



## PAYER-PROVIDER COLLABORATION

Fostering stronger relationships to achieve  
high-quality, affordable care

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# PAYER-PROVIDER COLLABORATION: FOSTERING STRONGER RELATIONSHIPS



**Greater payer-provider alignment is needed for the U.S. health care system to achieve high-quality, affordable care.** While we're currently in a recovery phase, provider-payer collaboration absolutely will be a critical part of a rebuilding phase that comes after recovery, and provides an opportunity to retool the system into something even better. Hospitals and health systems must foster transparent, collaborative relationships to enhance case management and care coordination, ultimately improving outcomes and lowering costs. Hospital leaders participating in a virtual executive dialogue discussed how hospitals and health systems can develop stronger payer-provider relationships and how the field needs to shift because of the pandemic.

## KEY FINDINGS

- 1** The transition to value-based care is hampered by a fragmented reimbursement system with some payers facilitating a move to risk-based contracts, partnering with and openly sharing data with provider organizations, while others remain grounded in the fee-for-service model and unwilling to share transparent data.
- 2** Interoperability is the key to success for provider organizations under value-based contracts. Access to timely, actionable data is essential for quality and process improvements, as well as demonstrating performance to payer organizations.
- 3** The use of third-party analytics organizations can help eliminate disputes between payers and providers over interpreting patient and claims data in an effort to achieve common ground.
- 4** The shift to value-based care is highlighting a growing digital divide, as many small and rural organizations lack the staffing and technology resources to effectively collect and analyze population health data.

## VIRTUAL PARTICIPANTS



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**FOR HEALTH INNOVATION**

American Hospital Association | CHICAGO

**MODERATOR:** (*Suzanna Hoppszallern, American Hospital Association*): We're pleased to have you here to talk about fostering stronger payer-provider relationships. How are you working with payers to manage your patient population and how has it changed because of the pandemic?

**JEFF SCHRADER** (*Geisinger*): For those of you who may not familiar with Geisinger, we're a physician-led, integrated health care system. We're made of four components: a multispecialty physician group practice; a group of provider facilities including nine acute care hospitals across multiple campuses; a health plan; and a medical school. In terms of our relationship with payers during the pandemic, we've experienced more collaboration than in the past. There's been more willingness to work with one another and our relationships have been more collaborative. Our payers have worked with us to bend certain rules and regulations with regard to authorizations, for example, to facilitate timely care. I feel as though that's been the case across the Pennsylvania market, which is good. We hope to continue fostering these relationships as we make our way through the pandemic.

**MODERATOR:** So, Jeff, it's been a departure from what you've experienced in the past?

**SCHRADER:** Yes, it has been. The pandemic has definitely improved relationships with payers. At times, our working relationships haven't been that good. Since the start of the pandemic, many of our payers have stepped up to the plate and eased some of the burden, such as the hoops that we have to jump through for certain things to get reimbursed.

**LISA ISHII, M.D.** (*Johns Hopkins Health System*): Johns Hopkins Health System is primarily based in Maryland where we have four of our hospitals. We also have a children's hospital in Florida and a community hospital in Washington, D.C. Our relationship with payers is interesting. Maryland is a Centers for Medicare & Medicaid Services (CMS) waiver state.

For almost 40 years, we've had a unique all-payer, rate-setting system in place for hospital services. Our rates are determined by the state Health Services Cost Review Commission, so we don't negotiate hospital rates. We're not regulated for services provided outside of the hospital, including ambulatory surgery centers and clinics, but we do negotiate with payers for our professional fees. We also have six ambulatory care surgery centers in the Mid-Atlantic Region at this time.

Our biggest private payer in Maryland is CareFirst BlueCross BlueShield. The CareFirst CEO has been in his role for only a year or two. He's been up front in his desire to transition from fee-for-service to value-based care (VBC). Prior to the pandemic, we were discussing how to develop VBC models that make sense, but we've had to pause those conversations a bit. Instead, we've partnered with CareFirst, the city of Baltimore and the state to develop a regional response to the pandemic, focusing on telemedicine strategies, contact tracing and vulnerable populations. It's an important partnership.

**DAVID FOX** (*Baxter Regional Medical Center*): We're a community-based hospital in North Central Arkansas. What we're focused on is similar to what Lisa just shared. We're transitioning from a fee-for-service model into more of a qualitative population health strategy for our clinics.

**MODERATOR:** How long since you've been on this journey with your payers?

**FOX:** Our market is fairly complex in that we are a high retirement area. Medicare is our primary payer. However, for our commercial side, Arkansas BlueCross BlueShield is the primary commercial insurer. Strategically, we've worked closely with them to establish a better payer-provider relationship. That's not a new strategy or tactic. We continually sit across the table and try to understand each other's needs. We are always working toward a shared vision of how to become more impactful on achiev-

ing high-quality care and meeting the needs of our community, while also receiving the appropriate level of reimbursement.

**DARLENE FERNANDEZ** (*University of New Mexico Sandoval Regional Medical Center*): Prior to the outset of the COVID-19 pandemic, we were making some headway with a few of our payers in terms of looking at patient utilization of certain drugs and certain types of visits and where we were compared against the medical loss-ratio target. But, unfortunately, we still struggled with getting detailed data from some of our larger payers. When we try to have meaningful discussions, we're operating in the dark without real claims data. That's been a challenge and it hasn't improved with COVID.

**DAVID OTT** (*Mercy Health*): We are a Catholic health system based in St. Louis, and have about 45 acute care and specialty hospitals based in Missouri, Arkansas and Oklahoma. We also have a small footprint in Louisiana, Texas and Kansas. Right now, about 50% of our contracts are value-based. We feel as though we're cutting our teeth and getting better at it every day, especially as we transform the traditional approaches of managing a population to a population health approach. We have room to grow, but we're performing fairly well. The two greatest strengths of Mercy are that we're well-integrated and we have a large primary care footprint. Those are two of the foundations of value-based care.

We have world-class virtual care capability that we've integrated into everything we do. During the pandemic, it became a critical asset because we could reach all of our patients. As with everyone participating today, our organization had to cancel elective procedures during the early stages of the pandemic. With our virtual platform, we've been able to interface with our insured patients and we

are using it extensively now.

Our arrangements with BlueCross, Cigna and other large payers, as I mentioned, are shifting to value-based contracting. Some of those deals are upside only, but many have upside and downside risk, and some are entirely 100% risk. It's been an interesting transition. Some of the payers are more engaged than others. As an organization, our path forward is to identify our engaged partners and, frankly, go deeper with those relationships.

**DOUG WELDAY:** (*NorthShore University HealthSystem*): We have four Suburban Chicago area hospitals and one hospital in the northern portion of the city. As

a relative newcomer to the Chicago market, I would say the market here, as it relates to provider-payer relationships, is traditional. There's still a tremendous amount of fee-for-service activity. There's a limited amount of real collaboration between providers and payers in this community. And importantly relating to collaboration, we have relatively low Medicare Advantage penetration in this market. That's why I describe our market as relatively traditional. During the pandemic, several payers reached out and have been accommodating to help us address coverage and access challenges. We

still have some claim processing and payment issues, particularly around the patient obligations for members in Employee Retirement Income Security Act (ERISA) plans. And there are still a number of administrative challenges in coding and processing COVID-19 inpatient claims.

We continue our discussions about value-based contracting. And we are redoubling our efforts to identify opportunities to collaborate with the payer community, reemphasizing the benefits of working together. Together we need a more focused effort around delivering value and improving the health

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— David Ott —

of our communities. I think the pandemic has all of us asking whether we are doing what we need to be doing to reduce health disparities, reduce the chance of having the problems that we've experienced with the pandemic and preparing ourselves for the next one.

**MODERATOR:** Jason, can you share some of the trends you're seeing around the country in how providers are working with payers and how that has changed during COVID-19?

**JASON BURKE (3M):** We are interested in this discussion because we work with both payers and providers. We work closely with Medicare and with state Medicaid programs to bring them together with common ways to measure performance and quality, to improve patient outcomes. Our mission is to automate the administrative burden that occurs between payers and providers. For example, how do we fast-track preauthorizations by sharing clinical information between both organizations and automating workflows? The sooner we accomplish this, the more focused we can be on patient care and outreach.

An important shift that we've seen in the last couple of years is that payers are willing to have discussions and share information with providers as partners versus just having a financial relationship. If both organizations don't start working together collaboratively, it will be difficult to move to effective risk sharing models.

**OTT:** We're not going to move completely to value-based care overnight; it's a journey. When we do get payer data, we have to view it from a payer lens. It's heavily actuarial-based. In our discussions with our larger payers, we are seeing that they provide more data and more data transparency. But that level of engagement is occurring with a few —

certainly not with the majority — of our payers. For those payers with whom we are having the deeper discussions, we're looking at longer-term, risk-based contracts going forward.

Again, with our larger payers, there is willingness to share data, but we have to be specific about what we ask for. I'd like to see things move more quickly. We're finding that some payers are turning to third-party organizations to help them work through the disputes that arise as both sides view the data and have different interpretations. We all use different organizations to evaluate where we sit. We've been in situations in which payers question our analyses of the data. There is a push on both sides to use a neutral third party to download and evaluate the data so that we're looking at the same thing. There's too much of a disconnect today and it's slowing things down. I feel that's where the biggest challenge is in moving toward value-based care. As we start to move faster into risk arrangements, we need information from the payer to move us forward. We can get killed in a risk-based agreement if we don't know what we're taking risk for. We're fine with working with a third party to gain common ground. And it's absolutely essential that, if we're going to move into risk, we have means to reach a common ground or we don't move forward with those kinds of arrangements. And that goes to my point about going deeper with the fewer payers in the market.

**SCHRADER:** At Geisinger, it's the same sort of story. We have challenges in getting data from the insurance companies, particularly transparent data that has actionable items. The Pennsylvania market is slow to adopting value-based care. There are some national payers like Aetna and United that do have a tremendous amount of experience in value-based

**"An important shift that we've seen in the last couple of years is that payers are willing to have discussions and share information with providers as partners versus just having a financial relationship."**

— Jason Burke —

care. But then, the other major commercial payers within our market have been slow adopters.

**BURKE:** I agree with what both David and Jeff have said. We are seeing payers who are willing to share more data. But I'm hearing from both of you that you may need even more than what is being offered. What kind of data are you asking for from the payer? Are you willing to share more clinical information about patient care in exchange? And if you are, how much information? I know there's a fine line between sharing too much or too little as you negotiate the right deal for your organization. It's important to find that balance to do the right thing for the patient by sharing information that could speed up care and reduce length of stay.

**OTT:** We have a pretty big block of Medicare Advantage business and the deals are different with all of them. Some of them, as I mentioned, are just upside agreements tied to a medical loss ratio. For these, there are quality metrics we have to achieve to improve the risk-adjusted factor (RAF) score of the patient. CMS, as you know, assigns an RAF score to each Medicare Advantage beneficiary based on health status and demographic factors such as gender, age, Medicaid eligibility and disability, among other things. This all falls under the CMS Hierarchical Condition Category Risk Adjustment Model. It's pretty transparent because everything has to do with reimbursement. It's not that challenging, but it gets more complicated when you encounter redundancies in services. For example, we work with one payer that has its own house-call program. The cost of that program goes through our financials as an expense and it impacts our performance. Our physicians may place an order, but it's actually carried out through the house-call program. It takes a lot of coordination to eliminate the redundancy and the associated cost. To summarize, on the Medicare

Advantage side, the process is transparent. We may debate the data sometimes, but we learn a lot from the data and the process.

An organization's ability to effectively collect, use and share data depends on its level of integration. In our system, one of our major undertakings is taking a deeper look at physician alignment and compensation. We bought a lot of physician practices that generate their income off of Relative Value Units (RVUs). We have to make sure these practices continue to focus on coding things correctly, following up with patients and not just focusing on RVUs. This is a transformational process.

I have a strong bias toward moving to risk even on the commercial side, which is more of a challenge for some of the bigger payers because they're following an administrative services-only model. The client is king under these types of models. I believe the key to value-based care lies within the attribution model, which is more population-centric. Once payers assign patients to a provider or provider organization, the providers are responsible for the cost and quality of care for those patients. To manage these patients effectively, I want all of the claim information for those patients to examine utilization patterns and cost, and then we'll figure out how we can configure a solution that enables us to take on some of the downside risk to manage that population. We've been proactive in getting out in front of our payers and taking them through our approach to population health.

**"We have challenges in getting data from the insurance companies, particularly transparent data that has actionable items."**

— Jeff Schrader —

**MODERATOR:** Lisa, can you share how you feel about transparency and information exchange, particularly as they relate to clinician relations and the development of clinical pathways?

**ISHII:** Regarding transparency and relationships with

physicians, that's certainly something that we have been more focused on. We have an accountable care organization (ACO) for example, that has been successful with regard to savings. The ACO has relied on participation from nonemployed physicians in the region who have partnered with us. We have been transparent about quality outcomes and utilization and that has driven the success. We are in discussion with the BlueCross BlueShield plans today to develop care pathways and value-based care approaches and transparency. Those conversations are fresh and evolving at this point.

**WELDAY:** We still struggle to get good data interfaces with our payers in our marketplace. The current systems just aren't geared up to do that effectively. In addition, we're just a few months away from federal price transparency requirements taking effect unless something happens in the courts. That's going to radically impact many providers and payers. There's going to be a tremendous amount of energy expended by a variety of data analytics firms to analyze the information, attempting to validate the anomalies in the pricing that exists throughout the market. That clearly has the opportunity to shake things up as this goes into effect. From a policy perspective, there's the belief that this will be great for consumers. I don't feel consumers will see a lot of benefit in the short term; it's just too darn complicated. But I do think it will be of great benefit to health plans and employers, in particular, as they begin trying to weave their way through the data and find the best value in the provider space.

**MODERATOR:** Doug, you mentioned that the interfaces aren't there. Do you have plans to make some investments to facilitate a greater data exchange?

**WELDAY:** Yes, we're working aggressively on these efforts to try to have better data interfaces and inter-

changes. It's just that the aggressive work is moving at somewhat of a snail's pace.

**FERNANDEZ:** That's what is going on in our area as well. We're seeing movement from the larger insurers in developing value-based contracts. As others have mentioned, with the larger insurers, we are making some headway with access to data. However, one of our largest payers is not the greatest at being transparent with data. Maybe that's due to a lack of maturity with their systems, or it may not truly be a transparency issue.

**"We're seeing movement from the larger insurers in developing value-based contracts. With the larger insurers, we are making some headway with access to data."**

— Darlene Fernandez —

**MODERATOR:** We've covered some risks and concerns about collaboration with payers, but what do you think will be some hurdles to overcome?

**SCHRADER:** There are numerous challenges for providers as they shift to risk-based, or even partial risk-based contracts. It's especially challenging when working with insurance companies that are, quite frankly, just not there yet in terms of building their infrastructure to be able to share those data and come up with appropriate attribution models. This is more common among commercial payers. As others have said, working with Medicare Advantage plans is a bit easier. To move fully toward value-based care, we need all payers to build the infrastructure necessary to transition fully to risk-based contracting.

Another challenge is on the provider side. Organizations like Geisinger and Johns Hopkins have the infrastructure today and the knowledge to be able to transition fully toward value-based care. Not all organizations have that capability. Smaller, rural organizations don't have the people or the resources to be able to fully get there. These organizations will have to rely on the payers being able to assist with the transformation.

**MODERATOR:** Can you elaborate on what level of assistance from payers may be needed to accomplish this? We're interested in exploring whether there should be any financial incentives that payers can offer providers. What are some things with which payers can offer to help?

**SCHRADER:** That's a great question. Looking back at the transition to electronic health records, some payers were able to fund certain community hospitals to help offset those costs. In the shift to value-based care, payers can help providers build the clinical staff or the information services staff that can take the data that payers provide and make it actionable. And payers can provide actionable, transparent data to help providers in their work.

**MODERATOR:** Doug, what do you feel are some of the financial incentives that payers can provide to help providers in sharing patient information?

**WELDAY:** To Jeff's point, the primary thing payers can do is make sure they provide timely and actionable information that allows us to meet the specific objectives that are being set up relating to quality measures and performance targets. The other thing payers can do is to develop their data analytics around what the best practices are for achieving those objectives. The fact is that all of our providers want to deliver great care to their patients. Health plans have data from providers across the community and, in many cases, across the country. They

have deep resources around data analytics that I believe could be married with ours to improve performance. Right now, we're seeing payers provide information without context, as opposed to providing deep analytics and actionable information.

**BURKE:** Some of the payers we work with would probably say the same thing about providers. They would love to have more actionable data about patient care, that they can consume and use with their members, and also to provide more information back to their provider base at large. One question

I have is: When you're doing contracts with payers, based on performance, cost and quality, is it difficult to come to terms with how you're measuring that or do you rely on the payers to determine the model that will be used?

**FERNANDEZ:** There's always a challenge with reconciling how payers come up with the data analysis. When we have these reconciliation issues, or modeling issues, it takes several months to come to some type of consensus, and it requires give-and-take on both sides.

**SCHRADER:** In our market, there are some payers that are quite rigid in their programs. It's 'Take it or leave it.' They are going to measure in a specific way, with certain benchmarks, and there's no negotiation. But then, there are other payer organizations that will work with you to develop a program that will result in mutual success. We work with a mix of both at this point.

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