Guidehouse

Now is the Time for Payvider Adoption & Growth

Identifying Market Opportunities to Upgrade Your Business Model

Powered by the Guidehouse Center for Health Insights Payvider Market Index

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The rules of the game for delivering high-quality, cost-effective, consumer-centric care are changing, and payers and providers that don't adapt their business models will be left behind.

In this report, the Guidehouse Center for Health Insights identifies markets where payvider models are best positioned to disrupt incumbent hospitals, health systems, and health plans. The analysis is based on projected growth in health plan membership under capitated payment arrangements, relative to current utilization, cost, and quality performance.

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Introduction

The formula for health industry success is changing, accelerating payer-provider partnerships at a rate not seen before the COVID-19 pandemic. Membership growth is increasingly concentrated in Medicare Advantage, Medicare Exchange, and Medicaid lines of business. Policymakers and purchasers are showering payers and providers with millions of Medicare and Medicaid lives if they demonstrate the ability to manage these populations under a capitated per member per month fee (PMPM).

In certain markets, opportunities for **payvider models** have reached an inflection point that warrants immediate attention from payers and providers; in others, they are just beginning to emerge, creating a first-mover advantage for entities that can manage the risk of total cost of care. With millions of customers at stake, healthcare leaders must know where their market stands in the face of future disruption, where opportunities for risk-sharing are emerging, and how to position themselves to be first in the market to take advantage of membership growth and risk-sharing relationships and rewards.

The payvider model is a contractual or joint ownership arrangement between payers and providers. These models are quickly becoming the preferred method to incentivize payers and providers that demonstrably deliver on the Institute for Healthcare Improvement (IHI) Triple Aim to improve member health outcomes and experiences at lower costs.

For some, the COVID-19 pandemic made risk-based partnerships between providers and health plans more attractive because providers saw the benefits of PMPM payments as a hedge against declines in fee-for-service volumes. But all providers and payers should heed ongoing actions of policymakers and purchasers, which have been empowered to wield their purchasing power to address systemic affordability, quality, health equity, and access gaps exposed by COVID-19, including:

- Aging population expected to strain federal and state budgets.
- Rising mortality rates and decreasing life expectancy.
- Continued rise in health expense as a percentage of GDP driven by sustained increases in utilization rates, particularly amongst underserved populations, and commercial price increases.
- 60% projected increase in traditional Medicare spending per beneficiary over the next decade (2019 to 2029).
- Dissatisfied consumer confidence in care coordination, benefits, and surprise billing.

Exceptional value-based initiatives exist—and they have proven remarkably effective in yielding higher quality and lower costs.

Table 1: Mortality Rates, Costs, and Utilization Increase Under Traditional Medicare Fee for Service

IHI's Triple AIM Metrics	Medicare Population-Wide Trend (2007-2018)
Mortality Rate per 1,000	Increase from 8.2 to 8.7 [1]
HCAHPS Score Trend	No statistically significant change [2]
Risk-Adjusted Per Capita Cost	25% increase [3]
ED Utilization Per 1000	10% increase [4]

Achieving the Triple Aim—improving the health of populations, patient experience, and reducing the cost of care—is essential to payvider success

Payvider models take various forms, including:

- Provider-sponsored health plans.
- Direct employment of physicians by national payers.
- Joint ventures between payers and providers.
- Long-term risk-based contracting, administrative simplification, and integration of member (patient) services, including care management, telehealth, and wellness.
- Payers partnering with new entrants to impact referral patterns, disrupting traditional care delivery with value-based incentives for providers and patients.

Table 2: Triple Aim Metrics Applied to Medicare Advantage Beneficiaries

IHI's Triple AIM Metrics	Medicare Population-Wide Trend (2007-2018)
MA Enrolled Lives	11M to 24M Americans covered [11]
Enrollment Weighted Stars Average	3.18 to 4.07 [12]
Hospital Days/1000	2,122 to 1856 [13]
Year-over-Year Premiums	40% decrease (2010-2020) [14]
Average Beneficiary Monthly Premium	$44 to $25 (KFF, 2010-2020) [15]

Example No. 1: Medicare Advantage

More than 78% of Medicare Advantage enrollees are in plans rated four stars or higher. In these plans, members experience 23% fewer hospitalizations, 33% fewer emergency department visits, and 41% fewer avoidable acute hospitalizations than Medicare fee for service.[5,6] Nearly all are satisfied with their plan (99%), compared with 85% of traditional Medicare beneficiaries. As a result, Medicare Advantage is now the fastest-growing health insurance market segment. Seniors gravitate to Medicare Advantage plans in record numbers, and last year, capitated payments to Medicare Advantage and Part D plans composed more than two-fifths of federal spending for Medicare.[7,8] Gross profitability for Medicare Advantage is higher than any other health plan business line, at $200 PMPM in 2020. [9]

Key to Medicare Advantage plans' success is an uber-competitive market: collaborative arrangements between payers and providers to share the financial benefits of quality and efficiency improvements, with 62% of Medicare Advantage plans being HMOs. [10] These arrangements support innovations in care and service that enhance the member experience and position plans to achieve the highest possible ratings.

It should be noted that Medicare Advantage success is not rooted in enrollment of primarily healthy Medicare beneficiaries or in efforts to deny care. Rather, successful Medicare Advantage plans invest premiums for at-risk patients in care management, access, quality, and accurate coding initiatives to help to manage costs.

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2. Definitive Healthcare, September 18, 2019, https://blog.definitivehc.com/value-based-purchasing-score-trends.
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5. Freed, Meredith, et al., "A Dozen Facts About Medicare Advantage in 2020," KFF, January 13, 2021, https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.
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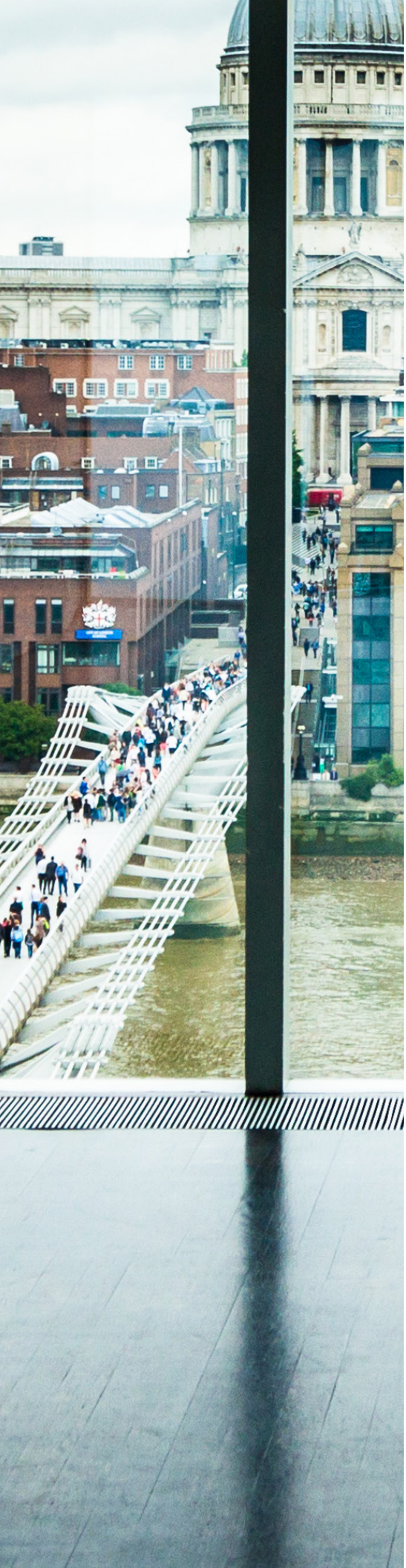
8. The Commonwealth Fund, "Medicare Data Hub," October 2020, https://www.commonwealthfund.org/sites/default/files/2020-10/Medicare%20Data%20Hub_October2020.pdf.
9. Tepper, Nona, "Insurers Set Sights on Growth in Medicare Advantage, Medicaid managed care," Modern Healthcare, March 6, 2021, https://www.modernhealthcare.com/insurance/insurers-set-sights-growth-medicare-advantage-medicaid-managed-care.
10. "Medicare Advantage," KFF, June 6, 2019, https://www.kff.org/medicare/fact-sheet/medicare-advantage/.



Example No. 2:
Medicaid managed care organizations

Managed care is becoming the preferred payment and delivery model for Medicaid. Forty states use managed care models to deliver Medicaid services, and 69% of Medicaid beneficiaries receive care under shared-risk contracts. [16]

COVID-19 accelerated membership in Medicaid managed care by over 15% in 2020, as many individuals who lost their jobs during the pandemic shifted to Medicaid coverage. This model continues to create growth opportunities for private insurers and providers that demonstrate skill in managing Medicaid populations. [17]

For example, Aetna reentered the Affordable Care Act market in February 2021, and shortly after, Aetna Better Health of Ohio, a MyOhio managed care plan, won the state's bid for a high-needs children's Medicaid managed care program. The state's OhioRISE goal is to serve approximately 60,000 Medicaid-eligible children, up to age 21, within the first couple of years. [18]

As healthcare purchasers and policymakers reward players that deliver on the Triple Aim—and as private-equity-backed, tech-enabled disrupters steer business away from poor performers—the market will continue to evolve. Now is the time for payers and providers to form shared-risk arrangements that take advantage of opportunities in their market and position them for long-term profitable growth.

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11. See Footnote 5.
12. CMS.gov, "2019 Star Ratings Fact Sheet," October 2020, https://www.cms.gov/files/document/2021starratingsfactsheet-10-13-2020.pdf.
13. KFF.org, "Financial Performance of Medicare Advantage, Individual, and Group Health Insurance Markets," August 2019, https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-appendix/.
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15. KFF.org, "A Dozen Facts About Medicare Advantage in 2020," January 2021, https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/.
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Market Events Creating Upside Growth Potential for Payviders

The old ways of managing consumer health will no longer suffice. To a certain degree, disruptive price transparency rules will ignite an Amazon-like care purchasing experience, particularly for prescheduled and elective services; as will patient self-scheduling and physician referral apps. It may soon be possible for patients to be able to use their smart phone to buy healthcare services or negotiate prices on the spot with cost-effective providers. (Think kayak.com or Airbnb, but for elective surgery.) Further, with digital health likely to permanently alter consumer access to care, traditional approaches to care management and consumer engagement will not generate the practice patterns needed to succeed. [19]

However, providers are not the only ones at risk in a post-COVID world. Digitization of patient/provider interactions makes the industry ripe for disruption as new entrants vie for purchasers' premium dollars. Examples include Oak Street Health, which partnered with Walmart to offer primary care for seniors in retail clinics; ChenMed, whose concierge-style medical centers cater to Medicare Advantage; and VillageMD, which partnered with Walgreens to deploy a home-based approach to primary care. [20, 21, 22] These organizations have unprecedented access to capital to enhance patient engagement and the digital consumer experience and grow on a national scale, posing a sizable threat to bothpayers and providers.

Additionally, the Centers for Medicare & Medicaid Services (CMS) is spending more than $1 trillion to rebalance its investments across Medicare Advantage, Medicare, and Medicaid premium outlays—to achieve policy goals and reduce taxpayer burden. Recently, MedPAC commissioners unanimously voted to recommend that the US Department of Health and Human Services streamline CMS's portfolio of advanced payment models. [23]

The MedPAC staff recommended that CMS "implement a more harmonized portfolio of fewer alternative payment models that are designed to work together to support the strategic objectives of reducing spending and improving quality."

Payviders that can improve care delivery, save Medicare money, improve performance on quality metrics, and reduce administrative burdens will be rewarded with more robust and predictable performance bonuses and membership.

For payers, the long-term implications could be significant:

- CMS will increasingly narrow value-based payment models to those that save Medicare money and are scalable to large populations, with a shift from voluntary to mandatory adoption.
- There could be a push to achieve payment parity between Medicare Advantage and Medicare by moving the Medicare Advantage base provider reimbursement rate to 95% of Medicare fee for service, with the ability to earn back up to 100% of Medicare reimbursement through improved performance.

For providers, the implications are also significant:

- Most markets will require value-based models to sustain margin.
- Commercial payers will continue to follow CMS's lead for alternative payment models, particularly in increasing geographies.
- Growth in specialty-specific payviders (oncology, nephrology, etc.) will create risk for providers, losing access to lives or lucrative parts of their business if they don't find ways to align and partner.
- Commercial payers and employers that are willing to replace traditional fee-for-service payments with even more lucrative PMPM payments in return for delivering on the Triple Aim will be attractive partners.

Overall, providers and payers have two choices: maintain the status quo or develop and grow payvider models to strengthen the ability to compete and improve margin.

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20. Pifer, Rebecca, "Walmart, Newly Public Oak Street Health Launch Clinic Partnership in Texas," Healthcare Dive, September 2, 2020, https://www.healthcaredive.com/news/walmart-newly-public-oak-street-health-launch-clinic-partnership-in-texas/584570/.
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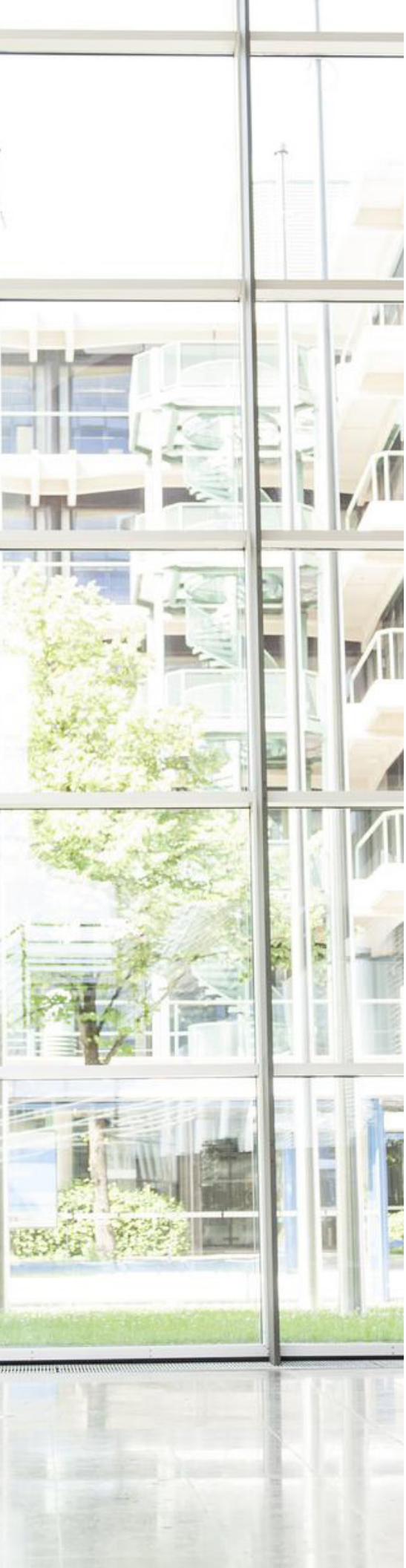
Table 3: Big-Bet and No-Regret Decisions for Payers and Providers

Big-Bet and No-Regret Decisions for Payers and Providers	
Path 1 – Maintain Status Quo	**Path 2 – Pursue the Payvider Option**
• Concentrate on commercial growth, especially growth in procedures, rather than Medicare and Medicaid membership growth.	• Recognize payers and providers both need trusted partners—more than ever—to jointly solve problems and excel at delivering on the Triple Aim.
• Maximize site of care reimbursement differentials, while they still exist.	• Undertake a data-driven analysis of membership, revenue, pricing, and profitability trends and projections by payer, provider, and type of service to inform tradeoffs between membership and volume shifts, physician employment, and financial risks in your managed care contracts.
• Pursue direct-to-employer contracts, to maintain in-network access, site of service coverage, and P4P bonuses.	• Consider capping year-over-year medical cost trends (taking downside risk for excessive cost over-runs) in key patient/employer populations.
• Don't post rates or opportunistically post rates despite risk of non-compliance.	• Recognize/achieve the 5%-15% extra revenue potential on advanced Medicare Alternative Payment Model through better quality, cost management and service scores (vs. traditional fee for service).
• Continue to endure brinksmanship FFS negotiations.	• Negotiate two-way reverse pay for performance with payers (e.g., penalties for poor attribution files, late reports, coding and documentation errors, and poor Net Promoter Scores).
	• Concentrate on making a more patient (member)-friendly experience at point of care, point of scheduling, point of payment, point of enrollment.
	• Cap denials at 1% or less while streamlining essential prior authorization functions to reduce unnecessary administrative burdens.
	• Jointly design and deploy insurance and wellness products/features that cater to target customer segments.
	• Streamline and automate the Top 10 payer/provider workflows to reduce administrative duplication and avoidable utilization and total cost by 5%-15%.
	• Develop purchaser and member "Value Dashboards" and the meeting cadence to demonstrate value to customers and purchasers on a regular basis.



For further details on the promise of payviders, consider the following:

- For years, Phoenix-based Banner Health and CVS Health business Aetna have been working together on innovative, value-based care models, forming a joint venture health plan in 2016. [24] In February 2021, the Banner|Aetna plan announced a long-term agreement to extend its joint venture relationship, citing an average cost savings of 8%-14%, improved member experiences, and growth to approximately 350,000 members. [25]
- This year, Southwestern Health Resources (SWHR), formed by UT Southwestern Medical Center and Texas Health Resources, ranked as the No. 1 Next Generation Accountable Care Organization (ACO) for the third consecutive year. SWHR, which manages care for 79,000 Medicare beneficiaries, has saved $67 million in total cost of care since 2017. [26]
- In Metro Detroit, Henry Ford Health System (HFHS) has fully embraced the payvider journey. In 2007, HFHS founded the Henry Ford Physician Network (HFPN), a clinically integrated network that brought together Henry Ford Medical Group and independent providers to improve quality of care and care efficiency. HFPN is one of the highest-performing Next Generation ACOs in the country. HFHS has also recently launched a new direct-to-employer partnership with General Motors, committing to offer a reputable, high-quality, efficient network to the market. [27]

24. Aetna and Banner Health Launch a New Joint Venture Health Plan in Arizona," CVS Health, October 31, 2016, https://cvshealth.com/news-and-insights/press-releases/aetna-and-banner-health-launch-a-new-joint-venture-health-plan-in.
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Markets Ripe for Payvider Adoption and Growth

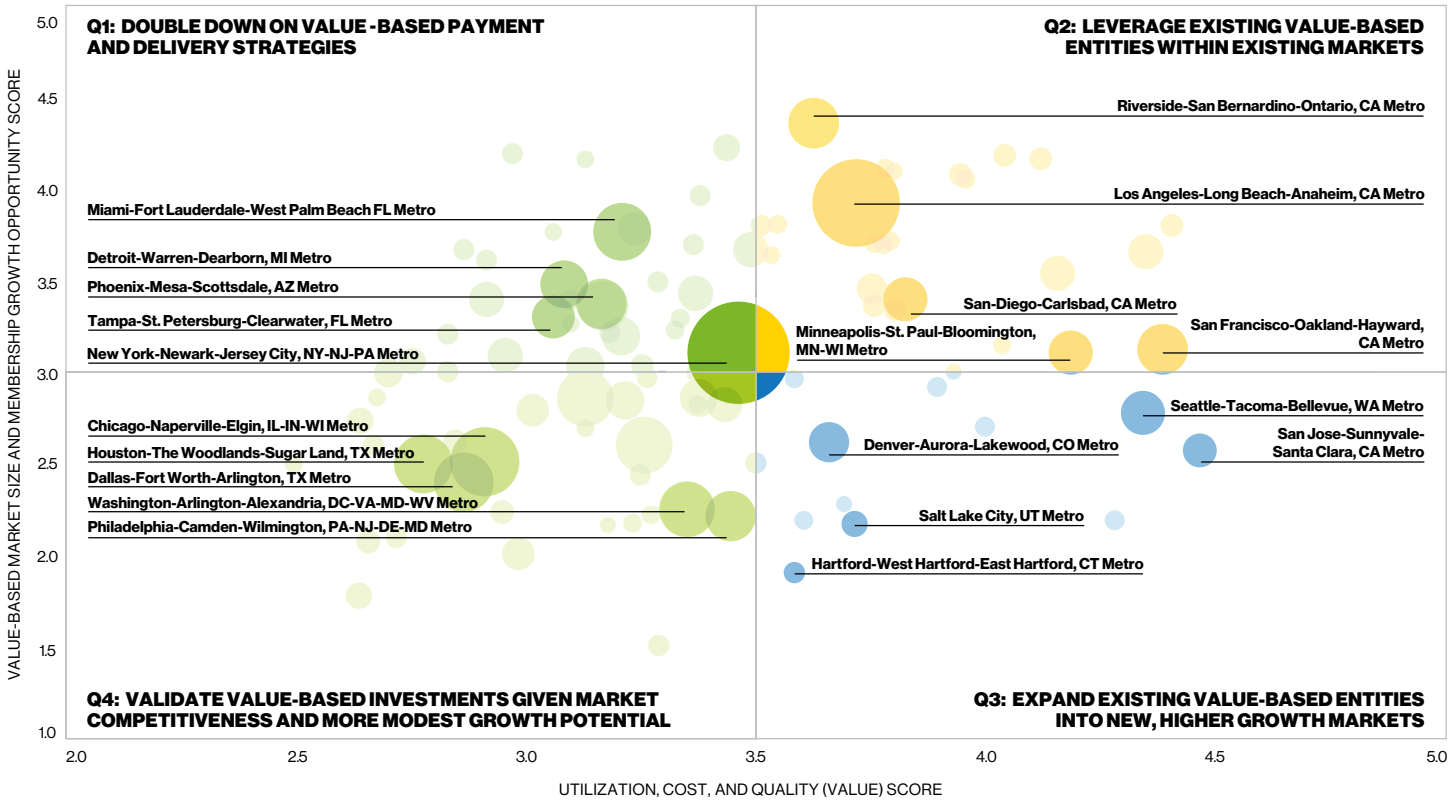
To understand how payers and providers can most effectively uncover profitable growth opportunities, Guidehouse performed a market disruption analysis that evaluated more than 100 markets based on market size and future growth of members under value-based arrangements (y-axis), relative to current-state cost, utilization, quality, and access performance (x-axis).

On the y-axis, market size and growth were scored based on a combination of current Medicare Advantage and Managed Medicaid penetration combined with expected enrollment growth.

On the x-axis, current market performance was rated based on performance related to cost and utilization (e.g., risk-adjusted Medicare per capita costs, emergency department utilization, and inpatient utilization), quality (age-adjusted mortality and access to primary care), and patient satisfaction (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Star ratings and Medicare Advantage Star ratings).

The four quadrants shown in the 2x2 matrix detail the extent to which opportunities for payvider partnerships with upside growth potential exist.

Graph 1: Payvider Market Index



Payvider Market Index Quadrant 1
Double Down on Value-based Payment and Delivery Strategies

Quadrant 1 represents high value-based membership growth potential (y-axis), with opportunities for a payvider to "double down" to begin to differentiate its outcomes to purchasers and members by honing their value-based payment and delivery operations (x-axis).

Example: Cleveland, Ohio. Cleveland's rating suggests there is substantial opportunity for incumbent payers and providers to improve value in terms of cost and quality as policymakers and demographic shifts fuel additional growth in Medicare and Medicaid managed care membership. Additionally, since several large hospital systems in the Cleveland area are known for being very specialty focused, this market is ripe for a payvider willing to trade membership for quality and total cost trend guarantees to enter or increase its presence to profitably grow.

Table 4: Quadrant 1's Top 10 Markets with Population of 500,000 or More

Market	Population 2020
New York-Newark-Jersey City, NY-NJ-PA Metro	19,216,182
Miami-Fort Lauderdale-West Palm Beach, FL Metro	6,166,488
Phoenix-Mesa-Scottsdale, AZ Metro	4,948,203
Detroit-Warren-Dearborn, MI Metro	4,319,629
Tampa-St. Petersburg-Clearwater, FL Metro	3,194,831
Charlotte-Concord-Gastonia, NC-SC Metro	2,636,883
Orlando-Kissimmee-Sanford, FL Metro	2,608,147
Cincinnati, OH-KY-IN Metro	2,221,208
Columbus, OH Metro	2,122,271
Cleveland-Elyria, OH Metro	2,048,449

Payvider Market Index Quadrant 2
Leverage Existing Value-based Entities within Existing Markets

Quadrant 2 represents high value-based growth potential given demographic/payer changes, with an opportunity to further differentiate existing value-based payment and delivery operations to achieve profitable growth.

Example: Albuquerque, NM. While moderate in size, several higher performing payers and providers currently reside in this market, including Presbyterian, an integrated delivery system, as well as a large independent physician association owned by Optum. Demographics and the payer market will continue to drive growth in managed lives/customers; therefore, payviders in Albuquerque will need to continue to invest in their ACOs and other value-based entities to compete for more capitated, value-based contracts, which in turn will set the pace for new digital substitutes, better care management, and personalized member services.

Table 5: Quadrant 2's Top 10 Markets with Population of 500,000 or More

Market	Population 2020
Los Angeles-Long Beach-Anaheim, CA Metro	13,214,799
San Francisco-Oakland-Hayward, CA Metro	4,731,803
Riverside-San Bernardino-Ontario, CA Metro	4,650,631
Minneapolis-St. Paul-Bloomington, MN-WI Metro	3,640,043
San Diego-Carlsbad, CA Metro	3,338,330
Portland-Vancouver-Hillsboro, OR-WA Metro	2,492,412
Sacramento-Roseville-Arden-Arcade, CA Metro	2,363,730
Pittsburgh, PA Metro	2,317,600
Providence-Warwick, RI-MA Metro	1,624,578
Milwaukee-Waukesha-West Allis, WI Metro	1,575,179

Payvider Market Index Quadrant 3
Expand Existing Value-based Entities into New, Higher Growth Markets

Quadrant 3 represents markets with relatively lower value-based membership growth potential given projected demographic/payer changes, but with relatively successful incumbents who know how to manage risk and will need to continue to optimize existing risk management operations to continue to grow, albeit more modestly than other markets.

Example: Des Moines, Iowa. From a market perspective, the market growth potential for Medicare Advantage and Managed Medicaid is on the lower end. Therefore, value-based incumbents in this market may want to consider expanding their footprint to other growing markets (e.g., geographically) to maximize their investment in value-based operations.

Table 6: Quadrant 3's Top 10 Markets with Population of 500,000 or More

Market	Population 2020
Seattle-Tacoma-Bellevue, WA Metro	3,979,845
Denver-Aurora-Lakewood, CO Metro	2,967,239
San Jose-Sunnyvale-Santa Clara, CA Metro	1,990,660
Salt Lake City, UT Metro	1,232,696
Hartford-West Hartford-East Hartford, CT Metro	1,204,877
Worcester, MA-CT Metro	947,404
Boise City, ID Metro	749,202
Des Moines-West Des Moines, IA Metro	699,292
Lancaster, PA Metro	545,724
Madison, WI Metro	664,865

Payvider Market Index Quadrant 4
Validate Value-based Investments Given Market Competitiveness and More Market Growth Potential

Quadrant 4 represents markets with lower value-based growth potential, given competitive dynamics and demographic/payer changes. In these markets, incumbent providers and payers should validate their value-based payment and delivery operations to date, given more modest growth potential.

Example: Dallas, Texas. Despite its location in a growing area of the US, Medicare Advantage penetration in Dallas is already high, with significant competition. The real opportunity is for the provider community to differentiate its population health management capabilities, cost management, and outcomes to profitably grow by capturing the incremental lives.

Table 7: Quadrant 4's Top 10 Markets with Population of 500,000 or More

Market	Population 2020
Chicago-Naperville-Elgin, IL-IN-WI Metro	9,458,539
Dallas-Fort Worth-Arlington, TX Metro	7,573,136
Houston-The Woodlands-Sugar Land, TX Metro	7,066,141
Washington-Arlington-Alexandria, DC-VA-MD-WV Metro	6,238,990
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD Metro	6,102,434
Atlanta-Sandy Springs-Roswell, GA Metro	6,020,364
Boston-Cambridge-Newton, MA-NH Metro	4,873,019
St. Louis, MO-IL Metro	2,803,228
Baltimore-Columbia-Towson, MD Metro	2,800,053
San Antonio-New Braunfels, TX Metro	2,550,960

Building a Successful Payvider Business Model

Based on Guidehouse's work with payers and providers in building strategic payvider models, those most successful start with an integrated scorecard focused on growing customers and delivering Triple Aim value in the form of increased quality, service, and affordability. This approach is in stark contrast with the traditional zero-sum, "I win, you lose" payer-provider model.

Table 8: Playbook for Payvider Collaboration

	From Traditional, Brinksmanship, Zero-Sum Negotiations with Opposed Goals (Traditional Managed Care Playbook)	To Strategically, Financially, and Operationally Aligned Scorecards that Put Members First
Payer Metrics	• Membership • MLR • ALR • Provider Discount of Charges • STARS Score • Risk Score	• No. 1 or No. 2 market share in terms of both members and share of wallet • Stable 3%-5% operating margin • Lower medical cost trend per beneficiary vs. market • 6%-8% ALR "best practice" (all in) • 80%-85% MLR "best practice"
Provider Metrics	• IP Market Share • Volumes • Cost/Case • Managed Care Contract Yield (1-Discount)	• Commercial Reimbursement Rates: Up to 150% of MCR; MA and MCD, 100% MCR • 20% of fees at risk, with 10% bonus upside • Purchaser, patient, member, physician net promoter score >30 (scale of -100 to +100) • Mutual penalties/rebates for underperformance

We believe the "rules of the game" set forth by policymakers and purchasers will catalyze a new set of behaviors among payers and providers. These rules will bridge the gap between current state and future state partnerships, wherein Triple Aim performance is rewarded with members and share of wallet.

Table 9: Reaching Future-State Payvider Collaboration: The Rules of the Game

Payer/Provider Interaction Points	Current-State Payer Provider Challenges	Future-State Payer/ Provider Behaviors
At the Payer/Provider Negotiation Table	Traditional, transactional, cyclical brinksmanship negotiations; centered on unit rate increases; with very high variation in prices/rates paid for identical services in a market (e.g., 160%-300% of Medicare); while each party creates new tactics (e.g., site of service rate differentials, new claim edits, payment policies, coverage policies, medical policies, steerage incentives, narrow networks) to manage medical costs vs. make money, while increasing administrative burden; with modest if any "dollars at risk" (i.e., 1%-3%).	CEO-CEO commitment to elevate the strategy/ business model to serve patients, members, and overall community; with transparent reimbursement rates, with standardized payment methodologies (MS-DRG, APR-DRG, EAPG, APC, etc.) claim edits, and payment policies that will reduce administrative costs and excessive unit costs; while aligning reimbursement with cost structures of efficient and effective providers; with up to 30% of fees at risk with a 20% bonus upside; with average commercial reimbursement approaching 150% of Medicare, which is a substantial decrease from current rates.
At the Point of Procurement or Sale to An Employer, or Federal or State Purchaser	**Medicare Advantage and ACA/Health Insurance Exchange:** Competitive bid process influences which plans purchasers can buy. **Medicaid Managed Care:** State procurement offices control which plans purchasers can buy. **Employer Sponsored Insurance:** Driven primarily by discount off charges.	**Employer-Sponsored Insurance:** More rigorous commercial procurement process that employs STAR-like ratings for ERISA and non-ERISA plans, with minimum coverage standards and member out-of-pocket cost-sharing limits, including significant penalties for quality and cost misses; with much more intentionally managed Payvider sales and retention strategy and pipeline.
At Point of Member Enrollment During Annual Open Enrollment	**Medicare Advantage Members:** Health Plan STAR ratings influence what members decide to buy. **ACA/Health Insurance Exchange Members:** Different-but-related STAR ratings available to prospective members.	**Commercial and Medicaid Members:** More comprehensive quality, access, and cost ratings for Medicaid managed care and commercial enrollees to inform individual consumers about customer service, appointment access, screenings, vaccines, etc., including more member price transparency and cost-sharing calculators.
At Point of Member/ Patient Scheduling	Cumbersome, untimely, labor-intensive prior authorizations; lack of reliable and timely quality, cost, and price quote information.	Reliable quality and cost data; centralized payer/provider scheduling service; rate/price transparency data; incentives to utilize excess capacity; streamlined/automated prior authorization process.

Table 9: Reaching Future-State Payvider Collaboration: The Rules of the Game

Payer/Provider Interaction Points	Current-State Payer Provider Challenges	Future-State Payer/ Provider Behaviors
At Patient Point of Care	Pockets of overuse, misuse, and underuse; tracked by payers and providers using disparate data sources in an untimely and/or sub-optimal manner.	Real-time clinician feedback, patient engagement, and team-based care; with integrated claims and medical records data; that streamlines, standardizes, digitizes, and automates a host of historically duplicative care management and logistics activities.
At Point of Payment and Collections	Myriad billing surprises, copays, deductibles, co-insurance, coverage limitations.	"No Surprises" reduces patient/member surprises, and payers selectively assume role/responsibility to collect patient out-of-pocket deductibles, copays, coinsurance, etc.
Follow-Up Care/ Care Coordination	High variability in care coordination services; lack of standards; duplicative efforts amongst payers and providers; resulting in unnecessary ED visits, readmissions, and complications.	Coordinated payer/provider follow-up care standards, ratings, rewards, and penalties that promote high reliability; integrated patient/ member engagement and campaigns, proactive palliative care, and hospice planning.
Ongoing Review and Improvement	Gaps in end-to-end insight in the continuum of care; siloed approaches to condition management, complex care, and transition care; assessing cost of care and clinical interventions on an episode-by-episode basis.	Monthly operating reviews and management by exception, calibration, and continuous improvement against quality and cost performance targets; population and whole health management.

The Medicaid Payvider Landscape is Evolving. Here's What You Should Know.

States face significant pressure to improve the stability of Medicaid programs, given increasing costs and a surge in COVID-related enrollment.

- Between February 2020 and January 2021, Medicaid enrollment grew by a median of 14.5% nationally, with some states experiencing enrollment increases of more than 20%. [28]
- In 2018, 33.9 percent of Medicaid payments were tied to a value-based payment model, comparatively lower than Medicare, Medicare Advantage, and Commercial. [29]
- States are evolving to become more prudent purchasers, applying value-based purchasing and alternative payment models to contracts with private insurers and providers.
- States also are investing in whole-person programs, including integrated behavioral health, pharmacy, dental, and long-term care.
- States continue to experience an increase in requirements for local care management, networks of social services, and dedicated resources for at-risk patient populations.

In 3-5 years, further inclusion of state social programs is anticipated, including the Special Supplemental Nutrition Program for Women, Infants, and Children and the Supplemental Nutrition Assistance Program, as well as alignment of school-based programs, increased reliance on telehealth, and incentives to drive increased community impact and improve health equity.

When to Make the Right Move

Industry incumbents can no longer treat the relationship between payers and providers as a zero-sum game. They need to plan for a future where increased partnership across payers can deliver incremental value, especially when CMS and selective employers are aggressively shifting into managed care. In fact, many providers will have no future in a post-COVID world until they make the switch to shared alignment and value-based payment.

As payers increasingly demonstrate interest in shared-risk models, providers need to know when it's their time to make the move. There are three questions to consider:

- **How well can your organization anticipate consumer needs and competitive disruption?**

  Does your organization have solid "wins" around consumer engagement, or do managed-care companies have the edge?

- **What impact do you project payment disruption in your market will have on fee-for-service contracts?**

  Is there still enough business to sustain the value-based care model? The key is to move out of fee-for-service before it becomes impossible to generate revenue needed to stay afloat. Don't wait until the fourth quarter to be intentional about the payvider movement.

- **To what extent is your organization capable of responding to disruption in care delivery?**

  It's important to consider if your organization has the infrastructure to provide virtual services and attract the types of patients you need to succeed. Additionally, the organization needs to be well-integrated with physicians such that it can provide exceptional care management. Finally, understanding if your cost structure requires high utilization of services at high prices is important to determine if a cost transformation should take place.

Healthcare organizations should look no further than their mission statements as a compelling argument for why now is the time for a payvider strategy. By uniting mission with fiduciary intent and developing partnerships to master fee for value, strengthen clinical and operational efficiency, and navigate disruption in healthcare delivery and consumer preferences, organizations can more skillfully create an engine of growth that supports sustainable margins and better health for all.

28. Mann, Cindy, State Health & Value Strategies, "Tracking Medicaid Enrollment Growth During COVID-19 Databook," March 5, 2021, https://www.shvs.org/resource/tracking-medicaid-enrollment-growth-during-covid-19-databook/.
29. Health Care Payment Learning & Action Network, "APM Measurement: Progress of Alternative Payment Models Methodology and Results Report," 2018, https://hcp-lan.org/workproducts/apm-methodology-2018.pdf.

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