RISK strategies CONSULTING

WHITE PAPER

Challenges and Opportunities in Assessing Healthcare Provider Networks

Quality, Cost, Equity, and Experience

Introduction

The building and management of medical provider networks serve as a reflection of a payor's foundational value to plan sponsors and members. Their value is often assessed by the financial discounts and other arrangements negotiated by the payor with the various providers as well as the depth, breadth, and size/ access of the provider panel included within the network A competitive provider network is also a significant barrier to entry for payors who wish to enter a geographic market or a market segment (i.e., commercial plans managed by payors and those regulated by Centers for Medicare and Medicaid Services including Medicare, Medicaid, and Marketplace (Affordable Care Act). Numerous factors impact the true value of the provider network for patients across the care continuum, and for comparisons to be made across payors. More of these elements go beyond discounts and pricing and also include quality, experience, and social drivers that need to be made available and measurable through more real time data exchanges, interoperability, and collaboration across care teams.

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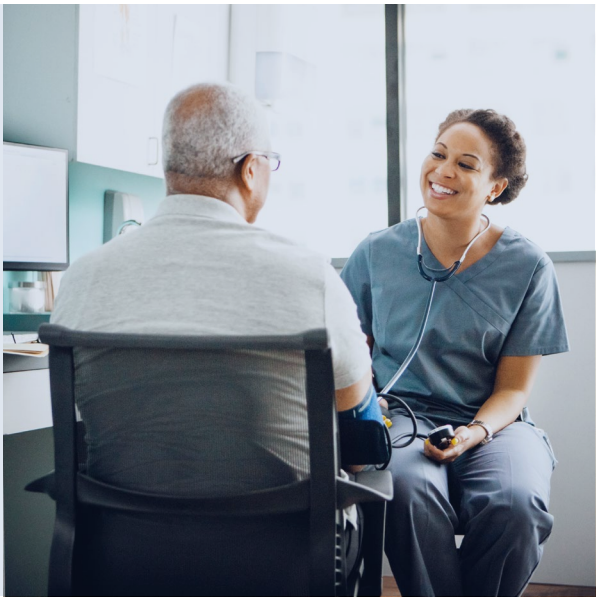
Provider Network Scrutiny

Fee-for-Service (FFS) and Value Based Contracting (VBC)

Provider networks have come under intense scrutiny for numerous reasons. The first reason is that the majority of network financial agreements are under a FFS arrangement, whereby providers are paid for the number and type of units of service they provide to patients. The market has come to believe this financial model creates incentives for inefficient/ overuse of care and services as well as revenue cycle enhancement behaviors by providers, whereby they up-code in order to maximize financial returns. The government and market response to this has been to create a variety of value-based models of care such as VBC arrangements, designed to address value over volume of services. The definition of "value" has evolved over time and measuring success fairly for all constituents in these programs has been challenging. Generally, value is measured as a combination of cost, quality, and experience components that are slowly evolving from process-based to outcomes-based, as more providers take part in these arrangements. Many factors have been considered and implemented to promote actuarially and clinically sound programs but because of the large variety of models that have been utilized, and the varying degrees of sophistication in their use, the industry still has more to learn to create sustainable models that give providers confidence in making a substantial change from FFS to comprehensive VBC.

Moreover, payment mechanisms and aligning incentives within the VBC models have changed in response to learnings. For example, bundled or episodic payments have slowly been moving from retrospective to prospective models, which are preferred by providers but more challenging to operationalize, and the use of different methods for risk adjusting within geographies to fairly measure performance without erecting hurdles for participants as their performance improves over time. Also, a large number of providers in VBCs are still in upside/ surplus models with little to no downside risk. And if they participate in Centers for Medicare and Medicaid Services models, the terms and conditions of these models may differ significantly from those with commercial membership through payors. Regardless of the type of VBC arrangement in which they participate, with a FFS payment model as their underlying payment mechanism, the volume of services revenue may outweigh incentive payments they receive through VBC models for many participants, undermining progression within these models.

To further illustrate, accountable care arrangements frequently sit on top of a FFS chassis of payment. In other words, the total cost of care management of the patient population attributed to the accountable care organization (ACO) is measured year-over-year, and when improvements are made, then the ACO and the payor/ plan sponsor share in savings achieved, at least partially dependent upon meeting quality outcome measures. But because the provider/ ACO has the FFS payment model in place, they still must meet organizational volume requirements such as those for number of visits, admissions, surgeries, and testing. The provider must also invest in tools and resources to help them meet the demands of VBC including more patient outreach, analytics and reporting, digital upgrades, social determinants of health inclusion, and more. The clinician most certainly believes these are the right actions to take for their patients but living in both FFS and VBC worlds is not a simple task.



Furthermore, staying abreast of the evolving trends and available models in which providers can participate within VBC can be exciting, but also daunting, for clinicians. For example, primary care physicians (PCP) may participate in a capitation arrangement for their services, and they may engage specialists, who are involved in their own VBC models such as total joint replacement episodes of care or oncology medical homes. PCPs are generally viewed as the patient quarterback, and to do so efficiently under a capitation or total cost of care model, they engage with other providers throughout the continuum of care, using a multi-disciplinary team approach, who are also focused on high value approaches. When done well, this optimizes communication across the team and reduces confusion for the patient. Interoperability across common or connected electronic health records and community health information exchanges exponentially supports this effort.

Utilization Management (UM)

The second reason is that a common belief exists that payors have typically created and deployed UM tools rather than clinical or care management strategies. The feeling is that existing approaches are designed to unduly limit care, and thus, adversely affect optimal quality outcomes for the patient. In fact, significant frustration continues that payors fail to understand and address the member experience from administrative and clinical standpoints. This is especially true for providers in risk sharing VBC arrangements. Their position is that if they are at risk for the services they provide, they have an inherent incentive to only order procedures and tests that are clinically necessary and to reduce unnecessary services; therefore, they do not need the UM oversight that simply slows down the provision of care and causes an administrative burden to their office staff. In response to provider abrasion, some payors have recently announced they will be decreasing UM for certain types of procedures.

Quality Metrics

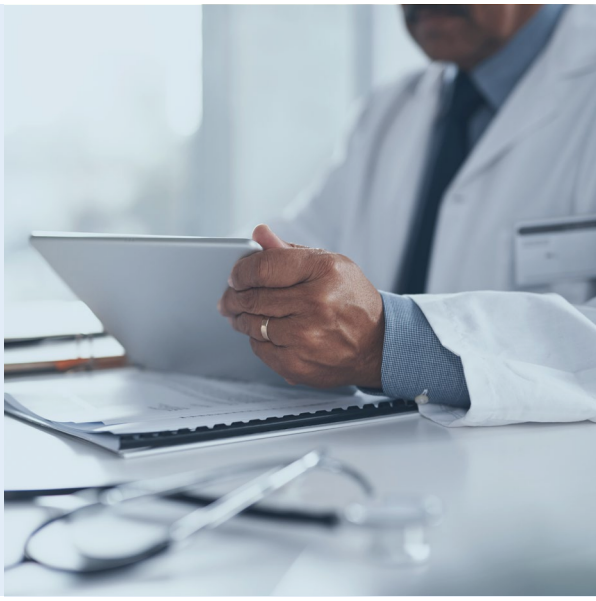
The third reason is that both payors and providers are reluctant to design and implement deep and thorough quality of care metrics that hold both parties accountable for creating true, high-performance networks that enable patients and plan sponsors to better know that the providers, and the care they are delivering, are of optimal value. Two reasons capitation models and their associated health maintenance organizations failed in the 1990s were the lack of supporting data and analytics and the concern for underutilization. The industry has come a long way with availability of data and reporting; however, the amount of data is not as important as the type of data. In other words, show clinicians where they are doing well, where gaps continue, and how they can improve the quality and cost for their patients. This means to not focus on whether a test was completed; instead, focus on how the treatment of the abnormal result from the test improved the health of the patient over time and how this improved costs to the patient and plan sponsor. To do this well, data needs to be real-time, not simply retroactive claims-based, and needs to be available across the entire patient journey. Interoperability solutions must be in place to connect disparate electronic medical records and data sets longitudinally.

Financial Accountability: Discounts and Transparency

Two additional considerations around financial accountability are also critical. The first is that, as mentioned previously, the most common contracting methodology is based on discounts for services delivered. This financial methodology does not adequately support insurance companies and plan sponsors, who need to establish accurate accruals and liabilities on a "per member per month" (PMPM) cost basis. The second financial accountability issue is the lack of transparency around agreed-to reimbursement levels between payors and providers. Both parties claim confidentiality around reimbursement levels including protecting themselves with such language in their contracts. While we understand the proprietary and market competitive nature of the issue at hand, we are also concerned that plan sponsors are expected to make a purchasing decision based on highly limited financial data for network options that also fail to adequately distinguish themselves with distinctive quality of care metrics and measures.

The contracted financial methodologies and transparency issues noted above concern in-network, or participating providers. While the complexities inherent in provider-payor negotiations are evident, even more elements are introduced when services are provided to members through the use of non-participating, or out-of-network (OON), providers. While overall payment rates may be unfavorable as compared to in-network fees, the member cost share may be quite significant, depending upon the specific plan design. For example, certain plans have no OON benefits except for emergencies, or if they do have an OON benefit, the cost share is typically meaningfully higher for the member and can be a heavy load within the structure of a high deductible health plan. Occasionally, overall costs become misaligned, and the payor portion may be acceptable or even favorable to the payor, while the member bears a large brunt of the payment responsibility. This can also occur when the OON provider is managed through a third-party medical network.

Importantly, new transparency laws have begun to shed some light on the reimbursement levels between payors and providers; however, the legislation and methodology around the publicly available transparency data is limited, flawed, and often inaccurate. One of the foundational causalities for the limitations around the accuracy of the transparency data is its failure to adequately address the inclusion and financial implications of value-based reimbursement (VBR). VBR monies are excluded from the core data sets released by the payors and providers when meeting the requirements of their filings. As always, in order for us to assess value and return on investment, we first need to gain a thorough understanding of the data elements and sets being utilized in the determination of the issue at hand. We also need to establish and utilize a clear, thorough, and distinct set of definitions, terms, and methodologies being utilized in order to accurately quantify and qualify stated or expected results.



The market is excited about VBC and corresponding VBR, but they are presently still in their infancy and evolving greatly. As a result, they are ill-defined and difficult, at best, to accurately assess. In fact, just as with the term "transparency," the definitions of VBR and VBC are overly broad and inconsistent. Realizing true VBC, with corresponding clinical and financial improvements, will require the market to adopt deeper and broader data sets and elements; distinctive, innovative, and measurable quality-of-care metrics as well as the adoption of new investments/ technologies. These investments/ technologies include, but are not limited to, groupers that take in and utilize traditional and non-traditional healthcare data to establish individualized episodes of care and a comprehensive risk-adjustment tool/ methodology that ensure the payor, provider, plan sponsor, and patients are each being treated fairly, thus avoiding surprises and enabling sustainability.

Other technologies and investments needed include claim adjudication platforms that pay the amounts due in an accurate and timely fashion, clinical management platforms that support optimal care and experience for the patient and provider, generative artificial intelligence-based reporting and analytics that demonstrate value as well as enable accurate accounting of monies due to various stakeholders based on actual versus expected performance.

Care Coordination and High-Performing Providers

Care Coordination

Despite the rise in popularity of alternative and VBC arrangements, the value or standards by which provider networks are measured are much too limited and do not encompass critical elements in patient care that can have a significant impact on costs, quality, and member experience. As mentioned, discount/FFS – and also Uniform Data System (UDS) carry the bulk of network assessment criterion, which greatly shortchanges the evaluative effort. To begin, let us examine the role of the primary care provider (PCP). At present, and this has varied over time, the industry values the contributions of primary care physicians as essential for delivering preventive care, addressing acute needs, managing chronic diseases effectively in conjunction with necessary specialty care, considering the most efficient sites of care, managing medications, and introducing alternative methods to proactively engage patients in person, virtually, and digitally. Many believe this is the optimal approach to managing acute and chronic care needs; however, complicating factors are making this highly challenging to carry out effectively such as burnout rates after the public health emergency, mergers and acquisitions placing additional obligations on physicians to comply with organizational directives, government regulations with respect to reporting and coding, payor administrative requirements, nursing shortages with many seeking contract work, and lack of interoperability with health systems and other providers.

Without adequate staffing and up-to-date operational systems and technology, diagnostic speed and accuracy are sacrificed. If a PCP cannot communicate efficiently with other members of the patient's care team, then the likelihood of unnecessary testing, lagging response times, and inaccuracies are increased. Having application programming interfaces or health information exchanges across PCPs, health systems, specialists, and other providers greatly increases the timely availability of health information and allows for bi-directional communication. If payors and patients are also connected to applicable access points, then a more comprehensive technology platform is achieved, optimizing communication.

Furthermore, how we think about who holds the PCP role is also evolving. The image of the hometown physician office around the corner that serves all members of the family may remain, but could just as likely be housed within a floor of our office building, in the nearby pharmacy clinic or urgent care center, or via an application on our phones. Dual-income households with different access needs and less time, emerging technologies, rising demand for more convenience, and clinician shortages are all driving forces behind these emerging options. Nonetheless to reiterate, with more options, comes a complementary requirement to focus on fragmentation vulnerabilities that may impact care coordination and on sacrificing the face-to-face relationship and/ or connectivity to other providers from whom patients may seek care.

High Performing Providers (HPP)

Physicians who have patterns of high quality and cost efficiency are frequently recognized by payors via certain designations within their provider directories. Historically, physicians have been deemed "HPP" predominantly from metrics related to their costs and payment rates, but an effort is being made to *also include quality measures* as a component of the definition for high performing. Claims data remains the most accessible source of information about providers for payors, so the definitions of cost and quality must be largely derivable from claims. Much can be gleaned from claims, but obviously, a claim does not offer as much transparency into these factors as does the medical record.

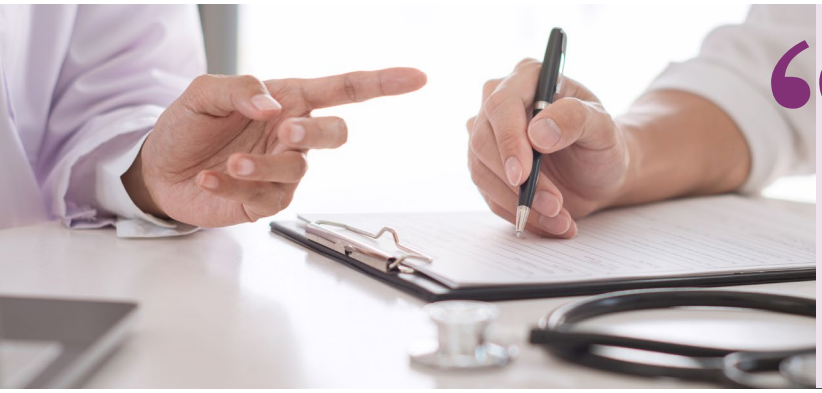
Let us elaborate on how we need to transform the measurement of HPPs from what is described above to a method encompassing true quality care across the entire healthcare ecosystem for a patient – the patient journey across and within all elements of the care continuum. First, providers are deemed qualified for the designation of HPP based on many claims-based factors, and historically, this has been mostly cost based. Now, more effort is being placed into including quality-type measures and can be summarized into identifying the following types of information that are present or absent within the claims history.

Information Types Present or Absent in Claims History

- A certain diagnosis was made.
- A certain test was completed.
- Certain visits were conducted.
- Certain medication prescriptions were filled by patients.
- An admission or readmission occurred.
- The length of stay is assessed.
- The emergence of complications was identified.

Most agree when a PCP has a strong pattern of excellent events versus unfavorable events over an extended period of time that this PCP is likely promoting better healthcare for patients than a PCP whose record is less stellar because this physician has a disciplined approach, competency, and engagement with their patients. Even though we can make reasonable assumptions that align patterns of behavior to the quality of care received by patients, a great divide remains between drawing solid, comprehensive conclusions around a patient's holistic health based on these types of measurements alone. This does not mean we should not continue measuring them, in fact we should – they are an excellent starting point – but these, too, are insufficient without deeper examination of the entire patient journey. For example, making a certain diagnosis is indisputably important, but having a *timely and accurate* diagnosis through optimized provider communication is equally essential. Similarly, prescribing patterns are other key indicators of quality, hence, knowing a prescription was filled by a patient is key but seeing the overall, comprehensive prescribing pattern of individual providers and across all the patient's providers are even better measures of quality for management of medical and behavioral health conditions.

When we use a single event, or even a series of single events, we are (only) examining a point in time; we are not closely monitoring a patient as they maneuver a PCP visit, a specialist(s) visit, an emergency room, a hospital admission, a post-acute facility, home care, pharmacy delivery, virtual care, digital application coaching, payor care coordination, and so on. The transition points in the journey are particularly vulnerable for care coordination activity, and where if interoperability does not exist, communication can falter resulting in wrong, duplicative, or missing information being relayed between healthcare practitioners or delayed care. Similarly, measuring an episode of care, while more comprehensive than a single event, is still deficient with respect to decisions leading up to the event and what occurred afterwards. To illustrate, for a musculoskeletal condition, was conservative treatment considered before surgery? Was the patient discharged with the appropriate home care and PCP follow up to avoid a readmission? How was the pain medication considered alongside the patient's other chronic condition medications, and was this communicated across the team? Does the patient have a caregiver at home, who may also be facing their own limitations? Is the pain causing the patient to have behavioral health symptoms? What about days away from work?



> Focusing on patient experience requires longitudinal evaluation of all the points of care, how they connect and intersect with others, and the outcomes along the way, while engaging the patient and monitoring for lack of understanding, adherence, or barriers.

Having a better patient experience is the optimal objective rather than monitoring if a PCP held a certain visit with the patient after another event noted on a claim. Focusing on patient experience requires longitudinal evaluation of all the points of care, how they connect and intersect with others, and the outcomes along the way, while engaging the patient and monitoring for lack of understanding, adherence, or barriers. Also, when evaluating provider performance, consideration needs to be afforded to the case mix of the patient panel that provides insight into the prevalence of high cost and complex medical conditions including medication usage. And, incorporating how the physician measures health disparities and special needs, connects patients with helpful resources, and then follows up for outcomes assessment are important. A path to including this depth of measurement is through truly connected technology platforms between the multi-disciplinary care team across the provider network that offers bi-directional real-time data exchange. We are simply not there yet, so much work remains to truly be in a position to measure the holistic patient experience through the lens of a high-performing provider network, although great work by many is being pursued. Notably, payors must be judicious in their use of these types of designations due to certain state regulations limiting their use, and they must be consistent and conservative in their methods, which can be limiting factors.

High Performance Network (HPN)

As HPP designations grow, they may further be utilized to build networks comprised of these high-performing providers, that is, an HPN. In addition to creating more depth with respect to quality and cost performance, HPNs need to meet network adequacy requirements in a market and contain enough PCPs and all types of specialists and ancillary providers. This type of intentional network design necessitates accounting for referral patterns that may have, in the past, been based on familiarity or a shared education or employment background. This means physicians must be willing to potentially disrupt their existing referral and admitting patterns, which could be difficult given the vertical and horizontal consolidation of health systems, making the plausibility and nature of an HPN variable by service area, dictated by the degree to which physicians can, or are willing to, support or advocate for this. Not only this, but provider consolidation is a bit of a moving target, resulting in potential changes of reimbursement, negotiating tactics, reporting structure, cultural shifts, and/or investment priorities.

Regular measurements of performance to ensure compliance with HPP requirements are essential as well as coaching for those who lapse. Ideally, the HPN is centered within a robust VBC arrangement as well. The HPN could be a total cost of care model for all conditions or could be condition specific, focusing on complex and high-cost medical conditions that require more high touch care coordination services such as transplants, oncology, etc. This could also include a center of excellence, which patients access locally or from afar via a medical travel benefit. The reader should know that a great deal of overlap exists between payor HPP listings. This is not just because many providers participate in multiple payor networks but also because demonstrating differentiation between network performance is difficult to accomplish when the measurement of success is based on high-level, yes/no type answers.

To summarize, having a PCP-centered approach, where the member is managed consistently with preventive care, treated for acute conditions, and proactively managed for chronic diseases throughout the continuum of care requires close collaboration within the entire multi-disciplinary care team including specialists. Communication must be optimized through up-to-date connectivity platforms, and patients and their care givers must be involved in their care. This also means transitions of care, a particularly vulnerable point, are handled promptly and patients are provided services in the right time and place.

With more care available in the home and virtually, patients can be reached at higher rates but if communication is not effective during these times, more fragmentation can occur. A saying is that care is local, and that is true in that the local market ecosystem needs to envelop patients going through various health journeys within their communities including social programs. This care can also be supplemented through centers of excellence and virtual programs.

Uniform Data System (UDS)

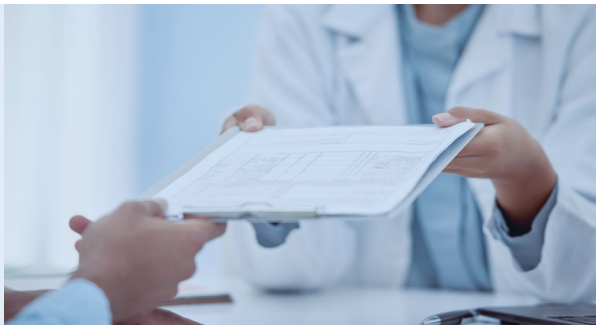
Let us examine the most common tool in use today by consultants and carriers to evaluate the competitiveness of payor networks: UDS. UDS is a compilation of book of business (BoB) discounts, developed by large health payors (i.e., health plans or payors) and benefit consultant organizations, and is considered the industry standard for measuring and reporting on provider networks across geographies where employees reside. Plan Sponsors care a great deal about the function of healthcare benefits within the realm of human resources, especially with respect to how their employees are engaged, the quality and methods by which their employees receive care, and how the total cost of care is well-managed. Plan sponsors know the health of their employees directly impacts productivity, loyalty, job satisfaction, and time away from work duties.

To address these concerns adequately, no component within healthcare benefits carries a greater weight than the composition and characteristics of the provider network. Many attributes of the network must be examined and understood to comprehensively assess a payor's provider network in addition to the use of UDS. For this reason, UDS is viewed by many as largely inadequate in its use as a foundational tool for evaluating and comparing provider networks across payors. Understanding the complexities of care coordination and high-performing providers, as described earlier, the reader can agree that a network discount is only one piece of numerous, complex elements that contribute significant differences to the true value of a network, and in fact, the methods by which network discount is calculated via UDS are viewed as inconsistent and oversimplified.

UDS Background

UDS began BoB compilation in the late 2000s for the purpose of helping self-funded plan sponsors decide, across the markets where their employees reside, the payors who have the most favorable healthcare pricing for inpatient, outpatient, and professional service types. As the reader can imagine, the answer to this research may significantly vary market to market. Payors will have negotiated more favorably in certain markets than others, and negotiation results may vary depending on specific service types. This is because certain geographies demand higher pricing, and some are dominated by a fewer number or type of providers and/or payors.

The most prominent determinant of "favorable healthcare pricing" has historically been the degree of unit cost discount from billed charges to allowed amounts achieved by the payors. The composition of the provider network in a geography versus those non-participating provider services also comes into play, which can be especially meaningful in rural areas, where employees may need to travel for specialty care.



UDS data content (Note, *not data usage*) supplied by the participating payors is decided by the UDS workgroup.[2] Content is compiled and shared twice annually over a rolling 12-month period, containing approximately six months of claims lag.[1] Data aggregation and layout per service type are dictated in detail.

Here is a high-level listing of what data is *included*:[2]

- Group claims only
- Private exchange business
- Claims from all providers (except for those noted to be specifically excluded)
- Claims from in- and out-of-network providers
- High-cost claims
- All claims covered under medical benefits
- Claims paid through product rental networks
- Other specified provider payments and those applicable to medical coverage not included in administrative fees for fully and self-funded business (for example, withholds, pay for performance, risk settlements, bonuses, pre-payments, provider incentives, care collaboration payments, provider fees to fund administrative functions)
- Claims adjudication adjustments

Conversely, below is a high-level listing of what data is *excluded*:[2]

- Claims for members aged 65 or older
- Medicare claims
- Medicaid claims
- Claims as secondary payor
- Mail order and retail prescription drug claims
- Dental claims not covered under medical benefits
- Vision hardware claims not covered under medical benefits
- Interest expenses
- Regulatory fees
- Prompt pay penalties
- Custom network claims
- Claim lines with ineligible charges
- Capitation payments
- Covered life assessments
- Network access fees
- Prisoner claims
- Railroad employee claims
- Denied and pended claim lines
- Claims for certain medical provider customers, who have a standard industrial classification of 8061 or 8062

Strengths of Using UDS Data

Having a standard, or uniform method, for viewing network discounts across payors is critical to evaluate provider network options more equitably across markets where employees reside. Evaluators of the discount data typically allow for a margin of error, commonly two percent in discount points, or four to five percent difference in unit cost.[3] Evaluation of service types (i.e., inpatient, outpatient, professional) is relevant with respect to comparison of employee utilization patterns, which are typically aligned to member demographics, medical condition mix, accessibility, and social drivers. Additionally, consultants use risk adjustment factors such as demographic and population health profile differences to calculate discounts more evenly within markets; for example, an older or sicker population is adjusted to create more equality across the payors.[4] Theoretically, risk adjustment levels the field more effectively; however, risk adjustment can be calculated using diverse techniques, so for this to be beneficial, consultants need to apply risk adjustment consistently, and payors need to agree on the rules applied, which should be re-examined annually. Unfortunately, this is not the current practice.

The value of the UDS data can be augmented by using other types of analyses in parallel: Repricing exercise and consideration of care management.[1,3] With a repricing exercise, plan sponsors and brokers have an opportunity to review and compare their historical claims data file to a claims file that has been reconfigured, or repriced, by payors using their current negotiated arrangements during the same, defined timeframe and with the same provider and service mix that was used by the plan sponsor's incumbent payor(s). An incumbent payor, who is competing to retain the plan sponsor as a client, may also request to reprice their own claims, using prospective, newly negotiated provider negotiated rates as compared to the retrospective, historical claims. Repricing brings additional detailed information for consideration, but also brings more complexity, time, and variation. Because each payor tends to have its own preferred repricing method, repricing conclusions cannot be sufficiently compared to other payors' assertions. Because of these factors, although repricing can bring more insights, many believe the inconsistencies associated with the exercise outweigh the benefits. As with other elements discussed, specific requirements for repricing, where the numbers are not presented variably at the discretion of payors, are essential in making this a more valuable supplement for network evaluation. For any variation amongst payor repricing methods, we need to understand the rationale for such divergence from a standardly recommended approach.

Clinical care management is becoming a more important and visible consideration that impacts medical costs as more payors compete on the quality, cost, and experience value of their member engagement, chronic disease management, concierge and advocacy programs, high cost claims focus, site of care redirection, medical policy development, use of evidence-based medicine protocol, utilization management expertise, focus on high-cost medical conditions, level of care advisement, and incorporation into value-based models of care (VBC). Some tout their programs can influence costs by anywhere from two to five percent of claims or more.[3]

Limitations of Using UDS Data

For some, particularly payors who are competing by virtue of submitting UDS data, the "U" in UDS may be more representative of "unstable" instead of "uniform." Reasons for this sentiment are numerous and representative of the changing healthcare industry, growing complexities of the provider network, and the accuracy of the submissions themselves. The network is far from simply a roster of hospitals and clinicians who have agreed to participate within a marketplace, and the variety of contracting methods is too large to include in a concisely written document. In fact, as previously mentioned, the specific providers are not the drivers of the data alone; the membership geography is the starting framework. Let us examine the top reasons why UDS is usually viewed as only one of many considerations for the proper evaluation of a payor network, and when used as the *foundation* for network comparison, is in fact, a flawed mechanism.

First, let us revisit the mechanics of examining a discount for evaluation and how these leave gaps in the assessment of the overall network effectiveness.[4] To reiterate, discount evaluation of a network using rolled up data submissions is oversimplified, vague, and allows for conjecture of the true value of the data as demonstrated by inconsistent results and rankings submitted by consultants, even within the same metropolitan statistical area. For example, when a payor, in one year's time, is depicted as having a three to five percent increase in discounts, then the reader of this information knows a more reliable approach, where data usage, rules, and methods are consistently applied amongst consulting firms is definitely needed, as this depiction is simply not doable.

Regardless of the data layout "specifications" being named as such, even dollar fields such as "discount, allowed, or eligible" can be open to interpretation, affecting validity of the analysis. The data studied does not entirely, if at all, accommodate utilization patterns, the overall size and mix of the network, the actual charges billed, the population demographics other than to examine a three-digit level zip code for employee residence, clearly delineated OON utilization, or other costs that are charged to the plan sponsor via bank accounts/ claim wire.

OON utilization, in particular, can create misalignment of costs, as described earlier when members receive OON services from independent/ third party medical networks (e.g., Naviguard, etc.), where the payors may benefit financially from a total paid amount, while members face high, OON payments. To leave dynamics such as these out of the picture limits the overall value of the assessment and comparison of payor networks, underscoring the need for payors and consultants to revisit and develop an improved approach.

We need for consultants to consider the totality of data and information more judiciously that is relevant to a network's *total value* and to *not* accept broad statements of value that are mentioned separately as adjustments or in an appendix and not a part of the core data under consideration. We also need to insist upon reaching agreement on the most appropriate methods of capturing those elements outside of claims activity that impact total costs. This should not be a concern over discovery of proprietary information, as the assessment is more broad-based than rate specific, even with said improvements.

While network breadth is oftentimes a compelling advantage, and many larger plan sponsors seek an expansive network, more of them are also looking for narrower, high-quality networks (or HPNs, as described previously), at least as another option for their employees, that may offer HPPs and/ or VBC providers. (In fact, questions about the presence of VBC providers have become routine in plan sponsor requests for proposals.) Yet, discount analysis can potentially offer more "credit" to the size and discount of the network over other important quality and cost-containing features.

What we have seen in the industry is an ebb and flow of interest in narrow networks since they tend to mostly attract non-utilizers or those who already seek services from the designated providers contained within them – many of us are not willing to switch from network providers to whom we have grown accustomed even with a higher premium price point; meanwhile, providers tire of the narrow network configuration, where they render services to basically the same patients but at even lower reimbursements. All this to say that when a payor offers multiple network options for selection, each option offered is worthy of a series of questions and answers to discern best choices for plan sponsor employees.

With respect to value-based arrangements in place with providers, whether they sit within large or narrow networks, great variety in construct of these programs exists for providers in the commercial segment, making the granting of UDS "credit" to these programs less straightforward and misrepresentative of the value they may offer to the overall network. For example, certain accountable care organizations may only cover fully insured, self-funded, or both sets of members. The arrangement may be upside only with performance payments linked to quality, cost, or both. The glide path to risk is slow, but hopefully progressive, which means year-over-year, surplus or risk-sharing percentages may change. The value model may or mostly cover the total cost of care or may only apply to specific condition or procedure-based episodes of care such as total joint replacement, cancer care, or obstetrics. The VBC network may only apply to certain payor products and may be single or multi-tier, meaning non-VBC providers may also be providing services to the same members as the VBC providers, either as supplemental providers or as a second tier, for example. The timing of these payments is also highly variable.

To illustrate, care coordination fees that are designed to incentivize quality or provider investments or that offer a vehicle for interim payments may occur monthly, quarterly, or vary with actual performance and outcomes. Sometimes, performance payments "simply" drive the FFS payment higher or lower based on specific outcomes. With total cost of care models, a reconciliation of quality and cost within the year under examination may occur several months after the end of the performance year, which may not be captured within the timeline assessed for the discount analysis. And by the way, especially with providers new to these programs, surplus and risk payment amounts are difficult to predict, and the amounts can vary depending on the parameters within the negotiated contract.

Notably, contract measurement is highly negotiable with commercial VBC contracts (unlike Medicare VBC, which dictates measurements and performance standardly). Also, the methods by which the payments are made to providers differ such as via plan sponsor claim wire access, special fees with self-funded plan sponsors, or additional payments made directly by payors for fully insured client membership; or payors may decide to secure certain guarantees with respect to these models with their clients.

Additionally, when a payor declares a certain number of members/ employees are aligned with value-based providers, the sophistication of the arrangement greatly impacts the true value to which this translates for the member and plan sponsor. To be declared "attributed" to VBC providers does not mean a great deal if the care coordination, aligned incentives, and patient engagement are not excellently managed, and providers are not all-in with supporting operational investments and functions. A common element across most VBC arrangements is they tout their objectives to improve quality, manage costs, and enhance the member and provider experience (quadruple aim). Clear indicators of each of these focus areas should be apparent, and UDS data specifications certainly do not adequately address these. Not only this, with attribution-based VBC models, patients/ employees may have no idea they are "attributed to" a VBC provider or what that means to them, so declaring member experience is enhanced requires more evidence of such. What all this means for discount calculations is that they may be more error-prone due to the degree of variability in payment amounts, methods, timing, and structure of VBC arrangements. For a more comprehensive view, then, taking the presence of these models into account and seeking validation of their impacts on total costs, quality, and member and provider experience are good practices.

Importantly, the overall composition of the provider network directly affects plan sponsor risk attraction. To illustrate, Blue Cross/ Shield (Blue) plans tend to have the largest and "friendliest" provider networks, which may translate into the worst risk for a plan sponsor in the form of attained discounts. This is because of the frequency and depth of claims exceeding outlier clauses (described in more detail below) due to sheer volume of claims that are a direct result of number of providers but also (frequent) Blue market dominance in addition to PMPM costs. This, in turn, leads to the need for improved risk adjustment accuracy considering case, provider, and service mixes, which as already described, is up for considerable diversification in techniques.

Moreover, when a discount percentage is stated from billed charges, billed charges can meaningfully vary between provider organizations in the same geography, not to mention those outside the member's zip code that are included in the analysis due to the need for medical travel especially in rural areas or for those seeking centers of excellence offered by payors such as many have noted with companies like Walmart. Not only this, but charges may be exemplified through several billing methodologies: straight fee-for-service (FFS) or they may be filed as a case rate, a global rate, or a per diem rate, and they may mirror Medicare billing methodologies or could be a hybrid of Medicare and custom negotiations. So, translating all these potential combinations into a simple discount is not sufficient, especially if plan sponsors are attempting to translate these discounts into per-member-per-month impacts. Furthermore, FFS contracts may also contain outlier provisions that basically cause a default to billed charges when the tallied charges meet a pre-defined threshold, and those charges may or may not be first dollar.

Another occasional practice with payor-network partnerships is for the payor to "buy down" the network such that in exchange for providing an upfront payment, the provider, typically a large health system, agrees to provide more favorable FFS rates or not increase them. As the reader can deduce, great variation amongst payor-provider contracts and partnerships makes the discount calculation a limited, albeit standard, analysis.

Lastly, this document lists areas of skepticism within the payor community regarding the practices of the competition, how they are represented to plan sponsors and benefit consultants, and how these factors can significantly impact costs to plan sponsors. Many believe, even with specification standards, too much flexibility exists including using the data specification form appendices, where participants share additional information.

This document is a *call to action* to all of us in the healthcare industry to expect more, not just more data, but more *transparency* in data that is meaningful for true network valuation and how this translates into consequences for patient care. The way to accomplish this is to include evidence of medical and pharmacy reimbursement structures that incentivize clinical outcomes and care coordination, and the data represented needs to reflect the efforts, programs with providers, and payment mechanisms from all sources (claim wire banking, upfront payments in exchange for FFS discounts, value-based incentives, percent of charge defaults and other outlier payments, etcetera). Broad sweeping statements or adjustments cannot be taken at face value or narrative alone; those simply result in inconsistent assumptions and generalizations with "credit" given, instead, value drivers within in the network must be more plainly, yet comprehensively, shared – and in the context of the market where members reside. See concerns below voiced by the payors and others in the health industry, who are concerned with fair, transparent, complete, and quality-oriented submissions for evaluation of provider networks, from which plan sponsors make important decisions regarding the health of their employees.

- Belief some payors do not abide by the data specifications, resulting in inflated discounts
- Insufficient auditing, questioning, and validating of the discounts asserted
- Suspected practice of including projected discounts for providers that will soon be in-network without consistent auditing of actuals
- Exploiting the inclusion or exclusion of custom networks to their advantage
- Applying out-of-network discount assumptions
- Suspicion some payors submit adjusted data as actual
- Need for better definition of claim types, which causes questions about claims classification accuracy and consistency amongst participants
- Provider mix differences between payors
- Three-digit zip code too high level
- Inclusion of claims where third-party vendor negotiations took place, making verification difficult
- Inclusion of VBC reimbursement that is wrought with assumptions, as previously described
- Exclusion of certain providers
- Exclusion of outlier claims
- Exclusion of pharmacy
- Exclusion of zero discount claims
- Exclusion of claims associated with providers under examination for fraud, waste, and/or abuse

In conclusion, for network valuation, as with any initiative of this size, scope, and importance, care must be taken to question, determine, and establish definitions of success, the goals to be accomplished, and a clear business plan with corresponding project plans that enable deployment and adoption on a sustainable basis. Furthermore, in-depth measures that examine quality, patient experience, and health equity in addition to costs require significant consideration. Traditional methods of valuing payor networks such as UDS have insufficient value as a standard vehicle for plan sponsors and benefit consultants to compare networks within geographies where employees reside. While the concept of "uniformity" is admirable, criticisms of UDS abound for a variety of reasons related to comprehensiveness, accuracy, consistency, and discretionary interpretation without the necessary auditing and validation of assertions made. The provider network is one of the most important aspects of employee health benefits, and plan sponsors have different views of the importance of breadth of the network versus smaller network options, and most also seek information about the progress of VBC inclusion within payor networks. The need for this will continue to grow with the number of alternative provider networks available to plan sponsors and consumers of healthcare.

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