

Multi-Payer VBC Strategy Is Essential for Cost Control, but Providers Must Get a Fair Deal

written by Theresa Hush | June 6, 2025



To meet its goals of controlling costs and improving patient care, Value-Based Care requires a near-universal, multi-payer strategy. Only when payment incentives induce cost-effective health care for all patients, as well as provider accountability and patient engagement, will we get that result. Incremental adoption of value-based payments is instructive, but this approach lacks impact when adopted payer-by-payer. At the same time, providers cannot yet adopt risk across all their payers without financial damage. For some providers, embarking on risk-based payments with just a single payer is too dangerous.

In fact, we are at a stalemate between payers and providers—and someone needs to blink, or health care spending will continue to gobble up GDP. That's already a real risk based on aging demographics and unrelenting cost escalation. Everyone seems to

agree that Value-Based Care has the right mechanisms to make health care more affordable and better value, but it's not happening at scale, and not fast enough.

In this and future articles, we'll address how payers can facilitate adoption of Value-Based Care initiatives by providers, and which payer-directed strategies they should implement.

The Problem for Providers Starts with Too Many Rules

It may seem simplistic, but the biggest challenge to providers' ability to control costs and meet Value-Based Care goals is the absence of standardization resulting from the number and variety of payers. A lack of universal health plan processes, reports, incentives, and data across government and many private health plans means that practices need to customize their management of each plan's enrolled patients. That requires resources.

Here's the dilemma for providers: Control of care costs is now established as a prime objective in CMS value-based payment models, but this can't be accomplished within a segment of patients, such as those enrolled in Medicare. The cost of care is determined by two basic factors—the care plan that physician and patient determine together, and the patient's ability to comply with that plan. Even if providers create dedicated population health activities and improvement activities targeted to a particular patient cohort, if there is no conversation and agreement between the physician and patient

regarding the care plan, these efforts will fail.

In short, physicians can't realistically treat patients differently based on health coverage, nor can they organize practice resources toward value-based payments in a way that focuses on cost control, patient decision-making, and interventions through a clinical team. It is unrealistic to expect good cost control with a single health plan through value-based payments alone.

An Even Bigger Problem: Payers Don't Want to Provide Patient-Centric Claims Data

Complicating matters, practices usually have no idea about their patients' usage of health care and costs beyond the services they provide. The deck is stacked against holding down costs if the practice doesn't even know what other diagnoses and treatments patients receive elsewhere, let alone the costs. That's not fair play.

Payers usually provide dedicated portals for viewing health plan data. They've invested in these vehicles, even as they know that providers will not use them. Why are providers so resistant? Because these portals provide a single-insurer, fragmented view of costs. Complicating matters further, since providers are now aggregating data within an ACO, health system, multi-specialty group, Independent Practice

Association, or Clinically Integrated Network (CIN), this lack of integrated provider claims data means that providers cannot access their strongest tools for cost. This is a major issue that we will address in a future article.

The Self-Sabotaging Risk of Playing Value-Based Care with One Payer

To understand the provider perspective of Value-Based Care, consider how the numbers work. Here's a small, hypothetical but representative example of one primary care practice. Let's say that insurance coverage among the patient population includes 54 percent of patients in Medicare, 30 percent in various commercial health plans, 13 percent in Medicaid, and the rest self-pay. The practice wants to participate in an [MSSP ACO](#). Since Medicare Advantage plans now have over half of total Medicare enrollment, the ACO "Medicare" payer mix is subdivided, closer to 27 than 54 percent.

With less than a third of patients in the ACO, the practice would have a hard time transforming its practice to risk or justifying the cost of infrastructure and resources necessary for Value-Based Care. Just the cost of aggregating data would be high relative to the value of that data. All Value-Based Care activities would be harder to do for a small cohort of the practice or the ACO.

The same holds true from an ACO perspective. ACOs are competing for practice attention if they specialize in Medicare-only risk

and can't achieve the weight needed to help practices universally adopt value-based strategies, because practices have multiple payers and can't pay attention only to one part.

Many ACOs specialize in Medicare-only risk and do not negotiate with private health plans. They hope to contain the financial threat of losses, but in so doing, the ACO sabotages its relevance to its provider network and constrains its tools to meet Value-Based Care goals.

Right-sizing for Value Requires that Providers Take Steps toward a Multi- Payer Strategy

All provider organizations need to individually and collectively create the groundwork for a Multi-Payer Value-Based Care Approach. This doesn't mean they need to adopt risk on Day One. It requires, however, anticipating actions that make it possible to reach the end goal of evaluating and acting on cost-effective, high quality care for all patients, regardless of coverage, and beginning discussions with payers on data.

For specialty practices, and organizations and academic health centers with vast referral networks based on specialty care, providers should expect episodic payment models to become mandatory in government programs and be transitioned into commercial health plans. Like other providers, they will need

to evaluate organization or participation in specialty CINs in order to create a large enough population for benchmarking costs, looking at procedural and treatment episodes for cost variation and cost drivers, and establishing a basis for negotiations with payers.

Within their own organizations, they must begin to look at patient populations comprehensively with data, only later segmenting them by payer for purposes of contract negotiation. All data aggregation from EHRs into repositories and analytics should include all patients, and internal risk adjustment methodologies, episodes of care, and data sharing with physicians should be payer-agnostic.

Only by visualizing the future of Value-Based Care as a comprehensive initiative across all patients will providers gain the tools needed to succeed under financial risk. Designating Fee-for-Service as “safe” and value-based payments as “high risk” will not help. As the market pivots to control of costs as a primary requirement for health care providers, universally implementing cost and quality strategies across patient populations is the only viable strategy for sustainability.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Susan Wilkinson