

Evolving Care Models

Aligning care delivery to emerging payment models



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Hospitals and health systems across the country are redesigning care delivery to improve quality and outcomes, enhance the patient experience, reduce costs and, ultimately, produce better population health. They are testing and implementing new care models to focus on prevention and better coordinate care across the many sites of care that touch patients.

The payment landscape for health care services has evolved to support providers' transition to new care delivery models. Over the past 10 years, payers have transitioned a growing portion of payments made to providers to alternative payment models (APMs). Also, commonly referred to as value-based payment models, APMs incent providers for quality and value, rather than volume.

This report from the AHA Center for Health Innovation provides an overview of the successes and challenges providers have experienced in aligning care delivery models with APMs, and provides lessons for those in the midst of this transition. Though the pace of the transition will vary by local market, payers will continue to shift financial risk to providers through more advanced payment models. Health systems are committed to advancing value-based care and will need to build new capabilities to succeed under these payment arrangements.

The AHA Center for Health Innovation based this report on information and insights from a number of sources, including interviews with hospital and health system leaders and other health care experts, surveys of hospitals and health systems, and a number of health care reports and research articles. A complete list of sources appears on Page 16 of this brief. We thank everyone for their contribution to this analysis.



KEY POINTS

1 APMs vary in the degree of financial risk they transfer to providers, and most providers today assume relatively low levels of risk. This approach provides stability to providers as they build up the required capabilities for taking on higher levels of risk.

2 APMs have gained significant traction in recent years, driven in large part by government payers.

3 Providers are juggling the challenge of developing the capacity to operate successfully in shared-risk payment models, while still caring for significant numbers of patients in fee-for-service arrangements.

The Changing Landscape of Alternative Payment Models

Today, more than a third of U.S. health care payments are value based, up from 23 percent in 2015. This significant shift from traditional fee-for-service (FFS) reimbursement models has been fueled in large part by the Medicare program, which has rolled out a number of programs that shift payment toward value, including the Medicare Shared Savings Program (MSSP) in 2011. The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which made sweeping changes to how Medicare reimburses physicians for their services, created an additional platform to drive APMs in Medicare.

Development of APMs in Medicare



Passage of Affordable Care Act, mandating **Medicare Shared Savings Program (MSSP) and Bundled Payments for Care Improvement (BPCI) initiatives**. The MSSP contains upside only and upside/downside risk tracks. BPCI requires providers to accept financial risk but allows choice between prospective or retrospective payment.

Launch of the **MSSP and Pioneer Accountable Care Organizations (ACO) Model**, a program for providers accepting higher levels of downside risk than the MSSP.

Start of **ACO Investment Model** offering additional support for providers in rural and underserved areas.

Passage of **MACRA**, tying a portion of most providers' Medicare payments to quality and/or value. Providers may choose one of two tracks: (1) Merit-based Incentive Payment System (MIPS), a pay-for-performance program, or (2) Advanced APMs, which include a discrete number of models selected by the Centers for Medicare & Medicaid Services (CMS).

Launch of **Next Generation ACO**, allowing experienced ACOs to take on greater downside risk than Pioneer ACO or MSSP.

Streamlining of MSSP and BPCI programs, creating shorter glide path for providers to assume downside risk under MSSP and standardizing payment model under BPCI.

Sources: Patient Protection and Affordable Care Act; Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); "Medicare Shared Savings Program," available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html; "CMS Finalizes 'Pathways to Success,'" an Overhaul of Medicare's National ACO Program, available at www.cms.gov/newsroom/press-releases/cms-finalizes-pathways-success-overhaul-medicare-national-aco-program; "BPCI Advanced," available at <https://innovation.cms.gov/initiatives/bpci-advanced>



What States are Doing with APMs

State Medicaid programs are also putting substantial pressure on plans (in Medicaid managed care) and providers to transition payments to APMs; most states have some type of APM or care delivery model in place (e.g., ACO, medical home, etc.), and many include mandatory value-based payment targets in their contracts with Medicaid managed care organizations.

What Private Payers are Doing with APMs

Movement toward APMs is also accelerating in the commercial market. For example, the Health Care Transformation Task Force, a consortium representing key payers and providers that includes Aetna, Anthem, several state-level Blue Cross Blue Shield plans, Geisinger, Kaiser Permanente and Sentara Healthcare, had nearly 50 percent of its provider and payer members' payment arrangements in APMs by the end of 2017 and aims to reach 75 percent by 2020. A small but growing number of employers — including Boeing, Intel and Walmart — are experimenting by directly contracting with health systems for certain groups of employees and/or through center of excellence programs, which typically negotiate bundled-payment arrangements with a limited number of high-quality, low-cost providers for specific episodes of care.

In certain cases, public and private payers are working together — at both the national and state levels — to align payment models. For example, the Comprehensive Primary Care Plus model currently has 56 participating payers across 18 geographic regions.

APM Models that States are Testing

APMs in Medicaid

TENNESSEE: The state requires Medicaid managed care organizations (MCOs) to make bundled payments to providers for 75 different episodes of care. In its first year of operation, the program reduced costs for covered episodes by \$11.1 million and, in 2016, the program reduced costs by \$14.5 million.

NORTH CAROLINA: The state is preparing to transition its Medicaid program from a fee-for-service delivery system to managed care in late 2019 and has established an Advanced Medical Home (AMH) program to strengthen the role of primary care practices in care management and quality improvement. The AMH program will initially include three participation tiers, with AMHs in higher tiers responsible for greater levels of care management and eligible for care management fees and incentive payments based on a standardized set of quality measures. ●

Sources: "TennCare's New Approach to Payment Shows Savings," <https://www.tn.gov/tennicare/news/2016/10/5/tennicare-s-new-approach-to-payment-shows-savings.html>; "Strategic Planning & Innovation," Division of TennCare, <https://www.tn.gov/content/dam/tn/tennicare/documents/2016EpisodesofCareResults.pdf>; "North Carolina's Care Management Strategy Under Managed Care," North Carolina Department of Health and Human Services, https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

Comprehensive Primary Care Plus (CPC+)

ARKANSAS: The Arkansas Health Care Payment Improvement Initiative brings together both public and private payers, along with Walmart, the State and Public School Employee Benefits program, and other self-funded employers, to promote patient-centered delivery models across the state and includes both medical home and episode-based payment programs. Unlike many medical homes, practices in Arkansas' program assume full financial responsibility for the total cost of care for their attributed patients. If a medical home meets benchmarks for quality metrics and reduces the total cost of care under a payer's preset threshold, the practice receives a shared-savings payment. In 2015, Arkansas was one of only three Comprehensive Primary Care (CPC) regions to achieve net savings as a state. In 2017, the state was selected as one of 14 states to participate in the CPC+ initiative, which extends Medicare participation in primary care medical homes to approximately 182 primary care practices throughout the state. The implementation of CPC+ represents the most recent phase in the state's progression toward a value-based, patient-centered delivery system. ●

Sources: "Arkansas Health Care Payment Improvement Initiative: 3rd Annual Statewide Tracking Report," Arkansas Health Care Payment Improvement Initiative, <https://achi.net/wp-content/uploads/2018/10/Arkansas-Health-Care-Payment-Improvement-Initiative-State-Tracking-Report-Year-3-Full-Report.pdf>.

Note: Excludes inpatient neonatal services, long-term services and supports, and inpatient psychiatric services for severe mental illness



Evolution in Care Delivery Models

KEY POINTS

- 1 Although hospitals and health systems approach health care transformation differently, there are common features as to how they are evolving their care models to improve value and health within their communities.
- 2 Hospitals and health systems increasingly are participating in value-based APMs, with ACOs and medical homes seeing significant growth.

Trends

By redefining care models and implementing value-based strategies, hospitals are taking steps to develop a culture in which patient-centered value and making a sustainable difference in their patients' health is a major focus for everyone in the organization. Alternative approaches to care delivery have clustered around four specific models: ACOs, medical homes, bundled payment programs and provider-sponsored health plans (PSHPs). ACOs and medical home models, in particular, have increased dramatically.

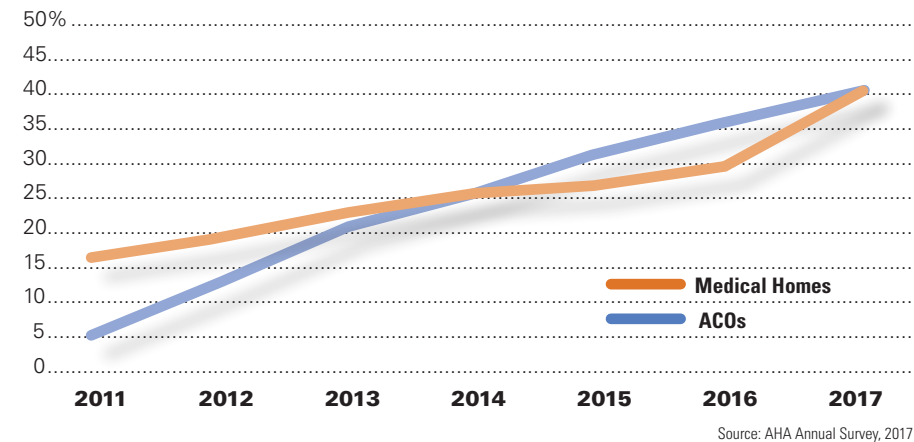
Redefining Care Delivery

Various service-delivery and payment models that aim to achieve better care for patients, smarter spending and healthier communities are still evolving and being tested. Health systems are implementing and refining a wide array of care delivery models. Health systems without previous experience chose to adopt one of the existing care models for the first time, and those with experience were adopting new processes and/or technologies to make the models more effective.

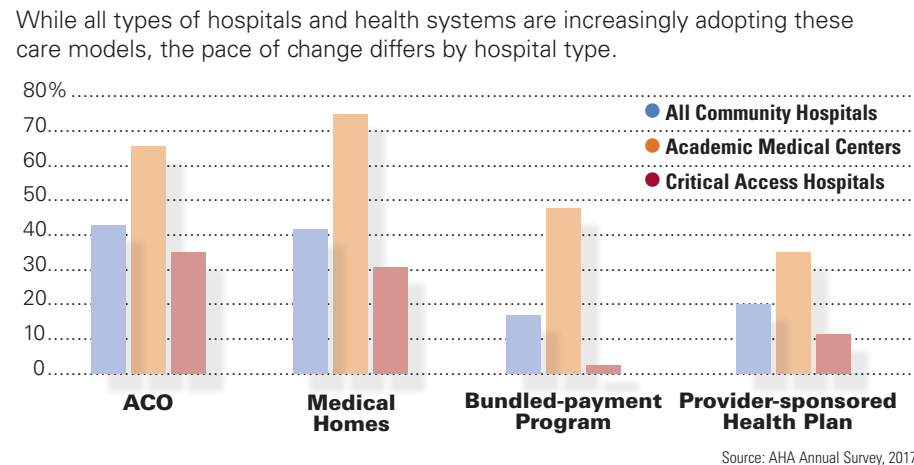
Health system leaders who have embarked on the change said they are committed to continuing the evolution because the approach is better for patients, but they cautioned that there is no silver bullet or app that can substitute for: setting an inspiring vision for care delivery; engaging clinicians early and often to develop agreement on evidence-based protocols and care plans; retraining staff to support the new approach; and building feedback loops to measure organizational performance and adjust accordingly.

“Health system leaders reported that adopting a new care model is **hard, time-consuming work** because it redefines the responsibilities of providers, who provides the care and how they do it.”

Growth in ACO and Medical Home Programs Among Hospitals, 2011-2017



ACO, Medical Home, Bundled-payment Program or Provider-sponsored Health Plan, by Hospital Type, 2017



The Alternative Payment Models Framework

This report uses the CMS Health Care Payment Learning and Action Network (HCPLAN) framework — which situates different payment models along a continuum of risk — to describe the APM landscape. Although payments are classified in discrete categories, the framework captures a continuum of clinical and financial risk for provider organizations.

Despite increasing adoption of APMs across payers, most of the dollars in value-based arrangements still flow through an FFS chassis, with few providers assuming responsibility for financial losses, and only 4 percent of arrangements flowing through population-based payments (Category 4). As a result, many health systems are grappling with how to evolve their care models to meet the objectives of APMs while still having the majority of their payment arrangements in FFS.

“Most of the dollars in **value-based arrangements** still flow through a **fee-for-service chassis.**”

CMS Health Care Learning and Action Network (HCPLAN)



CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE-FOR-SERVICE; NO LINK TO QUALITY OR VALUE	A Foundational Payments for Infrastructure and Operations (e.g., care coordination fees and payments for health information technology investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific, Population-Based Payment (e.g., per member per month payments, payments for specialty services such as oncology or mental health)
	B Pay-for-Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedure and com- prehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/ percentage of premium pay- ments in integrated systems)
	C Pay for Performance (e.g., bonuses for quality performance)		C Integrated Finance and Delivery Systems (e.g., global budgets or full/ percentage premium pay- ments in integrated systems)
		3N Risk-Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked To Quality



8 Common Principles of Evolving Care Models

Health systems are evolving their care models in different ways to meet their patients' needs and align with their organizational cultures. While the specifics differ, there are common underlying principles identified by the expert panel.

- 1 | Organize care delivery around the needs of patients across the care continuum** (e.g., inpatient, ambulatory, post-acute) through ownership or partnerships with affiliated providers, allowing health systems to better manage patients post-discharge and avoid costly readmissions.
- 2 | Significantly broaden the health care provider's scope**, from a narrow focus on individual patients' disease states and episodes of care to a broad focus on the health of populations, including addressing care needs across the continuum and considering health-related social factors — like housing and food insecurity — that have traditionally been far outside the health care sphere.
- 3 | Redefine the role of the physician from an autonomous actor to leader of an integrated care team** of advanced practice providers, nurses and others focused on creatively engaging patients and closing gaps in care. As one health system leader told us, creating a “culture of team” has been one of his organization's most substantial challenges.

4 | Introduce complex new workflows and technologies — including the use of real-time data to drive clinical decision-making and complementing the traditional medical visit model with proactive care management and telehealth programs.

5 | Deliver evidence-based clinical care and effectively use care management to support high-needs patients, including addressing the social determinants of health. This approach addresses patient needs upstream and reduces unnecessary and expensive inpatient hospitalizations and emergency department visits.

6 | Adopt IT infrastructure and analytic capabilities to track patient quality and cost outcomes, identify high-risk/high-cost patients and coordinate patient referrals, enabling care management teams to direct at-risk patients to the appropriate care setting and reduce unnecessary inpatient utilization.

7 | Evolve financial management systems to manage risk-based contracts, including tracking performance on contracts with downside risk and putting risk-mitigation strategies in place to ensure that APMs can sustainably finance the new care delivery model.

8 | Align governance and management processes to support alternative payment and care delivery — including processes to build provider buy-in, develop clinical alignment across the network and build new workforce capabilities — to enable care delivery transformation. ●



“ACOs need a sufficient number of attributed lives to minimize random fluctuations.”



The Four Most Common Alternative Care Delivery Models

Each model — while not exhaustive — represents the most common alternative care delivery frameworks in the field and observed in the literature. Each model includes a real-world example and emerging insights.

1 ACCOUNTABLE CARE ORGANIZATION

Networks of health care providers jointly responsible for improving patient outcomes and reducing spending for an attributed patient population. May involve a range of provider configurations, such as physician groups, behavioral health organizations, hospitals and health systems.

DESCRIPTION: Caravan Health works with rural and independent health systems to build ACOs under the MSSP.

KEY INSIGHTS: After reviewing several years of MSSP data, Caravan recognized a critical challenge: ACOs in a shared savings/shared risk model need sufficient scale to minimize random spending fluctuations in their attributed population. In 2019, the organization launched a national virtual Medicare ACO to aggregate attributed Medicare lives across rural health systems. While many individual rural ACOs had between 5,000 and 10,000 lives, the new ACO has 225,000. Caravan has set up care model requirements participants must adopt, an intensive training program to help health systems build necessary capacity, and a robust data analytics platform in which participants can compare their performance against regional partners and the national ACO. Caravan ultimately shares savings back with ACO participants based on a methodology that includes patient attribution and quality performance. Such an approach offers a way for smaller, rural providers to attain the scale needed to perform well under APMs. As Lynn Barr, Caravan's CEO, says, the goal is to "standardize an effective model that will get results and create a platform for change."

RESULTS: Caravan's national rural ACO is in its first year. However, other Caravan-affiliated ACOs to date have substantially improved their quality scores compared with baseline and generated savings more than 60 percent higher than the national average for MSSP ACOs.



2 MEDICAL HOME

Model of reorganizing primary care delivery. Under a medical home, an integrated care team — often encompassing a primary care provider, nurses, care managers and others — provides patients with whole-person, coordinated and accessible care. Some organizations pursue accreditation by an outside body (e.g., National Committee for Quality Assurance (NCQA) patient-centered, medical home certification), while others incorporate key features of the model without formal accreditation.

DESCRIPTION: Summa Health in northeast Ohio provides an integrated, team-based approach to primary care based on the principle "tasks for staff, decisions for physicians." Primary care physicians focus on difficult diagnostic dilemmas and building relationships with patients, while nurses, pharmacists and other team members take on clinical and administrative functions of the medical home model directed toward helping patients achieve better health outcomes.

KEY INSIGHTS: James Dom Dera, M.D., Summa Health's patient-centered medical home (PCMH) director, points to substantial evidence that robust primary care is the key to better population health and lower total cost of care, and believes primary care spending will represent a larger percentage of total health spending in the future. The best primary care delivery approaches, Dom Dera says, will build on the medical home model and incorporate increased virtual visits, patient education and links to social determinants of health. Dom Dera believes population-based payments can best finance such an approach; however, incentives must be aligned across primary and specialty care providers for the model to work effectively.

RESULTS: Due to improved care transitions, Summa Health's 2017 30-day readmission rate dropped to the lowest level in seven years. Additionally, 77 percent of Summa's primary care practices are PCMH-certified by NCQA, a large increase from the prior year.



3 INTEGRATED SERVICE LINES

Hospitals and health systems are organized around integrated service lines — based on specific disease states and/or care episodes (e.g., cancer, heart and vascular, neuroscience, etc.) — across medical specialties and the continuum of care. The approach differs from a traditional hospital organizational structure organized by medical discipline (e.g., surgery, radiology, etc.). Integrated service lines are well positioned to negotiate bundled payments with payers for specific episodes of care.

DESCRIPTION: Mount Sinai Health System (MSHS) in New York has offered a joint replacement, bundled payment program to patients with certain commercial insurance since 2016. Under the model, a care guide visits patients in the hospital, coordinates the transition home, manages outpatient and home-based, post-surgical care and arranges transportation to appointments.

KEY INSIGHTS: Niyum Gandhi, chief population officer at MSHS, says the approach requires a different mindset. "This isn't just a joint replacement program, it's a mobility program. Specifically, the program's ultimate goal isn't the surgery — the goal is pain-free walking, and there's more to that outcome than just the surgical procedure."

RESULTS: Since the start of the program, the percentage of program participants using the emergency department during the episode of care dropped from 26 percent to 3 percent.



4 PROVIDER-SPONSORED HEALTH PLANS

Health plans that are financially sponsored or acquired by hospitals, physician groups or health systems. Providers often take responsibility for total cost of care for the health plan's enrollees and accept some degree of financial risk from the plan. While the health plan receives a capitated payment for its enrolled population, it does not always pay providers on a capitated basis.

DESCRIPTION: Sharp HealthCare is an integrated delivery system in San Diego County that includes a provider-sponsored health plan. Sharp offers a robust, continuum-based care management program. The system receives approximately 30 percent of its revenue on a capitated basis (a significant portion comes from its health plan). Sharp is affiliated with a foundation-model medical group (Sharp Rees-Steely Medical Group) and an aligned independent practice association (Sharp Community Medical Group), and also works with a large number of independent physicians.

KEY INSIGHTS: Executive Vice President Dan Gross says adapting care management programs to meet the needs of individuals with specific chronic diseases is critical to effectively managing population health. One of the biggest challenges, Gross says, is aligning physician compensation with the health system's payer contracts, especially given varying degrees of physician affiliation with the system.

RESULTS: The system receives consistently high ratings and awards on quality, efficiency and patient-centered care, including awards from the Leapfrog group and Planetree. Sharp's health plan is also the highest member-rated health plan in California and has an NCQA accreditation of excellent.



Addressing the Challenges in the Transition of APMs

KEY POINTS

1 As a result of the slow on-ramp and divergent reimbursement strategies across payers, adoption of APMs by health systems has been wide but not deep, with many health systems participating in some form of APM but most not taking downside risk.

2 Many health system leaders want to transform their care models but struggle to finance the required changes under their still-predominant FFS payment model.

While government payers have sparked a paradigm shift around how to pay for health care during the past decade, they have allowed for a transition, granting providers time to build new capabilities without significant exposure to downside risk. And government payers are only one part of a health system's reimbursement landscape; commercial payers typically have lagged in their use of APMs. As a result of the slow on-ramp and divergent reimbursement strategies across payers, adoption of APMs by health systems has been wide rather than deep, with many health systems participating in some form of APM but most not taking downside risk. Many health systems now find themselves with one foot in fee-for-service and the other in alternative-reimbursement models. Health systems interviewed for this report all described being in a situation in which they want to transform their care models, but struggle to finance the required changes to their networks, processes and support systems.

7 Provider Challenges

Providers experimenting with APMs based on fee-for-service architecture have encountered the following challenges:

1 | Delivering care in new ways requires a source of funding, which is often not available under a shared savings model.

Providers who want to invest in new care delivery capabilities (e.g., data analytics) or offer innovative services (e.g., virtual care, approaches to addressing social determinants of health) not reimbursable under FFS struggle to finance their care delivery changes. While some providers receive upfront care coordination fees under a Category 3 model, shared savings represent the largest potential source of funding. However, because shared savings are not guaranteed and — if they materialize — are paid retrospectively, providers struggle to leverage them as a dependable financing source.

2 | Health systems that implement APMs with a subset of payers may jeopardize reimbursements under FFS contracts.

Providers often negotiate APMs with only a subset of contracted payers, but implement changes to care delivery for all patients incurring additional cost for innovative services. While providers may see shared savings under APMs, care delivery changes may drive down utilization across other payer contracts, reducing providers'

FFS payments without creating an opportunity to share in savings. One executive with Medicare FFS and Medicaid APMs put it simply: "Our commercial and MA [Medicare Advantage] payers are benefiting from the changes without providing any reimbursement."

3 | Reducing revenue under a shared savings APM may not immediately lead to a proportional decrease in expenses because health systems have substantial fixed costs. Under APMs, health system utilization and reimbursement often decline faster than expenses, meaning hospitals can temporarily see a drop in financial resources before costs decline.

4 | Opportunity to achieve shared savings decreases over time, as successfully decreasing spending leads to a lower benchmark in subsequent year. Under most shared-savings arrangements, payers reset providers' benchmark spend annually based on performance in the previous year. While providers initially may see savings, providers soon reach a new equilibrium where achieving additional savings is difficult. A health system executive focused on primary care transformation told us, "If I do my job well, there won't be any shared savings left."

5 | Technical decisions related to setting the cost benchmark can lead to highly variable results. For example, the Pioneer ACO used a national benchmark to establish target spending, which did not reflect regional variations in health care spending. Under the Next Generation model, CMS made changes to its risk-adjustment methodology mid-contract year, causing some health systems to see unexpected financial losses and exit the model.

6 | Attribution methodologies are imperfect, often leading to situations in which providers have limited to no relationship with attributed patients and little ability to influence their care. When patients are attributed to a provider but have no incentive (e.g., network restrictions, lower cost-sharing, etc.) to seek care from that provider, they may choose to go outside the provider's network.

7 | Success under shared savings or risk depends on scale. Providers' ability to achieve shared savings is also highly dependent on managing a sufficient number of attributed lives to avoid random fluctuations in spending. ●



Preparing for the Road Ahead

KEY POINTS

- 1 Payers will continue to push providers toward accepting greater levels of risk.
- 2 Providers will need to quickly build new capabilities to succeed under higher levels of risk. An APM Care Delivery Maturity Model offers a framework for providers to assess current capabilities and consider areas for development.
- 3 While parallel payment models will remain, the message from the field is clear: Transformed care models work best when a substantial portion of providers' reimbursement is in advanced payment models.

Providers interviewed for this report emphasized that HCPLAN Category 3 arrangements [see page 6] gave them an opportunity to rethink their most critical task: how to provide the best care for patients. Once they began implementing some care delivery changes — including a team-based care delivery model, use of care management to support complex populations and robust analytics to assist with identifying high-risk patients and tracking performance on quality and cost — they quickly saw that it was a superior way to deliver care. However, the payment model changes were insufficient to finance the truly transformative care they sought to provide. As one rural health system executive said, “It’s been a good experiment, but it’s not an endpoint.”

- **Providers agreed that payment models will move into more advanced levels of risk during the coming years**, including shared-risk models and population-based payments. Surveys of the field point to a similar conclusion. However, the pace of change will vary by local market. While Medicare and Medicaid programs will continue to push providers into more advanced risk arrangements, the commercial market is highly variable and tends to lag behind public payers for several reasons. First, putting together a risk-sharing option with a commercial payer may not be sustainable based on shared savings from reductions in utilization or costs of care unless the partnership is able to add covered lives. Second, most employer-sponsored plans are self-funded and many cover large numbers of employees across a wide geographic footprint, creating significant logistical challenges. Third, some health systems may be reluctant to forgo the financial security of important commercial FFS contracts while they experiment with APMs.

- **Providers will need to quickly build new capabilities to succeed under higher levels of risk.** Based on interviews with a broad cross-section of providers and a review of the literature, the AHA Center for Health Innovation has developed a maturity framework describing care delivery and organizational capabilities providers need to assume increasingly greater degrees of financial risk.

- **Although the pace of change may differ, the lesson from the field is clear: Transformed care delivery works best with a transformed payment model.** Providers that transition a substantial portion of their payment stream to advanced payment models are more likely to scale their alternative care models and reduce the inherent tension between competing payment models. As health systems' care models grew more mature, they developed confidence to take on greater levels of payment risk, which then financed greater changes in care delivery. ●

RURAL PROVIDER ACO



Winona Health

Description: Winona Health is an integrated delivery system in rural Minnesota. In 2015, the organization developed a Medicaid ACO using startup funds from the state’s Medicaid ACO program and, in 2016, created the MN Rural ACO with five geographically dispersed partners to serve Medicare beneficiaries. This ACO was supported by the MSSP ACO Investment Model to develop the infrastructure and managed by Caravan Health. Winona Health implemented an evidence-based population health management model, risk-stratifying patients to identify high-risk patients, developing a team-based primary care approach and using care managers to address gaps in care.

Key Insights: Winona Health leadership recognized that the organization needed greater scale to minimize random fluctuations in spending among its attributed population and also desires to expand the Value-based Purchasing (VBP) model to commercial payers. To advance its VBP model, Winona Health joined a national MSSP ACO in January 2019, serving 225,000 Medicare beneficiaries and managed by Caravan Health. Additionally, Winona Health is using its care delivery successes to negotiate new APMs with commercial payers.

Results: Winona Health does not yet have results related to participation in the national collaborative ACO. However, for patients enrolled in its Medicaid and Medicare ACO program for three or more years, emergency department (ED) visits declined by 37 percent and total charges decreased by 31 percent. ●



KEY POINTS

4 Alignment of payment models across payers is critical for more rapid and widespread adoption of new care models.

5 Organizations on the ground offer lessons about how to move up the maturity model, often using initial successes to negotiate additional and higher-risk APM arrangements with payers.

ACADEMIC HEALTH SYSTEM MEDICAL HOME



Cleveland Clinic

Description: Cleveland Clinic is an academic health system with a main campus in Cleveland, 11 regional hospitals, 180 outpatient locations in northeast Ohio and additional locations across the United States and internationally. In 2018, the organization created a “community care” division that includes primary care, components of the post-acute care network and its clinically integrated network of 7,100 providers, among others. The organization adopted a team-based primary care, medical home model, using predictive analytics to identify patients likely to experience adverse events and deploying care managers to support at-risk patients. Cleveland Clinic began its transformation with an MSSP ACO, but moved quickly toward Category 4 APMs to support its care model. By the end of 2019, Cleveland Clinic expects to have 60 percent of adult primary care under primary care capitation, providing significant flexibility to finance its transformed care model.

Key Insights: Cleveland Clinic incorporated a number of new specific initiatives to improve population health, including a program for providers and clinicians to proactively identify and close care gaps, and a care-at-home program for frail elderly patients that uses clinic-employed paramedics and virtualist physicians to reduce unnecessary ED visits.

Results: Since both programs were implemented, closure of care gaps increased 1,800 percent and ED visits among individuals enrolled in the care-at-home program decreased by 60 percent. ●

INTEGRATED FINANCE AND DELIVERY SYSTEM



Allegheny Health Network

Description: Allegheny Health Network (AHN) is an integrated delivery system owned by Highmark, which provides health insurance coverage to more than 4.5 million individuals. AHN is an open system, with 50 percent of its business from Highmark enrollees and 50 percent from other payers. AHN secured funding from a local foundation to support a care delivery pilot focused on diabetes and then expanded to other chronic diseases.




Key Insights: AHN has developed an approach to chronic disease management that changes specialty and primary care delivery and aligns providers’ financial incentives accordingly. The organization provides an integrated care model for individuals with diabetes, chronic obstructive pulmonary disease and congestive heart failure. Specialists — surrounded by an integrated care team — manage the highest-risk patients and train integrated primary care teams to manage rising-risk patients. Incentives are also aligned for downstream providers. Approximately 25 percent of primary care physician compensation is tied to quality performance, and a portion of specialist compensation will also soon be tied to quality.

Results: AHN demonstrated substantial savings related to diabetes management in its first 6-12 months and then negotiated a shared savings arrangement with Highmark to expand the pilot to other chronic diseases. Going forward, AHN plans to take higher levels of risk (e.g., chronic disease “bundle”) for Highmark patients and negotiate upside APMs with other payers. ●



Maturity Framework for New Care Models/Risk-sharing Arrangements



Hospitals are in the midst of navigating significant changes in how they operate and deliver care. Each organization can use the maturity framework to assess its current capabilities to determine the best type of value-based care for the organization. All providers need to rethink where they are on the risk continuum, where they will be in the future and whether they have the infrastructure systems needed to manage risk.

CAPABILITY	MATURITY LEVEL		
	BASIC	FOUNDATIONAL	ADVANCED
 <p>Care Continuum and Provider Network Management</p>	<ul style="list-style-type: none"> ● NETWORK Significant gaps in assets across care continuum (outpatient — inpatient — post-acute) ● AFFILIATION REQUIREMENTS Limited criteria for affiliation ● QUALITY IMPROVEMENTS No link to quality/value 	<ul style="list-style-type: none"> ● NETWORK Robust network (either owned or affiliated). Health systems can address most patient care needs across continuum through owned or affiliated providers. ● AFFILIATION REQUIREMENTS Contracts require commitment to shared quality/utilization metrics ● QUALITY IMPROVEMENTS Portion of payment to physicians tied to performance/value 	<ul style="list-style-type: none"> ● NETWORK Comprehensive, clinically integrated network ● AFFILIATION REQUIREMENTS Affiliation relationship contingent on meeting quality and cost-management objectives ● QUALITY IMPROVEMENTS Strong alignment of physician compensation with clinical objectives through use of incentives
 <p>Clinical and Care Management</p>	<ul style="list-style-type: none"> ● CLINICAL PROTOCOLS No standardization of clinical protocols ● CARE MANAGEMENT Limited, if any ● QUALITY IMPROVEMENTS Quality-improvement and disease-management programs exist but are not coordinated across different parts of the health system 	<ul style="list-style-type: none"> ● CLINICAL PROTOCOLS Shared clinical protocols and standards of care ● CARE MANAGEMENT Integrated care teams, including nonphysician providers; dedicated care managers for high-risk patients ● QUALITY IMPROVEMENTS Shared quality measures 	<ul style="list-style-type: none"> ● CLINICAL PROTOCOLS Process for updating protocols with latest evidence and monitoring adoption ● CARE MANAGEMENT Population-health and disease-management programs, including use of telehealth and new technologies, where appropriate; assessment of social determinants of health and referrals to community-based organizations ● QUALITY IMPROVEMENTS Culture of continuous process improvement with progressively evolving performance standards
 <p>IT Infrastructure and Analytics</p>	<ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Functional EHR but little interoperability with affiliates ● POPULATION HEALTH MANAGEMENT TOOLS Use of disease registries/reporting ● PERFORMANCE ANALYTICS Some ability to track performance against quality/utilization benchmarks 	<ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Strategy in place to integrate EHR and analytics platforms across network, though not necessarily common platform ● POPULATION HEALTH MANAGEMENT TOOLS Population health-management system to identify high-risk patients ● PERFORMANCE ANALYTICS Integration of clinical, administrative and care management data at patient-level; practice-level dashboards to track performance against quality/utilization targets 	<ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Common EHR, analytics and care management platform used across network ● POPULATION HEALTH MANAGEMENT TOOLS Ability to identify defined subpopulations for targeted interventions; use of predictive modeling to identify at-risk members; ability to facilitate and track closed-loop referrals to community-based organizations ● PERFORMANCE ANALYTICS Near real-time visibility into quality and cost performance

(Continued on page 13)



Maturity Framework for New Care Models/Risk-sharing Arrangements (*continued*)

CAPABILITY	MATURITY LEVEL		
	BASIC	FOUNDATIONAL	ADVANCED
 <p>Financial Management</p>	<ul style="list-style-type: none"> ● PRACTICE MANAGEMENT AND REVENUE-CYCLE MANAGEMENT Systems in place ● ACTUARIAL/RISK-MANAGEMENT CAPABILITIES Limited to non existent 	<ul style="list-style-type: none"> ● PRACTICE MANAGEMENT AND REVENUE-CYCLE MANAGEMENT Evolving to address evolving reimbursement models ● ACTUARIAL/RISK-MANAGEMENT CAPABILITIES Ability to negotiate and manage performance for contracts with downside risk; some risk mitigation in place 	<ul style="list-style-type: none"> ● PRACTICE MANAGEMENT AND REVENUE-CYCLE MANAGEMENT Systems fully aligned with reimbursement models ● ACTUARIAL/RISK-MANAGEMENT CAPABILITIES For provider-sponsored health plans, ability to perform claims payment, underwriting and meet reserve requirements
 <p>Governance and Provider Engagement</p>	<ul style="list-style-type: none"> ● GOVERNANCE STRUCTURE Informal ● OPERATING UNITS No change ● PROVIDER ENGAGEMENT Limited provider engagement in development of quality improvement programs 	<ul style="list-style-type: none"> ● GOVERNANCE STRUCTURE Structure in place to oversee APMs ● OPERATING UNITS New functions created to support contract management with payers and provider partners ● PROVIDER ENGAGEMENT Clinical and administrative leadership buy-in to support alternative payment/care delivery; workforce-development strategy in place to support transition; change-management strategy to guide organizational transformation 	<ul style="list-style-type: none"> ● GOVERNANCE STRUCTURE Corporate governance with clear roles for board, executive team, medical staff leaders with regard to clinical direction, state regulatory reporting, compliance, management and operations ● OPERATING UNITS Organizational model aligned with new care delivery and reimbursement models ● PROVIDER ENGAGEMENT Providers well integrated into strategic planning efforts



“Reformed **payment mechanisms** will only be as successful as the delivery system capabilities and innovations they support.”



Road Map to Advance Along the Maturity Model

The experiences of these and other provider organizations offer a road map for others seeking to accelerate their transition to greater levels of risk.

1 Develop and commit to a transformed vision of care delivery,

recognizing that the new approach may risk short-term financial losses, but will drive long-term success. Based on interviews conducted for this report, health systems that implemented new care delivery models saw better health outcomes, more satisfied patients and more engaged providers. As consumers and payers come to expect greater value from providers — including high-quality outcomes, a patient-centered approach and multiple pathways to access care (e.g., in person, virtual care, etc.) — health systems that develop such a vision and remain steadfast will be well positioned for long-term success despite initial challenges to finance the new system as payment models catch up.

2 Identify a source of financing for the care delivery transformation.

Building networks, transforming care delivery processes and investing in support systems all require capital. Some providers in more mature markets may be able to quickly negotiate risk-based contracts across multiple payers to finance their care delivery changes. Others may need to focus on a handful of payers (e.g., MSSP, Medicare Advantage, one commercial contract, etc.) or philanthropy to provide initial funding for care delivery transformation. For instance, health systems might negotiate upfront care management fees or “prepaid” shared savings, in which they receive funds upfront that are discounted against any savings generated.

3 Develop a proof of concept.

Implement changes and test the model, carefully tracking outcomes related to quality and cost for the relevant population.

4 Build financial-management capabilities to manage risk contracts.

As providers advance along the risk spectrum, they will need additional capabilities to manage contracts with payers. This function is critical to translating care delivery innovation into success.

5 Leverage the proof of concept to negotiate more advanced APMs with other payers.

Rather than waiting for payers to evolve their models, providers can use their proof of concept to proactively bring a value proposition to payers.

6 Align physician incentives with broader APMs negotiated with payers.

Providers interviewed for this report identified an inherent tension when health systems implement APMs designed to reduce unnecessary utilization while paying employed and/or affiliated physicians based on volume (e.g., relative value units). Provider organizations can work collaboratively with physicians to develop new compensation models — generally incorporating a base salary, a portion tied to quality, and a smaller portion tied to volume — that align physician incentives with APMs.



Accelerating Care Delivery Transformation

Conversations with hospital and health system innovators suggest that the interplay between care and payment models can act as both a brake and accelerator on transformation. While APMs were an initial catalyst to care delivery transformation, payment models have not evolved sufficiently to finance the new care delivery approaches. Leaders of organizations engaging in advanced models are experimenting with new care delivery models based on the belief that such changes will improve patients' health, but they are also struggling to transform care delivery under a payment system that is still largely one of fee for service. As one health system executive currently navigating APM and fee-for-service payment models said, the conflicting incentives in the system "are like telling your kid not to eat that candy, but if you eat it, I'll pay you."

In addition to reflecting the challenging dynamic between care delivery and payment models, hospital and health system leaders also explained how they can positively influence one another. By building care delivery prototypes, testing their models and bringing a value proposition to payers, health systems can achieve greater alignment in reimbursement from government and commercial payers, thereby further accelerating care delivery transformation. Such an approach creates a virtuous cycle where initial successes in care delivery and payment reform drive bolder care model changes and increased levels of financial risk. As payers continue to shift higher levels of risk onto providers, hospitals and health systems that can leverage this positive feedback loop to transition a substantial portion of their payment stream to APMs will be well positioned for success. Through the hard work of changing their care models, providers are poised to lead care delivery change to improve patient outcomes. ●

Expert Panel

The AHA Center for Health Innovation thanks the following people, organizations and sources for the time and insights that made this Market Insights report possible:



Lynn Barr
CEO and founder,
Caravan Health



James Dom Dera, M.D., FAAFP
Patient-Centered
Medical Home medical
director at NewHealth
Collaborative, Summa
Health's Accountable Care
Organization



Avi Herring
Manager of Manatt
Health Strategies



Suzan Manzi, M.D., MPH
Chair, Medicine Institute,
professor of medicine,
Allegheny Health
Network



Naomi Newman
Director of Manatt
Health Strategies



Jay Bhatt, D.O., MPH, MPA
Senior vice president
and chief medical officer
of American Hospital
Association, and presi-
dent, Health Research &
Educational Trust



Alison J. Fleury
Senior vice president of
business development,
Sharp HealthCare



Kevin Joyce
Vice president of
insurance networks,
business advisory services,
Atlantic Health



Adam L. Myers, M.D., MHCM, FACHE
Chief of population health,
and chair of Cleveland
Clinic Community Care



Ashley Ridlon
Vice president
of health policy,
Evolent Health



Benjamin K. Chu, M.D.
Managing director
of Manatt Health



Daniel L. Gross
Executive vice
president of hospital
operations, Sharp
HealthCare



Thomas Kloos, M.D.
Vice president, Atlantic
Health System and
operations, Atlantic
Accountable Care
Organization



Griffin Myers, M.D., MBA, FACEP
Chief medical officer
and co-founder,
Oak Street Health



Rachelle Schultz, EdD.
President and CEO,
Winona Health



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AHA CENTER FOR HEALTH

INNOVATION

MARKET INSIGHTS

The AHA Center for Health Innovation was launched as part of an American Hospital Association initiative to help our members on their journey of transformation. Our purpose is to lead, connect and transform the future of health care by sharing knowledge and accelerating change with market intelligence, key insights, targeted education, actionable data, and tools designed to help our members drive high-impact innovation.

For more information, contact Lindsey Dunn Burgstahler at 312-893-6836 | www.AHA.org/center