Provider Collaboratives: Six Ways to Make a Collaborative Work for You

AUTHOR
Mitu Ramgopal
Director, Business Development

Making a Collaborative Work For You

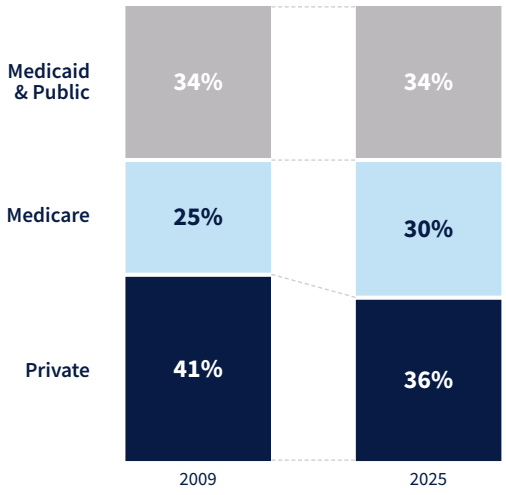
Health systems must develop new skills in order to succeed under the value-based payment models that are starting to proliferate. The shift toward these models is driven by a number of factors. Government and private payers are pushing health systems to provide high-quality care while constraining costs, insurance companies are consolidating, reimbursement rates are tight, and the patient population is getting sicker and older. At the same time, the health system payer mix is shifting. Government business is increasing, while commercial reimbursement rates are declining (**Figure 1**).

While widespread agreement exists that value-based payment is the way to go, there is no agreement on how to get there. Nor is it clear where to start—with a Medicare initiative, a private insurer or directly with a major employer. In the struggle to adapt, some health systems are joining provider collaboratives as a way to move toward population health.

To date, many provider collaboratives have failed to realize their full vision. For some, ineffective organizational dynamics can lead to indecision or dysfunction. For others, competitors seated at the same table may hinder the sharing of information and execution of effective strategies. And trying to align organizations at different readiness levels with varying objectives creates a challenging environment to move the outcomes needle.

Figure 1: Health System Payer Mix is Shifting

Tighter reimbursement rates will render subsidization strategies ineffective



Sources: *CMS and Lumeris Analysis*

Thus, before entering a collaborative, health systems must be methodical and fully evaluate the potential benefits of joining the group. Below are six areas that if overlooked, can have negative implications on your organization's value-based care strategy.

WHAT IS A PROVIDER COLLABORATIVE?

At its simplest, a provider collaborative is group of independent health care entities focused on a common goal or goals. The objectives and structures of individual collaboratives vary. Collaboratives centered around value-based care transformation are gaining traction. Examples include the Kentucky Health Collaborative, Initiant Health Collaborative, Texas Care Alliance and Partnership for Healthy Arkansas.

1. Don't make it a "me too" play

Health care systems should establish their own population health strategies, rather than expecting or allowing a collaborative to accomplish that task for them. Each health system is different, so a strategy that works for one organization might not be right for another.

In developing their individual strategies, provider entities must begin by evaluating their current capabilities for managing a patient population. This involves assessing the organization's preparedness in five essential areas:

1. Vision, leadership and governance
2. Physician network development and physician engagement
3. Care management programming
4. Experience with value-based contracts
5. Information system and analytics capabilities

To operate in these five realms, heath systems should consider establishing a population health service function. For example, a population health services organization (PHSO) maintains a portfolio of people, programs and health interventions that allow provider organizations to succeed in value-based payment arrangements.

The primary goals of a PHSO are to create a bridge across the traditional payer-provider divide and to support physician led-teams responsible for managing and coordinating care. Because PHSO development requires thoughtful investment of capital and meaningful scale, health systems may need to evaluate their internal capabilities. Because organizations can be at different starting points, it can be helpful to work with an objective 3rd party entity to facilitate strategy development. An operating partner that has a track record of building population health management infrastructure using proven methodologies may be an effective way to measure population health gaps and capabilities.

Figure 2: Value-Based Models Require New Capabilities

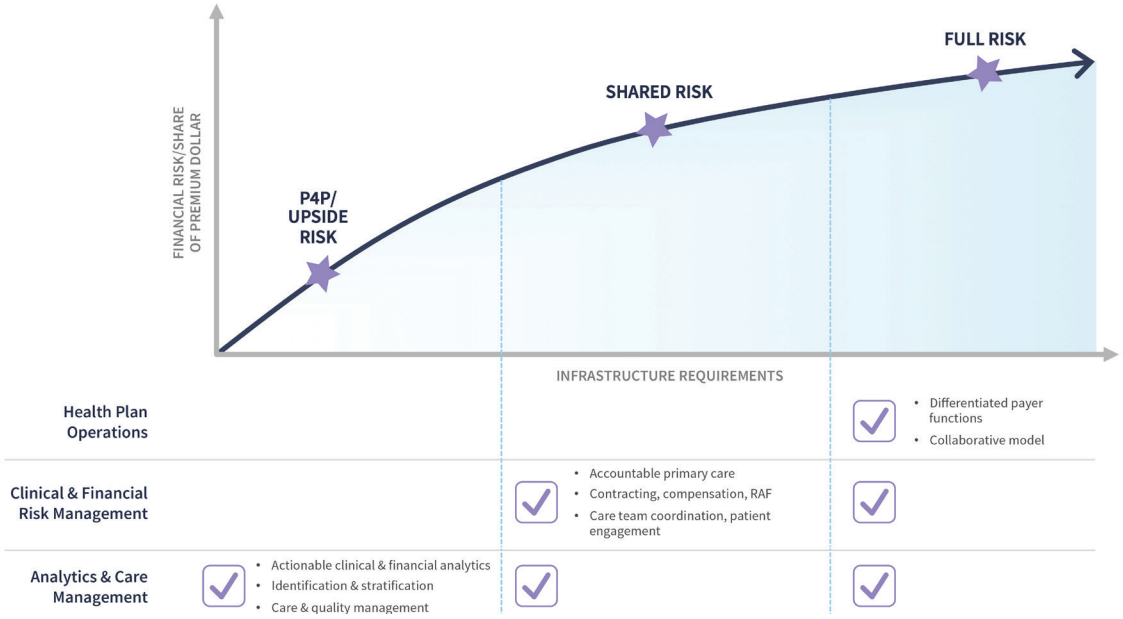


Figure 3: Capabilities For Value-Based Care Delivery

Does your organization have these capabilities today? Can your collaborative help you develop them?

ANALYTICS & CARE MANAGEMENT

- ☐ Volume to Value Strategy
- ☐ Population Management Opportunity Analysis
- ☐ Population Health
- ☐ Care Delivery Model Development
- ☐ Medical Care Management Program
- ☐ Pharm. Care Management Program
- ☐ Quality Improvement Program
- ☐ Revenue Management

CLINICAL & FINANCIAL RISK MANAGEMENT

- ☐ Organization and Governance Development
- ☐ Value-Based Contracting
- ☐ Provider Incentive Development
- ☐ High Performing Network Development
- ☐ Performance Measurement Structure Development
- ☐ Consumer Engagement Program(s)
- ☐ Practice Transformation

HEALTH PLAN OPERATIONS

- ☐ Actuarial/Underwriting
- ☐ Value-Based Benefit Design
- ☐ Marketing/Sales
- ☐ Enrollment
- ☐ Infrastructure
- ☐ Claims Payment/Customer Service
- ☐ Compliance and Audit
- ☐ Provider-Payer Contracting

2. Evaluate the collaborative's goals

Every collaborative has different goals, and health care organizations may have different definitions of population health. Leadership at one health system could view population health as having the information technology and analytics capabilities to track population health performance. Another system may view it as helping patients navigate the care continuum. And still a third might see it as accomplishing the gold standard of successfully managing risk-based contracts for patient populations. None of these visions are wrong, but before entering a collaborative, it's imperative to have your own definition of population health, to understand the group's definition, and to make sure the two align.

Common Provider Collaborative Goals

- Member education and sharing of best practices
- Group purchasing to reduce costs
- Advocacy and momentum-building for population health
- Vehicle for managing population risk

Equally important are understanding the collaborative's goals, determining whether all of the group's members share those goals, and making sure those goals fit with your organization's strategy. For example, if one provider organization enters the collaborative expecting that its primary focus will be on managing population risk, while another expects the focus to be on creating economies through group purchasing, collaborative members will have difficulty agreeing on how to proceed. As a result, one or both health systems likely will wind up disappointed because the collaborative will fail to meet its expectations or, even worse, won't accomplish either goal.

Also look into where the collaborative started versus where it is now. Did it launch with one goal but then switch focus? If so, why? It's important to know what the organization's priorities are and where and how it can help your organization accomplish its aims.

Key questions to ask include:

1. What are the collaborative's goals?
2. Do they fit with our overarching strategy?
3. Are the goals achievable?
4. Do all members understand and agree on the goals?
5. How are they prioritized and what is the timeframe for achieving them?
6. How is success defined?

3. Assess the collaborative's place on the population health spectrum

Health care organizations are at different levels of readiness in the five components needed for value-based care delivery. Before joining a provider collaborative, health systems must evaluate where they fall along the population health spectrum, determine their strengths and weaknesses, and set targets for addressing any gaps.

After figuring out your organization's readiness, evaluate where collaborative members are along the spectrum. If your health system is just starting its population health journey but collaborative members are much farther along, will your organization be ready to participate in or benefit from the group's efforts?

Conversely, if your organization is much farther ahead than the collaborative's members, what would you stand to gain from joining the collaborative? Would the others be able to contribute substantively to projects?

In all likelihood, a collaborative made of organizations at very dissimilar points on the population health spectrum would have difficulty aligning on a broad set of common goals. Absence of a cohesive strategy would limit organizational focus. On the one hand, a lack of focus could lead to inertia because members can't agree on worthy projects to undertake. On the other hand, it could result in the collaborative undertaking too many test projects, none of which gain traction. In the end, the collaborative itself may be seen as just another project. If no hard goals are tied to it, it could become a distraction.

4. Evaluate the members' objectives—or ulterior motives

In evaluating the makeup of a provider collaborative, it's important to look at its membership dynamics. One characteristic to examine is individual member's sway within the group. Is it a group of equals or do one or two dominant players drive the collaborative's priorities and activities?

This question gets back to whether members are close enough to one another along the population health journey that they can learn from each other. But size also could influence the power dynamic within the collaborative. Is the largest system in the collaborative driving the agenda, while smaller organizations follow along? If that is the case, does it work with your organization's strategy and allow you to accomplish your objectives?

Another membership dynamic to look into is the collaborative's turnover rate. A high turnover rate could indicate dissatisfaction with the collaborative's culture or performance, or insufficient staff or resources. It could

Table 1: Types of Collaboratives – What is the Goal of the Collaborative?

	The Group Purchasing Play	Analytics and Education	The Network Aggregator	The Risk-Bearing Entity
GOAL	Focused on pure scaling efficiency and resource pooling for traditional needs (e.g., durable medical equipment [DME])	Focused on developing common analytics and then leveraging those to drive clinical protocol development	Focused on building a CIN or "statewide network", usually with the intent of going direct to employer or gaining payer leverage	Most sophisticated end-state and greatest opportunity to drive savings, but no examples of this exist
PROS	• Great for smaller organizations • Relatively easy to justify (ROI) depending on resources required	• Good for starting to extract and use clean data • Helps more resource-limited organizations get together	• Build completeness without employing entire network	• Build scale to aggregate risk effectively • Share learnings across members
CONS	• Not a vehicle for population health/risk-based care	• Data is an important piece of population health, but not the entire strategy • Protocols are helpful, but not differentiated	• Lack of aligned strategy because members are at different places on the sophistication scale	• Need to align strategy across payers and potentially with competitors

also signal a lack of member commitment in terms of time and/or money.

Lastly, health systems should consider the collaborative's position in relation to their local market. Many provider collaboratives are formed on a regional basis, and participants potentially could be competitors.

This issue, too, gets back to where your organization is along the population health management spectrum. Before joining a collaborative, it's important to know if you're ahead of members in terms of the people, processes and/or technology needed to manage a population. If so, would joining the collaborative result in your organization sharing information that could cost it a competitive edge?

5. Leverage the strengths of the collaborative

As of yet, there are limited examples of collaboratives established with the goal of managing full risk. Without proof of concept, health systems should be wary of joining collaboratives with the idea it will get them to full risk. Reaching this ultimate goal might not be feasible because of the complicated and costly nature of bringing together independent organizations under a complex structure—one that:

- has a formal legal framework and governance body,
- allows members to share clinical and cost information,
- has the IT infrastructure and analytics know-how to find opportunities to improve clinical outcomes and lower costs,
- establishes care management and reimbursement incentive programs across physician groups,
- and has the actuarial and insurance expertise to develop insurance products.

Provider collaboratives with more pragmatic goals stand a better chance of meeting their objectives. Organizations considering forming a collaborative should first evaluate the current market in the region and examine where the potential members fall on the population health continuum. That analysis will help them to determine what local challenges exist and to develop meaningful objectives commensurate with where they are along the population health continuum. They can then leverage their combined strengths to reach those goals.

Table 2: Common Member Profiles – What types of organizations participate in the collaborative?

Profile	"The Follower"	"Ready for Change"	"Market Leader"
Characteristics	• Generally a smaller organization • Needs to keep up with the market	• Sizeable community health system • Willing and potentially best suited to change	• Perceived as the premier institution in the market, strong branding • Wants to be at the forefront
Key Desire for Joining	• Feels the need to maintain pace with the market • Often view as a substitute for own strategy	• Ready to take the next step, but doesn't feel prepared too do it alone	• Grow overall network • Gain scale leverage with payers • Drive referrals
Pros for Inclusion	• Adds scale • Population health strategy can still be shaped	• Often lower cost facilities with equivalent quality outcomes • Potentially more nimble than larger systems	• Ample capital and resources • Strong brand • Local influence
Cons for Inclusion	• Limited capital and resources • May have few capabilities to contribute	• May lack breadth of resources • May be aiding the competition at its expense	• More bureaucracy • Benefits mostly accrue to leader • Skewed representation in driving initiatives

For example, in a market where providers have little awareness of payment reform and potential members don't yet participate in risk-based contracts, the collaborative's main aims could be educating the physician community and cultivating the relationships and trust necessary to move the needle more toward population health management.

In markets where individual organizations are farther along the population health path, the conversation could center around how members could share experiences and best practices to leverage better outcomes for a particular disease state, such as diabetes or congestive heart failure.

Some collaboratives are forming central pharmacy and therapeutic committees with representatives across member hospitals, notes a Deloitte paper, "Provider collaboratives: Working together to navigate the changing health care delivery system." One collaborative's P&T committee has screened more than 4,000 medications to begin creating a common drug formulary, and members have agreed to implement weight-based antibiotic dosing. This move saves $2.8 million annually and advances the collaborative's goal of improving antibiotic stewardship.

6. Be honest about the investment

Provider collaboratives require a leadership structure and some form of financial contribution to cover expenses. In some collaboratives, members join together into a formal business entity, such as a limited liability corporation or shared services cooperative. Systems must understand local market regulations and how it impacts the collaborative's design and strategy. For example, what legal structures are necessary for a collaborative to contract with payers?

Before entering into a collaborative, it's important to know whether the time and money spent on the endeavor align with its benefits. These questions can help determine the potential for return on investment.

1. Do the financial and legal requirements match the potential impact of the goal? If the collaborative's goals are member education or shared learning but the organization has expensive dues and a complicated legal structure, the investment likely outweighs the benefits.

2. How is representation split between stakeholders? Key issues here are member representation on the governing board and rules governing member voting rights.

3. What level of commitment is required? Factors to think about are the amount of work required and by whom, whether membership and member participation are stable, and whether a cost should be attached to dropping out.

4. Are financial outcomes tied to the goals? In some cases, the link between goals and financial outcomes is clear. For example, if the collaborative's objective is to enter into group purchasing arrangements, the financial outcome is inherently tied to the goal. But in other cases, the link might be less obvious. If, for example, the goal is to adopt common metrics and care processes for diabetes treatment, should a financial incentive be tied to those goals to encourage physician behavior change?

5. Are you using resources on an activity that does not generate the highest impact? This question ties back to whether participation in a collaborative fits with your organization's overarching population health strategy. If the collaborative's objectives are focused on goals that would have little impact on your organization or on activities you could do more easily or less expensively on your own, the outcome won't be worth the resources you organization has invested.

In judging the potential return on investment, think about where you expect the collaborative to take your organization in three years. Can the organization realistically get you there and do so in a way in which the investment of time and money is commensurate with anticipated returns, be they financial or otherwise?

Source

"Provider collaboratives: Working together to navigate the changing health care delivery system," Deloitte, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-provider-collaborativ.pdf

In Summary

While provider collaboratives can be a beneficial part of a health care organization's journey to population health management, they shouldn't be viewed as a way to establish that strategy. Nor are collaboratives likely to be able to reach the point of serving as a vehicle for taking on full-risk contracts for their members. Still, participation in provider collaboratives can benefit health care organizations. Before entering into them, health care organizations should have a firm grasp of the collaborative's goals and whether they match and can advance the organization's objectives, members and member motivations, potential benefit beyond what the organization could do on its own, and the balance between investment and benefit.

About the Author

Mitu Ramgopal

As a member of the Business Development team, Mitu leads the development of our strategic partnerships across select markets in the South/Southeast. He has a background that spans strategic advisory, product management, and best practice research for various health systems, payer, and provider organizations. Mitu was previously with Decision Resources Group, where he led early product strategy, sales enablement, and client delivery efforts as a member of the Provider Analytics team. Prior to that, he was a management consultant with Kurt Salmon, where he managed a variety of projects ranging from strategy development to capital asset planning for large health systems and community hospitals. He has also previously held roles at the Advisory Board Company and UT-Southwestern Medical Center.

About Lumeris

We provide strategic advising and technology to help providers and payers get back to the way healthcare should be—and share in the rewards. We guide health systems and providers through seamless transitions from volume to value, enabling them to deliver improved and more affordable care across populations—with better outcomes. And, we work collaboratively with payers to align contracts and engage physicians in programs that drive high-quality, cost-effective care with satisfied consumers—and engaged physicians.

An industry recognized leader, Lumeris was awarded 2017 Best in KLAS for value-based care managed services for helping clients deliver improved clinical and financial outcomes. This was the second year we received this distinguished award. For the past six years, Essence Healthcare, Lumeris' premier client with more than 63,000 members in Missouri and Illinois, has received 4.5 to 5 Stars from the Centers for Medicare and Medicaid Services. We enjoy working with all of our clients, delivering these same results, and aligning our proven multi-payer, multi-population model with their value-based care vision.

For more information contact us at 1.888.586.3747 or go to Lumeris.com