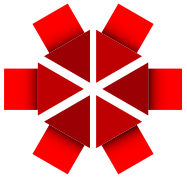

Domain Monitor: **Payer-Provider/PHM**

# Payer-Provider Partnerships: Extending Beyond the ACO

By Janice Young



The late April announcement by Aurora and Anthem is another reminder that the emerging relationships among payers and providers extend far beyond the ACO. The US landscape is a veritable potpourri of experimental insurance delivery collaborative models, many with roots that extend back several decades. Much of the current attention is focused on the ACO market and the recently announced CMS Next Generation ACO 2017 program. However, an assessment of all the existing models, and notably the continuing joint venture announcements among payers and providers, sheds a broader light on the potential of the future healthcare collaborative landscape.

## Delivery Models: Not just the ACO

There are at least six prominent payer/provider collaborative relationships in the 2016 market, (see table 1 below). These models run the gamut of fee for service, narrow network and shared and delegated risk models. Provider successes in the higher risk models have been sporadic and inconsistent. Although there are notable successes; overall, the provider industry struggles to establish the operational and clinical collaboration needed for industry wide and sustained successes and improvements.

Parallel to the ACO initiatives, narrow network products have also been (re)embraced as a means of focusing service and care delivery with qualified, high-quality, cost-effective provider networks. These products delivering an insurance product through a unique and specified network overcome the open network challenges of the Medicare ACO model and improve the ability to deliver and coordinate care for a defined population.

| Payer-Provider Collaboration and Product Models | | |
|---|---|---|
| Provider Owned/ Sponsored Insurance Plans | Insurance products developed and sponsored by providers and built around designated provider network, which may or may not be a qualified ACO. | Kaiser, Detroit Medical Center, Cleveland Clinic |
| Partnership Joint Venture Insurance Products | Insurance company partnership with provider organization(s) to create new insurance organization(s) or new insurance products. | Anthem/Aurora, Aetna/ Innova Health, Bright Health/ Centura Denver |
| Payer Contracted ACO or PCMH | Provider sponsored/developed ACO, contracting with a payer with financial, efficiency and quality improvement targets for a defined or self selected popula-tion. | Multiudes, including CareFirst, Cigna, BCBS |
| Narrow Networks | Limited network (may or may not be an organized ACO) of providers contracting with a payer as the unique/specified network for a defined product. | Multitudes, including BS CA, Cigna, Anthem |
| Payer Contracted or Rented Networks (traditional) | (Generally) broadly contracted networks — fee schedule/bundled payments, with or without limited performance-based risk sharing | All payers |
| Payer-acquired physician or-ganizations/Payer owned in-surance and provider networks | Insurance products developed and sponsored by the payer and delivered through owned and contracted provider networks, including ACOs, PCMH, centers of excellence, etc. | Humana/Concentra, Wellpoint/Care More, Optum/Monarch Health |

Table 1: Prominent Payer-Provider Collaborative Relationships (as of May 2016)



Provider success in either model requires the adoption of a new business and clinical model focused on population health, wellness, health, efficiency, quality and improved outcomes. It has proven difficult, if not impossible to successfully participate in a narrow network or delegated risk model with a fee for service business strategy. For providers, the greatest challenges for migrating to at-risk care models is finding a way to invest in new business models, operations and technologies – while simultaneously experiencing the erosion of fee for service income. And, even in the most supported and collaborative relationships between payers and providers, provider revenue opportunities are limited: risk is high and alignment between payers and providers can is often still fragmented and disconnected.

## Developing an integrated Business Model and Value Chain: Deeper Payer/Provider Collaboration

Surmounting the alignment, risk and investment challenges between payers and providers in ACO and network contracting relationships is a new emerging integrated model: the payer/provider joint venture. The announcement by Aurora and Anthem is the latest example of deeper payer/provider joint ventures. Additional recent announcements include Aetna/Innova Health and Elevate Health, a joint venture between Dartmouth Hitchcock Clinic and Harvard Pilgrim.

Payer/Provider joint ventures establish a much deeper integrated end-to-end healthcare business model. Through a deeper relationship, the promise of the joint venture payer/provider product is the delivery of high quality, cost effective health services to a targeted population at a lower cost. Key opportunities over other payer/provider collaborative models are:

- The tools and resources to surmount the very difficult network and ACO challenges of establishing and mastering the business, operational, clinical, analytics and technology infrastructure needed to succeed in managing population health and population risk and in engaging individual consumers and patients. This provides a more rationalized and quicker means to shift to consumer engaged, health-focused, value-based care model.
- A "soft cushion" enabling providers to benefit from new revenue sources, sustaining income as both the payer and provider learns how to reset financial and performance relationships in a market that incentivizes and rewards health and outcomes, rather than volume.
- An opportunity to align objectives, information, analytics, incentives and rewards through the full end-to-end healthcare insurance and delivery value chain - a critical step in fully imple-menting a truly value-based consumer engagement model.
- An accelerated evolution and market entry for value-based care products.

It is worth noting that this is the second chapter in payer/provider joint ventures. Early models existed from the late 1980s. Past, and even recent, history would suggest that an end-to-end payer/provider model does not automatically guarantee success. In February 2016, Mercy announced plans to sell its HealthPartners insurance business, unable to sustain a competitive insurance product. Note though that the joint venture model, such as that between Aurora and Anthem, is different from these previous models in which providers established an independent insurance business or payers buying and owning networks. Both models can suffer from a lack of focus and/or insurance business experience. The emerging joint venture model thus far brings highly credible experience among payer and provider partners, that may provide a better platform from which to extend more successfully into value-based care. Neither do joint ventures partners lose their respective independence, but, rather, execute together to bring a new product to market.



However, one of the greatest challenges of joint ventures is capitalizing on the strengths of each participant to create a new product that is greater than its individual components. Notably, in consumer and population health strategies, there is growing overlap, redundancy and a variety of disconnects among payer and provider programs. Payer/provider joint ventures have a fresh opportunity to realign and streamline end-to-end insurance, health and care delivery processes - a key factor contributing to high costs and quality challenges resulting from process, information and communication disconnects. Whether this can be accomplished remains to be seen. Joint venture partners retain independence and bring the joint venture product to market against a larger business backdrop on both sides. A streamlined, aligned insurance and delivery network to successfully execute a consumer-engaged, value based product will require core business and rationalization on both sides. Significant discipline and dedication will be needed to achieve the potential of this model.

## Payers and Providers: Who Will Win?

The question has often been raised - "who will win will, payers or providers?" Fundamentally, this is the wrong question to ask. It is arguable that the model that wins will be that one that promotes and incentivizes streamlined and aligned collaboration in how payers sell, how providers think about and deliver care and how consumer engage and embrace health.

## What's Next? What Should You Expect?

Undoubtedly payer/provider partnerships will continue all along the spectrum of relationships – at-risk, narrow networks, ACOs, joint ventures and acquisitions. Expect an experimental market for the next several years, with winning relationships and models (demonstrated lower costs, higher quality, satisfied consumers) emerging by the end of the decade. These new models, however, will put pressure on both health plans and providers to pursue and test different rela-tionship models and also to establish more rationalized and cost effective technology and busi-ness processes. Change, however, is difficult in an industry with multi-year contracts, en-trenched products and processes and the incumbent organizational challenges and barriers to change.

As they have done in the past to accelerate product and service innovation, health plans and joint ventures will likely set-up independent organizations and/or use third party partners to reduce these barriers to change. Similar to the HMO and CDHP eras, expect growth and expansion of third party organization service and technology organizations that provide a variety of solutions and capabilities for quality based, narrow network and at-risk programs. Expect increasing partnerships as well among technology companies and healthcare organizations supporting both technology platforms and services ("xyz in a box") that support the needs of aligned value based care. Examples of emerging relationships are provided in Table 2, below. These third party "value based services organizations" will include technology companies, consulting/systems integrators, possibly reinvented third party organizations (TPAs). This market will also provide a (re)new(ed) revenue stream opportunity for health plans, operating as service companies for both other health plan, new market ventures and at risk provider organizations.



| Value Based Services Organizations | |
|---|---|
| Payer Services Organization for At Risk Pro-viders | Insurance, financial, administrative, clinical and/or analytic services provided by payer/payer subsidi-aries for at risk provider/ACO administration, ex. Optum, Aetna |
| Consulting/SI Services Organizations | Insurance, financial, administrative, clinical and/or analytic services provided by (a) consult-ing/services organization for at risk provider/ACO administration. May include owned, licensed or partner technology and business services, ex. Cognizant, CSC |
| Technology Services Organizations | Insurance, financial, administrative, clinical and/or analytic services provided by (a) technology com-pany(ies) for at risk provider/ACO administration, ex. TriZetto |
| Joint Venture/Partnership Services Organizations<br>Technology/Services Organization<br>Payer/Technology Organizations<br>Provider/Payer Organizations | ex. McKesson/BCBSAZ |
| Third Party Services Organizations | Insurance, financial, administrative, clinical and/or analytic services provided by (a) third party for at risk provider/ACO administration. May include owned, licensed or partner technology and busi-ness services, ex. Lumeris, Availity, Evolent, Va-lence Health |

Table 2: ???

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