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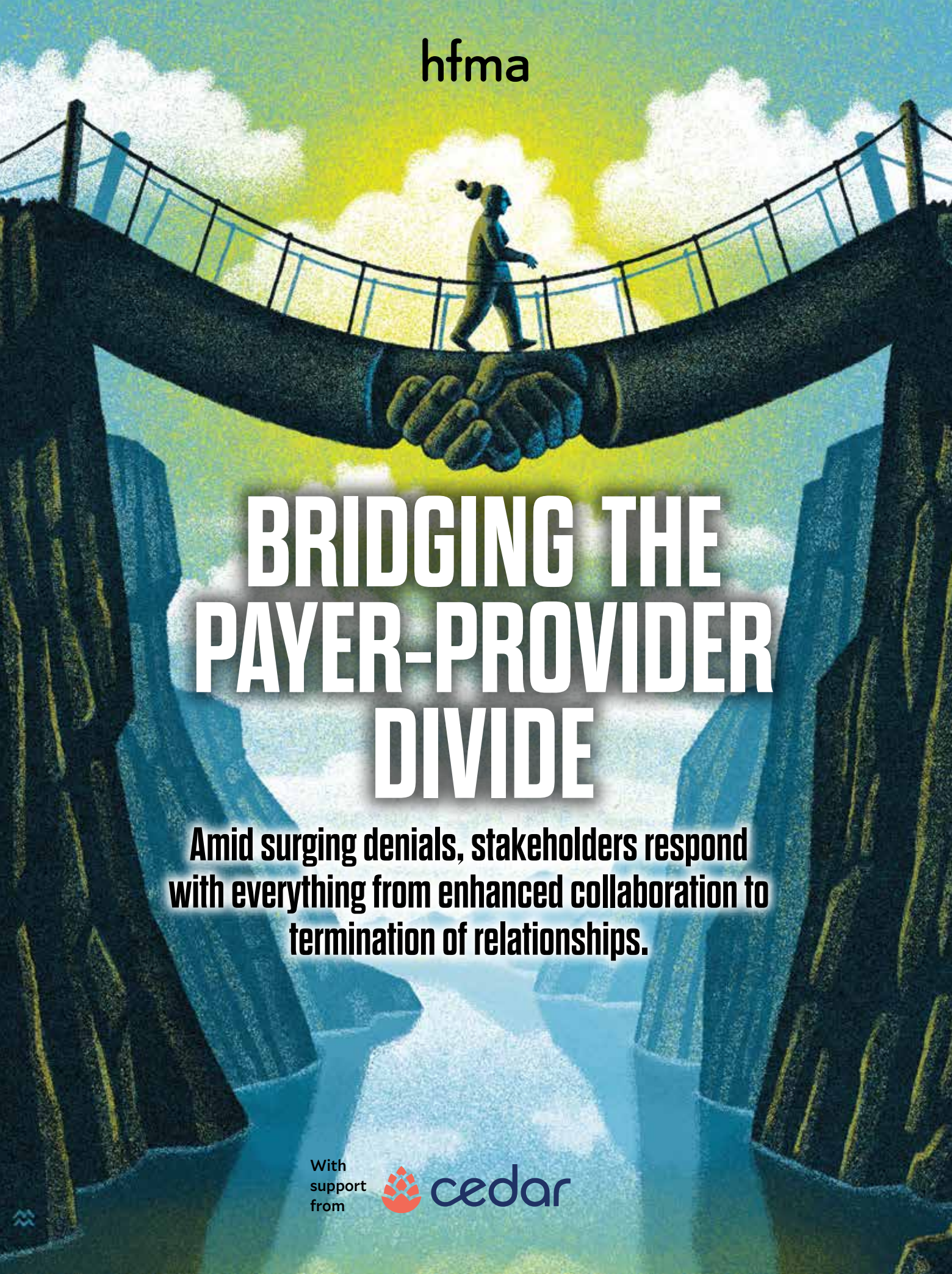


BRIDGING THE PAYER-PROVIDER DIVIDE

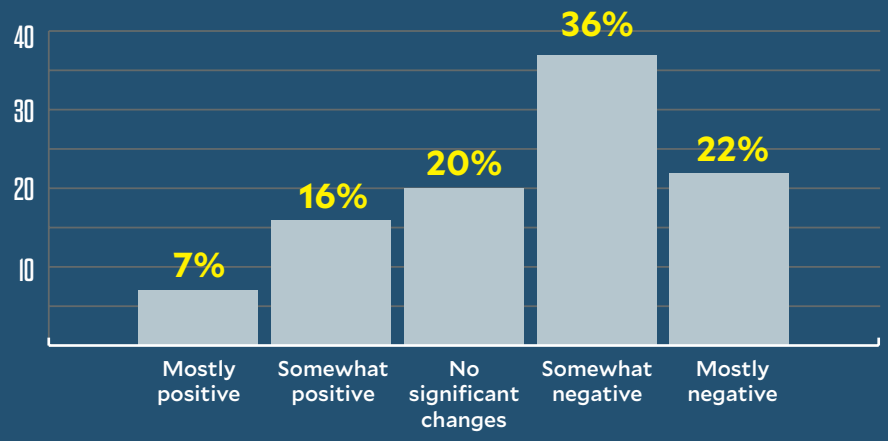
Amid surging denials, stakeholders respond with everything from enhanced collaboration to termination of relationships.

With support from cedar

Payer-provider relations have worsened

SURVEY QUESTION

How would you characterize the changes in your organization's relationships with payers over the past three years?



Source: HFMA survey in August of 102 hospital CFOs, with 102 responding to this question.

BY JENI WILLIAMS
HFMA Contributing Writer

Billie Jean Mounts, chief revenue officer for Cincinnati-based Bon Secours Mercy Health, once navigated a public standoff with one of the largest health plans in the nation.

The health system had terminated its managed care contracts with the payer when negotiations over reimbursement rates that failed to keep up with expenses came to an impasse. After an intense media campaign, legal action and a strategy backed by data, the organizations finally reached an agreement.

Despite that experience, even Mounts is surprised by the degree to which she says payers have, in recent years, been unsympathetic about the cost pressures hospitals and health systems face, particularly following the pandemic.

Mounts once got into an argument with a payer executive who said inflation was getting better at a time when inflation clearly was not.

"When I would point to any number of sources, including our own internal data and financial statements, to show them the increases in expenses that we were experiencing, especially coming out of COVID, they just refused to address it," said Mounts, FHFMA, CRCR, MBA, who spoke on payer negotiations at HFMA's Annual Conference. "They want to ignore it. And unfortunately, it seems like litigation is the only lever they really respond to."

No one wins when there is animosity between health plans and healthcare providers, least of all patients. They often must wait months to find out whether care will be covered and what their out-of-pocket cost will be as payers and providers negotiate the details. And there are signs that payer-provider relations have become more contentious in an era of rising denials and significant financial pressures, including a rate of inflation that, in some instances, outpaces growth in reimbursement.

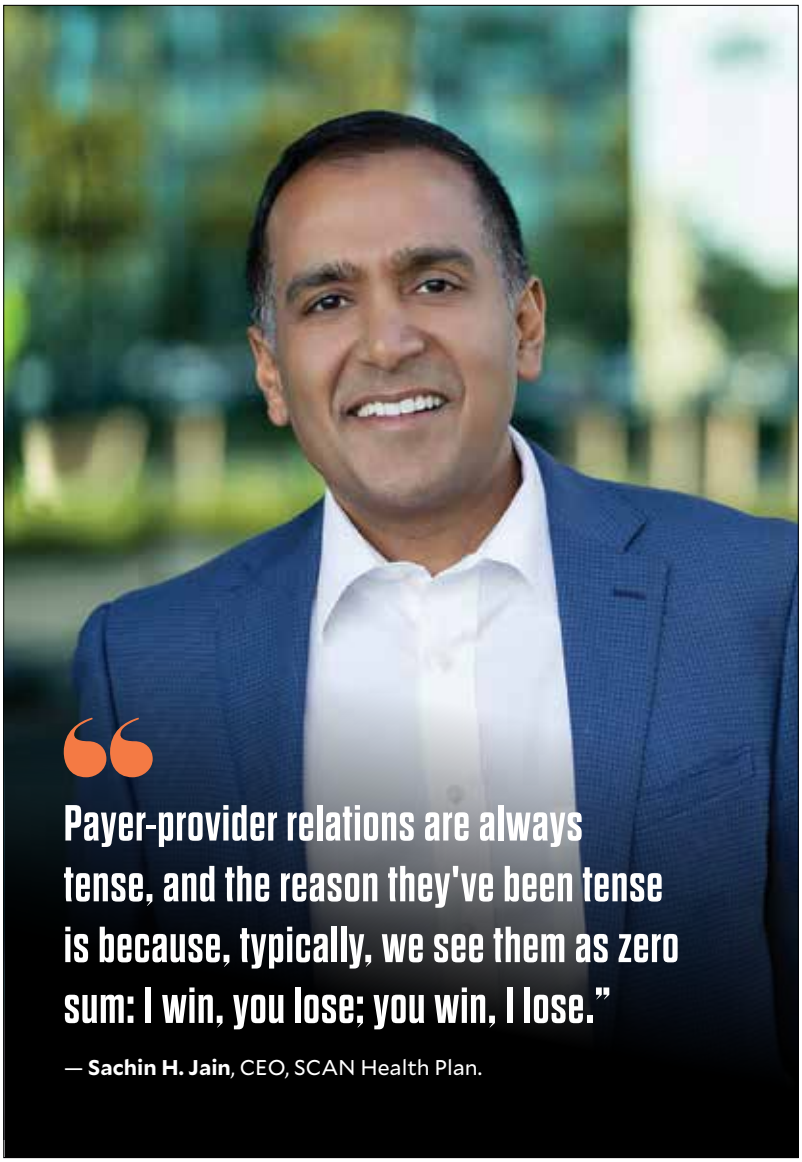
Nearly 58% of healthcare finance leaders say their organization's relationship with payers has become "somewhat negative" or "mostly negative" over the past three years, an HFMA survey found. Top reasons for frustration include what providers view as an intentional or systematic approach by payers to increase denials.

Blame the transactional relationship between payers and providers for the acrimony, one health plan executive suggested.

"Payer-provider relations are always tense, and the reason they've been tense is because, typically, we see them as zero sum: I win, you lose; you win, I lose," said Sachin H. Jain, MD, MBA, the CEO of SCAN Health Plan based in Long Beach, Calif. "And I think the cure to that is deeper, longer, more intentional partnerships between payers and providers."

Problems develop because payers and providers interact primarily around rates rather than thoughtfully considering how

COVER ILLUSTRATION BY MIRIAM MARTINCIC



> **Payer-provider relations are always tense, and the reason they've been tense is because, typically, we see them as zero sum: I win, you lose; you win, I lose."**
>
> — **Sachin H. Jain**, CEO, SCAN Health Plan.

to optimize value in healthcare. The result is a relationship that lacks strategic intent to build collaboration.

"That drives the highly transactional nature of [these relationships], which is where we're interacting primarily on rates annually as opposed to figuring out how we can work in a virtually integrated format or fashion," Jain said. "There's a lot of finger-pointing that goes on."

A true payer-provider relationship strategy, on the other hand, would require organizations to take a hard look at their performance and ask the question, "Is there a vehicle through which deeper, long-term partnerships with a smaller set of actors could lead to better outcomes, better health and financial outcomes for the communities that we serve?" Jain said. "And I think that that's not a question that has necessarily been asked and answered in that way."

A MATTER OF TRUST

What will it take to optimize these relationships so everyone — including the consumer — wins? One way would be to somehow boost trust among the parties involved.

Fundamentally, the trust formula between providers and

Rising rates of denials contribute to increased tension

SURVEY QUESTION

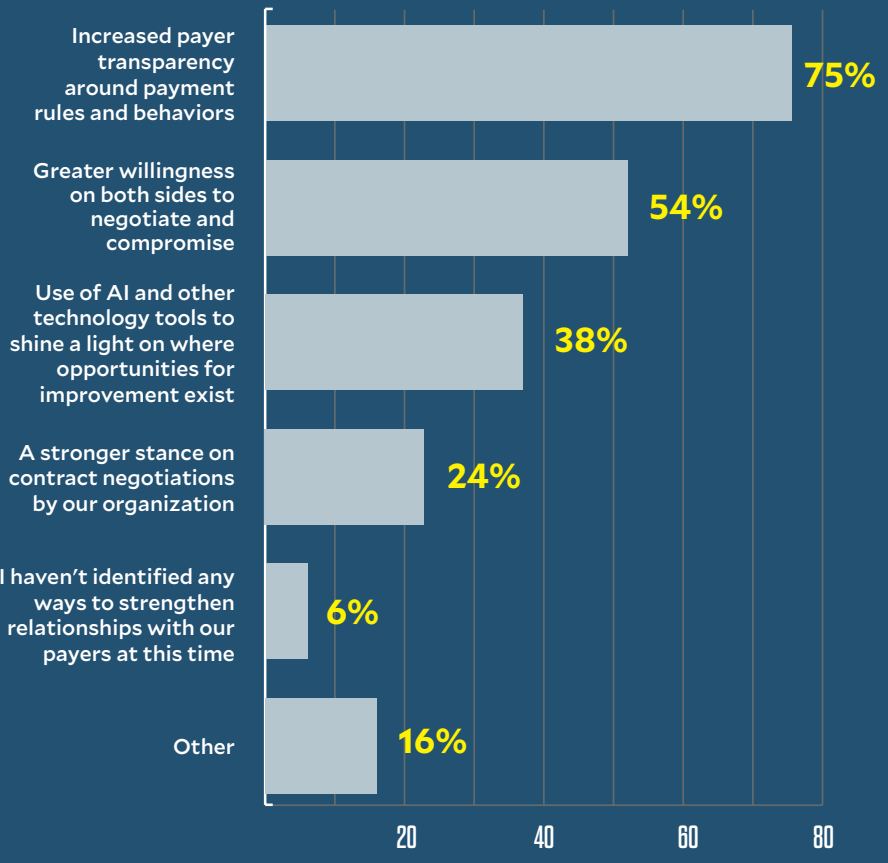
To what do you attribute the change in the relationship between providers and payers?

Source: HFMA survey in August of 102 hospital CFOs, including only the 59 who said payer relations have worsened in their organization. Multiple answers were allowed.

Payer transparency would improve relations

SURVEY QUESTION

What would strengthen your organization's relationships with payers?



Source: HFMA August survey of 102 hospital CFOs, with 97 responding to this question.

You would be shocked: They're going back years to audit claims, farther than they're supposed to, and they're taking back an entire claim instead of, like, a DRG downgrade. And there is such a high percentage of payer error here. They're just brazen."

— **Nicole McKinley**, director of denials prevention and management for M Health Fairview

▶ **Zeev Neuwirth**, MD, a physician and author, says that the trust formula between providers and payers has been decimated.

payers has been decimated, said Zeev Neuwirth, MD, a long-time physician executive and author of two books about healthcare disruption.

Providers lack confidence in payers' intent and question whether they are demonstrating transparency. They also don't believe payers are acting in providers' or patients' best interest — and vice versa, Neuwirth said.

"Trust is really broken and needs to be repaired and rebuilt if we are to successfully transform healthcare in our country," Neuwirth said.

A sticking point for providers is when they see fee schedules remain largely flat.

"On the provider side there's a real existential despair and anger that the payers just refuse to recognize this unprecedented increase in costs," said Scott Dewey, chief managed care officer for the payer-provider relationship consultancy PayrHealth, Austin, Texas, and a former health plan executive and revenue cycle leader.

DENIALS RISING ALONG WITH FRUSTRATION

Nicole McKinley, director of denials prevention and management for Minneapolis-based M Health Fairview, takes pride in a high-performing denials prevention unit at the health system, which slashed oncology denials by 25% last year. She's also frustrated by the amount of time and resources the health

▶ **Scott Dewey,** chief managed care officer for PayrHealth, says there is real existential despair on the provider side.

system must devote to its denials defense. Her team is seeing payer error rates of 30% to 40% in some denial categories, a percentage that far surpasses what she experienced as a revenue cycle leader in Ohio, where she worked prior to joining the Minnesota health system.

"These payers will just do some dirty tactics to get what they can, and it's causing all this spending and extra work and resources to review all this stuff," said McKinley, MHA, CSSGB.

"You would be shocked," she said. " They're going back years to audit claims, farther than they're supposed to, and they're taking back an entire claim instead of, like, a DRG downgrade. And there is such a high percentage of payer error here. They're just brazen."

These frustrations are compounded by the increased challenges related to prior authorization and denials — including AI-driven denials. Some providers believe denials are based on algorithms that are "fundamentally flawed and biased" and make it more difficult for providers to get paid for care they have provided, Neuwirth said.

"There's no question it's a major contributor to the burnout providers feel," he said. "I think it's really harming primary care in our country, because who wants to spend hours every day negotiating with payers around evidence-based medicine and procedures?"

On the other side of the equation are payers, who Neuwirth says are "trying to do their job by controlling costs."

"There's no question that there's been a fair amount of overutilization in healthcare; that's a fact," he said.

So, while providers bristle at continued challenges around prior authorization, medical necessity, level of care provided and more, Neuwirth said, the questions to ask are, "What is the alternative?" and "Is there a way for payers and providers to collaborate?"

PAYERS' PERSPECTIVE

Chris Jagmin, MD, deputy chief medical officer for Hartford, Conn.-based Aetna, understands the desire for improved collaboration from the payer and provider.

"We really do want to support our provider partners so that they can do what they went to medical school to do, which is take care of patients," Jagmin said. "I know that's why I went to medical school. We want to continue to innovate, too. Yes, we have some good [value-based] arrangements today. But we've got a lot more to do in collaboration [with healthcare providers], a lot more to do in the financing of healthcare with our partners. And we think as we do that, as we develop even more of these relationships, it's going to set us apart in the market, we'll be better able to serve our members."

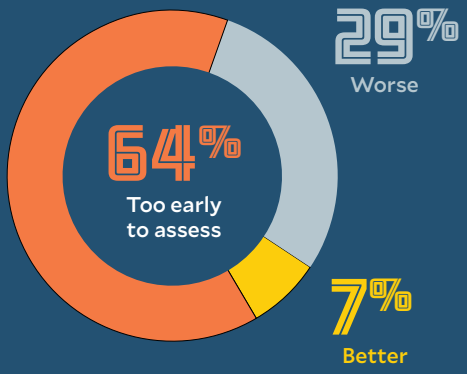
In contrast, Blues plan executive Donna Levigne, senior vice president of network business solutions for Health Care Service Corp. in Chicago, said she believes the state of payer-provider relations is strong.

FROM THE FIELD

Could AI make payer-provider relations better or worse?

SURVEY QUESTION

On balance, during the next three years, you expect AI to make relationships between your orgazinzation and payers:



Source: HFMA survey in August of 102 hospital CFOs, with 97 responding to this question.

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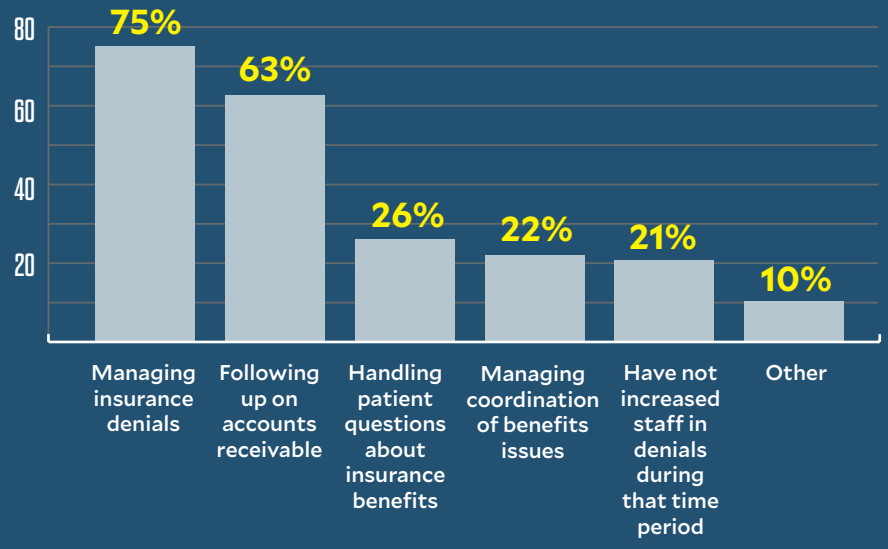
— **Chris Jagmin**, MD, deputy chief medical officer for Aetna

Deteriorating relations prompt hospitals to add staff

SURVEY QUESTION

Which of the following describes why you increased the number of full-time employees who are involved in patient billing during the past three years?



Source: HFMA survey in August of 102 hospital CFOs, with 96 responding to this question.
Note: Respondents could select more than one answer.

Having to call a patient to say, 'I'm so sorry, but we don't have your authorization here from your insurance company, so we have to reschedule your procedure, and I apologize that you've already taken PTO and arranged transportation,' that becomes a patient dissatisfier. They're not upset with their payer when that happens. They're upset with the provider."

— **Shannon King**, a longtime revenue cycle executive and a board member for HFMA's Arizona Chapter

"We continue to expand our relationship with providers through value-based care," she said. "We work with doctors, hospitals and other providers to connect our members to high-value care, with a focus on quality care and health outcomes."

It's an area where Neuwirth believes AI could one day pave the way for a new type of collaboration — a world in which providers and payers agree on the tools and algorithms that would automatically process prior authorizations and approve claim payment "in milliseconds, not days or weeks or even months." He believes that's a state that could be reached in three to five years.

In the meantime, the trust battle between providers and payers continues. And it's a situation many providers struggle to navigate.

Among respondents to the HFMA survey, three out of four believe increased transparency on the part of payers is vital to strengthening payer-provider relations. About 38% say use of AI and other tools could point to areas where payer-provider alignment around patient financial matters could be improved. And while 28% of respondents believe increased use of AI will make payer-provider relations worse, 63% say it's too early to tell.

Meanwhile, nearly 1 in 5 healthcare revenue cycle leaders say their organization's denials management processes are "not very effective" in the current environment, a Knowtion Health analysis found.[a] Among HFMA survey respondents, 75% have

a. "Race for cash: Pivoting your denials strategy for a new era," Knowtion Health, June 2024.

added more FTEs to handle insurance denials in the current environment, and 63% have added staff to follow up on accounts receivable.

CONSUMERS FEEL THE FALLOUT

Ultimately, strained relations impact consumer satisfaction — often with their healthcare providers.

Nearly 87% of CFOs surveyed by HFMA say strained payer-provider relations impact their ability to provide optimal care to patients. About three out of four believe strong payer-provider relations are vital to helping patients understand the healthcare billing process.

"Having to call a patient to say, 'I'm so sorry, but we don't have your authorization here from your insurance company, so we have to reschedule your procedure, and I apologize that you've already taken PTO and arranged transportation,' that becomes a patient dissatisfier," said Shannon King, a longtime revenue cycle executive and a board member for HFMA's Arizona Chapter. "They're not upset with their payer when that happens. They're upset with the provider. I'm constantly defusing things on my social media from friends who don't understand the industry and are frustrated with a provider when there are two parties involved — the payer and the provider."

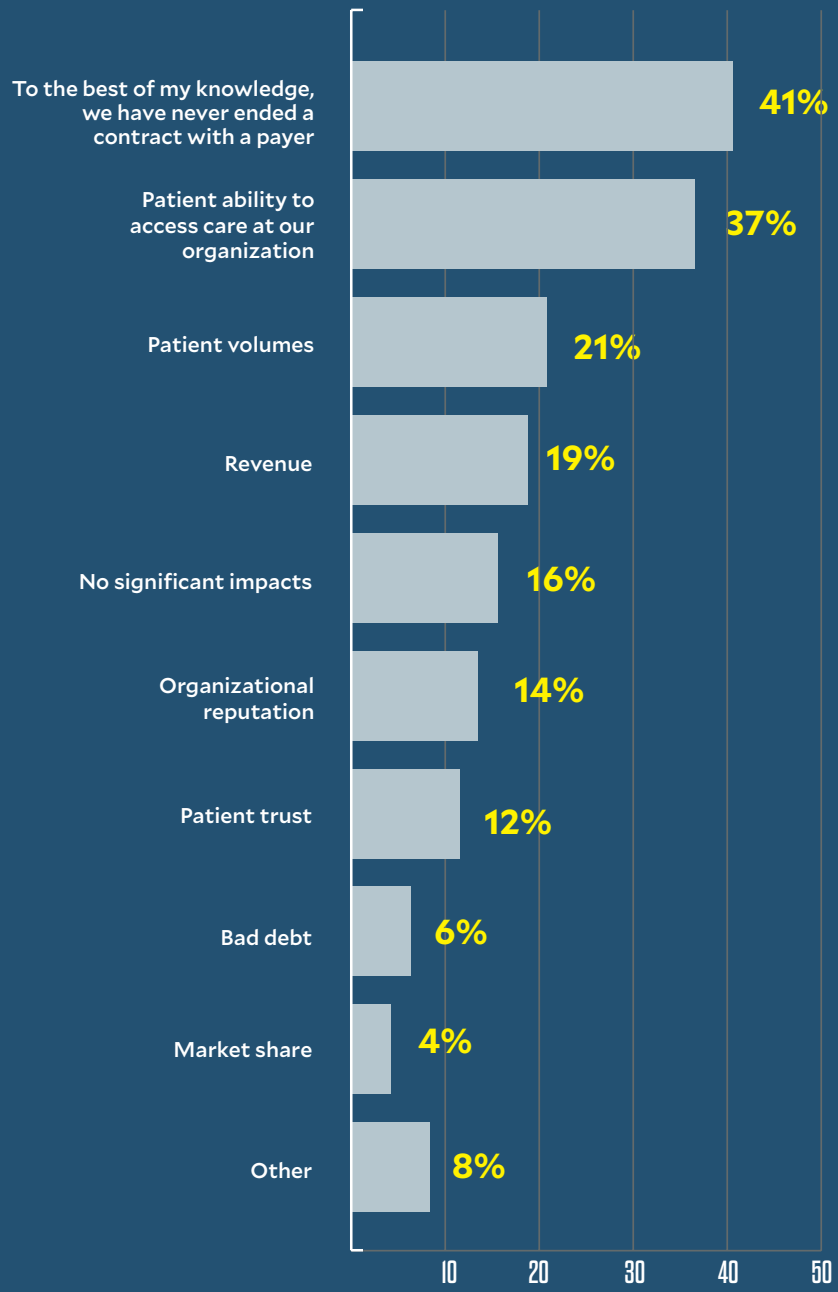
One common scenario occurs when claim payment delays or denials lead to slowdowns in delivery of a patient's explanation of benefits (EOB).

"They may have an estimate from us on what their out-of-pocket costs will be, but they won't know for certain until they get their EOB from

Diminished access tops provider concerns when contract negotiations break down

SURVEY QUESTION

Which of the following were negatively impacted if/when your organization ended a contract with a payer?



Source: HFMA survey in August of 102 hospital CFOs, with 96 responding to this question.
Note: Respondents could select more than one answer.

> **We just decided, let's get out in front of this while we still have somewhat of an opportunity to do so."**
>
> — **Melissa Wagner**, CFO, Brookings Health Systems

their carrier," said Bon Secours' Mounts. "If that carrier takes six to nine months to process a claim, it might be a year before they know their true out-of-pocket costs. By that point, a lot of times, people have forgotten they have that liability, so it feels like a surprise to them. We bear the brunt of that when it's not really our fault."

Provider satisfaction with EHR tools to help patients understand their bill is mixed: 12.5% find them "very useful," about 34% say they are "somewhat useful," and about 35% do not find them useful. Others say they don't have enough feedback to assess their value.

MEDICARE ADVANTAGE WOES

Tamie Young, vice president, revenue cycle for Stillwater Medical Center in Stillwater, Okla., was startled to discover that the Medicare Advantage plans the organization contracted with were a financial drain on the system.

"We found that we were making far less than regular Medicare rates and, in some cases, less than Medicaid rates on our Medicare Advantage plans," Young shared during an HFMA Region 9 webinar this past spring. Ultimately, the health system decided not to contract with Medicare Advantage plans in 2023. "There's a lot of unraveling you have to do, a lot of conversations when you start down this path and a lot of community education," Young said during the webinar.

She spent much of the fourth quarter of 2022 talking with residents in her rural community about their concerns, their options and how they could continue to receive care through the health system. Leaders also armed physicians and patient financial services staff with cards featuring answers to commonly asked questions so they would be prepared to respond to patients in the moment.

The health system eventually entered into a new contract with one of the Medicare Advantage plans it had let go. One quarter into the new agreement, leaders find discussions between the payer and provider are much more collaborative.

Similarly, Brookings, S.D.-based Brookings Health System leaders opted not to renew contracts with any Medicare Advantage plans, beginning in 2024, after experiencing what the health system views as preauthorization tactics used to delay or deny necessary care.

"Of the Medicare population being seen in our facilities, only 16% had Medicare Advantage," said CFO Melissa Wagner. With just three Medicare Advantage contracts in place and a low percentage of patients enrolled in these plans, plus the trends in prior authorization denials seen nationally, "We just decided, let's get out in front of this while we still have somewhat of an opportunity to do so," she said. "What was so frustrating is, it was such a small population, and we were spending enormous amounts of time on these denials."

As Brookings Health rolled out communications to community members, physicians and staff around the change, one regional health plan, Medica, came back to the health system to try to renegotiate a contract. Ultimately, Medica agreed to recognize Brookings Health's Rural Community Hospital Demonstration status in its payment model.

Today, Medica is the only Medicare Advantage plan with which Brookings Health has a contract.

"They really were trying to do the right thing for their patients," Wagner said. "I think the cancellation notice created a big red flag for them. Conversations happened pretty quickly and smoothly after that. They wanted to put our worries at ease [and] reiterate that they were doing things legitimately and fairly. From there, those conversations went as smoothly as they could have." ∎

About the author

Jeni Williams is a healthcare freelance writer and editor and a frequent contributor to *hfm*.

10 WAYS TO BUILD STRONGER PAYER-PROVIDER CONNECTIONS

Providers and health plans can establish a better baseline for a collaborative partnership

1 Assume positive intent. "I think most physicians and most hospitals and most payers want to do the right thing because they really are interested in [positive] outcomes for the member," said Chris Jagmin, deputy chief medical officer for Aetna. Often when issues arise, they stem from challenges around how to move information, he said. Jagmin said Aetna is working to ease information exchange with providers "We've essentially taken prior authorization and turned it off for more than 1,000 providers and facilities through our collaborative agreements through our value-based, common goals."

2 Be selective in determining whom to contract with. "We're letting it be acceptable that we may not contract with all payers to at least begin to put a premium on our participation," said Billie Jean Mounts, chief revenue officer with Bon Secours Mercy Health.

3 Hold monthly joint operating committee (JOC) meetings. "It's very critical to the success of your payer-provider collaboration that you host monthly JOC meetings," said Shannon King, a longtime revenue cycle executive. "Some providers do them quarterly. I don't think it's enough. … These JOC calls are an opportunity to engage your managed care team and obviously your contracted providers. These calls are not intended to problem solve. They're intended to raise awareness and anticipate that everyone's going to do their due diligence."

4 Take a hard look at how you're allocating limited staff to prevent and respond to denials. "You really need specialized teams responding to specialized types of denials," said Nicole McKinley, director of denials prevention and management for M Health Fairview. "You've got to hire coders, you've got to hire appeals nurses who are specialized in what they're doing, and you've got to be willing to pay for that support."

5 Establish value-based models with shared upside risk. "When we do better together, we win more together," said Sachin H. Jain, MD, CEO of SCAN Health Plan. "[In partnerships with shared upside risk], there's a spirit of collaboration. There's a spirit of cooperation. There's a spirit of partnership," he said. "In situations where it's really just about a rate, [we] land every year in a conversation where it's like, 'Give me more.'"

6 Look for ways to establish deeper, longer-term relationships with a larger number of entities. For example, in instances where SCAN Health Plan has established tenure arrangements with providers, with early term investments that support improved health outcomes, the health plan and providers have been able to co-design products.

"Already, the interactions are different," Jain said. One of the biggest lessons learned: "Let's not ignore the fact that trust between people makes a big difference," Jain said. "When you have people who are behaving honorably and who are thinking longer term, it creates substantial comfort that otherwise doesn't exist."

7 Communicate before there's a crisis. "Make the time, make the investment in that relationship so that there's a relationship there when that crisis happens," said Scott Dewey, chief managed care officer for PayrHealth.

8 Address the "rocks in shoes" before they become boulders of contention. "We proactively meet with our administrative simplification initiative partner on a regular basis to address the trends we're seeing, educate ourselves and work to get them resolved," said Bradley Becker, FHFMA, MHA, senior director payer strategy, Mason Health, and The Rural Collaborative, Shelton, Wash., and vice president, Rural Health Clinic Association of Washington. "Beyond this initial partner, we plan for regular meetings with other key plans."

9 Be comfortable being transparent. "Understand the leverage that a provider has in the dialogue with a payer," Mounts said. "Oftentimes, providers kind of think they're stuck, as if they're in a 'take it or leave it' type of situation. Be transparent with leadership in particular about how negotiations are going with a particular payer. It's important to have leaders' buy-in from the very beginning." You may need to terminate a relationship with a payer if a consensus can't be reached.

10 When payer-provider relationships end, create a community education plan. When Stillwater Medical pulled out of Medicare Advantage, the health system rolled out a robust community education plan that included a dedicated email and phone line, community presentations and FAQs on the health system's website.

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BRIDGING THE PAYER-PROVIDER DIVIDE

SUPPLEMENT

HFMA's report "Bridging the payer-provider divide" intended to identify ways that payers and providers work together to solve some of the problems related to delayed payment. Instead, writer Jeni Williams found how little can change without a big readjustment in attitudes by all parties involved. What follows is an analysis of Williams' report from Seth Cohen, president of Cedar, the supporter of the report.

How did we end up harming patients?

SETH COHEN

President
Cedar

Tension between providers and payers is nothing new in healthcare. What's alarming, though, is the extent to which this conflict has permeated the core of healthcare delivery.

According to the HFMA report "Bridging the payer-provider divide," 87% of healthcare CFOs believe that strained relations hinder their ability to provide optimal care to patients. Let that sink in. In an industry dedicated to healing, institutional conflicts are undermining the very mission we've sworn to serve.

Complicating matters further is the exponential growth of out-of-pocket patient responsibility. For the first time, most American private workers are enrolled in high-deductible health plans, exposing patients to the friction between providers and payers. As executives engage in a tug-of-war over rates and denials, patients are left holding the bag — or, more accurately, the bill.

An inability to negotiate sustainable reimbursement models has resulted in unsustainable patient cost share, and the consequences are profound. Medical debt remains a leading cause of personal bankruptcies in the United States. Health outcomes suffer too: Nearly half of patients report deteriorating health due to difficulty paying medical bills, and one in four adults skip care because of cost.

ACTION STEPS TO TAKE

Now that patients are directly impacted by payer friction, we should feel more compelled than ever to act with urgency. Though achieving superior payer-provider collaboration has long seemed unattainable, there are actionable steps we can take today to address this broken experience.

Integrate data to empower patients. Neil Kulkarni, vice president of customer and clinician solutions at Highmark Health, advises, "Start small." Using that approach, Highmark and the affiliated Allegheny Health Network partnered with Cedar to integrate critical health-plan data, including deductible status and HSA balances, into patient bills. The results: an 11% reduction in customer service requests, a 33% increase in HSA utilization and $17 million more in patient payments, in just one year.

Leverage AI for streamlined support. A connected bill pay experience that incorporates the payer is just the beginning. With rapid advances in AI and large language models (LLMs), integrating data from providers and payers opens up exciting new possibilities in patient support.

An LLM trained on this information could answer questions such as: "Want to know how a charge impacts your deductible?" and, "Need clarification on how coinsurance was calculated?" These queries could be addressed instantly, through a variety of ways, eliminating the back-and-forth that patients often face when seeking answers about their bills.

CONNECT THE DOTS TO IMPROVE HEALTH

These solutions and others like them represent a significant step forward for reducing payer-provider friction for patients in financial interactions, introducing a new ecosystem-targeted approach. By extending collaboration to include other stakeholders, it could open opportunities to address fundamental issues in affordability and access.

The technology exists. The opportunity is clear. What's needed is the courage to adopt innovative solutions because it's the right thing to do for patients.