4 Keys to Creating Financial Alignment in Payer-Provider Collaboration

By Yi-Ling Lin

Payer-provider collaboration offers the chance for insurers and health systems – players historically at odds with each other – to work together to improve outcomes and lower costs for patients and purchasers. Creating aligned financial incentives is a critical step in moving past the typically adversarial payer-provider relationship. It requires deft negotiations upfront and building collaborative infrastructure to manage the relationship for the long term and avoid public disputes that are damaging for both partners.

Let's examine four keys to building strong payer-provider collaboration.

One: Terms must be fair and reasonable for both organizations.

If the terms tilt too much toward one party, the other organization will feel shorted. This hinders efforts to build trust between the partners, eventually pulling them apart from each other. Aligning incentives is critical to delivering fairness. Conceptually, alignment is simple: When good things happen for patients, both organizations benefit financially. As with many aspects of contracting, the details of the contract determine whether this straightforward concept is put into practice.

Two: Figure out data sharing.

Data sharing is complicated in healthcare even when two organizations come from the same sector. Health systems and insurers have each developed their own data and measurables in silos, further complicating data sharing.

Health insurers have mountains of claims data compiled across many years and involving many health systems and physician groups. Health systems, however, struggle to find meaningful, actionable insights for clinicians in claims data, in part because claims data are often so delayed that it is too late for physicians to make use of these data in clinical decisions.

Other delays undermine provider confidence in health insurer data. Take a hypothetical example: In May, a health insurer reports to its health system partner that 50,000 patients are attributed to the health system as of March 31. Two months later, the attribution has been revised down to 45,000 as of May 31 because 5,000 patients did not have a claim recently enough and fell out of the attribution pool. The delay and the uncertainty about the data discourages health systems from using data from a health insurer partner.

Contracts that health systems and health insurers have with other parties also make data sharing more complicated, as these contracts may prohibit otherwise relevant data from being shared.

Three: Address insurance risk clearly in the contract.

Health systems need to work extra hard to understand insurance risk that is second nature to health insurers. For a health system evolving from a fee-for-service world to arrangements under which it is taking financial risk, navigating insurance risk is like being a detective in a new jurisdiction trying to tail a native of the area.

A health system's size is the biggest factor in the organization's capacity for taking on insurance risk. Larger entities can afford to take downside risk in return for greater upside potential. A smaller, rural health system, for instance, cannot afford that gamble. The rural system will not have enough attributed patients to offset high-cost outlier patients. For these smaller systems, one negotiating imperative is to find ways to limit this exposure, such as through stop-loss limits or disease-state carve-outs. In return for mitigating this downside risk, the upside provisions in the contract will be less generous to the rural health system.

Four: Communications and governance are critical to maintaining financial alignment.

The collaboration agreement must incorporate aspects of the ongoing relationship between a health system and a health insurer. Even if the first three keys described above are negotiated well, new developments and unanticipated consequences of the collaboration are bound to occur. It is the ongoing relationship that will enable the partners to smooth over these bumps in the road.

Regarding communications, establish a regular cadence of updates on the collaboration, such as written reports, conference calls, periodic face-to-face meetings, etc. These built-in communication opportunities will help each party better anticipate issues and work together to avoid new developments turning into more impactful and unwelcome surprises.

Likewise, the governance infrastructure should be set up to make adjustments to new developments and what the data tell us.

Two common examples of situations that frequent communications and solid governance can mitigate are:

- Legal or regulatory changes that have an impact on the financial terms; and
- Competition outside the collaboration. As more payers invest in providing care and more providers start health plans (often in joint ventures with insurers), organizations that are partnering on a contract can find themselves competing in other areas.

Putting the pieces together

Establishing a fair and aligned financial arrangement is at the heart of successful payer-provider collaboration. Negotiating fair terms and robust data-sharing arrangements and understanding the insurance risk go a long way toward embedding financial alignment in the relationship. Building in regular communication and governance infrastructure increases the resiliency of the initial financial alignment, enhancing the ability to adjust to changed circumstances.