UnitedHealth Group Incorporated - Division Director of Payer Strategy and Relationships at CommonSpirit Health

Interview conducted on May 25, 2023

Topics

Risk-Based Contracting, Pay-for-performance, Price Transparency, Negotiations, Cost Reduction, Healthcare Industry, Payer Plans, Hospital Systems

Summary

A Tegus Client speaks with a Division Director of Payer Strategy and Relationships at CommonSpirit Health about trends in the healthcare industry. The Director notes that Texas is catching up to other markets in terms of risk-based contracting and pay for performance deals, and that payers are using price transparency data to bring down unit costs in specific areas. They also mention the use of new business discounts, stratifying and peering membership, and the release of policies and reimbursement requirements that cut reimbursement at the hospital level. The Director believes that hospitals have an advantage in negotiations, as they are able to see the rates they are getting from payers but may not know how they compare to their competitors. The Director also notes that there may be differences in rates paid by different health plans within a faith-based system, depending on the dynamics of the relationship.

Expert Details

Division Director of Payer Strategy and Relationships at CommonSpirit Health. The expert can provide insight into their experience negotiating contracts on commercial rates with managed care in their role as the Division Director of Payer Strategy and Relationships at CommonSpirit Health.

The expert is the Division Director of Payer Strategy and Relationships at CommonSpirit Health. CommonSpirit Health delivers clinical excellence across a system of 140 hospitals and more than 1,000 care sites in 21 states. The Payer Strategy & Relationships (PSR) team is responsible to create innovative and transformative market and payer strategies, relationships and agreements that drive the future of CommonSpirit Health by optimizing revenue and increasing the number of people they serve.

The expert is also the Strategic and Legal Consultant for Healthcare Organizations at Bastion Health Consulting. Bastion Health Consulting is a consulting practice that provides strategic, legal, and operational guidance to healthcare organizations, including startups, providers, and payers. The expert's clients span the healthcare ecosystem, including provider data, mental health, health equity, and predictive AI. The expert's areas of expertise include managed care, contract negotiation, provider network development, regulatory counseling, and partnership management.

Prior, the expert was the former Vice President of National Accounts at Garner Health, leaving this role in 05/2022. In this role, the expert was responsible for owning and managing the relationship between Garner and its largest (by both size and revenue) employer clients and key brokers.

Prior, the expert was the former Marker Director for the West Region at Oscar Health, leaving this role in 08/2021 after 5 years of experience with the company. In this role, the expert was responsible for the development, execution, and management of Oscar's overall business initiatives and operations in the West Region (encompassing California, Arizona, and Colorado markets).

Q: (Payer Contracting Execs @ Providers) Can you speak to any new innovative strategies which national managed care plans are using to obtain better unit cost discounts from providers?
A: Yes, I can speak to this.

Q: (Payer Contracting Execs @ Providers) Do you see plans having different priorities on where they want the greatest discounts (e.g. inpatient vs. outpatient, pharmacy vs. CPT code etc) or do they tend to focus on the overall discount?
A: Yes, I can speak to this.

Q: (Payer Contracting Execs @ Providers) Do you see providers having different priorities in terms of where they are willing to “give and take” on discounts across service lines, regions etc?
A: Yes, and I can speak to this.

Q: (Payer Contracting Execs @ Providers) Are you familiar with Cigna’s strategy of optimizing unit cost/discounts market by market that they have discussed with investors?
A: No, I am less familiar with Cigna.

Tegus Client
Hello. Thanks for speaking with me. I am trying to understand what new sorts of strategies the big nationals, so Cigna, United, Elevance, Anthem and CVS are deploying in their contracting negotiations with big provider systems. Any new priorities, any changes in strategy.

Generally, what I’m hearing from the marketplace is that they think they're doing things that are going to be allowing them to drive down or improve their unit price discount position. So that's kind of the scope of what I wanted to cover with you in this discussion. If there's anything I should know about your role and also specifically around sort of geographic coverage, service line coverage. Just what's the sort of basis of experience on which you're going to be commenting? That would be great.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
So my entire career has been in the payer-provider space. My background actually is an attorney. But also, I've been on the business side. I've been pretty fortunate to get perspectives on both the payer side and the provider side since I've worked at large hospital systems, including where I am currently, as well as exchange plans, government-based plans both as a legal department and in-house counsel as well as heading up the P&L and the market division, payer strategy type of roles.

I'm currently overseeing Texas markets so I have insight into that. But in my prior roles and geographies, I've overseen Southern California as well as New York City hospital systems as well. So payer side, provider side, legal side, business side in New York, California and Texas. I guess you don't get much bigger than those three states. My role really on the legal side was negotiating the deals. So I was negotiating either the payer side contracts with the hospital systems or vice versa. And on the finance side, served as the main point of contact and the negotiation lead with the payers in the partnerships or P&L format.

Tegus Client
And this was just hospital side. Did you do physician groups, too?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Not as much. Earlier on in my career, when I was outside counsel, I did work with IPAs, multi-specialty groups, those types of smaller physician groups. And we did represent those types of physician enterprises as well. And the line of business scope is commercial exchange, MA, Medicaid, et cetera.

Tegus Client
Would your scope include anything to do with pharmacy? I mean, to the extent that hospital systems had their own pharmacy dispensing or used drugs as part of their service delivery. Did you have any insight into that? Or was it purely based on sort of the classic kind of DRGs and CPT codes?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. It was more on the medical side, less in terms of the pharmacy work. When I was in outset of plan, I did help with the PBM contract that they put in place, but we had a specific team that was looking closely at the formularies and how you establish those and whether you took a standard one or just have to create your own.

Tegus Client
So your observations over the last 18, 24 months, what has changed in how the big four nationals as far as you've seen, and I guess, this would be primarily stepping up the Texas market? Do you have full exposure to the big four in there? Is Elevance relevant at all or is that all HCSC?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I worked specifically more with on the Aetna and United side, some of the exchange side. So those are the plans that I know the best.

Tegus Client
So what are you seeing in terms of last 18, 24 months? Are they doing anything differently in how they're approaching provider systems, working with any new priorities that you're seeing, new types of terms, new bundles? Tell me what you're seeing.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes and what's interesting about Texas versus New York and California as an experience is that it's a relatively more straightforward market, let me put it that way. We've seen a lot of risk-based contracting. We've seen a lot more full risk capitation, things like that in California and New York. But Texas is a bit more behind, I think, in terms of moving towards that type of modeling in terms of driving unit discounts based on risk-based contracting.

So we're seeing more and more, I think, in the Texas market, sort of the base that's where being taken, especially with regard to pay for performance type deals whereas I'm sure you know, the discounts on the front end are seemingly offset as well as the hospital systems deliver and the physician groups deliver on the performance metrics that are established between the parties.

So I think one area where Texas is starting to evolve and really grow more quickly and catch up, for a lack of better term, to other sophisticated markets is in the area of risk-based contracting. And I don't think that's anything that's necessarily innovative or new in the national level, but I know for the Texas market, it's something that is being introduced more and more.

Another area where I see a lot more, I think, sophistication and a lot more nuance being built into how the payers are providing the hospital, pushing the hospital is with the price transparency data is coming through. I know on the hospital side, we're using a lot more consulting firepower and a lot more bandwidth and resources are being put toward understanding where the unit costs are landing vis-a-vis other competitors in the market, for example, or even within the payer mix that the hospital system has.

And I know the payers themselves looking at saying, hey, based on the rates that we're seeing nationally, based on what we're seeing in the market and based on the rates we're seeing with competitors, we think there is actually, for instance, based on a percentage of Medicare, a much higher reimbursement than we'd expect to see in this submarket or at this facility.

And they're taking a much more granular approach as sort of an overall trend approach to try and bring down unit costs in specific areas and to really help understand on their level where they can get discounts or where they're overpaying, for lack of a better term, in certain areas.

I know that one area where I've seen a lot of focus is moving dollars out of inpatient. I feel like this is very nuanced and based on the historical context. So in certain markets where a hospital system was the major dominant player, and they were able to demand higher rates on the inpatient side, for example, or if you had a specialty hospital that was best-in-class in terms of cardiology or oncology, they may have been able to

demand higher rates.

But now that we have centers of excellence that plans are starting to establish and allowing for more freedom of movement and more availability of centers of excellence, that allows more flexibility for their membership to move between either different hospital systems or even different states.

I think it allows them to have more leverage and saying, okay, we're not going to give you necessarily all the volume that you may have expected or if you want to drive volume to your hospital, we're going to designate you as a center of excellence, but we need cheaper rates because of volume or other options that are available, either locally or nationally.

So one thing I have seen that's kind of interesting is with these centers of excellence, historically, the factors that have been taken into account are, do you have enough volume for this specific service? And what are your outcomes? What are your readmission rates? How are your physicians performing? How satisfied are the patients?

One of the new factors that I've seen that has been introduced more and more is something called the cost efficiency factor. It's not even related to the quality of the care necessarily, but the cost itself is being factored into the determination of whether a facility would be considered a center of excellence, for example.

And obviously, the loss of the center of excellence designation is something that is not only hurtful to the reputation of the hospital itself but also has an impact on the accessibility of members and patients to that facility. So that's one way I've seen that plans have creatively, if you want to put it that way, used different tools to get better unit costs.

Two more areas I'll just bring up quickly. One is we're seeing plans. And I mean, I don't think this is necessarily new or innovative but we're seeing this more and more, plans seeking to get what they call new business discounts. So even if there's an established commercial rate that's been negotiated between the parties, if there is a new employer group that they bring on or something like that, and they're able to drive that membership to a hospital system.

Any new business that's brought in, we've seen percent discounts, for example, or discounted rate being applied to commercial rates for that particular book of business. So they're starting to stratify and peer the membership itself and the rates are reimbursable to hospital systems.

And then the last one that I'll bring up and this is less of a, I think, an innovative strategy, but it's a strategy or a tactic that's used is you can work over the course of months, even years to negotiate a managed care deal with the payer. And it's based on modeling, it's based on volume assumptions, it's based on all of these different factors.

And then based on the structure of the contract, some payers have the ability to release policies and to release reimbursement requirements that on the back end, basically, cut out at the knees the reimbursement that's modeled into the overall negotiation. So it's not necessarily a unit cost reduction that happens at the front end in the negotiation, but it's something that plans due to enable them to cut down their costs at a macro level with a large sort of sweeping reimbursement or operational change on the back end.

Tegus Client

Can you help me understand that? It sounds to me like what you're describing is a UM tool, like prior auth the heck out of stuff and just stop stuff that you as the provider would have anticipated happening with a given patient population. That particular type of payer just disappears. They site of service that stuff away or they prior auth it so it doesn't happen. Is that sort of what you're saying is happening there?

Division Director of Payer Strategy and Relationships at CommonSpirit Health

Yes. So for example, you have a particular service that you've negotiated at a certain rate, and there has been historical volume of that service. And then the payer releases a policy set for that particular service, patients or the membership is limited, has gone from an unlimited number of visits for that service in a year

to pen without the need for further authorization, for example.

So in fact, happening as the hospital says, okay, we're going to accept this service at this rate because we're used to seeing this volume. Now the payer has cut the log of that at half. Thus, the hospital reimbursement for that service is cut in half over the course of the life of the agreement. And the cost to the payer is much lower because they're restricting access to that particular service. So it's not that the service reimbursement went from $100 to $50. But the net realized at the hospital level is much lower.

Tegus Client
Do you happen to have like an example or two of specific services where that sort of thing has happened?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I think therapies are a really good example for that, whether it's PT, OT, ST. I think other examples are sort of where imaging can be done or must be done or whether certain procedures.

Tegus Client
Site of service?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, site of service type of things. So they may say in order to get coverage, you must go to an outpatient version of imaging, for example, versus facility-based, which I don't necessarily think that hospitals will agree. I don't think that hospitals necessarily disagree that, that's a bad thing. But if the modeling and the negotiation stuff is based on certain volume expectations, then that can obviously impact the overall value of the deal.

Tegus Client
Are you seeing the reverse at all of that? So thank you, this is a great list. I really appreciate it. Just on that last one, are you seeing the reverse of that at all? What I'm wondering about is understandings and gold cards out of particular types of prior auth policies, site of service policies, things along those lines in return for better rates? Is that sort of happening as well?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, absolutely. One of the biggest headaches where I think payers and providers like is the auth process, for example, as all the UM hoops that need to be jumped through. And I know that there is an effort on the part of payers and providers to just gold card certain services and allow them to flow through without any authorization or maybe they'll have capture limits. But before that, you don't need to sort of go through the process.

Obviously, I think it's one that takes into account a lot of different variables in terms of person power hours' time, but I'd be naive to think that it wasn't a cost-neutral or cost-beneficial impact to the payers as well to put stuff like that in place. I think the more optimistic, less cynical side of me wants to believe that it's creating efficiency and ease in the health care system, but obviously, it's not going to be done on either side if it comes at a sort of meaningfully negative financial impact. So I have seen gold carding come through more and more. And obviously, it's for, I think, things like therapies or other relatively less high-cost higher frequency type of service loans.

Tegus Client
I'm just curious on the specialty pharma side, that's something where there has been a fair amount of attention recently to try to shift site of service out of the hospital outpatient department. Is that something you would see or is that something that you would not see? Because that typically, I think, can be done on the medical benefit side, so maybe within scope, if you like, infusions or something like that? Or is that not what you would typically see as part of your scope?

Division Director of Payer Strategy and Relationships at CommonSpirit Health

Yes. I think personally, yes, the negotiations themselves do include things like infusion, high-cost drugs and other items that are not necessarily formulary-related but do have impact in that area.

Tegus Client
Are you seeing gold carding along those lines? Do you have visibility into increasing intensity on the part of the big nationals to shift the site of service infusions out of a hospital outpatient department? Is that a trend that you've seen?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Not that I've personally seen. I wouldn't be surprised because obviously, the facility components and the different costs are higher there, but I haven't seen it yet on my side.

Tegus Client
Let me ask you this, have you seen increasing gold carding specifically around the infusions and the high-cost therapies or that being increasingly part of the offer being put on the table? Or is it really more constrained to the PT, OT, more, shall we say, high-volume, low-price tag types of services in therapies?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I haven't seen it myself personally, at least in the Texas market.

Tegus Client
So let me just go back a little bit, actually, all the way up to the top if we can. So it sounds like you're seeing, as part of the Texas catch-up, increasing shift towards risk-based contracting. And what you described was a very simple structure of a pay for performance deal.

Hey, give us lower unit costs, we're going to basically take money out of the unit pricing, and we're going to throw that and more money into a performance-based model. So if you deliver on the performance, you're going to get more on the back end. But if you don't, but upfront, we're getting a lower kind of unit cost. Did I hear you right on that?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. I think that is correct. That was the fundamental theory behind it all. And from a payer side, obviously, they have much more visibility into the overall health economics of their membership. And even if we're not talking just one-for-one, you increase PCP visits or decrease readmission rates, it will give you a certain percentage.

On the back end, obviously, that stays meaningfully downstream with more acute, more higher-level care that they're avoiding. So even if they're giving back percentage points, they're still realizing savings. But it's a win-win, I think, in a lot of ways, including for patients.

Tegus Client
Yes. And it sounds like you're seeing more and more of. Could you just give a sense of the ranges of what that looks like? Is it like give us an extra like 0.5% or 2% less upfront and will sort of make a pay performance bonus that's 1.5x, whatever you would? Is there a way you could kind of give a sense of the orders of magnitude of what these arrangements typically look like and how they change from just a straight sort of fee-for-service deal? Or is that kind of hard to do?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, I think it's easier to give you a sense of the upside that's offered in terms of how that sits into the overall trend impact on a negotiation for example. It's so nuanced and so variable. In terms of upside, I'd say the low single-digit percentages is often where conversations start and move up from there in terms of realized upside from an overall revenue perspective.

So the way that many of these are structured is that there are various metrics. The various metrics have

targets. The targets have points associated with them. And some of your points is either linearly or some other way connected to the amount of that or the percentage of that upside percentage you're able to realize. So if you have a deal in place and you have a target of 100% across 20 metrics and you hit 50%, then you get 50% of whatever the agreed-upon upside is. That's just very basic. I don't think that's a confidential or proprietary thing.

Tegus Client
And then I as a payer perspective, if I can just kind of draw that out, if the bonus is, say, the prospective bonus at 100% all margins is like $100, I'm going to want a piece of that $100 taken out as incremental discount kind of in the fee-for-service.

And so I guess my question is, could I kind of assume a range here, like common industry practice, is like half of that is like $50 kind of like peanut butter sort of taken out an incremental discount along the way? Is it $100? Is it $20? Like how much gets sort of taken out in kind of incremental discount in return for a bonus of $100?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, I don't think they're necessarily aligned 100%. So making up a number here, like if the value of the upside deal is $10 million if that's something that you're able to realize if you had 100% of your metrics, are they looking to pull $10 million out of the commercial deal? I don't think it necessarily works that way.

And the reason I say that is from a hospital perspective, they're looking for upward increases and that can be based on 50 different factors. It can be based on areas that they want to grow their business. It can be based on historically low rates in a market that have not been realized. It can be based on whether they're the only player for certain specialty or they're a dominant hospitals, the way that they try and get increases is they try to be reasonable but they try and get as much money as they can here and there. And so I don't think there's necessarily a direct correlation between the two in terms of you take $10 million out here, we put $10 million back in the PRP, for example. I think they're related but they're not necessarily linked at the hip.

Tegus Client
You're saying don't try and simplify it? There is, in effect, something that looks like an incremental discount on the side, but it's going to be so linked with a variety of other strategic factors on the payer side and on the provider side that it's really hard for you to say, like $10 million, $5 million of that will like roll into incremental discount. It just doesn't really work that way and I get that.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, I think it's much more nuanced than that. I would say maybe at like P4P is something that plans are making available from 150 hospital systems down to a 15-person medical group. So the sophistication and the nuance in the negotiation varies widely, such that a plan may say, “Hey, yes, we're giving you a 10% discount, or we'll ask for a 10% discount on your rates, 15-person multispecialty group in Omaha”.

But you can make back 20%, but in order to make back that 20%, you need to give us a 10% and there's a direct line there between those two. But once you get larger and more complicated in terms of the service lines and things like that, I don't think it's as easy to draw a linear correlation between the two.

Tegus Client
I've heard a lot of bad reviews of the quality of the transparency data. And people essentially say, it's garbage in, garbage out. You're describing though, if I'm hearing you right, somehow the big nationals make sense of this information and using it in a fairly clear strategic way, working their way down to particular sort of red zones where they think that there's some real contracting opportunity and making a pretty good case for that. Help me to connect those two dots.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I agree that the transparency data that's been put out there, basically, payers and providers have been

somewhat forced or strong-armed to put information out that they don't want to. And they've either done this via doing it in an opaque way that sort of meets the minimum letter of the law but not the spirit of it, or they provide so much information that it's completely overwhelming and it's hard to make heads or tails of what's out there.

So I agree overall with the sentiment that transparency data is really not as useful as I think the creators of that initiative have hoped. However, I do think it's still better than nothing. And I do think payers have an advantage in that they are able to see across their entire network the rates that they're paying.

And so especially in markets where you have multiple systems that are competing against each other, where they talk on that. L.A., for instance, it's not dominated necessarily by one HCA or Tenet or Ascension or something like that or a Cleveland Clinic. And so payers are able, I think, to leverage data about rates and unit cost in a way that hospital systems can't.

We may have a sense from the transparency data and there's a lot of different organizations, startups, whatever, clearinghouses that are taking this data and trying to make head and tails of it and package it and sell it. And they're making money doing so. I think the high-level point is, yes, it's not as good as I think everyone hoped it would be, but it is better than nothing. And you have more organizations internally and departments internally and organizations externally that are taking that and trying to derive insights.

Whether they're sort of surgical and precise, that's a different question, but at least directionally or relatively they're able to show where hospital systems sit against each other. And so I think that's where a lot of the value of the transparency data is coming from, even though it's still opaque, I think, in a way that is not ideal.

Tegus Client
On the whole, do you think the transparency information helps payers give them more leverage or hospital systems? I mean, I have a view but what is your thought? Who's got the leg up with this?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I think it's probably the hospitals actually.

Tegus Client
Really? That's not what I was expecting.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. And I'm thinking through this sort of before I'm responding. Hospitals, I think, really, they have visibility, obviously, to the rates that they're able to get from the payers themselves. So hospital system enters a contract with LUCA for example. But I don't think they necessarily know, relative to their competitors in the market, how they are getting paid.

They may have a sense like I said, they may know that hospital system A is the premier hospital in the market, and they demand higher rates but they may not know directionally by how much. And so like I mentioned, the payers themselves can see the rates that they're paying and obviously, they're getting more insight from this data.

But I think hospitals, especially ones that are less sophisticated, haven't really had or less leverage in the market in terms of the negotiating power, may not have had a sense of where they sat or how far behind they were or what they might be able to demand. And so I think that's kind of why I responded in that way.

Tegus Client
And so my counter to you is to say the big nationals, in particular, have more resources to come through, analyze and make sense of the data to find those red zone sort of opportunity areas, outliers and focus attention around them, whereas hospital systems typically end, maybe the one that you're at is sort of at a different scale.

So maybe there's an equality level there if you have that kind of centralized. But hospitals specifically, first off, they're burdened with all kinds of other stuff going on right now. And so it's not like they have a lot of dollars to throw people at this problem and generally are not in a great position to ingest that kind of data. And therefore, the advantage, in my view, on this story would lead you to say that the advantage accrues to the payer and that, so.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. And I do think to a large.

Tegus Client
In your experience, what you're saying is the implication of what you're saying is when you sat down with United or CVS or whoever, it's been more often that you've taken the transparency data and been able to argue for improvements in your rate position, then they've taken the transparency data and come in and said, “Hey, you need to come to terms better in this market or that market.” Has that been your experience?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
So I think that it's actually allowed me to be more sophisticated and nuanced and educated in the negotiation from the hospital side. Because historically, we've been able to say, hey, we we've gotten a COLA escalator over the past three years, 3%, 4%, 5%, whatever the number is, and we want to build off of that.

But I think a good analogy is if you're working in a company and you're getting paid a certain salary, you expect a few percentage points, maybe high single digits, whatever, raised each year. But if I am now at that company able to see that the person sitting next to me with the same job, all doing the same amount of work, actually, their base salary is 20% higher than mine, then I'm going to go in and say, I want 20% plus the 8%. Because now I have better insight into what they're getting reimbursed if you want to put it that way.

Tegus Client
No, I totally get that logic. And what you're saying is with the intermediaries' vendors or because your institution has the analytical resources, you're able to bring that kind of information to bear. And when you've made that argument to the Uniteds, CVSs, Blues, what have you, they basically said, you know what, more or less you're right. This isn't just totally garbage data. They're saying, yes, you see the same thing, and all right, we will have a conversation.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, absolutely. And the information is over there.

Tegus Client
I guess I'm wondering in most markets, are you more of, shall we say, the lower cost provider? Or are you the, shall we say, premium provider? Because if you're historically kind of more at the lower cost end, then I tend to think religiously affiliated systems as more kind of safety net, as more kind of historically having lower rates, then that would tend to advantage you. Am I thinking about that the right way?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, I think that's a fair general statement where you're right, the hospitals, whether they're faith-based or they're nonprofit or they're city hospitals tend to be the ones that are like take on disproportionate shares of Medicaid, uninsured share.

Tegus Client
There are some nonprofit hospitals that do very well, I'm thinking. Maybe not in the Texas market, I don't know, but you know the ones in California. I just need to look up at Sutter and like some of those quasi-academic ones in New York.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, that is definitely a separate conversation but you know what I mean, like generally speaking.

Tegus Client
But it sounds like you are also seeing, if I can just ask, experiences where some of these health plans are coming to you and saying, you know what, in this particular zone, you're taking rates from our competitors that are substantially higher. We need to get this more in line. That is a scenario that you've seen play out?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Taking rates from competitors that are higher.

Tegus Client
Well, what I mean is like, okay, health plan X is coming to you and saying, from the transparency data, we know that health plan Y and Z, you're accepting rates that are like 2% or 3% or 5% less than ours. We need to get more in line. In this particular market, for this particular service line, you are seeing payers come to you with those kinds of observations that are correct. Does that scenario happen as well?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I'd say as my experience has been less that they come to me and say, hey, we're paying this. This we see that payer X is paying you less. My experience has more been along the line that, hey, we have contracts with five different hospitals within your market, your competitors basically. And the rate that we are paying those competitors is X percent less than what we're paying you. We can't give you a raise there.

I haven't seen them use the transparency data in that way yet. Whether they're doing it behind the scenes, that's a different question. I haven't had somebody explicitly come to me and say, we know your Blue Cross rates, for example, are 10% lower than ours. We need a discount. They haven't pulled that lever yet.

Tegus Client
Let me ask you a question then if I can and extrapolating as general as you want to you feel comfortable responding to. Are there markets where there are for, shall we say, the generic faith-based system will be, from historical legacy reasons, substantial differences that if those plans were to look at that information, they would see some outlier areas? Or is it, as a general rule, like among the larger sort of faith-based systems, that there's relative consistency across the health plans?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I would doubt that you'd find consistency. And the reason I say that is a lot of it is based on the market dynamic. So if the faith-based system is driven by historically someone that's extremely business-minded and entrepreneurial versus someone that's more sort of mission this very sort of kindly versus someone who is less about care, then you have much better rates there or if you're in a market where the faith-based happens to be the system in the market. So, yes?

Tegus Client
My question is a little different though. My question is a little different. Would we expect to see situations where in a particular market in a faith-based system health plan X paying a lot more than health plan Y? Does that scenario happen?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. It's based on the dynamics of the relationship.

Tegus Client
Because I mean you were talking about it a little later in your inventory if there are COE relationships or if there are specific employer, like, rates, things like that, there may have been historical strategic partnerships that have resulted in better rates that the other health plans may have now had a chance to

see with the transparency information and wonder why that's happened.

So let's talk about the new business discounts. I'm intrigued with a couple of these things, but I want to just probe on that. Is that something that's new? I mean, like really new, like last 18, 24 months new? Or it's always been there, you're just starting to see more of it?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I think it's been around for a while. I wouldn't say it's like necessarily a new and innovative strategy that they're trying to do. I think it's something that has been in the pockets of plans to talk about and be like, “Hey, okay, you know you got some rates but we really want to continue to drive volume to you if we bring in some new patients to your system. We want to make sure that we're able to realize some sort of discount from that.” So I think it's not new but we've seen them.

Tegus Client
Yes. The implication of what you're saying with both the new business discounts and in some sense with the COEs is that plans are getting more aggressive with networks or steerage within networks. Is that what you're seeing?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I think that's definitely true.

Tegus Client
How are they doing that? Is that just a pure network thing in a sense that you're part of some like super-narrow EPO? Or are they having a relatively open network and they're just being more aggressive? Are there tools sort of behind the scenes for which they're doing the steerage or is it all built in either the network or preferred co-pays, things like that?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I think it's both, and I think there's multiple strategies that are being deployed. Whether it's a very narrow network at a very discounted rate or it's, hey, on the UM side, we have three different hospitals that understand internally. And that's why on a sophisticated or leveraged strong physician hospital, they're going to push contract language that says there's no tiering, there's no steerage, like patients who have mostly and you will recommend that our hospital just as equally as any other hospitals in your network. But not all hospitals have the leverage or the sophistication to push that language into their contracts, so yes.

Tegus Client
So if that language is in place, then presumably the sort of behind-the-scenes steerage isn't happening and then it all has to be kind of upfront narrow network kind of a deal. Is that right?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. And I think the word presumably is a good one because the enforceability of things like that, how do you prove? But at least it's better than nothing in terms of having language in the agreement.

Tegus Client
Yes. I mean, I just wonder if there aren't like things that you're doing on the primary care side. So for example, I don't know, do you overlap at all in your market with WellMed or other sort of Optum Care provider groups?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
We do, but I don't specifically work on that relationship so I'm not as familiar with how those are operating.

Tegus Client
Totally get that but that would be a model conceivably. I'm not saying United does this. You're not saying

United does it, but that will be a model where there are policies put in place within the primary care group just basically favor hospital X over hospital Y. Wherever Optum Care, for example, sets up SLAs and has preferred relationships, their own preferred referral relationships and they have nothing to do with the United kind of network.

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes, potentially.

Tegus Client
These contracts, are they typically sort of like three-year terms? What's the term on the rate contracts with payers?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
I think a two- to three-year term is pretty standard. I don't think you really see anything beyond three. They have some preference.

Tegus Client
And typically, hospital systems are really kind of like suffering economically right now with all the cost pressures, operating costs, salary costs, et cetera and so forth. Are you guys trying to reopen contracts early and is that happening? Or is that not really happening? Payers are saying, “Contract lasts until that date and then we'll start talking.”?

Division Director of Payer Strategy and Relationships at CommonSpirit Health
Yes. So I don't think that happens and I think that's for a couple of reasons. One is it's much more disruptive to the hospital systems financials let me start with this. The strongest lever that a hospital system has in a contract is a termination cost. And whether or not a hospital system is willing to pull that lever is a big question to ask because if you want to go back to a payer and say, “Give us more money,” they're going to say, no, wait or why. And then you'll say, “Okay, well, if you don't give us more money, we're going to term and force us to get to the table.” But obviously, for all the reasons that you mentioned, financial pressures, disruption to the membership, et cetera, bad press, it's a very difficult lever to pull.

Tegus Client
Fantastic, you've been really great. Thank you so much for your time.