Defragmenting the Delivery System Through Quality and Contracting Alignment
Memorial Hermann Health System’s Approach

BACKGROUND
Memorial Hermann Accountable Care Organization (MHACO) is nationally recognized as the most successful participant in the Medicare Shared Savings Program (MSSP) for three consecutive years. While its ACO participation is relatively recent, Memorial Hermann attributes its success under the new model to its decade-long journey to establish an engrained culture anchored in one principle: do the right thing for the patient. It is this culture that has allowed Memorial Hermann to brave the practical barriers associated with clinical and financial integration. This case study details the health system’s journey to defragment the delivery system by aligning with physicians for the betterment of patients.

APPROACH
Long before Medicare’s ACO programs had been established, Memorial Hermann leadership believed the underlying issue of the fragmented and misaligned delivery system to be the disparate and volume-driven payment structures of various industry stakeholders. To combat this fragmentation, in 2007 the health system embarked to form a clinically integrated network (CIN) that would be built on patient-centered ideals and fueled with a culture that would allow, even encourage, change. Local physicians were invited by the health system to participate in a new organization aimed at reshaping the delivery of medicine to provide lasting value for patients and the community. The system would not tell the physicians how to manage their patients, nor would it pay physicians for joining the network; rather, the physicians and system would work together to improve quality of care.

Through a physician-developed compact, the practices were empowered with authority in Memorial Hermann’s decision-making, and health system leadership agreed to be loyal, transparent, and receptive to physician feedback. In return, the compact asked that physicians use evidence-based medicine, report quality data, participate in CIN meetings, and share their ideas. With the compact in place, Memorial Hermann then organized physicians into Clinical Program Committees (CPCs), delegating authority to make system-wide quality decisions (e.g., common pharmacy formulary, specialty-specific quality measures, etc.).

In 2009, Memorial Hermann shifted its focus to redesigning the delivery model, beginning with primary care. If the CIN was going to do what was right for the patient, primary care needed to be bolstered, aligned, and placed at the center of care delivery. The health system began to collect data, provide case managers, and wrap around each of the primary care practices regardless of whether the practice was employed or independent. Through this work, Memorial Hermann developed a more intimate understanding of how the practices functioned, and the physicians developed greater trust and appreciation for the health system.

Consistent with its original objectives to defragment and align the delivery system, in 2012 Memorial Hermann approached the physicians about allowing the system’s independent practice association (IPA) to represent their contracting interests. This way, the organizations would commit to the same quality standards, negotiate for improved rates, and be better positioned to request more data from commercial payers. With Houston’s average practice size of 1.8 physicians, the practices were disadvantaged in their negotiations with payers. Following Memorial Hermann’s invitation, 1,900 physicians—of whom only 100 were employed—agreed to allow the system’s IPA to negotiate on their behalf, with only 75 opting out. Because the physicians were well-positioned to define quality standards, especially given the work of the CPCs over previous years, Memorial Hermann requested input from the physicians regarding quality measurement prior to negotiating with commercial payers.

With the approval for single-signature contracting, Memorial Hermann approached commercial payers, detailing the organization’s quest for quality and demonstrating its superior outcomes. As part of those negotiations, Memorial Hermann requested claims files from its commercial payers to inform value-promoting strategies. However, even with commercial claims data, Memorial Hermann committed to following the same standards and care protocols for every patient, regardless of attributed payer.
Though the work to align contracting interests was a long and complex process, the power of alignment has given Memorial Hermann an advantage when recruiting ACO affiliate providers, particularly in the post-acute care space. Additionally, the physician compact provides a standard set of commitments that are still used by the network when adding newly affiliated post-acute care partners.

RESULTS TO DATE

Memorial Hermann has consistently earned significant shared savings bonuses through its participation in the MSSP, saving $92,974,537 over the past three performance years. Also, in collaboration with payers like Aetna and UnitedHealthcare, Memorial Hermann has designed commercial products that deliver value to employers. These plans have shown an increase in PCP utilization and decreases in costs for laboratory, pharmacy, radiology, and ambulatory facilities.

TOOLS & VENDOR PARTNERS

Memorial Hermann has worked collaboratively with Cerner as the alpha partner to develop the HealtheIntent platform, an enterprise data warehouse that allows the system to combine claims with clinical data to enhance analytical capabilities. Memorial Hermann has consciously invested in resources that leverage and support medical economics, including a full medical economics team comprised of actuaries, medical economists, sequel writers, and clinical- and payer-experienced analyst resources working in this space.

CHALLENGES WITH IMPLEMENTATION

Even with a strong, value-driven culture in place, joint contracting is a complex and challenging endeavor. To ensure success, the partnership must feel equal to all stakeholders, and the messaging to physicians must clearly demonstrate the mutual benefits. Memorial Hermann found it helpful to have representatives from the health system and the physician groups at the table during the discussion. Fostering the trust of the physicians took an investment of time and effort by the health system.

The network experienced a significant turning point when one payer refused to recognize the providers as a single-signature contracting entity during renegotiations. When the physicians decided to terminate the contract, the system agreed to do so as well. Keeping the provider partners aligned required a significant amount of effort, especially considering that this particular payer represented a significant amount of many of the practices’ patient panels. To stay together, physician leadership proactively organized several meetings, even one-on-one, physician-to-physician discussions to convince the practices to stay unified. After the network terminated the contract, the payer came back and agreed to renegotiate.

The mechanisms and the difficulties associated with single-signature contracting is simply an exercise underneath a larger accountable care umbrella. Both are methods for aligning providers through shared quality and financial incentives to defragment the delivery system.

Like many other provider organizations, Memorial Hermann struggled to obtain full claims files from its commercial payers. After negotiating to receive that data, the network had to develop the capabilities to digest claims files and use the information to inform future interventions.

KEY LEARNINGS

- **Don't discount culture** – According to Memorial Hermann leadership, 90% of this work is about creating a culture where difficult questions can be contemplated.

- **Give physicians decision-making authority** – Memorial Hermann continued to delegate authority to the physicians, first in developing the compact, then through the various quality committees. Provide opportunities for the entities to work together as equal partners.

- **Ownership is not required** – Of MHACO’s 500 PCPs, only 100 are employed. In the CIN, 3,500 physicians are independent and only approximately 350 are employed.

**Contributors**

Christopher Lloyd  
CEO  
MHACO and MHMD  
christopher.lloyd@memorialhermann.org

Dr. Charlotte Alexander  
President  
MHMD

Kate de Lisle  
CSB Program Manager  
ACLC  
katelyn.delisle@leavittpartners.com

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