HOW TO PREPARE FOR ACCOUNTABLE CARE

CONTRACTING: PRIORITIES AND NEGOTIATIONS

Presented by:

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“The healthcare policy world has crackled with high-level debate over ACOs in the past several years…But the types of ACO models being tried today are so varied and complex that it’s difficult to draw conclusions about their ultimate success. Despite the unanswered questions, providers are pumping massive investments into ACOs across the nation.”

-Joe Carlson, “Although patients may not know it, ACO’s are increasingly on their team, aiming to provide better care at lower costs”
Modern Healthcare, April 1, 2013
• Introduction

• ACO Airlines Analogy

• ACO Payer Contracting – 4 steps

• ACO Readiness Assessment

• Q & A
INTRODUCTION

WHAT IT TAKES TO ENTER INTO AN ACO CONTRACT...
WHAT IT TAKES TO MANAGE AN ACO CONTRACT...
And the healthcare system isn’t helping...
“In this country, we’ve been flying the Healthcare Airlines with planes that have no instruments, no gas gauge, no flight attendants, and we don’t know where we’re going or what we’re doing. And until we have transparency of results and share best practices among organizations to make all healthcare systems better, that’s what we’ll continue to fly.”

-James Weinstein, DO, MS, President and CEO of Dartmouth-Hitchcock Health System
Transitioning to ACO Airlines…
ACO AIRLINES

- ACO Growth
- Payment Models
- Attributes
- Infrastructure
ACO GROWTH (lift off):

- 2.4 million Medicare patients receive care through ACOs recognized by CMS (Centers for Medicare & Medicaid Services)
- 15 million non-Medicare patients get services from practices with CMS ACO status
- 8 million to 14 million patients are in ACOs run by commercial insurers
- 328 ACOs are reported as of November, 2012 up from 164 counted in September 2011— a 100% increase over the last year
- CMS nearly doubled the size of the ACO shared savings program as of January 1, 2013 with 106 new ACO contracts

Source: “ACOs already surging, poised for even more growth” amednews.com, 12/10/12
ACO PAYMENT MODELS (refueling):

The American Academy of Actuaries broke down five popular ACO payment models in a recent report (listed from lowest to highest level of risk):

1. “One-sided” shared savings - providers share in a portion of the savings they achieve in a modified fee-for-service model. There is only upside risk-no financial loss sharing

2. “Two-sided” shared savings - providers take on downside and upside risk in a fee-for-service based payment model

3. Bundled/Episode payments - providers receive a single payment for all of one patient’s services for one episode of care…They take on the financial risk if the cost of treating an episode of care exceeds the payment.
4. Partial capitation/global payments—providers may be at risk for some or all of physicians services…but not for hospital or other non-physician services

5. Global payments—providers receive monthly or annual payments, regardless of the care services they performed in that time period…The only way for a provider to increase its financial benefit is to increase efficiency and reduce costs

Source: “5 Payment Models for ACO Providers”, Heather Punke, Becker’s Hospital Review, 12/28/12
The Commonwealth Fund and the Institute of Medicine have identified 11 attributes of a payment system that would be superior to the current delivery system:

1. Care would be patient-centered
2. Care would be safe and effective
3. Care would be timely and accessible
4. Care would be efficient with little waste
5. Care would be coordinated among providers and across facilities
6. Continuity of care and care relationships would be facilitated
7. Collaboration among providers would deliver high quality, low cost care
8. Patient’s clinical information would be efficiently exchanged
9. Caregivers would engage patients in ways that would maximize health
10. Accountability for each aspect and for total care would be clear
11. Continuous innovation, learning and improvement would occur

Source: Kent Bottles, MD, medpagetoday’s KevinMD, Jan. 3, 2013
ACO INFRASTRUCTURE FOR POPULATION HEALTH MANAGEMENT (instrument panel)

<table>
<thead>
<tr>
<th>PATIENT POPULATION</th>
<th>GOAL OF SERVICE</th>
<th>INTERNAL CARE TEAM</th>
<th>INFORMATIONAL RESOURCES</th>
<th>EXTERNAL CARE TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Patients</td>
<td>Preventative Care</td>
<td>PCP Mid-Level provider RN LPN/MA PSR</td>
<td>Self Management Tool EMR IT Reports Quality Data Patient Feedback</td>
<td>N/A</td>
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<tr>
<td>Acute Patients</td>
<td>Episodic Care</td>
<td>PCP Mid-Level provider RN LPN/MA PSR Care Coordinator</td>
<td>E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback</td>
<td>Specialists ER &amp; Urgent Care Hospitalists Home Health Providers Social Workers Mental Health Providers Community Resources</td>
</tr>
<tr>
<td>Chronic Patients</td>
<td>Chronic Care</td>
<td>PCP Mid-Level provider RN LPN/MA PSR Care Coordinator</td>
<td>E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback</td>
<td>Specialists ER &amp; Urgent Care Hospitalists Home Health Providers Social Workers Mental Health Providers Community Resources Case Managers</td>
</tr>
<tr>
<td>End of Life Patients</td>
<td>Palliative Care</td>
<td>PCP Mid-Level provider RN LPN/MA Caregiver Care Coordinator</td>
<td>E-Visit Feedback Medication Management EMR IT Reports Quality Data Patient Feedback</td>
<td>Specialists Home Health Providers Social Workers Mental Health Providers Community Resources</td>
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</tbody>
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AdvocateCare, ACO

RESULTS TO DATE:
Oak Brook, Ill. Based Advocate Health Care is one of the few systems that has reported some results, including reduced readmission rates, from its ACO. The system launched AdvocateCare in partnership with Blue Cross Blue Shield of Illinois in 2011. Year-one data showed a 26% decline in readmission rates for ACO patients with chronic illnesses. It also released data showing at 10.6% decrease in its hospital admissions per ACO member and a 5.4% drop in emergency department visits.

CEO RESPONSE:
“We definitely have a foot in two worlds (volume & value) and on any day it’s problematic,” said James H. Skogsbergh, president and CEO of Advocate Health Care in Illinois. “When we look at our utilization numbers, for instance, we feel schizophrenic. ‘This number is good. No, it’s bad. No, it’s good!’ It takes more time to build new infrastructures than any of us think. Whatever amount of time you thought it was going to take, double it,” Skogsbergh warned.

(Source: “3 Years of PPAGA”, Beckers Hospital Review, March 25, 2013)
Next step: filling the seats through ACO Payer Contracting
ACO PAYER CONTRACTING: 4 STEPS

I. Reposition for value-based contracting

II. Assess the trust level of each ACO contracting payer

III. Identify criteria to use in aligning payer-provider goals and values

IV. Establish contracting priorities and develop negotiation strategies
Reposition for Value-Based Contracting...
# ACO Contracting Features: Traditional FFS vs. Value-Based

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<thead>
<tr>
<th>Feature</th>
<th>Traditional FFS</th>
<th>Value-Based Methods</th>
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<tbody>
<tr>
<td>Payment</td>
<td>Retrospective reimbursement</td>
<td>Prospective payment w/rewards &amp; penalties</td>
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<tr>
<td>Risk</td>
<td>None</td>
<td>Shared savings &amp; gain-sharing</td>
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<tr>
<td>Quality of Care</td>
<td>Assumed- P4P incentives</td>
<td>Measured &amp; reported w/rewards &amp; penalties</td>
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<tr>
<td>Provider Integration</td>
<td>Not required/optional</td>
<td>Hospital, physician, &amp; ancillary providers</td>
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<tr>
<td>Competition</td>
<td>Non-exclusionary; supply &amp; demand driven</td>
<td>Patient Channeling and provider exclusions</td>
</tr>
<tr>
<td>Data Reporting</td>
<td>None required/P4P</td>
<td>Cost &amp; quality metrics, utilization; patient satisfaction</td>
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ROADBLOCKS TO CREATING AN ACO:

According to Banner Health Network’s CMO, Dr. Tricia Nyugen

- Aggregating disparate data sources such as EHR systems and medical claims
- Creating analytics to identify populations by disease (disease registries) in order to focus resources on those with the highest need
- Changing the culture of practitioners from volume to value, from a sickness model to a proactive wellness model
- Finding physician leaders and engaging the physician community through communication and compensation
- Getting patients to change their habits and be more accountable with their own healthcare by creating awareness, and incentivizing health changes

### Cultural Repositioning:
**Traditional FFS vs. Value-Based**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Traditional FFS</th>
<th>Value-Based Methods</th>
<th>Required Repositioning Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Level</td>
<td>Low - Arms -distance contracts</td>
<td>Med-High - Joint commitments, data sharing, payment distributions</td>
<td>Building Trust (next slide)</td>
</tr>
<tr>
<td>Goal Alignment</td>
<td>Low - Goal conflicts: payers &amp; hospitals</td>
<td>Med-High - Protocol standards; common reports; savings distribution, shared risk</td>
<td>Meaningful Collaboration</td>
</tr>
<tr>
<td>Risk Disposition</td>
<td>Risk Adverse - No risk</td>
<td>Low-High - Shared savings; gain Sharing; capitation</td>
<td>Medical Expense Management &amp; Care Management</td>
</tr>
<tr>
<td>Inter-Communication</td>
<td>Minimum - Administrative (EOB); practice silos</td>
<td>Med-High - Joint payer meetings; referral protocols, patient engagement</td>
<td>Feedback &amp; Assessment</td>
</tr>
<tr>
<td>Technology Usage</td>
<td>Low - Paper; emails; etc.</td>
<td>Med-High - Electronic; EMR, EHR, RHIO, dashboards</td>
<td>Accepting &amp; Embracing Technology</td>
</tr>
<tr>
<td>Physician Behavior</td>
<td>Physician-Centric - Change resistant, Independent, minimum compliance, reactive</td>
<td>Other-Centric - Medical Home, payer collaboration, team leader oriented, engaged, pro-active</td>
<td>Collaborative Attitude with Triple Aim Perspective</td>
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</table>
Assess the trust level of each ACO contracting payer…
A long way to go…

**PRO:**

- “Traditionally, hospitals have thought as payors as competitors, or the enemy,” says John Halamka, MD, senior VP and CIO of Beth Israel Deaconess Medical Center in Boston. With Mounting pressure from healthcare reform to coordinate patients’ care throughout the continuum of care, hospitals and health systems will need to partner with payors to access healthcare analytics and manage population health.

- Dr. Halamka says “Establish relationships so you trust each other as collaborators,” he says. "Suddenly it isn’t you against the world; it’s the community working to solve problems collectively.”

- Hospitals and payors are realizing that to control costs and quality effectively, they will need to work with each other not just on insurance plans and claims data but on the long-term management of patients’ health.

Source: “Hospitals Partnering With the ‘Enemy’: How Payors Can Held Coordinate Care”, Becker’s Hospital Review, November 15, 2012
A long way to go…

**CON:**

• “I think there’s a bit of a skeptical audience: assessing how will you can trust a payer is like trying to decide which fox to leave in the chicken house for best results. Biases aside, there were some good checklist-type material presented that could be helpful.”

Source: Participant response to ACO Contracting Presentation, MGMA 2013, FMPC Conference, February 25, 2013
Payer Contracting is two-fold: 1) **Tactical**- contract/fee adjustments; 2) **Strategic**- payer relationship building

- **Low trust** causes friction and slows negotiations e.g. hidden agendas, win-lose thinking, defensive communication.
- **High trust** produces speed- e.g. transparent data, kept commitments, win-win-win solutions.

\[
\downarrow \text{Trust} = \downarrow \text{Speed} \uparrow \text{Cost} \\
\uparrow \text{Trust} = \uparrow \text{Speed} \downarrow \text{Cost}
\]

Source: *The Speed of Trust*, Stephen M.R. Covey
ACCOUNTABLE CARE CONTRACTING MATRIX

ASSESSING TRUST LEVELS
WHICH PAYERS HAVE INTEGRITY?

• Do they have a reputation of respect and trust?
• Do they have a culture of honesty?
• Do they listen to concerns and ideas?
• Do they admit to mistakes when they occur?
• Do they work through tough issues?
• Do they make and keep commitments?
WHICH PAYERS HAVE GOOD INTENT?

- Do staff care about the quality of their work?
- Do payer systems reward competition (win-lose) or cooperation (win-win)?
- Is information shared freely or withheld?
- Do communications prove to be honest and sincere?
WHICH PAYERS ARE CAPABLE?

• Do staff work effectively with others?
• Have they committed financial resources to achieve stated goals?
• Do they attract and retain knowledgeable and talented staff?
• Do they have a history of successful competition in the market?
WHICH PAYERS GET RESULTS?

• Do they deliver what they promise?
• Does their track record promote confidence?
• Do they take responsibility for successful results?
• Would you recommend them to other practices?
Identify criteria to use in aligning payer-provider goals and values...
ACCOUNTABLE CARE CONTRACTING MATRIX

ASSESSING TRUST LEVELS

CONTRACTING PRIORITIES BY QUADRANT

High
(10)

Low
(0)

TRUST

I

II

III

IV

SHARED GOALS

Few
(0)

Many
(10)
“It is time to stop shifting cost and align payers and providers around their common goals. Now is the time to bring together the two major constituents that affect cost, quality and outcomes. Payers and providers must collaborate in a meaningful way to truly manage the care and costs for our patients. And it all comes down to the need for alignment in three basic areas: clinical, economic and administrative.”

PAYER-PROVIDER AGREEMENT ABOUT:

- Definitions of clinical areas to be pursued as pilots e.g. orthopaedic procedures, cardiology episodes, …
- Best practice clinical guidelines that accommodate geographic variations, population differences, etc.
- Meaningful data extracted from payer claims and provider records to determine measures, targets, baselines & reconciliation processes
- Definitions of patient populations and attribution processes, e.g. age, condition, Medicare, Medicaid, Commercial enrollment
PAYER-PROVIDER AGREEMENT ABOUT:

- Reimbursement methods and amounts
- Financial incentives for cost, quality, and utilization e.g. gain-share terms
- Payment for support of care management programs e.g. care coordinators, case managers, quality tracking & reporting tools
- Population management program payments e.g. patient-centered medical home (PCMH) certification
PAYER-PROVIDER AGREEMENT ABOUT:

• Patient eligibility and benefit design e.g. payer information portals

• Availability of EHR portals for data sharing for patient’s history, medications and tests

• Capabilities of electronic conveyance of patient data e.g. reporting and reconciliations

• Auto-adjudication, feedback and transparency to reduce claim rejections
KEY PERFORMANCE INDICATORS: MGMA PERFORMANCE SURVEY

Results from this study on a scale from 1 to 5, with 5 being completely satisfied and 1 completely dissatisfied, reflect on the following:

1. **Payer Communications**: How satisfied are you with the amount of time it takes the payer to respond to your questions? *Avg: 2.5*

2. **Payer Communications**: How satisfied are you with the accuracy and consistency of the payer’s response to your questions? *Avg: 2.58*

3. **Fee Disclosure**: How willing is the payer to disclose the fee schedule used to reimburse your practice under the terms of your contract? *Avg: 2.95*

4. **Claims Appeal Process**: How satisfied are you with the claims appeals process? *Avg: 2.4*

5. **Prompt Payment**: How satisfied are you with the promptness of the claims payments? *Avg: 2.96*

6. **Rating System Transparency**: How transparent to you are the cost and quality measures used by the payer for its physician rating and/or pay-for-performance programs? *Avg: 1.89*

7. **Contracting**: How satisfied are you that the payer conducts two-way, good-faith negotiations during the contracting process? *Avg: 1.87*

8. **Innovated Payment Methods**: How willing is the payer to engage in innovative payment models or offer/innovate contracts based on concepts such as accountable care, shared savings, medical homes, or payment bundling? *Avg: 1.56*

9. **Overall current Satisfaction with Payer**: *Avg: 2.68*

Source: MGMA 2012 Payer Survey Results
Establish contracting priorities and develop negotiation strategies…
IDENTIFYING DESIRABLE BUSINESS PARTNERS:

• **PAYERS**
  – Claims histories
  – Actuarial models

• **MEDICAL GROUPS**
  – Trust assessment
  – Goal alignment evaluations

See “Who Do You Trust” MGMA Connexion, February 2013
ACCOUNTABLE CARE CONTRACTING MATRIX

I

Payer C

Payer G

II

Payer B

Payer D

III

Payer A

Payer H

IV

Payer F

Payer E
CONTRACTING PRIORITIES BY QUADRANT

PRIORITY #1: QUADRANT II

+ Negotiations can be quick and confident
+ Shared values and competencies

High (10)

Low (0)

- Trust

Few (0)

Many (10)

- Shared Goals

I

Payer C

Payer G

II

Payer B

Payer D

III

Payer A

Payer H

IV

Payer F

Payer E
PRIORITY #2: QUADRANT I

- Good business history - high trust
- Needs to improve organizational processes

I
Payer C
Payer G

II
Payer B
Payer D

III
Payer A
Payer H

IV
Payer F
Payer E

TRUST

High (10)

Low (0)

SHARED GOALS

Few (0) — Many (10)
PRIORITY #3: QUADRANT IV

<table>
<thead>
<tr>
<th>TRUST</th>
<th>Shared Goals</th>
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<tbody>
<tr>
<td>High (10)</td>
<td>- Accountable Care competencies in place</td>
</tr>
<tr>
<td>Low (0)</td>
<td>- Organizational cultures are in conflict</td>
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</table>

<table>
<thead>
<tr>
<th>quadrant</th>
<th>Trust</th>
<th>Shared Goals</th>
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<tbody>
<tr>
<td>I</td>
<td>Payer C</td>
<td>Payer G</td>
</tr>
<tr>
<td>II</td>
<td>Payer B</td>
<td>Payer D</td>
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<tr>
<td>III</td>
<td>Payer A</td>
<td>Payer H</td>
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<tr>
<td>IV</td>
<td>Payer F</td>
<td>Payer E</td>
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</table>
PRIORITY # 4: QUADRANT III

- Cultures and processes not aligned
- Contract history not satisfactory

* Consider Contract Termination

- Payer C
- Payer G
- Payer B
- Payer D
- Payer F
- Payer E
- Payer A
- Payer H
ACO READINESS ASSESSMENT
## ACO READINESS ASSESSMENT

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Development Required</th>
<th>Limited Capabilities</th>
<th>In-Place: Performance Evident</th>
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<tbody>
<tr>
<td><strong>Governance/Leadership</strong></td>
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<tr>
<td>• Stakeholders are committed to Triple Aim mission</td>
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<tr>
<td>• Inter-organizational representation in governance</td>
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<tr>
<td>• Capital and personnel resources necessary for mission</td>
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<tr>
<td>• Legal entity that meets ACO requirements</td>
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<tr>
<td>• Engaged physician leadership &amp; ongoing education</td>
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<tr>
<td><strong>Organizational Culture</strong></td>
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<tr>
<td>• Infrastructure supports patient population management</td>
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<td>• Collaboration tools and reports to support providers</td>
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<tr>
<td>• Monitoring of patient-centric needs &amp; solutions</td>
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<tr>
<td>• Physician led provider teams at treatment sites</td>
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<tr>
<td><strong>Relationships with other Providers</strong></td>
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<tr>
<td>• Sufficient patient access to PCMH providers</td>
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<td>• Dedicated primary care sufficient for population</td>
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<tr>
<td>• Specialist protocols supporting best practices</td>
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<tr>
<td>• Inter-provider communication processes &amp; agreements</td>
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<tr>
<td><strong>IT Infrastructure</strong></td>
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<tr>
<td>• EMR/EHR &amp; Practice Management Systems in place</td>
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<td>• Electronic data capture &amp; care management reporting systems</td>
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<td>• IT workforce with ongoing skill development programs</td>
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<tr>
<td>• Meaningful use of IT systems</td>
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<tr>
<td>CRITERIA</td>
<td>Development Required</td>
<td>Limited Capabilities</td>
<td>In-Place: Performance Evident</td>
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<tr>
<td>Clinical Management Infrastructure</td>
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<tr>
<td>• Clinical quality outcomes &amp; reporting capabilities</td>
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<tr>
<td>• Evidence-based standards of care employed</td>
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<tr>
<td>• Multi-level care management programs &amp; staff</td>
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<tr>
<td>• Clinical pathways for best practices monitoring</td>
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<td>Financial Risk Management</td>
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<tr>
<td>• Medical service expense (MSE) management capabilities</td>
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<tr>
<td>• Processes to assess financial risk of VBP models</td>
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<tr>
<td>• Cost accounting capabilities across episodes</td>
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<tr>
<td>• Provider-health plan partnerships</td>
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<tr>
<td>Ability to Receive &amp; Distribute Risk Payments</td>
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<tr>
<td>• Knowledge about quality incentive payment models</td>
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<tr>
<td>• Multi-provider agreements to distribute payments</td>
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<tr>
<td>• Access to actuarial support for payment distributions</td>
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<tr>
<td>• Financial reporting systems specific to risk payments</td>
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<tr>
<td>Patient Education &amp; Satisfaction</td>
<td></td>
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<tr>
<td>• Care management results available to patients</td>
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<tr>
<td>• Commitment to respect patient rights</td>
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<tr>
<td>• Method for patients to submit &amp; receive feedback</td>
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<tr>
<td>• Wellness activities &amp; community services for patients</td>
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• ACO AIRLINES ANALOGY
  – ACO Growth
  – Payment Models
  – Attributes
  – Infrastructure

• ACO PAYER CONTRACTING – 4 STEPS
  I. Reposition for Value-based contracting
  II. Assess the trust level of each ACO contracting payer
  III. Identify criteria to use in aligning payer-provider goals and values
  IV. Establish contracting priorities and develop negotiation strategies

• ACO READINESS ASSESSMENT
NEXT STEPS

• Assess internal capabilities & resources
  • Time availability
  • Internal expertise
  • Analytic tools & resources
  • ACO Readiness Assessment results

• Determine what should be outsourced
  • Readiness criteria development
  • Strategic payer negotiations
  • Payer relationship evaluations
  • Contracting priorities and strategies
HOW TO PREPARE FOR ACCOUNTABLE CARE

CONTRACTING: PRIORITIES AND NEGOTIATIONS

For more information about Reliance Consulting Group, visit:
www.RelianceCG.com

Or

Contact Dr. Schmitt directly: jschmitt@reliancecg.com