Successful Payer-Provider Collaboration: Key Factors Contributing to Success

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What you will learn: Chronic illness and population health management are treated optimally through collaborative efforts between provider networks and payer program design that stresses value-based care. As Aetna's program displays, the proof is in the patient outcomes.

Aetna Medicare began a program of collaboration with key physician groups in 2008. The rationale for the program included the belief that improving the quality of care for a Medicare Advantage population would be easier when the provider's skills and resources were aligned more closely with the strengths of the health plan's population management expertise. In the ensuing years and with the initial success of several pilot groups, the program grew and evolved to include now more than 100 such groups as of early 2014.

Important features include payment for achieving mutually agreed quality and efficiency metrics, robust data sharing, and collaboration on care management, including trained and experienced case managers provided by Aetna, preferably embedded with the physicians and staff.

We have reported on the success of the initial experience.[1,2] As the program has grown we have developed valuable, mutually rewarding and successful relationships with many provider groups, and the program has made a very real contribution to the success of our Medicare Advantage program and the health outcomes of our members and their patients. The initially reported group, InterMed in Portland, Maine, remains in the program and continues to achieve among the most impressive results in terms of quality and efficiency.

In seeking to identify the factors that might result in such a relationship becoming extraordinarily successful, we identified three additional provider groups that have each exceeded the agreed quality metrics, and in addition for which we have seen demonstrated a considerable reduction in acute avoidable admissions compared to Aetna market levels and unmanaged Medicare for the comparable geographic region.

Provider Groups With Favorable Results

Provider group #1: ProHealth Physicians is a physician-driven primary care organization based in central Connecticut. It is anchored by more than 300 primary care providers across 90 practice sites, who admit to 10 different hospitals throughout Connecticut. ProHealth has had an active Medicare Shared Savings Program (MSSP) since 2013 with more than 28,000 Medicare beneficiaries, and cares for more than 2,200 Aetna Medicare Advantage members. All physician practices are recognized level three patient-centered medical homes.

Provider group #2: TriValley Primary Care is a primary care medical group practice with seven community oriented medical offices serving Bucks and Montgomery counties in the suburban Philadelphia area. More than 1,200 Aetna Medicare Advantage members receive medical care from 32 providers, with all the physicians being patient-centered medical home certified.

Provider group #3: Intercoastal Medical Group, located in Sarasota, Fla., is a professional association of 20 family practices, 22 internal medicine physicians, 30 specialists and six nurse practitioners and physician assistants. The group's ancillary facilities include an ambulatory surgery center, laboratory and imaging services, and a weekend clinic for Intercoastal primary care patients. More than 1,700 Aetna Medicare Advantage members receive medical care from the Intercoastal physicians across seven practice sites.

Although the collaboration program overall is highly successful, and we have a number of provider groups with "highly favorable" results, we have identified four that we consider remarkably successful. All of these groups have been in collaboration more than two years, all have more than 1,000 Medicare Advantage members, and all have met all quality process and outcomes measurements required, in addition to 85 percent of all other targets. In addition, all groups have attributed

Table 1

Results for 2013. Note: acute admissions are exclusive of denials. Acute admissions that do not happen are a measure of quality with significant impact on cost.

Group	Effective Date	Medicare Advantage Members	Acute Admissions Per 1000	Acute Admissions vs. CMS 2010	30 Day All-Cause Readmission Rate	Embedded Case Manager as of 2013
ProHealth (CT)	10/1/07	2,210	193	-46%	6%	Yes
TriValley Primary Care	1/1/10	1,228	220	-48%	9%	Yes
Intercoastal	4/1/09	1,708	132	-63%	9%	Yes

medical cost ratio (MCR) at least 5 percent below our level for their respective markets and acute admissions per 1,000 at least 25 percent below their respective market levels (exclusive of denials).

This impact might be described as "dramatic," and considerably greater than might be anticipated by contracting incentives alone. We believe we have identified a swath of key features that might be causally associated with collaboration producing such dramatically successful impact at the intersection of quality and cost.

Medicare Care Management

Aetna provides a robust care management program, including case management at a ratio of one case manager for each 1,000 members. These are predominantly nurses, but also social workers, who provide a variety of services including management of advanced illness and chronic illness.[3] Our program for Advanced Illness has achieved significant success,[4] and for the 1.1 percent of members engaged annually we see a hospice election rate of 81 percent, a reduction in acute days of 82 percent, ICU days of 86 percent and high satisfaction.

The impact on chronic illness is also very successful. This case management is provided in collaboration with the provider group's physicians and staff, and embedded in the group when possible. It has been our experience that when care management is incorporated, between our organization and the provider groups, the result is better than either can provide alone. Case managers, particularly when working within the practice, also build relationships with physicians and staff that are valuable in many ways. Case managers deliver critical services, such as reviewing evidence-based quality gaps in care, alerting staff to acute inpatient admissions to area and out-of-area hospitals and skilled nursing facilities, and co-identifying with clinical staff patients who could benefit from care coordination and support services.

The results of these high-touch initiatives are noted in Table 1. In all cases we see an impressive impact on acute admissions, particularly compared to those of unmanaged Medicare patients for the same state in 2010 (latest data available) and to Aetna Medicare Advantage results for the same state (in all cases greater than 25 percent reduction). That the 30-day readmission rate remains low despite this speaks to the effective impact on the individual over time.

Common Features of Successful Provider Groups

There are some notable features common to these groups, and others identified with highly favorable impact at the intersection of quality and cost. The include:

- **Strong primary care.** All groups had a strong base of primary care physicians. Some of these groups also include specialists, but the primary care presence, influence and availability is central to the organization's mission. Interestingly, although relationships with hospitals are generally good, and although Aetna Medicare has shown good results for hospital-based provider groups, none of the groups noted here are owned by hospital organizations or have hospital-based leadership.
- **Immersive case management.** Although all collaborating groups have case managers assigned, only a minority of the more than 100 groups have embedded case managers. Nonetheless, all of these highly successful groups have embedded case managers, either working full-time in the practice or working locally in the community with frequent face-to-face contact with local provider teams and offices. All practices had an excellent and mutually supportive relationship with the case manager.
- **Disciplined model design.** In all of these groups there was strong physician leadership and commitment to quality improvement and impact, and to making the clinical and payer relationship with Aetna Medicare work. The physicians and leadership meet with us regularly to discuss cases, data, issues, concerns and strategy. Indeed, they have become more than clinical collaborators, and in most cases strategic partners.

If we can learn from the success of groups such as these, there is potential for considerable improvement for both quality and cost for accountable care and its variants, both locally and nationally. We plan to continue our evaluation of the factors that impact success across our collaborative relationships in order to share transferable processes and programs across groups who are eager to improve their Medicare population's quality of care, clinical outcomes and efficiency.

References

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