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# Better Care, Greater Value

## New Partnership Opportunities for Health Systems, Insurers and Physician Practices

**Over the past** 24 to 36 months, hospital and health system CEOs have become increasingly focused on closing business deals with physician practices or other providers in search of new growth opportunities, but there is some risk that the patients' perspective will be lost in this flurry of activity. Hospital, payor and physician leaders need to ensure their strategies are keenly focused on improving patient care. Becoming more aligned, together, is a growing trend in health care affiliations.

With new payment models aimed at rewarding value created over volume growth, physicians, hospitals and payors have an unprecedented opportunity to align around the interests of patients. In the past, the only way providers and payors could share in the value created through better patient outcomes and higher-quality care was if they were part of a fully integrated provider and financing system. Fragmentation has thus far resulted in competing priorities for these two sides.

But with health systems, physicians and payors under significant pressure to reduce costs and improve quality, all parties are exploring new relationships that have the potential to create shared value by improving quality, eliminating inefficiencies and aligning shared incentives. Independent community hospitals may also feel enticed to enter into these types of partnerships.

And with the Supreme Court's recent ruling on the Affordable Care Act, hospitals and health systems can no longer afford to wait on the sidelines and miss out on opportunities to form new relationships with physician groups and insurers. Hospitals and health systems deciding to wait to develop these relationships may lose their strategic positioning in the market and diminish their ability to construct affiliations that fit with their strategic priorities. Market-leading organizations will not stand still in this uncertain time.

## Recent Trends

Over the past 24 months, systems have increasingly sought affiliations with each other via mergers and acquisitions to create scale. Further, business arrangements with physicians and acquisitions of physician groups to increase alignment are accelerating at a pace not seen since the 1990s. More recently, these partnerships have evolved to include payors.

Insurance companies, faced with pressure to increase premiums in a stagnant economy and the need to cover a greater mix of patients, have sought to gain more predictability over how care is delivered by acquiring large physician practice groups and health systems. As one example, in September 2011, Optum, a subsidiary of UnitedHealth Group, the nation's largest health insurer, purchased the management arm of Monarch HealthCare, a 2,300-member physician group in Orange County. Humana, Cigna and WellPoint have made similar purchases of physicians, clinics and post-acute care providers.

Highmark Inc., Pennsylvania's largest health insurer, announced last year it would acquire West Penn Allegheny Health System, a Pittsburgh-area network that includes five hospitals and a 700-member physician group. Steward Health Care, a hospital chain based in Boston, last year began offering its own health insurance plan that will be 20% to 30% below market rates and cover treatment only in its own hospitals. And in Minnesota, Medica, a health insurer, and Fairview Health Services teamed up to form an ACO offering a health plan that will pay for services only in Fairview's seven hospitals and 350 clinics.

## Four Partnership Options

From the health executive's perspective, deciding which partnership approach is most attractive is not a simple, clear-cut endeavor, since each market is unique and each partner is different. The value proposition must be apparent to all parties, though the market strategies a provider can pursue may be impacted by the payor with which the provider is partnering. Choosing a partner, deciding on the best partnership model and prioritizing among market opportunities must all occur together.

Many hospitals and health systems are expanding their range of services beyond the operation of hospitals to function more as integrated networks that provide a broad array of offerings, including a mix of outpatient and post-acute services in addition to the services traditionally offered by hospital systems. Providers that operate as networks can capture revenue sources from a diverse group of patients, changing their patient mix to add those who need less hospital care. This is essential in an environment that is focused on cost-containment and changing care delivery models, e.g., preventive, palliative and chronic care. Health executives should be looking for this kind of expansion whenever possible.

As hospitals and health systems look to the future, there are a number of strategic options worth exploring:

1 **Create a Health Plan.** Providers may want to consider offering their own health plan if they can incorporate a large enough patient base to sufficiently spread the risk and have the capital resources to develop and fund a product. Under the old fee-for-service model, physicians and hospitals were incented to grow volumes of patients to admit, perform a test or procedure, etc. New payment schemes are experimenting with economically sustainable ways of keeping patients out of the hospital. Offering a health plan will help health systems align their interests with those of partnering doctors and enable hospitals and affiliated physicians to share in the value created by reducing costs and improving outcomes, helping offset the inevitable declines in hospital utilization.

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2 **Forge an Insurer Partnership.** Hospitals and health systems with less risk tolerance or fewer financial reserves can forge relationships with insurers that incent covered patients to be treated in their hospitals or outpatient facilities. Physician networks are required to define and implement care models that focus on improving quality and managing costs and utilization. Providers face a trade-off here: For the opportunity of becoming the hospital or facility of choice for subscribers of the insurance plan, the health system must work with the insurer on acceptable financial terms. These types of funds flow analyses are often foreign to health systems. However, the opportunity to share value created by effectively managing a patient population can be significant.

Kaleida Health of Buffalo and HealthNow (Blue Cross Blue Shield of Western New York) recently announced plans to form a physician-led network aimed at improving care coordination, reducing duplication and improving quality. We are likely to see this type of partnership growing in popularity, though it requires a common vision and a great deal of trust between all parties, as well as clear articulation of mutual objectives.

3 **Develop an Accountable Care Strategy.** Pursuant to the Affordable Care Act, several Accountable Care Organizations (ACOs) have been set up to serve Medicare and commercial patients. Under the terms of these types of organizations, providers agree to meet certain quality standards in caring for a group of patients. If the partners achieve a savings greater than a certain percentage compared with what would have been spent for the same patients in a fee-for-service model, they are rewarded with a share of the savings by the insurance company.

Many insurers are joining with providers to set up commercial, or non-Medicare, ACOs. One such ACO, AdvocateCare, was started last year in an alliance between Blue Cross Blue Shield of Illinois and Advocate Health Care of Chicago. After six months of providing care to 750,000 members, results suggest the effort is enjoying some success—at least when it comes to utilization. In the first six months of 2011, hospital admissions were 10.6% below the same period in 2010 and emergency room visits were down 5.4%.

While developing an ACO has certainly received the bulk of the press, it does not have to be the end goal for all provider systems. Rather, we suggest creating a strategy related to caring for populations based on outcomes. Many organizations have focused on creating bundled payment strategies (e.g., Henry Ford, Cleveland Clinic) and developing strategic relationships with other regional providers (e.g., Froedtert Health).

4 **Carve Out an Insurance Product to Offer.** Hospitals and health systems can negotiate with insurers to offer specific services tailored to certain groups of patients whose care the provider would manage for a negotiated fee. In the past, these kinds of carve-outs were used by insurers to manage behavioral health and substance-abuse services. In today's environment, some providers may want to think bigger by setting up comprehensive programs for chronic-care patients with diabetes or heart disease. This may appeal to insurers who want to eliminate a layer of contracted care managers who come between them and hospitals and skim off some of their revenue.

## Key Considerations

As health executives weigh their options and make choices about the types of alliances and partnerships they want to form, they need to carefully assess their position and the positions of other players in the markets in which they operate.

### Market Expansion Opportunities

The potential partners available to hospitals and health systems are largely dependent on local market dynamics, including respective market penetration and the types of populations served. Health executives should seek partnerships with payors and/or physician groups that will lead to incremental growth opportunities and that have complementary strengths.

### Resources and Risk Sharing

In order for partnerships to flourish, each organization has to be committed to its success and able to devote sufficient staff and resources to leverage the full value of the collaboration. This requires transparent

information-sharing and a clear understanding of the risks. Deeper integration holds the promise of greater potential cost savings and patient care management, but it also increases the level of risk in the partnership.

### Capturing Created Value

It is one thing to create patient value through improved clinical outcomes and reduced costs. It is quite another to capture that created value. Hospitals and health systems forging relationships with insurers will need to ensure the risk they assume in a newly formed relationship is commensurate with the financial benefits when they meet their agreed-upon targets. Providers must take caution that they do not enter into a relationship that leaves them overly vulnerable to downside risks and provides little upside benefit.

### Market Response

Organizations seeking a partnership have to anticipate the likely responses from the community and from competitors left out of an arrangement. In highly consolidated markets, collaboration between two large players risks raising accusations of anti-competitive behavior. Even if no legal action is taken, which is rare, this can still be a distraction from achieving cost savings and improving patient care coordination.

## Conclusion

It is our belief that market forces and federal and state policies will continue to push provider organizations to make deals and forge alliances with health insurers and physicians as they strive to make cost-containment efforts viable for their bottom line. In this environment of rapid change, health executives need to be nimble and prepared to act quickly and decisively as they consider new partnerships with insurers and physicians lest they risk erosion of their position along with their bottom line.❖


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