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The Payvider: An Evolving Model.

Zachary N. Goldberg
Thomas Jefferson University

David B. Nash
Thomas Jefferson University

Editorial

The Payvider – An Evolving Model

Zachary N. Goldberg, BS, BA[1] and David B. Nash, MD, MBA[2]

Affiliations:
Sidney Kimmel Medical College at Thomas Jefferson University, Philadelphia, Pennsylvania[2]Jefferson College of Population Health, Philadelphia, Pennsylvania

Corresponding Author:
David B. Nash
Jefferson College of Population Health
901 Walnut Street, 19th floor
Philadelphia, PA

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Introduction

The Triple Aim was first described by Don Berwick and colleagues in 2008 to establish a framework for improving health system performance.1 Increasing reports of provider burnout raised calls to convert the Triple Aim to the Quadruple Aim, which includes improving provider satisfaction.1,2 Adherence to the Quadruple Aim would enable the health care ecosystem of payers and providers to improve patient outcomes and decrease waste.

The US health care system lacks adherence to all components of the Quadruple Aim. In 2018, the United States spent 16.9% of its gross domestic product on health care.3 This is significantly higher than peer countries despite similar utilization of health care services.3 High costs of care are not associated with favorable metrics of population health in the United States. Compared to peer countries, life expectancy in the United States is 3.2%–6.4% lower and chronic disease burden in the United States is 21.4%–50% higher.3 High costs of care also are not associated with high quality of care in the United States. This is because of reluctance among government and health care leaders to reform payment models toward value-based care and prioritize evidence-based quality improvement practices.4 Additionally, half of US practicing physicians report being burned out.2 Provider burnout leads to lower patient satisfaction, increased cost of care, worse health outcomes, and more complications.1,2

Many experts believe the relationship between payers and providers must be transformed to meet the demands of all stakeholders. Health care systems of the future must grow and develop plans of engagement, intelligence, and infrastructure to meet the needs of a diverse patient population.5 We believe this can be accomplished by implementation of the Payvider, a partnership between a payer and provider rooted in vertical integration around shared adherence to the Quadruple Aim. By facilitating this partnership structure, vertical integration corrects challenging dynamics in many conventional mergers that force one party to yield control to another.6

This editorial examines the Payvider's future in the American health care system and its ability to impact the Quadruple Aim by answering 2 principal questions:
1) What are the key components of the Payvider that differentiate it from other care and coverage models?
2) What are the Payvider's main obstacles to success and how can they be overcome?

To answer the first question, we conducted 4 interviews with senior executives (2 chief medical officers and 2 chief executive officers) of 4 separate Payvider organizations in the Northeast and Midwest regions of the United States. Their commentary, offered anonymously, helped us to identify 3 key differentiating components of the Payvider that they believe uniquely position it for success in the current health care system. To answer the second question, we combined their commentary with a relevant literature search to identify 3 principal obstacles that the Payvider is most likely to encounter. We complete this analysis by offering proposed solutions

to overcome these obstacles, thus allowing the Payvider to improve the US health care system's adherence to the Quadruple Aim.

Key Components

The Payvider's structure has 3 possible models. The first and second are dominant models, in which a payer enters the care sector or a provider enters the coverage sector. This is done via acquisition or development of a provider or payer, respectively. The third is the partnership model, in which an independent payer and independent provider create a partnership with shared ownership of the Payvider. The partnership model is the primary focus of this editorial. This model most effectively uses vertical integration, because partners can work together to create the entire Payvider framework. Challenging structural components, such as shared financial risk and the provider incentive structure, are designed with the priorities of both the payer and provider in mind. Three of the 4 industry leaders interviewed oversee a partnership model Payvider organization. However, all 4 industry leaders agree the partnership model is the most likely to succeed in comparison to either dominant model. They cite the shared contractual ownership and subsequent ability to outline the framework of the entire partnership as the major factors that best position this Payvider model for success.

We contend the Payvider is uniquely situated to reestablish the patient as the central focus of the health care system. In the current fee-for-service (FFS) model of care, payers and providers consistently engage in price-based negotiations to maximize financial gains and minimize risks. This does not lead to improved outcomes or value for the patient because, like the FFS model, these negotiations are not primarily outcomes driven. Industry leaders believe the Payvider reduces the need for protracted price-based negotiations, which promotes greater focus on enhancing outcomes and the overall patient experience at a lower per-patient spend.

The Payvider considers many quantitative and qualitative metrics of success to create a more robust evaluation of the partnership. Although conventional measures, such as profit and earnings or patients seen and members retained, are necessary values to consider for organizational sustainability, they are not the only key metrics for these industry leaders. They believe other metrics offer equally important insights to determine if a Payvider is successful. They emphasize the strength of organizational culture, which can be established by evaluating satisfaction with the relationship between payers and providers in the Payvider. Adherence to all components of the Quadruple Aim is also heavily prioritized. This is built into the framework of the Payvider, which allows for new measurements of success to be created and later refined after assessment.

Obstacles and Proposed Solutions

The global consulting firm Guidehouse recently published a report advocating for wider adoption of the Payvider.7 Guidehouse analyzed more than 100 US markets to determine locations best suited for Payviders, focusing on metrics such as market size, future growth potential, and current-state value-based payment performance. Five metropolitan areas were

identified as the greatest opportunities for Payvider adoption and growth at this time.7 Guidehouse cited their high value-based growth potential, opportunity to differentiate value-based payment and care delivery operations, heavy utilization of Medicaid Managed Care Organizations, and high market segment of Medicare Advantage plans as fundamental reasons.7

For the Payvider to be successful, team members from the payer and provider must commit to the vertically aligned structure of the model to facilitate a strong organizational culture. One of the most important but commonly debated issues is economic responsibility for the high cost of health care. A survey of 3900 providers found that 59% believe payers have a major responsibility to decrease health care costs, while only 36% feel providers have that responsibility.8 This is despite 76% of providers acknowledging that they are aware of the costs of the care they provide.8 Only 7% of providers favored eliminating traditional FFS payment models, but there was a positive association between support for elimination of these payment models and providers having a more stable salary with bonus opportunities tied to outcomes.8

Providers with income determined primarily by the amount of health care services they provide face conflict when concurrently striving to reduce the costs of care and quantity of services. The Payvider's compensation model of shared financial risk and reward would shift the focus from quantity of care provided to quality of outcomes, thus better incentivizing providers to shift toward value-based care. Payers also benefit from reduced health care spend and increased cost savings, which can be shared between all partners in the Payvider organization. This strategy also has proven to be better for patient satisfaction. Vertically-integrated models of patient care and coverage have been shown to outperform other models of care and coverage in patient experience and overall patient perception.6

For the Payvider to also maintain focus on improving population health outside of care settings, it can create additional partnerships with local community organizations. Through these partnerships, the Payvider can better identify unique community health needs via Community Health Needs Assessments, care coordination transitions, health and wellness programs, and other public health activities.9 There is evidence that this strategy presents a potential positive benefit in the overall population health of a community.9 By prioritizing an organizational culture that is vertically integrated around mutual goals, the Payvider model appeals to all stakeholders and reduces protracted price negotiations.

The Payvider must prioritize technological innovations that allow high-quality care to be accessed and provided in an efficient manner. Chief among them is optimization of the electronic health record (EHR). EHR systems must allow for improved sharing between health care organizations and providers within the same organization. Failure to do so hinders value-based care because of repetitive testing and data entry.10 EHR systems also must provide improved outcome measurements and real-time cost tracking to help patients and providers understand the economic implications of care that is being provided.10 These improvements allow for more robust information sharing and increased data and analytics to drive enhanced outcomes and insights.

Payers operate primarily with patient claims data, which is used for billing, while providers operate primarily with clinical data, which is used to understand the patient's health status and health history. Although both are documented extensively, clinical data are more unconstructed and subjective because they include encounter notes from providers.6 Integration of these EHR components is more feasible in a Payvider because the payer and provider operate as one partnership organization. This reimagined EHR will allow the Payvider to understand the patient more comprehensively, while reducing the burden of conventional administrative tasks.

This convergence will be directly responsible for more powerful data and analytics that can be used to drive actionable change. Integration of claims and clinical data has already been shown to increase identification of chronic conditions such as cancer and diabetes, and increase identification of high utilizers of care.6 Deployment of these insights allows a Payvider to take a more tailored approach to primary, secondary, and tertiary prevention of disease while also finding solutions to promote value-based care. Additionally, social determinants of health have the largest impact on a patient's health over a lifetime – far more than any intervention performed in a care setting. Improved data and analytics made possible by a new EHR could allow a Payvider to address issues of social determinants of health for their patients that will keep patients healthier at a lower cost to the Payvider.

Without sufficient financial incentives for payers and providers, there will be little support for a large-scale conversion to the Payvider. This can best be accomplished by identifying the potential for cost savings in a Payvider that allows for reallocation of these resources to more beneficial practices. Early estimates have found there is potential for total cost savings of 15% or more in a Payvider, with organizations that embrace vertically-integrated partnerships (especially financially) saving the most.6

The Payvider also must address wasted health care spending, which could allow for more efficiently-delivered care without continued unsustainable increases in cost to all stakeholders in the system. A systematic review from 2019 found health care waste accounted for 25% of total annual health care spending in the United States, or $760 billion to $935 billion dollars.11 More than half of this wasted spending was caused by (1) pricing failures: waste from a deviation of prices from prices expected in a functioning market, and (2) administrative complexity: insufficient or improper regulations imposed by government agencies and/or payers related to coding and billing.11 Mutual agreement on pricing strategies and realignment of a fee structure toward outcomes could lead to a reduction in failure of pricing.

Conclusion

The Quadruple Aim helped create a framework for payers and providers to enhance the US health care system. However, US health care is still expensive, outcomes remain poor, quality is low, and providers are burned out. The Payvider is a model of vertical integration that presents an innovative way to increase adherence to the Quadruple Aim. We believe the Payvider's

structure, focus, and definition of success set it apart from other models of care and coverage. Moving forward, the Payvider must overcome obstacles of cultivating a strong culture, prioritizing technological innovation, and identifying cost-saving measures. Ultimately, the Payvider should use its key strengths to address issues of health equity that lead to disparities of care. Commitment to relevant social needs will help the Payvider further establish itself as the premier health care ecosystem of the future for all stakeholders at the expense of none.

Authors' Contributions

Mr. Goldberg and Dr. Nash developed the scope of the manuscript and outlined sources to be included and specific Payvider industry leaders to interview. Mr. Goldberg reviewed the prevailing literature and conducted interviews with selected Payvider industry leaders to supplement the rapidly evolving literature. Mr. Goldberg drafted the manuscript with Dr. Nash's consistent input and revisions. All authors contributed to the interpretation of sources, inter- views with Payvider industry leaders and made critical revisions to the manuscript.

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