

AMPLIFYING THE IMPACT OF PARTNERSHIPS

A SIMPLE FRAMEWORK TO HELP ENGAGE PAYERS AND PROVIDERS



Support
provided by



Robert Wood Johnson Foundation

The views expressed here do not necessarily reflect the views of the Foundation.

CONTENTS

EXECUTIVE SUMMARY	3
INTRODUCTION AND CONTEXT	4
PAYER AND PROVIDER INTEREST INDICATORS	5
THE FRAMEWORK	9
DETAILED PAYER/PROVIDER PROFILES	12
ADDITIONAL CONSIDERATIONS	22
APPENDIX: METHODOLOGY	23
APPENDIX: GLOSSARY OF KEY TERMS	24

EXECUTIVE SUMMARY

Providers and health plans both have important roles in the healthcare ecosystem, and both have important roles to play in helping to secure and advance the health of those they serve. The Robert Wood Johnson Foundation and Oliver Wyman have partnered to create a simple framework to help researchers (and other likeminded organizations looking to drive change and impact at scale in healthcare) better engage them in mutually beneficial partnerships that help ensure research actually leads to change. For this project, we defined partnerships to cover a broad range - from widespread adoption of evidence-based models, to informing and supporting the development of evidence through thought partnership.

The framework is built along two dimensions: Focus on mission-oriented activities and movement away from today's healthcare paradigms. The dimensions are more fully explained in Section 5.

Within the framework, we have identified six representative profiles of payer and provider organizations:

1. Innovators
2. Academics
3. Current-State Optimizers
4. Mission-Driven Experimenters
5. Operational Philanthropists
6. Stepping Toward Value

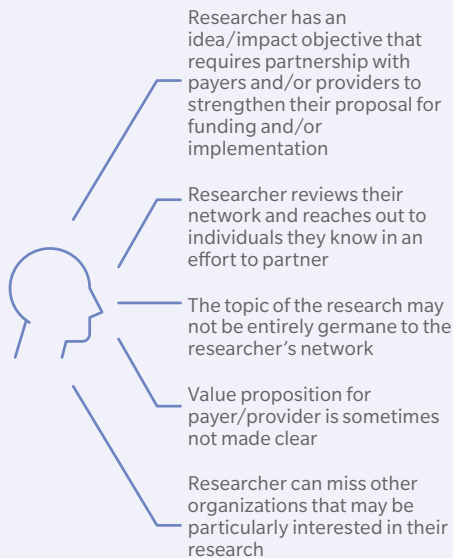
Organizations within each profile could be suitable partners for a variety of potential endeavors, depending on the researcher's interest. The framework provides a starting point for researchers to consider (1) which types of organizations they should partner with in their endeavor, (2) what the potential receptivity of the organization will be toward partnership, and (3) what topics the organization will be most interested in. While this framework certainly helps narrow the playing field for researchers (or widen it, as the case may be for someone looking to expand and scale their efforts), it should be noted that the profile information should be supplemented by due diligence on the part of the researcher. The due diligence could include examining recent regulatory changes, local market context, and position of the individual they are talking to at the organization. Furthermore, there is the possibility that organizations will evolve and could move along the framework as their internal and market conditions evolve.

While these profiles hold true for both payers and providers, we also examined a number of characteristics that allowed for nuanced differentiation between payers and providers in terms of interests and priorities. These dimensions ranged from tactical areas of focus (such as business operations) to mission-driven areas of interest (such as community focus) and novel areas (such as consumer centeredness).

INTRODUCTION AND CONTEXT

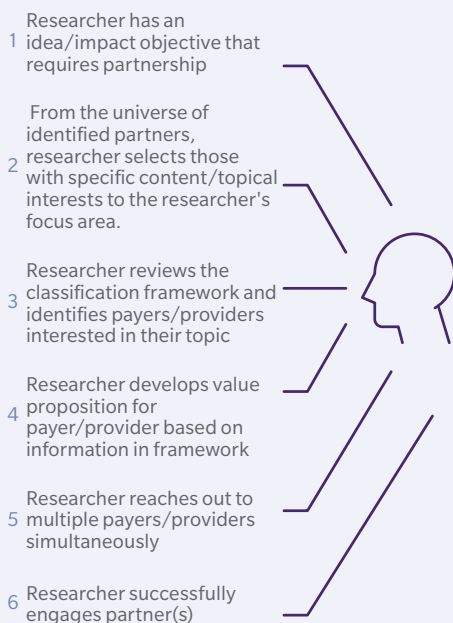
Situation today

Currently, researchers rely on word-of-mouth to help find potential payer/provider partners for their research efforts



How to use the framework

The framework will allow researchers to systematically approach multiple payers and providers for potential partnership



Today, many researchers rely on word of mouth to help find potential payer/provider partners for their research efforts. Researchers usually review their networks and reach out to individuals they know in an effort to partner. This is a great way to start, but it limits the potential for many more and different kinds of partnerships.

To help health services researchers think more expansively about with whom and how they might partner on new analyses and studies, we put together what we hope is an easy-to-use framework that can guide outreach.

We encourage researchers to engage with this framework before, during, and after forming their ideas and impact objectives. It is our hope that through engaging with this framework, researchers will be better able to understand the complexities and priorities of the payer and provider landscape that are important to consider as part of any effort to engage these stakeholders.

The framework ensures that researchers are able to:

1. Extend the view of their networks and potential partners beyond immediate contacts and geography.
2. Identify attributes that help them make sense of potential partners' pain points, interests, and capacities so as to frame their impact objective in consideration of how well it helps to advance the right partner's goals and/or meet other important criteria for the researcher, including ability to scale and spread their research findings.
3. Strategically translate and disseminate innovations or research findings to healthcare sector stakeholders in ways that resonate more readily with them.
4. Better understand underlying factors that help shape payers' and providers' mindsets/orientations toward changes in payment and delivery, how they operationalize their missions, and engage consumers.
5. Leverage signals in the external environment in conjunction with the payer and/or provider organization's internal operations to assess readiness or reluctance to engage in certain kinds of projects.

Ultimately, we hope this framework will offer researchers a more strategic view of a set of healthcare stakeholders who are typically harder to engage, but share common interests. We believe that by systematically approaching the appropriate payer and/or provider with opportunities that are tailored to meet their specific needs, research can achieve greater impact.

PAYER AND PROVIDER INTEREST INDICATORS

This framework categorizes payers and providers into six distinct, but overlapping profiles. Prior to reviewing the six profiles, it is instructive to understand the characteristics/interest indicators that will be important markers when you are making decisions about which organizations might fit within each profile. It should be noted that we used a mix of qualitative and quantitative factors (as called out in the methods section) in the development of each profile. While understanding the profile characteristics/interest indicators is extremely important, we would strongly advocate supplementing the information with your own research on the potential partner, the local market, and the position/orientation of the individual you are talking to. (For example, the individual may be biased toward value-based care, but the organization may display all the characteristics of a current state optimizer as described below.)

INTEREST INDICATOR 1: MISSION FOCUS

While every organization works in service to a mission, in our vernacular, mission-focused characterizes organizations that embody a commitment to serving vulnerable populations, and addressing the social determinants of health. Mission-focused organizations often talk about the “triple bottom line” or “quadruple bottom line” to signify that their business cares about more than revenue and profit and makes decisions based on other factors (such as their impact on the overall health of the community).

Mission-focused payer and provider organizations tend to:

- Have not-for-profit status: Most mission-driven organizations that have a strong community service and mission mindset (as we have defined it above) and tend to maintain a non-profit status. While for-profit organizations may also be mission-driven, their mission typically is oriented toward services or programs that drive up market share and increase profit margins.
- Demonstrate strong commitment to vulnerable populations: This is sometimes exemplified by language in their mission statements and Board membership composition (for example, expertise in sectors that serve vulnerable populations). In practice, however, “mission-driven” goes beyond mere references – for many, it is a core identity that drives the culture of the organization.
- Focus on Medicaid populations: A provider’s or payer’s orientation toward a community mission focus can often be determined by the concentration of their Medicaid membership/patient focus. Those that have a larger share of this population tend to be more community mission oriented.
- Have charity care as a percent of revenue and/or have a high portion of their community benefit dollars spent on initiatives that address community health needs (further information available at www.communitybenefitinsight.org).

INTEREST INDICATOR 2: OPERATIONAL FOCUS

All organizations ultimately must function as businesses – no margin, no mission. The important question for researchers is how much of an organization’s time, effort, and resources go into dealing with operational issues versus partnering on research ideas or initiatives. Some helpful attributes to look for when assessing whether an organization is more or less operationally focused include:

- Financial health: A negative or falling operating margin or net income, as evidenced in an annual report on the company’s website, demonstrates that an organization may be more inwardly focused. For payers, looking at the MLR or claims ratio is also a good indicator of financial health. A poor or falling credit rating is another strong negative signal.
- M&A activity: Recent (past few years) or pending mergers/M&A activity, particularly where significant integration within an overlapping geography is required.
- Size and scale relative to peers: A smaller organization in trouble will be less likely to be able to continue other activities or develop new models.
- Geography: Geographic dispersion may also be an indicator, as it may imply more operational organization structure and layers of bureaucracy.

INTEREST INDICATOR 3: INNOVATION FOCUS

Given the challenges of healthcare today, such as reducing costs while maintaining outcomes, innovation is a constant focus of the industry. However, there are some organizations that orient more heavily toward innovation than others. These organizations are typified by the following characteristics:

- Strategic investments and acquisitions of companies not focused on care delivery or risk management
- Specific subsidiaries, e.g., an incubator, groups, or roles focused on innovation or revenue diversification
- Partnerships with startups and innovators both within healthcare and outside of healthcare
- Innovation or diversification positions on the executive team (such as a Chief Innovation Officer)

INTEREST INDICATOR 4: CONSUMER FOCUS

Patient and member centeredness are top of mind in the current business environment, regardless of sector. You will be hard-pressed to find an annual report or CEO statement that omits this concept – it is a clear focus of the healthcare community. However, there are a number of organizations that are truly focused on the consumer – and these organizations can be found by looking for the following:

- High consumer satisfaction scores through tools like NCQA, HEDIS, or HCAHPS
- High Net Promoter Score (NPS): The higher the better, but any organization who uses this term (even if their scores are low) shows a focus on the consumer
- The presence of patient and consumer advisory councils, particularly if actively engaged in dialogue with the Board or business leaders

- The presence of “consumer” positions on the executive team, such as a “Chief Consumer Officer” or “Chief Experience Officer”
- Board members affiliated with traditional direct-to-consumer companies, for example the CEO of a consumer packaged goods company sitting on the board of a health system
- Stated consumer-centric or patient-centric goals, including transparency resources and information-sharing initiatives (such as mission/vision statements, investor or earnings presentations, or other initiatives)
- Accreditation for consumer-centric activities, such as through Planetree’s Person-Centered Excellence Certification that represents the highest achievement in patient and family centered care (www.planetree.org).
- Advertising spend and the positioning of advertisements toward consumers

INTEREST INDICATOR 5: MOVE TO VALUE-BASED HEALTHCARE

Value-based healthcare (VBHC) has been a priority for the healthcare industry for some time. At its essence, it means shifting from getting paid for visits and transactions to getting paid for quality and outcomes, and is accompanied by a necessary transformation in care models to deliver those outcomes. Mature VBHC organizations that are making a real shift to value-based care will show a true commitment to adopt risk-based models and innovate to create new models of care. Someone looking to engage an organization committed to value-based care might look for some of the following attributes:

- Participation in Accountable Care Organization (ACO) initiatives for commercial or Medicare members
- Payer/provider partnerships, including joint ventures or co-branded insurance products
- Providers launching insurance products that indicate a willingness to assume risk for the total cost of care of their members
- Partnership with community organizations that takes on risk, in an effort to better manage a patient population
- Participation in Centers for Medicare & Medicaid Services (CMS) Innovation Center Model Demonstrations or Pilots; this also provides a window into specific initiatives and areas of interest
- Active downside risk-taking on value-based contracts (for example, capitation as opposed to simply shared savings), and what portion of their business is comprised of contracts that put them (or their partners) at risk for higher costs

INTEREST INDICATOR 6: COMMUNITY FOCUS

Many organizations focus on the communities in which they provide services as a way to give back to that community, make it a better place to live, work, learn, and play, as well as to increase their brand perception and standing in those communities. This can range from direct giving through foundations, or large-scale initiatives in collaboration with local community organizations to innovative use of community benefit dollars for providers. These activities may or may not be associated directly with clinical healthcare goals, but will usually be tied to social factors that impact a community’s health and the well-being of its population.

Someone interested in identifying community-focused organizations might look for:

- Presence of a corporate foundation, including the priorities and areas of focus of the foundation
- Representation from the payer or provider on the foundation leadership or the foundation Board
- Well-established community partnerships, such as community-based collaboratives
- Community grants and giving from the operating budget as a portion of total revenue
- A community advocacy forum that allows members of the community to engage directly with the company
- Businesses with a large footprint in the community, significant number of employees, or large market share
- Businesses and resources focused primarily on one main geographic region as a place of business
- Statements about inclusive local sourcing for services and talent from “local only” vendors (<https://hospitaltoolkits.org/purchasing/>)
- Place-based investing: leveraging resources such as endowments, land, establishment of low-interest loan programs to improve communities’ overall health and well-being.

INTEREST INDICATOR 7: ADVOCACY

A priority for some organizations is changing the “rules of healthcare” through policy advocacy. While most organizations will have a government affairs champion in their organization, the focus can differ dramatically. Someone interested in learning more about the policy focus and objectives of an organization may look at:

- Lobbying spend, with the caveat that spend can be for a variety of different purposes
- Appearances on Capitol Hill and purposes of those visits
- Known disputes with local governments and departments of insurance
- Public statements on policy goals and needs

THE FRAMEWORK

Utilizing what we learned from the interest indicators and a series of interviews and secondary research, we have created a simple framework that separates payers and providers into six profiles along two dimensions: (1) focus on mission-driven activities and (2) focus on operating in the status quo (today's model).

The first dimension – “focus on mission-driven activities” – matters because it determines a great deal about an organization’s willingness to focus on activities and programs that appeal more to a moral imperative versus a purely economic one. For example, primary prevention by addressing the social determinants of health and/or addressing the needs of socially vulnerable populations would indicate a stronger mission focus. Our belief is that distinguishing more mission-driven organizations will help drive more purposeful and topical engagement with the right partners.

Organizations to the right of the framework would find issues that appeal to their natural inclination to focus on mission more appealing. (See page 5 for a more complete description of mission focused organizations.)

Organizations on the left of the framework tend to be more receptive to opportunities that speak importantly to their bottom lines and are secondarily interested in the moral imperative (mission). Researchers should be mindful of the importance of proving the return on investment (ROI) of their proposed initiative to these organizations.

The second dimension is “focus on today’s model” — succeeding in the status quo. There is a significant amount of change required to reinvent a broken US healthcare system by dramatically lowering costs, enhancing outcomes, and improving experiences. Some organizations have truly embraced this need, while others are oriented to operating in today’s world – with a vast spectrum lying in between the two extremes.

Organizations toward the top of the framework are more willing to experiment with the future trajectory of health and healthcare. These organizations have structures available for partnerships that further their explorations in a variety of new delivery and payment models. They are more likely to have dedicated innovation centers or subsidiaries.

Organizations at the bottom of the framework are more focused on succeeding in today’s model – hence, they are more likely to look for partnerships that will help them win in today’s business environment. These may include cost transformation partnerships and enhancing the quality of their current physician network.

We encourage you to explore the framework, not solely in terms of the profiles and their positioning on the two dimensions, but in terms of fit for your research interests and goals relative to a putative partner's interests and priorities, as we feel this fit is a better indicator.

More innovation and diversification, disruption of today's model

Innovation arms
Diversified subsidiaries
Visible strategic investments
True value-based transformation

FOCUS ON TODAY'S MODEL



More "operate today's business"

Current financial trouble
Subscale to drive investment
Publically traded status
Recent or planned large M&A

Lower
For-profit
Commercial focus

FOCUS ON MISSION-DRIVEN ACTIVITIES

Higher
Active community foundation
Medical focus
NPF status
Stated mission
Charity care

Note: Size of bubbles does not indicate number of organizations, rather, represents the span of x-axis and y-axis that each profile could cover

Further, we recommend a portfolio-based approach whereby researchers reach out to a set of multiple “best-fit” partner candidates for their objectives.

A sample list of questions for researchers to evaluate their own preparation prior to and during use of this framework includes:

YOUR DILIGENCE AS A PARTNER

- Have you clearly defined your goals and impact objectives?
- Have you defined metrics to measure your outcomes and impact?
- Have you documented how your objectives impact the business goals of potential partners?
- What are the “must have” characteristics of a partner that will let you achieve and scale your impact objectives?
 - Any required capabilities (or capability gaps)
 - Are there any regulatory considerations (such as Medicaid expansion, women’s health as a policy priority)
 - Any geographic considerations (such as need a focused urban population vs. need populations across many geographies)
- Who from your network might you initially consider engaging as a partner or to connect you with potential partners?

PLANNING AS YOU USE THE FRAMEWORK

- Will you update your impact objectives and/or messaging to align with payer/provider priorities?
- Are there profiles that make the most sense to engage with, given your impact objectives?
- What organizations will you reach out to?
 - How will your outreach align with your existing network and relationships?
 - Can you use the framework to extend your network by asking for introductions?
- What objective metrics will you look at to identify high potential partners?
- Have there been any recent changes at organizations on your list that will impact if and how you engage them?
 - Leadership changes
 - Planned mergers
 - Changes in focus and priorities
- What is your tactical outreach plan?
 - Who will you target in each organization?
 - What is the specific “pitch” and posture for each organization?

DETAILED PAYER/ PROVIDER PROFILES

Each of the profiles is distinct in that we observe noticeably different approaches to how organizations run their businesses, their interests and priorities, and how one can best engage in partnering with them. The profiles are meant to represent attitudinal differences, as opposed to purely demographic differences between payers and providers. This means there will be organizations at the margins that may exude qualities of more than one profile, indicating overlap between profiles.

CURRENT-STATE OPTIMIZERS

Key Interests, Pain Points, and Priorities: Current-state optimizers are trying to make the best of the market as it currently operates, and as such, orient their efforts toward playing within today’s market rules. Leadership may be focused on near-term performance as a matter of purpose and intent or as a matter of necessity, as current-state optimizers are often sub-scale to invest for change or distracted by poor financials or significant merger and acquisition (M&A) activity. They will likely not have invested significant resources into VBHC or other innovative healthcare transformation initiatives. They may also not have the bandwidth to do so. In some cases, this may be driven by high and stable market share (including a steady flow of members or patients) or dynamics involving the local competitive environment and local regulation.

Relative scoring across interest indicators	
Mission focus	Lower
Operational focus	Higher
Innovation focus	Lower
Consumer centricity	Lower
Move to VBHC	Lower
Community focus	Lower/Moderate
Advocacy	Lower/Moderate

Focused on surviving in the “health market of today” and operating/growing their business sustainably.

Current-state optimizers are most likely to respond well to efforts focused on reducing administrative costs (payers and providers) and reducing medical costs (mainly payers, but providers in this profile also care when the medical cost is related to bad debt), enabling growth of specific lines of business, achieving scale efficiencies, and enhancing business model sustainability.

Approaching Current-State Optimizers: Look for providers that are for profit/public companies, payers and providers that have financial trouble or are subscale to drive investment, and payers or providers that have little in the way of value-based care initiatives. Successful partnerships with current-state optimizers are most likely to arise out of existing, established relationships with organizations and individuals as

(1) business needs may limit bandwidth for conversation and (2) many current-state optimizers do not have an obvious partnership-focused engagement layer (such as innovation group or diversification subsidiary). When engaging current-state optimizers, any partnership proposal should have a clear, measurable financial impact or ROI target tied to business needs.

A HYPOTHETICAL EXAMPLE: PARTNERING WITH A CURRENT-STATE OPTIMIZER

As part of a healthcare-focused research organization that prided itself in developing new, efficiency tools for healthcare, Rachel was excited about what she had just co-created with her partners. Her idea was based on the premise that repurposing waiting rooms and implementing a few key staffing changes could radically change patient wait times, while also allowing for faster throughput of patients. While the idea worked in theory, she wanted to try it out in practice. She had approached a few safety-net hospitals through mutual acquaintances, but they didn't have the resources to try what she was suggesting.

While looking for ways to identify additional partners, she came across a framework that purportedly helped researchers find the right "match" for their initiatives. She took the framework, and applied it to the 14 hospitals that were within a four-hour driving radius. She used the scoring indicators, coupled with recent news reports and a scan of the hospital's websites, to place each hospital on the framework, and three fell into the current-state optimizer category.

Based on the publication, she knew that current-state optimizer would be open to transformational initiatives that would enable an organization to be more successful in today's environment – fee-for-service medicine looking for high throughput models and faster patient turnaround. She used the checklist to tailor her message appropriately, bringing in data around how many more patients a physician could see in his or her workday using her workflow optimization strategy – and on average, how much additional revenue that translated to for the hospital system. Given the strong focus on return on investment, her first outreach was to the finance organization within each hospital – the Chief Financial Officers and the Senior Vice Presidents of Finance. Now, she was playing the waiting game to see who would bite.

STEPPING TOWARDS VALUE

Key Interests, Pain Points, and

Priorities: Payers and providers stepping toward value have begun to respond to shifting market trends in healthcare to best position their businesses for the future. They have begun to embrace VBHC as the evolution of how they need to operate to lower the cost of care and improve outcomes. However, they are likely not completely pushing the boundaries of VBHC or consumer centricity, but instead are actively thinking about and testing these topics within their organizations. Their financial health will be sufficiently robust to allow for focus on initiatives beyond just running the business.

Relative scoring across interest indicators	
Mission focus	Lower
Operational focus	Moderate/Higher
Innovation focus	Moderate
Consumer centricity	Moderate
Move to VBHC	Higher
Community focus	Moderate/Higher
Advocacy	Moderate

Actively trying to best position themselves to provide value in the “health market of tomorrow”

Organizations that are “stepping towards value” will be most likely to respond to initiatives focused on ACO effectiveness, new models of care delivery, payer and provider partnerships, and some other areas, such as consumer-centric business models. They will be interested in designing, scaling, and proving the effectiveness of programs.

Approaching Organizations Stepping Toward Value: Look for organizations with a growing number of value-based arrangements (such as ACOs), but more limited partnerships that stop short of fully integrated payer/provider models (for example, true shared risk for patient outcomes). Successful partnerships will be based on shared goals around defined impact objectives. Researchers looking to partner should approach these organizations with defined, quantifiable metrics around program impact (such as quality outcomes). They will sometimes, but not always, have established partnership layers to approach.

PARTNERING WITH ORGANIZATIONS STEPPING TOWARD VALUE: A HYPOTHETICAL EXAMPLE

Miguel thought he had stumbled upon an important discovery. As part of his research efforts, he had discovered that provider-specific Medicare Advantage (MA)-Star rating measures showed a high correlation with the actual quality of care offered within Hillsborough county. He worried, however, that his information was too limited at present to make any generalizations of the data and to examine this at scale (for example, across the state of Florida, or even across the country). He knew that this was a big deal for MA plans, as a high Star rating meant a 5 percent revenue bonus from CMS. He wanted to test out his hypothesis, but knew he couldn't go to just any health plan. He needed one that had particularly good relationships with their providers so that the providers would

agree to partner with the plan to test his initial findings. By looking at the framework, he determined that the 'Stepping Toward Value' profile would be most suited to launch a potential partnership. He looked at all the MA plans with a presence in Florida and aligned them against the framework. There were two that were identified as possibilities, based on their launches of ACOs and other provider partnerships (as stated on their website). To be safe, he also assessed the plans in Georgia – they could serve as a backup in case no one from Florida was interested. He used the framework to guide his proposal and focused almost exclusively on (1) quality outcomes and (2) the opportunity to build deeper provider relationships.

ACADEMICS

Key Interests, Pain Points, and

Priorities: As a group, academics are focused on furthering scientific advancement through research and education. This profile represents the only group that does not encompass both payers and providers (it is only comprised of providers). They tend to think about funding differently, due to support from different sources (such as endowment funds) relative to other payers and providers. Many

academics have also completed acquisitions to increase their presence and negotiating power with payers and, as healthcare costs continue to rise, are acting more like innovators and are stepping toward value. They will be more open to academic research and publication, as it is part of their core DNA versus organizations that fall into one of the other profiles we've discussed so far. Finally, based on how the endowment dollars are allocated and the population that visits these institutions, their makeup may be more like a safety-net hospital, but they will likely not face the same level of financial constraints that a safety-net hospital might experience.

Academics will skew higher than others toward medical advances, precision medicine, tech transfer and commercialization, and studies that could lead to publication. They face less sustainability issues than other institutions, but will have much higher pressure to publish innovative and impactful research to help raise additional money to fund further research efforts.

Approaching Academics: Look for Academic Medical Centers associated with a university or other organizations with significant endowments or direct giving.

Relative scoring across interest indicators	
Mission focus	Moderate
Operational focus	Lower
Innovation focus	Moderate/Higher
Consumer centricity	Lower
Move to VBHC	Moderate
Community focus	Moderate
Advocacy	Lower/Moderate

Unique funding structure allows this group of providers to take a less financially-oriented approach to research and care delivery.

Academics will look for targeted/quantifiable proposals, but metrics tracked will likely be less commercial in nature. In many cases, these organizations will have dedicated research-based enterprises as part of their organization, which should be the first point of approach. Because of funding sources, one may also have success with specific individuals and individual priorities that extend beyond the enterprise as a whole. For example, an Academic Medical Center may have a center or department with a specific focus on genomics and mapping the human genome.

PARTNERING WITH ACADEMICS: A HYPOTHETICAL EXAMPLE

Divya had just finished programming her machine-learning algorithm that would allow for better detection and diagnosis of behavioral health conditions based on patient responses to their existing HRA (health risk assessment). She knew there was an opportunity here – to begin with, there was a major shortage of behavioral health providers across the country. As if this wasn't enough to hamper efforts to treat behavioral health conditions, the stigma associated with going to a psychiatrist/psychologist exacerbated the issue of diagnosing patients late in their disease progression.

With the algorithm complete, she needed a database of HRA information on which to run her analyses and compare the outcomes with actual diagnosis data. She knew this would involve getting access to thousands of deidentified patient records, along with their deidentified HRAs. However, she had no idea where to start. She recalled that her colleague had recently sent across an RWJF sponsored paper on partnering with payers and providers. Looking through the figures, she quickly realized that her best potential partners would fall in the “Academics” category.

She knew she wanted to work with institutions that were known for their behavioral health treatments and this was exactly the right place to start. Not only would they be interested in what she had to offer, but their name on the publication would add a lot of credibility to the work. Some quick secondary research led to the names of university associated hospitals with well-known mental health treatment programs. Having decided who to approach the next day, she packed up to go home.

INNOVATORS

Key Interests, Pain Points, and

Priorities: Of all the profiles, Innovators are most focused on “changing the game” – disrupting how healthcare is done today. They recognize that healthcare as a business and as a service is not sustainable, actively investing in innovative ways to drive tangible impact. They think about innovation broadly in ways that extend beyond value-based care and include a heavier focus on consumer-centricity, diversification or development of new businesses, technology, and more. While they are likely to pursue innovation for financially-motivated purposes vs. mission oriented goals, they invest and partner with health startups and other innovators.

Relative scoring across interest indicators	
Mission focus	Lower/Moderate
Operational focus	Moderate/Higher
Innovation focus	Higher
Consumer centricity	Higher
Move to VBHC	Higher
Community focus	Moderate
Advocacy	Moderate

Dedicated to developing and supporting innovations which will help shape the future of healthcare

At the core, innovators look for ways to drive the sustainability of their business beyond care delivery and managing risk because they worry about their ability to make money from the traditional way healthcare works. They tend to have technology-driven consumer apps that are robust, and they think of “enablement” as a business and a set of capabilities they are trying to sell to others who are not as far up the curve.

Approaching Innovators: Look for strategic investment in startups, diversification or innovation subsidiaries, and scale across a combined provider system and health system. Proposals should focus on meaningful innovations with a compelling business rationale. One example may be testing the uptake and impact of a bold new idea for a consumer app. Start by looking for Directors/VPs (for example, Head of Strategy) responsible for areas of interest, or participate in innovation programs, such as labs and incubators. Where possible, leverage connections to high-level executives to discuss innovations that could impact their business or community.

PARTNERING WITH INNOVATORS: A HYPOTHETICAL EXAMPLE

Shawn had been working on behavioral health for a long time. She watched as the industry went from offering integrated services, to carving it out separately from physical health, to going back to a more integrated model. She had recently published on the negative impacts of separating physical health from behavioral health. In her opinion, the two were inextricably linked and dealing with chronic disease in isolation would have little an impact if the patient also suffered from schizophrenia. She was glad that there was movement back toward an integrated solution.

However, the reality was that behavioral health was still carved out, and there was a spate of vendors out there that offered it as a stand-alone solution – and it was unlikely they would go away any time soon. Their model was too entrenched in the industry. She also knew that many of them had built expertise in managing behavioral health – and losing that would be a travesty. She had come up with what she felt was an innovative solution that allowed behavioral health vendors to assume full risk (through capitation or sub-capitation) from either payers or providers that were at risk themselves. Now, she wanted to have conversations with organizations to see if that was even possible before developing a grant proposal.

She turned to the framework supported by the Robert Wood Johnson Foundation. Based on the characteristics of each of the profiles, she determined that integrated delivery networks (IDNs) that were in the Innovator profile were likely best positioned to help her. Not only were they at risk for their populations, they also had both payer and provider aspects to help test her model. Quick secondary research identified the list of nearby integrated delivery networks. Using the interest indicators, she identified who would likely be an innovator. Now, the time had come to start calling around to see if they outsourced their behavioral health treatment and management.

OPERATIONAL PHILANTHROPISTS

Key Interests, Pain Points, and Priorities: Operational philanthropists are very focused on serving their altruistic mission, but are facing challenges which may distract them or create bandwidth issues that do not enable near-term investment in their missions or other innovation priorities. Like current-state optimizers, they may be challenged with financial performance, a recent or pending merger, or be subscale to drive significant investment. They are likely less developed across innovation, consumer and VBHC, in part due to these constraints. In general, they have strong community ties through programs and outreach, particularly for vulnerable populations.

Relative scoring across interest indicators	
Mission focus	Higher
Operational focus	Moderate/Higher
Innovation focus	Lower
Consumer centricity	Lower
Move to VBHC	Lower
Community focus	Higher
Advocacy	Lower/Moderate

Working to serve their mission and communities, but facing other issues which may reduce their bandwidth and commitment to innovation.

Key interests include community health programs and other programs that support local vulnerable populations, including social determinants of health. In the near term, they resemble current-state optimizers. Often less directive, they are likely interested in initiatives that support the sustainability of their business (such as through administrative

or medical cost reduction). They may be interested in broader innovations, but invest with less purpose focus, given more pressing near-term priorities.

Approaching Operational Philanthropists: Look for not-for-profit status and missions dedicated to community or vulnerable population related topics (e.g. social determinants), lagging financial performance, or recent or planned merger and acquisition (M&A) activity. They seek partnerships that provide community benefit but do not require substantial time/resources from the organization itself. The approach should start with Directors/VPs responsible for topics of interest, or with local leaders. As with current-state optimizers, a personal relationship may be the only way to get their attention. For example, approach the local level of a national health system, where you likely know an individual and chances are this person will also be less distracted by issues playing out at the national level.

PARTNERING WITH OPERATIONAL PHILANTHROPISTS: A HYPOTHETICAL EXAMPLE

As a lead researcher in a community-based research organization, Teresa was passionate about serving the vulnerable population. So much so, that she organized her research around Medicaid eligibility and the impact of benefit richness on the populations utilization patterns. In devotion to her cause, she volunteered with Meals-on-Wheels four times a month, delivering meals to low-income individuals.

This experience gave her firsthand understanding of the struggles people face as they fought to balance their daily needs such as sustenance and childcare with their healthcare needs. So many of the people she brought meals to were clearly suffering from a chronic condition and had trouble staying healthy. They told her of having made choices between paying for food versus paying for their medication. During one her food delivery trips, inspiration struck: Would it make sense for a health plan to address food insecurities for their members? Then, members could take their medications, and eat the healthy food that the plan provided. Would this have an impact on overall medical cost? It was potentially a win-win situation all the way around.

Teresa referenced the framework co-developed by RWJF to see how she could go about finding a partner. It appeared that the operational philanthropists fit the profile to go after – they focused on vulnerable populations and would likely be interested in something like this. Luckily, she knew the medical director of the local Medicaid plan (one she knew was constantly struggling financially). If she could broker a partnership between Meals-on-Wheels and the health plan, she could study the total medical cost consequences of addressing food insecurity for chronically ill individuals. While the plan couldn't fund this, they were necessary for providing the claims cost data. If she could get the plan to agree, this could form the basis of a new grant application. Using the framework for guidance, she started outlining how to approach the plan and the story she needed to sell them on this effort. First, it should save them money, second, it shouldn't cost them anything other than some time from an analyst to pull the data, third....

MISSION-ORIENTED EXPERIMENTERS

Key Interests, Pain Points, and

Priorities: Mission-oriented experimenters are most focused on changing healthcare for the better through a mission-driven approach. They combine innovative, experimental approaches with a sense of philanthropy and mission. They are focused on both local communities as well as broader, national initiatives. They have a range of experiences and histories, but tend to be more focused on government programs (Medicaid and Medicare populations)

and incorporate social determinants of health (such as food, housing, and transportation) more directly into how they expect to contribute to the health of their members and patients and how they expect to earn a return on their healthcare dollar.

These organizations will skew toward initiatives focused on social determinants of health, broad programs focused on vulnerable populations, patient centeredness (focusing on an individual through healthcare interactions as opposed to consumer centeredness which takes a broader view of an individual), healthcare quality, and other mission-oriented initiatives.

Approaching Mission-Oriented Experimenters: Look for organizations with a healthy bottom line, a sizable portion of their business coming from serving government programs (e.g. Medicaid) and uninsured or uncompensated consumers, and potentially dedicated roles or functions focused on innovation or philanthropic initiatives. Provide transformative proposals that serve their philanthropic ambitions. For example, large scale initiatives focused on addressing social and economic injustices (such as housing programs, healthy food communities) may resonate well. Set up focused initiatives through Directors/VPs responsible for narrow or specific topics of interest, while broader projects that impact the entire enterprise or community can go through innovation programs/layers.

Relative scoring across interest indicators	
Mission focus	Higher
Operational focus	Moderate
Innovation focus	Higher
Consumer centricity	Higher
Move to VBHC	Higher
Community focus	Higher
Advocacy	Moderate

Strong sense of mission, aimed at accomplishing a goal that extends beyond the profits of stakeholders, coupled with a forward-thinking approach to solving health care problems

PARTNERING WITH MISSION-ORIENTED EXPERIMENTERS: A HYPOTHETICAL EXAMPLE

Jason considered himself to be an authority on health equity research. He knew from experience that very few organizations were thinking about health equity in the payer and provider world. He had personally tried outreaching to at least a couple of organizations and was met with a “yeah, that’s interesting, but not right now”. He wasn’t sure what the reason was for the lack of interest - were they distracted by something else? Was he not presenting the importance of the problem appropriately? It was for all these reasons that the RWJF-sponsored framework was a key resource for him. By reading the paper and looking back at the individuals he had reached out to, he realized that most of the organizations he had approached fell in the operational philanthropists category. He had naturally oriented toward small Medicaid plans that would worry about health equity, not realizing that they would not have the wherewithal to dedicate the effort and resources he would need. What he needed was an organization that aligned with the mission-oriented experimenter category – they were financially healthy and had both the commercially insured and government insured populations to be interested in health equity research and its outcomes. Heartened, he used the interest indicators to compile a list of organizations that fit the bill. This time, he hoped to be more successful.

ADDITIONAL CONSIDERATIONS

As you engage with and use this framework, there are a number of additional considerations to keep in mind that will help maximize your success in developing partnerships.

1. It is important to consider both the individual and the organization when engaging. You may come across individuals within organizations who have very different mindsets than their enterprises, or who work in different silos of the organization. This means that they will likely see opportunities and challenges differently than the decision makers in their organizations. It is important to look for champions willing to innovate, to try new things, and that have an openness to test and/or learn at organizations within each of the profiles. It's also important to understand that even champions will require organizational approval to support projects that require time to complete, access to the organization's resources, or dollars and ultimately, support from key leaders whose viewpoints may differ based on what they see as organizational priorities.
2. Business needs and priorities evolve, both for specific organizations and for the industry as a whole. One should expect organization's strategies to change over time. What they are focused on today may be different tomorrow and we therefore expect them to move between profiles. This is particularly true for organizations dealing with a near-term financial issue or merger who may move up the vertical access of the framework once they have more time or dollars to invest in new initiatives. We have provided considerations for identifying organizations throughout the profiles and along interest indicators in the appendix of this document.
3. Business priorities are not everything. It is important to remind yourself that if you're not hitting the business priorities and don't have a business-oriented hook, you will have more difficulty developing a shared interest with a payer or provider. But, if you default to business priorities, then a whole set of public health priorities and initiatives not supported by commercial activity will go unaddressed. While we have taken this into account when developing the framework and in discussing the approach to each organization profile, the researcher may find a greater willingness among payers and providers in each profile to engage on a variety of topics.

APPENDIX: METHODOLOGY

We executed five major activities to develop the Payer/Provider Classification Framework, each focused on adding depth of understanding of researcher and innovator needs and payer and provider characteristics, aspirations, and interests. The process was iterative by nature and relied upon subjective judgment based on expertise interacting with many payers and providers in the market on a regular basis, both by the core team and by subject matter experts that were engaged. The process resulted in a framework that helps describe differences in payers and providers supported by a set of six distinct, easy to understand profiles.



RESEARCHER/GRANTEE INTERVIEWS

(Understand priorities and challenge, gain feedback on framework hypotheses)



PAYER AND PROVIDER INTERVIEWS

(Inform classification framework through understanding of priorities, goals, and actions)



SUBJECT MATTER EXPERT INTERVIEWS

(Learn from experts who are in the market with payers and providers everyday)



PAYER/PROVIDER RESEARCH

(Understand characteristics through subscription-based data sets, proprietary data sets, and company documents)



HYPOTHESIS-DRIVEN WORKING SESSIONS

Ideate with subject matter experts and a core working team

The five activities were:

Researcher Interviews: We interviewed a series of researchers to understand their priorities and challenges engaging potential payer and provider partners to help assess which dimensions of a framework matter most and how they characterize potential partners. We also used these interviews to gain feedback on framework hypotheses throughout the iterative process, incorporating direct researcher feedback where relevant.

Payer and Provider Interviews: We endeavored to get a first-person understanding of payer and provider priorities by interviewing key executives at a handful of organizations. The organizations spanned types of payers (such as national versus local, commercial versus Medicaid, for profit versus not-for-profit) and providers (such as for-profit versus not-for profit, religiously affiliated versus not, integrated with health plans versus not).

Subject Matter Expert Interviews: We learned from experts on payers and providers who are in the field, having partnership discussions with them every day. These experts provide a critical understanding of the differences between what a payer or provider might say and how they might actually behave or what actions they may take – a critical component to making the framework as useful for researchers as possible.

Payer and Provider Research: We tested many of our hypotheses through research into objective measures about payers and providers, leveraging subscription-based datasets, proprietary data sets, and company documents. Metrics such as financial performance, number of strategic investments, and for-profit status helped us understand the spread of potential partner organizations, which was a powerful tool when complemented with stories and anecdotes from in-market experience.

Hypothesis-Driven Working Sessions: In order to develop hypotheses, test them, and iterate on ideas based on the information in steps one through four, we held working sessions with a number of different constituencies. We incorporated ideas and feedback from these workings sessions into various iterations/evolutions of the framework.

APPENDIX: GLOSSARY OF KEY TERMS

Payers – Organizations responsible for the cost of providing health benefits and improving the quality of care. In this report, we use the term to refer to health insurers, and although many of the findings may be applied broadly, are not referring to government (such as CMS or state Medicaid plans).

Providers – Organizations that provide healthcare services directly to individual consumers. Hospitals, doctors' offices, and convenient care clinics are all examples of providers.

Fee-for-Service (FFS) – Payment model under which providers are paid for each service delivered (for example, an office visit, test, etc.). This model incentivizes quantity – not quality – of care.

Value-Based Healthcare (VBHC) and Fee-for-Value (FFV) – Umbrella term for models that deviate from the traditional FFS model and pay providers based on process and/or outcomes, such as lower blood pressure in patients, and not amount of consultations held.

Accountable Care Organizations (ACOs) – Network of providers that shares financial and medical responsibility for providing coordinated care to patients. Characterized by a payment and care delivery model that ties provider reimbursements to quality metrics and reductions in the total cost of care for a population.

Patient Centered Medical Homes (PCMH) – Team-based healthcare delivery model that provides comprehensive and continuous care to patients with the goal of maximizing health outcomes.

Financial Performance, Operating Margin, and Net Income – Measures that refer to the amount of profit generated by an organization that can either be paid out to investors or reinvested in the business. Operating margin is at its simplest revenues less costs incurred. Net income factors in gains and losses from investments, endowments, and other sources of funds beyond operating activities.

Medical Loss Ratio (MLR) or Claims Ratio – A measure of financial health and is the percent of premium an insurer spends on claims relative to administrative expenses. A lower MLR generally implies a better managed, more profitable business. Under the Affordable Care Act (ACA), insurers are capped on their MLR at 80 percent (for individuals and small groups) or 85 percent (for large groups).

B2B – Business to business transactions, such as selling a health insurance plan to an employer.

B2C – Business to consumer interactions and transactions, such as engaging a consumer directly.

B2B2C – Business to business to consumer interactions, such as the relationships between a health insurer (B), an employer (B), and an employee (C).

Net Promoter Score (NPS) – A measure of consumers' willingness to recommend the products or services of a company. NPS ranges from -100 to 100.

QUALIFICATIONS, ASSUMPTIONS, AND LIMITING CONDITIONS

Oliver Wyman was commissioned by The Robert Wood Johnson Foundation to develop a framework that helps researchers think more expansively about with whom and how they might partner on new analyses and studies.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

This report does not represent investment advice or provide an opinion regarding the fairness of any transaction to any and all parties. This report does not represent legal advice, which can only be provided by legal counsel and for which you should seek advice of counsel. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

ABOUT OLIVER WYMAN

Oliver Wyman is a global leader in management consulting. With offices in 50+ cities across nearly 30 countries, Oliver Wyman combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. The firm has more than 5,000 professionals around the world who help clients optimize their business, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is a wholly owned subsidiary of Marsh & McLennan Companies [NYSE: MMC], the world's leading professional services firm in the areas of risk, strategy and people.

Marsh is a leader in insurance broking and risk management; Guy Carpenter is a leader in providing risk and reinsurance intermediary services; Mercer is a leader in health, wealth and career consulting; and Oliver Wyman is a leader in management consulting. With annual revenue of more than \$14 billion and nearly 65,000 colleagues worldwide, Marsh & McLennan Companies provides analysis, advice and transactional capabilities to clients in more than 130 countries.

The Company is committed to being a responsible corporate citizen and making a positive impact in the communities in which it operates. Visit www.mmc.com for more information and follow us on LinkedIn and Twitter @MMC_Global.

Oliver Wyman's Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions. Oliver Wyman launched the Health Innovation Center (OWHIC) in 2011 dedicated to promoting positive change in healthcare. OWHIC champions innovation by disseminating proven innovations; envisioning market-based solutions to today's and tomorrow's challenges; and establishing a cross-industry community of thought-leaders to share and shape ideas.

For the latest on the business of transforming healthcare, visit health.oliverwyman.com. Follow Oliver Wyman on Twitter @OliverWyman.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years, the Robert Wood Johnson Foundation has worked to improve health and health care. We are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives.

For more information, visit rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

AUTHORS

Parie Garg, PhD

Partner, Health & Life Sciences Practice

parie.garg@oliverwyman.com

Chris Schrader

Principal, Health & Life Sciences Practice

chris.schrader@oliverwyman.com

Copyright © 2018 Oliver Wyman

All rights reserved. This report may not be reproduced or redistributed, in whole or in part, without the written permission of Oliver Wyman and Oliver Wyman accepts no liability whatsoever for the actions of third parties in this respect.

The information and opinions in this report were prepared by Oliver Wyman. This report is not investment advice and should not be relied on for such advice or as a substitute for consultation with professional accountants, tax, legal or financial advisors. Oliver Wyman has made every effort to use reliable, up-to-date and comprehensive information and analysis, but all information is provided without warranty of any kind, express or implied. Oliver Wyman disclaims any responsibility to update the information or conclusions in this report. Oliver Wyman accepts no liability for any loss arising from any action taken or refrained from as a result of information contained in this report or any reports or sources of information referred to herein, or for any consequential, special or similar damages even if advised of the possibility of such damages. The report is not an offer to buy or sell securities or a solicitation of an offer to buy or sell securities. This report may not be sold without the written consent of Oliver Wyman.