Payor Partnerships

Insights from Premier's PACT Population Health Collaborative

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Executive summary

Accountable Care Organizations (ACOs) hold promise as new models that can better coordinate care delivery to improve population health and reduce cost trends. To assist organizations in developing the skills needed to deliver coordinated, accountable care, the Premier healthcare alliance launched its Partnership for Care Transformation (PACT™) Population Health Collaborative in 2010. Through this effort, Premier works with member health systems across two tracks: those ready to implement ACOs in local markets through the Implementation Collaborative, and those interested in identifying their gaps and building the necessary capabilities to launch an ACO through the Readiness Collaborative.

After nearly three years, PACT members have found that establishing a healthy payor partnership based on transparency, shared value propositions, aligned incentives and shared risk for the management of population health is a foundational capability for an effective ACO. Though many payor/provider arrangements exist, there is little information on which ones are the most prevalent. This white paper provides detail on the various ACO/payor arrangements of 22 PACT health systems, as well as their corresponding payment structures and covered lives.

Payor partnerships can take on many different "flavors," depending on the payor relationship and appetite for change. PACT members are engaged in a range of value-based payment arrangements—including pay-for-performance incentives, shared savings and capitation contracts. Typically, these contracts pay claims according to the preexisting fee-for-service arrangements, but then add care management funding and/or shared savings distributions. In the future, the expectation is that the providers will take on additional risk until they reach capitated arrangements.

In the public market, the most popular choice for PACT members is to participate in the Medicare Shared Savings Program (14 out of 22 members). Within that program, most (13) members have elected to participate in the less risky savings structure (called track 1), which does not impose penalties on providers that fail to meet cost savings goals. Other options members are implementing include Medicaid programs (10), usually to provide coordinated care to patients with one or more serious chronic illnesses.

It is much more common for shared savings to carry downside risk in commercial markets, as PACT members report 11 downside arrangements in place with commercial plans. Added risk requirements may be due to the fact that commercial payors have bottom line obligations, and are less tolerant than public payors of losses. The most popular way to begin a value-based relationship with a commercial payor at a lower risk level is to implement care management agreements, and eight such commercial agreements were reported by members of the collaborative.

Additional contracting options include those with provider-owned plans (9 agreements), Medicare Advantage (13 agreements) and self-insured employers (8 agreements).

Beyond looking at the number of agreements in place, the largest number of people (748,430) are covered under a no risk shared savings agreement. Particularly in the early years of accountable care, when investment requirements are high and new models of care delivery are still being tested, this is proving to be the most attractive option for PACT members. In the commercial markets, Medicare Advantage and Medicaid, many providers are also experimenting with care management fees, managing 393,630 lives under these types of arrangements.

Of the members prepared to assume greater risk, most lives are covered under a downside risk shared savings program (469,305), followed by bundled payment (165,000). Very few members of the collaborative are yet prepared to assume the risk of capitated payments, and generally experiment with this form of reimbursement using a smaller sized population (52,670 covered lives across all members of the collaborative).

PACT members also reported different ways to share savings with payor partners. In the public market, the range of savings provided to the ACOs by payors such as Medicare and Medicaid runs between 25 to 60 percent, depending on the risk assumed by the provider. Arrangements with commercial payors are usually more generous, typically offering providers between 50 and 80 percent of any achieved savings. However, private sector agreements are more likely to include downside risk for failure to achieve cost and quality goals.

Members of the PACT Collaboratives have developed a number of key insights and lessons learned on how to appropriately structure a successful payor partnership. These lessons are vital to those considering value-based contracting, as many provider organizations underestimate the complexity of the new relationships they must form. Based on the experiences of PACT Collaborative participants, the most successful provider organizations entering into value-based contracts with payors do the following:

- Perform upfront financial due diligence to appropriately fund new operating activities, such as population health data and care management;
- Receive, share and analyze data;
- Clearly delineate the roles and responsibilities of the respective partners;
- Engage senior-level leaders to create a culture to support internal changes and collaborate with payor leaders to build trust and a long-term relationship;
- Risk-adjust the population and establish outlier protections for the provider;
- Move from silos to integrated activities to support population management;
- Integrate care management activities;
- Measure quality, cost and satisfaction to set contract terms with realistic expectations;
- Reconcile savings;
- Design effective shared-savings distributions and incentives for providers that effectively change physician behavior and practice patterns to deliver against ACO goals; and
- Pace the efforts of the organization's care management activities with value-based contracting efforts.

Why Payor/Provider Collaboration Is Necessary

The transition to accountable care is expensive. According to the American Hospital Association, organizations beginning the ACO journey should expect to spend between $1.7 to $12 million to develop the infrastructure and resources needed.

Not only do ACOs require extensive capital in order to rework care models, invest in information technology, develop deeper analytics capability and recruit new staff with population health management skills, they also need to reduce costs and utilization through improved chronic disease management and improved health outcomes. However, considering the infrastructure investments required, few providers can afford to sacrifice revenues from reduced utilization without being compensated for the additional care management programs and a portion of the savings these efforts generate.

This is where payors join in this new partnership. Payors are able to incent efforts to improve overall health and reduce utilization of healthcare services through shared savings payments to providers, or by paying for interventions that positively affect health, including care management, patient portals and other services that traditionally are not reimbursed but that yield longer term savings. Moreover, payers can protect providers, who are taking performance risk in improving quality and lowering the cost of care, from unanticipated outlier costs and risks.

But payors are more than just a financing engine. They are able to quickly organize large populations of people through their insurance products, and also have data and analytical capabilities that providers need in order to manage population health and evaluate the effectiveness of individual providers, including claims data on utilization, population demographics and health outcomes. Payors also have deep experience in population health analytics. This information is required to conduct predictive modeling, appropriately target services based on the needs of the population, and establish performance targets and other interventions. Because ACOs take responsibility for an entire population, it also is critical for them to track services received outside the ACO network. This can only be done if payor partners provide cross-continuum claims data, giving a full picture of services provided in order to identify opportunities to improve care, contain costs and prevent duplication of services.

Payors also play a vital role in health engagement. To encourage individuals to make better health choices, payors can create benefit design plans in collaboration with providers to remove barriers to healthy living, such as waiving co-pays for maintenance medications needed to manage chronic disease or providing free preventive health screenings.

Payor partner contributions needed for success

- ACO investments are significant, and often need to be supported with incentive payments from payors that will benefit from the transition.
- ACOs need access to all claims data to know what services are being used and accessed out of network, whether pharmacy prescriptions are being filled, etc.
- Without payment and incentives for coordination, reduced utilization, enhanced quality, etc., the goals of the ACO are not financially sustainable.
- Payors can assist with medical management goals, including population management, disease management, formulary development, etc.
- Payors are instrumental in developing value-based benefits, such as reduced co-pays for maintenance medication, waived payments in exchange for health assessments, etc.

Payor Partnerships – Options for Value-Based Payment

In the past, providers' contracts with payors were limited to payment terms, which usually involved fee-for-service reimbursement, occasionally with quality bonuses or capitation for some portions of covered lives. The contracts that ACO leaders are entering currently include much broader terms such as patient-centeredness criteria, quality metrics, information technology capacity, delegated and aligned care management functions and expanded financial incentives. Typically, these alternative contracts pay claims according to the preexisting fee-for-service arrangements, but then add care management funding and/or shared savings distributions. In the future, the expectation is that the providers will take on additional risk until they reach capitated arrangements with risk corridor protection or exceptions for outliers.

Many organizations pursuing accountable care already participate in alternative payment mechanisms in the private sector, albeit on a limited scale. Moving toward risk-based arrangements with payors allows a provider organization to incrementally build the financial and clinical infrastructure necessary to support accountable care. In fact, based on data collected from Premier's market-based assessments of ACO readiness, providers that are the most prepared to become ACOs have at least some experience with risk-based relationships and alternative contracts with payors.

Value-based contracting comes in many "flavors," and providers usually select their entry point based on their opportunities to shift utilization patterns, as well as their risk tolerance and capacity for change. However, based on nearly three years' experience among members of the Premier collaborative, some common attributes have started to emerge across these different entry points:

- No matter what the model, providers will not be entitled to bonus or incentive payments unless quality and efficiency standards are met
- In many of the models, the provider is held accountable for overall medical costs, including costs for care delivered outside of the provider network with the exception of outliers
- Many models require providers to access and analyze large payor claims data sets to evaluate the quality and cost of care, including whether providers are implementing evidence-based clinical guidelines

Below is a summary of the different forms of value-based contracting, presented by their level of assumed risk.

Care Management Fees

In this model, payors will reimburse providers for offering care management programs, such as disease management or a Patient-Centered Medical Home (PCMH). These payments are typically based on per member, per month management fees, or an increase to a provider's fee-for-service payments rates (e.g., a 10 percent enhancement for PCMH compared to typical primary care). These arrangements usually include bonus programs for those practices that meet quality targets.

Bundled Payment/Episode of Care Payment

Under bundled payment, payors and providers create a target price for hospital, physician and possibly post-acute services provided during an episode of care, usually set by applying an agreed upon discount to historical costs. In a retrospective model, participants are paid under the existing fee-for-service (FFS) system, but at a negotiated discount. At the end of the episode, the total payments are compared to the target, risk-adjusted price, and providers are able to share in any resulting savings. In a prospective model, the total discounted payment is made in a bundle in advance, and providers are paid for services out of the bundle. Over time, this payment model is intended to align incentives and reduce overall spending. However, in order to ensure that spending declines and quality improves, payors may put in place a penalty structure to recoup funds from providers that do not achieve these goals, or pay prospectively to ensure higher spending does not occur. This payment model can be helpful in aligning specific specialists and hospital services.

Shared Savings

Under shared savings, the payor pays all claims for a specified target population at pre-agreed fee-for-service rate, while providers focus on the interventions most likely to optimize outcomes and reduce utilization. If the actual cost of care for the population is less than the projected risk-adjusted cost (possibly minus a target or confidence interval), the excess funds are placed in a savings pool. The provider then receives a percentage of the savings, subject to its achievement of benchmark levels of performance on measures of quality and patient experience. Shared savings models generally take two forms – one where there is no downside risk for failing to achieve cost targets, and one where the provider agrees to "pay back" spending above the benchmark. The one-sided risk model is usually utilized in the first two to three years of the arrangement if the provider network does not have significant risk management experience.

Partial or Full Capitation

Capitated payments typically are paid periodically (e.g., monthly), or fee-for-service can be paid initially with an annual reconciliation against a global cap, based on the terms of the agreement. These rates can be set based on projected spending, and adjusted on the risk scores of the attributed population. Capitation rates may be augmented based on a quality and/or patient satisfaction measures. Furthermore, capitation programs do not necessarily need to cover all medical costs. Partial capitation models may include specified components of medical spending such as physician services or inpatient hospital care.

Implementing a Successful Payor Partnership

Recreating the relationship with a payor is a complex undertaking that involves considerable risk. Because of this, many have been wary to enter into these new types of relationships. On the provider side, many consider a value-based payor contract too risky because of the high cost to redesign care for the current fee-for-service system, lack of overall incentive and weak adoption of these shared savings models by payors. On the payor side, many are nervous to work with emerging ACOs that most need the financial support, opting instead to go with more established organizations that have already made all the necessary investments in population management, with a track record of proven results. Both payors and providers must meet somewhere in the middle for the accountable care relationship to begin.

To help providers better understand how to initiate and maintain a successful payor partnership, Premier and more than 20 other healthcare experts defined requirements, specific capabilities and business functions that are necessary for success. What follows are the essential activities that need to be completed in order to create successful working relationships with payors.

<u>Establish or redesign relationships with payor partners</u>

Value-based contracts involve considerable risk. To avoid unnecessary strain to the operational health of the organization, contract terms must be achievable and adequately funded. As such, ACOs need to perform extensive due diligence in order to have an accurate process and plan for targeting high-cost populations, identifying areas of potential savings and funding care delivery changes that will achieve gains in health outcomes at a pace that can be accomplished. Essential to the process is predictive and financial modeling to accurately estimate the bottom line impacts of value-based contracting to the hospital, physicians and the ACO. Also essential to the relationship is ensuring the provider is held responsible for risks it can control. This involves risk-adjustment and protections against outlier costs. The results of this planning should inform decision-making around the providers' ability to accept risk, and, in turn, the type of value-based contract they choose to pursue.

Do Your Financial Due Diligence

Hawaii Pacific Health and Hawaii Medical Service Association (HMSA), the parent company of Blue Cross Blue Shield of Hawaii, made national headlines with an extensive five-year partnership that aligns the two organizations to push for improved quality at a reduced cost. The Hawaii agreement covers Hawaii Pacific's four hospitals, 49 outpatient sites and care provided by its 1,300 affiliated physicians.

The shared-savings agreement makes 50 percent of the hospital's annual pay increases over the contract term dependent on achieving quality improvement and cost savings thresholds. The more savings Hawaii Pacific generates, the more HMSA will pay them. If financial losses occur, HMSA and Hawaii Pacific share in the loss.

Before settling on the financial terms, Hawaii Pacific used multiple data sources and financial models—including Premier, an actuarial firm and health plan models—to get an accurate handle on costs, revenues and savings opportunities under a risk-based deal. It is crucial providers invest in deep financial analysis, use different economic models and engage in clinical opportunity analysis to truly understand the implications before inking any partnership deals.

Design and maintain integrated contracting mechanisms with ACO participants and payor partner(s)

Once a payor relationship is established, it needs to be maintained with a clear understanding of evaluation measures that will be used to assess performance over time, sharply delineated roles and responsibilities for contract management, and a set structure for reviewing progress and reconciling financial results.

A key part of this process involves designing and implementing new compensation systems for primary care, specialists, hospitals and post-acute providers that align and incent continuous improvement around accountable care goals of lower costs, better outcomes and improved quality. Although a range of compensation models are possible, including bonus systems, pay-for-performance programs and shared savings, it is best practice to ensure that providers who will be paid under these new mechanisms have input into selecting the final compensation model, the amounts of compensation that will be tied to outcomes and the pace of transition in order to gain their support. Moreover, each of these models may require their own processes for distributing financial incentives, which must be created before the contract goes "live."

Collaborate with payor partners to manage the population experience

Essential to the process of managing the population experience is case management. In almost every market, a small proportion of the population consumes the majority of healthcare services. These "heavy users" need to be identified and engaged early, as they often are the sickest and most in need of preventive care interventions. Part of the solution may be a collaborative redesign of benefit plans to remove barriers to healthy living, such as waiving co-pays for maintenance medications needed to manage chronic disease or providing free preventive health screenings. Other options may involve targeted outreach by nurses or case managers to help coordinate care.

Sharing Data With Partners

When Blue Cross and Blue Shield of Minnesota in 2010 entered into a "shared incentive" payment agreement with Fairview Health Services, the insurer realized it had to change its traditional approach in order for both parties to succeed.

Unlike traditional contract negotiations, the parties instead entered into a long-term, collaborative partnership. Under the arrangement, Fairview gets paid a basic rate, but over time the focus shifts to incentive payments based on measureable improvements in cost and quality. As both parties' fortunes are linked, Blue Cross plays a key role in working with Fairview to identify and address cost drivers and quality gaps by sharing data and trends that inform care system practices.

As Fairview takes responsibility for an entire population, they need to be able to track all of the services people receive outside the network. The way to do this is via Blue Cross' historical claims data tracking patients from across the care continuum. The data also provides Fairview with a better understanding of where opportunities exist to improve care and contain costs. It is crucial that providers considering an ACO arrangement are able to get timely, trended performance data with targets and benchmarks, and that they have the ability to analyze the data.

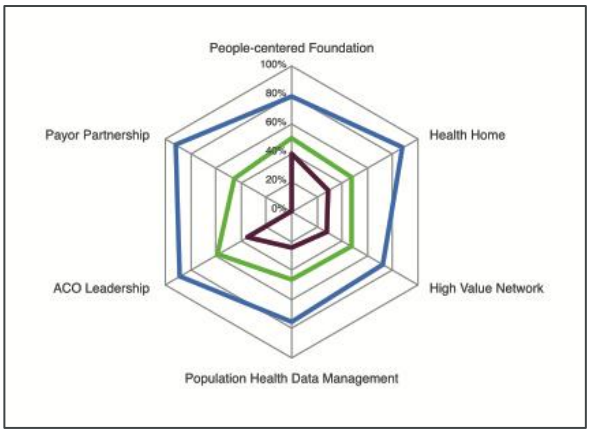
Traditionally, this has been a challenge in the relationship, as payors and providers both need to assume a role in better managing, coordinating and integrating services provided. Successful relationships have in place clearly defined roles to understand who's doing what for the high-risk individuals, and ensure that all interventions from either the payor or the provider are coordinated, and not duplicative.

Because of the careful coordination needed, it's not enough to just manage value-based contracts from a financial perspective. Instead, payors and providers need to create broad governance systems to jointly manage ACO strategy, offerings, beneficiary outreach, as well as the participant network to ensure adherence to cost and quality goals.

Ensure transparency of information needed to manage defined ACO population(s)
Extensive data exchange between providers and payors needs to happen if ACOs are to achieve their goals. This requires an established system whereby data from payors (e.g., claims, pharmacy, and lab utilization and cost data) and providers (e.g., clinical information) are shared to support joint care management and ACO operations. Often, this requires rules for data exchange that specify what data will change hands, the frequency of exchange, specific reporting mechanisms and elements of reports, which will meet legal requirements concerning transferred confidential data.

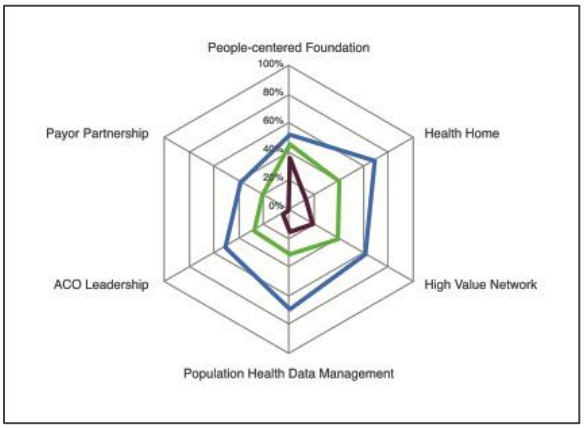
Overall State of Readiness of PACT Collaborative Members
Based on the requirements, specific operating capabilities and business functions identified, it is possible to assess providers' readiness to implement various elements of an ACO, including payor partnerships.

Premier Implementation Collaborative
Members of the Implementation Collaborative consist of health systems that are able to pursue accountability for a portion of their population today, evolving from fee-for-service to value-driven business models. Implementation members self-report an average readiness score of 42 percent regarding payor partnerships. In other words, Implementation Collaborative members at the start of the initiative, on average, were considered to be in the second of four stages of readiness.



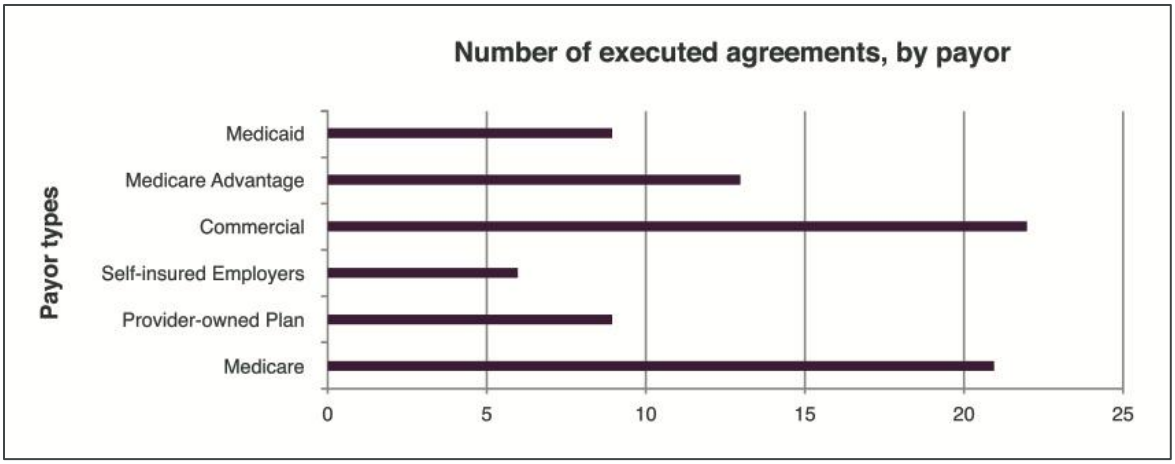
Premier Readiness Collaborative
Members of the Premier Readiness Collaborative are working to develop the organization, skills, team, operational capability and tools necessary to develop a coordinated care delivery model. As such, they tend to be in the early stages of ACO formation, and have less mature payor partnerships, as the diagram shows.

Organizations that are further along the journey to accountable care generally have existing value-based contracts, including bundled payments or pay-for-performance contracts, or they own a provider-sponsored health plan. Outside of these examples of value-based contracting, few Readiness Collaborative members had developed partnerships with payors that included shared savings or other risk-sharing reimbursement. Further, some members also reported adversarial relationships, which will need to be overcome before a true payor partnership can be entertained.



Potential Payor Partners
For organizations that are prepared to enter into more mature risk-based contracts, such as shared savings or capitation, it is important not to take a myopic view of the potential payor partners in any given market. Medicare is one potential partner through the Medicare Shared Savings Program, Bundled Payments, the Pioneer Program and other payment demonstrations through the Center for Medicare and Medicaid Innovation (CMMI). Still other providers are looking to create payor partnerships within state Medicaid programs.

In private markets, accountable care principles are being implemented in many places as providers and payors drive toward new, value-driven models of care in lieu of traditional fee-for-service. Effective, private payor partnerships are perhaps most well known in Minneapolis, where Fairview Health Services has been a leader in implementing four value-based ACO agreements with commercial payors. However, it's not just commercial plans that are interested in partnering to deliver more accountable care. As an example, major employers are beginning to see the value of applying accountable care principles to their self-funded employee health plans. Many provider organizations are working with their own employees and self-insured plan to pilot test accountable care programs. Still other provider groups are starting their own—or expanding existing—health plans. In fact, members of the Implementation Collaborative have executed, value based contracts in place with a wide array of payor types.



Private market options include:

- **Commercial plans -** Insurers are beginning to enter into accountable care agreements with health systems as an insurance product. The rewards for meeting mutually agreed on quality standards and cost reductions include bonus payments and shared savings to the accountable care network.
- **Self-funded employers -** Large self-insured employers are ripe for turning to ACOs to provide their care. In some markets, employers project health spending on a per-capita basis for employees over a multi-year time period, and make agreements with partnering health systems to share in savings if total costs are below the per-capita benchmark.
- **Provider health plan** - Organizations that own health plans have experience reducing unnecessary services, hospitalizations and emergency visits through care and utilization management, and acute and chronic care management strategies. As these are fundamental requirements for ACOs, these organizations should be poised to move more quickly than others. Moreover, working with an owned health plan provides a safe "learning laboratory" that will help minimize risk when assuming accountability for additional populations.

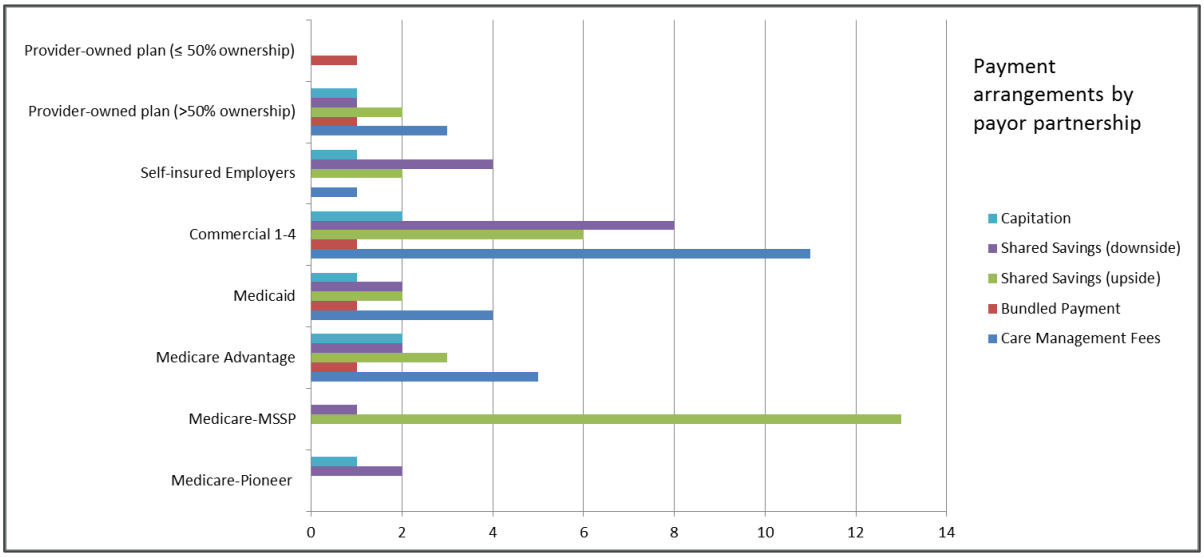
Potential Contract Options
Members of the Premier Implementation Collaborative participate in a broad range of value-based contracts with a host of different payor partners.

In the public market, the most popular choice for members is to participate in the Medicare Shared Savings program (14 out of 22 members). Within that program, most (13) members have elected to participate in the less risky track 1, which does not impose penalties on providers that fail to meet cost savings goals.

Other options in the public market include the Medicaid population. Despite early fears that accountable care would "cherry pick" the healthiest, lowest cost populations, that has not been the experience of members implementing these new models. In fact, members of the Collaborative report nine agreements with state Medicaid programs, usually to provide coordinated, accountable care to patients with one or more serious chronic illness. These contracts may be attractive to health systems because chronic patients generally have higher healthcare costs, thus representing a large cost savings opportunity (and a larger shared savings payment) with appropriate disease and primary care management.

In commercial markets, it is much more common for shared savings reimbursement to carry downside risk. In fact, members of the Implementation Collaborative report 8 downside shared savings arrangements in place with commercial plans. Added risk requirements in the commercial markets may be due to the fact that these payors have bottom line obligations, and are less tolerant than government payors of losses in early years of the program. Although "no risk" arrangements in the commercial market are rare, there remain options for providers that want to implement value-based contracting. The most popular way to begin a value-based relationship with a commercial payor at a lower risk level is to implement care management agreements, and 11 such commercial agreements were reported by members of the Collaborative.

The chart below summarizes the number of contract agreements that are in place among members of the Implementation Collaborative, organized by payor and contract type.

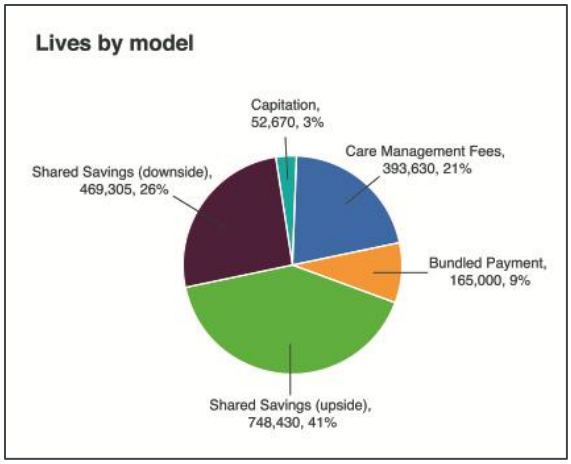


Beyond looking at the number of agreements in place, it's illustrative to show the scope of these value-based contracts, as measured by covered lives. Based on reported numbers from members of the Implementation Collaborative, nearly 1.8 million lives are covered under some form of value-based contract.

The largest number of people (748,430) are covered under a no risk shared savings agreement. As noted earlier, these agreements provide an opportunity for developing ACOs to test and participate in a value-based relationship with a payor, without fear of experiencing losses if cost and quality targets are not met. Particularly in the early years of accountable care, when investment requirements are high and new models of care delivery are still being tested, this is proving to be the most attractive option for members of the Implementation Collaborative.

In the commercial, Medicare Advantage and Medicaid markets, many are also experimenting with care management fees, managing 393,630 lives under these types of arrangements.

Of the members prepared to assume greater risk, most lives are covered under a downside risk shared savings program (469,305), followed by bundled payment (165,000). Very few members of the Collaborative are yet prepared to assume the risk of capitated payments, and generally experiment with this form of reimbursement using a smaller sized population (52,670 covered lives across all members of the Collaborative).



Based on the experiences of Collaborative members, selection of a payor partner and a value-based contract option depends largely on:

- Provider's capabilities to assume responsibility for population health
- Provider's ability and willingness to assume added risk
- Payor's willingness to transparently share claims data
- Payor's willingness to share savings in an equitable manner.

Range of Savings Provided to the ACO
Members of the Implementation Collaborative report a range of different ways to share savings with payor partners. The type and the size of the split generally varies by payor.

Public payors
Based on the experience of organizations participating in the Implementation Collaborative, the range of savings provided to the ACOs by public payors as Medicare and Medicaid runs between 25 percent to 60 percent. The size of the split is usually contingent upon the level of risk assumed by the provider, with those prepared for downside risk eligible to earn up to 60 percent of the savings. Lower risk options such as care management generally offer more modest financial incentives. To mitigate risks for outlier claims, most of these arrangements tend to be no-risk models, but in downside or capitated forms, typically will include a cap to limit provider losses.

Commercial payors
ACO-type arrangements with commercial payors are usually more generous, typically offering providers between 50 percent and 80 percent of any achieved savings. Some members also report arrangements that offer providers 100 percent of all achieved savings, but these are not as common as those that provide a savings split. However, as noted earlier, private sector agreements are more likely to include downside risk for failure to achieve the cost and quality goals than those in public markets. To mitigate the risk for outlier claims, some providers will negotiate "risk corridors" that exclude high cost cases such as burns or transplants, or set an outlier cap for claims above a specific dollar amount (i.e., $200,000).

Employer payors
Employers offer a broad range of splits, ranging from 100 percent of savings with downside risk, to 50-50 splits in upside only arrangements.

Lessons Learned from Premier's Collaborative

It is easy for provider organizations to underestimate the complexity of the new relationships they must form with payors. Sharing data, integrating care management activities, measuring quality, cost and satisfaction, reconciling savings, setting realistic performance expectations and designing effective shared-savings distributions are all important and intensive efforts that emerge when negotiating payor contracts. The potential barriers many providers will face in this area include:

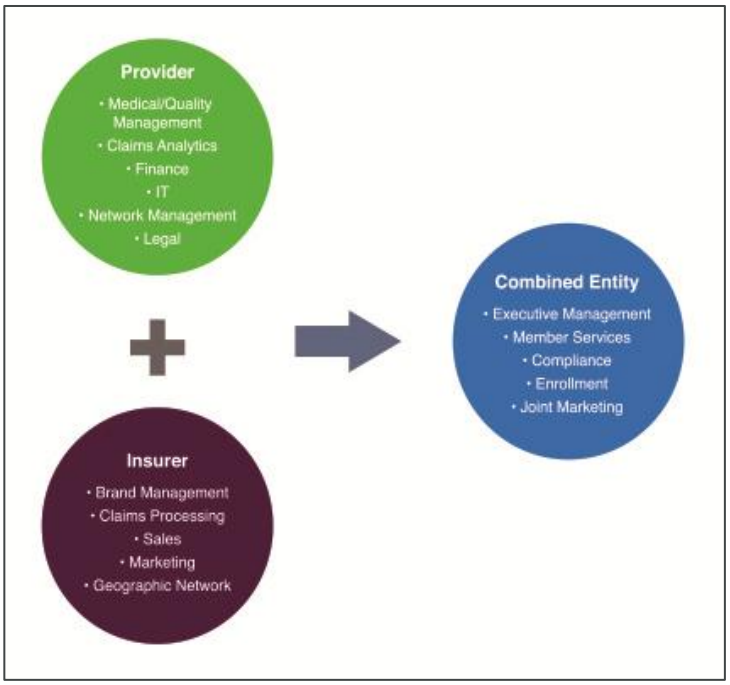
- Contract terms with initial cost and quality performance expectations that are unrealistic;
- Underinvestment by the ACO in key new operating activities (such as population health data and care management);
- Inability to effectively change physician behavior and practice patterns to deliver against ACO goals because of uncertainty around revenue impact of new contracts;
- Patients' concern about the nature of the contract terms and potential negative impact on their health; and
- Lack of broad buy-in from operational managers in both organizations.

Based on work with leading providers in the accountable care space and more than 100 health system readiness assessments, Premier has the following observations for providers as they develop new relationships with payor partners.

Financial due diligence is a necessary exercise: Any provider considering an ACO must have a firm grasp of the financial implications before negotiating with payors. Understanding total costs of the population, including outlier risks and risk adjustment; conducting utilization and benchmarking analyses; and forecasting the impact on both revenue and expenses are all part of the process. Having a working knowledge of various payment alternatives is also important. There are many financial scenarios, depending on bundled payment, care management, capitation options and specific bonus structures. The use of multiple data and financial models to set appropriate goals is recommended. To their disservice, many providers are not appropriately investing in this level of financial analysis before entering discussions with payors.

Access to data, and the ability to analyze it, will make or break partnerships: Because ACOs take responsibility for an entire population, it is critical to track all of the services people receive outside of the ACO provider network, and identify high-cost patients. This can only be done if payor partners provide historical claims data from across the care continuum. A full data set exchange should be part of any partnership agreement. Further, having the full picture of services provided is critical to understanding where opportunities exist to improve care and contain costs, and to evaluate the performance of individual providers in areas such as the application of evidence-based care. Negotiating comprehensive and timely access to data is a critical point of discussion as new partnerships are being formed. Meanwhile, it is also critical for providers to be ready to process and analyze the data that is being shared. Efficiently sifting through this mountain of information and effectively leveraging it to manage populations will require a sophisticated data platform and specific analytical expertise.

Clear delineation of strengths, responsibilities and accountability- The new relationship between payors and providers is not simply financial. There is also a division of labor that will most likely result in new responsibilities for key functions such as care management. It's important to gain clarity on how the two partners will collaborate to care for patients, and which party has responsibility for the various functions and activities. It's also important to ensure that each organization does what it does best. The ACO contract should clarify the new roles and responsibilities related to these pre-existing activities, as well as the parties that will be responsible for each new population management activity, including case management, beneficiary outreach, disease management programs, etc. Both parties should also agree on the measures that will determine success, and there needs to be an effective member attribution process.



Changing Culture Starts at the Top
Phoenix-based Banner Health Network is a predominant player in the emerging field of accountable care, having partnered with Aetna to offer a commercial ACO, being accepted as the first ACO into the CMS Pioneer program and teaming up more recently with Blue Cross Blue Shield of Arizona to deliver enhanced services to Arizonans.

There are many challenges when partnering with other organizations, but one of the biggest in creating an ACO involves changing culture, says Chuck Lehn, Banner's CEO. Changing the mindset of industry, patients and organizations from focusing on treatment to a broader focus on prevention and wellness needs to start at the top.

To transform healthcare, the executive leadership and governance at the partnering organizations must set the tone, committing to change and providing the resources to support transformation. Changing cultures also requires leaders, who were once adversaries or competitors, to collaborate and learn to trust one another so that ACO arrangements can succeed. This requires frequent engagement, complete transparency of information and other efforts. "Everyone is going to have to change their thinking and behaviors in some ways for this to work," says Lehn.

Cultures must adopt and adapt to new relationships: To achieve success in accountable care, payors and providers must come together like never before as part of the same team. The long history of approaching contracting as adversaries must be put aside. This effort starts at the top levels of both organizations, which must lead and invest in change management to ensure their respective staffs are operating with new mindsets and viewing the other side as a true partner. Activities that will support effective cultural change include setting realistic expectations for ACO outcomes, effectively aligning incentives, putting past differences behind, and committing to ongoing communication and training. There must be an overt recognition that both parties need one another—and must collaborate—to succeed in bending the cost curve, improve quality and support the backfill in lost revenue. On that point, there should be recognition that the payor partner will increase the number of people in the network or grow market share, which helps to offset losses the provider partner can expect to experience. No more annual contract negotiations. Any agreement should include a three-year arrangement and imply an even longer-term commitment.

Collaborative, consistent leadership is needed to achieve success: Joint leadership is required for effective change management and contract execution. Leaders from both the provider and payor organizations should regularly meet to coordinate activities, evaluate metrics and results, discuss quality improvement opportunities, tackle issues together and make other efforts that build trust between the parties. Formalizing the structure by forming a joint operating committee also helps with change management and adoption of new processes and protocols. Most importantly, the leaders of the two organizations must set the tone based upon a core set of partnership values that include transparency, honesty and sharing.

Shared savings distribution strategies are a challenge: Aligning various providers through appropriate distribution of financial incentives and rewards based on performance is a complicated activity. Failure to develop an aligned strategy for shared savings will undermine an ACO's ability to drive desired provider behaviors and achieve targeted outcomes. Shared savings and how that is calculated is crucial and must be crafted as a win-win for both parties. Many organizations are wrestling with how to effectively map savings and incentives for individual providers. Leaders need to ensure that primary care and specialty physician incentives are designed collaboratively, based on pre-defined measures and awarded for the delivery of high-quality care. All parties – health systems, providers, and payors – must be aligned and rewarded for achieving higher quality at a lower cost.

The complexity of relationships makes reconciliation a challenge: The financial arrangements of an accountable care partnership are more complicated, and the process for reaching agreement and measuring contract terms is even more complex. It may be three to six months after the close of a rate year before the final payment reconciliation occurs. Providers must keep this front of mind as they make financial and operational plans. This is why upfront financial due diligence is so crucial, as is having senior leaders invest in the time to build trust with their counterparts at payor organizations.

The pace of an organization's care management and value-based contracting efforts must move harmoniously. Like many things in life, striking a balance between developing one's care management acumen and value-based contracting efforts is crucial. A big push to developing your organization's case management capability without the savings opportunities means reducing utilization and revenue for the hospital or health system, undesirable in a fee-for-service environment. And, getting into shared savings agreements without care management capabilities means repeating the mistakes with risk-based contracting in the 1990s.

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