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From Adversary to Partner: Insights for Payers and Providers

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The list of challenges payers and providers must overcome to remain relevant in their markets seemingly grows longer by the day. Depending on the market, organizations face increased competition from large, integrated companies—or looming pressure from new tech-savvy entrants like Amazon and Google that are unencumbered by the operating challenges and fixed-cost infrastructures of legacy healthcare providers. In some markets, the combination of Medicaid expansion and aging baby boomers reaching Medicare eligibility is creating a greater proportion of customers enrolled in government programs, with lower average payment rates than private insurers. Employers are increasingly wary of rising costs for their commercially insured employees—and challenging payers and providers to aggressively price their products to compete for their business. And if competition and cost pressures weren't enough, consumers now expect the seamless experience they have grown accustomed to from other industries.

In response, payers and providers are increasingly teaming up and forging new partnerships, which range from contractual agreements for specific lines of business to joint ventures, or the creation of entirely new companies. In some instances, the partnerships are spurred by the incursions of new, integrated competitors that are intent on gaining market share by targeting key employer groups and population segments. In other markets, payers and providers might see an opportunity to expand and differentiate their businesses through a joint approach. In either scenario, payer–provider partnerships are intended to transform how all parties work together and deliver results on cost, access, and consumer experience.

Key Board Takeaways

As health system boards explore payer–provider partnerships, key questions to discuss include:

- What "problem statements" would this partnership address?
- How would this partnership further and sustain our long-term relevance in the communities we serve?
- How would this partnership advance our mission?
- How would this partnership improve the experience of our customers?
- What is the ideal future state for this partnership?

Aligning Visions and Coming Together

For nascent payer–provider partnerships, it's important to find a way forward that is unencumbered by how each organization has historically operated with regard to its counterpart—which sometimes includes past acrimony. In any given market, payers and providers often have a history of transactional—and sometimes adversarial—negotiations for fee-for-service contracts. Organizations need to leave behind those tensions at the outset of discussions if they want to truly leave behind the zero-sum interactions of the past and expand their respective businesses.

Establishing Trust with Transparency

At the beginning, each organization must commit to open, transparent discussions to establish a fact base and forge a common understanding of the goals, interests, competencies, and business complexities of its counterpart. Early discussions may need to establish definitions for commonly used terms like "risk-sharing," "network adequacy," or "utilization and medical management," which often

are defined and operationalized differently by payers and providers.

Initial discussions should include direct meetings between the leaders of each organization, with the goal of building trust and establishing problem statements, directives, and goals for the partnership. These discussions can also identify what each organization needs to make a successful transition to the new model. Providers may need to establish that they will be able to grow their attribution and access the premium dollar of their payer counterparts to prepare their organizations for taking on risk. Payers may need guarantees from providers that they will work together to "bend the trend" on the total cost of care for their members, so they can competitively price their products.

After leaders establish broad parameters for the partnership, the next phase of discussions needs to engage the echelon of executives with more responsibility for the day-to-day operations of each organization. Leaders should clearly communicate to these executives the long-term vision for the partnership, and what they foresee will be required to spur necessary change.

Key Strategic Considerations

As the partnership's strategic vision starts to take shape, leaders should discuss and evaluate their organizations' respective capabilities and competencies, whether they are in the delivery of care, network and benefit design, or information technology. These conversations can help determine which organization will handle specific aspects of the partnership's operations, and uncover capability gaps that will require further investment and development prior to launch.

Ideally, the partnership will enable each organization to deliver the value of its core capabilities—and scale back from areas where their partner has a stronger footing. For instance, participating providers might take the lead on medical management, enabling health plans to focus on benefit design, claims management, and the consumer experience. These efforts are intended to simplify the partnership's operations and eliminate redundant activities or processes that produce little value to customers.

In areas where new capabilities or investments are needed, it's important that prospective partners have frank conversations regarding those needs. For instance, one organization might agree to make further investments in information technology to facilitate data sharing and integration. The partners may then need to determine whether the new infrastructure can be used with other business partners, or if the investment is exclusive to the new partnership.

Structuring the Partnership: Form Follows Function

The structure of any given partnership ultimately should be shaped by the partners' shared vision, objectives, principles, and parameters for that partnership. It's critical that they commit to transparent conversations about what will need to take place to truly transform how they deliver care together, and establish a timeline for achieving their goals. Throughout the process, payers and providers also will need to be mindful of how the partnership affects their other relationships within a given market, as well as how it affects their existing book of business.

These considerations ultimately will help shape the structure of the partnership's scope, including how narrowly or broadly defined its operations will be within a geographical area or line of business, and the relative level of integration between participating organizations.

Looking Ahead

In the next decade, it's likely that highly capitalized companies with the ability to achieve scale—whether they're large, integrated systems or new entrants from the technology sector—will continue to expand their presence in healthcare.

Whether they are loosely constructed contractual arrangements for a given line of business or tightly integrated efforts that fuse organizations' business systems, partnerships offer potential benefits to both payers and providers that they couldn't achieve otherwise. Working together, they have an opportunity to thrive in a rapidly changing, intensely competitive healthcare environment where simply maintaining the status quo is no longer tenable.

The Governance Institute thanks John Poziemski, Managing Director, Kaufman, Hall & Associates, LLC, for contributing this article. He can be reached at jpoziemski@kaufmanhall.com.