# A Model for Value-Based Provider/Payer Partnerships

With the recent spotlight on accountable care, payer and provider organizations are seeing an opportunity to collaborate to drive down medical cost trend and increase their commercial market share through lower premiums. Providers are creating integrated health care partnerships with payer organizations to align financial incentives, focus on improving outcomes and reduce redundancies. In an eight-month period between 2011 and 2012, the market saw a 38 percent increase in ACOs with hospitals, payers and physician groups.[1] And 43 percent of organizations that are or plan to be part of an ACO will utilize a commercial shared savings model rather than a Medicare ACO or Medicare Shared Savings model.[2]

Forward-thinking organizations can develop a strategic approach to accountable care by identifying unique partnerships. According to a 2012 Optum study,[3] hospitals and physician groups are the most likely ACO partners, but other organizations, including payers, skilled nursing facilities and long-term care facilities, are becoming involved as well (see Figure 1).

The purpose of this paper is to outline the key actions required to drive successful accountable care:

- Build a *governance structure* that will operationalize decision-making, leadership and accountability

- *Engage and align physicians* for stronger partnership

- Manage *clinical and financial risk* to identify and measure probabilities and outcomes

- Enable physicians to make better decisions through *measuring clinical performance*

- Help providers *clinically integrate* to work better together

- Focus on *population management* to avoid costly outcomes and empower consumers

- Invest in *information technology* to connect and strengthen the delivery system

**Figure 1. Physicians and Hospitals Most Common ACO Partners; Other Partnerships Less Common**

*Q: Which groups or organizations are participating in the ACO you have joined or will join?*
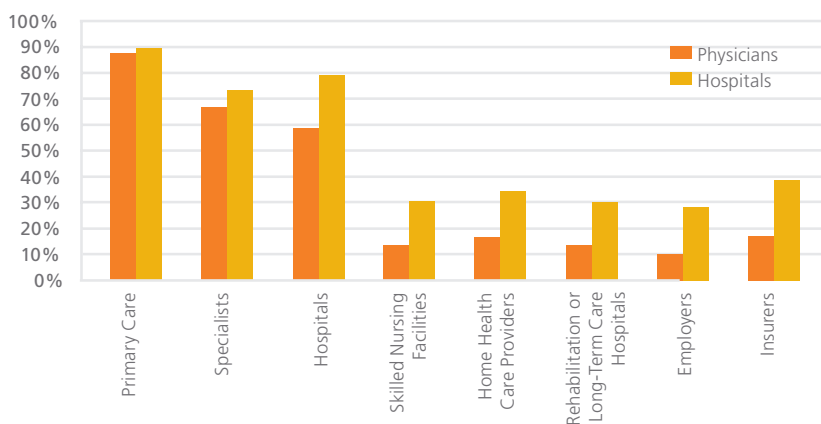
## Governance Structure

*Accountability and cross-organizational alignment are key components*

Today's health care market in the United States is a jumble of fragmented and siloed services where each stakeholder makes decisions to support its organizational needs instead of the needs of the overall population. The US health care system has been built out of a reimbursement model that does not reward for coordination across the continuum but for providing a volume of services. As payer-provider integration accelerates, governance and organization models must build in accountability for providing "integrated" care—high quality at a lower cost.

Internally, a governance structure that involves all partners is critical; strong governance that fosters financial and clinical accountability will lead to long-term stability and success. To drive overall strategic direction and accountability, a governance model that establishes an executive leadership team, an operational leadership team, a project management team and a physician leadership team is required. In addition, offices of clinical transformation, physician alignment, marketing and member engagement, analytics, technology and finance will be responsible for the delivery of the expected results. We utilize the term "office" to instill a sense of structure.

The executive leadership team is responsible for managing the venture's overall direction. If the ACO is made up of separate organizations, leadership from both the payer and provider organization is required to ensure collaboration and alignment of goals and decision-making. If the ACO is a single-provider organization, leadership should be composed of executives across organizational functions. Regardless of the ACO make-up, the executive team serves to define the guiding principles that align the partners to deliver on the defined clinical and financial goals.

The operational leadership team is comprised of senior-level leaders who have the authority and accountability to make and implement changes to day-to-day operations. These operational changes can include clinical, financial and support functions, including population management, network management and technology, but do not include changes to the provider clinical practice.

The physician leadership team, reporting directly to operational leadership, consists of key community physicians who act as evangelists to all physicians and clinicians for the partnership while fostering future success. The team should consist of PCPs, specialists and hospitalists who work in different settings and practices, offering a comprehensive perspective of the care delivery system's opportunities and challenges.

It is critical that members of all leadership teams share the same vision of making health care more affordable, incentivizing quality rather than quantity and changing the care delivery model. A cohesive and consistent message among the partners' leaders establishes and emphasizes the importance of the partnership's mission and vision.

An ACO Project Management Office (PMO) has a place in the ACO's leadership hierarchy and reports to operational leadership. The strategic importance of the PMO should not be overlooked; it coordinates and communicates across all functional offices. PMO team members work with subject matter experts to identify initiatives that meet overall partnership goals. The PMO manages scope, implements changes and measures success. It is accountable to the executive team and operational team and is responsible for reporting projected and actual budgets and financial performance.

The following key functional offices should be driven by tactical teams that report to the operational leadership team:

- **Office of Finance** is accountable to the board and the senior operational team for the development and approval of the shared-risk contracts and cost reduction measurements. (Cost reduction measurements should be validated by actuarial experts to ensure understanding of medical trend impacts.)

- **Office of Clinical Transformation** aligns with the physician leadership team and is responsible for identifying and delivering clinical savings opportunities, including practice redesign, hospital service line design, population health management and continuity of care. This office must be led by clinical experts, including physicians, nurses, care managers, behavioral specialists and social workers.

- **Office of Marketing and Member Engagement** is accountable for the cross-organizational marketing strategies for member enrollment and engagement and for product and benefit design.

- **Office of Analytics** mainly supports the clinical transformation initiatives in developing information to evaluate opportunities, validate saving targets and measure the results for each initiative.

- **Office of Technology** is responsible for driving the overall IT strategy to leverage current systems and capital investment, while ensuring information sharing across the continuum of care.

- **Office of Physician Alignment** works closely with the physician leadership team and is accountable for engaging with the entire network to communicate upcoming changes, educate on new policies and obtain feedback on progress/challenges.


## Engage and Align Physicians

*Utilization improvement is only possible when physicians are aligned with the ACO*

Physician engagement is essential for turning paper savings into actual savings. While organizations can contract to get better unit cost pricing, taking on risk is a useless effort until care delivery and utilization patterns change. To engage physicians, consider the following practices:

1. *Engage physicians early to listen to concerns*—Engaging physicians early in the move toward accountable care to listen to their issues and barriers will help the ACO organization address the challenges proactively.

2. *Identify physician champions*—Physicians that can act as trusted change leaders need to be identified early and selected carefully. Physician leaders should be involved in every aspect of clinical transformation and ultimately champion the transformation to the larger provider community.

3. *Support transparency and peer discussions*—The design and review of physician reporting, practice variation and care redesign must be driven by practicing physicians in the ACO with support from health plan medical directors. Physician-to-physician feedback is key to effecting long-term change in practice patterns.

4. *Involve physicians in monitoring cost savings*—Provide physicians with information on opportunities for savings and the positive impact to their revenues and outcomes.

## Manage Clinical and Financial Risk

*Upside and downside risk should be part and parcel of ACO financial arrangements*

Most provider organizations today are not built to manage risk. In many of the current fragmented payment models, physicians continue to be reimbursed on a fee-for-service (FFS) basis, although there may be some pay-for-performance (P4P) stipend attached. FFS reimbursement encourages volume-based care and discourages care coordination and cost reduction. Even the P4P models, while sometimes based on quality, do not focus on efficient and effective use of resources or evidence-based medicine to drive cost reductions.

Fee-for-value, on the other hand, takes costs out of the system through improved utilization. To incentivize decreased utilization, providers take on a level of risk based on their ability to impact outcomes. The essence of a payer-provider approach is to create interdependence between the partners so that each organization has a vested interest in reducing costs—instead of the old model of shifting costs or maximizing revenues.

An upside and downside (profit and loss, respectively) risk-sharing financial model is a key driver of success for an ACO partnership. ACO models at the Centers for Medicare & Medicaid Services (CMS) have upside as well as downside risk on a defined population, capping both downside and upside savings based on a predefined cost-of-health-care baseline.

According to the 2012 Optum study,[3] few providers feel prepared to take on financial risk (see Figure 2). Providers can prepare for risk by developing competencies in clinical performance management, clinical integration and population management, as outlined in the following three sections.

**Figure 2. Though Few Providers Prepared for Greater Financial Risks, ACO Partnership Has Positive Effect**

*Q: How prepared are physician/hospital practices in your community to assume greater financial risk for managing patient care?*
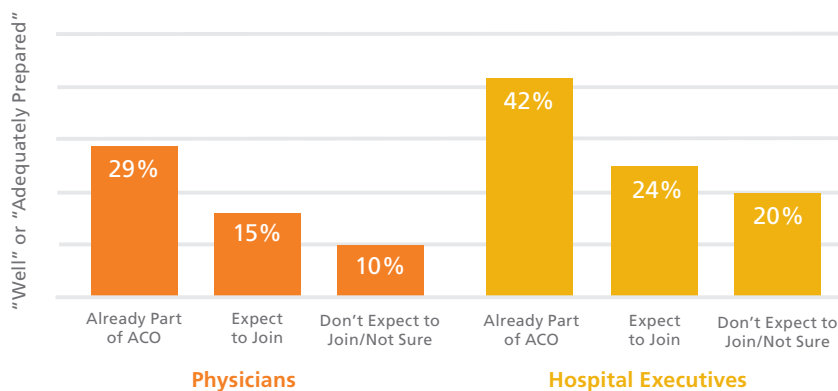
## Manage Clinical Performance

*Define and share the right financial and clinical benchmarks with the right leadership teams*

It is important for accountable care partners to understand their financial, clinical and quality performance on a macro level and on a micro level—a macro level to see overall progress toward goals and a micro level for specific populations and for specific interventions. Monthly macro and micro financial, clinical and quality metrics offer the organizations a current-state view, allowing them to see the impact of their interventions and the opportunity to realign strategies and priorities. Metrics should help the leadership teams understand utilization, costs, patient satisfaction, evidence-based care adherence, trends and outcomes.

As the partners come together, the executive team in conjunction with physician and operational leadership defines the clinical benchmarks and performance goals early. These benchmarks and goals become a road map for value, can help identify the areas of opportunity and can subsequently define industry-accepted targets that make sense for their organization.

Performance metrics must be transparent to all levels of the organization to encourage integrated accountability and ownership of change. The metrics should be shared on a monthly, quarterly and yearly basis and compared to the previous month's and previous year's performance. The goals of the metrics should be to:

• Define the per-member-per-month (PMPM) savings on a macro and micro level

• Illustrate physician performance and variation to drive change

• Measure hospital utilization and costs

• Identify in-network and out-of-network utilization and PMPM

• Measure adherence to evidenced-based protocols

• Measure patient satisfaction with care delivery, programs and physicians

• Validate that the implemented interventions had a positive impact on clinical outcomes

• Understand trend deflections on a macro and micro level

• Measure quality improvements of targeted programs

Executive leaders must not just compare the organization to other non-ACO groups but also benchmark performance using industry-accepted benchmarks that have been agreed to by all parties. This will allow the team to identify inpatient, outpatient, professional and pharmacy utilization and cost outliers.

As outliers are evaluated, a root-cause analysis should identify specific interventions for improving results. The root-cause analysis should evaluate opportunities, including physician variation, alterative care settings, evidence-based adherence, population health management failures and out-of-network opportunities to reduce inappropriate utilization—ultimately reducing costs.

## Clinically Integrate

*Care integration requires re-thinking the care delivery processes at macro and micro levels*

The term clinical integration is consistently referred to as a fundamental cornerstone to accountable care and fee-for-value, but there is no consistent, single definition of clinical integration.

Based on Federal Trade Commission (FTC) statements, the following can describe five primary legal characteristics of clinical integration.[4] Organizations must achieve efficiencies by:

• Monitoring and controlling quality, service and costs

• Selectively choosing a physician network that includes primary care and specialist

• Having a well-developed care management program that uses evidence-based guidelines for a broad spectrum of diseases and disorders

• Showing significant investment by physicians in both time and capital

• Integrating data management, enabling extensive data collection, information sharing, quality reporting and utilization review

Clinical integration is far from easy. Clinical processes can be fragmented, redundant, conflicting and—perhaps most daunting—heavily ingrained. Integration of care requires rethinking the delivery processes to coordinate patient care services across people, functions, activities and operational units to maximize the value of services delivered.

Becoming clinically integrated means collectively defining acute and disease-specific standards of care, educating physicians on the standards, providing tools to support physician compliance and measuring physician performance against the defined standards. The key to clinical integration is to continually monitor and evaluate performance that will identify areas of opportunity to improve care delivery across providers and improve physician performance.

To accomplish such a redesign, a multi-organizational and multi-disciplinary operations and clinical team should be assembled to establish a baseline of current processes and develop new, integrated, innovative care processes. As part of this effort, evidence-based guidelines should be reviewed and approved by the clinical team, and physicians need to be informed of and held accountable for following the protocols.

In addition to redesigning clinical services and programs, clinical integration must redefine continuity of care. The redesign must focus on care transitions to support patient-centered care delivery across the continuum: from the primary care physician (PCP), to specialty care, to the facility, to long-term care and to the home.

Changes to clinical processes across services can offer opportunities to improve clinical care and increase overall patient satisfaction at the macro level. For example, more emphasis could be placed on providing support and services to PCPs to change the way they manage a patient population and deliver care. Clinical processes could also be targeted to the micro level, such as identifying specific physician outliers or less-effective inpatient processes.

As the ACO addresses issues at a macro and micro level, a new integrated process will emerge that removes duplication, leverages resources and improves outcomes.

## Manage the Population

*Understand population and individual needs and provide support using all partner resources*

To succeed, provider and payer organizations need to find ways to consistently and cost-effectively interact with and coordinate patient-centered prevention and care. But it's not just engaging the providers—it's also empowering the patient to make better health care choices to prevent or manage illness.

Each day, people make decisions that affect both their health and, subsequently, their health care costs. The Centers for Disease Control and Prevention found that 50 percent of an individual's health status is determined by behavior—not genetics, environment or access.[5] Even when the best treatments are offered, patients do not always adhere to the prescribed treatments. Studies have shown that half of chronically ill patients do not follow long-term treatment plans.[6] Patient-centered health management ensures that all individuals have access to reliable health care tools, resources and information to enable appropriate and lasting behavior change.

According to a 2006 study released by the Department of Health and Human Services, of the $2.3 trillion annual health care spend, about $1.5 trillion could have been prevented, delayed or curtailed through lifestyle modifications.[7]

Under all commercial ACO models, payers and providers play a critical role in patient empowerment that can lead to better outcomes. For example, organizations can engage patients/members in wellness and health initiatives through targeted, timely communications and embedded advocates or other specialists. Such programs can reduce an organization's risk exposure over time by increasing individuals' awareness of the personal and financial benefits of better health.

Another patient empowerment technique is benefit plan design that drives positive member behavior, including the use of rewards for members who engage in improving their health or, for members who do not, additional premium, deductible or copayment increases.

Central to successful population health is identifying and prioritizing the individuals in need of help. The first step is to define a standard risk-stratification process, which will identify and mitigate the impact of at-risk populations and disease conditions. Once the population is stratified, evaluate the information from both a population level and an individual level.

- **Population-level management**—Identify and stratify by disease to define the areas that the ACO should evaluate to implement evidence-based care and disease management programs; these programs should incorporate evidence-based medicine protocols and the appropriate services, tools and technology by risk level (high, medium and low)

- **Individual-level management**—Identify and stratify the population on an individual basis to find the riskiest patients in the population; included in this stratification are the risk factors, total costs, inpatient costs, pharmacy costs, outpatient costs and probability of inpatient stay

After stratification of the population, the next step is the creation of a comprehensive program focused on medically fragile and high-risk populations using multiple outreach channels and standard evidence-based protocols. To create such a program, develop standard cross-organizational criteria to ensure consistent identification and selection of these patients. As patients are identified, new care-delivery standards and processes are collaboratively developed that support all individuals who could interact with the patient.

To manage high-risk members, a community-based approach that leverages a care management team that includes a physician, care manager, pharmacist, behavioral specialist and social worker delivers the most value. Payers typically have the most experience with care management, but a 2012 study[3] confirmed that providers who are part of an ACO are preparing for care management as well (see Figure 3). Even so, a care management team should not only include members of the medical group but could also include individuals from the health plan, community resources and vendor partners. While the physician provides the care, the care manager can support the patient as an extension of the practice. The care manager leads a collaborative process of assessment, planning, facilitation and advocacy to meet the patient's individual needs. The care manager's interventions focus on ensuring patients are seeing the right care provider as indicated by the physician, taking the right medications, receiving the right and most clinically appropriate care and living a lifestyle that will afford them improved health.

**Figure 3. ACO Partners Better Prepared for Additional Care Management Responsibilities**

*Q: How prepared are physician/hospital practices in your community to assume greater responsibility for managing patient care?*
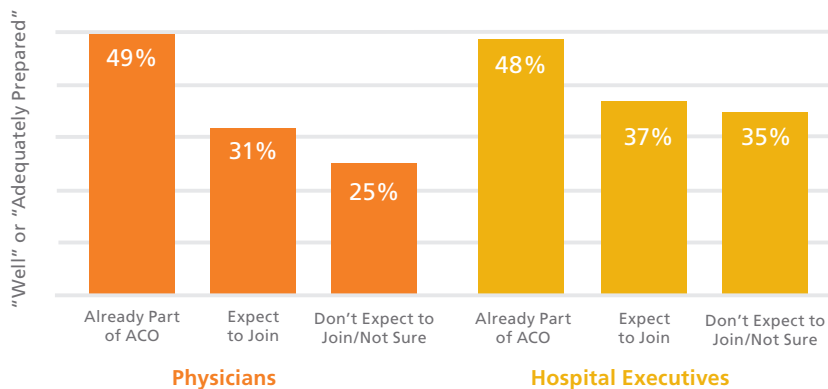


For those members that are not at high risk, a "health advocate" or "health coach" approach can ensure the proactive support of consumers' health care needs. The advocate is a source for a member's health-related questions and needs, helping the member navigate the health care system and promoting access to care and overall well-being. The goal is to create trusting and lasting relationships that support long-term behavioral change by focusing on the member's individual needs.

## Information Technology

*Leverage technology to support the sharing of information and drive decision making*

Integrating IT systems and aggregating data across multiple organizations will lead to higher quality, more effective and more efficient patient care. The components an ACO requires to accomplish these goals include an electronic health record (EHR), a health information exchange (HIE), data management resources, a clinical analytics solution and patient registries.

An EHR system that captures necessary patient data, supports care-related transactions and provides clinical decisions to support the use of the evidence-based protocols is critical.

Real-time data sharing through an HIE solution will promote clinical integration and support the goals of the ACO. The HIE enables the electronic distribution of all types of information—including laboratory, radiology, prescriptions, orders, hospital discharge summaries, continuity-of-care documents and transcribed reports—to all physicians and payers within the exchange. The use of an HIE allows physicians, payers, hospitals and care managers to proactively engage with each other to manage care and costs.

Real-time sharing requires more than just setting up pipelines for data transfer. There needs to be a shared data warehouse, whether physical or virtual, with meaningful, compatible clinical information and claims data for standardized reporting across the organization. Sitting on top of the data warehouse is an analytics solution that supports predictive modeling, quality measurements, gaps-in-care analysis, evidence-based medicine and financial performance. With compatible data, augmented with analytics and predictive modeling, value-based partnerships can measure progress against their clinical, financial and utilization goals—and ensure population health management, clinical integration and care improvement.

As part of the integrated data solution, the ACO should utilize common patient registries to identify patients at risk for poor health outcomes based on specific risk factors. These registries allow clinicians and other care managers to proactively address these concerns to minimize disease progression and maximize health outcomes by precisely targeting interventions for patients who will benefit most.

## Conclusion: True Partnership Is the Key to ACO Success

Creating a fully functional ACO requires significant investment, including infrastructure development and the hiring of resources to coordinate care, measure performance and engage patients. But when payers and providers partner, start-up costs can be minimized across participating organizations and significant savings can be achieved by leveraging each organization's assets and resources.
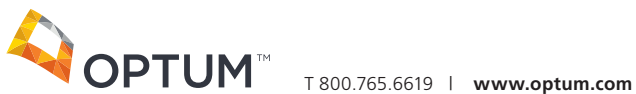
When payer and provider partners are aligned through upside and downside risk, it drives fundamental change in health care delivery, not just reimbursement changes. These arrangements ensure each partner shares in the savings but also shares in the risk if the targets are not met. The organization achieves its clinical and financial goals as the partners focus on accountable care.

## About Optum

Optum is an information and technology-enabled health services company serving the broad health care marketplace, including care providers, health plans, life sciences companies and consumers and employs more than 30,000 people worldwide. For more information about Optum and its products and services, please visit www.optum.com.

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