Unlocking the Value of ACOs

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Unlocking the Value of Accountable Care Organizations by Choosing the Right Contractual Approach

There has got to be a better way! That's the common lament from all aspects of the health care industry from providers, payers, and patients alike when talking about the relationship between those three parties. It not unusual to hear complaints like, "misaligned financial incentives", the "tyranny of the 15-minute visit", or it's an "unsustainable system".

Accountable Care Organizations (ACO's) are being hailed as that better way by establishing a system of coordinated care that shares in financial risks and rewards to eliminate current problems with existing payer, provider, and patient relationships. Coordinated care s is considered "the most promising path toward financial sustainability and away from alternatives that shift costs onto patients, providers, and private purchasers."[i]

ACOs hold providers and payers jointly accountable for maintaining the health of their patients, giving them strong incentives to cooperate and save money by avoiding unnecessary tests and procedures.[ii] When an ACO succeeds in both delivering high-quality care and reducing the cost of that care below what would otherwise have been expected, providers can share in the savings.[iii]

While ACOs offer a great deal of promise, they will face many of the same problems plaguing traditional healthcare relationships if they are structured poorly. Fortunately, ACOs can learn from other organizational models ranging from governments, to non-profits to commercial enterprises that have been successfully working under similar relationship structures. These models can provide the necessary guidance for negotiating and structuring a collaborative, ACO risk-reward relationship.

This paper offers those who wish to develop successful ACO agreements a proven negotiation and contracting process that has been proven successful in properly structuring such relationships. The process, as set forth below, has been termed "relational contracting" by the International Association of Commercial Contract Management and Vested ™ by the University of Tennessee.

Fee-For-Service is Costly to All

There continues to be tremendous pressure in the United States on the healthcare industry to control the rising costs of healthcare. Medical bill inflation is rising faster than the broader consumer price index of about 2 percent annually.[iv] In late 2015, the U.S. Bureau of Labor Statistics reported consumers' healthcare inflation up 2.9 percent. The historic fee-for-service model is openly blamed for these rising costs. Additionally, economists fear that healthcare will soon be unaffordable for most citizens.

Paul Ginsburg points out in a recent Wall Street Journal article that if providers stand to make more money by the more tests and procedures they perform, it's no wonder that health-care costs have skyrocketed in recent years.[v] He adds that given medicine's growing complexity and the increasing number of Americans with chronic diseases, paying numerous providers to work independently on a fee-for-service basis makes little sense.[vi]

Experts across the industry are promoting the need to move from the fee-for-service model to value and quality based models.[vii] There is a strong belief that eliminating the historical fee-for-service model will have significant impact on driving down the cost of healthcare. Like other physicians, Ginsburg promotes a model where payers and providers work together and share in both savings and losses; providing incentives to care about the quality and efficiency of patient care.[viii]

The State Health Care Cost Containment Commission released a report[ix] that supports these views and calls for creative approaches to cutting costs and moving towards a coordinated care-model.[x] "The

opportunity exists to transform how healthcare is delivered. The goal is straightforward but ambitious: Replace the nation's reliance on fragmented, fee-for-service care with comprehensive, coordinated care using payment models that hold organizations accountable for cost control and quality gains."[xi]

Why an ACO?

In 2011, the Affordable Care Act introduced the concept of the ACO to establish much needed coordination between providers while also attempting to reduce rising costs.

In effect, the ACO strives to ensure that providers share responsibility for keeping patients well. The primary care physician remains at the center of the model with the aim of incentivizing cost control while improving the care received by the ACO patient.

ACOs are capturing nationwide attention as they develop at an ever-increasing pace. According to the Centers for Medicare and Medicaid Services, the Affordable Care Act includes an attractive provision that financially rewards those Medicare ACO's which are able to lower their growth in health care costs, achieve quality care performance standards, while simultaneously putting patients first.[xii] This is quite a shift from the traditional fee-for-service model where the physician is paid for each test and procedure ordered.

The same is true for Commercial ACOs. This emerging model offers doctors and hospitals financial incentives to provide high quality care while keeping costs down. "If an ACO succeeds in both delivering high-quality care or improving care and reducing the cost of that care below what would otherwise have been expected, it will share in the savings it achieves."[xiii] To do both (coordinate care and reduce costs), the ACO needs to have structured incentives and contractual supports in place to move mainstream delivery of health care toward accountable care.[xiv]

Commercial payers are attracted to the quality of care and outcomes delivered under this model, and have worked closely with healthcare organizations to form their own Commercial ACO relationships. David Muhlestein, PhD, JD, senior director of research and development at Leavitt Partners, reports that in 2015 120 organizations have become ACOs in public and private programs, bringing the total to 744 since 2011.[xv] Muhlestein reports continued growth in the number of people covered by these arrangements. He estimates that there are 23.5 million covered ACO lives with only 7.8 million being part of the Medicare ACO programs. His research points out that commercial payers such as Cigna, UnitedHealth, and Aetna have significantly expanded their involvement in ACOs since 2011 and indicates that the growth will continue.

Commercial ACOs are different from Medicare ACOs in that a commercial payer, rather than Medicare, is incenting the provider for quality and cost outcomes. Commercial insurance companies set their own ACO quality metric parameters, typically[xvi] focused on decreasing the cost of healthcare services and improving patient care. To be eligible to share in the savings, these quality and performance measures must be met by the provider.

In the Commercial ACO business model payers aim to treat physicians as genuine partners. Historically, physician practices report having very little negotiating leverage with commercial payers and feel cheated when they experienced declining reimbursements. They blame lower compensation on commercial payers trying to slow the healthcare inflationary impacts on their own business. Physicians found themselves in what they viewed as a "take it or leave it" position. It is exciting to see physicians being invited to collaborate with commercial payers as payers have realized that to be successful physician buy-in is a key ingredient.

A History of A Lack of Trust

Forming these Commercial ACOs with commercial payers has been a cultural shift for providers. The Chartis Group describes the traditional provider payer relationship as arms-length at best, with interactions limited to negotiations over reimbursement, coverage policies and conflicts related to denied claims and overpayments.[xvii]

The American Medical Association indicates that because of their prior experience with health insurers, some physicians may not be sanguine about the possibility of a win-win ACO collaborative with a health insurer. Many physicians have had to shoulder the disadvantageous terms of take-it-or-leave it contracts, cope with black box payment rules and fight unresponsive bureaucracies to provide their patients the care they need.

In addition, physicians' practices continue to be plagued by avoidable administrative inefficiencies and a lack of transparency that diverts valuable time and resources from patient care. In the most unpleasant cases, physicians have had to resort to litigation to rectify these and other negative effects of dealing with health insurers. This history is likely to jade some physicians' view of potential health insurer ACO collaboration.

Charting A Value Based Path Forward

With an untrusting fee-for-service landscape in place, it is little wonder that providers are wary of entering into a highly collaborative ACO relationship with commercial payers. Nevertheless, ACOs are a viable way to enhance patient care while controlling costs.

Therefore, getting providers to trust the commercial payer and willingly enter an ACO arrangement is critical for success. In fact, the American Medical Association's Practice Management Center[xviii] advises that a commercial payer cannot secure the requisite physician buy-in, until the following are in place:

1. The physicians are involved in selecting and/or developing the quality and cost effectiveness metrics;
2. The methodology, including any risk adjustment mechanisms, the health insurer utilizes to determine physician performance is fair, statistically valid and fully transparent;
3. Physicians have access to the data that the health insurer utilizes to evaluate performance;
4. Physicians receive timely and readily understandable feedback concerning performance with professional assistance from respected peers when improved performance is desired;
5. Physicians have an opportunity to appeal performance determinations that they believe are inaccurate; and
6. Physicians have an opportunity to appeal performance determinations they feel are inaccurate.

Each of these points can be addressed by a more relational contracting model or Vested ™ approach to developing highly collaborative outcome based relationships, such as an ACO. A relational contract is based upon a business relationship built on trust between the parties. While, there still exist explicit traditional operational and legal terms and conditions documented in a contract, the difference in a relational contract is that there are also explicit and implicit terms, conditions and understandings which guide the parties' behaviors towards each other.

A relational contract stands in contrast to the more traditional or classical contract. Traditional contracts are arm's length agreements meant to get the best "deal" at a fixed point in time. The party with the most power and least to lose is often victorious. When purchasing widgets that are identical with plenty of fair market competition, arm's length transactions can provide the best price and value to both the buyer and the seller. Traditional contracting approaches become less suitable as the business outcomes

both parties are trying to achieve require a relationship built on high levels of cooperation, such as in providing and paying for medical care.

Ian MacNeil, a contract scholar, wrote, "Classical law views cooperation as being 'of little interest' and external to the contract. In part this is because it assumes a common base of presumed rules by the parties."[xix] If that common base of presumed rules is mutually beneficial, then the parties are playing on an even playing field. If, however, one party assumes rules that benefit themselves at the expense of the other party, the relationship is lopsided. The party able to exert more power will get better financial terms at the other party's expense until the relationship ends. If both parties assume rules that each is it the relationship for their own gain, the parties take turns exerting control until the relationship ends.

To develop a mutually beneficial ACO model, the parties must change their past relationship and contracting practices and embrace a new model for negotiating highly collaborative relationships. A successful model has two elements: A set of behavioral rules to establish and maintain trust, and a contract structure to support collaboration between parties with differing points of view. According to research done by the University of Tennessee[xx], highly collaborative relationships follow both contractual and behavioral rules. These rules shape both the parties behaviors while in the relationship and influence the contractual architecture. Following these rules during the formation of the relationship positions the parties to better perform towards a shared set of outcomes throughout the duration of the relationship.

Suzanne Madden says if you look at objectively at payers you'll see that they are in a different industry than healthcare providers.[xxi] Payers are in the finance industry and providers are in the healthcare business. She goes on to say healthcare providers are essentially "vendors" from the payer's point of view. The role of providers is to provide healthcare to patients and the role of the payer is to pay as little as possible for the care. She views the bottom-line costs as the driving-force behind how healthcare payers operate.

Building and Maintaining Trust

To provide both better care and reduced costs, Commercial ACO relationships need to be based on mutual trust. It is that simple, but not necessarily easy. "**Trust** is *the* core quality of any collaborative partnership. Trust lowers transaction costs, fosters innovation and provides the necessary space for the flexibility and agility needed in today's markets."[xxii]

Yet, with trust comes opportunism, described by Oliver Williamson, the Nobel Prize winning economist as "self-interest-seeking with guile". Opportunism in today's pressured environments can be very attractive to decision makers who are expected to continually improve results. Leaders in payer and provider organizations are pressured to improve financial results.

In a system where the commercial payer is financially incentivized to reduce costs, and the provider is financially incentivized to maximize services in a fee-for-service model, each party can feel as if the other is out to take advantage of them. The problem is that the payers and providers alike see no way to change how they each achieve those results other than pressuring the other party to concede to their own demands. That sense of needing to protect oneself from the other party's demands justifies opportunistic behavior and erodes trust.

Case in point, the 2015 Revive Health Payer Trust Index finds that physicians broadly distrust health insurers and believe they interfere with their ability to provide quality care.[xxiii] The 600 primary care and specialty physicians polled said the quality of coverage and number of claims denials are what most influences their opinion of health insurers.[xxiv]

Medscape, a Web resource for health professionals, polled over 6,000 physicians in an online survey about the physician-payer relationship. Based on survey findings, Jane Antonio reports that when providers are asked for advice on dealing with insurers, some doctors were strongly negative.[xxv] Twenty-two percent urged peers to be aggressive, telling them to "fight", "be tough", or "lawyer up".[xxvi] Another eight percent voiced despair or suggested leaving medicine, with imperatives like "quit", "pray", or "scream".[xxvii]

Trust exists when a person or organization has confidence in a positive result even when the issues and outcomes are out of their control, **and** there is risk of a potentially negative consequence. Partners also trust one another when neither side has reason to expect that it will be taken advantage of, and whenever possible, will even do things that advance the other's interests.[ssviii]

Because trust is so fundamental to a Commercial ACO's success and a history of opportunism such a real threat to success, negotiators should establish processes centered on six social norms. The six guiding principles are outlined in Getting to We, Negotiating Agreements for Highly Collaborative Relationships[xxix]. Agreeing on a set of principles reduces the possibility of opportunism, leading to a fairer and balanced workable decision making process.

The Six Guiding Principles

The six guiding principles act as social norms for businesses and ensure that the parties interactions are fair. But agreeing on a single standard of fairness is impractical and unworkable in a complex business relationship.

Businesses that understand the nature of opportunism also recognize that there are actions they can take to minimize the risk or effects of the behaviors of the other party. The most powerful way to exert control to stem the effects of opportunism is to create an atmosphere that encourages trust by regulating behavior and monitoring the activities of both parties.

The six guiding principles guide the parties' behaviors as they negotiate everything, from financial incentives, to governance to the definition of "maintaining patient health". It is critical to remember that the principles drive collaborative behaviors. The six core principles that help establish and maintain trust are:[xxx]

Reciprocity: Reciprocity obligates them to make fair and balanced exchanges. If one party accepts a business risk, the other must be prepared to do the same. If one party commits to invest time and money in an important project, the other party must be prepared to agree to reciprocate.

Autonomy: At the individual level, autonomy refers to the ability to act based on reasons and motives reflecting the individual's own values and convictions. The same applies to business relationships. People want to make their own decisions, free from the power of another; they want to work as equals and they want to be part of a process that allows them to make decisions in their best interest and the best interest of the group.

Honesty: In a collaborative relationship, the parties must commit to the principle of honesty. Fundamentally, the honesty principle obliges the parties to tell the truth, both about facts in the world and about their intentions and experiences.

Loyalty: Loyalty is chosen as a principle because it obliges the parties to be loyal to the relationship. Loyalty to the relationship—or "relationship first" thinking—will come when the parties' interests are treated with equal importance.

Equity: Equity has two equally important components: proportionality and remedies. Proportionality means one party may get a larger distribution of rewards (remedy) than the other to compensate that party for taking greater risks, or making investments (proportionality). An equitable remedy allows the parties to come to a fair resolution when the contract itself may otherwise limit the result or be silent on the matter.

Integrity: The principle of integrity refers to past events, when the parties were involved in similar situations. Simply stated, integrity means consistency in decision-making and in actions.

"These are principles of action, telling the parties how to act and behave in relation to one another when establishing and living the relationship."[xxxi] As the parties jointly commit to follow these principles over the course of the relationship, the relationship is freed from the need to purse opportunistic behavior to improve financial results.

These principles become the rules for cooperation that MacNeil noted were missing from the traditional contracting approach. Furthermore, when both parties act in accordance with these principles in relation to one another, the parties show that they care more about the relationship than for their own short term self-interests. It is by agreeing on and abiding by these principles that trust is created and maintained.

Social controls can be very powerful especially where contractual controls are not able to encompass all possibilities -- a condition that describes many complex and interdependent relationships. Using a relational contracting approach, such as Vested™, will establish the contractual controls necessary to deliver on the overarching outcome of maintaining patient health.

Five Contractual Rules for More Collaborative Relationships

According to the authors of Vested Outsourcing, Five Rules that Will Transform Outsourcing[xxxii] there are five rules all highly collaborative relationships follow when establishing business relationships. The conversations that arise from following these rules help the parties work out those often-nebulous relationship rules of conduct. These rules were developed from research conducted at the University of Tennessee:

1. Focus on outcomes, not transactions.
2. Focus on the what, not the how.
3. Agree on clearly defined and measurable outcomes.
4. Optimize pricing model incentives for cost/service tradeoffs.
5. Leverage a governance framework that provides insight, not merely oversight.

Each of these five rules can reduce opportunism (defined as self-interest seeking with guile) because the rules help the parties focus on developing a mutually beneficial three-way relationship (patient, provider and payer). From that relationship flow the varied transactions necessary for the parties to coordinate patient care. Opportunism thrives in environments where relationships are secondary to the gain from a single transaction.

The rules also interact with each other to make the practice of opportunism even less attractive. To some degree the rules guide the parties to act rationally in the decisions that they make. For example, leveraging an insightful governance framework (Rule 5) helps the parties achieve their clearly defined and measurable outcomes (Rule 3).

The following section provides an overview of each of the five rules, how the rules help to control opportunism, and how they work together to reinforce the creation of a highly collaborative relationship.

Rule 1. Focus on Outcomes, Not Transactions

By focusing on outcomes, the parties close off the traditional opportunistic playground for providers where every service is an opportunity to get paid (fee for service). The fee-for-service model has been openly blamed for the rising costs of healthcare. Historically, providers treated the patient and retrospectively sent the bill to the payer for payment. Thev model was designed to reward for volume. The more the provider treated the patient the more they were paid.

Rushika Fernandopulle points out that in the fee-for-service model every health care issue or question tends to become a doctor visit (because it is paid for) which leads to reactive care, and in turn leads to framing the job as taking care of one patient at a time.[xxxiii] Fernandopulle compares this practice to a never-ending series of widgets on an assembly line. He goes on to say that by continuing to pay doctors by RVUs (relative value units or "productivity") is not a good idea. Instead, providers need to see their jobs as having a defined population who are their responsibility, and their role is to improve their health, and keep them out of trouble (e.g. the hospital, emergency room, and unnecessary procedures).

Fernandopulle advocates that under a collaborative model providers can now be creative to meet patient needs – whether by the doctor, nurse, social workers, or health coach; and whether it be in person, by email, text, video, group, home, or hospital visit.[xxxiv] He adds that providers love being able to do what they went into medicine to do – taking care of patients and be creative in doing so, and not feel like assembly line workers.

By focusing on outcomes to achieve patient wellness, providers, payers and patients are encouraged to make decisions to achieve coordinated care. Likewise any additional services and medical tests the provider or patient want would be viewed through the 'outcomes' filter to see whether it aligns with the goal of coordinated care for patient wellness. Keeping an eye on coordinated care will inevitably reduce costs for unnecessary services, but with the added goal of patient wellness, patient care will not be sacrificed simply to save money.

Rule 2. Focus on the What, Not the How

This rule is particularly powerful when combined with optimizing the pricing model (Rule 4) in eliminating opportunism. By focusing on the "what" providers are encouraged to invent less costly ways to coordinate care while maintaining patient health. To truly focus on patient health as a viable source of revenue—not fees for services—payers must develop financial incentives that reward providers for maintaining patient health,

By way of example, let's assume that the "what" facing providers and payers is reducing office visits to monitor a patient's blood pressure. One cost effective way to maintain patient's health would be to promote patients' use of technology to check their blood pressure at home. However, if the provider loses a source of revenue in the fee for service model in the form of a payment for the visit, providers may be reluctant to agree to at home monitoring. The provider must weigh the risk of the possibility that the patient will not regularly monitor his/her blood pressure, or will inaccurately perform the monitoring. Both scenarios could lead to the development of a potential more serious health issue.

Therefore, the financial incentive to the provider cannot come merely in the form of a rebate for cost cutting. That type of incentive might be perceived by some providers are too risky for the patient. The financial incentive must be based on the larger outcome—overall patient health.

Rule 3. Agree on Clearly Defined and Measurable Outcomes

This rule provides precision around what is to be achieved by the parties. To work for the benefit of all parties, the measures ought to be jointly owned and developed collaboratively. In this way, no one party (payer, provider or patient) shoulder more than their fair share of the burden to meet the outcomes.

Any deviations from meeting the outcomes caused by opportunism would be quickly identified and raised for discussion in the governance process (Rule 5). As indicated earlier in the paper, passive opportunism often relies on the other party not being aware of the act or only becoming aware after some time had passed. The fact that the opportunistic act interfered with the clearly defined outcomes, regardless of the offending party, would give rise for discussion by all parties to the agreement. In effect, governance plus clear measure creates an environment for trust to flourish.

Rule 4. Optimize Pricing Model Incentives

As referred to in the discussion under Rule 2 the payer actively wants the provider to manage patient health by thinking in more innovative ways. To do that, payers and providers alike should buck the traditional fee-for-service payment model. The benefits being two-fold: that payers and providers are actively engaged in the process of maintaining patient health, and the rewards for patient health are shared equitably amongst the parties.

The financial model should be biased towards rewarding innovation rather than merely meeting the standard of care; therefore, it is in both the payer's and provider's interests work collectively to deliver overall patient health rather than treating the sick.

UnitedHealthcare has engaged in collaborative relationships aimed at rewarding providers for pa-

tient health.[xxxv] The company reports that slightly more than 11.5 percent of its total spending on health care services is tied to incentive contracts that reward providers for increased collaboration, outcome-based results and improved cost-efficiencies.[xxxvi]

These incentives based contracts include capitation agreements[xxxvii] for physicians and hospitals, shared savings and shared risk agreements, global risk patient-centered medical home pilots and bundled payment arrangements. Because of these types of agreements, UnitedHealthcare's individual and employer-sponsored plan participants experienced an 11 percent reduction in hospital admissions and an eight percent reduction in emergency visits.[xxxviii]

UnitedHealthcare's President of Networks, Dan Rosenthal credits the success to building collaborative relationships with care providers and ensuring plan participants have access to high-quality, cost effective care. He explains that "Working with care providers to ensure they have the right support and initiatives will help connect the people we serve to the most effective care, place a greater focus on the quality of their care, and compensate providers for improving patients' health."[xxxix]

Rule 5. Leverage a Governance Framework that Provides Insight, Not Merely Ovversight

This final rule provides that glue to allow the parties to achieve their over-arching goals. Insight based governance will help identify and address behaviors that are tending towards the opportunistic. It is a forum that allows the provider to call out the payer on behaviors that don't match the five rules. Likewise, the payer can raise concerns with providers to understand the root cause of an issue, such as when overall patient outcomes are not improving

Governance structures are usually set up to give teams from both parties the responsibility for managing performance and the relationship. The principle of putting two people together, one from each party, at each level in the hierarchy to jointly manage an element of the arrangement is sometimes called 'two in a box'. These 'two-in-a-box' relationships, particularly at the lower levels in the hierarchy, meet daily or weekly to address issues as they arise, not once they morph into serious problems. A robust relationship is thus formed making opportunism hard to consider even without the controls brought about by the other four rules. If opportunism begins to creep into the relationship, then senior leaders can openly discuss it at a Quarterly Business Review

Daniel Finke, Aetna's CEO for Accountable Care Solutions, cites trust as being an important part of the payer-provider relationship as a growing number of providers transition to value-based models and assume more risk for the quality and overall cost-effectiveness of patient care.[xl] He believes that providers and payers can each benefit by working together to establish ACO's, introduce ACO-based products and even form joint ventures. However, the ultimate success of these arrangements depends on how well each party can establish appropriate trust and leverage the other's strengths.

In 2014 Aetna reported that their multi-year risk-sharing accountable care collaboration with Arizona based Banner Network netted $5 million in shared savings and a five percent reduction in average medical costs for members in the insurer's Whole Health plan.[xli] The team also reported improved cancer screening rates, blood sugar management for diabetic members and reduced avoidable hospital admissions.[xlii]

Insight based governance based on the Six Guiding Principles will go a long way to helping the parties establish the requisite level of trust. When an ACO starts from a basis of trust, payers and providers can openly review each organization's capabilities in care management, data analytics, and patient engagement. They can decide together on the programs that are best suited to support the patient populate and achieve quality and cost outcomes.

When applied to a Commercial ACO these five rules will meet the AMA's suggestions noted above and will transform traditional payer/provider relationships, improve patient treatment and decrease costs.

Successful ACO's in The Market

United Healthcare stresses that successful ACOs require forging a different relationship with the provider community with an emphasis on collaboration, transparency and long-term commitment.

Memorial Herman Accountable Care Organization (MHACO) created a branded accountable care network with Aetna.[xliv] Finke explains that both parties were seeking to create a new model of care for patients and create a health plan product designed to be priced around the new care model. They wanted to find ways for everyone involved in the care of a patient population to collaborate with one another. There efforts have paid off and it is reported consistent membership growth and cost and quality improvements. MHACO reports improved efficiencies and lowered costs from 2013 to 2014 achieved by:

- Increasing generic prescription rates
- Reducing avoidable emergency room visits
- Reducing 30-day admission rate
- Reducing impactable medical days
- Reducing impactable surgical days

Finke summarizes that providers and payers can share and learn from each other's data and expertise. With common goals for patient outcomes, providers and payers can get one step closer to the triple-aim: improved care quality, lower cost and a better patient experience.

It takes considerable time and managerial resources to become a full-fledged ACO.[xlv] While many organizations have failed to fully realize all of the goals of accountable care many have made significant progress in transforming how they deliver care.[xlvi] Muhlestein points out that a full transformation cannot be realized in just a year or two.

Aetna's Vice President of Network and Product Strategy Accountable Care Solutions, Amy Oldenburg, also addresses transformation as a long-term endeavor. "We know that it takes three years for motivated ACOs to make changes necessary to impact real savings and quality improvements."[xlvii]

The Center for Medicare and Medicaid Services (CMS) acknowledges that the longer an ACO is in operation, the greater the savings they generate. Pioneer Accountable Care Organizations, a CMS innovation center initiative, was able to achieve more cost savings during their third year of operations than the first year.

Conclusion

ACO's offer a great deal of promise in creating a better system of coordinated patient care that permits payers and providers to share in financial risks and rewards. Most importantly, coordinated care will allow providers to enhance the quality of patient care while better managing costs.

This promise of both delivering high-quality care and reducing the cost of that care below what would otherwise have been expected, requires trust, behaviors that drive the relationship for the good of all parties, and contracting rules that govern the relationship for the mutual benefit of all parties.

The five rules outlined in Vested Outsourcing, Five Rules that Will Transform Outsourcing and the six guiding principles outlined in Getting to We, Negotiating Agreements for Highly Collaborative Agreements offers the best pathway to success. Organizations ranging from governments, to non-profits to commercial enterprises have been working under relationship structures that provide the necessary guidance for negotiating and structuring a collaborative, risk-reward relationship, there is a greater opportunity to create highly successful ACO's.

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Audrey Cushing is Strategic Sourcing Director in the supply chain management organization at a Fortune 100 financial services company. Prior to joining her current employer, Audrey served in a similar capacity at The Hartford Financial Services Group, after several years of successively more responsibility for similar functions at MassMutual. Her areas of expertise include business process outsourcing (BPO), request for proposals, supplier relationship management, service level agreements, and complex negotiations, often with large multi-national service providers.

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