

Payer-provider partnerships are dramatically changing today's healthcare landscape, but are they really a new thing? And how will their increasing prevalence influence the future of care, either for better or worse? We're exploring these questions and concepts in our original series, *Essential Insights, Expert Voices*, and we've called upon several industry leaders to draw on past and present experiences and points of view to guide us.

[In our first piece](#), we heard from Dr. Jennifer Terrell, Senior Medical Director for naviHealth, and Greg Baumer, naviHealth's Chief Growth Officer. Today we're talking to Marilyn Denegre-Rumbin, JD, MBA, and Director, Payor-Reimbursement Strategy for Enterprise Marketing with the Center of Excellence at Cardinal Health, as she shares her take on the topic.

Payer-providers partnerships: a 'pendulum swing back'

While some see this emergence of payer-provider partnerships as a new trend, Denegre-Rumbin was quite familiar with similar collaborations when she worked at Anthem and United Healthcare twenty years ago.



Marilyn Denegre-Rumbin

Both commercial payers had developed programs working towards more payer-provider partnerships, and Denegre-Rumbin was tasked specifically with leading network development, specifically in Indiana, Ohio, and Kentucky. There were payment and care models with capitation, Denegre-Rumbin says. "We had employer-payer-provider relationships and that included multi-specialty groups that contracted partnerships to enact special programs for drug utilization, disease management, preventive care, and chronic illnesses. The goal managing the cost of care with quality outcomes."

These multi-specialty groups were ultimately responsible for managing the cost of care for patients with chronic conditions and disease management on a per patient, per month basis. "We collaborated on identifying satellite offices to meet market access and would drive patients to these multi-specialty groups," says Denegre-Rumbin. "These groups were *soup to nuts* operations—they would offer everything from lab, pharmacy rehab and specialists," she recalls. For example, working closely with national/regional employer groups, Denegre-Rumbin and her staff would have the data of the top ten disease factors, drug utilization and hospital admission rates in their population, then set up programs to mitigate costs and increase quality care.

“When we see this happening now, this is just us seeing the pendulum swing back to a model that worked but was open to refinement,” she says.

“Skin in the game:” The benefits of more payer-provider partnerships

The factors determining success or failure among these partnerships are as varied as the partners themselves. But Denegre-Rumbin sees “patient involvement” as a key indicator of integrated care models moving in the right direction.

Since risk sharing models have been lackluster, they’re looking for another formula, says Denegre-Rumbin. And the future seems bright for the payers and providers who are bringing consumers and patients into the mix. “Patients and their caregivers must have skin in the game, this translates into financial responsibility and medical adherence for better outcomes” she says. “Once you tell patients they are part of the solution, you begin to tear down the walls of the problem.”

Physician productivity is still a challenge to overcome, and on that front, the Centers for Medicare and Medicaid Services (CMS) is stepping up to help, per Denegre-Rumbin. In the fall of 2017, Seema Verma, CMS Administrator, announced the *Meaningful Measures* program, which intends to revamp and reduce the number of quality indicators, make them more achievable, and reduce the burden on physicians overall, Denegre-Rumbin reports.

The challenges of payer-provider partnerships in real-time

At Cardinal Health, Denegre-Rumbin and her colleagues are looking at how payer-provider partnerships will affect ambulatory surgical centers, outpatient facilities and post-acute and home care points of care. She explains one area in particular that offers both a challenge and an opportunity: “Hospital procedures are 50% higher reimbursement for inpatient procedures. This also means a higher cost than outpatient settings. Though a great opportunity for ambulatory centers, they would have to make it up in volume, rather than the same number of cases.”

What makes this approach challenging is the way it could expand ambulatory centers’ overhead, which is why CMS is exploring ways to offer incentives to direct suitable patients to a quality point of care for the best outcome and still control cost,” says Denegre-Rumbin. This presents another opportunity—as ambulatory surgical centers expand services, they will have the opportunity to partner with payers and employer groups for market access and new payment arrangements.

Claims adjudication represents yet another obstacle to more efficient payer-provider partnerships, per Denegre-Rumbin. “It takes months to get reimbursed,” she explains. And a big part of that delay, in her opinion? Siloed incentives.

Who are the winners when it comes to efficient reimbursement? The Blues have it, according to Denegre-Rumbin, but it boils down to massive amounts of data and resources. “They can leverage their ‘sister’ Blues, compare models, and consolidate data across the country, and physician groups want to work with them because they know they will be reimbursed within a reasonable timeframe,” she says.

Looking to the future: PACs, premiums, and preventive care

Denegre-Rumbin believes the Blues will continue to innovate—and excel—in the payer-provider partnerships arena. In fact, they’re already starting to look at working with providers again, looking at APMs, and looking at how to manage PAC, she says. As they move forward though, they’re also moving back to models that worked two decades ago. “Once the Blues perfect this—and they will because they have the resources and the data—they will be able to go into the community, engage with providers and patients, and ultimately reduce the cost and increase the quality of care,” Denegre-Rumbin says.

Another innovation to watch for, per Denegre-Rumbin? More payer-employer groups. “You’ll see instances where payers will go directly to employer groups and say, ‘We have everything under our umbrella, and every month for your 13,000 members and families, you’ll pay a monthly premium to the hospital,’ (PMPM) “she explains. “Then, they’ll look at rehabilitation, pharmaceuticals, and other costs, they’ll look at disease states and see how much the cost is projected, and they’ll try to put in place preventive care.”

Denegre-Rumbin saw this approach play out while working for Anthem. “We would make sure we had enough flu vaccines ordered in the spring, then we would go on-site to make sure flu shots were offered to everyone to minimize illness, keep them out of the hospital, and direct them to urgent care to reduce costs,” she recalls. To further strengthen this strategy, nurses and physicians were also made available in many employer groups, she adds.

At Cardinal Health, there’s currently a clinic on-site to manage care and costs—with the dual goals of enhancing productivity and keeping employees healthy, Denegre-Rumbin reports.

As for bundles, Denegre-Rumbin believes there will be lots of gyrations. “We know that the

Healthcare LAN Network and CMMI are seeking new payment and care models for 2018-2020. They have been retrospective with the goal of seeking new methodologies that offer solutions and incentives to drive quality and contain cost, she says. There is a critical difference between CMS and commercial payers. Commercial payers have close hands-on relationships with community providers and can implement changes very quickly. The answer to their success is the access to data. Commercial payers can pull the data and analyze quickly to guide their work, she says. “When you try to capture Medicare data, you can only get data that is 18 months old—not efficient, and that type of data collection takes time and the data has to be massaged. In comparison, commercial payer claim data is 45 days with timely analysis.

What about PACs? Denegre-Rumbin says payer-provider partnerships are looking for incentives outside the hospital walls. They also want to better manage care in that first 90 days with no readmissions, and ensure the patient is not only managed financially but that the resources are assessable and utilized for good outcomes. In conclusion, as we move from fee for service, to integrated care and new payment models with risk, there are four areas to keep on the radar for success in 2018, they are Population management, Population analytics, Care management, financial modeling and management.

According to Denegre-Rumbin, Charles Mayo said it best, “The past 50 years have been marked by advances in the science of medicine. The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered.”