Five Trends in Value-Based Reimbursements

Should Your Organization Be Moving to Network-Wide Scale Now?

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Value-Based Reimbursement Contracts are a Growing Healthcare Industry Force

The value-based reimbursement (VBR) trend is the latest in a series of healthcare reforms, and from the approaches seen in industry publications and conferences, this trend seems to have a promising trajectory. The key elements of VBR are more mature than prior efforts, and participants are much more focused on collaboration than any prior programs. Clinical analytics systems are well developed and beginning to provide critical insights. Both sides are recognizing each other’s unique contributions, and newly formulated common interests and shared risk are beginning to drive new investments in technology and care models.¹

The architects of the pilot and early-adopter VBR programs are clear that they seek continuous improvement—finding repeated, incremental, and practical opportunities to deliver better care while reducing costs. Payers and providers acknowledge that they need to think of VBR as an extended experiment, recognizing it will take three to five years to gain the expertise and operational support needed for implementation on a wide scale.

Accordingly, it is important to establish exactly where the VBR trend is today, to explore how VBR is likely to develop over the next two to five years, and to understand how to invest in operational solutions that drive VBR success.

Figure 1. Evolution of Healthcare Payment Models, 2009-Present

<table>
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<tbody>
<tr>
<td>CAPITATION</td>
<td>PIONEER/MSSP ACOS</td>
<td>PAY FOR VALUE</td>
</tr>
<tr>
<td>1980s: Payers gave PCPs a fixed PMPM to manage HMO members</td>
<td>CMS programs for provider groups treating Medicare FFS patients; shared savings if quality and cost goals met</td>
<td>EPISODE OF CARE</td>
</tr>
<tr>
<td>MEDICARE ADVANTAGE</td>
<td>BUNDELED PAYMENTS</td>
<td>SHARED SAVINGS</td>
</tr>
<tr>
<td>CMS-designated payers who received a fixed PMPM for members and sometimes passed that to PCPs</td>
<td>CMS program to pay hospitals and specialists a fixed fee for designated procedures</td>
<td>TOTAL COST OF CARE</td>
</tr>
<tr>
<td>PAY FOR PERFORMANCE</td>
<td>PCMH PROGRAMS</td>
<td></td>
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<tr>
<td>Payers withheld some of FFS payments and gave P4P bonus to PCPs if performance goals were met</td>
<td>Commercial and CMS programs paying PCPs extra payments for higher levels of care coordination</td>
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</table>

SOURCE: NaviNet, Inc.

¹ Throughout this discussion, the term “payer” is intended to mean the “risk-bearing entity that assembles a network to care for patients.” This could be a traditional health insurance company, a Medicare Advantage or Medicaid plan, or a large integrated delivery system that is taking risk for its own employees or other population.

ABOUT THIS PAPER

NaviNet, a technology company at the crossroads of payer-provider communications, is seeing the value-based reimbursement trend affect the relationships between our payer customers and provider networks. In order to better advise our customers on their approach to payer-provider networking, and to use industry analysis to influence our own product direction, we felt it important to step back and look at this trend strategically.

To that end, we set out to research value-based reimbursements by examining and curating what the myriad of industry thought leaders are saying and by conducting focused primary research. In this paper, we describe the research and findings, and conclude with a discussion about what NaviNet is doing to support this important industry direction.

EVOLUTION

Healthcare has been trying to evolve past the flaws in the Fee-for-Service (FFS) model for decades. Early efforts started in the 1980s with capitation programs (see Figure 1). Payers reimbursed primary care physicians (PCPs) a fixed fee per member for all healthcare provided. More recently, the federal government introduced Medicare Advantage (a similar payment model to capitation, specifically for Medicare members), and commercial insurers piloted Pay for Performance (P4P) programs, which allocate additional payments for PCPs who meet certain quality metric targets.
None of these efforts was perfect, but lessons were learned. This led to the Centers for Medicare and Medicaid Services (CMS) proposing—and the industry widely adopting—the Triple Aim, which is the overarching goal to simultaneously improve the health of the population, better the patient experience, and reduce the cost of care.

CMS subsequently initiated a number of Medicare pilot and experimental programs. The most prominent were Pioneer and Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) and Bundled Payments for Care Improvement (BPCIs). Shortly afterward, leading commercial insurers expanded their P4P programs to patient centered medical home (PCMH) initiatives, which gave higher payments to providers to cover increased care coordination for chronically ill patients.

Those early pilot programs have delivered promising results. Four common VBR contracts appear to have moved out of pilot mode and into more widespread scaling: Pay for Value, Episode of Care, Shared Savings, and Total Cost of Care.

**Five Definitive Trends**

The momentum of this trend can be seen in both the volume and the depth of the industry publications about VBR. To understand the current state of VBR, NaviNet invested in reading and synthesizing hundreds of articles, blog posts, press releases, and presentations. From that research we observed the following five key trends:

- The **growth trend** in VBR is strong and continuing
- The **results to date are promising**, especially in the population of patients who are incurring the highest costs
- The industry is **converging** on four distinct VBR models after a period of pilot implementations
- There is a **remarkable consensus** between payers and providers on future direction, including the extent of the adoption that is likely
- We are already seeing all sectors in the industry do seminal work on the **key capabilities** needed to be successful in scaling VBR—organizational, processes, and technology.

**TREND #1. STRONG GROWTH IN VALUE-BASED REIMBURSEMENT CONTRACTS**

Late 2013-early 2014 seemed to mark the shift from pilot mode to the first phase of scaling. The number of contracts announced rose, and the type of contract was more advanced. This marks a clear transition from the “early adopter” phase to the “fast follower” phase.

According to recent NaviNet research, in the first half of 2014, press releases on commercial plans described 61 distinct new arrangements, covering all types of VBR, including Pay for Value, Episode of Care, Shared Savings, and even one Total Cost of Care program (see Figure 2).

The national health plans and virtually all of the large Blues plans are reporting most of this activity. No small plans made announcements—and only a handful of Medicaid plans did. In the third quarter, the pace of activity remained strong, with at least 33 new contracts being announced, including announcements by several smaller plans. All of the national plans have announced that they each will have more than one million lives in VBR contracts by year-end, and all are on track to meet that goal.

**Figure 2. Commercial Value-Based Reimbursement Announcements, Jan-Jun 2014**

| 61 New Commercial VBR Announcements |
| Made from Jan-Jun 2014 |

| 21 DISTINCT PAYERS WITH ANNOUNCEMENTS |
| Nationals on track for > 1 million members by end of 2014 |
| Larger Blues all very involved |
| Small plans, Medicaid plans beginning to be active |

| INVOLVES AT LEAST 2.75 MILLION MEMBERS |
| 467,000 in ACOs |
| 770,000 in P4V or Shared Savings |
| 1,520,000 in PCMH (3 Blues, in IN, NJ, and PA announced their total membership) |

| Involves 27 States |
| CA, CT, IN, ME, NJ, OH, PA, RI each had three or more announcements |

SOURCE: NaviNet, Inc.
In a snapshot taken in April 2014, AIS research identified almost 600 distinct VBR contracts (see Figure 3). Slightly over half were CMS Fee-For-Service contracts (either Pioneer or MSSP ACOs or the CMS BPCI initiatives). The new growth spurt is happening on the commercial side. In total, these arrangements cover approximately 18 million lives.

The world of managed government programs is also paying attention to the VBR trend. As CMS and the state Medicaid programs add quality metrics and shared savings incentives to their contracts for Medicare Advantage and managed Medicaid, plans are now starting to pass those metrics and incentives on to selected providers in their networks (see Figure 4).

Growth in the managed government programs could add significantly to the lives under VBR contracts, given these programs’ substantial scale and reach:

- CMS contracts with 488 Medicare Advantage plans, covering 15.3 million lives, or 30% of Medicare population

- 35 states have Managed Medicaid contracts, covering 29.1 million lives, or 44% of Medicaid population.

SOURCE: Statehealthfacts.com

This growth is beginning to be seen among providers, as well (see Figure 5). According to The Advisory Board, among its hospital/IDN client base, most 2013 revenue—almost 80%—still comes from Fee-for-Service payments, with the rest coming from a value-based payment model.
Figure 6. Seven New Jersey Providers Involved in Multiple Value-Based Reimbursement Programs

<table>
<thead>
<tr>
<th>Health System</th>
<th>Commercial Programs</th>
<th>Government Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantic Health Systems</td>
<td>Aetna ACO</td>
<td>CMS MSSP</td>
</tr>
<tr>
<td>Hackensack</td>
<td>Horizon ACO</td>
<td>CMS BPCI</td>
</tr>
<tr>
<td>Holy Name Medical Center</td>
<td>Horizon ACO</td>
<td>CMS BPCI</td>
</tr>
<tr>
<td>JFK Medical Center</td>
<td>Horizon ACO</td>
<td>CMS BPCI, CMS MSSP</td>
</tr>
<tr>
<td>Lourdes Hospital</td>
<td>Horizon ACO</td>
<td>CMS BPCI, CMS MSSP</td>
</tr>
<tr>
<td>Partners in Care</td>
<td>Horizon ACO</td>
<td>CMS MSSP</td>
</tr>
<tr>
<td>Regional Women’s Health Group</td>
<td>AmeriHealth NJ</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Horizon Bundled Payment</td>
<td></td>
</tr>
</tbody>
</table>

SOURCES: cms.gov and NaviNet, Inc.

TREND #2. THE EARLY RESULTS ARE PROMISING

Numerous studies are being published on the pilot and early-adopter results, and the results are sufficiently promising that plans and providers are continuing on to the next step. It is clear that the art and science of results measurement is still in its infancy, and published results cannot be routinely confirmed by national organizations or peer groups. However, the organizations reporting results seem to be rigorous and have solid data to back up their findings.

The published results tend to focus on answering three different questions:

1. Does actively managing care actually deliver better outcomes and lower costs?

Boston Consulting Group’s extensive analysis compared the quality outcomes of Medicare Advantage patients (proactively managed for targeted quality metrics) with Medicare FFS patients (reactive management only) over several years. Their results show a dramatic reduction in adverse outcomes, with three different metrics showing lower percentages within the managed population (see Figure 7).

<table>
<thead>
<tr>
<th></th>
<th>Medicare Advantage</th>
<th>Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>6.8%</td>
<td>1.9%</td>
</tr>
<tr>
<td>ER Visits</td>
<td>40.5%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Complications</td>
<td>21.2%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>


Figure 7. Medicare Advantage Quality versus FFS
In a recent *New England Journal of Medicine* article, “Toward Increased Adoption of Complex Care Management,” by C.S. Hong et al, Massachusetts General Hospital reported that by using specially trained, primary care-integrated, complex care management techniques, they reduced the total cost of care for three different cohorts of patients by 6-19%.


In both of these studies, the focus was on the sickest patients—the ones with complex, high-cost conditions. With both showing positive results, it seems that the answer to the question could very well be, “Yes, active management does indeed get us closer to the Triple Aim with this cohort of patients.”

2. Can providers actually reap any rewards under value-based contracts?

Industry analysts are heavily scrutinizing the CMS Pioneer and MSSP ACO contracts, which are systematically administered across multiple providers. Much has been written about the challenges providers have faced in these programs. From those assessments, a “rule of thumb” has emerged that it takes three years for these programs to be financially successful. This rings true, given the substantial change in care patterns and provider-side analytics and management tools needed. However, there is some good news in the preliminary results, which CMS announced in September 2014. Of the 204 ACOs with final reporting completed, 49 ACOs, or 24%, improved on 30 of 33 quality metrics and generated $652 million in total savings, thereby earning over $301 million in shared savings.

3. Can ordinary practices really bend the cost curve and improve outcomes?

Payers have been implementing PCMHs and other programs over the past several years, especially the Blues plans, which have a large market share and can drive volumes of patients into practices. Three different Blues plans recently published their promising results (see Figure 8). All of these programs focus on populations with chronic diseases including diabetes and asthma, which benefit from proactive management. These studies did not show any cost or quality improvement for the generally healthy populations.

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**Figure 8. Published Results for PCMH Programs**

<table>
<thead>
<tr>
<th>Commercial PCMH</th>
<th>In high-risk population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>↓ 8-11%</td>
</tr>
<tr>
<td>Medical Costs</td>
<td>↓ 21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pay for Value Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Control Score</td>
</tr>
<tr>
<td>Pneumonia Vaccinations</td>
</tr>
<tr>
<td>ER Visits</td>
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<table>
<thead>
<tr>
<th>PCMH Program</th>
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</thead>
<tbody>
<tr>
<td>Quality Composite Score</td>
</tr>
<tr>
<td>Prevention Composite</td>
</tr>
<tr>
<td>Adult Medical Costs</td>
</tr>
</tbody>
</table>

SOURCES: Press releases/annual reports from Independence Blue Cross, Horizon Health Services, Inc., and Blue Cross Blue Shield of Michigan.
TREND #3. THE INDUSTRY IS CONVERGING ON FOUR DISTINCT VBR MODELS

PAY FOR VALUE (P4V)
The most basic model comprises a “bonus” program that rewards providers for attaining defined targets in quality metrics. Typically, this has been an entry point, with limited risk and reward—and limited opportunity for major cost savings. It is used to gain basic experience in focusing on process metrics: Does the provider adhere to the evidence-based best practices for their specialty? The programs originally were targeted toward PCPs and are now being applied to many other types of contracts, including hospitals, specialists, rehabilitation centers, and other ancillaries (see Figure 9).

SHARED SAVINGS
This model is an extension of the P4V model, with more potential upside but higher quality and cost savings targets, focusing on a defined population of patients who have chronic or high-cost conditions. Payers and providers share a robust care management program with proactive screenings and treatment programs, tight coordination within a mini-network of specialists and hospitals, and frequent analysis of transparent quality and cost metrics to search for improvement opportunities. Some level of FFS payments is made based on patient visits, and if the targets are achieved, quarterly or annual shared savings payments also are made. Payers also may pay a monthly care coordination fee to ensure the provider can hire the additional staff needed for the increased level of work in the office.

TOTAL COST OF CARE
The most sophisticated model expands on Shared Savings, including disease prevention goals for the entire population, and a layer of provider financial risk. The logistics are similar to the Shared Savings program, but at the quarterly evaluation, if the provider has exceeded the agreed-upon cost targets, the provider must return some reimbursement to the payer. Many believe this is the end goal of the VBR trend.

SOURCE: NaviNet, Inc.

Figure 9. Types of VBR Contracts with Goals and Typical Evolution Path

SOURCE: NaviNet, Inc.

EPISODE OF CARE
For providers whose work revolves around discrete diagnoses and treatments, the Episode of Care (or Bundled) program is being used. This involves an agreed-upon flat payment for a well-defined set of services from initial diagnosis through completed outcome, cutting across all contributing providers. Typically, the flat fee is less than the expected total of the FFS claims for the same services. This mini-network of providers is, therefore, incented to improve care coordination and reduce waste and inefficiency for the episode. If they do, there is typically a shared savings distribution.
In a historically polarized industry like healthcare, a wide range of expectations about future developments would be no surprise. Two recent studies put this to the test, with both asking the same question about the likely future mix of reimbursement between FFS and the various VBR models. McKesson asked its payer customers how they expected its payment mix to evolve. The Advisory Board asked its hospital/IDN client base how their revenue streams would evolve. The answers are remarkably similar (see Figure 11).

Industry analysts generally agree on these models but with slight variations. McKinsey groups VBR contracts into three types based on the role of the provider in caring for patients: Partner, Healer, and Component Provider (see Figure 10). The roles of Partner and Healer have the most responsibility for quality and cost outcomes, so they have the highest expectations for metrics, payments, and risk. Other providers will be responsible for only components of care and will continue to receive FFS payments but with performance metrics to tie the payments to quality. In the McKinsey model, the Shared Savings and Total Cost of Care models described above are merged into population-based payments.

**TREND #4. THERE IS A REMARKABLE CONSENSUS ON THE FUTURE**

In a historically polarized industry like healthcare, a wide range of expectations about future developments would be no surprise. Two recent studies put this to the test, with both asking the same question about the likely future mix of reimbursement between FFS and the various VBR models. McKesson asked its payer customers how they expected its payment mix to evolve. The Advisory Board asked its hospital/IDN client base how their revenue streams would evolve. The answers are remarkably similar (see Figure 11).
The McKesson study shows that payers expect their FFS payments to shift from 55% to 32% of their payment mix, while VBR payments would rise to about 68%. The Advisory Board study starts at a different baseline revenue mix, as provider FFS revenues include Medicare FFS payments, which are excluded from the mix in the McKesson study. But the providers also believe that their VBR revenues will be above 60% in five years, even including Medicare. That level of consensus shows confidence that the results that can be attained will be worth the investments both sides need to make to fully succeed at the VBR contracts.

Boston Consulting Group goes further, predicting that not only will VBR succeed, but that it will become the basis for competition among providers, payers, and joint partnerships. Their assessment is that winners, both payers and providers, will be able to earn sustainable competitive advantage through:

- Better access to, and analysis of, clinical data
- Deeper insights on how to improve outcomes
- More effective networks and partnerships to develop new value-adding innovations
- First mover advantage.


TREND #5. TRANSFORMATIONAL CHANGES TO SUCCEED AT VBR ARE ALREADY UNDER WAY

For quality and cost improvements to be realized to their full potential, payers and providers realize they must significantly transform the way they work. The special “ACO” units that most organizations set up sufficed for the pilot stages, just as special groups were created as manufacturing and retail companies began shifting toward Total Quality Improvement. But most companies, notably General Electric, eventually trained the entire company in Total Quality practices and wove the key mindset, technology, and processes into everyday life throughout the organization. Similarly, healthcare payers and providers must expand and retrain so that the work needed to deliver high-quality care and patient satisfaction at a lower cost is embedded in daily routines.

Some of this work is already under way:

- **More insightful data.** Both payers and providers are investing heavily in analytics engines. They are using them to become more adept and insightful at identifying population health improvement opportunities. For instance, one payer holds biweekly calls with the care coordinators in practices with shared savings contracts to review the most recent analytics runs. They then collaboratively assess the progress of their shared patients and decide on the next critical steps to achieve their joint quality and cost goals.

- **Better outcomes measures.** The International Consortium for Health Outcomes Measures has created an overall framework for moving beyond process and compliance metrics toward true patient outcomes, and is actively working on specific metrics and targets for some key conditions. This multi-stakeholder consortium is trying to address a surprising gap in the industry’s ability to define what constitutes a good outcome.

- **Organizational refocusing.** Provider organizations are going through structural change. Large integrated delivery networks are continuing their consolidation of physician groups, and existing physician consortiums are taking on new roles. Providers are adding new competencies in population health, contract management, and care coordination.

- **Shifting competitive strategies.** Provider organizations are beginning to gravitate toward new kinds of competitive strategies (see Figure 12). The historical strategy of demanding cost-plus reimbursements and keeping beds full at all costs is likely to prove limiting in a VBR world. According to The Advisory Board, three different competitive models are beginning to emerge:
  
  - **The high-volume, low-cost, high-quality institution**, which will offer general services, perhaps as the next iteration of the general community hospital.
  
  - **The destination acute care institution**, offering world-class technology at premium pricing, or a high degree of specialized services, each with an efficient and high-quality model
  
  - **The population health institution**, which takes on the responsibility for the care and cost management of designated individuals.

![Figure 12. Providers Embarking on New Strategies](source)

**Figure 12. Providers Embarking on New Strategies**

**PROVIDERS EMBARKING ON NEW STRATEGIES**

- **High-Volume**: 25%
- **Destination Acute**: 29%
- **Population Health**: 19%
- **Mixed**: 26%

SOURCE: ©2014 The Advisory Board Company. “Results from the 2013 Accountable Payment Survey.” All rights reserved.
– **New lines of business.** The traditional payers are creating new lines of business specifically to serve the VBR market, such as Aetna’s Accountable Care Solutions unit and WellPoint’s Caremore group.

There is much more work to be done. Both payers and providers will need to continue adapting their current IT infrastructure—for instance, modifying the payer’s payment systems to reduce the manual interventions involved in quarterly shared savings payments or modifying the referral and authorization workflows to keep VBR-covered patients in the right networks.

**REAL-TIME HEALTHCARE NETWORKING**

One area that remains a challenge is the infrastructure for real-time healthcare networking. Much work has been done with HIEs and in some situations they can be effective. But the challenges are many – poor data quality, legal and liability concerns, lack of funding outside major metropolitan area, and systems incompatibility – and adoption has been very slow.

To overcome these challenges, the industry needs a different approach to networking, one that explicitly focuses on driving adoption by linking the exchange of clinical information to the day-to-day workflows that are part of the normal revenue cycles for providers. For a model of this approach in other industries, consider Amazon and Walmart. They have implemented very successful electronic supply chain networks based on transactions that are mandatory to place orders and get paid. In healthcare, if clinical interoperability flows are intertwined with the reimbursement flows with payers, similar results can be achieved.

![Figure 13. Integrated Payer-Provider Workflows for VBR](image)

While most providers have installed some kind of electronic record system, two recent studies have found that fewer than half of the nation’s hospitals can transmit a patient care document, while only 14 percent of physicians can exchange patient data with outside hospitals or other providers.

“We’ve spent half a million dollars on an electronic health record system about three years ago, and I’m faxing all day long. I can’t send anything electronically over it,” said Dr. William L. Rich III, a member of a nine-person ophthalmology practice in Northern Virginia and medical director of health policy for the American Academy of Ophthalmology.


Intertwining clinical and administrative work is also required for VBR contracts to succeed, as VBR requires the payer to be part of the interoperability solution. Successful collaborations for high-quality patient care and sustained cost reductions under VBR involve a level of payer-provider information-sharing even higher than that seen in Amazon’s and Walmart’s retail supply chain management. This means new applications and integrated workflows at the organization level, at the practice level, and at the patient level (see Figure 13).

To accomplish the dual goals of increased adoption of clinical data exchange and collaborative workflows for VBR contracts, the industry should seek a more robust solution than HIEs as they have been implemented thus far, as they focus at solving one element - sharing clinical data across provider organizations and electronic medical records (EMRs). What’s needed is an expanded solution to collect and distribute important data across the network.
administrative/clinical data in ways that providers will adopt and continue to use. This, in turn, will overcome the common resistance to “message overload” and particularly to the distribution of general “evidence-based guidance” that is not connected accurately to specific patient situations.

In this more robust network, it’s easy to envision a communication session that uses patient-specific administrative transactions – before a patient visit, for instance, or during a post-visit referral – to retrieve and display the clinical and VBR contract information that is relevant specifically for that patient. The key transactions, which occur today in massive volume and frequency on payer-provider portals, and which can be enriched to support VBR contracts, are:

- **Eligibility and Benefits** checking: health systems are learning that E&B is the biggest open switch when it comes to runaway cost and the ability to guide the practice of medicine with financial stewardship in mind—checking benefits up front is the best time and place to provide patient- and condition-specific guidance

- **Claim Status Inquiry** transactions will be replaced by **Incentive Program Status** applications that track revenue realization opportunities that are inherently connected to clinical process and outcome metrics

- **Referrals** will take on more significance as the referral becomes the vehicle for steerage and leakage prevention based on cost, quality, and network tiering criteria

- **Authorizations** will become a central real-time method by which the clinical protocol organization(s)—a mix of today’s “health system” and “payer” functions—express and enforce their medical policies, care plans, and care pathway determinations.

The benefits of using these transactions, which have been lacking in most HIE implementations, are the following:

(1) An empowered user who has initiated a dialogue with the approving, reimbursing body and is waiting for an approval; and

(2) Current, patient-specific, and condition-specific timing that targets the data being requested and minimizes the provision of out-of-date or inappropriate information that may be found in “prospective” clinical recommendations.

Furthermore, this approach allows for easier handling of essential tasks like managing HIPAA access rights across heterogeneous provider organizations.

The real-time healthcare network needed by the industry builds on both HIEs and payer-provider portals with a rich, expanded set of modern networking and communication tools for system-to-system, system-to-person, and, most important, person-to-person interactions. This type of networking is the key concept behind NaviNet’s new NaviNet Open networking platform. With such a network, payers and provider together can collaborate to address issues such as:

- **Providing real-time access to care coordination messaging** and patient care events across the network, using a variety of data standards for clinical document exchanges, such as HL7 ADTs, C-CDAs, and X12 278s

- **Making information accessible around the point of care** to provide clinicians and patients with both clinical and financial information for decision support

- **Collaborating on shared tasks to improve quality and patient satisfaction**, such as managing proactive campaigns for targeted screenings

- **Sharing key data files**, such as provider network structures by contract and lists of attributed members, in a way to allow both payers and providers to make additions, changes, and deletions

- **Gathering data from disparate EMRs to support metrics** for multiple payer programs and electronically submitting them via the emerging HL7 Quality Reporting Document Architecture (QRDA) standards

- **Receiving access to a multi-payer view of performance reports** that result from the metrics, with tools to allow drill-downs that drive continuous improvement activities.

Accomplishing this will take a sustained focus by the industry on the concepts of continuous improvement. This means that we need to build relevant applications today based on data that is actually available and reliable today. For instance, if the ADT transaction can be reliably populated with only the key identification fields, we should build an application that uses that information as a triggering event, and retrieve the relevant clinical information and contract-related payer guidance from other sources. From there, we can expand on the adoption and reliability of relevant data standards, and build applications that deliver the next phase of value to individual participants and to the network of the entire community.

The research underlying this paper has shown that a new spirit is taking hold, one that does not expect to solve the industry’s issues with one major program. Instead, we are encouraged by steady evolutionary progress, implementing each step as a collaborative venture and gaining the momentum that only a collaborative network effect can achieve.
NaviNet, a real-time healthcare communications company, has thoroughly re-architected its offering to support the fundamental requirements of real-time networking for healthcare. The new product, NaviNet Open, was released for general availability earlier in 2014 and consists of the flexible platform, network services, APIs, configuration tools, and value-based applications needed to evolve with the value-based reimbursement direction over the coming years.