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## partnering with payers? key lessons to keep in mind

As providers enter into risk-sharing arrangements with payers, they will benefit from keeping in mind several optimal practices employed by others.

### AT A GLANCE

Key factors healthcare leaders might wish to consider when evaluating potential partnerships with payers include:

- > Use of safeguards to prevent a payer from using benefit design to shift expected volume from high-revenue service lines or channels
- > Right to participate in narrow networks
- > Use of segment-specific language, which protects providers from payers that may try to extend a rate decrease from one patient segment to another
- > Exclusive co-branding
- > Automatic price increases if volume is not achieved

Both payers and providers are realizing their current business models are broken. Providers' ability to sustain margins by relying on high commercial rates to cover losses on Medicare and Medicaid is threatened as government programs account for a growing share of hospital payer mix and as commercial enrollment declines. At the same time, payers face the impact of health insurance marketplaces, also called exchanges, in the individual and small group markets, pricing pressure from large commercial accounts, and a host of regulatory changes that threaten payer margins.

As a result, payer and provider organizations, traditionally "distant neighbors" who met in heated rate negotiations, are finding common ground in the objectives of improved population health, improved patient experience, and reduced per capita costs. They are learning to align their incentives around value in the hope of becoming effective partners.

The benefits of such partnering can be many. Providers see opportunities to replace declining revenues by moving upstream to accept risk and grow market share, and payers see opportunities for stronger partners to participate in the new value-based contracting and the expansion of coverage under the Affordable Care Act (ACA). Since the act's passage in 2010, more than 500 accountable care organizations (ACOs) have been created, with nearly half including partnerships between commercial insurers and various types of provider groups.

### Characteristics of Today's Partnerships

Several important considerations can be seen in relation to recent industry collaborations.

*Risk profile determines the type of partnering opportunity.* Market reform requires all providers to rethink where they are on the risk continuum, and where they will be in the future. Options for risk-sharing vary widely, from shared savings to private-label contracts for products designed for the new

private health insurance exchanges. All of these options provide opportunities for a contract or partnership with an insurance company (see the exhibit below).

Providers that decide to move upstream to capture a greater share of premium revenue are faced with a range of “make-buy” decisions on acquiring the infrastructure systems needed to manage risk. Given these new business requirements, a majority of providers have decided that it is better to seek a partner with these capabilities than to attempt to build the insurance functions internally. A few health systems are going so far as to acquire their own insurance licenses, but many of them view this strategy as a last resort.

**Goals are financial as well as practical in nature.**

Unlike many partnerships in the past, today’s collaborations aren’t necessarily based in a provider’s desire to improve access to capital. Many financially strong organizations with AA ratings are leading the way in developing risk sharing-partnerships. Examples of these include CHE Trinity Health with Blue Cross Blue Shield of Michigan, Inova and Banner Health with Aetna, Advocate Health with Blue Cross Blue Shield of Illinois, and Partners Healthcare with Blue Cross Blue Shield of Massachusetts.

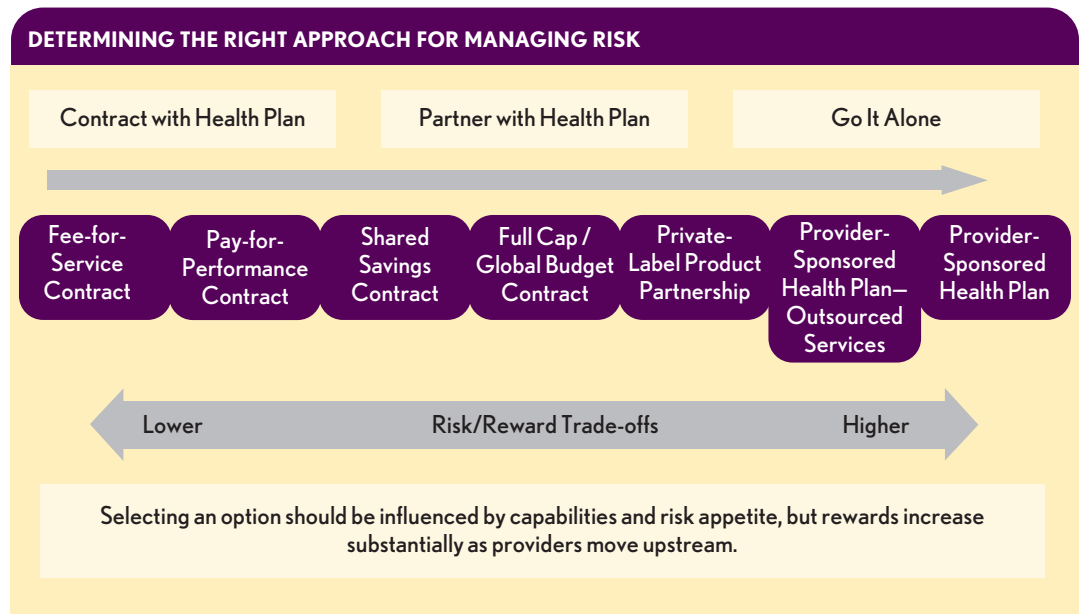
Goals of a partnership can include practical objectives such as:

- > Avoidance of the need to get an insurance license
- > Access to key infrastructure such as informatics, care management, marketing, and retail sales
- > Ability to leverage a partner’s brand or distribution system
- > Access to segment-specific expertise managing narrow or tailored network design

**Partnerships are market and segment specific.**

Most partnerships are targeted at specific geographic areas and market segments, such as employee health, commercial ACOs, or narrow network individual health insurance exchange products.

Effective commercial partnerships offer the potential of shared savings from reductions in utilization or costs of care. However, these benefits alone may not be sufficient to replace revenue lost from declining commercial utilization or the impact of reform-driven payment change. Unless the partnership is able to grow market share and add covered lives, the new alliance may not provide a sustainable business model. Therefore, putting together an effective partnership requires providers to take into account factors specific to the market and segments served, such as:



- > Competitive landscape
- > Payer landscape
- > Population growth and trends
- > Geographic reach of the health system and strength of its physician network (e.g., Will the participating provider be a dominant health system with strong share and coverage, or a second- or third-tier competitor with a weaker network and limited geographic coverage?)
- > Market position of a potential payer partner
- > Penetration of managed care products in each market segment
- > Price structure of the market and the pricing strategy to gain or move share
- > Medical cost structure in the market (e.g., Is the market loosely managed with high opportunity to reduce costs through better utilization management, or is it well-managed with less opportunity for utilization-driven savings?)

### Selecting the Right Partners

Once the characteristics of today's provider and payer partnerships are understood, focus naturally shifts to the process of selecting the right partners. To be successful, efforts should be led by senior leadership and be based on a formal request for information (RFI) process.

**Senior-level guidance is imperative.** Pursuing a partnership is a strategic decision that requires the development of new business models. Thus, planning and negotiating these partnerships shouldn't be left to typical contracting teams. It is vital for the C-suite to lead these discussions.

Consider just a couple of examples where such structuring has benefited organizations. In 2010, when Dignity Health, Blue Shield of California, and Hill Physician Partners developed a pilot ACO around total cost of care for 40,000 CalPERS employees in the Sacramento market, planning discussions required senior leadership of all three organizations to reach an agreement that shared risk among the three parties, rather than just moving the risk around. The traditional managed care contracting division had been mainly accustomed to aggressive bargaining over acceptable rates, with no attention to issues of

product design, utilization, or financial integration. It took the top leadership of the three groups meeting together to work through these issues and sign a deal.<sup>a</sup>

Leadership at CHE Trinity Health in Livonia, Mich., the second largest not-for-profit health system in the nation, recognized it needed a new model for working with payers as part of its transition to value-based contracting. The organization created an executive-level "office of payer and product innovation" to oversee partnerships and product development. The office makes use of population health analytics services. Staff use claims, clinical data systems, and other data sources to stratify membership attributed to the CHE Trinity's risk-sharing contracts into various risk categories and directs the patients into several different care delivery models. At the same time, the organization continues to dedicate its traditional rate negotiation and contract management team to its fee-for-service contracts, which continue to generate the majority of payments.

**Potential partners should participate in the formal RFI process.** Payers often argue that risk-sharing collaborations work better for providers than going it alone because the partnerships require less capital to start, align payer-provider incentives, are scalable, and have attractive investment returns. However, payers' capabilities can vary substantially. These differences can best be addressed by requiring potential partners to complete the RFI process.

Consider how Holy Cross Hospital, a 500-bed hospital in Fort Lauderdale, Fla., and member of Catholic Health East (now CHE Trinity Health), benefited from an RFI prior to entering into an ACO with Florida Blue that manages 10,000 lives. Holy Cross was looking for ways to optimize value-based contracting, and it established the goal of selecting a partner with a large enough book of business to justify investment in the necessary infrastructure to support participating in the population health management market. Holy Cross had no shortage of interest from commercial insurers, so it had potential partners

complete the formal RFI process. (See the exhibit below for a sample of typical RFI questions.) The RFI was sent to the 10 major commercial insurers in the market, all of which had existing contracts with Holy Cross.

Holy Cross received nine responses and then narrowed the field to six who best met the evaluation criteria. The six payers were then invited in for day-long interviews to discuss their proposals. The parties were able to talk about business philosophies, potential deal structures, and cultures. Holy Cross then scheduled more detailed discussions with two finalists, eventually picking Florida Blue for its first partnership.

During the RFI process, Holy Cross found there was substantial variation in what the insurers were proposing. Insurers' proposals varied not only by the business models proposed, but also by the patient attribution methodologies. Some payers also were open to changing approaches once the interviews took place, because many of them also were new to the game and learning as they went along.

Holy Cross is continuing conversations with a number of the other major carriers in the region. In the next five years, Holy Cross expects a significant portion of its commercial business will

transition to value-based contracts and wants to keep lines of communication open with all potential partners.

### Tailoring Products and Partnerships to the Organization's Needs

Products and partners are not one-size-fits-all for success. Each situation requires careful examination and an understanding of how product structure and partnership will best serve market needs as well as the entities' business goals.

At CHE Trinity Health, key factors leadership considers when evaluating potential products and partnerships include:

- > Targets for growth and profitability by market segment
- > Defensive goals to protect share
- > Objectives and requirements to develop new experience and capabilities
- > Resource requirements for successful market entry

Products for various market segments are chosen based on their ability to provide an optimal combination of price, benefits, and network configuration to attract consumers to the CHE Trinity Health system.

Sometimes, multiple partnerships will be needed. As an example, at CHE Trinity, market researchers

#### SAMPLE RFI QUESTIONS HEALTHCARE ORGANIZATIONS SHOULD POSE TO PAYERS

- > How do you envision payers and providers working together to improve quality and cost effectiveness in the future?
- > How would you structure our business relationships and what options would providers in a clinical information network have for contracting with them for various insurance products?
- > Have you already undertaken similar provider partnerships? What was their size and structure and how were they capitalized?
- > What metrics do you use to measure quality and performance, and what were the gainsharing arrangements for physicians and the hospital?
- > What is your experience with patient-centered medical homes, bundled payments, disease management, and benefit design?
- > How would you envision migrating your relationship with our provider groups to take on greater risk for medical costs?
- > What do you consider the key business terms to be in such an agreement?
- > What care management capabilities would you support building at the provider network level?
- > How would you describe your data support and predictive marketing capabilities?
- > What are your plans to develop products for specific market segments (Medicare Advantage, private health insurance exchanges, narrow network commercial)?
- > How would you describe your corporate culture, and why do you think it would be a good fit?

determined some partners were competitive when serving markets around Medicare Advantage products but not commercial segments. Thus, the organization found benefit to considering a range of payer partnerships and employer relationships to achieve its growth objectives.

Consider the following examples where the organization tailored products and partnerships to best meet its business goals.

In Western Michigan, after extensive market research, CHE Trinity Health elected to develop a narrow network, private-label Medicare Advantage product with Blue Cross Blue Shield of Michigan that is different than current Medicare Advantage products in the market.

In Southeast Michigan, CHE Trinity Health decided to avoid product risk by electing to participate in Blue Cross Blue Shield's existing Medicare Advantage product through a value-based contract.

In a large metropolitan market in Ohio, CHE Trinity Health concluded that failure to participate in the emerging private health insurance exchange market could adversely impact its operating income in the region. Because analysis indicated the exchange business was likely to be positive even with lower payment rates, CHE Trinity Health decided to partner with a large, dominant insurer. This approach made the most sense given assumptions the insurer would have the largest market share of any payer creating a narrow network product.

Across the state line in northern Indiana, a different approach was used. CHE Trinity Health elected to partner with a smaller specialty HMO, and it injected more competition into the market by bringing a narrow network product to the exchange under its own brand.

CHE Trinity Health's go-to-market decision in each instance was influenced by consumer research and focus groups examining brand strength and preference toward Trinity Health or its prospective insurance partner.

### **Incorporating the Right Safeguards to Mitigate Contract Risk**

Each contract should be structured to mitigate risk to the provider and support a balanced partnership. Examples of safeguards CHE Trinity Health uses to protect its interest in partnership relationships include the following.

**Anti-steerage language.** This safeguard prevents a payer from using benefit design to shift expected volume from high-revenue service lines or channels.

**Right to be included in all narrow network products.** This safeguard prevents payers from forming exclusive relationships with other providers that may impact the success of products including the provider.

**Exclusive co-branding.** This safeguard prevents dilutions of the brand associated with use in other products in the market.

**Automatic price increases if volume is not delivered.** This safeguard protects providers from payers that do not enforce out-of-network rates or use other levers to significantly reduce utilization without offsetting volume increases.

**Segment-specific language.** This safeguard protects providers from payers who may try to extend a rate decrease from one patient segment to

#### **QUESTIONS FOR ALL NARROW-NETWORK PRODUCTS**

##### **Questions for All Narrow Network Products**

- > Is the payer looking for a discount of commercial rates? How much?
- > What is the proposed length of the contract?
- > Is this an exclusive narrow network?
- > Which physicians are included in the network?
- > Will this be the payer's only offering for the proposed segment, or will there be a broad network offering as well?
- > What does the benefit design of the product look like?
- > How will the premium be priced?
- > Is your partner willing to co-brand the product?

##### **Segment-Specific Questions**

- > Which exchange segments is the payer targeting (e.g., individual, small group)?
- > Will the product be offered at every exchange tier?
- > Will products be offered on and off the exchange?

another (for example, extending from an exchange to a small group product).

In addition, Trinity carefully reviews the design of the care model to assure a differentiated consumer experience and high-value results.

**Keeping in Mind Lessons Learned by Others**

After nearly two years, experienced payers and providers seem cautiously optimistic about the future of these new business models. A number of risk-sharing partnerships have achieved positive utilization reductions and have shared savings with hospital and physician partners. Holy Cross, for example, reports that it is on schedule to earn its first performance bonuses this summer under its Florida Blue contract, and its new model is supporting value-driven care.

That said, not all partnerships meet desired business and clinical service goals. Some early ACOs have disbanded after not meeting desired objectives. Before pursuing a risk-sharing endeavor, providers should consider the following cautions based on lessons learned from others who have gone before them.

*Identify “no regret moves” up front.* These include improvements in population health status or patient experience that will be broadly beneficial to your mission regardless of the financial benefits that may eventually accrue from the partnership.

*Expect to deal with issues related to physician buy-in and alignment of compensation incentives.* Most physicians still receive the bulk of their compensation based on some relative value unity productivity formula, while most shared savings are achieved by reducing unnecessary hospital and outpatient utilization. The two goals can be hard to align. Unless there is an accompanying growth in market share, the new partnership business model may not be sustainable.

*Effective partnerships will require development of new skills in customer management and patient engagement.* In some Blue Cross Blue Shield total-cost-of-care contracts, out-of-network patient migration actually increased after the partnership contracts were signed despite overall reductions in admissions to participating network hospitals.

*Organizational conflicts are inevitable with initiatives such as this.* The newfound agreement around the Triple Aim objectives of improved population health, enhanced patient experience, and lower per-capita healthcare costs will not necessarily eliminate traditional payer-provider tensions. There is a need to accept disagreements as part of the partnership process and put mechanisms in place for managing when they occur—and escalating response by the appropriate managers and leaders whenever necessary.

It is important to remember that we are moving from a business-to-business market to a business-to-consumer market as the full ACA reforms roll out. Given our experience to date, partnerships are the preferred business approach to making the transition. ●

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