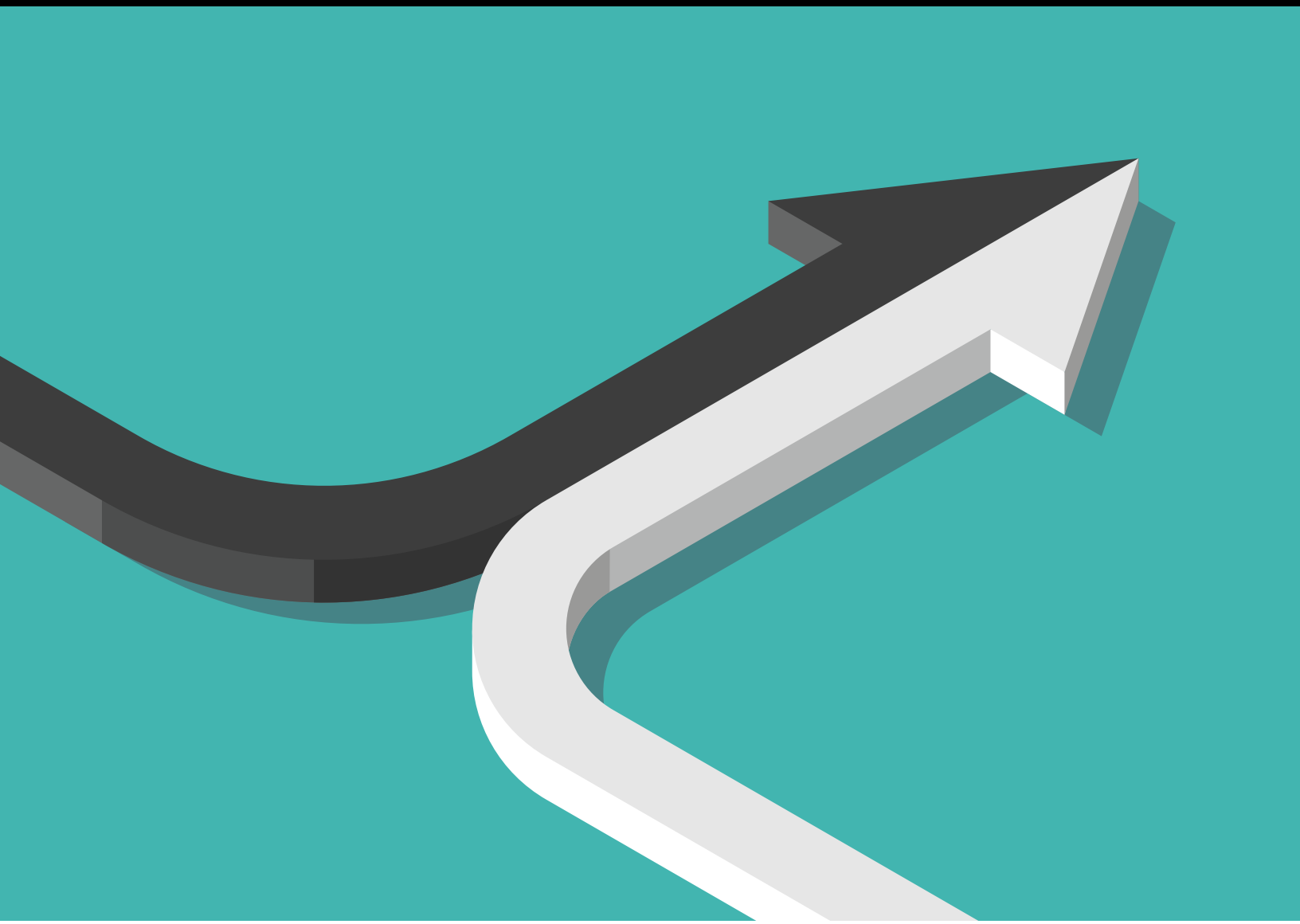
American Hospital Association™

Advancing Health in America



KNOWLEDGE EXCHANGE

Advancing Provider-Payer Collaboration to Eliminate Administrative Complexity

How providers and payers can reduce friction, inefficiency and operating costs

Sponsored by: Turquoise

Introduction

Advancing Provider-Payer Collaboration to Eliminate Administrative Complexity

How providers and payers can reduce friction, inefficiency and operating costs

Administrative complexity costs the U.S. health care system $265 billion annually. Most of this complexity builds up in the space between payers and providers, where agreements are negotiated, claims are processed, and payments are reconciled. Fragmented processes and misaligned incentives create friction that neither side can resolve alone. This Knowledge Exchange e-book explores how hospital and health system executives view the opportunities and barriers to payer-provider collaboration, and the organizational and operational changes needed to reduce administrative complexity, improve alignment, and create more streamlined, lower-friction relationships.

The discussion underscored that administrative complexity is a strategic challenge that affects financial performance, workforce productivity, payer relationships and the patient experience. Organizations that invest in standardization, interoperability, intelligent automation and collaborative payer engagement are likely to be better positioned to reduce friction and redirect resources toward patient care.

Executive Tips

8 executive insights on building more efficient, lower-friction provider–payer partnerships

COMPLEXITY

Administrative complexity remains a major financial and operational burden. Denials management, prior authorization requirements, and increasingly complex payer policies consume significant resources and delay reimbursement. A growing gap exists between contract terms and the operational realities of payment and adjudication.

MISALIGNMENT

Patients often experience the consequences of payer-provider misalignment. While administrative disputes may originate between providers and payers, patients frequently hold providers responsible for delays, denials, prior authorization barriers and affordability challenges. Improving transparency and reducing complexity is as much a patient experience issue as an operational one.

STANDARDIZATION

Standardization offers one of the greatest opportunities to reduce administrative waste. Greater consistency across payers in prior authorization, eligibility verification, contracting and reimbursement processes could streamline operations and improve efficiency.

REAL-TIME RESULTS

Future-state models point toward real-time authorization, adjudication and payment. Integrated scheduling, shared data exchange and payer-provider interoperability initiatives illustrate a longer-term vision in which providers and payers operate from a common source of truth. Such models could reduce denials, accelerate reimbursement and provide patients with clearer cost information before care is delivered.

SHARED UNDERSTANDING

Providers and payers need a shared understanding of coverage and reimbursement requirements. While reimbursement is ultimately governed by contract terms, differences in how eligibility, coverage and payment rules are interpreted and applied create administrative burden, delays and denials. Greater alignment at the point of service could enable more real-time adjudication, improve payment accuracy and provide patients with clearer information about their financial responsibility before care is delivered.

EMERGING AI

AI is emerging as both a solution and a source of competitive escalation. AI is helping streamline denials, coding, documentation and appeals, but providers and payers may be engaged in an AI-driven arms race that automates inefficiencies rather than eliminates them.

PROCESS REDESIGN

Technology modernization must be accompanied by process redesign. Moving to common platforms, centralized revenue-cycle operations and integrated workflows can improve visibility and coordination. However, simply layering technology onto fragmented processes is unlikely to deliver meaningful simplification without broader operating-model changes.

ACCOUNTABILITY

Closer payer-provider collaboration requires trust and shared accountability. Reducing administrative friction requires greater transparency, shared standards, aligned incentives and a commitment to solving problems collaboratively.

Participants

Carrie Beier, MBA
Director of IS Applications
Meadville (Pa.) Medical Center

Deborah Berini, MHA
Chief Executive
Providence Alaska, Anchorage

Eric Fish, M.D., MBA, FACOG
President and CEO
Schneck Medical Center, Brownstown, Ind.

Chris O'Dell
President
Turquoise
San Diego, Calif.

Shannon Sale, MHA
Executive Vice President and Chief Administrative Officer
Grady Health System, Atlanta

Julia Swanson
Senior Vice President, Transformation and Performance Excellence
Henry Ford Health, Detroit, Mich.

Michael Ugwueke, MPH, DHA, FACHE
President and CEO
Methodist Le Bonheur Healthcare, Memphis, Tenn.

MODERATOR
Suzanna Hoppszallern
Senior Editor, Center for Health Innovation
American Hospital Association, Chicago

MODERATOR SUZANNA HOPPSZALLERN *(American Hospital Association):* **From your perspective, what are the biggest drivers of administrative complexity today, and where do you see the greatest opportunities for providers and payers to simplify the experience for patients and staff?**

SHANNON SALE *(Grady Health System):* Over the past several years, we've seen growing variability among health plans, making it increasingly difficult to navigate coverage requirements and reimbursement policies. At the same time, denials and the administrative burden associated with them have continued to escalate. We've implemented AI tools to help review records and support the process, but the workload remains substantial and significant revenue is still tied up in appeals and reimbursement delays.

CHRIS O'DELL *(Turquoise):* Is administrative complexity being driven primarily by evolving payer policies, AI-enabled processes, or the expansion of contract-related requirements? Many organizations describe a shift from managing a single contract to navigating an increasingly complex web of policies and rules.

SALE: It's all of the above. What was once a single contract has evolved into layers of products, policies and requirements that must be continuously monitored. A patient who appears to be covered under one plan may turn out to be in a different product with different rules, creating additional administrative work. At the same time, providers and payers are increasingly using AI to gain an advantage, adding another layer of complexity and uncertainty to the process.

ERIC FISH *(Schneck Medical Center):* We're seeing a rise in denials that are difficult to justify. In one instance, we appealed hundreds of denied claims and were successful in every case. We also continue to see services downcoded, only to have those decisions overturned on appeal, which creates unnecessary work and delays reimbursement. We're beginning to deploy AI tools of our own, but for a small rural hospital, the administrative burden remains significant.

MICHAEL UGWUEKE *(Methodist Le Bonheur Healthcare):* In many cases, denials have become the default starting point, forcing providers to spend significant time and resources appealing decisions and seeking clarification. In our market, long-standing narrow-network arrangements add another layer of complexity, as patients often move between health systems when employers change plans. This creates confusion for patients, who frequently hold providers responsible for insurance coverage limitations and resulting bills.

CARRIE BEIER *(Meadville Medical Center):* As a community-based health system with hospitals, clinics and specialty practices across a large geographic area, one of our biggest challenges is helping patients understand their financial responsibility. Changes in benefit designs can shift costs to patients even when provider billing practices remain unchanged, and providers often bear the frustration that follows. Accurately estimating out-of-pocket costs remains complex, and administrative burdens continue after care is delivered, including denials that require resubmission and appeal before payment is ultimately approved.

O'DELL: A recent Health Affairs analysis found that nearly a quarter of U.S. health care spending is tied to administrative waste. With hundreds of thousands of health plan networks, each with its own rules for payment, prior authorization and eligibility, the system is inherently complex. The sheer number of variations makes it extraordinarily difficult for providers, payers and patients to navigate efficiently.

DEBORAH BERINI *(Providence Alaska):* Alaska's payer landscape is distinct, as Medicare Advantage has a very limited presence in our state. Even so, providers continue to face administrative challenges related to prior authorization, denials, eligibility verification, and reimbursement across multiple coverage programs. As part of Providence, we benefit from dedicated contracting and payer-relations teams that help us address these challenges and support the unique needs of Alaska's healthcare environment.

JULIA SWANSON *(Henry Ford Health):* As health

systems grow through acquisitions and partnerships, they often inherit a patchwork of physician groups, contracts, networks and workflows. A key priority has been to create a more unified approach through physician integration, standardized payer contracts, common technology platforms and centralized revenue-cycle operations. These efforts help reduce administrative complexity, improve coordination and deliver a more consistent experience for patients and providers. While the transition is ongoing, aligning technology and operating models is essential to simplifying interactions with payers and reducing the burden across the system.

O'DELL: Price transparency policies were intended to help patients understand the cost of care before receiving services. While publishing rates was an important step, rates alone don't provide a complete picture. Ultimately, reimbursement is determined by the underlying payer-provider contract terms — including bundling rules, coverage criteria, network requirements and utilization management policies.

The long-term goal is greater transparency and a more efficient payment process. If providers and payers could rely on a shared understanding of eligibility, coverage and reimbursement rules at the point of service, many claims could be adjudicated in real time. That would reduce administrative burden, minimize denials and give patients a clearer understanding of their financial responsibility before care is delivered. Achieving that vision is complex, but it underscores the link between price transparency and broader efforts to simplify payer-provider transactions.

MODERATOR: What changes is your organization making internally, from governance and education to workflow redesign and technology investments, to overcome existing inefficiencies?

BEIER: In our organization, responsibility for accurate billing and reimbursement largely rests with the revenue cycle and IT teams. Systems and workflows are designed to ensure that charges are captured appropriately.

SALE: It requires both operational and clinical engagement. In radiation oncology, for example, we recently found that physicians were not fully aware of evolving coding requirements, leading to reimbursement issues that our systems did not always catch. Revenue cycle, IT and clinical teams must work together to stay current. We've responded by implementing ongoing physician education and quarterly training to keep pace with changes.

O'DELL: The cost of submitting a claim can range from about $20 for a straightforward bill to more than $200 for a complex one. Much of that expense stems from the gap between expected reimbursement and what is ultimately paid. Even within an organization, expectations may differ among clinicians, revenue-cycle teams and payers. When that gap is significant, entire teams on both sides are dedicated to identifying, disputing and recovering dollars, perpetuating a costly cycle rather than reducing the underlying complexity.

BEIER: When health systems acquire new practices or launch new services, one of the greatest challenges is navigating the revenue cycle. Reimbursement rules vary by payer requirements, site of care, provider status and billing structure. While clinical integration is key, determining what can be billed, how it should be billed and how payment will be received is frequently one of the most complex aspects of implementation.

SWANSON: Administrative complexity often begins much earlier than the revenue cycle. Strategic deci-

CARRIE BEIER | MEADVILLE MEDICAL CENTER
"While clinical integration is key, determining what can be billed, how it should be billed and how payment will be received is frequently one of the most complex aspects of implementation."

sions about where services are delivered and how they are organized can have a significant impact on reimbursement and authorization requirements. Infusion services are a good example. As demand expands beyond oncology, organizations must align pharmacy, clinical, payer and revenue-cycle strategies to determine the most efficient model. Rather than managing authorizations and reimbursement separately at each site, centralized hubs can build expertise, standardize workflows and better navigate increasingly complex payer requirements.

MODERATOR: What do providers need most from payers to reduce administrative complexity, and where are you already seeing progress?

UGWUEKE: One of the most meaningful improvements would be greater standardization of prior authorization requirements across payers. Providers and patients would benefit from a consistent set of rules for common services, regardless of the health plan. Today, authorization requirements can vary significantly from one payer to another, creating confusion, administrative burden and care delays. A more uniform approach would simplify workflows, improve transparency and make it easier for everyone to understand what is required before care is delivered.

FISH: A more streamlined authorization process could reduce administrative burden, but it must include appropriate safeguards. Any simplified approach requires clear expectations and accountability from both providers and payers to avoid disputes over coding, services rendered, or reimbursement. Success depends on creating a process that is both efficient and transparent for all parties involved.

O'DELL: The greatest opportunities for standardization include managed care contracts, prior authorization and utilization management, payment processes and network mapping. If providers and payers could more consistently verify coverage, eligibility and payment rules at the point of service, it would help reduce avoidable denials and administrative friction.

BERINI: In Alaska, we recently passed legislation that sets response-time requirements for prior authorizations — 72 hours for standard requests and 24 hours for urgent requests. The law does not reduce prior authorization requirements, but it requires health plans to respond within defined timeframes. It represents an important step toward greater accountability and predictability in the process.

O'DELL: The opportunity for standardization varies by market and depends largely on who bears the financial risk. When a payer primarily serves as a third-party administrator for a self-insured employer, there is often greater flexibility to adopt standardized processes because the payer provides administrative services rather than assuming insurance risk. The dynamic is different when the payer is responsible for the financial risk, particularly in smaller or rural markets, where utilization and cost management considerations can make standardization more challenging.

SWANSON: It's important to recognize that providers can also bear financial risk and that this is an opportunity to potentially reduce administrative burden such as prior authorization requirements. In those arrangements, the focus shifts from regulation to collaboration between providers and payers. Success depends on establishing agreements that align incentives,

CHRIS O'DELL | TURQUOISE

"The long-term goal is greater transparency and a more efficient payment process. If providers and payers could rely on a shared understanding of eligibility, coverage and reimbursement rules at the point of service, many claims could be adjudicated in real time. That would reduce administrative burden, minimize denials and give patients a clearer understanding of their financial responsibility before care is delivered."

clearly define responsibilities and support shared accountability for cost, quality and patient outcomes.

O'DELL: In one Michigan market, a large self-insured employer has simplified the employee experience by partnering with a narrow network of providers and setting predictable out-of-pocket costs. Because the employer assumes the financial risk, it can streamline payment and shield employees from much of the administrative complexity behind the scenes. Employees know what they will pay up front, even if adjustments or reconciliations occur later, creating a more transparent and consumer-friendly experience.

MODERATOR: From the provider perspective, what steps are you taking — including the use of AI — to improve the efficiency, accuracy, and timeliness of payer-provider transactions?

UGWUEKE: About a year ago, we outsourced our revenue cycle operations to a third-party company to access AI-enabled capabilities and expertise gained from working across multiple health systems. At the same time, our transition to Epic gave us the opportunity to redesign the revenue cycle end to end. Since then, we've gained much greater visibility into performance, improved collections, and streamlined administrative processes, including appeal letters and denial management. Overall, they've provided a level of transparency and efficiency that we struggled to achieve internally.

SWANSON: We took a different approach and brought our revenue cycle operations in-house. After our Epic implementation, we standardized the revenue cycle across the organization, which became especially important as we expanded and nearly doubled the size of our delivery system. That approach has reduced administrative costs associated with claims management and reimbursement while strengthening overall performance.

One lesson we've learned is that technology, including AI, is only as effective as the underlying data. To realize its value, organizations need accurate, organized, and up-to-date information, along with processes that keep pace with changing regulations and contract requirements. Without that foundation, AI simply adds another layer to an already complex environment rather than solving the problem.

O'DELL: Even when AI is implemented effectively, I think there's an important question: Does it ultimately narrow the gap between what providers expect to be paid and what they actually receive, or simply raise the stakes? On the one hand, AI can reduce inefficiencies and improve accuracy. On the other hand, if both payers and providers are using increasingly sophisticated tools, it can escalate capabilities rather than reduce friction, making the environment more complex for everyone involved.

UGWUEKE: We meet weekly with our revenue cycle partner to review dashboards, performance metrics, and operational priorities. We have full visibility into areas with challenges and work closely with physician groups, case management teams, and hospital departments to address barriers and collect more fully with less friction from payers. The level of transparency is significant. We have access to extensive data that helps us identify issues and improve performance across the system.

BEIER: We work closely with providers, but the revenue cycle team plays a key role in ensuring that documentation and coding decisions align with billing requirements. When issues arise, our revenue integrity

SHANNON SALE | GRADY HEALTH SYSTEM

"It requires both operational and clinical engagement. In radiation oncology, for example, we recently found that physicians were not fully aware of evolving coding requirements, leading to reimbursement issues that our systems did not always catch. Revenue cycle, IT and clinical teams must work together to stay current."

staff provide guidance on the most appropriate selections. That support is valuable, but it also highlights a broader challenge on provider education related to billing.

FISH: Physicians receive limited training in coding, and given growing clinical demands, their focus is understandably on patient care. As a result, many organizations rely on coding and revenue cycle teams to ensure that documentation is accurately translated into appropriate codes and reimbursement. Today, much of that work is performed by coders, but we're looking to expand the use of AI to support and streamline the process.

MODERATOR: If you were to make an organizational decision right now that would move you to a more collaborative, efficient process with the payers, what would be the one or two things you would do?

UGWUEKE: I think everyone agrees, at least in principle, that simpler processes are better. The challenge is agreeing on a common approach and building the trust needed to follow through.

That's why it would be valuable to bring providers, payers, and patient representatives together. If we truly put patients at the center, we should be able to focus on what helps them access the care they need without unnecessary concerns about coverage, reimbursement, or out-of-pocket costs. Establishing a set of shared standards could be a good starting point. As trust grows and stakeholders demonstrate accountability, those efforts can expand and become even more effective.

BEIER: We are working with the VA to integrate scheduling and prior authorization processes. The goal is to enable VA care teams to schedule appointments directly in our system and submit electronic prior authorizations simultaneously. By connecting the VA's platform to our MEDITECH environment, we hope to streamline scheduling, improve payment timeliness and create a better experience for veterans.

We're also exploring similar collaborations with commercial payers. For example, Highmark is piloting a data-sharing initiative that provides the information needed for claims review and denial management upfront, reducing manual work and helping accelerate denial resolution. The effort is being tested across both hospital and physician practice settings to improve administrative efficiency and streamline the reimbursement process.

SWANSON: As both a provider and a health plan, we see significant opportunities to better align care delivery and coverage. We recently strengthened that connection by bringing the health plan more closely under the Henry Ford Health brand and are implementing a shared Epic payer-provider platform to improve interoperability, eligibility verification, and care coordination. We've also reorganized how our teams work together, within appropriate regulatory guardrails, to reduce administrative burden and identify scalable approaches for partnerships with other payers. While we're learning from our integrated model, we're applying those insights to broader risk-based arrangements and collaborations across the market.

O'DELL: At first glance, many would say payer-provider collaboration is at a low point. Yet when health

JULIA SWANSON | HENRY FORD HEALTH

"One lesson we've learned is that technology, including AI, is only as effective as the underlying data. To realize its value, organizations need accurate, organized, and up-to-date information, along with processes that keep pace with changing regulations and contract requirements. Without that foundation, AI simply adds another layer to an already complex environment rather than solving the problem."

system and payer CEOs come together, their goals are often more aligned than people assume. Many leaders on both sides express openness to approaches that reduce denials, simplify reimbursement and streamline administrative processes. Hospital leaders often ask, "Would a payer ever agree to same-day payment with no accounts receivable and no denials?" Payer executives frequently respond, "We're open to that, too."

The challenge is not agreement on the vision. It's translating that vision into day-to-day operations. While progress can be slow as organizations work through clinical, operational and policy details, there are signs of movement. In some markets, employers and other stakeholders are helping drive greater alignment and build momentum for more collaborative models.

SWANSON: Part of the challenge is that we keep trying to improve the system by adding new requirements and processes on top of the old ones. Over time, that adds more complexity rather than less. Sometimes we need to step back and ask, "If we were designing this from scratch today, what would it look like?" The goal isn't just to make incremental changes but to identify a fundamentally better approach and determine the first practical steps toward getting there. Without that reset, we risk continuing to layer complexity onto an already complicated system.

O'DELL: There's irony in payer-provider contracting. We've found that most contracts are far more similar than people think. There are differences at the margins, particularly in legacy agreements, but the core structures and requirements are often remarkably consistent. That reality suggests there may be more opportunity for standardization than many assume. Moving from hundreds of individually negotiated agreements to a more streamlined approach isn't necessarily about redesigning everything — it's about overcoming the organizational, operational and contractual complexity that has built up over time.

BEIER: From an IT perspective, one of the biggest challenges is the growing complexity of payer-specific requirements. Different contracts, services, and locations often require unique codes and workflows, making standardization difficult. This complexity reinforces the need to step back and rethink the process rather than continuing to layer new requirements onto an already complicated system. The administrative burden on billing teams is significant, and greater simplification could improve efficiency for everyone involved.

O'DELL:

The challenge is not agreement on the vision. It's translating that vision into day-to-day operations.

Sponsor

Turquoise

Turquoise is building tomorrow's way to get healthcare paid. The company's **Transaction Efficiency Platform** connects pricing data, contract intelligence, and revenue cycle workflows in one unified system, giving finance teams across healthcare the precision to cut through administrative waste and walk into every negotiation knowing exactly where they stand. The result: patients get clear costs upfront, not surprise bills.

LEARN MORE AT:

turquoise.health