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Respectful Payer Provider Collaboration Can Achieve the Best in Value-Based Care

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For decades, fee-for-service, the primary payment structure for health care in the United States, has led to doctors and payers being pitted against each other as adversaries, periodically meeting to negotiate contracts with their fists up, ready to fight over their respective bottom lines. Each side enters the fray angry; the results of this pugilism rarely inure to the benefit of patients. The focus of negotiations is all about unit price, individual and incremental units of care and costs of care. Rarely is the impact to the patient even a remote consideration in these discussions, as there is almost no conversation as to whether patients will get better, if the use of costly resources are actually in the patient's best overall interest, and whether their experiences with their health care providers are something to boast about.

But there is an alternative path that virtually all agree can dramatically improve patient care. In fact, the current movement toward "value-based care" provides an opportunity for physicians, other health care professionals, and industry to partner with payers to consider what contributes most significantly to patients' outcomes and experiences, regardless of the incremental unit of care, whether it is covered or not, and the cost of care. If it costs more now, but ultimately reduces the overall cost and improves outcomes when interventions are appropriate and early, should we not do it?

The opportunity that value-based care provides is profound. It provides the opportunity to step back and take a longitudinal, holistic, more comprehensive view of patient care. It allows providers, payers, purchasers, and other stakeholders to look at patient outcomes and to assess what has the greatest impact on those outcomes, rather than the often myopic focus on the intermittent and uncoordinated services that are most often provided today.[1]

One model of value-based care that is often used to engage specialists is called "episodes of care." This model takes into account the full spectrum of services and the associated costs of those services for a particular diagnosis, procedure, or health care event during a specified period of time (Figure 1). In Figure 1, the rainbow background reflects the full spectrum of care related to the treatment of the trigger event or diagnosis that qualifies a person for that particular episode. The hands across the top depict the partnership required to ensure that a person's care is coordinated across the full spectrum, facilitated by communication and collaboration. The Day 1 and last day boxes illustrate that an episode is a series of services that occur for a person within a specific period of time.[2]

In the episode of care model, focus shifts from care rendered by 1 provider to all of the care rendered to 1 person across the full care continuum. The person becomes the focus of attention and ensuring an optimal outcome for that individual is the goal supported by all stakeholders in the continuum.

Although the terms "episodes of care" and "bundled payments" are often used interchangeably, in general, when people refer to bundled payments, they are talking about prospectively paid, risk-based bundles (ie, the provider who is contracted as the episode conductor gets paid up front, and is at risk for all services rendered to the patient, regardless of whether they themselves provide those services, or if they are provided elsewhere along the continuum).

Many of these episode models are retrospective, upside-only models that sit on a fee-for-service chassis. Providers are not at financial risk, and there is no "bundle" paid up front; rather everyone who cares for the patient during the episode is paid at their contracted fee-for-service rates. Once the episode period is over, if the fee-for-service costs come in under the targeted budget, savings are shared with providers.

The primary goal of bundled payments and the episode of care models is the same: to improve outcomes for patients, to improve patient experience, and to reduce costs of unnecessary care. For all intents and purposes, the goals, regardless of whether called

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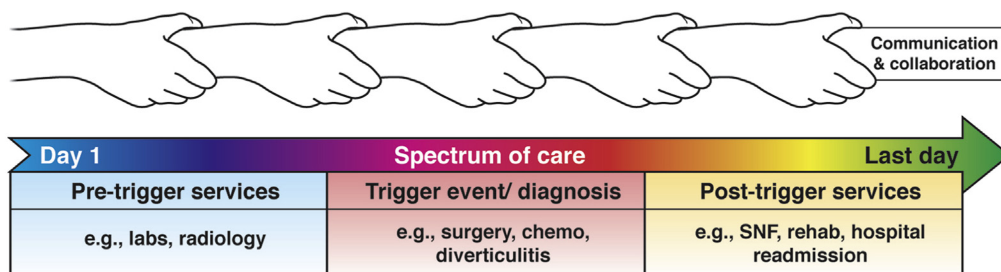

Figure 1. Episodes of care. SNF, skilled nursing facility.

episodes or bundles, are exactly the same, regardless of whether a risk component is involved.

This model is most successful when it is designed collaboratively between all health care parties who have an interest in the patient: professionals, providers, industry, and payers. This requires that all parties take a deep breath and prepare to partner with their historical rivals. It requires that each party enter into the discussion understanding that none has all of the answers. It also requires that each party show respect for the others and be willing to listen. It requires that all parties be willing to try something that may not be perfect at first, and to continuously communicate and collaborate moving forward to make changes that will improve patients' outcomes and experiences, and ultimately reduce potentially unnecessary care and excess cost.

In an episodes of care model, the patient population is stratified so that variation in cost and care can be studied among clinically similar patients with like outcomes. Critical to the success of the model is a redefinition of roles. Instead of the payer being viewed as the emperor who has all of the power, the payer is the facilitator who helps build the construct, and provides data that allow the clinical partners to make meaningful decisions about patient care.

The model respects the health care professionals as the clinicians in charge of patient care. Those who have the greatest success with this value-based model are those who study the data shared by the payer, identify the variations in delivery and cost of care, and develop clinical best practices that the doctors themselves adopt throughout their own organizations to standardize and optimize care. It is not the payer who determines how many or which tests; it is the clinicians who take ownership of doing the right thing in the right manner for the right patient in the right setting at the right time. The payer is a partner who shares data that facilitate the creation of these clinical pathways, which are developed and owned by the health care professionals. This focus on outcomes provides opportunities for all stakeholders to think differently and to consider how other stakeholders in the health care ecosystem, whether they provide traditional or nontraditional services, could have a positive impact on each patient's outcomes.

Increasingly, nontraditional services are being embedded within value-based models that are altering health care delivery, many of which are applicable to gastroenterology.

Health Care Service Corporation has partnered with Feeding America to provide access to healthy food for its members in need, recognizing the impact that food insecurity has on individuals' and families' health status.[3] Feeding America's 2018 Map the Meal Gap research demonstrated that in counties with high food insecurity, 1 in 8 people have diabetes and 1 in 3 people experience obesity.[4] This groundbreaking initiative recognizes and addresses how socioeconomic issues cannot be conveniently disconnected from overall health status and ultimately result in an avoidable burden to the health care system as a whole.

Lyft has partnered with Humana Medicare and the Blue Cross Blue Shield Association to provide car services to ensure that members are not missing health care appointments because they lack reliable transportation.[5] In a fee-for-service payer environment, car service would not be covered for a commercial member to get to the doctor's office; it is an incremental cost of care. In value-based models with a focus on patient outcomes, there is recognition that getting a patient to the doctor has an obvious and significant impact on their outcome.

Kaiser Permanente has partnered with Enterprise Community Partners in 2 initiatives that elevate homes as essential to health and well-being. The Healthy Neighborhoods approach will be applied to evaluate and address the physical, social, and economic factors that determine the health and well-being of people and communities. Developers who qualify for loans will target reductions in chronic diseases, such as diabetes and asthma, and solutions to such issues as mental health, social cohesion, and economic security.[6]

Horizon Blue Cross Blue Shield of New Jersey is piloting several services not traditionally covered by health insurance in its extensive and innovative Episodes

of Care program (Supplementary Figure 1).[7] One pilot will include yoga instruction for patients with low back pain, one of the most common and costliest conditions in America, to strengthen a person's musculoskeletal core; mitigate the need for opioids, surgery, or other costly interventions; and allow the person to get back to work and life more quickly, with less trauma and recovery time. Another pilot includes peer counseling for patients with substance use disorders, a proven and cost-effective therapeutic approach that may reduce relapse and readmissions, and is considered among the most enduring interventions available for people with substance use disorders, yet often not covered in traditional fee-for-service plans. Recognizing that chronic conditions carry significant behavioral health comorbidities that have a direct impact on the patient's physical manifestation of disease and outcomes, Horizon has embedded a behavioral health component into their inflammatory bowel disease episode.

Nontraditional, focused interventions can have a lasting and important impact on patient wellness and overall disease remission. In fact, nontraditional interventions may cost less compared with traditional medical interventions, yet have longer lasting efficacy through breaking down the artificial barriers between social and disease-specific determinants of health. The challenge is to integrate these innovative initiatives into today's mostly stagnant and paralyzed health care finance and delivery mechanisms, and to more broadly release these initiatives into the health care system as a whole.

Furthermore, there is an opportunity within value-based care to consider subpopulations of patients with disease conditions that affect a relatively small portion of the population, but carry tremendous physical, emotional, and financial burden for the individual and their family/support system and to the overall health care system. Consider the multitude of interventions and treatments that a person with a chronic rheumatologic or gastrointestinal condition might experience to receive a proper diagnosis and treatment plan. The patient may move from one health care professional to another over many years, describing their symptoms to each new specialist, undergoing extensive, repetitive, and/or unnecessary diagnostic laboratory, imaging, and procedural services, receiving medications to treat their symptoms but not their underlying condition, before they even get to a proper diagnosis [personal communication].

Fee-for-service encourages disjointed care (ie, in fee-for-service, a patient may be financially more lucrative in terms of diagnostic testing and evaluation while they remain sick, than once they have transitioned into the actual remediation of the root cause of disease). If health care professionals were better connected and understood what to look for and who to collaborate with to address the patient's symptoms, it is likely that the person would make it to the appropriate provider much sooner. This would reduce the burden of the disease symptoms, and potentially unnecessary or avoidable services that may have been rendered by disconnected doctors working within the fee-for-service construct.

The movement to value-based care is evolutionary and requires time. The most collaborative models begin as retrospective, with an upside only, which supports the concept of partnership, while ensuring that all parties are ultimately ready to move to a risk-based model after having collectively achieved success. Providers engage as episode conductors, primarily accountable for all of the care rendered to each patient regardless of whether they themselves deliver that care, but are not at financial risk. This has tremendous opportunity, because all who care for the patient continue to be paid at their fee-for-service rates while beginning to transform their care delivery through a focus on outcomes. The episode conductor reviews and studies the data with the payer and other stakeholders and makes decisions to optimize the care for each patient. This is an opportunity to identify the best potential partners in the continuum for caring for the individual patient.

For each episode, Horizon uses a practice level, case mix adjusted methodology to calculate financial targets, where 2 years of historical data are used to simulate the episode and demonstrate the opportunity had the practice been in the episode program for the past 2 years. After establishing the mean, and removing outliers, the financial target is established for the episode. For practices that are really lean, an additional amount may be added to provide greater upside opportunity to those practices who are already engaged in improving outcomes and experiences while reducing costs. The Horizon model is different in that one never wants to punish the provider partners who are the most effective and efficient; one wants to incentivize them more to deliver stellar care.

At the conclusion of the episode measurement period, if quality and patient experience metrics are met and savings attained, the provider shares in those savings (ie, earns potentially more than in a traditional fee-for-service model). If no savings are attained, the parties assess where opportunities may have been missed, but the provider does not owe money back to the payer, which remains the entity at risk. Incentives are aligned so that the payer and providers work to create success together. It is only when consistent success is achieved that there is a move to providers taking accountability

for costs and repayment of fees when no savings are achieved.

Value-based models are designed to pay health care providers for outcomes, and to create more accountability and comprehensive care to the patient. Courage and leadership are now needed to bring value-based care into the everyday practice of medicine and to provide the appropriate data analytics to make this the standard for all care delivery. It requires that fists come down and minds be kept open, and a belief that creating partnerships with those who have historically been adversaries will lead to benefits for all. It requires humility and the willingness to acknowledge that none of us has all the answers. It requires trust that, together, we can create something more meaningful than anyone of us can individually. Above all, it requires that we listen to and respect one another.

Supplementary Material

Note: To access the supplementary material accompanying this article, visit the online version of *Clinical Gastroenterology and Hepatology* at www.cghjournal.org, and at https://doi.org/10.1016/j.cgh.2019.07.001.

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Conflicts of interest
The authors disclose the following: Lili Brillstein is Former Director, Episodes of Care, Horizon Blue Cross Blue Shield of New Jersey; has consulted for Nestle Health Science, UCB, and Unified Women's Health; and served on Advisory Boards of US Women's Health Alliance, Quality Cancer Care Alliance, and Tapestry. Joel V. Brill has consulted for Aimmune Therapeutics, AnX Robotica, Aries Pharma, Astellas Pharma US, Augmenix, Baxter, Biogen, Braeburn Pharmaceuticals, Bristol Myers Squibb, Cardinal Health, Digma Medical, Diopsys, Diversatek, Dune Medical, Echosens, EMD Serono, Endogastric Solutions, EO2 Concepts, Exalenz, Gala Therapeutics, GeneNews, GI Therapies, Gilead Sciences, Glaukos, Halt Medical, HepQuant, ImpediMed, Indivior Pharmaceuticals, Insightec, Lumendi, Mallinckrodt Pharmaceuticals, Medtronic, Natera, Nuviera, Pacira, Proteus Digital Health, Rebiotix, Reflexion, Seno Medical, Senseonics, SonarMD, Sunovion, Tusker Medical, UCB Pharma, and Vertos Medical; and has options/warrants with GeneNews and SonarMD. Brian Currie is Former President and CEO of Long Island Health Network.

26 The Horizon EOC program now covers 26 episodes, making it one of the largest programs of its kind in the U.S.

- Total Hip Replacement
- Total Knee Replacement
- Knee Arthroscopy
- Low Risk Pregnancy
- Colonoscopy
- Combined Low/High Risk Pregnancy
- Breast Cancer
- CHF
- CABG
- Hysterectomy
- Diverticulitis
- Crohn's Disease
- Prostate Cancer
- Prostatectomy
- Colon Cancer
- Lung Cancer
- Low Back/Laminectomy
- Pregnancy Newborn Care
- GERD/Upper Endoscopy
- Shoulder Replacement
- Onc - Breast, Colon, Lung, Rectal
- Substance Use Disorder
- IBD with Depression/Anxiety
- Lumbar Spinal Fusion
- Cardiovascular Disease (CAD)
- Oncology Medical Home

Supplementary Figure 1.