

Direct Contracting With Accountable Care Organizations: The Purchaser Perspective

BRUCE W. SHERMAN, MD; AND BRIAN KLEPPER, PHD

The health care purchaser marketplace is steadily moving toward value-based arrangements that align incentives between providers and health care purchasers (plan sponsors), reward performance, and transparently share the savings between both parties. Early initiatives, such as the center of excellence (COE) program adopted by Lowe's, Walmart, and others, targeted specific high-cost surgical interventions, incorporating the use of high-quality health care entities and bundled pricing to optimize outcomes while ensuring predictable case costs.¹ Similarly, organizations with geographically consolidated workforces, such as Boeing and Microsoft, have partnered directly with local integrated delivery networks for comprehensive care delivery.^{2,3}

The pandemic has intensified pressure on employers and other plan sponsors. A reduction in sales and tax bases, along with a continued increase in health care costs, has driven active exploration of alternative approaches. At the same time, there has been a remarkable proliferation of so-called point solutions that are being marketed directly to employers to address unmet health care market needs. Health plan sponsors' growing interest in solutions external to health plans is an indication of the potential for accountable care organizations (ACOs) to contract directly with area employers. Accordingly, this article provides insight into health care purchaser priorities and considerations for direct contracting opportunities, along with considerations for interested ACOs.

CURRENT STATE

Purchasers are acutely aware of relentless year-over-year health benefit cost increases. Their focus has largely been directed toward improving outcomes for prevalent and high-cost conditions through the use of case and condition management programs, which are often provided by their health plan. Continued purchaser reliance on health plans

for health care service delivery has effectively perpetuated the status quo, thereby limiting opportunities for exploration of alternative health care solutions.

To better understand health care cost drivers and reveal opportunities for improvement, purchasers have traditionally relied on claims analyses that detail health plan performance. Although the data can provide insight into the allocation of expenditures, the context critical for data interpretation is typically lacking. Comparison with health plan benchmark values, routinely used in plan performance evaluation, provides what might be considered a biased standard for health care utilization and costs. Additionally, it obscures the potential for disruption from high-performance solutions that can improve outcomes while also lowering costs.

There is an appetite for change. The Willis Towers Watson 2020 Health Care Delivery Survey revealed that 73% of employers plan to adopt different health care delivery models in the next 3 years, which is an increase from the 53% reported for the prior period.⁴ These models include COEs, high-performance narrow networks, and other alternative delivery models. The survey also found that 34% of employers currently offer market-specific health care delivery solutions based on availability and workforce needs, with the number expected to increase to 56% during the next 3 years. According to the survey, only 6% of employers currently contract directly with health care providers.⁴ The potential for both stakeholders is evident: With a narrower network, clinicians appreciate the potential to increase volume from employers, and employers have the potential to favorably affect health care expenditures.

UNDERSTANDING PURCHASER OBJECTIVES

To successfully pursue direct contracting arrangements with employers or other plan sponsors, ACOs must understand the challenges that employers face in providing health benefits to their employees and family members. The health

plans have de facto ownership of the employer medical benefits marketplace, effectively marginalizing ACOs, which, as a result, no longer have direct involvement with purchasers. To assume a more significant role with purchasers, ACOs must understand purchasers' unmet health benefits needs, their willingness to explore and commit to direct contracting opportunities, and their perspectives on the measurement of value generation. Once established, these findings can serve as a basis for ACO-purchaser collaboration and offering development, leading to enhanced purchaser acceptance and yielding mutual value.

For most purchasers, the overarching objective of direct contracting is to reduce health care costs, with the understanding that improvements in care quality and patient experience can contribute meaningfully to the achievement of this goal. Introduction to ACO quality improvement approaches, linked to accountability measures as value-based payments, can broaden purchaser perspectives regarding alignment of stakeholder interests.⁵

Purchasers have also been introduced to a parade of new, high-performing, point-solution health care vendors apart from the health plans. These options have raised awareness that new paradigms can deliver better health outcomes for less money than the usual purchaser experience. Disintermediating the health plan as a "middleman" between clinical service providers and the purchaser has the potential to eliminate a sizable administrative expense while also fostering innovation in both care delivery and contracting.⁶

Even so, the status quo offers a level of purchaser comfort. Health care cost increases are generally predictable and anticipated, and purchasers seem to have become used to cost-shifting to enrollees as a ready solution for mitigating the increased expense. Importantly, without a context for the possible benefits—improved outcomes, better patient experience, and lower health care costs—purchasers may view their health plan experience as the lesser of evils and remain committed to the existing service delivery model, despite the potential value of other options.^{1,2,5,7}

Reluctance to change may also result from a lack of benefits department support. Benefits departments are often understaffed and rely on brokers, consultants, and the health plan for strategic guidance. For employers already facing high health care costs, the idea of investing additional resources for direct contracting relationships with health care service providers is daunting. For this reason, direct-contract proposals must offer turnkey solutions to minimize the burden of employer implementation.

Purchaser interest in direct contracting may also be limited by broad health plan networks that offer enrollees substantial

choice. Benefits managers may interpret any significant disruption or limitation as a threat to employee satisfaction. With the current tight labor market, employee turnover due to changing or restrictive benefits is a material concern.

Yet purchasers' tolerance for disruption is growing, particularly as health care prices and expenditures have continued to increase, and their appetite for further cost sharing has diminished.⁸ Interest in alternatives to health plan offerings has grown among self-insured employers of all sizes and particularly among those with more than 5000 employees.⁸ Still, only 7% of employers (but 26% of employers with >5000 employees) include a narrow network plan option, which offers services that are similar to what a direct-contract arrangement for health care services would offer.⁸

CONSIDERATIONS FOR ACOS

Offering scope. By virtue of their organizational design and performance objectives for health plans, ACOs may understandably gravitate toward a similar, risk-based contract offering for employer purchasers. As noted, this effort may be particularly challenging for ACOs without sufficient infrastructure. The absence of claims administration, marketing, communications, and contract negotiation capabilities may represent a substantial barrier to market entry. However, alternative high-value service line offerings, such as musculoskeletal care or ambulatory surgery centers, may attract purchaser interest.

Although few ACOs truly excel at offering multiple high-value service lines, that may not be a limitation for purchasers who are eager for demonstrably better health care outcomes. That represents a real opportunity for providers dedicated to higher-quality, more efficient, and lower-cost care. ACOs may attract interest from purchasers in their available high-value service line offerings. Additionally, ACOs may also benefit by partnering with specialty care management firms outside their existing services—including musculoskeletal care, cancer care, and ambulatory surgery centers—that are willing to warranty high performance.

The tide is turning, especially among large employers that are feeling pinched by their health care burdens. In 2020, the Connecticut State Employees' Health Plan decided to move away from fee-for-service reimbursement for surgeries and other hospital services in favor of bundled pricing.⁹ In 2021, the New Jersey State Employees' Health Plan brought in value-focused health advisors as reviewers, and they recommended pursuing a range of high-performance solutions not offered by the current plan administrator.¹⁰ These examples of employers straying from the traditional path would likely not have occurred 5 years ago. Indeed, these cases are part

of a larger trend that is becoming increasingly attractive to purchasers who are dissatisfied with the status quo.

Organizational structure. The ACO configuration and governance structure is likely to influence its effectiveness in a direct-contract setting with purchasers. Relative to health system-based ACOs, provider-owned ACOs likely have the greatest inherent alignment between business goals and purchaser objectives, as operational efficiency and clinical quality can assume greater relative priority in the context of substantially lower infrastructure costs. Yet health system-based ACOs may be in a better position to assume responsibility for core services that health plans traditionally provide, including case and care management, as well as claims administration. In any case, for ACOs to be successful with direct-to-purchaser contracting, unrelenting attention to clinical and financial risk reduction is paramount as the basis for payment commensurate with its ability to achieve quality outcomes and cost performance targets.

Infrastructure development. For ACOs, direct purchaser contracting requires competencies well beyond those involved in risk-based contracting with Medicare or commercial health plans.¹¹ Additional resources are needed, including sales/marketing and support teams that can interact with purchaser clients and prospects. Operationally, ACOs must master claims processing, data analytics, enrollee resource support, and other functions. Some of these services may be available through existing ACO resource channels. As ACOs expand their direct contracting business, it will become increasingly important to have dedicated personnel for these infrastructure roles. What is unclear is the extent to which the additional expense of these added administrative services will erode the potential savings gained from disintermediation of the health plan.

An accessible provider network is another vital component of a direct-to-purchaser offering. ACOs may already have a substantial clinician network, but with increased size comes inherent variability in quality and outcomes. Further, the geographic distribution of the purchaser's benefits enrollees in relation to the existing ACO provider network may have a substantial influence on the suitability of that ACO for direct contracting. Geographically localized employers may find it easier to identify a suitable regional ACO for contracting, whereas corporations with nationally distributed workforces may contract directly with ACOs where they have specific geographies in specific high-count workforce regions, as is the case with Boeing² and General Motors.¹² Narrow provider networks, such as high-performance or ACO-based networks, may be a reasonable consideration provided that sufficient but not excessive patient volumes can be managed within the direct-contract arrangement. The shift from a discount-based

health plan network model to a quality- and value-based payment model may be particularly challenging for smaller ACOs, especially when those entities are simultaneously providing services under both contracting scenarios.

From a clinical perspective, 2 components stand out as important infrastructure priorities. First, data analytics capabilities are essential for effective population health management, especially with regard to the growing interest in health inequities among commercially insured subpopulations, such as racial/ethnic minorities and low-wage workers.¹³ Second, with increasing recognition of the importance of social determinants of health as a contributor to individual health status, detailed awareness of available social support service offerings will be helpful.

Establishing value. Because their financial model is risk based and aligned with purchaser goals, ACOs are well positioned to deliver better health outcomes and/or lower costs for purchasers. Ideally, ACOs can demonstrate their value via third-party validated performance data and client testimonials, focusing on both process (high-value and low-value service utilization patterns and closure of gaps in care) and outcomes measures (health/well-being status and health care costs). The credible demonstration of value is essential for purchasers, as it represents the foundation for their willingness to proceed with disruptive change. Importantly, ACO data analytics capabilities should allow for modeling that assesses the opportunity represented by direct contracting, particularly in relation to existing health plan-provided offerings.

The **Table** is intended to be illustrative and shows conservative savings achieved by real-world high-performing vendors within specific high-value health care service line niches. Each vendor represents a "risk reduction module." With a broad-based offering, an ACO that has a risk-based financial model aligned with purchaser goals may be well positioned to aggregate these capabilities under a single contractual umbrella, with the potential for generating significant savings on total health care spending.

Initial efforts. After an ACO has identified purchaser priorities, ACO stakeholders may want to approach purchasers with modest direct-contract offerings that provide better health outcomes and/or cost performance in high-value service line niches. Such an approach would minimize the risk of disruptive benefits changes that could result in enrollee dissatisfaction. Examples include worksite or near-site direct primary care services,¹⁴ bundled payment COEs for surgeries or other procedures,¹ and management of musculoskeletal care.¹⁵ Financial solutions, such as hospital claims review or high-value claim resolution, are also immediately powerful and reinforce the point that better results are readily available.

Table. Typical Net Savings With Select High-Performance Service Line Niche Programs^a

Program	Niche as percentage of total health care spend ^b	Savings within niche ^b	Savings from total health care spend ^c	PEPY savings ^c
Primary care ^d	10.0%	30.0%	3.0%	\$461
Direct contracting ^e	18.0%	35.0%	6.3%	\$969
Diabetes/cardiometabolic care management ^f	17.0%	30.0%	5.1%	\$784
Musculoskeletal disorder management	14.0%	35.0%	4.9%	\$753
Imaging	6.0%	30.0%	1.8%	\$277
Cancer	7.0%	25.0%	1.8%	\$269
Specialty Rx management	6.0%	35.0%	2.1%	\$323
Rx pricing optimization	10.0%	15.0%	1.5%	\$231
Rx formulary optimization	10.0%	15.0%	1.5%	\$231
Across offerings			28.0%	\$4297

PEPY, per-employee per-year; Rx, prescription drug.

^aSavings net of services fees. Values are estimates, intended to be illustrative rather than precise.

^bSolution results may interact and not be cumulative.

^cAssumes 2020 blended rate of \$15,375 PEPY health plan costs per Business Group on Health, 2019.

^dPrimary care typically consumes about 10% of total health care spend but influences care and cost throughout the care continuum, driving appropriate and disrupting inappropriate treatment practices.

^eIncludes reference-based pricing, bundled pricing, and centers of excellence.

^fIncludes diabetes, coronary artery disease, hypertension, chronic kidney disease, and obesity.

With these offerings, ACOs can generally complement, rather than compete with, existing health plan offerings. Successful implementation demonstrates the value that can often then be leveraged into an expanded scope of services. However, it is important to note that the potential for value is likely greatest within a full-service at-risk model; direct primary care, bundled payment for surgeries, and condition management programs may generate some cost savings, but they are unlikely to reach the extent that a broader offering can provide.

Some purchasers have opted to start with comprehensive direct-contract offerings with area ACOs for a full scope of health care services.² Typically, these have been included as a distinct benefits option (such as a high-performance

or exclusive provider network) among other established health plan offerings. This approach allows enrollees to select their preferred benefit design, minimizing disruption. Over time, as ACO value is more clearly quantified, the purchaser's plan design for the ACO option can be made more financially attractive to enrollees to generate increasing enrollment.

Anticipating purchaser priorities. As noted, purchasers considering direct contracting with area ACOs can be expected to ask hard questions to determine whether a solution merits consideration as part of a larger health benefit offering. The questions below represent some, but not all, of the concerns that ACOs may face in their direct contracting marketing efforts.

1. **Are there convincing data that the ACO works and that it delivers better results than conventional approaches?** Can the ACO show longitudinal data demonstrating consistent delivery of better health outcomes and/or lower cost within its marketed service offering? Data that have independent, third-party validation are even better. Purchasers may question the ACO's analysis findings and may want to investigate their calculation methodologies to make sure the ACO is not making unreasonable assumptions or manipulating the data to its advantage.
2. **How well do current ACO capabilities align with purchaser priorities?** Is there a good match, or are there internal development needs within the ACO that need to be addressed to improve requested services prior to consideration for direct contracting? Are there external resources that can be utilized to address gaps?
3. **Do past clients vouch for the ACO?** Are there client testimonials (with contact information, so potential clients can speak with them directly) that convey high satisfaction with the ACO's services? Few things are as convincing as a client detailing a vendor's performance.
4. **How does the ACO scale?** Can the ACO demonstrate that it is able to deliver consistently high performance in different locations and with groups that have differing characteristics?
5. **Are the ACO's service outcomes sustainable?** Do these outcomes endure and remain effective over time? The ACO may deliver measurable impact within 3 months, but can it show that the impact endures over sustained periods?
6. **Are the ACO's solutions easy to deploy?** How does the ACO integrate with other key organizations/functions in the health care services ecosystem? As programs and tools that are managed separately can impede workflow, it is critical to understand how the ACO solution fits into existing processes.
7. **Will the ACO guarantee results?** Is the ACO confident enough in its performance that it is willing to put its fees at risk in relation to identified performance targets? This is the litmus test for any vendor, and those that are unwilling to do so may warrant disqualification.

Other considerations. In the current health plan-driven scenario, many purchasers have partnered with innovative point-solution vendors to address what they see as unmet needs. Purchasers may want to incorporate those

point-solution offerings alongside ACO-provided services. Alignment and integration with these offerings may be a reasonable consideration, in that the effort demonstrates an interest in collaboration. Cross-referrals between the ACO-provided service and the point solutions can enhance value generation for both entities.

Depending on the scope of the anticipated ACO direct-contract offering, health plans may perceive them as a market threat, even when the initial scope of engagement does not affect health plan-provided services. ACOs should be aware of the possible implications, which have the potential to negatively affect plan-negotiated reimbursements to the ACO across the full range of health plan business.

Another area of potential concern relates to the demands of the purchaser-ACO contracting process. Health plans have traditionally negotiated provider discounts as part of their scope of services, with no involvement from purchasers. With direct contracting between purchasers and health plans, the process could be complex and demanding, with each purchaser seeking more favorable contract terms. The resulting contracting demands may necessitate a substantial resource investment for ACOs.

CONCLUSIONS

In increasing numbers, purchasers of health benefits are exploring alternatives to better manage rising health care expenditures. Although interest is growing, there are few practical examples, and most involve larger employers and ACOs. Greater alignment of purchaser and provider interests—in relation to quality, cost, value, and the patient experience—can help stakeholders transition away from a fee-for-service model to one that rewards value and promotes workforce health and well-being. And although the proverbial devil is in the details, a reasonable path exists toward greater direct contracting between purchasers and ACOs.

Author Affiliations: Triad HealthCare Network (BWS), Greensboro, NC; Case Western Reserve University School of Medicine (BWS), Cleveland, OH; Worksite Health Advisors (BK), Orange Park, FL.

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Send Correspondence to: Bruce W. Sherman, MD, 117 Kemp Rd E, Greensboro, NC 27410. Email: bruce.sherman@case.edu.

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