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Navigating the New York State Value-Based Payment Roadmap

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Navigating the New York State Value-Based Payment Roadmap

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Foreword

New York's health care system is currently undergoing an unprecedented amount of change, and nowhere is that more apparent than in its Medicaid program. The Medicaid Redesign Team, established by Governor Andrew Cuomo in 2011, set forth a vision for a transformed Medicaid program that is now taking shape—especially as implementation of the transformational Delivery System Reform Incentive Payment (DSRIP) program begins to hit full stride. Serving more than 6 million New Yorkers annually, Medicaid is a bedrock safety net for many of the state's most vulnerable residents, and sustaining the program for the long-term requires changes in both the way health care services are delivered and paid for.

Navigating the New York State Value-Based Payment Roadmap—prepared for the Medicaid Institute at United Hospital Fund by Rob Houston, Katherine J. Heflin, and Tricia McGinnis from the Center for Health Care Strategies—explains in simple terms how New York's Medicaid program plans to transform the way it finances health care services, moving from volume- to value-based payments (VBP). This transition is an essential one for reinforcing the broader goals of the Medicaid Redesign Team recommendations, and for sustaining the delivery system reforms that will emerge from DSRIP. Moving to VBP in this \$60 billion per year program holds real promise for both improving the quality of care and reducing costs.

As New York State begins to more fully define and implement its approach to VBP in Medicaid, a number of policy and operational issues must be considered. This guide describes the vision presented in the State's VBP roadmap, giving providers and other stakeholders a list of open questions—many of which are in the process of being answered by the State's active stakeholder engagement process. We hope it helps Medicaid stakeholders keep track of the many moving parts involved in this considerable effort.

As always, we welcome your comments on our work.

JAMES R. TALLON, JR.
President
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Introduction

In June 2015, the New York State Department of Health (DOH) released *A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform* (the “Roadmap”), which laid out a vision for value-based payment (VBP) in Medicaid over the next four years.¹ The Roadmap, which was developed by the State and its VBP Workgroup, was written primarily for the Centers for Medicare & Medicaid Services (CMS) as a condition of the State’s Delivery System Reform Incentive Payment (DSRIP) agreement. In addition to fulfilling this requirement, the Roadmap: (a) outlines the State’s strategy to have 80-90 percent of Medicaid managed care payments (in dollars) to providers shifted from fee-for-service (FFS) payments to VBP by 2020; (b) describes the new payment approaches and the types of provider organizations that will be involved; and (c) answers key questions about potential VBP approaches. Achieving the State’s ambitious VBP goal depends on reforming both the delivery system and payment methodologies. DOH intends to use DSRIP, the State Innovation Models (SIM) initiative, and related initiatives as catalysts for reforming how care is delivered, paving the way for Medicaid providers and managed care organizations (MCOs) to enter into new VBP arrangements that align with these new care models.

Although the Roadmap provides an overview of many of the steps that the State intends to put in place over the next four years, it is not a complete blueprint for the transition to VBP. There are still many details to be developed by the VBP Workgroup, its subcommittees, and clinical advisory groups (CAGs).² These details will define the standards and guidelines for VBP, but the real transition will take place through negotiations between providers and MCOs. The State also emphasizes that the Roadmap is a “living document” that will be updated annually, which will allow the State to incorporate lessons from DSRIP implementation, continued stakeholder input, and multipayer alignment efforts with CMS into future versions of the Roadmap.

The change in payments outlined by the Roadmap will undoubtedly have a significant financial and organizational impact on providers, including hospitals, small and large primary care and multi-specialty practices, other specialty providers, federally qualified health centers (FQHCs), and community health centers (CHCs). Therefore, it is imperative that providers

What is the Roadmap?

The New York State Roadmap for Medicaid Payment Reform is:

1. An overview of the State’s Medicaid value-based payment strategy and how it aligns with other federal, commercial, and State initiatives.
2. A living document that will evolve with stakeholder input and DSRIP implementation experience.
3. A means to achieve the goal of 80-90 percent of Medicaid managed care payments to providers being VBP approaches by 2020.

¹ Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/vbp_roadmap_final.pdf

² More information on these groups can be found in the section “VBP Workgroup Subcommittees and Responsibilities.”

and other stakeholders become familiar with the Roadmap and its potential impact on the health care delivery system. This guide describes the Roadmap and is intended to help providers and stakeholders prepare for the transition from FFS to VBP and be more informed participants in the ongoing implementation of the Roadmap's vision. In developing the Roadmap, the State is also very aware of VBP trends in the broader health care system. Commercial insurers and Medicare are making concerted efforts to drive the system away from the volume imperative in the FFS system toward various levels of VBP. Aligning Medicaid payments with these broader trends should also make life easier for the many Medicaid providers with Medicare and commercial beneficiaries among their patients.

Roadmap Goals and Background

VBP is a broad concept that involves paying providers for value in health care services. Examples of measurable values worth paying for include achieving improved health outcomes, choosing evidence-based processes, managing the costs of care, and implementing effective care coordination strategies. VBP is a significant change from FFS payments, which simply pay for a service to be performed regardless of the result. FFS payment arrangements unintentionally—but almost inevitably—reward providers financially for performing a high volume of services. The Roadmap describes the types of new payment arrangements between providers and MCOs that would count toward the 2020 VBP goal. While the Roadmap's VBP approach is heavily aligned with DSRIP, it is not exclusively a DSRIP document. Rather, it is intended for all provider organizations that contract with Medicaid MCOs, including accountable care organizations (ACOs), independent practice associations (IPAs), hospitals, clinics, and other providers.³ Within the broad goal of 80-90 percent of total MCO payments to providers statewide in VBP arrangements, the State has set a goal that at least 35 percent of payments to providers by fully capitated MCOs be risk-based (Level 2 or 3) VBP arrangements.⁴

With the Roadmap's high-level goals in mind, providers can start by determining their current level of VBP activity and developing a strategy to shift toward VBP. The remainder of this guide focuses on what the Roadmap means for providers and what questions still need to be addressed by the State, the VBP Workgroup, subcommittees, and CAGs.

³ Performing Provider Systems are not legal entities that can contract directly with MCOs, but they may become ACOs or IPAs for purposes of VBP contracting. Financially challenged providers, such as those classified as Interim Access Assurance Fund (IAAF) providers and providers requiring Vital Access Provider (VAP) and/or Vital Access Provider Assurance Program (VAPAP) funding, are encouraged to join shared savings (Level 1) VBP agreements, but will not be allowed to share risk (Level 2 or higher).

⁴ VBP risk levels are discussed in more detail in the section "Transitioning to Greater Levels of Risk in VBP."

What the Roadmap Means for Providers

The Roadmap will undoubtedly change the way providers in the State of New York do business with Medicaid, and will influence not only payment methodologies, but also care delivery, data exchange, and their business models. To prepare for this new reality, providers will have to understand the contents of the Roadmap. Three main aspects of the Roadmap will affect providers over the next four years: (1) selecting VBP options; (2) transitioning to levels of risk-based VBP; and (3) implementing changes in managed care contracting. It is important to note that selecting a VBP option and a VBP risk level are separate decisions, but these two components will make up a single VBP “approach” (Figure 1) that will evolve over time.

Figure 1. Constructing a VBP Approach



These choices, and other related topics, are explored in detail below. The matrix in Figure 3 lays out descriptions of the resulting approaches.

Selecting VBP Options

The Roadmap lays out four specific VBP options that providers and MCOs might use to improve patient outcomes and reduce costs. These options, based on payment model and/or population served, include: (1) All Care for Total Population; (2) Integrated Primary Care; (3) Acute and Chronic Bundles; and (4) Total Care for Special Needs Subpopulations. The Roadmap does not express a preference for one option over others, allowing providers and MCOs to choose from the menu of options. All options include a quality component, in which a portion of payments is contingent on performance on quality metrics that measure patient outcomes.

- **All Care for Total Population.** Under this option, providers would be responsible for the total cost of care (TCOC) of services received by their attributed patients. It is possible that individual provider organizations (such as integrated delivery systems, hospital systems, or independent practice associations), as well as PPSs, could choose this VBP option.

- **Integrated Primary Care.** In this arrangement, patient-centered medical homes (PCMHs), advanced primary care (APC) practice providers, or other provider entities (e.g., PPSs, ACOs, or IPAs), would be responsible for the services, costs, and outcomes directly associated with good primary care (e.g., avoidable hospital admissions), but not for costs beyond the primary care practice’s control (e.g., cancer care).
- **Acute and Chronic Bundles.** In acute care bundles, providers would be responsible for patient-focused bundles of care for a specific acute patient condition or episode of care (e.g., maternity care). Providers and MCOs can also form chronic care bundle arrangements, which manage all care involved for patients with a specific chronic condition, such as diabetes for a pre-determined amount of time (e.g., annually). Under both these bundled arrangements, providers receive a financial incentive if costs are reduced below a pre-established benchmark.
- **Total Care for Special Needs Subpopulations.** In this option, providers that focus on working with special needs subpopulations (e.g., people with severe comorbidities or disabilities) would be responsible for the specific care needs and TCOC for these individuals.

In addition to these four options, the Roadmap mentions the possibility of “off-menu” VBP options that could also count toward the 2020 goal. These options are not specified in the Roadmap, though loose criteria can be found in Appendix II of the Roadmap. These arrangements would be established by the providers and MCOs and would not need to be approved by the State, but must reflect the goals of the Roadmap and would be subject to periodic audits.

It is important to note that the State has also outlined the possibility of combining VBP approaches. For example, a provider and MCO may choose to create a chronic care bundle and a TCOC contract for the subpopulation of individuals with serious and persistent mental illness. In addition, contracts can also “carve out” specific services from a TCOC calculation.

Transitioning to Greater Levels of Risk in VBP

The Roadmap classifies VBP by levels of financial risk that a provider will assume, breaking it down into levels from 0 to 3; the levels are described in Figure 2. The levels are structured so that as providers move up a level, they will assume greater financial responsibilities for costs that exceed the benchmark and may be able to recoup a greater proportion of savings. While the State defines a Level 0 of VBP risk, it also emphasizes that it does not consider this level a VBP arrangement for purposes of meeting the 2020 goal. Only levels 1 through 3 are considered VBP contracts.

Figure 2. VBP Risk Levels

VBP Risk Level	Description
0	Enhanced FFS. Providers may receive a quality bonus, be subject to a quality withhold, or receive a payment for enhanced care coordination. There is no provider risk.
1	Upside only shared savings without provider risk. Providers still receive FFS payments, but have incentive to reduce costs and improve quality through a shared savings arrangement tied to cost benchmarks and quality metrics. There is no “downside” risk, so providers do not have to pay money to MCOs if they exceed cost benchmarks.
2	Upside and downside risk-sharing arrangements. As in Level 1, providers have a shared savings incentive, but are also accountable if costs exceed benchmarks and must reimburse MCOs a percentage of the excess amount if this is the case.
3	Prospective payments that largely replace FFS. MCOs pay providers on a per-member, per-month (PMPM) basis for a patient’s TCOC. Providers may also be paid on a prospective basis for a bundled payment for a specific episode of care or for managing a specific chronic condition.

Source: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*, available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

The Roadmap does not specify how quickly provider organizations must transition to higher-risk levels beyond the collective goals indicated for the State. It is assumed that providers and MCOs will enter higher-level VBP arrangements at their own pace based on the provider’s size, capacity, prior experience with VBP, and other factors. However, while initial entry for many providers into VBP may begin at Level 1, providers are expected to progress toward arrangements with financial risk (Levels 2 and 3) over time.

The Roadmap also provides a helpful chart juxtaposing the four VBP options with the four VBP risk levels to show examples of how each level can be achieved for each option, thus mapping out potential VBP approaches. This chart has been reproduced in Figure 3.

Figure 3. Transitioning to Provider Risk: Determining VBP Approaches

VBP Risk Level →	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP*
VBP Options ↓				
All Care for Total Population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM capitated payment for primary care services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective bundled payment (with outcome-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM capitated payment for total care for subpopulation (with outcome-based component)

* Requires experience with previous levels and mature provider organizations.

Source: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*, page 15, available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Payments under VBP arrangements are also dependent on quality of care and patient outcomes. While this exact mechanism is not specified, the Roadmap provides examples of how VBP arrangements can be constructed to reflect quality performance (Figure 4). More detail on this topic will be provided by the VBP Workgroup subcommittees and CAGs.

Figure 4. Potential Quality Incentives Based on VBP Level and Outcomes Achieved

Percentage of Outcome Targets Met	Level 1 VBP Upside only	Level 2 VBP Upside and Downside	
		<i>When actual costs < budgeted costs</i>	<i>When actual costs > budgeted costs</i>
≥ 50% of outcome targets met*	50-60% of savings returned to PPS/ providers	90% of savings returned to PPS/ providers	PPS/ providers responsible for 50% of losses.
< 50% of outcome targets met	Between 10% and 50%–60% of savings returned to PPS/ providers (sliding scale in proportion with % of outcome targets met)	Between 10% and 90% of savings returned to PPS/ providers (sliding scale in proportion with % of outcome targets met)	PPS/ providers responsible for 50%–90% of losses (sliding scale in proportion with % of outcome targets met)
Overall outcomes worsen	No savings returned to PPS/ providers	No savings returned to PPS/ providers	PPS/ providers responsible for 90% of losses

* Following the concept of rewarding “value,” meeting targets would imply scoring higher than an absolute threshold, or a threshold set relative to other providers. MCOs and providers can opt to agree to (also) reward relative improvement over time.

Source: *A Path toward Value Based Payment: New York State Roadmap For Medicaid Payment Reform*, page 18, available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Implementing Changes in Managed Care Contracting

For the State to move toward VBP arrangements, its contracts with Medicaid MCOs will need to be modified or restructured. The Roadmap does not give exclusive contracting responsibility to PPSs, nor does it require MCOs to form VBP contracts solely with PPSs. However, if providers choose to contract at the PPS level, or as a subset of the PPS, their contract terms would change. Before entering into a PPS-based contract, providers should consider the costs and benefits of entering into such an arrangement.

The State will submit modified MCO contract language to CMS, and has outlined a number of specific amendments it plans to include. Proposed amendments that will directly influence providers are listed below.

- To incentivize the adoption of VBP arrangements between providers and MCOs, the State will increase capitation rates for MCOs that have a higher percentage of VBP arrangements in place with providers. MCOs receiving this increase will be required to increase payments to providers engaged in higher-level VBP contracts.

- MCOs will be required to increase the percentage of provider payments in VBP arrangements each year, though a rate of increase or benchmark is not specified. MCOs will be required to submit an annual report outlining the percentage of providers under VBP arrangements and identifying these providers.
- MCO contracts may be risk-adjusted in new ways to accurately reflect patients' true TCOC and account for social determinants of health.
- The State may help ease the transfer of some risk from MCOs to providers by modifying some of its existing risk requirements, including regulations around reinsurance and reserves.

VBP Workgroup Subcommittees and Responsibilities

While the Roadmap establishes a vision for VBP in New York State, there are still many questions left to answer and parameters to define. This section describes the VBP Workgroup subcommittees that have been established by the State to fill in the details of the broad framework provided by the Roadmap.

The five subcommittees of the VBP Workgroup are made up of providers, MCOs, State officials, consumer groups, consultants, and other key stakeholders. The decisions made by the subcommittees and adopted by the Workgroup will increase clarity about how the State will implement VBP over the next four years. The subcommittees will also generate corresponding guidance and standards for providers and MCOs. The subcommittees and their responsibilities are listed below.

1. **VBP Technical Design (Group 1):** Determine technical details for VBP approaches, including shared savings, bundled payments, and capitated approaches, as well as standardization across PPSs and providers. Issues to address: cost benchmarking, patient attribution, stop-loss mechanisms, and shared savings percentages.
2. **VBP Technical Design (Group 2):** Discuss VBP design issues related to outcome measurement and implementation. Issues to address: technical definition of VBP for use in DSRIP measurement, inclusion and exclusion of specific health care services, quality and outcome metrics and benchmarks, and the design of the VBP Innovator Program (described below).
3. **Social Determinants and Community-Based Organizations:** Determine how to include social determinants of health in payment methodologies and outcomes measurement and how community-based organizations can be engaged to support VBP. Issues to

address: methods to capture savings across public spending, housing determinants, and training needs for community-based organizations.

4. **Regulatory Impact:** Identify and address regulatory and contractual barriers to VBP implementation. Issues to address: antitrust laws and regulations, anti-kickback measures, network adequacy, privacy and HIPAA concerns, contracting changes and approvals, certification, and dispute resolution.
5. **Advocacy and Engagement:** Focus on the best ways to communicate with all Medicaid stakeholders about VBP. Issues to address: upholding consumer “right to know” regulations, patient incentives, and informing patients of their eligibility for consumer incentives.

The State has also established CAGs, primarily made up of clinicians, to focus on a specific subpopulation or condition (e.g., defining an episode of care or bundled payment criteria). The CAGs will help define parameters and quality measures for VBP approaches targeted at these subpopulations and conditions, supporting the VBP Workgroup in its efforts to produce evidence-based and patient-centered methodologies.

Remaining Questions

Since many of the details for implementation of the Roadmap have yet to be worked out, it may be difficult for stakeholders to ready themselves completely for VBP based on the Roadmap alone. Therefore, it is important for providers and all stakeholders to understand these outstanding aspects and how the Roadmap may be affected once there is more detail. This section outlines issues that still need to be defined, and discusses the potential impacts of these decisions.

Which providers will enter into VBP contracts with MCOs?

The Roadmap does not dictate which providers will form VBP arrangements with MCOs. Instead, the Roadmap leaves this option flexible and offers a discussion of the different potential “levels.” In many cases, providers themselves, not PPSs, will be the key negotiators, since providers and payers know each other already and will likely continue these relationships. However, as arrangements shift to risk-based Level 2 and 3 payments, PPSs may be better positioned to assume financial risk as they build up accountability and infrastructure. While some PPSs have already completed Certificate of Public Advantage (COPA) applications,⁵ the State may still have to enact legislation or specifically define and regulate how such negotiations should take place, to avoid potential legal concerns.

⁵ https://www.health.ny.gov/health_care/medicaid/redesign/copa/index.htm

How will combined VBP approaches work?

Under the Roadmap, the State has laid out a number of payment reform options and made it possible for providers to combine methodologies when contracting with MCOs. However, how these mixed methods will work together is unclear. For example, a bundled payment for specific conditions such as an acute care episode (e.g., knee replacement) or management of a chronic condition (e.g., diabetes) might be difficult to integrate with a global payment or shared savings arrangement that uses a TCOC calculation, since the costs could potentially be included in both. The services and costs associated with a bundled payment would likely have to be excluded from the TCOC calculation, but this could create competing incentives among providers and make some services and procedures difficult to assign to a specific bundle or to TCOC. Greater clarity from the State on expectations for how these VBP structures could work together effectively would be useful.

How will patients be attributed to providers?

The number of “attributed lives,” or patients assigned to a provider, is critical to ensuring appropriate accountability and the accurate measurement of quality and cost metrics. The ultimate decision on a preferred attribution method is assigned to the VBP Technical Design Subcommittee (Group 1). The Roadmap gives providers and MCOs the option to agree on alternate attribution methods, then provide their patient-level attribution data to the State.

How will costs be benchmarked?

To measure savings or losses relative to past performance or other standards, providers and MCOs must establish a benchmark with which to compare it. The Roadmap states that savings or losses incurred in Level 1 and 2 arrangements will require an agreed-upon ‘virtual budget’ that will be risk-adjusted based on historical costs and characteristics of the patient population. Providers and MCOs will use these risk-adjusted virtual budgets to negotiate “target budgets” for VBP arrangements. According to the Roadmap, the State will not directly influence these negotiations or set rates for these budgets; it will also not determine global payments or bundled rates. Rather, the State will use one standard methodology to calculate these target budgets, measure performance, and distribute this information to providers and MCOs. This methodology will be discussed and finalized by the VBP Technical Design Subcommittee (Group 1).

What quality measures will be used and how will they be tied to payments?

While the Roadmap states that all VBP approaches must link payments to quality in some way, it does not define what quality measures will be used and how payments will be specifically tied to quality. The State intends to empower VBP Technical Design Subcommittee (Group 2) and the CAGs to construct a set of VBP quality measures, building primarily on the current DSRIP and Quality Assurance Reporting Requirements (QARR) measures, which may include patient-reported outcome measures (including quality of life metrics). The State may also encourage or require MCOs to curtail shared savings and increase shared losses for providers if quality targets are not met. However, it seems unlikely

that the State will establish a specific method of doing so, given its position that it will not determine rates or influence negotiations between providers and MCOs.

How will the VBP approach interface with other State programs?

While the Roadmap mentions both the DSRIP program and New York's State Health Innovation Plan (SHIP), how exactly the VBP program will work alongside other existing and emerging programs remains undefined. To align these initiatives effectively around common goals and avoid duplicative or competing efforts, the State must address issues such as: (1) patient attribution; (2) duplication of care management and coordination efforts across MCOs, providers, and programs; (3) quality metric alignment; and (4) ensuring that patients are not confused by the multiple initiatives working together. The framework for how these initiatives and organizations will interact will likely be considered by the VBP Workgroup, as well as the SHIP Council.

How will smaller providers engage in VBP?

Smaller provider organizations (such as rural practices, and private practice physicians not connected with a PPS or hospital system), as well as CBOs, may experience more difficulty transitioning to VBP, especially if they do not benefit from the DSRIP payments. Though these organizations will likely be able to enter into Level 1 VBP arrangements with MCOs, many smaller providers may lack the necessary internal expertise and capacity to share risk at VBP levels 2 or 3. Further, some small and independent providers may worry that the sheer size of PPSs could create market power that may adversely affect their own contracting negotiations. As a result, these providers may benefit from tailored guidance from the State as to how to construct VBP approaches with MCOs.

How will the VBP Innovator Program work?

The Roadmap discusses the creation of a VBP Innovator Program that will support multi-year Level 2 or 3 VBP agreements between providers and MCOs that enter into these arrangements early in the process. The voluntary program will reward provider participants with an increased upside (up to 95 percent of shared savings). The criteria for this program will be decided by VBP Technical Design Subcommittee (Group 2) and must be approved by the VBP Workgroup.

Will patient wellness or lifestyle incentives be used?

The Roadmap mentions the State's intention for VBP approaches to also offer positive patient wellness and lifestyle incentives and encourage patients to make optimal health choices. While "positive incentives" that reward healthy lifestyle choices (e.g., entering a smoking cessation program) and provider choices (e.g., choosing to contact a PCP rather than going to the emergency department) may be used, "negative incentives" that add patient costs for health care service utilization (e.g., copayments or co-insurance) will not be permitted. Providers and MCOs may receive enhanced payments for offering positive incentives, and providers are expected to use community-based organizations to help address social

determinants of health. These issues will be discussed in the subcommittees on Advocacy and Engagement and Social Determinants and Community-Based Organizations.

Conclusion: Moving toward VBP

Through the Roadmap, the State of New York has designed an ambitious plan to move 80-90 percent of managed care payments to providers to VBP by 2020. The plan is quite flexible and allows providers and PPSs to define many aspects of their own approach to VBP to suit their capacity and current comfort and experience with VBP.

With that said, moving 80-90 percent of provider payments into VBP is a major undertaking. Over the next four years, providers will have to make a concerted effort to adapt their business models to maximize revenue under value-based—as opposed to volume-driven—payments, and build their capacity to accept risk. If leveraged fully, the DSRIP incentives and State Innovation Models investments can help providers build the necessary clinical and operational capacity to succeed under VBP arrangements. Many of the challenges providers will face in doing so have been outlined in this paper. A variety of issues, including attribution, benchmark setting, and the role of PPSs vs. other provider organizations in VBP, will need to be clarified to make this VBP goal a reality. The State has expressed a willingness to support providers in many ways to make these transitions, and to accomplish this goal. Even more importantly, to successfully transition to VBP, providers, MCOs, and the State must have shared objectives and mutually beneficial approaches that align their interests, as well as the interests and objectives of other VBP efforts in the Medicare and commercial sectors.

Appendix: Glossary of Terms

Term	Acronym	Brief Definition
Accountable Care Organization	ACO	A group of doctors, hospitals, and other health care providers, who provide coordinated high quality care to patients. ACOs are intended to tie provider reimbursements to quality metrics and reduce the total cost of care for attributed patients. When an ACO succeeds both in delivering high-quality care and reducing costs, it will receive a financial benefit, typically through a shared savings or shared savings/risk arrangement.
Advanced Primary Care	APC	New York's emerging model of primary care delivery—an augmented patient-centered medical home (PCMH) that provides patients with timely and integrated care. With enhanced access to teams of providers, the APC model aligns and leverages multiple ongoing initiatives and emphasizes prevention, health information technology, care coordination, and shared decision-making among patients and providers.
Alternative Payment Model	APM	A payment model that incentivizes providers to improve quality and outcomes, and to contain costs. APMs help to promote patient value and efficiency by shifting some financial risk to providers. APMs are a broad term for the variety of risk-based or budget-based payment models in use today such as accountable care organizations.
Attribution		The process of assigning individuals to a provider or group of providers (e.g., PPSs, ACOs, or IPAs). That group of providers is then responsible for the care of these individuals.
Avoidable Hospital Use		A term used to indicate hospital service use that could have been avoided or was unnecessary, such as non-emergency use of the emergency department.
Bundled Payment		An initiative that links multiple services beneficiaries receive during an episode of care into a single payment. This system holds providers responsible for both cost and performance, usually with the goal of encouraging care coordination. Bundled payments may lead to improved care transitions, fewer rehospitalizations, and better delivery of appropriate care following discharge—potentially at a lower cost.
Capitation		Payment methodology wherein an organization is paid standard fee per covered patient (often per member per month), to reimburse all services rendered (the total cost of care).
Centers for Medicare & Medicaid Services	CMS	The federal agency, part of the U.S. Department of Health and Human Services, responsible for overseeing state administration of Medicaid as well as administering Medicare and coordinating some services for Medicare-Medicaid enrollees.
Community-Based Organization	CBO	Public or private organization that is representative of a community or a significant segment of a community, and is engaged in meeting health, human services, educational, spiritual, or public safety needs of the community.

Term	Acronym	Brief Definition
Delivery System Reform Incentive Payment	DSRIP	Resulting from the Section 1115 waiver program, a federally funded initiative that provides states with funding to support hospitals and other provider organizations that commit to changing how care is provided to Medicaid beneficiaries. In 2014, New York became the seventh state to have a DSRIP program approved; it began implementation in 2015. Its primary goals are to stabilize the safety-net system and reduce avoidable hospital use by 25 percent over five years. DSRIP is the largest piece of the MRT waiver amendment, with a total allocation of \$6.9 billion.
DSRIP Eligible Providers		DSRIP definition of providers—such as hospitals, safety net providers, and CBOs—that are able to participate in the program and be part of PPSs. Detailed lists of qualifying institutions are available at the NY DSRIP Program Project Design Grant Application Instructions (http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_design_grant_application_instructions.pdf).
DSRIP Year	DY	The year of the DSRIP project (0-5) in which a project or goal is planned.
Electronic Medical Record	EMR	A patient record that contains clinical data. An electronic medical record is a digital version of a paper chart that contains all of a patient's medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment.
Emergency Department	ED	Medical treatment facilities specializing in emergency medicine, the acute care of patients who present without prior appointment either by their own means or by that of an ambulance.
Episode of Care		Methodology that includes all services provided to a patient with a medical problem, usually within a specific period of time, across a continuum of care in an integrated delivery system. Each episode of care includes a defined set of services delivered by designated providers in specified health care settings related to treating a patient's medical condition or performing a major surgical procedure.
Fee-for-Service	FFS	Payment to medical providers for the number of hours, visits, or services rendered. Payment is based on the volume of services provided rather than process, quality, or outcomes involved.
Health and Recovery Plan	HARP	Managed care plans for adults with significant behavioral health needs, facilitating the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols.
Health Information Exchange	HIE	Infrastructure that enables the electronic transmission of health care data among providers, facilities, organizations, and government agencies.
Health Information Technology	HIT	Information technology infrastructure, hardware, and software applied to health care, which provides a secure exchange of data between consumers, providers, government and quality entities, and insurers.
Independent Practice Association	IPA	An association of independent physicians that provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. IPAs are legal vehicles developed to primarily contract with third-party payers.

Term	Acronym	Brief Definition
Integrated Delivery System	IDS	Organized, coordinated, and collaborative networks of health care providers that offer a continuum of services to a particular patient population or community. A goal of an efficient IDS is to be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population or community served, and have systems in place to manage and improve them.
Long-Term Care	LTC	Services and care that help meet high-need individuals' medical and non-medical needs for long periods of time. Such services can include traditional medical services, social services, housing, and activities of daily living. Those receiving this care are usually living with a chronic illness or disability and cannot care for themselves.
Managed Care Organization	MCO	Health care organizations that administer medical benefits and absorb financial risk in exchange for a predetermined monthly fee. MCOs combine the functions of health insurance administration, utilization management, and care coordination, and contract with a network of hospitals, physicians, and other providers to provide health care services.
Medicaid Redesign Team	MRT	An entity established by Governor Cuomo in January 2011 as a means of finding new ways to lower Medicaid spending in New York State during the 2011-12 fiscal year. The MRT is made up of stakeholders and health care experts from throughout the state, and has continued its work in the form of 10 work groups, convened to address more complex issues and cooperatively create a multi-year roadmap for state health care reform.
Medical Loss Ratio	MLR	The percentage of premium an insurer spends on administration, marketing, and profits, rather than on claims and expenses that improve health care quality.
MRT Waiver Amendment		A program that allows New York to reinvest \$8 billion in Medicaid Redesign Team generated federal savings back into the state's health care delivery system over five years. The waiver amendment contains three parts: (1) Interim Access Assurance Fund—temporary, time-limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without unproductive disruption (\$500 million); (2) DSRIP—including Planning Grants, Provider Incentive Payments, and administrative costs (\$6.42 billion); and (3) other MRT purposes—to support health home development through a State Plan Amendment, and investments in long-term care workforce and enhanced behavioral health services through managed care contract payments (\$1.08 billion).
New York State Department of Health	DOH or NYSDOH	The department of New York State government responsible for improving and promoting the health, productivity and well-being New Yorkers.
Off-Menu options		Value-based payment (VBP) arrangements that MCOs and providers can jointly agree to pursue outside of those outlined in the Value-Based Purchasing Roadmap. Such arrangements must reflect the Medicaid VBP principles described in the Roadmap and must be considered Level 1 or higher.
Patient-Centered Medical Home	PCMH	Method of organizing primary care that emphasizes care coordination and communication to provide patients with timely, well-organized, and integrated care. The PCMH model also seeks to enhance access to teams of providers within a health care organization.

Term	Acronym	Brief Definition
Per Member Per Month	PMPM	A total cost of care payment that refers to the dollar amount paid to a provider each month for each person for whom the provider is responsible for providing services.
Performing Provider System	PPS	Partnerships formed between providers responsible for performing a DSRIP project. Under this arrangement, PPSs include DSRIP-eligible providers, with a designated lead provider for the group that will be held responsible for ensuring that the PPS meets DSRIP program requirements.
Primary Care Provider	PCP	Health care practitioners who are responsible for monitoring an individual's overall health care needs. A PCP is often a physician, but could also be a physician assistant or a nurse practitioner.
Project Advisory Committee	PAC	State-mandated, internal advisory entities within every performing provider system (PPS) that offer recommendations and feedback on PPS initiatives. The PAC should be involved in the various facets of developing a PPS's DSRIP Project Plan and then engaged in the implementation and oversight of the Project Plan.
Quality Assurance Reporting Requirements	QARR	A set of clinical and administrative performance measures required to be reported by the NYSDOH. The State publishes the QARR results for public consumption and uses the results in decisions affecting health plan operations. The State has incorporated national Health Plan Employer Data and Information Set (HEDIS) as well as other state-specific measures within QARR. These measures are required to be reported annually by health plans for their commercial, Medicaid, and Child Health Plus programs (as well as Family Health Plus, eventually); data must be audited by certified auditors from National Committee on Quality Assurance (NCQA) Licensed Organizations. The QARR is posted on the Department of Health's website (www.health.state.ny.us/nysdoh/mancare/mcmain.htm).
Risk-Based Arrangement		Sometimes called "budget-based contracting," risk-based arrangements are payments predicated on an estimate of what the expected costs to treat a particular condition or patient population should be. Managed care organizations or other payers usually base expected costs on sophisticated and actuarially sound models.
Safety Net Provider		An entity that provides care to underserved and vulnerable populations whose lack of health coverage or other social and economic vulnerabilities limits their ability to access mainstream medical care. Such programs often have very specific definitions for which providers fall into the category. Safety net definition details are posted on the Department of Health's Website (www.health.ny.gov/health_care/medicaid/redesign/dsrip/safety_net_definition.htm).
Shared Savings or Shared Savings/Risk		These payment models can be either one-sided (upside—just shared savings without risk) or two-sided (upside-downside—shared savings/risk). In both, the providers receive a percentage of savings relative and benchmarked costs. Two-sided (shared savings/risks) models require providers to share in the financial risk by accepting some accountability for costs that exceed the benchmarks.
State Health Innovation Plan	SHIP	Roadmap to achieve the "Triple Aim" for New Yorkers: improved health, better health care quality and better consumer experience, and lower costs. The intent and goal of the SHIP is to identify and stimulate the spread of promising innovations in health care delivery and finance that result in optimal health outcomes. The plan was established in April 2013 as a result of a State Innovation Models (SIM) grant.

Term	Acronym	Brief Definition
State Innovation Models	SIM	Initiative funded by the Centers for Medicare and Medicaid Innovation, part of CMS, which provides financial and technical support to states for the development and testing of state-led, multipayer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs.
Total Cost of Care	TCOC	Calculation that includes the complete range of health care services for patients typically used in population-based or shared savings payment methodologies.
Vital Access Provider Program	VAP	Program that makes funding available to providers who are qualified based on the high need and poverty rates of the populations they serve to improve community care and financial stability for these safety-net providers.
Value-Based Payment	VBP	A strategy used to promote quality and value of health care services. The goal of VBP is to shift from volume-based payment, such as fee-for-service, to payments that are linked in some way to evidence-based processes or patient outcomes.
Waiver Program		Authorization used to provide flexibility in addressing their populations' particular needs with the resources available. On the federal level, the Social Security Act allows states to waive certain federal Medicaid requirements in order to establish programs for specific populations or purposes.

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Health Policy Brief

Glide path framework for connecting primary care with upstream population health activities

Stronger connections to improve health

Recognizing that access to quality health care is necessary but not sufficient for good health, many health leaders are coming together to implement upstream population health activities that address the social determinants of health. The infrastructure and financing to successfully bridge health care with community-based organizations, however, is not yet fully developed. This policy brief describes a new framework for health leaders and policymakers to use as they build and strengthen these connections.

In response to stakeholder discussions on the challenges of addressing the social determinants of health in a primary care setting (see text box on page 2), the Health Policy Institute of Ohio developed a “glide path” framework outlining the activities and partners needed to:

- Connect primary care with community-based resources
- Create linkages between primary care and the broader environmental conditions that impact health

Framework description

The glide path framework (see Figure 1) provides a structure for aligning health care payment and delivery system transformation activities with state and community-level population health planning efforts. The glide path also serves as a tool to prompt discussions about specific strategies and financing mechanisms that build and support structural connections between primary care and community-based prevention and social service organizations.

Policy recommendations

Executive branch

1. Develop a strong state health improvement plan (SHIP) that addresses all levels of the glide path framework.
2. Provide adequate resources and staffing for **backbone organizations** housed within the Ohio Department of Health (such as the Ohio Chronic Disease Collaborative) and allow grant or contract funds to be used for backbone coordination activities that address the social determinants of health (glide path levels C, D and E).
3. Explore single-instrument grant awards to local health departments that allow for flexibility in addressing needs across sectors or silos, including activities at levels C, D and E of the glide path that may not fit into existing categorical grants.
4. Continue to identify and incorporate outcome measures and pay-for-performance (P4P) models in Medicaid managed care contracts that incentivize providers and managed care plans to more effectively address behavior change and basic needs (glide path levels A and B).
5. Explore waivers that allow Medicaid to cover community-based programs that support behavior change and address basic needs (glide path levels A and B).
6. Develop payment models (e.g. accountable care models) that encourage and incentivize Medicaid managed care plans and providers to work with local health departments, social service agencies and other community-based organizations to address basic needs, behavior change and community conditions (glide path levels A, B, C and D).

Legislative branch

1. Routinely assess the potential impact of proposed legislation and policy decisions in sectors such as transportation, education and criminal justice (glide path level E) on population health outcomes, health equity and healthcare costs (similar to the Common Sense Initiative, referred to as a “**Health and Equity in All Policies**” approach).
2. Enact legislation to implement recommendations in the HPIO report, **Improving population health planning in Ohio**, including three new requirements for local health departments and tax-exempt hospitals designed to increase the effectiveness and efficiency of state- and community-level health planning in addressing all glide path levels.
3. Explore the establishment of a **wellness trust** for Ohio—a sustainable pool of public and/or private funds that could be used at either the state or the local level to address upstream factors that impact health and healthcare costs (glide path levels C, D and E).
4. Bring together local health departments, hospitals and other partners within a legislative district to identify, implement and evaluate strategies to improve upstream conditions that impact health (glide path levels A-E).

Background

In September 2015, the Ohio Department of Medicaid (ODM) and Ohio Department of Health (ODH) contracted with HPIO to facilitate stakeholder engagement and provide guidance on improving population health planning. One of the objectives of this project was to align population health priority areas and strategies with the design and implementation of Ohio's patient-centered medical home (PCMH) model.

Developed as part of Ohio's State Innovation Model (SIM) initiative, the Ohio PCMH model acknowledges that strong connections between primary care providers and community-based resources can help patients stay well or manage chronic conditions. Under Ohio's model, a fully transformed PCMH is expected to:

- Actively connect members to broader social services and community-based prevention programs
- Ensure ongoing bi-directional communication with social services and community-based prevention programs
- Collaborate meaningfully with partners based on achievement of health outcomes
- Actively engage in advocacy and collaborations to improve basic living conditions and opportunities for healthy behaviors

The glide path framework provides examples for how to operationalize the "potential community connectivity activities" component of the Ohio PCMH care delivery model.

The framework, which takes the shape of a funnel, illustrates the social, economic and physical environment factors that impact health at the top and downstream system impacts of specific health conditions at the bottom. Boxes labeled A-E describe the types of activities (on the left) and partners (on the right) involved in helping patients stay healthy at each level of the glide path.

Boxes A and B of the glide path outline activities and partners needed to directly connect primary care with community-based resources that help patients meet their basic needs and engage in behavior change. At the higher levels of the glide path (boxes C-E), sectors beyond health (such as education, transportation and social service organizations) are responsible for many of the decisions that impact population health outcomes.

Comparing the glide path to other public health models

Similar to the social-ecological model,¹ the glide path describes the role of community conditions (such as nurturing school environments/positive school climate), and the broader social, economic and physical environment that shapes those community conditions (such as educational attainment, residential segregation and air pollution). More importantly, the glide path framework describes the types of activities and partners needed to make improvements at each of these levels.

The glide path also complements the **Health Impact Pyramid**, a framework developed by Dr. Thomas Frieden that describes different types of public health interventions and emphasizes the critical importance of addressing socioeconomic factors to improve health.² The glide path differs from the Health Impact Pyramid in two key ways. First, the pyramid focuses on public health interventions, while the glide path centers on primary care and pathways to connect primary care

with community-based prevention resources, including public health organizations and sectors beyond public health. Second, socio-economic factors are positioned at the top of the glide path diagram to illustrate upstream determinants, contrasted with downstream consequences. The pyramid does not refer to the upstream/downstream concept and places socio-economic factors at the base of the pyramid.

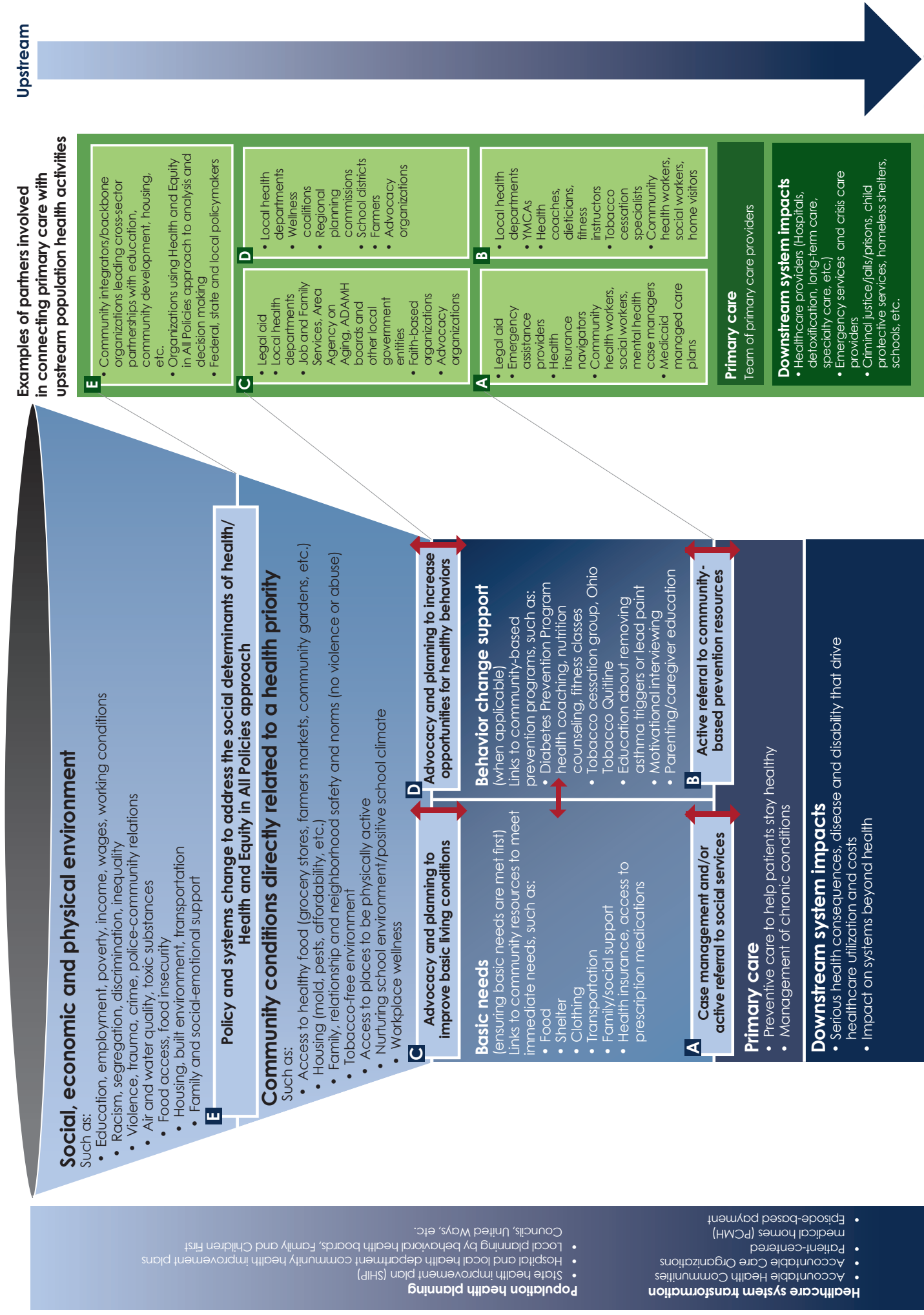
Role of public health and other community partners

Figure 1 provides examples of partners involved in connecting the various levels of the glide path framework. Public health plays a strong role in coordinating or leading many of these activities, particularly at levels B, C and D on the glide path. Local health departments, for example, often coordinate wellness coalitions that lead efforts to reduce tobacco use or partner with school districts on farm-to-school projects or Safe Routes to School programs. Local health departments are also getting involved in policy and systems changes to address the social determinants of health such as paid sick and family leave and criminal justice policies (box E on the glide path).

Addressing boxes C through E of the glide path requires coordination between health care, public health and sectors beyond health through:

- **Health and Equity in All Policies:** A collaborative approach to incorporating health considerations into decision-making across sectors and policy areas, including the use of Health Impact Assessments to identify ways that policy decisions in sectors such as education, criminal justice and housing may affect population health outcomes
- **Community integrators or backbone organizations:** A distinct entity with the capacity to bring partners together to define, measure and achieve common goals

Figure 1. “Glide path” framework to connect primary care with upstream population health activities



Source: Developed by HPIO as part of a population health planning project commissioned by the Governor's Office of Health Transformation, Ohio Department of Health and Ohio Department of Medicaid.

Implementation examples and financing mechanisms

HPIO's report [Improving population health planning in Ohio](#) provides specific examples of models and programs that can connect primary care practices with community-based resources to help patients with basic needs and behavior change (levels A and B). The report also describes how activities in levels A-E of the glide path are most commonly funded, as well as innovative financing mechanisms to support these activities, such as:

- Wellness trusts
- Block grants or single instrument grant awards that allow for flexibility in addressing needs across sectors or silos
- Gain sharing and outcome-based payment
- Global payment

Under a traditional fee-for-service payment system, there is little incentive for providers to address a patient's health-related social needs. However, as healthcare payments transition to more value-based arrangements, financial incentives are changing. Within a fully transformed health system, savings to downstream systems brought about by improved health outcomes should be reinvested upstream to increase the capacity of community-based organizations to address levels A-E of the glide path.

Recognizing the relationship between health-related social needs and healthcare costs and outcomes, the Centers for Medicare & Medicaid Innovation recently

Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities model

In January 2016 CMS launched the **Accountable Health Communities model** funding opportunity, a pilot program designed to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' impacts total health care costs and improves both health and quality of care. The model encourages alignment and connectivity between clinical and community services and focuses on identifying and addressing health-related social needs in at least the following areas:

- Housing instability and quality
- Food insecurity
- Utility needs
- Interpersonal violence
- Transportation needs beyond medical transportation

CMS will fund 44 cooperative agreements and plans to announce awards in the fall of 2016.

launched the Accountable Health Communities (AHC) model (see text box). The glide path framework provides health leaders with a tool to ensure that innovative healthcare payment and delivery models, such as AHCs and Accountable Care Organizations (ACOs), include the wide range of factors that impact health and deliberately build structural connections between downstream and upstream partners.

Questions to prompt alignment between primary care and population health planning

- 1. PCMH provider to patient:** What do you need to stay healthy, recover or manage your condition?
- 2. Patient to PCMH provider:** What programs and services are available in my community to help me stay healthy, recover or manage my condition?
- 3. PCMH provider to community organizations:** What resources do you have to help my patients meet their needs and how can they get connected? What is your current capacity?
- 4. Community organizations to PCMH providers:** What are your patients' biggest strengths, needs and challenges? How can we help?
- 5. Health improvement planning groups (SHIP, local health departments, nonprofit hospitals):** What are the community conditions and characteristics of the broader social, economic and physical environment that are promoting or harming health? What evidence-based policies and programs are available to address these issues? What partners do we need to implement these policies and programs?

To download the complete report,
"Improving population health planning in Ohio," visit
www.hpio.net/populationhealth



Notes

1. Krug, Etienne G., et. al., eds. "World report on violence and health." Geneva, Switzerland: World Health Organization, 2002
2. Frieden, TR. "A framework for public health action: The Health Impact Pyramid." American Journal of Public Health. 2010.

BEYOND MEDICAL CARE FACT SHEET

Paying for value over volume through payment reform

What is paying for value over volume?

U.S. healthcare is built on a fee-for-service (FFS) system, which pays a provider for each specific service delivered to a patient. FFS often incentivizes providers to deliver a greater volume of services to patients, without accounting for efficiency, cost or quality of care. Driven by widespread dissatisfaction with high healthcare costs, poor health outcomes and fragmented healthcare services under FFS, and accelerated by provisions in the Affordable Care Act (ACA), the U.S. healthcare system is gradually transitioning away from FFS to a value-based payment system.

In an ideal environment, a value-based payment system accounts for quality of care, outcomes, and cost, and incentivizes integrated and coordinated care for patients.

What is payment reform?

Although FFS is still the most common payment system in Ohio and in the nation, many changes are underway.¹ Payment reform or innovation refers to policy and system changes designed to shift from paying for volume to paying for value. Payment reform includes a continuum of payment mechanisms that differ in the extent to which providers are held financially accountable for performance (see Figure 1).

The continuum of payment reform mechanisms described in Figure 1 are often used in combination with one another. Transition along the payment reform continuum is not always linear. Nationally in 2014, approximately forty percent of commercial in-network payments were tied to value. Of this 40% of value-oriented payments, 53% put the provider at financial risk based on performance.²

Changes in payment mechanisms can also accompany changes in healthcare delivery models and vice versa. For example, Patient Centered Medical Homes (PCMH) receive care coordination payments in exchange for delivering enhanced primary care services to patients and meeting set performance objectives. Accountable Care Organizations (ACOs), which are integrated networks of providers that manage the care of a defined

patient population, may enter into global payment and shared savings/risk arrangements with payers. Under a shared savings/risk arrangement, providers share in "savings" if the cost of managing their patient population is less than a set global payment amount and/or risk financial loss if the cost of care is above a set amount.

What does payment reform have to do with prevention?

As providers take on increased financial risk and are held accountable for good health outcomes, they are seeking out new ways to help patients stay healthy.

Figure 2, the U.S. Health System Transformation 3.0 Framework, was envisioned by health policy experts to describe the transition away from a FFS "sick care system" to a "community-integrated health system."

In Era 3.0, providers and payers are encouraged to consider the health of tomorrow's potential patients in addition to today's patients, driving greater investment in upstream primary prevention strategies. The 3.0 era "community-integrated health system" pays for value and measures success based on the health outcomes of geographic populations, such as the health status of residents of an entire county or state, rather than specific patient populations.³ In this environment, providers are incentivized to go beyond managing a diabetic patient's A1C levels, for example, and instead hold shared accountability for reducing the overall prevalence of type 2 diabetes within a geographic population.



What are the potential policy mechanisms to accelerate payment reform?

The federal Centers for Medicare and Medicaid Innovation (CMMI), within the Centers for Medicare and Medicaid Services (CMS), has advanced many payment reform initiatives across the nation to explore what works to improve healthcare value. These initiatives, ranging from developing ACOs and episode-based payment models to primary care transformation, provide states with valuable opportunities to substantially increase investments in prevention. Visit the [CMS innovation website](http://www.cms.gov/innovation) for more information on these initiatives.

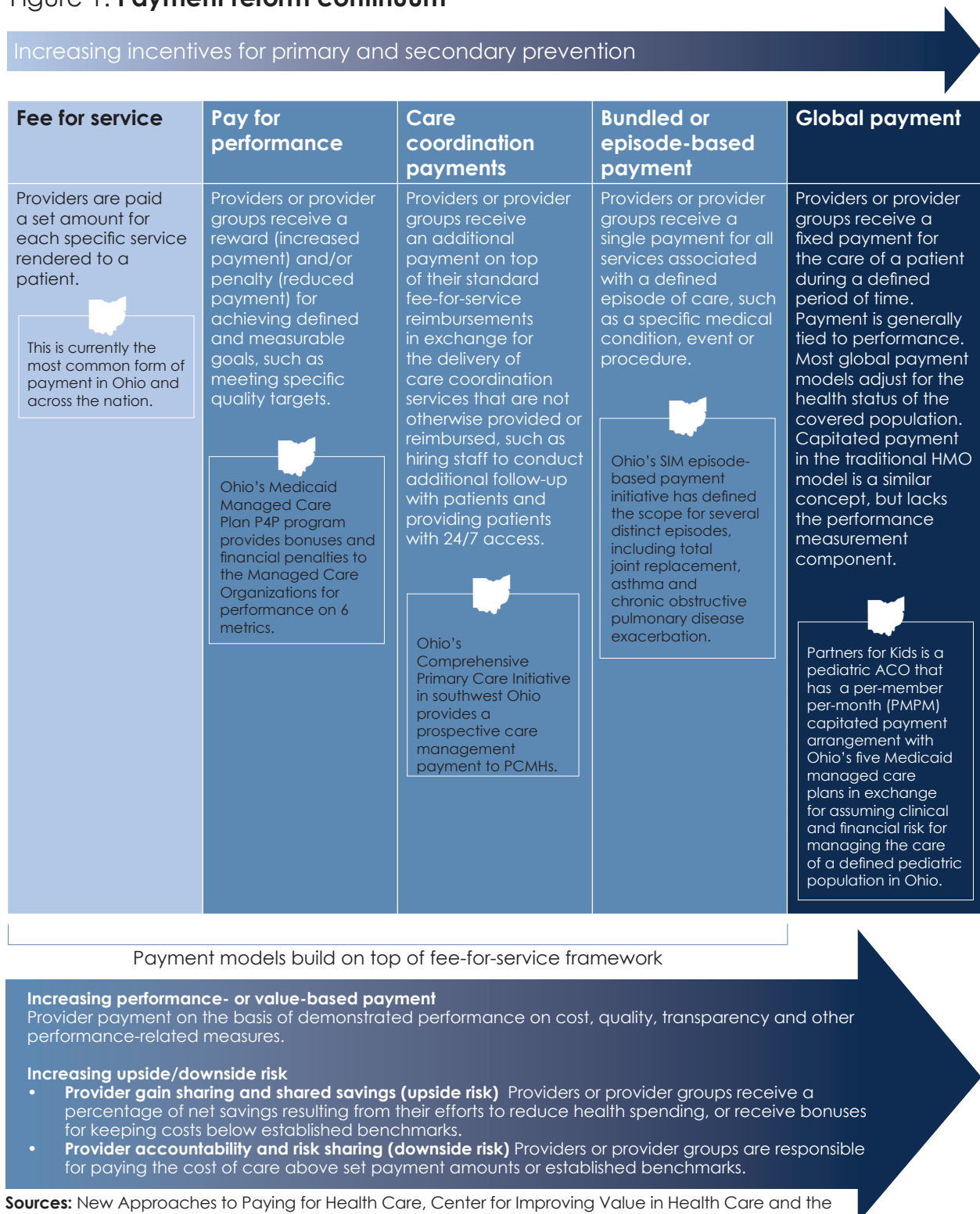


State governments also are accelerating the transition to value-based payment systems that incentivize prevention through strategies such as:

- **Medicaid payment for prevention activities:** Using federal options, such as section 1115 waivers, to expand the type of services covered by Medicaid, including community-based interventions. Waivers must be budget neutral, and are approved for a five year period. For example, Texas used a waiver to support health improvement efforts, including prevention activities.⁴

- **Accountable care models:** Encouraging and supporting the spread of accountable care models. Accountable Care Communities and Accountable Communities for Health take the ACO model one step further to include entities outside the healthcare system, such as community-based social service and public health organizations. For example, Oregon established Coordinated Care Organizations (CCOs). CCOs assume global risk for Medicaid patients in a geographic region and have flexibility to pay providers in innovative ways that allow for greater investments in community-based prevention.⁵

Figure 1. **Payment reform continuum**



Sources: New Approaches to Paying for Health Care, Center for Improving Value in Health Care and the Colorado Health Institute; The Payment Reform Glossary, Healthcare Quality and Payment Reform; 2014 National Scorecard on Payment Reform and Definitions of Payment Model Terms, Catalyst for Payment Reform

Figure 2. U.S. health system transformation 3.0 framework

Health system characteristic	Era 1.0 Sick care system	Era 2.0 Coordinated health care system	Era 3.0 Community-integrated health system
Objective	Acute care and infectious disease focused	<ul style="list-style-type: none"> • Patient-centered care • Coordinating episodes of care across levels of care and managing chronic conditions 	<ul style="list-style-type: none"> • Population and community health outcomes • Optimizing the health of populations over the life span and across generations
Payment methodology	<ul style="list-style-type: none"> • Fee-for-service • Rewards volume of services 	<ul style="list-style-type: none"> • Value-based payments • Health care provider rewarded for better patient outcomes, better patient experience of care, and lower total cost of care 	<ul style="list-style-type: none"> • Recognize value with long-term time horizons and capture multisector financial impacts outside of health care cost • Sustainable financing alternatives such as population-based global budgets
Population health improvement	Not addressed	Focused on health of patients/clients only	Focused on health outcomes for geographically defined population, including upstream socioeconomic and developmental correlates of health

Source: Abridged version of Exhibit 2 in *Applying a 3.0 transformation framework to guide large-scale health system reform*. Halfon, et al. *Health Affairs*, 2014.

- **Upstream PCMH:** Encouraging and supporting the spread of PCMH models that link clinical and community resources in order to actively address contributors to health that are outside of the healthcare system. Community Health Teams, for example, use social workers and community health workers to help patients connect to social services. They may also advocate for population-level policy change, such as housing code enforcement to improve asthma outcomes. Minnesota, North Carolina, Vermont, Iowa and Rhode Island are using Community Health Teams to coordinate care to address the underlying conditions that lead to poor health.⁶

Ohio's State Innovation Model (SIM) initiative

CMS' State Innovation Model (SIM) initiative awards federal grants to states to design and test new healthcare delivery and payment system models.

In February of 2013, CMS awarded Ohio \$3 million for a SIM Round One Model Design grant. As a result, Ohio developed a plan to accelerate health system transformation in the state through the implementation of PCMHs and episode-based payment models.⁷ In December 2014, CMS awarded Ohio an additional \$75 million for a Round Two Model Test grant for implementation of episode-based payments and roll-out of a state-wide PCMH model over a four-year time-frame.

Round Two Model Test awardees are required to develop a state-wide plan to improve population health. As part of this plan, states must identify opportunities that maximize the impact of proposed health system transformation activities on population health, as well as on healthcare cost and quality. The SIM initiative provides a unique opportunity for Ohio to invest deeply in prevention as a vehicle to improve population health or community building.

What's the landscape in Ohio?

Providers in Ohio are involved in a number of CMMI initiatives related to payment reform and healthcare system transformation. In addition, Ohio has many private-led initiatives that pilot and implement a wide range of payment reform activities including PCMHs, ACOs and pay-for-performance arrangements.

Ohio's payment reform goals

Capitalizing on Ohio's SIM activities and other public and private payment reform initiatives in the state, Ohio's Office of Health Transformation has laid out a 5-year goal for payment innovation. Starting in 2014, the state aims to have 80-90% of Ohio's population in value-based payment models within five years with participation across both Medicaid and commercial payers.

In addition, the 2016-17 state budget requires Medicaid managed care plans ensure that at least 50% of payments to providers are value-based by July 2020.⁸

Figure 3. Ohio's 5-year goal for payment innovation

	Patient-centered medical homes	Episode-based payments
Year one (2014)	Focus on Comprehensive Primary Care Initiative (CPCI)	State leads design of six episodes: Asthma acute exacerbation, COPD exacerbation, perinatal, acute non-acute PCI and joint replacement
Year two	Collaborate with payers on design decisions and prepare a roll-out strategy	State leads design of seven new episodes: URI, UTI, cholecystectomy, appendectomy, GI hemorrhage, EGD and colonoscopy
Year four	<ul style="list-style-type: none"> • Model rolled out to all major markets • 50% of patients are enrolled 	20 episodes defined and launched across payers, including behavioral health
Year five	<ul style="list-style-type: none"> • Scale achieved state-wide • 80% of patients are enrolled 	50+ episodes defined and launched across payers

Source: Governor's Office of Health Transformation, April 2015



Payment reform recommendations

The following strategies would accelerate the transition from volume to value in a way that incentivizes investments in prevention.

Public and private payers can:

1. Tie payment arrangements to performance on risk-adjusted outcomes measures (such as percent of patients who successfully quit smoking), not just process or clinical-encounter measures (such as percent of patients screened for smoking status).
2. Explore shared savings arrangements that require a percent of any financial savings be reinvested into community-based prevention activities.

Ohio's Medicaid program can:

3. Continue to pursue more outcome measurement and pay-for-performance (P4P) in Medicaid managed care and explore section 1115 waivers that could allow Medicaid to cover community-based prevention interventions.
4. Encourage Medicaid managed care plans to work with local health departments, social service agencies and other community-based organizations to address non-medical issues that impact health such as housing, violence, and access to opportunities for healthy eating and active living.

Public and private healthcare leaders can:

5. Support the spread of accountable care models (ACOs, Accountable Communities for Health, etc.) that reach larger numbers of Ohioans and incentivize greater investment in community-based prevention activities.
6. Ensure that ACOs and ACO-like organizations

are specifically designed to improve health outcomes. This can be accomplished through governance and design, delivery system enhancements, tying payment to performance on population health metrics and data sharing across sectors.⁹

7. Explore ways to take the PCMH model upstream, such as care coordination fees that explicitly include coverage of Community Health Teams, Community Health Workers, and other services that actively link patients to community-based organizations that address non-medical factors such as housing and healthy food access.
8. Maximize the impact of Ohio's State Innovation Model (SIM) initiative by integrating community-based prevention into the PCMH model and other payment and delivery transformation activities, and by developing a strong SIM Population Health Plan that supports upstream prevention strategies.

Public health leaders can:

9. Coordinate with Medicaid managed care plans, ACOs, and other healthcare partners and communicate how local health departments and other community-based partners can help them to address health behaviors and community conditions.

Behavioral health leaders can:

10. Coordinate with Medicaid managed care plans, ACOs, and other healthcare partners and communicate how local behavioral health (ADAMH) boards and community-based behavioral health providers can help them to address housing, substance abuse prevention, and mental health early intervention.

Recommended resources

- **Ohio SIM initiative information**, Governor's Office of Health Transformation
- **National scorecard on payment reform**, Catalyst for Payment Reform, 2014
- **Payment reform glossary**, Center for Healthcare Quality and Payment Reform
- **New Approaches to Paying for Health Care**, Center for Improving Value in Health Care and the Colorado Health Institute, 2012

- **Opportunity knocks again for population health: Round Two in State Innovation Models**, IOM discussion paper, 2015
- **Healthy outlook: Public health resources for systems transformation**, American Public Health Association, 2015
- **Accountable Communities for Health: Opportunities and recommendations**, Prevention Institute, 2015
- **Community-Centered Health Homes: Bridging the gap between health services and community prevention**, Prevention Institute, 2011

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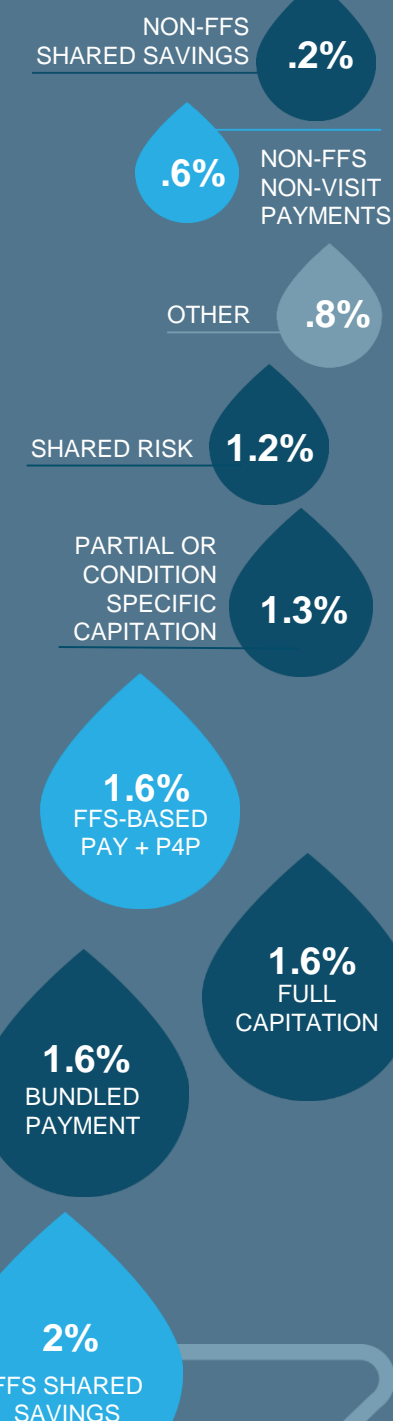
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2013: 10.9%

NATIONAL SCORECARD

on Payment Reform

Catalyst for Payment Reform has set a target of **20%** of payments being value-oriented by 2020. How are we doing in 2013? The results of the first annual Scorecard are in and **10.9%** of all commercial in-network payments are value-oriented – either tied to performance or designed to cut waste. Traditional fee-for-service (FFS), bundled, capitated and partially capitated payments without quality incentives, make up the remaining **89.1%**. Progress toward value-oriented payment is evident, but much more needs to be done.



What portion of value-oriented payments place doctors and hospitals at financial risk for their performance?

Of the 10.9% of payments that are value-oriented, most put providers at financial risk for their performance, though more than 40% offer a potential financial upside only.

57%

OF VALUE-ORIENTED PAYMENTS
are “at risk”

43%

OF VALUE-ORIENTED PAYMENTS
are “not at risk”

Only

11% of all hospital payments

6% of all outpatient specialist payments

6% of all outpatient PCP (primary care physician) payments

are value oriented

2020 GOAL 20%

2013 10.9%

©2013 Catalyst for Payment Reform

Tracking the Nation's Progress on Payment Reform was funded with support from The Commonwealth Fund and the California HealthCare Foundation. Utilizing the National Business Coalition on Health's eValue8 health plan survey, the project was conducted in partnership with NBCH and the following business coalitions: the Colorado Business Group on Health, the Memphis Business Group on Health, the Northeast Business Group on Health, the Pacific Business Group on Health, and the Virginia Business Coalition on Health. CPR thanks these organizations, CPR's Project Director Andréa Caballero Dilweg, and the health plans that provided data for the Scorecard for their significant contributions to this project.



Benchmarks for Future Trending

Attributed Members



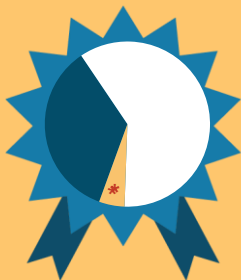
Share of Total Dollars Paid to Primary Care Physicians and Specialists

Of the total outpatient payments made to physicians and specialists, 75% is paid to specialists and 25% is paid to PCPs. Over time, this figure will show if there is a rebalancing of payment between primary and specialty care.



Non-FFS Payments and Quality

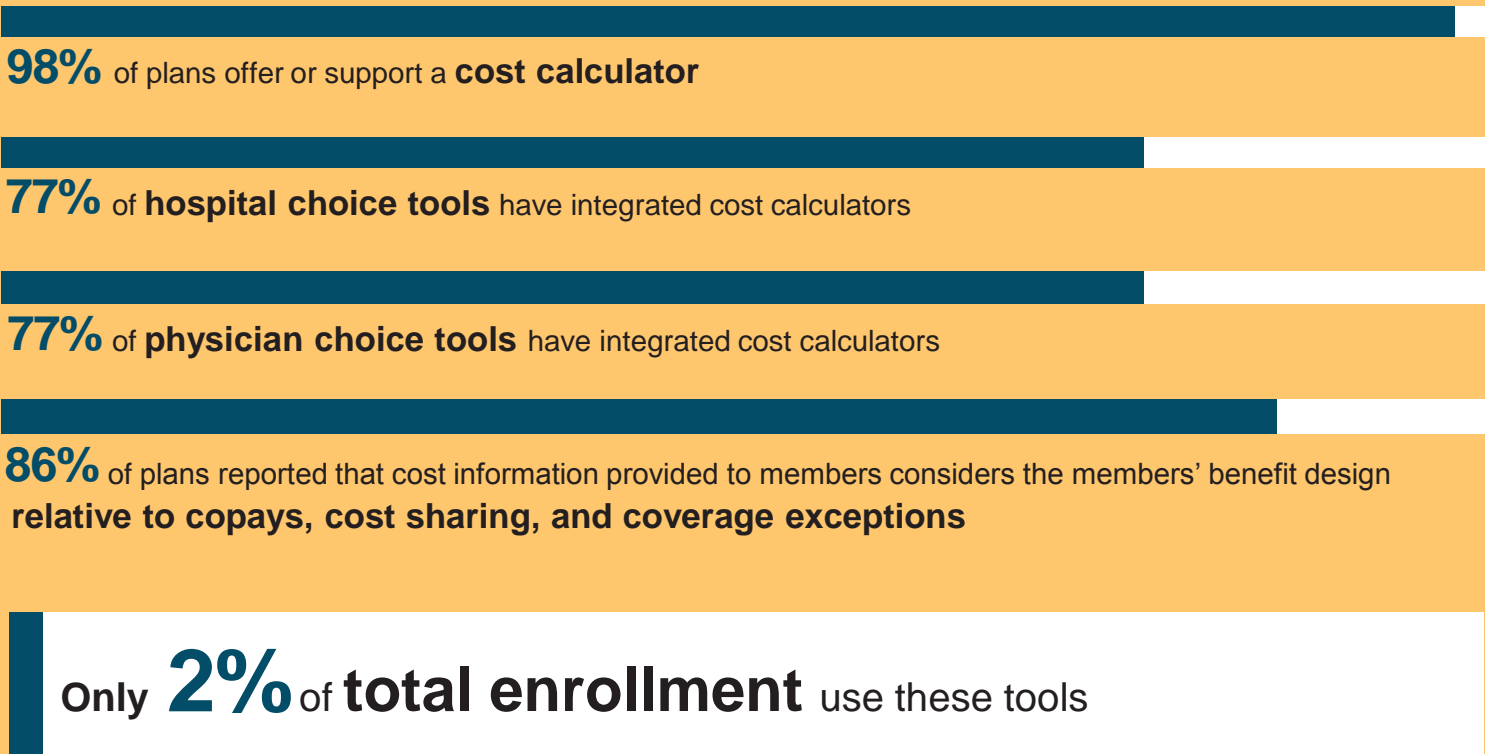
Quality *is* a factor in
only 35%
of non-FFS payments



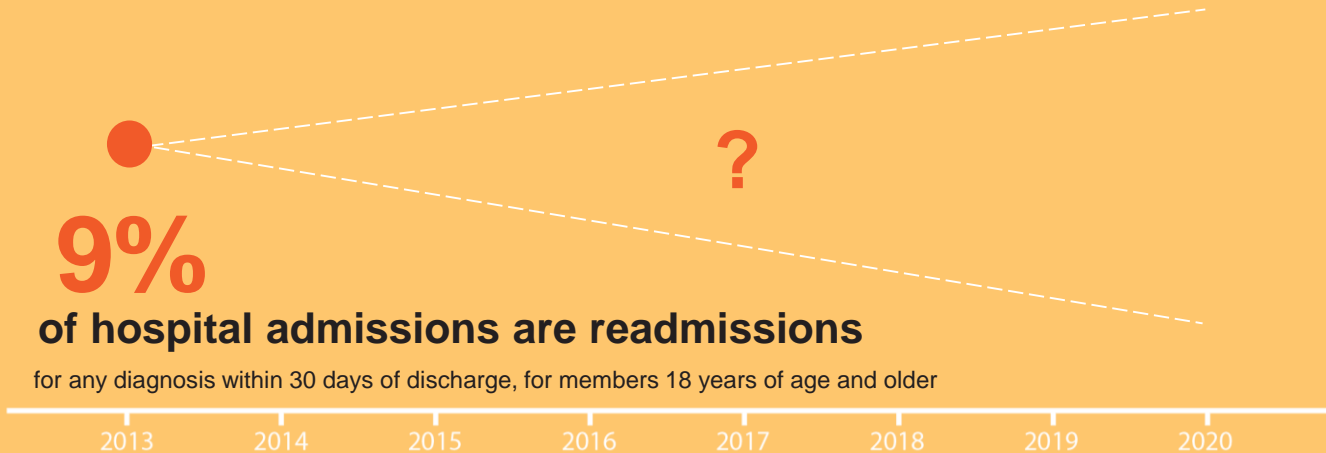
Quality is *not* a factor in
60%
of non-FFS payments

* Unclassified

Transparency Metrics



Hospital Readmissions*



* Derived from data submitted to eValue8 using NCQA's all-cause readmission measure. Not an official NCQA Benchmark.



How-To Guide: Evaluating Payment Reform Programs

December 2015

How to Use this Guide

This guide serves as an introduction to CPR's [Payment Reform Evaluation Framework](#) and is intended for use primarily by self-funded employers and other purchasers of health care interested in evaluating the outcomes of a particular payment reform program. We hope it will also be useful to health plans, health care providers and others in the health care system.

The Payment Reform Evaluation Framework has four core domains, each of which contains a targeted list of questions aimed at the sponsor of the payment reform program, such as a health plan, to assess whether the program is having a positive impact and would be appropriate or beneficial to the purchaser's population. The four domains of the Framework include questions seeking a general description of the program, and those specifically related to the program's feasibility, cost, and quality.

The Framework can be used to evaluate an existing program or to design the evaluation of a new program. It is meant to be used to evaluate one program at a time, not an entire payment reform strategy. It can also help purchasers assess the business case for involving the population for whom they purchase health care in a program.

Ultimately, we hope the Framework helps establish standard parameters for evaluation in the marketplace, enabling the comparison of results from a variety of different programs, the identification of successful approaches and the further spread of those approaches.

Disclaimer: Partnering with a health plan or provider partner to implement and/or evaluate an innovative payment reform program will likely require a specific negotiation. CPR is not providing legal advice or direction on how to address these specific negotiations. This guide is for informational purposes only. Before making any decisions about whether to use CPR's Payment Reform Evaluation Framework in whole or in part and to understand the legal implications of doing so, purchasers should consult with a qualified legal professional for specific advice.

I. Introduction

As health care costs for employers and other health care purchasers and consumers continue to rise, without solid evidence that the quality of health care is also improving, purchasers, health plans and health care providers have begun to experiment with delivery system and payment reform programs. The goal of such programs is to decrease overall health care spending, while improving the quality of care. However, while many payment reform programs have been implemented over the past few years, limited data exist to demonstrate their effectiveness; it is still largely unclear whether they will produce their intended outcomes of better quality and lower costs.

This uncertainty regarding outcomes is due, in part, to the lack of a standard evaluation framework to help gauge the impact of such programs. As a result, every evaluation is different. At best, this means evaluations are well suited to provide results for specific programs, but these results cannot be compared across programs. At worst, this gap allows program sponsors to tailor their evaluations to highlight successes and deemphasize failures.

Therefore, the objectives of this guide are to 1) introduce purchasers to a standard approach for evaluating payment reform programs, 2) help purchasers identify which metrics might best help them to evaluate a payment reform program's impact on health care quality and cost, 3) send a unified message to providers and program sponsors as to what outcome measures are most important to employers and other purchasers of care, and 4) influence others in a position to evaluate payment reform programs, such as health plans, health care providers, and benefit consulting firms, to encourage rigor and consistency when performing analyses of the outcomes.

The [Payment Reform Evaluation Framework](#) is meant to be used on one payment reform program at a time – it is not meant to evaluate an entire, multifaceted payment reform strategy. For example, a health plan might administer a prospective bundled payment program with 10 of its contracted orthopedic practices for hip and knee replacements. This framework could be used to evaluate the specific prospective bundled payment program.

In addition to standardizing the evaluation process, the Payment Reform Evaluation Framework can help purchasers considering pursuing a new payment reform program to make a clear and measurable business case for doing so. The Framework provides answers to four critical questions commonly asked when “making the case” for program adoption:

1. Did the program reduce health care spending in relationship to the trend, or at least keep the trend flat?
2. Did quality of care improve, or at least stay the same?
3. Was consumer feedback positive, or at least neutral?
4. Is the program feasible to implement, replicate, scale, and maintain over time?

While payment reform programs are a popular and potentially effective way to reduce costs and increase the quality of care, a standard evaluation process is essential to ensuring that these programs achieve their intended outcomes and create value.

What are Payment Reform Programs?

For the purposes of this guide and the Payment Reform Evaluation Framework to which it refers, a health care payment reform program is a discrete arrangement between a health care purchaser or payer and a health care provider or providers that utilizes an alternative, value-oriented method of provider payment to drive both improvements in the quality of care and reductions in the cost of care for a defined population.

Today, the vast majority of payment reform programs utilize one or more of the following payment methods:

- Fee for service (FFS) plus shared savings and shared risk, such as those arrangements that support accountable care organizations (ACOs), patient centered medical homes (PCMH)
- FFS plus shared savings only
- Capitation (full, partial, or condition-specific) in which provider payment is based, in part, on quality performance
- Bundled payment in which provider payment is based, in part, on quality performance
- Quality incentives (e.g. FFS plus pay for performance)
- Payment for non-visit functions (e.g. care coordination fees, investments in health information technology)
- Non-payment policies for specific services or events (e.g. hospital acquired conditions or early elective deliveries)

More detailed definitions of these payment methods are available [here](#).

The Need to Evaluate Payment Reform Programs

An enormous movement is underway to change how providers are paid in both the public and private sectors. This investment in time and effort will be well worth it if these reforms result in significant improvements in the quality and affordability of care, while reducing the overall cost of care. Currently, however, the research that is available is mixed; while one study shows a particular payment method to be effective, the next one questions its efficacy. Therefore, it is essential to experiment, evaluate results, and continue to innovate over time.

Complicating matters is the fact that program results may depend heavily on context. How well a given payment reform program succeeds depends on the skills and motivation of the specific parties involved, the design of its incentives, the implementation approach, the population it serves and the dynamics of the market in which it is implemented.

For example, a particular payment reform program may be far more successful if the majority of health care purchasers participate, thereby making the incentives in the program more meaningful to participating health care providers. However, the results of one program may not be generalizable. Thus, there is a pressing need to amass more evidence on the impact of various approaches to be able to draw general conclusions, and it will be far easier to aggregate these results if we use a standard approach. A consistent method of evaluation will also allow for greater comparison of outcomes across programs, and send a clear signal to program sponsors about what types of impact are most meaningful to purchasers and other stakeholders.

In addition to the methodological benefits of a standardized evaluation process, it may also produce richer data. Program sponsors and others being asked to provide information may be more willing to do so if they aren't receiving multiple requests from multiple parties, especially when each request seeks information that is slightly different from the next. The reporting burden on sponsors, plans, and providers has been a significant issue in the quality measurement movement, and it has resulted in resistance to using meaningful measures.

Such evaluation will also address key, practical questions such as: Should an existing program continue? Are changes to the program needed to improve results? Is it feasible to replicate the program or expand its scale? Employers and other health care purchasers will want to know the answers to these questions, and hold program partners accountable for results they have promised or are contractually obligated to produce.

How Should We Evaluate Payment Reform Programs?

There are many approaches to evaluating payment reform programs and there is no "one size fits all" method; however, standardization could be extremely beneficial to the industry, for the reasons described above. Recognizing this, CPR sought input from an expert advisory committee to develop a framework to evaluate payment reform programs. Our advisory committee included:

- Michael Bailit, Bailit Health Purchasing
- Michael Chernew, Harvard University
- David Cowling, CalPERS
- David Cutler, Harvard University
- Guy D'Andrea, Discern Health
- Brooks Daverman, Div. of Healthcare Finance and Administration, State of TN
- François de Brantes, Health Care Incentives Improvement Institute
- Vicky Ducworth, The Boeing Company
- Anna Fallieras, GE
- Robert S. Galvin, Equity Healthcare
- Paul Ginsburg, University of Southern California
- Mark McClellan, The Brookings Institution
- Elizabeth Mitchell, Network for Regional Health Improvement
- Dana Safran, BCBS of Massachusetts

In addition to the substantive input from the advisory committee, we obtained feedback on the feasibility of the Framework from three national health insurers. CPR also sought input from its diverse member base, which includes large private employers, and state Medicaid, employee and retiree agencies. We would like to thank all participants in this process for their contributions, though CPR takes full responsibility for any shortcomings.

The Advisory Committee emphasized the need to focus the evaluation on the cost and quality impacts of a payment reform program. CPR also felt strongly about assessing the feasibility of a program, as the value of any cost or quality gains can be amplified if the program can be sustained, scaled, and replicated. The health plans generally expressed confidence that they could respond to the metrics, but voiced concerns about the reporting burden they face, given that many different parties are asking them to share and report results. Lastly, CPR employer-purchaser members noted the importance of staging the evaluation process, starting with gathering background information to put results in context, and then collecting outcomes information at regular intervals over time.

To be clear, we did not focus on research methodology. We did not determine, for example, whether it is always best to have a comparison group or to use particular benchmarks, or whether an evaluation is only credible if it contains a randomized experiment versus a difference-in-difference analysis. Instead, we concentrated on the domains we believe are most critical to address in any approach to the research, including program design, feasibility, cost and quality, and the specific elements within those domains employers and other health care purchasers most want to know about.

Overview of CPR's Payment Reform Evaluation Framework

CPR's Framework is divided temporally into two sections:

- 1) Initial Assessment, focused on the four domains of program design, including a general description of the program, and questions related to the program's feasibility, cost, and quality.
- 2) Ongoing Monitoring, focused on program outcomes regarding cost and quality.

1. Initial Assessment

Program Design: General Description

This section is meant to gather largely descriptive, background information from the program sponsor about the nature of the program, including its goals, the lines of business in which it is offered, its availability by region and market, which purchasers are eligible to participate, and for which insurance products it is available. The section also asks about the provider payment methods at play, how quality targets are set, and what complementary benefit designs are in place or could enhance the success of the program. The questions in the General Description section are meant to provide context for any results, as well as give the prospective participating purchaser a sense of what to expect.

Program Design: Feasibility

The Feasibility domain tries to gauge whether the program is viable from an implementation standpoint, asking questions related to additional administrative costs or investments that may be required on the part of various stakeholders. This section also inquires as to whether the program can be replicated and scaled, recognizing that programs that succeed in a singular situation, but are difficult to implement, will have limited application. The Feasibility section also asks what means are used to ensure provider and consumer participation in the long term.

Program Design: Cost

The Cost domain seeks details on the mechanisms through which the program intends to reduce costs, its impact on total health care spending in comparison to benchmarks, and how any savings may be passed on to employers and other health care purchasers. The Cost section also features questions for specific payment models including bundled or episode-based payment, shared savings and shared risk, capitation, and pay-for-performance.

Program Design: Quality

The Quality domain focuses on various clinical quality and patient satisfaction and experience measures. This section also inquires as to whether the program ties provider payments to important quality indicators, incentivizes providers to improve their performance based on these quality indicators, and/or uses quality measures to evaluate results.

Unique to this domain of the Framework, this section references another CPR resource, the [CPR Employer-Purchaser Priority Measure Set](#). In doing so, the Quality section seeks to assess whether the payment reform program addresses any of the twelve priority clinical areas highlighted in the Priority Measure Set. CPR chose these clinical areas based on an HCI³ analysis of commercial claims data to identify conditions representing the biggest area of spend for which there was also large variation in the quality of care and payment amounts. The 12 priority clinical areas HCI³ identified are: pregnancy, hypertension, low back pain, diabetes, depression, osteoarthritis, breast cancer, arrhythmia, asthma, coronary artery disease, gastrointestinal endoscopy, and upper respiratory infection. Discern Health helped CPR identify the best measures to pair with these priority clinical areas, as well as “cross cutting quality measures” that gauge person-centeredness, preventive care, and patient safety, emphasizing National Quality Forum-endorsed measures and outcomes measures wherever possible.

2. Ongoing Monitoring

Program Outcomes: Cost and Quality

These sections are designed to help purchasers collect outcomes data for the program on an ongoing basis. The Cost section focuses on whether the program generates savings, incurs costs, or has an impact on total health care spending. This section also requests program sponsors to report any changes in performance on measures of efficiency. The Quality section asks how the program has impacted performance on quality measures that could identify any unintended negative consequences resulting from incentives created by the program, as well as

the results on the clinical quality and patient satisfaction and experience measures the program uses.

When evaluating payment reform programs, even while leveraging a standard approach, it is important to acknowledge that there will always be challenges to generalizing results. Market dynamics are likely to impact the success of programs; for example, in markets with significant competition among health care providers, providers may be more likely to accept and succeed under payment methods that bring them financial risk. Benefit design has an impact as well – do consumers have an incentive to seek providers who offer higher-value care, and will that patient volume be enough to convince providers to accept and succeed under new forms of payment? There are so many factors at play in every payment reform program that it may not be possible to draw direct causal lines between the reform approach and results. However, if applied consistently, the Payment Reform Evaluation Framework could help purchasers and other stakeholders compare the results of various programs offered by a common sponsor, as well as compare the outcomes of similar programs across different program sponsors, and amass results over time.

Who should use the Payment Reform Evaluation Framework?

Many different parties may be in a position to use this Framework for program evaluation. While CPR's primary audience is employers and other health care purchasers, the Framework could also be of use to health plans and providers who implement their own programs, as well as to benefit consultants and others asked to evaluate programs on behalf of health care purchasers.

In some cases, purchasers may wish to use this Framework to evaluate programs they have initiated directly with health care providers. In other cases, purchasers may ask a health plan to respond to the questions in the Framework as part of a process for evaluating whether the purchaser wants to partner with the plan on just one program (in the case of an existing relationship with the plan) or for all services offered (as a prospective customer). In addition, purchasers may want to use responses to the questions in the Framework to help them understand in advance the administrative and financial implications, should they decide to enroll their population in a program.

Health plans may also find this evaluation framework helpful. Not only could they use it as a starting place for a consistent approach within their own companies, or across their industry, but they can also refer to it as a guide to what employers and other health care purchasers want them to track and report.

Some health care providers may be in a position of implementing payment reforms within their own organizations. For example, an accountable care organization would need to determine how to pay its participating providers to pass on the incentives it experiences through a shared savings or shared arrangement. Such an ACO may wish to track the impact of its payment approach and use this evaluation framework as a starting point.

Furthermore, benefit consulting firms are asked regularly by their employer-purchaser customers for help in understanding the success of various health care delivery and payment reform programs. In turn, benefit consultants query health plans and health care providers regularly about their results. They could choose to use this framework as a common ground and starting point for evaluations, thereby streamlining the administrative process and burden for plans.

We hope this tool will be useful to many parties and will serve to establish consistency in how various stakeholders evaluate their payment reform programs, allowing for more robust comparisons across programs and reducing the unnecessary reporting burden on program sponsors.

When is it Appropriate to Use the Framework?

CPR's Payment Reform Evaluation Framework can be used for various purposes and at different times in the life of a payment reform program. For instance, it can be used at the start of a new program to design the program's evaluation, or it could be used to determine the impact of a well-established program from its inception to the current period. Depending on the scope, scale, age, and intensity of the program, the outcomes portion of the Framework could be used as frequently as quarterly and as infrequently as annually.

Similarly, the Framework could be used in each of the variety of ways an employer or other health care purchaser can participate in a payment reform program:

Health Plan-Developed Payment Reform Program

Purchasers can participate in an existing payment reform program offered by their health plan(s). A purchaser may elect to gain access to such program "as-is," which may limit the ability to specify the terms of the evaluation.

Jointly Developed Program between the Health Plan and Purchaser

A purchaser may also work with a health plan to leverage its existing provider network and contracts and collaborate to establish specific payment reforms and evaluation arrangements. Part of the program development must include the design of the evaluation. Determining the evaluation specifications up front means the required data will be collected and there is agreement among parties to share such data.

Purchaser- Health Care Provider Direct Contracting

Purchasers may contract directly with a physician group, hospital or other facility or integrated delivery system to implement a payment reform program. In this scenario, the purchaser would bypass its health plan to contract directly for services from the health care provider, even though the purchaser will rely on its health plan or another third-party administrator to process claims and provide related services. The contract could encompass all health care services or just those associated with a specific condition or event (e.g. a specific chronic illness, or patients needing a particular procedure). The purchaser will need to consider what contractual terms must be in place to conduct an adequate evaluation.

Help CPR Improve the Payment Reform Evaluation Framework Over Time and Learn from Evaluations

CPR's Payment Reform Evaluation Framework reflects the thinking of some of our nation's leading experts in payment reform and program evaluation. However, there is no single right way to evaluate a health care delivery or payment reform program. Additionally, how we evaluate programs may need to change over time as new payment and delivery reforms emerge. We hope this Framework advances the consistency and rigor with which the health care industry is evaluating its efforts to reduce costs and improve the quality of care. If you have ideas for how we can improve the Framework, please give us feedback.

Furthermore, CPR hopes that the Framework can help create a more intense learning environment that enables the health care industry to spread successful approaches more rapidly and avoid design flaws and other pitfalls that evaluations may uncover. In addition for sharing ideas for how to improve the Framework, we also invite you to share the results of your payment reform programs by submitting entries into [CPR's National Compendium on Payment Reform](#).

Accountable Care Organizations: Looking Back and Moving Forward

By Rob Houston and Tricia McGinnis, Center for Health Care Strategies

IN BRIEF

Accountable care organizations (ACOs) have become increasingly prevalent in the United States. These organizations shift more accountability for health outcomes to providers and many have shown positive results for improving care and reducing costs – for Medicare, Medicaid, and commercial populations. This brief, made possible by the Robert Wood Johnson Foundation, identifies key lessons from ACO activities across the country to date. It examines how ACOs can build upon these initial successes and informs policymakers, researchers, and foundations about key considerations to further the development of effective ACO approaches across the health care market.

Just three or four years ago, accountable care organizations (ACOs) were being compared to the mythical unicorn – an intriguing idea, but one impossible to see in reality. Today, ACOs are very much a reality, with roughly 750 in operation – for Medicare, Medicaid, and commercial populations – serving 23.5 million people across the United States.¹ ACOs are designed to achieve the Triple Aim of better health, improving patient experience, and lowering costs.² While not all ACOs have demonstrated success in delivering better health outcomes at a lower cost, many have achieved promising results.^{3,4,5}

Although ACOs are rapidly emerging, the ACO model is still new and evolving. To investigate barriers, promising trends, and emerging opportunities for ACOs, the Robert Wood Johnson Foundation and the Center for Health Care Strategies convened ACO leaders, researchers, and subject matter experts from across the country in July 2015. The discussion revealed that leading ACOs are exploring common strategies to drive short-term success and long-term sustainability, such as: enhancing population health management approaches; providing effective, integrated care to high-need, high-cost subpopulations; and aligning Medicare, Medicaid, and commercial ACO efforts. This brief: (a) identifies key lessons from ACO activities to date; (b) examines how ACOs can build upon initial successes; and (c) informs policymakers, researchers, and foundations about considerations to further the development of effective ACOs.

ACOs: An Overview

ACOs are designed to achieve the Triple Aim by shifting varying degrees of financial responsibility for patient outcomes to the provider level, e.g., physicians and hospitals, rather than the payer level, e.g., Medicare and managed care organizations (MCOs), where these responsibilities historically lie. Two factors are driving this shift: (1) providers, including care teams, are best positioned to effectively coordinate care for the patients they serve; and (2) if providers' financial compensation is tied more closely with health outcomes and efficiency, they will seek to improve care coordination for patients and make cost-effective choices regarding services and procedures. A delivery model that supports these features has the potential to improve patient outcomes and reduce costs.

To achieve the Triple Aim, ACO models typically involve three distinct, yet overlapping components:⁶

- **Value-based payment methodology:** ACOs incorporate value-based payment (VBP) arrangements that incentivize providers to focus on patient outcomes and health status rather than volume of patients seen or services provided. VBP approaches may take different forms, but typically go beyond pay-for-performance and include upside-only shared savings models, upside/downside shared savings models, or global payments.
- **Quality improvement strategy:** ACOs are responsible for tracking and measuring specific quality metrics to indicate that patient outcomes are improving and/or evidence-based processes are being used. Some, but not necessarily all, metrics may be tied directly to the payment methodology, meaning that performance on these metrics will trigger either a quality incentive (such as an increased percentage of shared savings) or a disincentive (such as not receiving any shared savings).
- **Data reporting and analysis infrastructure:** To coordinate care and effectively manage the costs of care across providers, ACOs must develop the data capacity to securely transmit patient information. In addition, ACOs must aggregate and analyze patient-level clinical and cost data to better target patients, provide services, coordinate care, and track overall cost and quality performance.

How these three components of ACO models are constructed and interact depends on what type of ACOs are formed. Some ACOs involving government payers, like those participating in the Pioneer ACO program, Medicare Shared Savings Program (MSSP), or some Medicaid ACO programs have detailed requirements for payment methodology, quality metrics, and/or data sharing. Other ACOs, especially commercial models, are more likely to use criteria developed through negotiations between the ACO and an MCO.

Achieving the Triple Aim

ACOs are designed to achieve the Triple Aim by shifting varying degrees of financial responsibility for patient outcomes to the provider level.

ACO Progress to Date

ACO arrangements are forming in community settings and across Medicare, Medicaid, and commercial payers. There are roughly 750 ACOs established to date, serving approximately 23.5 million patients in all 50 states.⁷ ACOs come in all shapes and sizes. Some large integrated health systems and hospitals have become ACOs; multi-specialty provider groups have developed ACOs without hospital participation; and smaller providers, such as federally qualified health centers (FQHCs), have banded together to form “virtual” ACO arrangements to help coordinate care for the participating member organizations.⁸ There are even a few Medicaid ACOs that are led by MCOs. Some of these ACOs are already reporting positive results for improving patient outcomes and controlling costs; see Exhibit 1 for key attributes and broad results to date across the various ACO models.

Exhibit 1: Key Attributes and Broad Results of Current ACO Models

Attribute	Medicare		Commercial ACOs	Medicaid ACOs
	MSSP	Pioneer ACO		
ACO Prevalence	<ul style="list-style-type: none"> 333 ACOs in 47 states⁹ 	<ul style="list-style-type: none"> 18 ACOs in 8 states¹⁰ 	<ul style="list-style-type: none"> 528 commercial contracts¹¹ 	<ul style="list-style-type: none"> 66 ACOs in nine active state-based programs¹²
Key Model Features	<ul style="list-style-type: none"> Shared savings payment methodology 33 quality metrics 	<ul style="list-style-type: none"> Designed for large hospital systems Shared savings system with higher risk/reward potential than MSSP Same 33 quality metrics as MSSP 	<ul style="list-style-type: none"> Often independent contracts between ACOs and MCOs Many feature narrow provider networks¹³ 	<ul style="list-style-type: none"> Various approaches to payment including shared savings and capitation Various approaches to quality measurement
Results to Date	<ul style="list-style-type: none"> CMS has reported results for different cohorts of MSSP ACOs based on start date, which have shown significant savings, but it is difficult to aggregate these results,^{14,15} though only 26% of ACOs received shared savings payments¹⁶ ACOs consistently improved on 27 of 33 quality metrics¹⁷ Increases in patient satisfaction relative to patients not enrolled in ACOs¹⁸ 	<ul style="list-style-type: none"> \$304M in savings over three years¹⁹ ACOs consistently improved on 28 of 33 quality metrics²⁰ Increases in patient satisfaction relative to patients not enrolled in ACOs²¹ Began with 32 participants; 14 have left the program 	<ul style="list-style-type: none"> Not many publicly reported results available across programs due to proprietary information and difficulty comparing results^{22,23} 	<ul style="list-style-type: none"> CO, MN, and VT have collectively reported \$129.9M in savings^{24,25,26} ED visits in OR decreased by 22%²⁷

Initial Priorities for ACO Development

Virtually all ACOs tend to focus initially on similar areas of development, regardless of the payer, population, or model. Four key common areas are outlined below:

- **Adapting to a new business model.** The most common VBP method among ACOs is a shared savings/risk model. If the ACO achieves a total cost of care that is less than an established benchmark, it earns a percentage of the savings achieved, subject to meeting quality expectations. Profit maximization under this model requires a shift away from revenue-focused strategies to cost-containment strategies. This change also involves an important and difficult cultural shift for provider organizations and practitioners that takes time to get right.
- **Enabling efficient data sharing and analysis.** Timely and accurate data exchange among ACO providers is a precursor to success. However, ACOs -- especially those that are newly formed from multiple existing entities -- may have very different data systems, electronic health record (EHR) software, and administrative capacities to share data. ACOs must establish an effective data-sharing protocol to improve care coordination, which may require converting providers to use EHRs, establishing interoperability, and combining relevant clinical and cost data. Initial ACO efforts also tend to focus on building the in-house data analytic capacity necessary to manage the total cost of care and inform new care management strategies.
- **Stratifying patient populations.** ACO cost and quality improvement efforts are often grounded in analyzing the health needs of their attributed patients. ACOs typically stratify their patient population by common care needs, conditions, and expenditure levels and then deploy tailored interventions based on these characteristics. For example, patients who are homeless may need to be linked with a care team with a housing coordinator, whereas a high-risk pregnant mother would need a different constellation of care team members and interventions. Best practices in this area are still being developed, but it is clear that delivering the right intervention from the right person at the right time is a critical component of achieving the Triple Aim.
- **Improving care coordination and care management.** Many ACO efforts aim to achieve shared savings by eliminating inefficiencies, communicating better internally and across providers, and performing well on quality metrics. As previously mentioned, having integrated and interoperable data systems are a key element to achieving this goal, as patients often receive their care from multiple different systems. Additionally, most care coordination and care management programs establish personalized patient care plans that all care team members and providers can refer to and update. Other structures such as interdisciplinary care team meetings and real-time alerts to indicate when patients enter into a system of care are also cornerstones of successful care coordination and care management efforts.

By mastering these four foundational program elements, ACO providers and administrators hope to position their organizations to significantly lower the cost of care, improve quality, and achieve shared savings.

Current ACO Trends

As well-established ACOs mature and learn from their initial efforts, several notable trends are emerging. Six of the most widespread developments in ACO design are outlined below.

Refining Strategies for Specific Subpopulations

While MSSP ACOs, Pioneer ACOs, and most Medicaid ACOs tend to serve broad payer-based populations, most of these ACOs emphasize improving care coordination for subpopulations as the primary strategy for achieving cost savings. Many efforts to date have focused on high-need, high-cost populations (also known as super-utilizers). These patients often have poor access to care and the care they receive is often fragmented, without communication across physical and behavioral health providers. Care for these patients may be significantly improved through targeted high-touch interventions, and cost savings are more likely to accrue quickly through shared savings payment methodologies. Many ACOs are stratifying their populations to identify these patients and provide them with appropriate care. Given that the drivers of these patients' health needs often go beyond physical health, ACOs are developing partnerships with behavioral health providers, social service agencies, and other community-based organizations to address the social determinants of health as well. One initiative serving a specific subpopulation is Hennepin Health, which coordinates services for childless adults with incomes under 133 percent of the poverty level in Hennepin County, Minnesota. The organization, a partnership encompassing Metropolitan Health Plan, Hennepin County Medical Center, NorthPoint Health and Wellness Center (an FQHC), and the Human Services and Public Health Department of Hennepin County, provides physical health, behavioral health, and social services. The program addresses the full range of non-medical needs, including providing patients with respite or permanent housing. These efforts have been very effective. For the more than 100 patients that Hennepin Health has placed in housing, inpatient utilization dropped 29 percent, and inpatient costs fell 72 percent. These patients' ED visits also decreased by 55 percent and their ED costs lowered by 52 percent.²⁸

While some ACOs focus solely on targeted subpopulations, other ACOs that serve a broader patient population have also aimed specific efforts at high-need, high-cost patients. ACOs must align the balance between targeted efforts and population-based models in order to help the whole of the population as well as the most vulnerable members. The Camden Coalition of Health Care Providers in New Jersey is a good example. Originally conceived as a program to help super-utilizers through data-driven targeting of patients and home-based care team visits, Camden Coalition is now a state-recognized Medicaid ACO that has expanded to serve a broader group of 35,000 patients, though it continues to target high-need, high-cost patients. There is also a rising number of ACOs serving specific age groups, such as pediatric patients, and conditions, such as behavioral health-focused ACOs or proposed Medicare ACOs focused on renal failure. These ACO structures offer primary care providers and specialists associated with a

specific patient population the opportunity to benefit from the ACO trend and reap shared savings from better-coordinated care.

Consolidation

Across the country, both providers and payers are consolidating their market shares, and many provider organizations are positioning ACO development as an important part of such a strategy. By coordinating care effectively through a large ACO that serves many patients, providers have the potential to create economies of scale that can achieve greater savings with a lower administrative burden. Larger ACOs can also mitigate financial risk due to variability in per patient costs.

The potential downsides of this consolidated market power, however, include the potential for driving up the total cost of care, marginalizing smaller safety net providers such as FQHCs and small physician practices, and limiting consumer choice.²⁹ If such market consolidation continues, federal, state, and local officials should be vigilant to ensure that anti-competitive practices from these large entities do not adversely affect markets and patients. Some Medicaid ACO programs have already taken steps along this path, such as New Jersey's requirement that its Medicaid agency and the Department of Banking and Insurance evaluate the impact of its geographically based Medicaid ACOs on the areas they serve.³⁰

Regional ACO Development

There is a growing interest in ACOs that are responsible for the entire patient population in a defined geographic area within a state. Cost measurements and payments for such models are typically population-based (on a prospective per member per month basis) and calculated as a total cost of care across all services under the ACO's scope of services. Unlike typical ACO shared savings agreements, which are based on the traditional fee-for-service model and adjusted based on shared savings, these fixed, prospective global payments allow ACOs to manage their own budgets in innovative ways. For this reason, many of these ACOs integrate services beyond physical health, including behavioral health, long-term care, dental, and social services. Some geographically based models, like Oregon's Medicaid Coordinated Care Organizations, allow for flexibility in payment for items and services that are non-medical but may improve health, such as air conditioners or housing support for homeless individuals. While many of the population health-based models are in their infancy, increased profits may also be possible by decreasing total cost of care under capitated or global payments or creating more accurate risk-adjustment methodologies that account for non-medical factors such as the social determinants of health.

Virtual and Rural ACO Development

While early ACO adoption has occurred primarily in urban and suburban settings, interest is emerging among smaller provider organizations and in rural settings. Such ACOs are using technology to create "virtual" ACO arrangements that allow smaller providers to organize and coordinate care more effectively. Many of these arrangements have a safety net focus and involve public hospitals, FQHCs, community health centers, and community-based organizations that can help address the needs of complex patients. One example of a virtual ACO is the Federally Qualified Health Center Urban Health Network (FUHN) in Minnesota, a collaborative of

10 FQHCs that serve the Minneapolis/St. Paul metro area. These FQHCs — which previously competed with each other for funding, patients, and resources — now work together to drive down costs and improve care as one of the state’s Medicaid ACOs.

Because access to care, especially specialist and behavioral health care, is difficult in rural areas, rural providers such as safety net hospitals and health centers are particularly interested in forming virtual arrangements to improve care coordination efforts and enhance preventive care. Some of these ACOs are also looking toward telemedicine as a promising way to bring patients and providers together virtually. An example of a rural ACO is Community Health Accountable Care (CHAC) in Vermont. The nine FQHCs that compose CHAC are located throughout the primarily rural state and share infrastructure and resources. CHAC serves all patient types as a rural MSSP ACO, Vermont Shared Savings Program Medicaid ACO, and through commercial arrangements with MCOs.

Narrowing Provider Networks and Referral Patterns

ACOs, particularly those in the commercial sector, have been experimenting with narrow provider networks as a strategy for reining in costs and improving care. MCOs have initiated many of these narrow networks. In a typical arrangement, an MCO will create an ACO with a limited number of provider organizations that have demonstrated a pattern of high-value care (for example, exceptional performance on quality metrics) and a willingness to provide specific services for a lower price. Since there are a limited number of providers in the network, the MCO can negotiate lower prices with their providers than they normally would with a wider network. This could also benefit these high-value providers, as they can gain greater patient volume.

ACOs are also experimenting with referral patterns as a cost-containment strategy, referring patients to high-quality, efficient specialists. A recent study by the Integrated Healthcare Association found that commercial ACOs in California reported savings for patients who received more effective care direction, such as referrals to high-value specialists within the ACO’s limited network. This approach helped control costs in two ways: lower specialist fees due to a narrow network, and lower co-pays for members since they were referred to an in-network provider.³¹ While such models could help reduce costs through high-value providers and negotiating leverage, there is also a balance that needs to be achieved, as limited networks could also restrict consumer choice and access to care based on location and wait time.³²

Improving Data Analytics and Forecasting

As ACOs continue to gain experience in coordinating care, many are investing in advanced data analytics to gain a greater understanding of their patient sub-populations and develop forecasting tools. While some ACOs have home-grown predictive modeling tools, others have purchased commercially available tools, hired contractors, or gained access to publicly available data resources. Washington State developed an integrated social service client database that links data across state agencies — including Medicaid, public health, criminal justice, family services — which gives it the capability to identify patient risk across agencies and track costs and outcomes at the state, community, family, or individual level. The database supports the



Investing in Data Analytics

Many ACOs are investing in advanced data analytics to gain a greater understanding of their patient sub-populations.

Predictive Risk Intelligence System (PRISM), a predictive modeling and decision support tool, that helps providers and administrators implement care management interventions for high-risk patients.³³ Washington's ACOs for public employees are using this database to target patients and improve care coordination. Once the state's Medicaid ACO program is launched, its participating Medicaid ACOs will have access to this tool as well. These tools could help improve risk adjustment methodologies and result in more accurate payments for high-risk patient subsets. Efforts such as PRISM, which aggregate data beyond medical procedures, may be particularly helpful in addressing social determinants of health at the population level.

Barriers and Challenges

ACOs are at a critical juncture for identifying key challenges and emerging solutions that may help sustain these models. Conversations with ACO leaders, researchers, and policymakers reveal common challenges facing the ACO movement.

Creating Sustainable Financing Models

Most ACOs initiate contracts under a shared savings or shared risk financial arrangement. One important aspect of the shared savings methodology is setting the benchmark; payers must decide how and how often to “rebase” the benchmark against which actual savings (or losses) are calculated. In the first few years of an ACO's operations, it may be feasible to put the necessary care management and technological pieces in place to achieve significant savings compared to the benchmark. However, as the benchmark is reset over time, this financial model creates diminishing incentives to participate since the benchmark gets progressively lower based on past successes. Unless payers adjust their approach, this method penalizes efficient providers. Some Pioneer ACO programs, such as the Dartmouth-Hitchcock ACO in New Hampshire, have cited this imbalance in rewards as a reason for their withdrawal from the program.³⁴

Payers are considering a variety of approaches to offset this potentially powerful long-term disincentive for participation. In its most recent MSSP rules, CMS responded to this disincentive by changing the weighting of the annual benchmarking procedure from 60 percent for the most recent of the three calculated years to an even distribution.³⁵ This allows cost-effective ACOs to reap slightly more of the savings if they continuously decrease costs year after year.³⁶ Other potential approaches include: (1) transitioning to regional benchmarks; (2) holding the benchmark fixed over a longer period; and (3) transitioning to prospective global payments.

Working across Organizations

Effective care coordination requires collaboration across organizations and can be achieved by creating integrated cross-organizational care teams, facilitating timely and accurate data exchange, and coordinating administrative tasks. Coordinating care may be particularly daunting for providers working outside of an integrated health system or multi-specialty practice, though even large health systems may struggle with coordination. Independent organizations are likely to have different ways of doing business, including varying: staff capacity and care team structures; workflow processes; EHR software; administrative structures; and communication methods with outside organizations. This is especially the case with organizations that have very

different business models – such as behavioral health providers and other community-based organizations – but are critical partners to effectively managing high-need, high-cost patients.

Further, some organizations may not be willing to participate in or collaborate with an ACO due to high start-up costs, a history of competition or mistrust of potential partners, or concerns about revenue reduction. To function effectively as ACOs, these organizations will need to determine ways to overcome these differences and enter into mutually beneficial partnerships.

Providing Patient-Centered Care

While many ACOs tend to focus initial efforts on improving provider-led care, effectively engaging patients in their care and developing care teams that help patients meet their own care goals are critical elements for achieving success. This vision of patient-centered care is not new, as care delivery models such as patient-centered medical homes (PCMH) have laid the groundwork. However, the imperative to be more patient-centered is perhaps stronger under ACO models, as financial incentives could help drive positive care coordination efforts.

ACOs are beginning to look at ways to engage patients more effectively to improve patient experience and address social determinants of health that can impact health outcomes and exacerbate spending. For example, Maimonides Medical Center in Brooklyn, NY has a dedicated staff person whose job is to engage the Department of Corrections and facilitate care coordination for corrections-involved patients. This role has helped Maimonides coordinate care for individuals while they are still in jail and ease their transition when they are released by making sure they have things like prescriptions, Medicaid coverage, appointments scheduled with necessary providers, and housing plans. By shoring up these social needs, Maimonides is able to reduce the likelihood that these individuals will show up in the emergency department in crisis shortly upon release.³⁷

Addressing the Social Determinants of Health

ACOs are recognizing the importance of engaging patients more effectively and addressing social determinants of health that can impact health outcomes and exacerbate spending.

There are some significant barriers to providing patient-centered care through ACOs. One major barrier is that many ACO models attribute patients retrospectively based on utilization. While retrospective attribution preserves patient choice, it also means that the ACO does not know which patients will be assigned until they serve them for a long period of time. A prospective attribution method, which assigns patients to an ACO based on past utilization patterns, may be more effective in building relationships and encouraging providers to be proactive with patients, resulting in greater patient engagement and more effective ACO care coordination activities. Additionally, patients and consumers are largely not engaged in the governance or design of ACO programs or operations. It is possible that involving patients and soliciting their input could result in more patient-friendly operations and produce greater patient engagement.

Measurement Limitations

Although many ACOs are showing positive results on controlling costs and improving quality, the measures ACOs are held accountable for are limited in terms of capturing important health outcomes. While quality metrics tend to capture performance on specific outcomes, such as

lower avoidable readmissions, or processes, such as screening for depression, they may not accurately measure the overall health of the patient. This makes it difficult to assess the true impact and efficacy of ACO arrangements. Patient experience should also be accounted for, and while such metrics such as the Consumer Assessment of Healthcare Providers and Systems survey are widely used, they generally focus on a patient's experience with his or her providers and the health care system. Metrics that measure a patient's own assessment of his or her health outcomes could be a more reliable assessment of patient experience but are challenging to capture. Additionally, few ACOs are collecting data and measuring specific racial, ethnic, or language-based health disparities, which could be fruitful to improving quality, patient-centeredness, and reducing costs if addressed.

It also remains difficult to evaluate the impact of specific interventions and strategies on cost and quality. For example, conducting a randomized control trial of an ACO intervention to address a specific subpopulation is a lengthy process and is not realistic given the need to produce short-term results. In ACOs, like many health care interventions, it is difficult to benchmark values, isolate variables involving a patient's health status, and compare them to a control group since there are so many factors affecting the patient's health. By aligning or standardizing methodologies for evaluation purposes – including quality metrics, benchmarking, and risk-adjustment methodologies – more consistent conclusions can be drawn across ACO interventions.

Aligning ACO Models

Many ACOs participate in contracts with Medicare, Medicaid, and commercial entities. These arrangements are often complex and may widely differ, including elements such as: governance requirements; payment structures; quality metrics; reporting requirements; and data availability. While different patient populations may require tailored quality measures and risk adjustment methods, this variation creates a substantial administrative burden on ACOs and can hamper improvement efforts.

Nevertheless, some ACOs are striving to achieve economies of scale by serving Medicare, Medicaid, and commercial populations under an ACO arrangement. These ACOs are forming from coast to coast, from large hospital systems like Montefiore Medical Center in New York to AZ ConnectedCare in Arizona. Some safety net providers are also participating in multi-payer initiatives, such as AltaMed, the largest FQHC in the United States based in Los Angeles and Orange counties in California. It has developed an independent practice association (IPA) to expand its network and function as an ACO. AltaMed's operations are all paid on a partially capitated basis (the clinic accepts Medicaid, Medicare, commercial, and dually eligible Medicare-Medicaid enrollees) and the IPA has a fully capitated arrangement for Program for All-inclusive Care for the Elderly enrollees.³⁸ While it may make sense from a business standpoint for ACOs to serve different populations using a single infrastructure, alignment remains elusive and it is not yet clear whether such alignment will lead to the economies of scale that providers are pursuing.

Leveraging Economies of Scale

Some ACOs are striving to achieve economies of scale by serving Medicare, Medicaid, and commercial populations under an ACO arrangement.

Data Sharing

While arrangements like ACOs help make the business case for provider investments in data sharing and analytics, challenges remain. Building the cross-provider infrastructure for effective data sharing takes a significant amount of upfront investment and commitment from those providers. While some may receive support through federal meaningful use incentives³⁹ as well as some state-based funding (e.g., State Innovation Model (SIM) grants), there are still many providers that have not built the infrastructure, staff capacity, EHR interoperability standards, or have a health information exchange capable of transmitting information among providers yet. The MSSP and Pioneer models have limited funding targeted to rural or safety net providers for this purpose and Medicaid and commercial ACOs generally lack access to additional funding beyond what is described above.

Additionally state and federal regulations or policies that require patients to opt-in to data-sharing arrangements create both perceived and legitimate barriers to information sharing. The most discussed regulation is 42 CFR Part II, which requires patients to approve the release of alcohol or drug abuse history or treatment. ACOs must determine how to protect patient information while also sharing data freely and effectively among providers to help manage patient care.

Opportunities to Help ACOs Realize their Full Potential

Medicare, Medicaid, and commercial ACOs are becoming more widespread and some of them have seen measurable success, but these models are relatively new and there is still much room for improvement. There are many ways that policymakers, researchers, and funders could foster their development. Below are six of the most relevant opportunities:

1. Encouraging movement toward greater accountability

Payers and ACOs are exploring key strategies to continue the shift toward greater accountability, including: transitioning to capitated or global payment arrangements; expanding scopes of services beyond physical health to include mental health and substance abuse services, long-term care, dental services, and social services; and using prospective attribution models so that ACO providers are aware of which patients they are responsible for and are encouraged to be more directly accountable for managing the health of these patients.

Policymakers and payers are already looking toward incorporating some of these strategies, such as the Next Generation ACO model's emphasis on prospective attribution, and will likely continue to pursue such endeavors to enhance accountability. Funders and researchers can also support initiatives that foster this shift at the provider level and/or determine the efficacy of these methods and their impact on costs, quality, and patient experience.

2. Breaking down policy and regulatory barriers

Policymakers can help providers and payers facilitate population-based or multi-payer ACO arrangements by breaking down barriers and regulations that inhibit data sharing. Policymakers can allow greater flexibility for funds designated for a specific purpose to be used for broader

activities. For example, CMS might expand the definitions of what Medicare and Medicaid funds can be used for, such as supporting social services payments, or what services qualify as medical expenses for MCOs. State governments could pool state social service (such as housing) and Medicaid resources to provide a unified source of funding to address non-medical needs that may contribute to higher utilization of health care services. Federal regulators appear to be considering revisions to 42 CFR Part 2.⁴⁰ Changes to the regulations could help patients with substance use disorders get better-coordinated care from their providers, who may not otherwise be aware of full patient histories because of current data-sharing regulations. ACOs can use foundation support to work toward interoperability of EHRs and other methods of facilitating information exchange among providers, including physical, behavioral health, and long-term care providers, as well as social service agencies and community-based organizations.

3. Facilitating multi-payer ACOs

If ACO arrangements are expected to truly change the way providers do business, over the long run multi-payer alignment and participation will be critical. Payers and providers must work together to identify the program elements where alignment is crucial, and, conversely, areas where payer variability is acceptable. For example, it would be beneficial to establish a measurement set of common conditions that cut across patients served by most payers, while allowing certain quality metrics to vary due to conditions prevalent in payer populations (e.g., Medicaid patients may need prenatal care, but Medicare patients rarely do). Additionally, aggregating data across ACO models is difficult due to risk adjustment and benchmarking that vary widely among ACO programs. Several federal initiatives, including the Health Care Payment Learning and Action Network (LAN) and the SIM initiative, are promoting alignment across health reform models, but there is still much work to be done. Research into the impact of multi-payer ACOs would help elucidate the pros and cons of alignment and specialization. Finally, policymakers or funders can help foster these developments by funding multi-payer ACO pilots or providing funding opportunities for ACOs to develop the infrastructure to take on these complex care coordination efforts.

4. Refining risk adjustment across populations and services

As ACOs assume greater financial accountability, improvements to risk-adjustment will be especially important. More sophisticated risk-adjustment mechanisms will help with potential adverse selection problems, where providers may avoid treating high-need, high-cost patients due to fear of driving up costs in a total cost of care calculation. In addition, if these methods account for social determinants of health, regional costs, and other non-medical factors, ACOs may be better positioned to enter into prospective, risk-based, or population-based payment arrangements. Risk-adjustment will also be critical for accepting global payments across large populations, as even a one-cent difference in payment could mean a large difference in population-based ACOs that serve hundreds of thousands of patients across multiple payers. In particular, precise risk adjustment will help ACOs stratify their high-need, high-cost patients, build tailored interventions to suit these needs, and efficiently allocate personnel and resources to provide the right level of care for each patient. Policymakers, researchers, and funders can help providers improve risk-adjustment techniques to include different populations and services by supporting research into these areas and investing in actuarial modeling. Efforts that are more

basic might involve investing in actuarial consultants to develop advanced risk-adjustment tools, while more far-reaching activities could entail pooling aggregate data from patients across the country to discover the most important factors affecting health to more effectively calibrate risk adjustment models.

5. Managing market consolidation

As market consolidation continues, policymakers, researchers, and funders may want to explore ways that ACOs drive or counteract this phenomenon. While it is not known what the exact effect consolidation will have on health care markets, and whether this effect will be positive (improved efficiency and coordination) or negative (increased costs and less patient choice), there is likely to be a large effect on these markets and the driving role ACOs can play in creating provider market power.⁴¹ While the federal government may have already begun to discourage further hospital mergers through provisions in the Medicare Access and CHIP Reauthorization of 2015,⁴² the impacts of ACOs on this trend should be explored by researchers positing future outcomes of actual or potential mergers. This could be done through an economic study with a national scope or an in-depth analysis of a state, city, or regional market. Once this information is obtained, federal, state, or local policymakers may want to take steps to regulate consolidation based on the research findings, or possibly help providers and payers prepare for the new market dynamics.

6. Encouraging greater patient engagement in care

ACOs are tasked with providing more effective patient-centered care, and encouraging patients to engage in their own care is a perfect opportunity to do this. While ACOs are using many methods to engage patients, many admit they need to do a better job in this area, especially in issues related to addressing cultural and ethnic disparities. Researchers and foundations can support these efforts by determining what methods of patient engagement are working and helping to spread such models. Further, policymakers can support changes in ACO quality measurement standards to include metrics that assess health outcomes that are important to patients. While many ACOs already measure patient experience metrics, these measures usually gauge satisfaction with the care delivery process, not outcomes. By measuring patient-reported outcome metrics, ACOs may be able to gain a more accurate picture of their patients' true experience with the health care system.

7. Improving measurement of ACO success

Policymakers, researchers, and funders can help measure ACO success more accurately by supporting rigorous studies on ACO progress. Research efforts could conduct randomized control trials of ACO interventions or across interventions for subpopulations or to address health disparities. In addition, further research on whether ACO providers are better equipped to implement such interventions than other providers may be worthwhile. ACO impact may also be more effectively measured if outcome measures were more reliable. While there are currently efforts underway to address shortcomings in statistical analysis and improve comparative outcomes research at the Patient-Centered Outcomes Research Institute and the Dartmouth

Institute for Health Policy and Clinical Practice, it may still be worthwhile for policymakers and foundations to invest in research in this area.

As mentioned earlier, standardizing ACO measurement practices so performance can be compared across states, regions, payers, and populations can help the field. Potential areas of improvement include standardizing: (1) benchmarking techniques for savings and quality; (2) quality metrics; and (3) prospective and retrospective attribution guidelines. However, since ACOs are still a relatively new concept, standardizing processes at this point may be premature and inhibit the development of promising practices and innovation. Due to this tension, it may make sense to invest in evaluation techniques that strategically analyze ACO results, such as filtering results on many different outcome metrics to determine which are most salient.

The Future of ACOs

ACOs continue to proliferate and ACO results continue to roll in. These trends show no signs of subsiding, and though not all ACOs have made measureable strides toward the Triple Aim, many have improved quality and patient experience while simultaneously reducing costs. As this momentum continues to build, there are many opportunities to support this work. Since not all ACOs have been successful, targeted research and investment could help identify differences between successful ACO models and those that struggle. These findings could generate lessons to guide future ACO activity and encourage replicability or standardization across models. In addition, since the comparative efficacy of particular ACO models has not been proven, policymakers and funders should not be afraid to forge ahead on innovative ACO model enhancements, such as multi-payer alignment, population-based ACOs, and subpopulation-focused ACOs. As providers and payers continue to work toward ACO arrangements that improve quality, reduce costs, and enhance patient experience, policymakers, researchers, and foundations can help them reach these goals by providing key support for these initiatives.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop better models of organizing, financing, and delivering health and health care services, especially for people with complex needs. For more information, including additional ACO-related publications, visit www.chcs.org.

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