PAYERS AND PROVIDERS: DISTANT NEIGHBORS OR EFFECTIVE PARTNERS?

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For most of the past three decades or longer, payers and providers have been distant neighbors and traditional business adversaries—sometimes friendly, sometimes hostile, but seldom collaborative.

Until recently, there have been sufficient resources to allow both parties to grow and remain profitable. Health care spending has exceeded the growth in the GDP by 1.5% to 2.5% in most years since 1965, which has allowed providers to increasingly shift their deficits from public payers to private insurers who in turn raised rates to their customers. But this is no longer the case.

The impact of the 2008-2009 recessions, pressure from government and business, and the stimulus provided by the Affordable Care Act has slowed growth and created a market where top line revenue growth is likely to shrink. In 2010, National Health spending increased only 3.9% over the year before, the lowest rate in 51 years according to the Centers for Medicare and Medicaid Services. The annual growth in 2009 also slowed. We believe that the slower growth market will provide the motivation for providers and payers to pay greater attention to the issue of how to reliably deliver higher value care, and explore the potential synergies of partnered relationships.

We believe that the foundation of the future healthcare market must embrace the principles of an efficient clinically integrated network (CIN). In many markets, partnerships between payers and providers will build from this base. Effective provider activity will mean the quality delivery of care coupled with the efficient delivery of care with low unit costs. Effective payer activity will mean the ability to develop products that are responsive to the consumer and the purchaser of care—and the ability to support those products jointly with providers in an organized system of population health management.

Results of this transformation will not be uniform and will depend on the requirements of local markets and whether the right products can be designed for the right geographic
areas. Much of the old environment and way of doing business will be needed to stay in place while the new neighborhood is constructed. But it may not be too far afield to predict that we are transitioning to a marketplace where partnered arrangements between effective payer activity and effective provider activity are the rule rather than the exception.

**WHAT ARE THE NEIGHBORS DOING?**

We wrote last summer that while CMS was a major catalyst for change, the leading edge of reform is coming first from commercial payers who are moving forward on their own Accountable Care solutions. Payers are adapting faster and are proving at least as innovative as the federal government, and are now working towards reform with an emphasis on collaboration. There is substantial evidence that most major payers and increasing numbers of providers now see collaboration as a major part of their new business strategy.

A recent AHIP conference in Washington on delivery system reform reported 30 different Accountable Care Model arrangements in a dozen different states; 151 different Patient Centered Medical Home partnerships in all 50 states; several partnerships for Bundled Episode of Care Payments; and three Comprehensive Global Payments experiments. Another recent study of ACO activity by Leavitt Partners identified 168 different Accountable Care Organizations being formed nationally. Hospital systems sponsored 60% of these new ACOs, physician groups 23%, and health plans 16%.

Efforts to change how the nation pays for health care are moving forward and picking up speed. Payers are backing a broad introduction of quality goals, improved performance standards and patient involvement, and are focusing on improved information transparency and leveraging of technology. Cigna, for example, has announced a new “Collaborative Accountable Care” business model. This model seeks to improve delivery of evidence-based care, improved coordination and patient engagement to reduce avoidable care, optimization of levels of care, and reducing rewards for medically unnecessary care in the market.¹ In addition, the Cigna model provides incentives for providers able to beat expected cost trends and provides for a three, not one year, contract term.

¹ Kang Jeffrey, MD, MPH, Cigna’s Approach to Collaborative Accountable Care, Summit of Shared Accountability, October 18, 2011
UnitedHealth Group became the latest payer to announce a change in the architecture of its compensation model from fee-for-service to fee-for-value. Under the plan being rolled out UnitedHealth will tie provider compensation to quality goals such as avoidance of hospital readmissions or health screenings, not just volume. In making the announcement UnitedHealth said it was ramping up its “Value Based Contracts” from 1% to 2% of its insured members today to 50% to 60% of its commercial membership by 2015.

At the same time UnitedHealth also announced plans to launch 8 to 10 new Accountable Care organizations in 2012 in partnership with organized hospitals and physician groups; new incentives to primary care physicians in three to five new markets; and a significant expansion of medical home initiatives which already cover 500,000 patients in 21 different agreements.

Not surprisingly, most other national plans are adapting similar ACO-like business models.

The plans are moving to the point of view that the traditional fee-for-service incentive system is wrong for both payers and providers; that there is the wrong level and form of competition; that information and transparency has been missing; and that the strategies and business structures have been primarily defensive and not focused on value optimization.

**A BLURRING OF MARKET BOUNDARY LINES?**

While the collaborative business models are moving ahead, both payers and providers will continue to make investments that further their individual business agendas. At times, these investments may blur the neighborhood boundaries and seem more competitive that cooperative. For example, some national carriers are making investments in large, organized medical groups to fill in gaps in their delivery systems, or to fuel the growth of divisions that provide direct care services to the market. Provider systems which are building ACOs may move into the payer product space by entering the Medicare Advantage market, or by entering the individual market by direct contracting with State Insurance Exchanges.

During the past year, for example, UnitedHealth Group acquired Monarch HealthCare, a 2,300 physician specialty group based in Irvine, California. In February, WellPoint announced its acquisition of CareMore Health Group which has 54,000 Medicare Advantage members, but more importantly, owns 26 clinics in Arizona, California and
Nevada. Although not the stated intentions, the acquisitions position payers to control a greater portion of the premium dollar while improving penetration of the growing senior market.

Payer primary care physician alignment may also become a larger issue for providers in the future. The growth of Patient Centered Medical Homes may position payers in some markets to become ACOs at the expense of hospital sponsors. The increasing relationships between payers and primary care physicians may not yet be in the category of a “land grab” between insurance companies and the hospital industry as one observer suggested recently, but the results are clear: Blue Cross of Michigan, which launched its statewide PCMH initiative in 2009, has reported 11.1% lower hospital admissions, a 6.6% decline in ED visits, and a 3.3% increase in generic drug use.

It may be more likely, however, that payers and providers will opt for a collaborative middle ground, such as the plan Carilion Clinic in southwest Virginia is developing with Aetna as part of their accountable care agreement. Under the agreement, Carilion and Aetna are developing co-branded commercial health plans that will be offered to business and individuals later this year.

Carilion will continue to directly offer its own Medicare Advantage products to the market, but will take advantage of Aetna’s scale by purchasing selected administrative services from the provider. Since Carilion’s group already features an integrated medical record, Aetna members will have more information and control over their health decisions and dollars.

The product boundaries between payers and providers will vary state by state, and within markets and sub-markets within each region. The main objective for both payers and providers will be matching the right providers and purchasers and making the investments needed to support an effective care model.

**DEVELOPING YOUR COLLABORATIVE FOCUS**

It seems certain that most providers will have the opportunity to collaborate in some sort of clinical value creation project with commercial payers in the next few years. In fact, it is likely to be a requirement to protect or grow market share. So having the mindset which promotes collaboration, not just year-over-year hard-nosed negotiations, will be critical in developing effective long term partnerships.
We believe shared-risk partnerships will gradually replace fee-for-service contracting, first as overlays to current contracts, and later as global or partial capitation arrangements. These new types of contracts will require collaboration from areas outside the control of managed care contracting and will need to be negotiated at the most senior executive levels.

Getting collaboration right promises tangible benefits: lower unit costs through shared resources, better quality, a unified face to customers, and the development of innovative products which can match the right providers to the purchasers’ preferred benefit plan designs.

Collaborations can also fail for any number of reasons. These can range from "too much talking and not enough doing," to information overload or lack of transparency, to fear of infighting or inability to manage conflicting priorities, to not knowing who to praise for success or to hold accountable for lack of it. Here are some basic suggestions for your team as you move forward through your market transition.

- **Focus on Product and Market Synergies First.** Successful partnerships require the sharing of risks and the sharing of skills and a movement away from the dispersed provider silos to shared accountability for results. If you are going to start by planning the ACO structure before you have agreement on what you are trying to provide the customer, you may encounter difficulties later on: a successful collaboration requires a focus on market first, matching the right providers and purchasers, and structure second. Collaboration should begin with a discussion of what the product for the market ought to look like, and what the requirements in resources and skills from the partners will be to assure optimum value for the customer.

- **Make Sure Everyone has “Skin in the Game.”** The Federal Trade Commission recently rejected an application for a suburban Washington ACO clinical integration program because there was no investment by individual physician participants, and no formal mechanism for dealing with individual quality or disciplining a member hospital that failed to assure physician compliance except for expelling them from the network. On the positive end of the spectrum, a major California payer recently launched its own ACO program with global per member per month budgets split into several broad categories. The hospitals, physician

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groups and the plan all have a piece of each budget category, including both the up and downside results. The key to their successful planning was to get the three groups to sit down and show their cards and to stake their success or failure on the cumulative efforts of the partnership.

- **Use Positive not Negative Financial Incentives.** The experience of early TCOC experiments evaluated by BDC in 2011 indicated that all providers were able to earn bonuses for quality and many were able to beat the comparative market trends against which they were evaluated. None of the participants had any exposure to significant financial risks. The positive early wins allowed the programs to gain broad provider buy-in and enabled payers to achieve their goals of cutting the rate of health spending for all participants. The experiments have been succeeding because organizations didn’t need to “bet the farm” to partner with their formerly distant neighbors.

- **Expect, Accept and Actively Manage Conflicts.** Experience in a variety of industries indicates the inevitability of organizational conflict in complex collaborative relationships. Even the most experienced executive can be surprised, mistakenly assuming that efforts to increase collaboration will significantly reduce organizational tensions. So be prepared: differences of opinions and perspectives, competencies and strategic focus can actually generate much of the value that can come from collaboration across organizational boundaries. There is a need to accept conflicts as part of the collaborative process and put mechanisms in place for managing it at the point of conflict – as well as escalating it up the management chain when necessary.

- **Identify Your “No Regret Moves” Before you Start.** Most health care executives recognize the need to change, but moving from fee-for-service to a value-based business model can be tricky even if you are convinced this is the way to go. So before you start down the road of collaboration make sure you have identified those moves you need to accomplish which will be broadly beneficial to your mission no matter how change pans out. For instance, committing to the development of a CIN would be a good start for most providers. Agreeing to follow evidence-based medicine as a gold standard would be another. Having an appropriate positioning strategy for the emerging Health Insurance Exchange market would be a third. And finally, recognizing it is time to evolve from pure tensions to creative tension with your neighbors would be good for all parties.

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**CONCLUSION**

So as you approach your collaborations with your neighbors, no matter whether you are a payer or provider, you will need to be comfortable with a certain amount of ambiguity since some decisions may be made beyond your domain of control or expertise. With this in mind, we pose three final questions:

- **Do you have a transition plan in place you believe in?** As a health system, do you have a plan in mind of how to move from where you are now to where you need to be by harnessing an effective provider network that can deliver high quality care with low unit cost? Or if you are a payer, do you have confidence you have the right products for your customer’s markets and the alignment with your partners to support these products with better management and better unit costs?

- **Do you have an overarching agreement that outlines your collaborative relationship?** Defining and gaining an understanding of the goals, principles and key measures for success is an important part of new collaborative or ACO-like agreements. The use of an Oversight Council for collaborative projects to provide structure and process for joint planning, as well as a forum for dispute resolution, is a tool used successfully in several TCOC type projects, together with a Clinical Services Committee with team members from both providers and payers to jointly plan for improvements.

- **Are you prepared to sign a long term agreement?** Longer term payer-provider contracts are the cornerstone of most new ACO agreements. Payers are asking for them. The new Total Cost of Care contracts between HealthPartners and Allina in Minneapolis have a seven year term. Three years is more typical, such as the agreements signed in Boston recently between Partners HealthCare and Blue Cross. Collaboration may not be forever but the new agreements are generally for a longer term than most providers have experience with. Is your organization comfortable with the risks and complexities of long term collaboration?

You may not be able to answer yes to all of these questions immediately. But if the goal of collaboration is the triple aim of improving the health of a defined population, improving the affordability of healthcare, and upgrading the quality of the individual patient’s experience these are issues that need to be answered to convert your formerly distant neighbors into an effective partner.

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