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Interoperability and Payers — A Recipe for Impactful Preventative Care

Seamless exchange of actionable data is key to increasing quality metrics, membership, and reimbursement for payers moving into the care delivery space

Table of Contents

Introduction

The United States ranks last on healthcare quality — despite spending more of its gross domestic product on healthcare than other high-income countries, according to the Commonwealth Fund's annual Mirror, Mirror 2021: Reflecting Poorly, which analyzes 71 performance measures across five domains: access to care, care process, administrative efficiency, equity, and health care outcomes. The top-performing countries overall are Norway, the Netherlands, and Australia; the worst performer is the U.S. and has been every year since the study began almost two decades ago.

This report and others of its kind have added to mounting evidence that the United States is not getting commensurate value for its money. And this has not escaped the notice of American healthcare consumers. A recent poll from Gallup and nonprofit West Health found that 44 percent struggle to pay for healthcare, and a vast majority — 93 percent — feel that what they pay is not worth the cost.

This crisis of high cost and low value is driving a myriad of changes, including new policies and mandates from the government, innovations in healthcare technology, and market shifts. One of these market shifts is a gravitational pull between payers and providers to form "payviders."

Why now?

With 10,000 people aging into Medicare every day, and all baby boomers projected to be over 65 by 2030, Medicare Advantage (MA) is the fastest-growing health insurance market segment. A record 3,834 plans were available for the 2022 plan year in MA, according to a recent analysis from the Kaiser Family Foundation, an 8 percent increase over 2021 and the largest number on the market in a decade.

Payers are attracted to the ballooning MA market's steady per member per month (PMPM), increased member retention, and record-setting Centers for Medicare & Medicaid Services (CMS) payment increases. As CMS continues to shift to value-based payments, payers are more incentivized to manage care quality to maximize reimbursements. These factors are driving payers into the care delivery space, and fueling the rise of payer providers — with many reporting record-breaking profits.

"The 'one-size-fits-all,' 'I-win-you-lose' approach is no longer a good business model."

— Travis Sherman, Director of Guidehouse

The reverse is also true, with providers entering the payer space much more frequently than ever before. A new survey from the Healthcare Financial Management Association (HFMA) and sponsored by consulting firm Guidehouse found that nearly 60 percent of health systems plan to play a greater role in risk management by becoming payviders. Health systems are also looking to diversify their risk-based payment strategies, with 52 percent planning to enter into commercial employer-based risk contracts, 49 percent into Medicare payment models, 36 percent into managed Medicaid, and 33 percent into direct-to-employer partnerships.

"The 'one-size-fits-all,' 'I-win-you-lose' approach is no longer a good business model," says Travis Sherman, Director of Guidehouse. "Industry disruption has created new opportunities for health systems to rethink the structure of their payer and provider partnerships, reassess their markets for new entrants with a willingness to innovate together, and readjust their network strategy to align with where their market is going."

Finding the value

According to a survey of payers from Change Healthcare, increased use of value-based care has helped improve the quality of care, boosted patient engagement, and reduced costs. Among the discoveries in the State of Value-Based Care Report were:

- A 5.6 percent reduction in unnecessary medical expenses.
- Reported increases in quality of medical care from 80 percent of payers.
- Improved relationships with providers and better patient engagement.

Contrasting with the traditional fee-for-service approach, in which providers are paid for each service they perform, value-based healthcare is based on outcomes, so providers who improve the patient's overall health are rewarded. The so-called "payvider" model perfectly aligns with the patient's goals in a way that previous models could only pay lip service to. Aligned incentives between the payer and patient, focusing on refined care coordination, make for excellent preventative care and a better overall experience.

When payers and providers come together, it is a convergence of goals that benefits patients.

And the momentum toward value-based care is growing, with health plans partnering with or acquiring providers. Vertical integration strategies, in which different levels of the healthcare supply chain combine, result in the payer and provider sharing both the risk and rewards of managing member care — so it is in everyone's interest to deliver cost-efficient , quality care while also reducing financial risk and increasing profitability.

Providers and hospitals are compensated based on patient outcomes, quality, and cost containment — not quantity — and are therefore de-incentivized to see the patient more often than is necessary or order tests that are not needed. When payers and providers come together, it is a convergence of goals that benefits patients.

"The level of partnership we're seeing evolve, especially as it relates to downside risk, creates a win-win for both organizations," said Pam Jodock, senior director of health business solutions at HIMSS, said in Healthcare IT News. "It helps the provider organization make immediate course corrections when appropriate, and it also helps the payer in managing costs and improving relationships with providers."

Enter technology

The need to eliminate inefficiencies between providers and payers is a massive opportunity for healthcare IT organizations, who now find themselves center stage. Technology is needed to improve quality metrics and increase a payvider's membership numbers, reimbursement rates, and net profits.

The expectations of consumers, who feel empowered to make choices about their healthcare, and cost considerations on both sides of the equation have also increased demand for technology that identifies and eliminates inefficiencies. But meeting these goals for payer providers is not without challenges.

Creating a technology roadmap is an important step in preparing for increased collaboration between payers and providers, while embracing new regulations such as the 21st Century Cures Act, the interoperability and patient access rules from the CMS, and efforts to drive price transparency.

Technology is needed to improve quality metrics and thereby increase a payvider's membership numbers, reimbursement rates, and net profits.

Technological innovations that simplify existing processes and break down information silos will play a key role in providing high-quality care in an efficient manner, and the optimization of the electronic health record (EHR) is paramount. Data exchanged between providers, labs, hospitals, ambulatory care centers, and virtual care organizations must be aggregated, normalized, and made actionable to drive analytics insights.

Efforts to bridge information gaps by eliminating silos are often hindered by existing IT that make it difficult to work together, requiring complex data-sharing agreements or months of work to integrate disparate systems. But without interoperability, payer providers are severely limited.

Challenges of interoperability

In an increasingly disparate and disconnected healthcare environment, it's hard to achieve interoperability. Aggregating, streamlining, and normalizing health data from a disparate network of clinical endpoints can be extremely cumbersome without a uniform way of ingesting it. And data aggregation for payers and making it usable is even more difficult because of the ever-increasing number and diversity of data sets coming in from structured and unstructured sources.

Regulatory efforts around interoperability, primarily from CMS, are meant to create an ecosystem of data exchange among healthcare stakeholders — a sweeping goal that should not be forgotten, according to Danielle Lloyd, senior vice president of private market innovations and quality initiatives for clinical affairs at AHIP.

"How do we make sure not only that the consumers have the information they need easily at the ready, but that their providers have the information they need to advise them on their care and their health and wellness?" Lloyd said on the Healthcare Strategies podcast. "And by doing so, how do we enable the healthcare system to improve access to services, quality of care, equitable care, and affordability?"

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About Health Gorilla

Improving outcomes with organized, actionable health data

Health Gorilla is improving outcomes with organized, actionable health data as healthcare's single connection to a national network of aggregated data. Our solutions provide the building blocks that provider teams and payers need to improve clinical and operational efficiencies without complex data-sharing agreements or months of integration work.

Health Gorilla's Health Interoperability Platform (HIP) was built using Fast Healthcare Interoperability Resources (FHIR) standards, and allows digital health leaders to access complete clinical histories, order and review labs, and share records with other stakeholders.. Integrations done piecemeal can take up to six months of engineering time, but with Health Gorilla you can go-live in just a few weeks.

By leveraging Health Gorilla's HIP for integration or access via cloud platform and securely storing data in our FHIR-native database, you can:

- Connect to care sites in all 50 states with more than 220 million patients.
- Order and receive results from over 120 lab services providers, including Quest Diagnostics and LabCorp.
- Access complete past medical histories, de-duplicated and consolidated into one longitudinal record.
- Find and fill care gaps with social determinants of health (SDOH) scores for a more holistic view of patients.
- Eliminate duplicative testing and unnecessary visits.
- Improve post-acute follow-up, reduce readmissions, and understand utilization patterns.

Patient360 is Health Gorilla's out-of-the-box solution that enables the retrieval of up-to-date medical records with a full history, including medications, instantly from a vast array of sources. Patient360 also gives providers a way to continuously monitor patient outcomes for any updates in treatments, lab results, or medications, as well as the capability to retrieve medical records in bulk for large groups of patients to facilitate care for clinics participating in managed care initiatives.

Patient360 is patient data-sharing software built on our Health Interoperability Platform. It allows providers to retrieve clinical records and social determinants of health for a holistic patient view. Patient360 aggregates a single longitudinal record consolidated from thousands of care sites and new encounter notes that Patient360 users create are accessible by providers across the network. With aggregated data that is normalized to a FHIR format, Patient360 is available via a web-based application or API.

Leading payer providers can use Health Gorilla's interoperability platform to generate quality metrics, grow membership, and increase reimbursement rates through impactful preventative care. Equipping care teams with access to updated clinical and social determinant data in one platform allows them to leverage existing technology and workflows to deliver superior care experiences that improve patient outcomes.

- Deliver impactful preventative care by finding and filling care gaps. Improve member experience as well as post-acute follow-up.
- Refine risk modeling with real-time clinical data access and SDOH data.
- Improve operational efficiency, eliminate duplicate tests, and understand utilization patterns.

If you are a payer and want to know how Health Gorilla's interoperability solutions can help, we are here to answer any questions you might have. Visit healthgorilla.com to learn more and contact us anytime to schedule a meeting or a demo.


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