. Payers see all claims presented by a plan member, while a provider may only see claims they've generated. By working with each other and freely exchanging information, payers offer a full view of where there may be duplicate costs.

To do so, it's essential to have a performance tracking and analytics tool that is easily accessible by your providers. When providers are able to see how they are performing, they can feel driven to hit targets more consistently while also having the peace of mind that they will be paid fairly.

However, it's not only about their performance, but also about the cost. The majority of physicians, between 53-62% that receive cost-related information, say that they have contemplated or altered their practices as a direct result of this data.⁴ It's also important to make providers privy to cost-related information, because this level of data transparency benefits everyone.



53%

Percentage of physicians that receive cost related information that say they have contemplated or altered their practices as a direct result of this data.

Conclusion

Collaboration and an improved payer-provider relationship are the keys to successful value-based payment contracts. Mutual understanding of each other's goals, clarity of terms and measurements, as well as a transparent analytics program accessible to both parties can bridge the gap that has grown between payers and providers.

If payers and providers can work in tandem, both can circumvent years of ambiguous data and unsatisfactory reimbursement. When done effectively, alignment, clarity, and transparency can mean better care for patients and a smoother drive together toward value-based payment.

References

¹<https://www.navigant.com/insights/healthcare/2019/risk-readiness>

²<https://medeanalytics.com/blog/the-road-to-value-based-care>

³<https://ehrintelligence.com/news/developing-quality-measures-to-succeed-in-value-based-care>

⁴<https://www2.deloitte.com/us/en/insights/industry/health-care/volume-to-value-based-care.html>