Provider transparency update

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A key goal of our provider transparency initiatives is to improve quality while managing health care costs. One of the ways this is done is by giving certain providers (payment innovation providers) in our various payment innovation programs (e.g., Enhanced Personal Health Care, Bundled Payments, Medical Home programs, etc.) (the programs) quality, utilization and/or cost information about the health care providers (referral providers) to whom the payment innovation providers may refer their patients covered under the programs. If a referral provider is higher quality and/or lower cost, this component of the programs should result in their getting more referrals from payment innovation providers. The converse should be true if referral providers are lower quality and/or higher cost.

Providing this type of data, including comparative cost information, to payment innovation providers helps them make more informed decisions about managing health care costs and maintaining and improving quality of care. It also helps them succeed under the terms of the programs.

Additionally, employers and group health plans (or their representatives or vendors) may also be given quality/cost/utilization information about payment innovation providers and referral providers so that they can better understand how their health care dollars are being spent and how their health benefits plans are being administered. This will, among other things, give them the opportunity to educate their employees and plan members about the benefits of using higher quality and/or lower cost health care providers.

We will share data on which we relied in making these quality/cost/utilization evaluations upon request, and will discuss it with referral providers - including any opportunities for improvement. For questions or support, please refer to your local market representative or care consultant.

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