The Payvider Movement

Part 1 of 3: What is a payvider, and why should health systems make their strategic move now?

Is this the age of the payvider?

By now, most health systems are familiar with the term "payvider" (an integrated delivery and finance system). Many have been weighing the pros and cons of initiating their own payvider solution, perhaps for years. But, for them, there has been no catalyst strong enough to set the payvider wheels in motion. That critical tipping point may well be here, however, as health systems feel increased pressure to make greater financial and strategic impact even as strong headwinds make it difficult to make the advances that will enable them to grow. Fortunately, technology, regulations, and market dynamics have turned a corner and are now favoring those providers looking to become payviders. By all indications, the time to move on the payvider option is now.

Payvider 101 (What is a "payvider" anyway?)

A payvider is perhaps best described as an integrated delivery and finance system. In other words, it is an entity that sells and administers a health plan product and then delivers the associated care. It is both payor and provider (thus "payvider"). The payvider solution works with a wide range of health plan structures, including self-insured groups, fully insured groups, individual and small groups, Medicare Fee-for-Service, Medicare Advantage, Medicaid, and more.

There are three payvider models:

1. The **joint venture model** brings payors and providers together in alignment to develop their own health plans. Both share the same goals of improving patient care and attracting a greater number of members, although this model commonly puts the payor in the lead role.

2. For the **insurance company as provider model**, the payor transitions to become the provider of healthcare. This gives the insurance company greater overall control of costs while adding some level of convenience for the member (since everything is handled by one entity).

3. In a **provider plan model**, the health system creates its own health plan and retains control of the finances, having no obligation to share with other partners. The provider can put patient care at the forefront while fully benefiting from any and all savings they create through efficiency and quality improvements to their own healthcare services.

Model #3, the provider plan, puts the health system squarely in the driver's seat, while models #1 and #2 take the provider out of that position of control.

The joint venture and insurance company as provider models have rarely resulted in either financial stability for the health system or true care transformation.[1] Instead, they now represent the "corporatization of American healthcare," a scenario in which providers are increasingly managed (versus managing) throughout the process and much of the value created is absorbed by the intermediaries versus being shared among providers, employers, and health plan members. The provider plan model is designed to mitigate those issues.

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Why should a health system be motivated to become a payvider?

There are many reasons for a health system to become a payvider. First and foremost on many health systems' minds are financial viability and stability. A payvider strategy can help health systems achieve that. Health systems that become payviders have the opportunity to build strong bonds with self-funded employer groups, thereby capturing market share and improving their payor mix. They can also add diversified revenue through administrative and program fees, as well as drive a significant cost savings on one of their organization's largest expenses: their own employee health plan.

But the real motivation for becoming a payvider is the opportunity to drive care transformation through payment reforms and eliminating misaligned incentives and structural barriers, such as compensation design, that prevent many providers from delivering the best care in the most efficient manner.

Take for example the advanced primary care model, which uses a team-based, multimodal engagement approach to patient care. In this model, primary care physicians are able to have a larger patient panel while also spending more time with patients when needed by using a team of information-connected colleagues that includes nurse practitioners, clinical pharmacists, behavioral health providers, and care navigators to handle less-complex patients and routine tasks. This team-based medicine approach, enabled by real-time data sharing and secure member communication, lowers costs, improves outcomes and patient satisfaction, and reduces provider burnout. But most health plans don't currently have strong reimbursement strategies for this optimal care delivery. When providers are integrated into the health plan, though, the payment redesign can help to drive the care redesign.

A provider-led payvider model (the provider plan) is perhaps the best way to achieve the true aim of value-based care: creating cost savings while simultaneously optimizing patient outcomes.

Payviders also have access to better data and visibility. As Dr. Jonathan Slotkin, chief medical officer for Contigo Health, LLC observes, "Every successful provider-sponsored health plan that I have seen has had one key thing in common: each leverages modern data analytics and reporting technology to effectively manage both the provider and the payor sides of their health plan offering."

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The vital role of data and analytics

Economics and healthcare market forces stimulated the need for innovations such as payvider solutions, but it is advanced data and analytics that have made them viable.

Bringing clinical and claims data together can:

- Deliver high value for both cost and care
- Help enhance financial performance while also improving outcomes
- Empower collaborative decisions around clinical care, cost efficiency, and the consumer experience
- Support new, alternative payment models
- Guide and motivate investment in preventive care and quality management[2]

With better access to data comes better management potential

The payvider that accesses data and analytics can establish a next-best-action (a.k.a. NBA) tool. This single integrated data repository captures a complete picture of a patient's medical history, social determinants of health, current care plans, claims data, and more. Then, through algorithms and artificial intelligence, it helps identify the next best actions. The combined data also contributes to a more informed patient-centered medical home, providing plan members the necessary care coordination and navigation they need to help ensure the right care at the right time and place.

Such data can aid the primary care physician and full care team in guiding patients throughout their care journey. Further, benefit design and a network tiering structure can be optimized by data, helping to drive domestic utilization and promote use of in-network providers.

Additional advantages can include:

- Benefit and reimbursement strategy focused on advanced primary care, patient-centered medical home care, and preventive care
- High-value prior-authorization strategy, integrated communications, and situational rules, such as "gold carding"
- Integration of ancillary benefits, including pharmacy, dental, and vision, to support whole-person care

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Better data leads to better management. And better management leads to better outcomes.

A recent survey[3] of payors by Change Healthcare revealed that value-based care helps improve quality of care, patient engagement, and cost reduction:

Payors reported a

5.6%

cost reduction related to unnecessary medical expenses.

80%

reported increases in quality of medical care.

73%

saw improved patient engagement.

Why NOW is the time to initiate a payvider solution

Health systems are feeling the need for change

Labor expense and shortages are now everyday trials. Capital markets are changing as bonds are downgraded. Traditional contracting is no longer working as payors increasingly squeeze providers. More than ever, health systems must make a positive impact, both financially and strategically. Unfortunately, many simply continue to rely on traditional approaches in this nontraditional environment, somehow expecting different results.

Cutting operating costs while discreetly raising prices, for instance, or adding ancillary services are merely short-term fixes. Instead, health systems needing healthy change must embrace a different strategy.

According to The Keckley Report,[4] there are three distinct changes that providers must make now to find success in the future state of healthcare:

1. Creating regional systems of health via cooperation among public health and health-delivery entities in the interest of sharing data and resources across multiple organizations
2. Increasing competitive strength in price and value, made possible through the integration of financials and care delivery
3. Emphasizing greater accountability by health plan members, fueled by infusing self-care in care management

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The good news? The stars are aligning for the payvider solution

While health systems might have found it challenging to initiate their own payvider solution in the past, technology, regulation, and market dynamics have now shifted to health systems' favor.

Today data integration is much improved thanks to more health information exchanges and fast healthcare interoperability resources data standards. There is greater information integration into electronic medical records, meaning that benefit design information, prior authorization, and preferred providers can now be integrated into clinical decision support systems. Meanwhile, the maturation of artificial intelligence and machine learning are accelerating next-best-actions tools, improving diagnostics, and enhancing population health trends.

On the regulation front, lawmakers are paying closer attention to healthcare affordability, access, and equity. New pricing-transparency requirements call attention to disparate rates between hospitals and payors and are driving normalization of market rates (all of which are addressed by the payvider solution).

At the same time, employers are growing increasingly frustrated as conventional approaches are no longer effective. Employers are now confronted with an aging employee population[5] stricken with metabolic disease and chronic conditions including obesity, diabetes, and musculoskeletal issues.[6] Younger employees are facing a higher incidence of cancer.[7] Behavioral health and substance use disorder issues have exploded since the pandemic.[8] Employers are ready for a better solution.

Beyond the factors making it practical to initiate a payvider solution, there are also emerging opportunities for health systems who do so. With more providers entering the value-based care space come new occasions to create mutually beneficial arrangements. For instance, syndicate networks bring regional health systems together to enable access to high-quality, high-value care outside of a single hospital service area. Health systems also have the opportunity to create a payvider network, with each participating health system offering reciprocal care and rates in the interest of serving employer groups having multiple locations, remote workers, or travelers that extend the call for care beyond the local service area. By creating a national primary network, payviders can eliminate dependence on specialty wrap networks.

With good news comes greater risk to those who wait

Perhaps the greatest incentive to act now is that others are already making the move.

More providers are experiencing a sense of urgency as industry disruption forces them to rethink current payor and provider partnerships and reassess where their best opportunities lie moving forward. Payors don't want to miss out either and are vigorously building and investing in primary care resources so they can capture control of where and how care is delivered.

As the carriers dive deeper into this space, and as value-based care comes to the commercial/employer plans, if health systems fail to create their own payvider solutions now, they risk being consumed by the carrier's solutions. Without the strength of their own payvider program, providers stand to lose valuable leverage in network negotiations and could see their market share eroded by third-party disrupters offering point solutions and alternative care-delivery options. Conversely, a payvider strategy helps health systems create a barrier of protection—a strategic moat of sorts—against payors and other market disrupters.

Simply put, health systems must evolve to survive. Fortunately, that has become more viable and attractive than ever.

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Evidence that payvider works

More than 300 U.S. health systems currently have some sort of health plan.[9] Having a unique ability to see and navigate the entire care experience (after all, they are providing the care), the payvider then has the added benefit of greater visibility and increased influence. Here are a few real-world examples of payvider solutions.

Kaiser Permanente, as of June 30, 2023, has a health plan with 12.7 million members (up 81,000 members since December 31, 2022),[10] an annual operating revenue of $95.4 billion in 2022,[11] and a high market share, including the highest rankings in six key regions.[12] According to Forbes, in 2023 the plan earned an average grade of 4.3 out of 5 from the National Committee for Quality Assurance.[13] Kaiser Permanente continues to earn a strong reputation for its blend of low cost and high quality,[14] thanks to the integration of health plan and care systems and its focus on prepaid (capitated) products, including HMOs and EPOs.

UW Health/Quartz exemplifies how the payvider solution can contribute to financial strength for a health system, as illustrated in a recent article by the Foundation of the American College of Healthcare Executives (FACHE). Creating its own health plan allowed UW to mitigate swings in the market and recover from the unexpected volume changes and loss of high-margin elective procedures caused by the COVID-19 pandemic.[15] Also, predictable capitation payments enabled UW to diversify revenue and achieve financial stability, ending each year with positive margins while other systems in the fee-for-service world saw financial devastation. Further, because UW owns its own plan, it has been able to invest in care innovations, like virtual care and other digital capabilities—including a hospital-at-home care model—all fully or partially funded by the savings afforded by its plan's capitated population.

Phoenix-based **Banner Health** and CVS Health business **Aetna** came together to form a joint-venture health plan in 2016 in their pursuit of a value-based care model.[16] Based on the success of that venture—citing an average cost savings of 8%–14%, improved member experiences, and growth to approximately 350,000 members as a product of that relationship—the two organizations announced in February 2021 that they had committed to a long-term agreement that extends the joint-venture relationship.[17]

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It's not a new concept

While many health systems view the payvider solution as a daring new model, the reality is that this concept has been around in the healthcare environment for nearly a century.

Although the term "payvider" was still decades away, the model was introduced in the 1920s.[18] With the onset of the Great Depression, providers initiated the original form of health insurance, offering care services to individuals on a prepaid basis.[19] It was the first employer-sponsored hospitalization plan and the forerunner of the modern HMO, a strong idea that led to the creation of Blue Cross organizations.[20]

How and where to start a payvider solution

According to Contigo Health, the best place for a health system to begin its payvider solution is right at home with its own employee health plan. There they can learn and grow in a more controlled and familiar environment. Then, leveraging the knowledge, experience, and credibility gained through their own program, they can expand with the engagement of local self-insured employers who would benefit from the health system's payvider solution. Methodically, the payvider solution can then be sold to larger employers, including those having multiple locations in multiple markets.

The need is clear, and the time is now

By all indications, with health systems facing relentless pressures and a more imminent need for change—combined with favorable forces of evolving technology, regulations, and market dynamics—the time of the payvider movement has arrived. In the remainder of this three-part series, we will present additional insight to help health systems take advantage of this unique opportunity.

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