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FEATURE STORY

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implementing clinical and financial collaboration between payers and providers

The experiences of two healthcare provider organizations highlight successes and challenges associated with collaborations between payers and providers.

Healthcare payment reform is beginning to generate some early successes in the form of reduced costs, improved quality, and aligned incentives. But healthcare finance leaders are likely to encounter several strategic and operational potholes along the way.

Two case studies illustrate the challenges and rewards hospitals and health systems are likely to experience in pursuing clinical and financial collaborations with payers aimed not only at optimizing revenues, but also at reducing costs through operational changes. Hospitals and health systems should make sure they have a clear vision and a detailed plan for what they want to accomplish and how they will accomplish it.

Case Study: A Successful Collaboration

An independent practice association (IPA) in the south comprising several hundred primary care and specialty physicians, nurse practitioners, and physician assistants had successfully managed professional and facility costs associated with approximately 200,000 Medicare Advantage and health maintenance organization (HMO) lives on a capitated basis for nearly a decade. Facing new competitive pressures from large, integrated delivery systems in their market, IPA leaders pursued a two-pronged strategy to

AT A GLANCE

An IPA learned three important lessons while implementing a clinical and financial collaboration with its payers:

- Eliminate mixed messages.
- Focus on delivery and operational changes, not just payment change.
- Set realistic expectations and deliver on them.

optimize the top line: First, attract new patients under Medicare and under contracts with commercial preferred provider organizations (PPOs), and second, lock into potentially lucrative shared-savings payment arrangements with payers that rewarded the IPA for reducing avoidable costs and utilization from local hospitals and postacute care providers.

With its growth-oriented strategy in place, the IPA approached clinical and financial collaboration with its top payers in four steps.

Set a simple, compelling goal. Clinical leaders drafted and communicated a simple goal to their clinician owners: Optimize clinical outcomes and service over the next five years, so the IPA can grow its top line via more patients and shared savings.

Get the data. To manage new patient populations, the IPA knew it needed to invest in new data sources and systems to manage care. Without such data, it would not be able to employ the methods that made it successful under capitation, such as managing bed days, specialty referrals, and ancillary and prescription drug variation.

So the IPA needed to acquire claims-level data from multiple payers and mine the data to identify unexplained physician and hospital practice variation. At first, the payers suggested they could release only high-level, per-member, per-month utilization, mix, and cost statistics for a given population. These reports provided some high-level insight into broad categories of overuse, underuse, and misuse (e.g., inpatient days, emergency department [ED] visits, prescription drugs, and skilled nursing facility utilization) and unit cost savings opportunities. However, the reports fundamentally failed to capture unexplained, physician-specific variations at the heart of managing costs and improving quality. IPA leaders insisted on acquiring detailed payer claims data (without competitor unit payment rates) on attributed patients, and ultimately received a file of the raw claims.

The IPA subsequently ran several reports (using a simple database query tool) to identify instances of avoidable utilization opportunities across high-cost patients, high-cost types of services, and high-cost sites of service by physician. The physicians were interested in the tangible evidence of unexplained variation.

Validate the data and prioritize the opportunities and ROI. Next, the provider and payer validated a series of reports that pinpointed specific areas of quality improvement and cost reduction. The two parties did this by linking the payer claims data to the IPA's billing and medical records data. Then, during a biweekly meeting, the two parties shared findings on physician practice variations with the physicians most affected.

Within two months of initiating their partnership, both parties resolved key data gaps, prioritized specific initiatives, and created a high-level financial pro forma that quantified the revenue and cost implications of reducing avoidable inpatient days and skilled nursing days, improving generic prescription fill rate, reducing discretionary imaging and lab services, and reducing ED utilization, among others.

Commit to operational changes. This step was crucial to both parties learning to trust each other. Basically, the IPA and its key payers reported to each others' boards why these priorities had not been addressed in the past and what would be different this time. The parties agreed to conduct monthly CEO-to-CEO progress calls. The CFOs and chief medical officers of the IPA and the payers agreed to meet monthly to confirm that key information gaps, incentive gaps, staff gaps, and implementation barriers were addressed this time.

IPA-Payer Collaboration: Lessons Learned

A year after this strategy was implemented, some key lessons learned have emerged.

Eliminate mixed messages. Early on, certain IPA leaders were quite outspoken about their past experience and expertise with managing costs

out of HMO and Medicare Advantage populations. That initial posturing squelched some physicians' willingness to publicly explore new ways to reduce costs and improve quality for Parts A and B Medicare and PPO patients, who had different age, gender, and health status profiles. Ultimately, the data analytics were critical to demonstrating better ways to deliver care to all patient populations involved. After eight to 10 weeks of data review and dialogue, key IPA leaders acknowledgedthat the IPA had not yet made the investments to get the next 20 percent of cost savings out of the system, and IPA leaders would need to commit the time and political capital to act on the data findings.

Focus on delivery and operational changes, not just payment change. At several points throughout the process, IPA conversations became heavily focused on payment models and incentives. At these points, leadership intervened and reminded physicians that unless they committed to making care changes that would reduce the cost of care, the payer's only other alternative for reducing costs was to make fee schedule cuts. A favorite saying became, "Care delivery changes are our first step toward successful payment and compensation reforms we can live with."

Set realistic expectations and deliver on them. The third lesson learned related to how to effectively communicate expectations to the physicians. For each physician, the IPA spelled out what changes they could expect as the IPA expanded its reach beyond Medicare Advantage and HMO business to PPO and traditional Medicare business.

For example, the message to primary care physicians related to reducing avoidable utilization as part of their role as coordinator. The exhibit below illustrates other key messages.

Leadership also presented a realistic view of the investments required to succeed under shared savings contracts, including $10 million in electronic health records (EHRs), reports, clinical staff, and training. The IPA presented its case to a few payers and received funding (cash, rate increases, and grant funding) to hire nurse practitioners and physician assistants, among others. Those investments in cost savings solutions ultimately resulted in significant (10 to 20 percent) reductions in avoidable utilization in select patient cohorts (e.g., behavioral health and diabetics), which allowed the payers and provider, together, to differentiate themselves in the market from competitors.

Case Study: A Not-So-Successful Attempt at Collaboration

A large health system with four hospitals and an employed medical group with more than 120 physicians in a highly competitive market pursued clinical and financial transformation. However, without a clear vision or thorough plan, they found themselves floundering.

The health system began investigating clinical and financial collaboration with payers after it

A PROVIDER'S MESSAGES ABOUT CHANGE COMMUNICATED TO PHYSICIANS

Primary Care Impact Statement	Specialist Impact Statement
Conduct daily planning meetings to discuss the day's work.	Expect fewer subspecialists to work for the IPA.
Create patient care plans, particularly for chronically ill patients who have not had recent physician visits.	Reduce potentially avoidable readmissions, inpatient and skilled nursing days, tests using clinical protocols, and evidence-based clinical delivery standards.
Use physician variation reports to reduce unexplained variation and leakage outside of the health system.	Use physician variation reports to reduce unexplained variation.
Practice at the top of your license (i.e., do physicians' work, not the work of nurses, administrators, or clerical personnel).	Link your electronic health record to the IPA's health information exchange engine, so that test results, notes, and patient history are shared.

The case-study independent practice association (IPA) communicated to each physician what operational changes would take place as a result of the organization's new strategy for clinical and financial collaboration with payers.

was outbid for a sizeable cardiology group practice by a smaller, clinically integrated health system that was able to integrate the independent cardiology group into its EHR and lucrative performance-based payment contracts with three commercial payers.

From the onset, the large health system's approach to clinical and financial collaboration with payers was flawed. System leaders reacted to the cardiology practice loss by pursuing a "me-too" strategy to create a clinically integrated provider network capable of directly contracting

Implementing Clinical and Financial Collaboration for Orthopedic Bundled Payment

The exhibit outlines how a provider, payer, and third-party administrator (TPA) should collaborate to implement a discounted, hospital-physician bundled payment for an orthopedic episode of care involving hips and knees. The process can be quite complex, representing a major barrier to successful clinical and financial collaboration.

	Bundled Payment Process Flow	Key Transactions and Data Flows for Discussion
1. Front-End Operations	1. The provider defines what is in its bundle benefit.	The provider specifies the "covered versus uncovered services or benefits" in the bundle by code.
	2. The provider defines its bundling network providers (e.g., surgeons, radiologists).	The TPA sets up a special provider network for each bundle, which requires the TPA to set up a "plan and product code" for the bundle.
	3. The provider sells its bundle to an employer, which provides an eligibility file to the TPA.	The provider prioritizes the insurance exchange platforms on which it will sell its bundle.
2. Patient Management	4. The patient (employee) determines he or she needs a bundle by visiting the provider website or calling the provider or an insurance exchange.	The provider and TPA consider how potential patients could receive "auto-alerts" prospectively.
	5. The patient shops or is referred for the bundle.	The TPA quotes prices to patients, provides education material, etc.
	6. The patient registers at the provider for a bundle, and schedules appointment.	The TPA verifies eligibility, conducts authorization, issues admission notification, schedules patient, assists with travel, and transfers necessary medical records.
	7. The patient receives the bundle and follow-up care.	Care coordination, discharge planning, coding, documentation, and follow-up care integration occur between the payer and provider.
	8. The provider bills the TPA/payer for the bundle, using standard UB/HCFA forms.	The TPA must accommodate hospital, physician, ancillary, and even patient claim submissions, and create new logic (e.g., notice of admission indicators, denial codes) to process claims correctly.
3. Claims Payment	9. The TPA acquires the claim and adjudicates it.	The TPA confirms eligibility, authorizes service review, and calculates applicable payments.
	10. The TPA distributes funds to provider on the employer's behalf.	The TPA manages facility 835 notification, physician paper notification, and check or electronic fund transfer distribution.
	11. The provider distributes payments internally per formula.	The TPA manages withhold calculation, customized gain-share distribution formula, audits, and reconciliation activities.
4. Reports Analytics	12. The TPA reports results to employer, provider, and patients.	The TPA manages per-member-per-month reports; physician profiles; patient profiles; hospital profiles; and cost, quality, service, and resource dashboards with drill-down capabilities.

with commercial payers for bonus payments, over and above the normal physician fee schedule. The system hired a consultant to assist with the design of a clinically integrated network to provide the basis for the payer-provider collaboration. The consultant assessed the market and prioritized particular physicians deemed essential for integration into the network.

Next, the system engaged those physicians in educational sessions on the topic. However, the conversation quickly turned to financial incentives and payment models. The health system brought in compensation consultants to review its compensation and directorship stipends for independent and employed physicians. The consultants presented their report, which drew bright lines between winners (primary care) and losers (specialists). This zero sum, internally focused perspective created an enormous amount of internal dissension, and the system could not get its physicians to agree to a gain-sharing distribution model, let alone to the broader vision of a clinically integrated network that could compete with the top providers in the market. To leadership's dismay, an additional group of high-performing specialists defected to the same smaller competitor with the data, staff, and infrastructure/systems the physicians needed to provide the demonstrably better care to their patients.

Many lessons can be drawn from this experience. This large, historically successful system over-reacted to the loss of a key group of physicians. It misread the importance of articulating and sticking to a clear vision (other than "bigger is better") in a time of significant change. It misread what its best physicians wanted, which was more than the best financial "deal" in the market. It overlooked the fundamental operational/clinical issues (e.g., lack of operational EHR, undersized primary care base, poor analytics, and poor managed care relationships) that were at the root of its competitive disadvantages in the market. Unlike the IPA profiled in the first case study, the large health system's leadership team was not willing to challenge cultural norms that had historically prevented administration from informing clinical decisions, let alone intervening. Leadership struggled to operationalize a "data fed and physician led" process to assess, design, develop, test, and implement cost and quality improvements to maintain margins on lower unit reimbursement. With its deteriorating financial position, the board elected to replace the health system CEO with a clinical, data-oriented CEO who had experience building and running clinically integrated health systems.

Opportunities and Implications for Finance Leaders

As these two case studies illustrate, payment reforms including fee-for-service payment cuts, shared savings, and capitation are starting to catalyze clinical and organizational redesign within and between payers and providers.

Health system financial leaders at the helm of successful clinical and financial transformation tend to collaborate with payers in a few areas. Consider the following financial and clinical collaboration tips.

Strategic collaboration. Define the "end game" with each of your top three payers. Is the end game simply to reduce the administrative burden and improve payment accuracy, timeliness, and market rates? Or is the end game to attract new lives or reduce referrals outside your health system? If you are uncertain, understand the patient populations, provider partners, and performance metrics you want before you move too far ahead with a "me-too" strategy.

Administrative collaboration. Left unchecked, clinical and financial collaboration with payers can be quite expensive from an administrative and operational perspective. Before entering into shared savings and/or bundled arrangements, consider ongoing administrative expenses. Evaluate your current costs to document, code, bill, and collect any new payment streams, such as bundles. Engage your payers in conversations to cut costs by up to half. Outsource certain administrative functions (e.g., bundled payment administration) to firms that can do the work faster, better, and cheaper.

The sidebar, "Implementing Clinical and Financial Collaboration for Orthopedic Bundled Payment," on page 4 outlines some of the complexities around administrative collaboration with payers, as you develop your clinical and financial collaboration pro forma.

Clinical collaboration. Clinical collaboration starts with sharing clinical and administrative data. Finance leaders need to brush up on clinical data analytics, so that they can integrate a wide array of quality and avoidable utilization data with financial metrics, to design payment and incentive models that reward quality, service, and affordability.

Healthcare payment reform is moving from concept to reality. Long-term success requires finance leaders to better understand clinical processes, and clinical leaders to become more familiar with costs and revenue implications. It requires health plan leaders to understand provider dynamics, and vice versa. It requires both payers and providers to keep the end customer first—whether the customer is called "patient" or "member." Some leaders will rise to the challenge of clinical and financial collaboration between providers and payers. Others will not. Those that don't will most likely be worse off. ●

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