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Executive Summary

The Health Care Payment Learning and Action Network (HCP-LAN) *Roadmap for Driving High Performance in Alternative Payment Models* initiative aims to identify and disseminate best practices from commercial, Medicare, and Medicaid alternative payment models (APMs) that have successfully lowered health care costs, improved quality of care, and enhanced the patient and provider experience. As an initial step in this effort, the HCP-LAN team conducted a targeted literature review and interviews with a diverse set of stakeholders to identify emerging themes related to successful APM design and implementation. The results will inform the HCP-LAN's approach to gathering and validating best practices from payers and providers in high-performing APMs.

This paper summarizes many of the key themes that emerged from the literature sources and interviews, and includes the following highlights:

APM Planning and Design Components & Features

Infrastructure investments, flexibility in risk frameworks, provider knowledge of risk-based contracting, and high-value networks were among the most frequently discussed design and planning elements of APMs in the research. Stakeholders widely agree on the need for payments to providers to support infrastructure, although payers and providers may disagree about the duration of this financial support. Health plans indicate a willingness to tailor reimbursement to a provider's ability to take on risk, and experts emphasize that providers should be well-versed in APM contract negotiation, especially when it comes to two-sided risk. Accountable Care Organizations (ACOs) and bundled payment participants often focus on post-acute care organizations as they develop high-value networks.

APM Implementation Strategies

Critical strategic areas for APM implementation include leadership, health information technology (HIT), care coordination, provider engagement, and patient-centeredness. An essential building block for successful transformation is the presence of strong, committed health plan and provider leaders, particularly those who can build trust with one another and with front-line practitioners. Payers and providers are enhancing health information technology (HIT) and sharing data in new ways to support care transformation, yet numerous barriers prevent stakeholders from realizing HIT's full potential. Care managers facilitate a wide array of patient-focused activities, though some researchers express skepticism about care coordination as a major driver of savings. There is widespread agreement that clinicians, patients, and families should be involved in the design and implementation of APMs. The research highlighted numerous ways to support clinicians and patients and improve their participation in new payment models.



Multi-Payer Collaboration

Multi-payer arrangements can reduce provider burden, promote a culture of collaboration, align quality measurement, and establish common data infrastructures. As in all APMs, achieving success likely depends on striking the right balance between competing interests and goals as model designers develop payment mechanisms, quality performance frameworks, and other components. However, having a strong, neutral convener is seen as a key success factor. Stakeholders highlighted anti-trust concerns and local insurance markets as potential barriers to multi-payer APM implementation. In some cases, provider readiness is seen as a greater barrier to APM implementation than lack of multi-payer alignment.



APM Characteristics

Several articles in this targeted review analyzed whether certain APM and provider characteristics, such as size and level of experience, are correlated with different aspects of success in APMs. While the findings are mixed, one of the more consistent findings suggests that hospital integration is not necessary to achieve savings.

The success of any APM is multi-factorial. Numerous provider features, design and implementation decisions, market characteristics, and environmental and policy factors affect the ability of a payment model to achieve its goals. In that sense, isolating generalizable impacts of specific correlates of success remains more complex. While the research provides an overview of key issues surrounding APM implementation, not every factor identified will be relevant to the success of all APMs.

The research summarized in this report is not exhaustive. Due to resource constraints, a streamlined approach was taken, focusing on five salient health-related journals and select and timely gray literature sources. Furthermore, many of the findings on correlations of success lacked strong evidence. For example, journal articles often did not seek to isolate the effect of specific actions or APM features that may have contributed to better outcomes. Although some researchers thoughtfully speculated as to which APM features were most impactful, they generally refrained from drawing conclusions about causal relationships.

Introduction

The HCP-LAN is supported by the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare federally-funded research and development Center (FFRDC), operated by MITRE. In the spring of 2018, the HCP-LAN commenced work on the *Roadmap for Driving High Performance in APMs*, or “APM Roadmap,” a new initiative to accelerate the adoption of APMs that successfully lower health care costs, improve care, and enhance patient and provider experiences. Specifically, the project aims to identify several high-performing APMs, study their design and implementation strategies, and synthesize best practices for broad dissemination to payers and providers. The effort focuses on specialty and population-based payment models, with an emphasis on APMs classified in categories 3 or 4 of the [HCP-LAN APM Framework](#)¹.

In laying the foundation for this work, the HCP-LAN team conducted background research to go beyond the white paper series on payment model design and other collaborative initiatives within the HCP-LAN and gain new insights into successful APM implementation. A primary goal of this research was to obtain information about potential correlates of successful APMs, including characteristics of APMs such as size or level of experience, as well as payer or provider actions taken during the design or implementation of an APM that potentially impacted outcomes. The background research also focused on identifying common challenges encountered in APM implementation and potential solutions for overcoming barriers.

This exploratory research included a targeted literature review of 28 articles from five key medical and health care-related journals, including the *New England Journal of Medicine*; the *Journal of the American Medical Association*; *Health Affairs*; the *American Journal of Managed Care*; and the *American Journal of Accountable Care*. HCP-LAN team members also consulted 25 gray literature sources such as industry reports and evaluations of new payment models and conducted 30 stakeholder discussions with individuals who have deep understanding of and experience in APM implementation. These discussions spanned multiple stakeholder categories, including payers, providers, patients, academics, consultants/vendors, purchasers, and implementers of multi-stakeholder collaboratives.

The research objectives were twofold: First, that the information gathered support the development of a detailed set of interview questions to guide discussions with payers and providers selected for inclusion in the APM Roadmap; and second, that the information gained enable the HCP-LAN team to begin building a knowledge bank to help validate findings from these interviews. This report highlights top-level themes and issues raised in the reviewed literature and stakeholder discussions; it is not intended to provide a full assessment of each featured topic. The information is largely divided into two categories, including promising practices and challenges related to APM implementation. The term “promising practices” is used to describe common practices in the field and activities or ideas that

¹ In 2016, the LAN Alternative Payment Model Framework and Progress Tracking Work Group created the APM framework that could be used to track progress toward payment reform. The framework was subsequently updated in 2017. Categories 3 and 4 of the framework include shared savings models and population-based payment models.

stakeholders and researchers believe are potentially helpful to APM success. Information categorized under “challenges” generally illustrates barriers to APM implementation identified in the research, and in some cases includes suggested solutions for overcoming obstacles. A description of the methods used to inform this paper can be found in the [Appendix A](#).

APM Planning and Design Components & Features

APM design is a highly complex undertaking that requires many decisions about the structural features or “building blocks” to include in a payment model. The background research addressed several different structural components of APM design, especially regarding the financial aspects of a new payment system.

APM Infrastructure Investments

Transitioning to advanced forms of value-based payment typically begins by building on a fee-for-service (FFS) structure, though providers can encounter difficulties securing the financing to make upfront investments in care delivery infrastructure.

Promising Practices:

Many APM initiatives offer financial support to providers to help cover transformation and enhanced care coordination costs, which can take the form of per-member per-month (PMPM) fees, lump-sum start-up payments, enhanced FFS rates, or grant money.^{2,3} Payers emphasize the value of upfront investment strategies and note that helping providers develop their population health management infrastructure is critical to improving cost and quality.^{4,5,6} In stakeholder interviews, purchasers encouraged the development of shared infrastructures within markets, rather than the creation of separate population health management systems by individual health care organizations. For example,

² Takach, M., Townley, C., et al. (2015). "Making Multi-payer Reform Work: What Can Be Learned from Medical Home Initiatives." *Health Aff (Millwood)* 34(4): 662-672.

³ Kroening-Roché, J., Hall, J. D., et al. (2017). "Integrating Behavioral Health Under an ACO Global Budget: Barriers and Progress in Oregon." *The American Journal of Managed Care* 23(9): e303-e309.

⁴ Anthem Public Policy Institute. (2016). "Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment." Available at: https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19l/mjq0/~edisp/pw_e244942.pdf

⁵ Arkansas Center for Payment Improvement. (2017). "Arkansas Health Care Payment Improvement Initiative. 3rd Annual Statewide Tracking Report." Available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=482>

⁶ Damberg, C.L., Sorbero, M.E. et al. (2014). "Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions." Available at: https://www.rand.org/pubs/research_reports/RR306.html.

one purchaser observed that a state collaborative had the capacity to take information from payers and providers and distribute aligned reports.

Challenges:

It is common for initial transformation funds and infrastructure investments to gradually decrease as new payment models become sustainable and achieve cost savings. Implementers of APMs have described concerns about gradually decreasing care management support, especially when funding is used to support new staff positions,⁷ noting that diminishing fees do not account for fixed analytics and care management staff costs. By contrast, payers and purchasers caution that providers can become dependent on investment payments that were intended to be temporary.

Key Takeaways:

- ✓ Many APM initiatives provide financial support to providers to develop population health management infrastructures. Both the literature and stakeholder interviews support these investments as critical to improving costs and quality.
- ✓ It is common for initial investments to providers to gradually decrease as APMs become financially self-sustainable, although reduced investments can be challenging for providers.
- ✓ Payers and purchasers caution that providers should not depend on initial investment funds and envision shared population health infrastructures as a solution.

Risk Framework Flexibility

Provider practices vary in their abilities to manage population health and take on financial risk.

Promising Practices:

The literature demonstrates a consistent theme that payers are willing to tailor reimbursement to providers’ abilities to assume risk.^{8,9} Payers note the importance of allowing providers to gain confidence and experience with APMs before risk is introduced,¹⁰ and emphasize that providing

⁷ Kroening-Roché, J., Hall, J. D., et al. (2017). "Integrating Behavioral Health Under an ACO Global Budget: Barriers and Progress in Oregon." *The American Journal of Managed Care* 23(9): e303-e309. (Higgins, 2016)

⁸ Higgins, A., Stewart, K., et al. (2016). "Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?" *The American Journal of Accountable Care* 4(1): 43-46.

⁹ Alliance of Community Health Plans. (2016). "Rewarding High Quality: Practical Models for Value-Based Physician Payment." Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

¹⁰ Higgins, A., Stewart, K., et al. (2016). "Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?" *The American Journal of Accountable Care* 4(1): 43-46.

options along the risk-bearing continuum is important for provider buy-in.¹¹ Plans may introduce risk along a spectrum and evaluate providers along the way to assess their readiness for more risk.¹²

In addition to offering flexibility in the risk framework, researchers suggested that payers loosen prior authorization requirements (especially for behavioral health) for providers that take on substantial financial risk. They reasoned that these providers are already held accountable for utilization and spending, thus lessening the need for plans to impose significant prior authorization restrictions.

Challenges:

Providers interviewed agreed with the need for flexibility in the risk framework but noted the difficulty in reacting to shared saving and loss rate changes, as well as other contract terms. They explained that abrupt changes in financial contract terms hurt their ability to maintain or realize returns on investments in infrastructure. One APM evaluator suggested that revenue from different payers and lines of business may provide more stability and mitigate risks for providers transitioning into value-based payment arrangements. Organizations with significant commercial preferred provider organization (PPO) business may be better able to offset initial losses in Medicare and Medicaid risk arrangements.

Key Takeaways

- ✓ Viewpoints captured in the literature and stakeholder interviews support flexibility in risk frameworks as critical to the success of APMs.
- ✓ Stakeholders discussed revenue sources from different payers and lines of business as a key risk mitigation strategy for providers transitioning into value-based payment arrangements.
- ✓ Stakeholders have also suggested that prior authorization requirements be loosened for providers assuming higher levels of risk.

¹¹ Anthem Public Policy Institute. (2016). "Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment." Available at: https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19l/mjq0/~edisp/pw_e244942.pdf

¹² Alliance of Community Health Plans. (2016). "Rewarding High Quality: Practical Models for Value-Based Physician Payment." Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

Payer-Provider Contracting

The design components of APMs may be created or refined through the payer-provider contracting process.

Promising Practices:

Several resources addressed the contracting process, underscoring the need for providers to be well-versed in two-sided risk contracting, particularly in negotiating realistic financial targets and considering populations included in the risk arrangement. Providers who spoke to the HCP-LAN identified several best practices associated with contract negotiation and emphasized the need to ensure that contract terms with payers enable fair compensation for providing high-value care. They stressed the importance of looking closely at whether incentives will benefit participating organizations (e.g., benchmarks that reward improvement over attainment), and whether an APM contract length is long enough (e.g., multi-year versus annual) to justify infrastructure investments, realize cost and quality impacts, and provide financial stability to providers. Providers specifically cautioned against terms that unfairly withhold shared savings, such as making certain savings ineligible or setting unrealistic financial benchmarks.

Research by Premier Inc. indicates that two-sided risk models should have a minimum of 20,000 covered lives to minimize the risk of outliers and patient panel sizes comprising a minimum of 30 to 50 percent of a provider's patients in the risk arrangement to influence behavior.¹³ Providers confirmed this perspective in interviews and noted that stop-loss provisions and reinsurance cannot entirely protect providers from random variation. Ensuring that an APM contract is designed to create needed volume, such as through strategic decisions about the type of services covered (e.g., bundled payment options for more common conditions) or decreased out-of-pocket spending for patients, may also be important in obtaining provider participation.¹⁴

Challenges:

One stakeholder mentioned difficulty with finding payers willing to enter into downside-risk-based contracts. Conversely, payers reflected that provider readiness to execute a population health management contract is a significant barrier to APM implementation. Payers noted that providers can be unwilling to participate in APMs, in part, because of economic incentives to remain in FFS arrangements. Finally, several stakeholders mentioned uncertainty about the future of value-based payment as a barrier to planning for sustained APM implementation over the long term.

¹³ Damor, J. and Hardaway, B. (2017). "Ready, Risk, Reward: Building Successful Two-Sided Risk Models." Premier Inc. Available at: <https://learn.premierinc.com/white-papers/building-successful-two-sided-risk-models-premier-inc>

¹⁴ Ridgely, M. S., de Vries, D., et al. (2014). "Bundled Payment Fails to Gain a Foothold in California: the Experience of the IHA Bundled Payment Demonstration." Health Aff (Millwood) 33(8): 1345-1352.

Key Takeaways:

- ✓ Experts suggest that providers should be well-versed in risk contracting, particularly down-side risk, when negotiating financial targets and considering patient populations in a risk arrangement.
- ✓ For two-sided risk arrangements, provider organizations must ensure there will be enough covered lives in an APM to balance risk and create adequate volume.
- ✓ Negotiating APM contracts is difficult and sensitive to change, particularly as FFS siloed structures continue to exist.

Benchmarking

Benchmarking methodologies are significant for determining whether providers achieve savings in value-based payment initiatives, and providers often cite flawed benchmarking strategies as a challenge.

Promising Practices:

Payment models commonly use either historical benchmarks based on a provider’s own past spending or regional benchmarks focused on expenditure levels in a specific geographic area. Historical benchmarks encourage providers with higher baseline spending to participate in value-based payment initiatives, as high-cost organizations find it easier to achieve savings relative to their own prior performance.^{15,16,17,18,19}

APM designers may move to more expenditure-based benchmarks in an APM’s service area to balance incentives among high- and low-efficiency organizations and encourage more savings. Researchers at Harvard Medical School suggest that APMs transitioning from historical to more regionally based

¹⁵ McWilliams, J. M., Chernew, M. E., et al. (2015). "Performance Differences in Year 1 of Pioneer Accountable Care Organizations." N Engl J Med 372(20): 1927-1936.

¹⁶ McWilliams, J. M., Hatfield, L. A., et al. (2016). "Early Performance of Accountable Care Organizations in Medicare." N Engl J Med 374(24): 2357-2366.

¹⁷ Saunders, R., Muhlestein, D, McClellan, M. (2017). "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time." The Health Affairs Blog. Health Affairs. Accessed at <https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171120.211043&format=full&> on July 19, 2018.

¹⁸ MedPAC. (2018). [Status report on Medicare Accountable Care Organizations](#). (Transcript of presentation by MedPAC staff, pp. 136-184).

¹⁹ United States Department of Health and Human Services, Office of the Inspector General. (2017). "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reduced Spending and Improving Quality." Available at: <https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf>

benchmarking methodologies must do so gradually, as rapid transition may cause providers with higher baseline spending to drop out of value-based initiatives, particularly in two-sided risk contracts.²⁰ Gradual transition to regional benchmarks could help preserve the participation of higher-spending APMs, as could methods to address how the historical component of the benchmark is rebased during the conversion.²¹

The researchers also propose that incorporating patient-reported survey measures into regional benchmarking could strengthen risk adjustment and help distinguish changes in case-mix from changes in coding practices. In benchmarking, there is an incentive to “upcode” to make a patient population appear sicker than it is, in order to set an artificially higher benchmark; higher benchmarks, particularly inflated ones, are easier to create savings against. Although regional benchmarks are adjusted for attributed populations based on the Hierarchical Condition Category (HCC) model, which predicts spending based on diagnosis codes supplied by providers, they could be adjusted further by using health measures from the Consumer Assessment of Healthcare Providers and Systems survey.²² An increase in HCC scores without an accompanying increase in patient reports of worsening health status could signal upcoding.²³ This approach could mitigate these adverse incentives. The value of accurate HCC coding was confirmed by providers interviewed, who noted that dedicated efforts to accurately code and audit HCC codes is a best practice for achieving success on cost metrics.

Challenges:

Stakeholders observed that historical benchmarks in oncology may discourage providers from using high-cost, novel therapies that may increase spend against prior years’ benchmarks, when novel therapies were not available for use.²⁴ Researchers emphasize that while novel therapies may initially increase spending, they could also reduce downstream costs of care (e.g., hospital, emergency department use). The Innovation Center’s Oncology Care Model (OCM) incorporates a novel therapy adjustment, which in certain cases (e.g., FDA-approved use) can raise a benchmark so as not to discourage novel therapy use.²⁵

²⁰ Rose, S., Zaslavsky, A. M., et al. (2016). "Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking." *Health Aff (Millwood)* 35(3): 440-448.

²¹ Ibid.

²² Ibid.

²³ Rose, S., Zaslavsky, A. M., et al. (2016). "Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking." *Health Aff (Millwood)* 35(3): 440-448.

²⁴ Muldoon, L. D., Pelizzari, P. M., et al. (2018). "Assessing Medicare's Approach to Covering New Drugs in Bundled Payments for Oncology." *Health Aff (Millwood)* 37(5): 743-750.

²⁵ Ibid.

Key Takeaways

- ✓ APM benchmarking methodologies are a significant factor in achieving provider savings.
- ✓ Regional benchmarking may cause high-cost providers to drop out of APM initiatives, so transitioning away from historical benchmarks must be done gradually.

Attribution

Attribution is a multifaceted APM design component requiring decisions about differing methodologies, such as whether patients are attributed on a prospective or retrospective basis and which types of clinicians have patients attributed to them.

Promising Practices:

Several sources, including a set of recommendations by a HCP-LAN multi-stakeholder work group, supported the need for providers to know the patients for whose care they will be accountable. Stakeholders stressed the importance of knowing this information at the beginning of the performance period, with updates provided monthly.²⁶ Providers interviewed expressed concern that payers may be unwilling or unable to share attribution information, such as in APMs with retrospective attribution.

According to the HCP-LAN, the best approach for patient attribution is a patient’s voluntary, self-reported choice of a primary care provider. This is because patient choice encourages patient engagement, and because primary care providers leading the coordination of care within an APM are often held accountable for managing patient and financial outcomes. According to some stakeholders, patient selection combined with certain benefit designs may also be an effective way to drive care within an APM and keep patients in the network, as “patient leakage” can be a significant issue for providers participating in an APM. When it is not possible to obtain patient selections, the HCP-LAN recommended using a claim- or encounter-based approach that prioritizes primary care physicians. Patients should only be attributed to specialists if it is not possible to definitively identify a primary care provider via retrospective claims and encounters approaches.²⁷ Regardless of which method is used, the HCP-LAN advises that patients should have information about the providers to whom they are attributed, and APM designers should strive to use the same attribution approach for cost and quality performance assessments and align attribution approaches across models in different lines of business.²⁸

²⁶ The MITRE Corporation (HCP-LAN). (2016). “Accelerating and Aligning Population-based Payment Models: Patient Attribution.” Available at: <http://hcp-lan.org/workproducts/pa-whitepaper-final.pdf>

²⁷ Ibid.

²⁸ Ibid.

Challenges:

Some stakeholders raised concerns that there may be cases in which a primary care physician is accountable for a patient whose health outcomes are more likely affected by specialty care. Some providers told the HCP-LAN they support using retrospective attribution methods to attribute patients to specialists they see more often than their primary care physician. Compared to prospective attribution or retrospective attribution to primary care providers, this approach could better ensure providers are held accountable for patients they see often enough to impact health outcomes.

Key Takeaways:

- ✓ Providers should understand attribution and have an awareness of the patients for whom they are accountable.
- ✓ Opinions varied regarding whether patients should be attributed to primary care physicians versus specialists seen more often.
- ✓ Patient selection of primary care providers is an attribution method that could improve patient engagement.

Effective Quality Performance Measurement Systems

APMs need effective performance measurement systems to accurately assess the quality of care that providers deliver and must establish clear incentives for providers to deliver high quality care.

Promising Practices:

The HCP-LAN's [white paper](#) on performance measurement in population-based payment models offers a central recommendation to use measures to “address overall system performance and be oriented increasingly toward assessment of outcomes, not the processes used to produce them.”²⁹ The Measure Applications Partnership (MAP) convened by the National Quality Forum (NQF) similarly recognizes the need to “ensure that measurement approaches promote quality across the care continuum” and to focus on high-value measures including outcome measures.³⁰

In the interest of reducing provider burden and confusion associated with conflicting or misaligned measures used by different payers, the HCP-LAN and others recommend using and aligning existing core sets, such as those developed by the International Consortium for Health Outcomes

²⁹ The MITRE Corporation (HCP-LAN). (2016). “Accelerating and Aligning Population Based Payment Models: Performance Measurement.” Available at: <http://hcp-lan.org/workproducts/pm-whitepaper-final.pdf>

³⁰ National Quality Forum. (2017). “Measure Applications Partnership: Maximizing the Value of Measurement: MAP 2017 Guidance, Final Report.” Available at: https://www.qualityforum.org/Publications/2017/03/Maximizing_the_Value_of_Measurement_MAP_2017_Guidance.aspx

Measurement.^{31,32,33} Additionally, some initiatives offer flexible reporting to allow providers to focus on measures most relevant to their patient populations.³⁴ In stakeholder discussions, patient advocates emphasized the need for patient-reported outcome measures (such as tools from the [Patient Reported Outcomes Measurement Information System](#)) as well as stronger communication, shared decision-making, and safety measures. CMS has established a [Meaningful Measures](#) framework to identify high-priority and impactful quality measurement areas and promote alignment across public and private initiatives. Thus, APMs may consult the Meaningful Measures framework as a resource to help identify and select individual measures.

Choosing measures based on sound measurement and implementation science is seen as an important element of effective performance systems. The MAP suggests that the NQF endorsement process plays an important role in evaluating a measure's evidence base, reliability, validity, feasibility, and usability.³⁵ As a best practice for quality measurement, the HCP-LAN recommends robust measure testing on increasingly large samples of providers, with model developers incrementally adjusting measure specifications in light of data collected. Similarly, the Alliance of Community Health Plans (ACHP) notes that working with physicians to tailor measure specifications and establishing measure sets that reflect provider goals are important practices for ensuring that measurement systems accurately assess provider performance.³⁶ Some researchers also suggest that model designers may want to consider risk adjusting for patient socioeconomic characteristics as one way to encourage participation of providers with high proportions of minority patients.³⁷

HCP-LAN recommendations include establishing absolute measure targets (as opposed to relative targets) to give providers a clear sense of expected achievement levels and using a range of scores and a corresponding range of incremental payment adjustments instead of a single performance target.³⁸

³¹ The MITRE Corporation (HCP-LAN). (2016). "Accelerating and Aligning Population Based Payment Models: Performance Measurement." Available at: <http://hcp-lan.org/workproducts/pm-whitepaper-final.pdf>

³² Arkansas Center for Payment Improvement. (2017). "Arkansas Health Care Payment Improvement Initiative. 3rd Annual Statewide Tracking Report." Available at: <http://www.achi.net/pages/OurWork/Project.aspx?ID=112>

³³ Takach, M., Townley, C., et al. (2015). "Making Multi-payer Reform Work: What Can Be Learned from Medical Home Initiatives." *Health Aff (Millwood)* 34(4): 662-672.

³⁴ Ibid.

³⁵ National Quality Forum. (2017). "Measure Applications Partnership: Maximizing the Value of Measurement: MAP 2017 Guidance, Final Report." Available at: https://www.qualityforum.org/Publications/2017/03/Maximizing_the_Value_of_Measurement_MAP_2017_Guidance.aspx

³⁶ Alliance of Community Health Plans. (2016). "Rewarding High Quality: Practical Models for Value-Based Physician Payment." Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

³⁷ Lewis, V., et al. (2017). "ACOs Serving High Proportions of Racial and Ethnic Minorities Lag in Quality Performance." *Health Aff (Millwood)* 36(1): 57-66.

³⁸ The MITRE Corporation (HCP-LAN). (2016). "Accelerating and Aligning Population Based Payment Models: Performance Measurement." Available at: <http://hcp-lan.org/workproducts/pm-whitepaper-final.pdf>

This approach is similar to the one used by the Arkansas Health Care Payment Improvement Initiative (AHCPII), which makes provider participation contingent on meeting a series of quality and utilization targets over time.³⁹

Challenges:

Both the MAP and the HCP-LAN point to the problem of significant measure gaps, although the HCP-LAN concludes that existing quality measures are sufficient to initiate providers' transitions to population-based payment models,⁴⁰ and has provided recommendations on how to expedite the development of meaningful outcome measures.⁴¹ Relatedly, the lack of provider infrastructure to collect and report rich clinical and patient-reported data constitutes a significant challenge to measure development and implementation.⁴²

Key Takeaways:

- ✓ Quality measure sets should generally be aligned across payers to the extent possible to alleviate provider burden and should include outcome measures.
- ✓ Quality measures should be well-tested for reliability and validity.
- ✓ Stakeholders suggest that health plans should work with providers and patients to establish quality measure sets, and that measures should reflect provider and patient goals.
- ✓ Both the lack of availability of certain outcome measures and lack of effective performance measurement infrastructure present challenges to quality measure development and implementation.

³⁹ Arkansas Center for Payment Improvement. (2017). "Arkansas Health Care Payment Improvement Initiative. 3rd Annual Statewide Tracking Report." Available at: <http://www.achi.net/pages/OurWork/Project.aspx?ID=112>

⁴⁰ The MITRE Corporation (HCP-LAN). (2016). "Accelerating and Aligning Population Based Payment Models: Performance Measurement." Available at: <http://hcp-lan.org/workproducts/pm-whitepaper-final.pdf>

⁴¹ Ibid.

⁴² Ibid.

High-Value Networks and Partnerships

One of the primary goals of health care payment and delivery reform efforts is to reduce silos of care and incentivize integration across settings.

Promising Practices:

Providers emphasize that high-value networks comprised of hospitals, specialists, behavioral health providers, and post-acute care providers are needed to effectively coordinate care in APM arrangements.⁴³ While establishing an adequate network may remain the health plan’s role, creating partnerships with high-value organizations and promoting effective communication and coordination within the network is seen as a role for providers.

A key focus in many APMs has been to identify and integrate high-value, low-cost post-acute care providers into the APM network. High-performing ACOs have touted meaningful partnerships with skilled nursing facilities (SNFs),⁴⁴ and partnerships with low-cost, high-quality post-acute care providers are critical for driving down per-episode costs in bundled payments.⁴⁵ High-performing ACOs may use performance on quality measures as an important consideration when establishing network arrangements and deciding which providers will be part of the ACO.⁴⁶ Some hospitals also report tracking quality and utilization outcomes of post-acute providers and analyzing data for potential business arrangements and referrals.⁴⁷ Other APMs have partnered with post-acute care providers to better monitor patient care after transitions, such as sending care managers to round in post-acute care facilities. A majority of Next Generation ACOs (NGACOs) used evidence-based transition protocols (e.g., Coleman model, Project Re-Engineered Discharge, or Project Better Outcomes by Optimizing Safe Transitions) to improve coordination with post-acute care providers.⁴⁸

Some research supports the concept that reducing post-acute care spending, and specifically decreasing or shifting spending away from institutional care, can drive savings. Researchers found that

⁴³ Damor, J. and Hardaway, B. (2017). “Ready, Risk, Reward: Building Successful Two-Sided Risk Models.” Premier Inc. Available at: <https://learn.premierinc.com/white-papers/building-successful-two-sided-risk-models-premier-inc>.

⁴⁴ Health Care Transformation Task Force. (2017). “Levers of Successful ACOs: Insights from the Health Care Transformation Task Force.” Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

⁴⁵ Hiller, M., Ireton, B. et al. (2018). “Ready, Risk, Reward: Keys to Success in Bundled Payments.” Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>

⁴⁶ Health Care Transformation Task Force. (2017). “Levers of Successful ACOs: Insights from the Health Care Transformation Task Force.” Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

⁴⁷ RTI International. (2018). “Evaluation of the Maryland All-Payer Model: Third Annual Report.” Available at: <https://downloads.cms.gov/files/cmmt/md-all-payer-thirdannrpt.pdf>

⁴⁸ NORC at the University of Chicago. (2018). “Next Generation Accountable Care Organization Model Evaluation First Annual Report.” Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

reductions in SNF spending in the Medicare Shared Savings Program (MSSP) were due to lower use of inpatient care, fewer discharges to SNFs, and shorter SNF stays. They note, however, that “[s]pending reductions were more consistent with clinicians working within hospitals and SNFs to influence care for ACO patients than with hospital-wide initiatives by ACOs or use of preferred SNFs.”⁴⁹

Purchasers are also working directly with providers to build high-value networks. Employers have noted that this relationship can be particularly beneficial, as employers may have aligned incentives to keep employees healthy and to eliminate wasteful health care services. Employers have contracted directly with Centers of Excellence (COEs) to deliver better cost and quality outcomes, funding investments in infrastructure and paying fixed rates to perform a given procedure. COEs may improve employee satisfaction by simplifying billing and paperwork, providing concierge services, and reducing out-of-pocket expenses (e.g., waiving deductible and out-of-pocket costs). Employers have used benefit design to incentivize the utilization of COEs, but should recognize that employees’ willingness and ability to travel can diminish their use of COEs.

Challenges:

In rural areas, post-acute care resources can be limited.⁵⁰ Thus, while partnering with post-acute care organizations may be feasible, some areas still struggle with lack of post-acute care beds from the outset.

Key Takeaways:

- ✓ Payers and providers see a need to establish high-value networks to coordinate care and drive savings through reduced and/or more efficient utilization.
- ✓ A common practice is identifying and integrating high-value post-acute care providers into the APM network.
- ✓ Purchasers can work directly with providers to build high-value networks through Centers of Excellence (COEs), and by incorporating benefit designs.

⁴⁹ McWilliams, J. M., Gilstrap, L. G., et al. (2017). "Changes in Postacute Care in the Medicare Shared Savings Program." JAMA Internal Medicine 177(4): 518-526.

⁵⁰ RTI International. (2018). "Evaluation of the Maryland All-Payer Model: Third Annual Report." Available at: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

APM Implementation Strategies

Stakeholders highlighted strong leadership, robust health information technology capacity, enhanced care coordination, continuous quality improvement, physician engagement, and patient-centeredness as some of the most important focus areas in APM implementation.

Leadership & Culture

The research suggests that an essential building block for successful payment and care delivery transformation is the presence of strong, committed health plan and provider leaders, particularly those who can build trust with one another and with front-line practitioners.

Promising Practices:

The literature discussed leadership at both payer and provider organizations. For health plans, researchers suggest there are benefits when leaders take a broad view of reform, encompassing the full care continuum rather than focusing on individual settings.⁵¹ Experts underscore the need for health plan leaders to understand their roles in assisting providers with practice transformation, particularly through infrastructure support and the sharing of relevant, actionable data.⁵²

For delivery system leaders, including hospital and ACO leadership, commitment to value-based reform is seen as essential. The Health Care Transformation Task Force (HCTTF) emphasizes the need for leaders to promote an organizational culture committed to transformation, noting that “[h]aving a high-value culture means that all levels of the organization – particularly the leadership – demonstrate an internally-motivated commitment to excellent patient outcomes (quality) that are achieved at the lowest possible cost.”⁵³ Survey and case study information from commercial health plans show that some payers evaluate providers’ commitments to care delivery transformation as part of selection criteria for accountable care contracts.⁵⁴

Through their work with APM participants, HCTTF and Premier Inc. see the value of leaders who work to align incentives, measures, and governance structures across multiple APM contracts; include

⁵¹ Maeng, D. D., Khan, N., et al. (2015). "Reduced Acute Inpatient Care Was Largest Savings Component of Geisinger Health System's Patient-Centered Medical Home." *Health Aff (Millwood)* 34(4): 636-644.

⁵² Beckman, H., Healey, P., et al. (2015). "Improving Partnerships Between Health Plans and Medical Groups." *The American Journal of Managed Care* 21(9): 647-650.

⁵³ Health Care Transformation Task Force. (2017). "Levers of Successful ACOs: Insights from the Health Care Transformation Task Force." Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

⁵⁴ Higgins, A., Stewart, K., et al. (2016). "Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?" *The American Journal of Accountable Care* 4(1): 43-46.

patients in redesigning care; and involve practitioners in planning implementation projects.^{55 56} Additionally, program staff at the Commonwealth Fund suggest that delivery system leaders should work to establish a culture in which medical professionalism is valued and physicians have autonomy to treat patients according to their individual needs and goals.⁵⁷

Payers expressed that a value-oriented culture can grow organically, from the bottom up, in provider organizations. Giving physicians an ownership stake and a vote in their provider organizations instills the sense that “everyone is in it together.” Establishing term limits for provider organization leadership positions can encourage new ideas, and creating leadership training programs helps emerging physician leaders develop practice management capabilities.

Challenges:

In interviews, some stakeholders indicated that leaders of provider organizations are still reluctant to move away entirely from FFS models and need to understand that the transition to value-based care is not only desirable, but necessary. These stakeholders believe that, at least in Medicare, fee schedule updates will be flat at a time when operating expenses are increasing. Unless leaders move provider organizations to population-based payment models and eliminate unnecessary waste in unmanaged environments, providers will see smaller profit margins.

Key Takeaways:

- ✓ Strong leadership is critical to developing a value-oriented culture for APMs to be successful.
- ✓ Stakeholders note that leaders in payer and provider organizations need to recognize that the move to value-based payments is not only desirable, but necessary.
- ✓ While leadership and culture may be developed from the top-down, there are several bottom-up approaches to develop culture within a provider organization.

⁵⁵ Health Care Transformation Task Force. (2017). “Levers of Successful ACOs: Insights from the Health Care Transformation Task Force.” Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

⁵⁶ Damor, J. and Hardaway, B. (2017) “Ready, Risk, Reward: Building Successful Two-Sided Risk Models.” Premier Inc. Available at: <https://learn.premierinc.com/white-papers/building-successful-two-sided-risk-models-premier-inc>.

⁵⁷ Hall, D. and Zezza, M. (2014). “Developing an Incentives Playbook: Aligning Influences in the Era of Reform.” The American Journal of Accountable Care 2(3): 42-45.

Health Information Technology

Technology Readiness and Functionality

As payers and providers shift toward value-based operations, expectations about the role of technology remain high.

Promising Practices:

Stakeholders emphasize the importance of provider technology readiness at the beginning of APM participation. For example, some health plans report using provider health information technology (HIT) capabilities, such as EHRs, disease registries, and meaningful use competencies, as eligibility criteria for accountable care partnerships.⁵⁸ Because the adoption of EHRs and other technology changes have disruptive potential and may prevent providers from focusing on improved patient care,^{59,60} there can be value in having EHRs already in place as transformation commences.

Providers need HIT to serve multiple functions, such as performing analytics to identify high-risk patients, supporting information exchange across care teams, and tracking patient utilization to inform care redesign and care delivery.^{61,62} Many providers are enhancing EHRs to incorporate order sets, protocols, visit templates, and evidence-based guidelines to improve the consistency of care.^{63,64,65} APMs also use EHRs to monitor provider performance and have indicated that sharing data on individual performance may influence provider behavior. For example, NGACOs primarily track financial, utilization, patient satisfaction, and practice-based quality data. Typically, financial, utilization, and population health data are tracked monthly, with patient satisfaction generally tracked

⁵⁸ Higgins, A., Stewart, K., et al. (2016). "Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?" *The American Journal of Accountable Care* 4(1): 43-46.

⁵⁹ Friedberg, M. W., Rosenthal, M. B., et al. (2015). "Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care." *JAMA Internal Medicine* 175(8): 1362-1368.

⁶⁰ Dorr, D.A., Cohen, D.J., and Adler-Milstein, J. (2018). "Data-Driven Diffusion of Innovations: Successes And Challenges In 3 Large-Scale Innovative Delivery Models." *Health Affairs* Vol. 37 NO. 2 (2018): 257-265.

⁶¹ The Lewin Group. (2017). "Comprehensive End Stage Renal Disease Care (CEC) Model, Performance Year 1 Annual Evaluation Report." Available at: <https://innovation.cms.gov/Files/reports/cec-annrpt-py1.pdf>

⁶² L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

⁶³ Hiller, M., Ireton, B. et al. (2018). "Ready, Risk, Reward: Keys to Success in Bundled Payments." Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>.

⁶⁴ Mostashari, F. and Broome, T. (2016). "The Opportunities and Challenges of the MSSP ACO Program: A Report from the Field." *Am J Manag Care* 22(9): 564-568.

⁶⁵ The Lewin Group. (2017). "Comprehensive End Stage Renal Disease Care (CEC) Model, Performance Year 1 Annual Evaluation Report." Available at: <https://innovation.cms.gov/Files/reports/cec-annrpt-py1.pdf>

annually. NGACOs noted that sharing data with providers through dashboards is often integrated into the EHR.⁶⁶ A majority of NGACOs reported using claims and electronic clinical data, and reported integrating, on average, six to seven types of data, including Medicare claims, pharmacy, primary care, laboratory, and specialty care data. They also incorporated state or disease registry data and/or patient-reported data. Several NGACOs attributed improved care coordination and chronic disease management to HIT capabilities.⁶⁷

Challenges:

Stakeholders report that many EHRs have functional limitations. In the Comprehensive Primary Care Initiative (CPCI) evaluation, for example, some practices reported that EHRs were limited in their ability to support care plans and care management.⁶⁸ Additionally, providers report difficulty in extracting and sharing data or generating reports.⁶⁹

Data Sharing

Adopting new ways of sharing data is considered foundational for the success of APMs, especially in population-based payment models.

Promising Practices:

Stakeholders suggest payers and providers should work together to align and document data sharing efforts and policies in ways that support alternative payment.⁷⁰ In addition, the HCP-LAN recommends that patient-level data should “follow the patient, which requires payers and providers to collaborate on patient identifiers.”⁷¹

The background research also identified several types of information that can be particularly helpful to share with providers, including detailed claims and eligibility data and information about patient

⁶⁶ NORC at the University of Chicago. (2018). “Next Generation Accountable Care Organization Model Evaluation First Annual Report.” Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

⁶⁷ Ibid.

⁶⁸ Mathematica Policy Research. (2018). “Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report.” Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

⁶⁹ Dorr, D.A., Cohen, D.J., and Adler-Milstein, J. (2018). “Data-Driven Diffusion of Innovations: Successes And Challenges In 3 Large-Scale Innovative Delivery Models.” *Health Affairs* Vol. 37 NO. 2 (2018): 257-265.

⁷⁰ The MITRE Corporation (HCP-LAN). (2016). “Accelerating and Aligning Population-based Payment Models: Data Sharing.” Available at: <https://hcp-lan.org/workproducts/ds-whitepaper-final.pdf>

⁷¹ Ibid.

utilization;^{72,73} longitudinal member records;⁷⁴ continual information on attributed populations;⁷⁵ and patient satisfaction and clinical outcomes measures.⁷⁶ Several resources indicate that health plans recognize the need to provide data in actionable formats, such as providing predictive analytics to identify potential at-risk or high-risk patients;⁷⁷ information that allows clinicians to accurately compare their actions and performance to peers and vetted guidelines;⁷⁸ reports on “hot spotters,”⁷⁹ and suggestions for how to make actionable changes.⁸⁰ In the Comprehensive End Stage Renal Disease (ESRD) Care model, participants report that new software allows them “to rapidly identify available dialysis chairs and reschedule appointments and to manage non-ESRD chronic diseases, to track patient hospitalizations, and to access hospital discharge summaries.”⁸¹

Some health plans are helping providers learn how to use the data they share. For example, providers in Anthem’s Enhanced Personal Health Care Program receive customized help from “transformation teams” that teach them to interpret and use the data to improve care.⁸² CPCI and Comprehensive Primary Care Plus (CPC+) participants report that receiving tailored assistance with data and reporting,

⁷² Hiller, M., Ireton, B. et al. (2018). “Ready, Risk, Reward: Keys to Success in Bundled Payments.” Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>.

⁷³ Friedberg, M. W., Rosenthal, M. B., et al. (2015). “Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care.” *JAMA Internal Medicine* 175(8): 1362-1368.

⁷⁴ Anthem Public Policy Institute. (2016). “Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment.” Available at: https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19l/mjq0/~edisp/pw_e244942.pdf

⁷⁵ Higgins, A., Stewart, K., et al. (2016). “Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?” *The American Journal of Accountable Care* 4(1): 43-46.

⁷⁶ Alliance of Community Health Plans. (2016). *Rewarding High Quality: Practical Models for Value-Based Physician Payment*. Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

⁷⁷ Higgins, A., Stewart, K., et al. (2016). “Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?” *The American Journal of Accountable Care* 4(1): 43-46.

⁷⁸ Beckman, H., Healey, P., et al. (2015). “Improving Partnerships Between Health Plans and Medical Groups.” *The American Journal of Managed Care* 21(9): 647-650.

⁷⁹ Anthem Public Policy Institute. (2016). “Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment.” Available at: https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19l/mjq0/~edisp/pw_e244942.pdf

⁸⁰ Beckman, H., Healey, P., et al. (2015). “Improving Partnerships Between Health Plans and Medical Groups.” *The American Journal of Managed Care* 21(9): 647-650.

⁸¹ The Lewin Group. (2017). “Comprehensive End Stage Renal Disease Care (CEC) Model, Performance Year 1 Annual Evaluation Report.” Available at: <https://innovation.cms.gov/Files/reports/cec-annrpt-py1.pdf>

⁸² Anthem Public Policy Institute. (2016). “Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment.” Available at: https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19l/mjq0/~edisp/pw_e244942.pdf

including online technical assistance, was helpful as they began to use data more regularly.⁸³ The concept of providing timely feedback is viewed as important to helping providers implement changes more rapidly to reach quality and utilization goals.⁸⁴ Additionally, multi-stakeholder collaboratives may address some of the challenges associated with EHR infrastructure and data sharing, but interviewees reported that the lack of trust in the accuracy of data, and how it will be used (e.g., to calculate measure scores), has been a barrier to establishing collaboration on EHR infrastructure.

Challenges:

NGACOs reported that gaining access to data outside their networks, interoperability within the networks, and HIT costs were significant challenges.⁸⁵ Service vendors interviewed suggest that data is difficult to standardize and store in data warehouses, and that minor changes to data formats have significant downstream impacts on data quality.

Technical assistance was viewed as one way to overcome some challenges; however, the lack of timely and complete data continues to be an issue, even with intensive use of HIT and performance measurement.^{86,87} In interviews, providers repeatedly raised concerns about the reluctance of payers to share data. They believe that payers' inclination to treat data as proprietary is attributable to historical mistrust between payers and providers, and the historical use of this data to negotiate rates. Providers indicated that truncated claims data and reports run from payers' systems are insufficient for effective care management. Other stakeholders have mentioned an unwillingness of vendors to provide standardized clinical data or make necessary technical changes for efficient quality reporting^{88,89} and reluctance of hospitals to send data to Health Information Exchanges (HIEs).⁹⁰

⁸³ Dorr, D.A., Cohen, D.J., and Adler-Milstein, J. (2018). "Data-Driven Diffusion of Innovations: Successes And Challenges In 3 Large-Scale Innovative Delivery Models." *Health Affairs* Vol. 37 NO. 2 (2018): 257-265

⁸⁴ Friedberg, M. W., Rosenthal, M. B., et al. (2015). "Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care." *JAMA Internal Medicine* 175(8): 1362-1368.

⁸⁵ NORC at the University of Chicago. (2018). "Next Generation Accountable Care Organization Model Evaluation First Annual Report." Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

⁸⁶ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

⁸⁷ Dorr, D.A., Cohen, D.J., and Adler-Milstein, J. (2018). "Data-Driven Diffusion of Innovations: Successes And Challenges In 3 Large-Scale Innovative Delivery Models." *Health Affairs* Vol. 37 NO. 2 (2018): 257-265.

⁸⁸ Mostashari, F. and Broome, T. (2016). "The Opportunities and Challenges of the MSSP ACO Program: A Report from the Field." *Am J Manag Care* 22(9): 564-568.

⁸⁹ Perla, R.J., Pham, H., et al. (2018). "Government As Innovation Catalyst: Lessons From The Early Center For Medicare And Medicaid Innovation Models." *Health Affairs* 37(2): 213-221.

⁹⁰ Mostashari, F. and Broome, T. (2016). "The Opportunities and Challenges of the MSSP ACO Program: A Report from the Field." *Am J Manag Care* 22(9): 564-568.

Additionally, researchers have noted “exaggerated” concerns about patient privacy and confidentiality security requirements as barriers to communication.⁹¹

Key Takeaways:

- ✓ Health information technology is critical for providers to manage population health and succeed in APMs.
- ✓ Payers and providers need to work together to establish EHR infrastructure and data sharing mechanisms across all providers, and to address common challenges (e.g., lack of actionable, timely, and complete data).

Care Coordination

Across APMs, health plans and providers have incorporated care coordination as a major focus of activity, viewing it as a crucial strategy for improving quality and patient experience while reducing costs.

Promising Practices:

Health plans report offering critical technical assistance to providers in the areas of care transitions at discharge, COE referrals, and disease management.⁹² Provider organizations, in turn, are hiring nurses, social workers, and other staff to perform these and other activities⁹³, sometimes as part of a multi-disciplinary care management team. Some APMs, including most NGACOs, have a centralized staff for care management that supports participating providers across the organization.⁹⁴

One of the most common care coordination functions within APMs is identifying potentially high-risk or clinically vulnerable patients, often through risk models that stratify patients using claims, clinical, and utilization data. Multiple stakeholders noted the importance of using care navigators to connect high-risk patients to services and incorporating socioeconomic status and behavioral health data into

⁹¹ Dorr, D.A., Cohen, D.J., and Adler-Milstein, J. (2018). "Data-Driven Diffusion of Innovations: Successes And Challenges In 3 Large-Scale Innovative Delivery Models." Health Affairs Vol. 37 NO. 2 (2018): 257-265.

⁹² Higgins, A., Stewart, K., et al. (2016). "Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?" The American Journal of Accountable Care 4(1): 43-46.

⁹³ The research identified many different types of provider activities related to care coordination, including developing comprehensive care plans across the continuum of care; education patients about avoidable risks; monitoring compliance with treatment; reviewing medications to prevent adverse events; addressing non-medical needs of patients, such as housing and transportation; revamping discharge processes, enhancing telemedicine services; routinely reviewing new information received about patients; and engaging patients in end-of-life care coordination or discussion about advanced directives.

⁹⁴ NORC at the University of Chicago. (2018). "Next Generation Accountable Care Organization Model Evaluation First Annual Report." Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

clinical processes and programs. Providers also noted the importance of targeted interventions for patients who are on trajectories to becoming the highest need or most costly, versus those already there. Some researchers caution, however, that predicting who will be high-cost can be erroneous.⁹⁵

One key APM success theme that emerged out of provider interviews is the importance of payers helping less advanced providers by supporting care management infrastructure, performance improvement programs, and patient-centric activities. More advanced provider organizations may be more capable of integrating and delivering care management functions. Providers with more experience in population health management, for example, suggested that these activities are best accomplished by providers (who are closer to patients), and that it is counterproductive for payers to perform these functions on behalf of advanced providers. These providers recommended that payers divide financial responsibility agreements to transfer these functions, and the associated administrative dollars, to advanced providers. They noted payer reluctance to relinquish administrative dollars for care management programs as a barrier to APM implementation.

The level of evidence about care coordination as a correlate of APM success is limited and varies across sources. In an evidence review of the impact of care models designed for patients with complex health needs, The Commonwealth Fund found mixed results, although there are indications of improved quality in some models.⁹⁶ An evaluation of the Pioneer ACO model found that the presence of the embedded care manager in the clinic setting was associated with better Group Practice Reporting Option quality performance.⁹⁷ It also found, however, that using claims and EHRs as ways to target individuals needing care management was associated with lower preventive care scores.⁹⁸ CPCI evaluators found an association between practices reporting more timely primary care follow-up after acute care and lower hospitalization rates.⁹⁹

⁹⁵ McWilliams, J. M. and Schwartz, A. L. (2017). "Focusing on High-Cost Patients - The Key to Addressing High Costs?" N Engl J Med 376(9): 807-809.

⁹⁶ The Commonwealth Fund. (2015). "Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis." Available at: https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2015_oct_1843_mccarthy_models_care_high_need_high_cost_patients_ib.pdf

⁹⁷ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

⁹⁸ Ibid.

⁹⁹ Mathematica Policy Research. (2018). "Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report." Available at: <https://downloads.cms.gov/files/cmmi/CPC-initiative-fourth-annual-report.pdf>

Challenges:

Given the heavy emphasis on care coordination, care managers often perform numerous duties and may become overwhelmed, leading to turnover.¹⁰⁰ To support care managers, some APM participants have monitored caseloads, clarified staff roles, added staff, and allowed care coordinators at different locations within a system to meet and compare notes regularly.¹⁰¹

In many APMs, care coordinators reach out to patients after discharge. Some hospitals report that patients can be reluctant to respond to outreach efforts if they believe a follow-up call is about collecting money.¹⁰² Hospitals and primary care practices also indicate that patients can be contacted by multiple coordinators from different provider organizations, leading to patient frustration.^{103,104} Other barriers to effective care transitions include patients' inability to afford skilled nursing care, or their lack of adequate support systems or places to go.¹⁰⁵ Furthermore, it can be difficult to coordinate care when beneficiaries seek care from providers outside the APM network.¹⁰⁶

Some health care leaders have expressed concern about their abilities to adequately quantify the return on investment for care management.¹⁰⁷ Several researchers, too, are skeptical of the role of care coordination as a major driver of savings in the Medicare Shared Savings Program, at least as it pertains to cost reduction and utilization. Findings of a 2017 study analyzing MSSP data suggest that "early savings in the Medicare Shared Savings Program have not accrued in the areas that would be expected if they were driven by care management for high-risk patients and prevention of hospitalizations for ambulatory care-sensitive conditions or hospitalizations in general."¹⁰⁸ Researchers have also questioned whether focusing on high-cost patients is as valuable as reducing low-volume services.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

¹⁰² RTI International. (2018). "Evaluation of the Maryland All-Payer Model: Third Annual Report." Available at: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

¹⁰³ Ibid.

¹⁰⁴ Mathematica Policy Research. (2018). "Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report." Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

¹⁰⁵ RTI International. (2018). "Evaluation of the Maryland All-Payer Model: Third Annual Report." Available at: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

¹⁰⁶ NORC at the University of Chicago. (2018). "Next Generation Accountable Care Organization Model Evaluation First Annual Report." Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

¹⁰⁷ Health Care Transformation Task Force. (2017). "Lever of Successful ACOs: Insights from the Health Care Transformation Task Force." Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeverofSuccessfulACOs6.pdf>

¹⁰⁸ McWilliams, J. M., Chernew, M. E., et al. (2017). "Medicare ACO Program Savings Not Tied to Preventable Hospitalizations or Concentrated Among High-Risk Patients." *Health Aff (Millwood)* 36(12): 2085-2093.

One policy expert from Harvard Medical School emphasizes that care coordination has not been proven to lower costs, believing that the lack of savings is due (in part) to the fact that care coordination corrects underuse, and that care coordination itself is costly.¹⁰⁹ At the same time, however, the expert stresses a belief that care coordination represents better care, and suggests it meaningfully improves patient experience.¹¹⁰

Key Takeaways:

- ✓ Health plans and providers indicate that care coordination is a crucial strategy for reducing costs and improving quality and patient experience, though evidence is still emerging.
- ✓ Both the literature and interviews describe strategies for coordinating care, including identifying high-risk patients, developing comprehensive care plans, patient engagement, and communication across providers.
- ✓ While some providers note that payer support and technical assistance in this area can be critical for APM success, other more advanced providers may prefer to manage care coordination functions.
- ✓ Some researchers have voiced skepticism toward the return on investment of care coordination infrastructure.

Continuous Quality Improvement

To move toward value-based payment, provider organizations will need the infrastructure, knowledge, and training to support quality improvement. This includes recruiting, training, and retaining dedicated staff to perform data analytics as well as dedicated staff for performance improvement.

Promising Practices:

In many high-performing ACOs examined by the HCTTF, data analysts worked closely with quality improvement professionals to identify opportunities to improve their quality measures and worked with clinical teams to redesign work flows to improve performance. Dedicated quality improvement staff serve to identify high-priority measures that are associated with positive patient outcomes, and to develop dashboards so that physician leadership and front-line staff can easily track progress.¹¹¹ Transparency about the performance of individual clinicians was considered particularly important for making clinicians aware of their own performance gaps, and bolstered clinicians' intrinsic motivation

¹⁰⁹ McWilliams, J. M. (2016). "Cost Containment and the Tale of Care Coordination." N Engl J Med 375(23): 2218-2220.

¹¹⁰ Ibid.

¹¹¹ Health Care Transformation Task Force. (2017). "Levers of Successful ACOs: Insights from the Health Care Transformation Task Force." Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

to improve the quality of care they provide.¹¹² Creating linkages between performance and compensation or network contracts has also been discussed as a best practice for quality improvement.

Evaluators of Maryland’s All-Payer Model observed an increased uptake of various methods of continuous quality improvement, such as Lean Six Sigma, Toyota’s Kata; 5South and Plan, Study, Do Act.¹¹³ These models, evaluators say, emphasize engaging hospital staff from all levels and generally incorporate evidence and data. The evaluators also note that “[a]doption of a systematic CQI process was usually driven by a highly engaged hospital chief executive.”¹¹⁴

During interviews, providers agreed that quality improvement programs to reduce care variation are essential. They described strategies such as using internal teams to build tools that pull EHR and claims data to look at average costs per patient for given diagnoses and identify performance gaps. This information can be used to identify outlier physicians, examine and discuss the reasons behind variations in care, research evidence-based guidelines in the literature, and promote clinical best practices internally.

Challenges:

Many providers report problems with workforce limitations,¹¹⁵ and note that staff often have steep learning curves for analyzing and using claims data.¹¹⁶ Data feedback information may be difficult to understand, and practices may lack the necessary time and expertise to use it effectively.¹¹⁷

¹¹² Ibid.

¹¹³ RTI International. (2018). “Evaluation of the Maryland All-Payer Model: Third Annual Report.” Available at: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

¹¹⁴ Ibid.

¹¹⁵ Dorr, D.A., Cohen, D.J., and Adler-Milstein, J. (2018). "Data-Driven Diffusion of Innovations: Successes And Challenges In 3 Large-Scale Innovative Delivery Models." Health Affairs Vol. 37 NO. 2 (2018): 257-265.

¹¹⁶ L&M Policy Research, LLC. (2016). “Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report.” Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹¹⁷ Mathematica Policy Research. (2018). “Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report.” Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

Key Takeaways:

- ✓ Both the literature and stakeholders noted several successful quality improvement strategies, including leveraging dedicated quality improvement staff and infrastructure, creating linkages between performance on quality measurement and compensation, and establishing learning collaboratives to spread best practices.
- ✓ Stakeholders discussed care variation reduction programs and embedded clinical pharmacologist strategies for quality improvement.

Clinician Engagement

Design and Implementation

Providers, as well as some payers, discussed the importance of engaging clinicians as partners in value-based transformation and working with them to design and implement APMs.

Promising Practices:

Stakeholders point out that when clinicians are engaged at the conceptual stage of collaborative projects, they are more likely to be energized and gain senses of ownership.¹¹⁸ The HCTTF’s study of high-performing ACOs emphasizes the need to include employed and non-employed physicians in the ACO leadership board.¹¹⁹ An evaluation of the CMMI Pioneer program noted that some ACOs mandated clinician participation in governance and decision making.¹²⁰

The research highlighted several areas in which payer-provider collaboration is particularly helpful, such as gaining consensus on the measures that will be used. For example, while some clinicians prefer to use existing measure sets to reduce burden, others may want to customize measures in ways that make them more meaningful and relevant to their patient populations.¹²¹ Additional areas for design collaboration include deciding how patients will be attributed,¹²² resolving how specialties will be

¹¹⁸ Beckman, H., Healey, P., et al. (2015). "Improving Partnerships Between Health Plans and Medical Groups." *The American Journal of Managed Care* 21(9): 647-650.

¹¹⁹ Health Care Transformation Task Force. (2017). "Levers of Successful ACOs: Insights from the Health Care Transformation Task Force." Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

¹²⁰ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹²¹ Alliance of Community Health Plans. (2016). "Rewarding High Quality: Practical Models for Value-Based Physician Payment." Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

¹²² Beckman, H., Healey, P., et al. (2015). "Improving Partnerships Between Health Plans and Medical Groups." *The American Journal of Managed Care* 21(9): 647-650.

assigned (if both primary and specialty medicine are practiced),¹²³ and choosing performance targets.¹²⁴ Payer-provider collaboration is also important to continue throughout APM implementation. ACHP notes that giving providers timely and actionable data, and following up with targeted coaching and support, is a best practice for improving quality performance.¹²⁵

Intrinsic and Extrinsic Motivations

Recruiting and retaining clinicians in an APM may be positively influenced by the structure of financial and non-financial incentives.

Promising Practices:

Researchers advise that financial incentives must reach front-line providers.^{126,127,128} Payment to individual physicians, advanced-practice nurses and other non-physician staff, and the distribution of higher payments to highest performers may be a motivating strategy to reduce total cost of care and improve quality.¹²⁹ Further, the Medicare Payment Advisory Commission (MedPAC) has highlighted the need for aligning primary care and specialist incentives.¹³⁰ One payer interviewed by the HCP-LAN suggested that instead of paying physicians through FFS, provider organizations should solicit investments from payers to move clinicians to salaries with quality bonuses.

Although gainsharing and financial incentives are often viewed as key methods for recruitment and alignment with APM goals, the literature reviewed speaks to the non-financial motivations of clinicians as well, such as the ability to do meaningful and appropriate work aligned with a physician’s goals and

¹²³ Ibid.

¹²⁴ Hiller, M., Ireton, B. et al. (2018). “Ready, Risk, Reward: Keys to Success in Bundled Payments.” Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>.

¹²⁵ Alliance of Community Health Plans (2016). Rewarding High Quality: Practical Models for Value-Based Physician Payment. Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

¹²⁶ Hall, D. and Zezza, M. (2014). "Developing an Incentives Playbook: Aligning Influences in the Era of Reform." The American Journal of Accountable Care 2(3): 42-45.

¹²⁷ Health Care Transformation Task Force. (2017). “Levers of Successful ACOs: Insights from the Health Care Transformation Task Force.” Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

¹²⁸ Alliance of Community Health Plans. (2016). Rewarding High Quality: Practical Models for Value-Based Physician Payment. Available at: https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

¹²⁹ Ibid

¹³⁰ MedPAC. (2018). “Status report on Medicare Accountable Care Organizations.” (Transcript of presentation by MedPAC staff, pp. 136-184). Available at: <http://www.medpac.gov/docs/default-source/default-document-library/jan-2018-meeting-transcript99f411adfa9c665e80adff00009edf9c.pdf?sfvrsn=0>

values¹³¹ and to positively impact the lives of others.¹³² Clinicians also may have interest in participating in initiatives that qualify as advanced alternative payment models under the Medicare Access and CHIP Reauthorization Act (MACRA).¹³³ Purchasers indicated to the HCP-LAN that payment incentives should be combined with public reporting that highlights variation in provider performance, and that encouraging a culture of improvement through the use of aligned measures (and measure specifications) can be more important than penalties and bonuses for quality performance.

Mechanisms for Supporting Clinicians

The research identified multiple ways to support clinicians as they transition to a more value-driven environment through an APM.

Promising Practices:

Maintaining engagement with clinicians in APM efforts can be difficult, in part because they are heavily focused on delivering care and may not be well-versed in the administrative financial aspects of a particular APM model.¹³⁴ Some organizations appoint physician champions with leadership and change management training.^{135,136} In structuring communication, sources indicated that it may be more effective to proactively distribute information to providers, rather than relying on clinicians to access websites or portals,¹³⁷ and that peer-to-peer communication can be particularly useful.¹³⁸ Providing autonomy for physicians as they implement changes is also seen as an important.¹³⁹

¹³¹ Beckman, H., Healey, P., et al. (2015). "Improving Partnerships Between Health Plans and Medical Groups." *The American Journal of Managed Care* 21(9): 647-650.

¹³² Hall, D. and Zezza, M. (2014). "Developing an Incentives Playbook: Aligning Influences in the Era of Reform." *The American Journal of Accountable Care* 2(3): 42-45.

¹³³ Hiller, M., Ireton, B. et al. (2018). "Ready, Risk, Reward: Keys to Success in Bundled Payments." Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>.

¹³⁴ Afendulis, C. C., Hatfield, L. A., et al. (2017). "Early Impact of CareFirst's Patient-Centered Medical Home with Strong Financial Incentives." *Health Aff (Millwood)* 36(3): 468-475.

¹³⁵ Hiller, M., Ireton, B. et al. (2018). "Ready, Risk, Reward: Keys to Success in Bundled Payments." Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>.

¹³⁶ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹³⁷ Afendulis, C. C., Hatfield, L. A., et al. (2017). "Early Impact of CareFirst's Patient-Centered Medical Home with Strong Financial Incentives." *Health Aff (Millwood)* 36(3): 468-475.

¹³⁸ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹³⁹ Beckman, H., Healey, P., et al. (2015). "Improving Partnerships Between Health Plans and Medical Groups." *The American Journal of Managed Care* 21(9): 647-650.

Offering learning opportunities related to the specific APM features, performance improvement, and/or practice transformation was also described as a common practice. Educational activities for clinicians and other staff take many forms, such as webinars, newsletters, in-person meetings where challenges and successes can be shared, participation in learning groups or collaboratives, individualized coaching, and more. Some ACOs provide financial incentives (or penalties) that encourage participation in activities, such as meeting attendance or quality improvement efforts.¹⁴⁰

Challenges:

One study of CareFirst's patient-centered medical home reports that many physicians said they were not motivated by monetary awards, and most lacked an understanding of how the shared savings incentive worked.¹⁴¹ Experts emphasize the importance of educating physicians about incentive structures¹⁴² and ensuring the size, timing, and dissemination of rewards are effective in motivating change. They point out that rewards that are too small or arrive too late may diminish motivational impact and suggest strategies such as separately delineating incentive payments on a pay stub or providing them in person at meetings.¹⁴³

In an evaluation of the CPCI, practices indicated that peer-to-peer and in-person learning opportunities were especially valued; however, they noted challenges in finding the time to participate in learning opportunities.¹⁴⁴ Practices also found some activities duplicative or nonspecific to practice needs and felt that participation of EHR vendors in learning activities would have been helpful.¹⁴⁵ In response to feedback, CMS made several changes to educational sessions and created cross-regional learning communities, such as action groups focused on specific topics including medication management and shared decision-making, as well as forums for physician practices that had the same EHR.¹⁴⁶

¹⁴⁰ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹⁴¹ Afendulis, C. C., Hatfield, L. A., et al. (2017). "Early Impact of CareFirst's Patient-Centered Medical Home with Strong Financial Incentives." *Health Aff (Millwood)* 36(3): 468-475.

¹⁴² Damor, J. and Hardaway, B. (2017). "Ready, Risk, Reward: Building Successful Two-Sided Risk Models." Premier Inc. Available at: <https://learn.premierinc.com/white-papers/building-successful-two-sided-risk-models-premier-inc>.

¹⁴³ Hall, D. and Zezza, M. (2014). "Developing an Incentives Playbook: Aligning Influences in the Era of Reform." *The American Journal of Accountable Care* 2(3): 42-45.

¹⁴⁴ Mathematica Policy Research. (2018). Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report. Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

¹⁴⁵ Ibid.

¹⁴⁶ Ibid.

Key Takeaways:

- ✓ The research captured stakeholder recognition of the need to engage clinicians in the design and implementation of APMs.
- ✓ Financial incentives by themselves are not always enough to obtain or retain physician interest in APM goals and processes.
- ✓ Payers and providers are incorporating various types of communication and learning activities into APMs to boost clinician engagement.

Patient-Centeredness

For health care payment reform to succeed, it must accomplish the goals of achieving patient-centered care and engaging patients as partners in managing their health and care.

APM Design and Implementation

Promising Practices:

The HCP-LAN’s Consumer and Patient Advisory Group (CPAG), a multi-stakeholder group created to provide insights about the impact of APMs on patients, has developed guidance for successfully incorporating patient-centeredness into new payment models. The CPAG’s [Principles for Patient- and Family-Centered Payment](#) envisions a multi-faceted framework for patient engagement, beginning with involving patients and families in the design, implementation, and evaluation of payment and care models. The principles underscore the importance of APM participants recognizing patients as partners in their own care; adopting measures that are meaningful to patients; ensuring that financial incentives are transparent; improving health equity; and using technology to support patient engagement.¹⁴⁷ The HCP-LAN also advocates for patients to have information about their attribution in a payment model, cost data about providers, shared decision-making opportunities, and influence over how their personal health care information is shared.¹⁴⁸ Several of these concepts were reinforced in stakeholder interviews. For example, some consumer advocates observed that patients should have a place at the table with payers as they begin to design APMs, so that they can provide input in areas such as measure selection, payment incentives, infrastructures for better patient-clinician communications, shared-decision-making, and care team development.

¹⁴⁷ The MITRE Corporation (HCP-LAN). (2016). “Consumer and Patient Affinity Group Principles for Patient- and Family-Centered Payment.” Available at: <http://hcp-lan.org/workproducts/cpag-principles.pdf>

¹⁴⁸ The MITRE Corporation (HCP-LAN). (2016). “Accelerating and Aligning Population-based Payment Models: Patient Attribution.” Available at: <https://hcp-lan.org/workproducts/pa-whitepaper-final.pdf>

Many APM designers are incorporating patient-centered activities into new payment models, including the largest public payer, CMS. CMS requires that a Medicare beneficiary be included in a MSSP ACO's governing body and that CPC+ practices convene patient and family advisory groups, among other actions. The HCTTF found that some high-performing ACOs go beyond specific program requirements to engage larger numbers of patients across payers.¹⁴⁹ Experts advise that the process used to select patient representatives should be transparent and modifiable as needed.¹⁵⁰ It is important to have multiple patient representatives on any advisory board to give patients adequate voices, and ACOs with racially, ethnically, and/or socioeconomically diverse populations should ensure that representatives reflect their populations.¹⁵¹ Once patient representatives are selected, ACOs can foster meaningful engagement by providing them with a foundational knowledge about the APM, such as through a comprehensive orientation; ensuring there is sufficient time on meeting agendas for their input; covering their expenses for participating; and helping them cultivate relationships with the broader ACO patient population through town halls and other strategies.¹⁵² Bioethicists also suggest that "evaluating engagement in itself is an ethical obligation."¹⁵³

Various public and private payers have required or encouraged providers in APMs to offer increased access to care, employ patient-focused care coordination strategies, and support shared decision-making. A majority of NGACOs use patient engagement strategies such as contacting patients for annual wellness visits, encouraging self-tracking of health, and offering patient education programs.¹⁵⁴ The Oregon Coordinated Care Organization (CCO) model provides spending flexibility to enable the provision of social support services, which researchers speculate may have contributed to cost savings. Evaluators of the CCOs note that "[t]hese programs typically targeted adults and patients with multiple comorbidities, consistent with our finding that savings were primarily attributable to these groups."¹⁵⁵

One study identified in the literature investigated the interrelationship between patient-centered practices and cost. Using retrospective longitudinal data from the Medical Expenditure Panel Survey (MEPS), administered by the Agency for Healthcare Research and Quality (AHRQ), the study's authors analyzed whether individual components of patient-centered medical homes impacted expenditures

¹⁴⁹ Health Care Transformation Task Force. (2017). "Levers of Successful ACOs: Insights from the Health Care Transformation Task Force." Available at: <https://hcttf.org/wp-content/uploads/2018/01/LeversofSuccessfulACOs6.pdf>

¹⁵⁰ DeCamp, M., Sugarman, J., et al. (2015). "Meaningfully Engaging Patients in ACO Decision Making." *The American Journal of Accountable Care* 3(2): 30-33.

¹⁵¹ Ibid.

¹⁵² Ibid.

¹⁵³ Ibid.

¹⁵⁴ NORC at the University of Chicago. (2018). "Next Generation Accountable Care Organization Model Evaluation First Annual Report." Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

¹⁵⁵ McConnell, K. J., Renfro, S., et al. (2017). "Oregon's Medicaid Reform and Transition to Global Budgets Were Associated with Reductions in Expenditures." *Health Aff (Millwood)* 36(3): 451-459.

for Medicare beneficiaries.¹⁵⁶ Among their findings, patients with regular sources of care that provided office hours at night or on the weekend were associated with significantly lower costs in some categories, including outpatient and emergency department (ED) expenditures.¹⁵⁷ This did not, however, hold true for inpatient or pharmacy costs. When patients had “little to no difficulty contacting a regular source of care over the telephone during regular business hours,” there was an association with significantly lower total health care expenditures. This finding included lower inpatient costs, but not lower expenditures for outpatient, ED, pharmacy, and other health services.¹⁵⁸ Furthermore, pharmacy costs were higher when providers asked about medications and treatments prescribed by other doctors. The study authors speculate that better medication management may be the reason for the higher prescription costs.¹⁵⁹

Challenges:

Patient advocates pointed out that the technical language and complexities of payment reform can cause some patients to feel intimidated and discourage involvement in APMs. Thus, there is a need to provide training opportunities, using plain language, to build the capacity for engagement. As APMs are implemented, patient representatives also suggested helping all patients understand their benefits and drawbacks, as well as why patients may not receive the services they expect to receive.

Patient Feedback

Promising Practices:

Numerous models require APMs to meet specific patient experience survey targets to qualify for incentive payments. As with many providers, Maryland hospitals report doing more to analyze poor scores in patient experience, which is part of the at-risk component of their global budgets. They use case reviews, meetings with clinicians and staff, and forums in which patients can share their stories as some of the strategies to address negative feedback.¹⁶⁰ The CPCI evaluation showed that most practices used patient surveys and almost half had a patient and family advisory council (PFAC) in 2016. While participants agreed that both mechanisms were helpful in obtaining feedback that

¹⁵⁶ Stockbridge, E. L., Philpot, L. M., et al. (2014). "Patient-Centered Medical Home Features and Expenditures by Medicare Beneficiaries." *The American Journal of Managed Care* 20(5): 379-385.

¹⁵⁷ Ibid.

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ RTI International. (2018). "Evaluation of the Maryland All-Payer Model: Third Annual Report." Available at: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

promoted practice changes, some providers thought PFACs were more beneficial because they initiated more meaningful conversations.¹⁶¹

Some researchers have attempted to assess whether payment and delivery transformations with patient-centered features have impacted patient experience scores. In a study of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance in Medicare Pioneer and MSSP ACOs, researchers found meaningful improvements in some measures of patient experience and reports of significantly better overall care among medically complex patients.¹⁶² Specifically, they report that “patients served by ACOs reported improvements in domains more easily affected by organizations (access to care and care coordination) but not in domains in which changes in physicians’ interpersonal skills may be required to achieve gains (interactions with physicians and physician ratings).”¹⁶³

Challenges:

Some staff worry that the time spent addressing patient experience restricts other necessary activities, and clinicians also believe that some level of dissatisfaction arises from patients who receive clinically appropriate care that does not meet their expectations.¹⁶⁴ Both patient surveys and PFACs also had challenges, such the time required to distribute and analyze surveys and difficulty identifying PFAC meeting times that were ideal for both patients and practice staff.¹⁶⁵

Key Takeaways:

- ✓ Stakeholders recognize the importance of involving patients in APM design and implementation.
- ✓ Advocates emphasize the need to help patients learn about APMs in order to build consumer capacity for meaningful feedback and participation in APM activities. They also emphasize that financial support may be necessary to eliminate barriers to participation.
- ✓ APMs are incorporating patient-centered activities into their operations, and evidence is emerging about potential benefits.
- ✓ Best practices are emerging about how to most effectively obtain and utilize patient feedback, such as thoughtful implementations of patient and family advisory councils.

¹⁶¹ Mathematica Policy Research. (2018). “Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report.” Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

¹⁶² McWilliams, J. M., Landon, B. E., et al. (2014). “Changes in Patients’ Experiences in Medicare Accountable Care Organizations.” *N Engl J Med* 371(18): 1715-1724.

¹⁶³ Ibid.

¹⁶⁴ RTI International. (2018). “Evaluation of the Maryland All-Payer Model: Third Annual Report.” Available at: <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

¹⁶⁵ Mathematica Policy Research. (2018). “Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report.” Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>



Special Considerations for Multi-Payer Collaboration

Multi-payer arrangements can reduce provider burden, promote a culture of collaboration, align quality measurement, and establish common data infrastructures. In some cases, however, provider readiness is viewed as a greater barrier to APM implementation than lack of multi-payer alignment. The creation of multi-payer collaboratives involves many of the same decisions as sole-payer payment models, although it generally requires consensus among a more complex group of stakeholders. As in all APMs, achieving success likely depends on striking the right balance among competing interests and goals as model designers develop payment mechanisms, quality performance frameworks, and other components. Having a strong, neutral convener is seen as a key success factor. Stakeholders highlighted anti-trust concerns and local insurance markets as potential barriers to multi-payer APM implementation.

Stakeholder conversations revealed two views of multi-payer models. On one hand, many individuals view these initiatives as essential in transforming the health care field and making significant strides toward value-based payment. To these stakeholders, multi-payer models represent the ultimate goal in national payment reform. One stakeholder specifically questioned whether sole-payer APMs may achieve savings because providers can shift costs to other non-APM payers, and observed that multi-stakeholder collaborations can help prevent that from happening. Others who spoke with the HCP-LAN believe that many of the goals of reform can be met without multi-payer collaboration. They emphasize that multi-payer arrangements must recognize differences in programs, populations, and care goals, and they suggest that complete alignment should not be the goal. In some cases, provider readiness is viewed as a greater barrier to APM implementation than lack of multi-payer alignment.

The limited nature of the background research yielded few resources dedicated to specific considerations for observations about multi-payer initiatives. In fact, designing successful multi-payer initiatives involves many of the same decisions as sole-payer initiatives, such as determining payment incentives, performance measures, and provider participation criteria. In bundled payments, stakeholders must also come to agreement on a bundle definition. The research did underscore, however, that finalizing agreements about these and other APM components in a multi-payer initiative can take an extraordinary amount of time and introduce new hurdles and complexities. Some of the observations about multi-payer initiatives reflected in the literature and stakeholder interviews include the following:

Payment mechanisms. Agreement over payment has been described as “arguably the most contentious part of multi-payer collaboration.”¹⁶⁶ Researchers from the National Academy for State Health Policy point out that standardized payment methods and amounts can relieve provider burden and provide transparency, while flexibility allows greater innovation. Their study of multi-payer

¹⁶⁶ Takach, M., Townley, C., et al. (2015). "Making Multi-payer Reform Work: What Can Be Learned from Medical Home Initiatives." *Health Aff (Millwood)* 34(4): 662-672.

medical home initiatives identified varying approaches to setting payment rates, such as paying based upon a patient panel or tiering reimbursement according to provider competencies.¹⁶⁷ In order to better assist providers with less scale, particularly small or rural providers, commercial payers may vary payment rates by patient volume.¹⁶⁸

Volume. Researchers studying the California Integrated Healthcare Association’s multi-stakeholder bundled payment pilot underscore that episode volume may have more significant impact than payment amounts. In that model, a narrow bundle definition resulting from a compromise among the multiple parties failed to capture the necessary amount of volume to justify investments in redesigning clinical care and payment processes.¹⁶⁹ While the narrow definition helped to minimize provider financial risk, the authors suggest alternative methods to accomplish this result, such as risk adjustment and stop-loss provisions.¹⁷⁰

Performance measurement. Stakeholders see the potential for multi-payer quality measure alignment as a critical way to reduce provider burden on measures. Stakeholders told the HCP-LAN that some ACOs may be evaluated on as many as 120 measures. Agreement on a more parsimonious, common set of metrics may serve as an important first step in building trust and moving toward consensus on other issues. Alignment on quality measurement reporting methods has also been described as a desired practice for multi-payer efforts.

Data feedback. Developing a common framework for data feedback can promote efficiency and reduce provider burden while providing a more comprehensive view of performance. This effort involves decisions related to vendor selection, a management structure for the framework, cost allocation, training, consensus on the content and scope of tools or reports, and more. Many payers in the CPCI program sought to produce a single report or tool that aggregated data across payers. Although some regions were successful, this effort was hindered by the cost and time required, as well as operational and legal issues.¹⁷¹

Multi-Payer Initiative Conveners

Researchers suggest that multi-payer initiatives must have a primary convener with credibility among both payer and provider communities, though there is not a “one-size-fits-all” approach as to which

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

¹⁶⁹ Ridgely, M. S., de Vries, D., et al. (2014). "Bundled payment fails to gain a foothold In California: the experience of the IHA bundled payment demonstration." *Health Aff (Millwood)* 33(8): 1345-1352.

¹⁷⁰ Ibid.

¹⁷¹ Mathematica Policy Research. (2018). "Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report." Available at: <https://downloads.cms.gov/files/cmml/CPC-initiative-fourth-annual-report.pdf>

type of entity should assume this role. One study describes the advantages of choosing state entities as the convener of multi-payer medical home initiatives, including: extensive purchasing power through Medicaid and state employee health plans; legislative and executive branch leadership; and the ability to offer antitrust protections through the state action doctrine.¹⁷² A large employer interviewed agreed that states should take the lead in establishing multi-stakeholder consensus related to infrastructure needs for both payers and providers, quality measure alignment, and payer and provider training. In states with significant purchasing power, there may be unique state opportunities to integrate behavioral health and social services.

States can, however, wear multiple hats as conveners, participating payers, and regulators, and having a convener that is seen as neutral is important. In different markets, multi-payer collaboration may be led by public-private partnerships, academic institutions, private organizations, or even independent contractors. According to interviews with providers, dominant payers may be well-positioned to drive alignment, particularly in a market with less advanced providers. In states with large employers in a market, one purchaser also suggested that employers should use purchasing power leverage to engage in triangular discussions with plans and collaboratives to drive alignment.

According to the CPCI evaluation and stakeholders consulted, a strong convener is important in facilitating collaboration, unity, and consensus among payers. Other factors contributing to payer collaboration include a history of working together and the presence of “payer champions” who influence the active participation of other payers.”¹⁷³

Challenges with Multi-Payer Collaboration

Antitrust protections may limit collaboration on payments across payers. As previously mentioned, state-action policies can provide antitrust protection in certain circumstances. Where payers do not have these protections in place, multi-payer collaboration has focused primarily on aligning quality measurement and provider selection criteria, and payers negotiated directly with providers.¹⁷⁴ Other barriers mentioned in the literature include the competing interests of payers and providers, lack of a technology infrastructure for claims processing, and time-consuming regulatory hurdles.¹⁷⁵

¹⁷² Takach, M., Townley, C., et al. (2015). "Making Multi-payer Reform Work: What Can Be Learned from Medical Home Initiatives." *Health Aff (Millwood)* 34(4): 662-672.

¹⁷³ Mathematica Policy Research. (2018). "Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report." Available at: <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

¹⁷⁴ Takach, M., Townley, C., et al. (2015). "Making Multi-payer Reform Work: What Can Be Learned from Medical Home Initiatives." *Health Aff (Millwood)* 34(4): 662-672.

¹⁷⁵ Ridgely, M. S., de Vries, D., et al. (2014). "Bundled payment fails to gain a foothold In California: the experience of the IHA bundled payment demonstration." *Health Aff (Millwood)* 33(8): 1345-1352.

Regardless of the benefits multi-payer collaboration may provide, local insurance markets and policy environments may be the largest barriers to implementation. Payers in many markets have already invested in several sole-payer APMs, each with its own payment methodologies, quality metrics, and provider participation criteria. As a result, multi-payer collaboration requires more justification to accommodate or replace existing APMs in a given market. In addition, state and federal policy environments must be conducive to reform (e.g., legislative or executive action and funding support). As previously mentioned, the federal government’s role has been critical in moving forward with multi-payer APMs (e.g., CPC+, OCM, Maryland All-Payer Model, Vermont All-Payer ACO, Pennsylvania Rural Health Model, and state innovation models) and partnering with Medicare and Medicaid in multi-payer reforms will continue to be critical for health system transformation.¹⁷⁶

APM and Provider Characteristics

Researchers have examined APM and provider characteristics, including size, hospital integration, and experience in APMs, to ascertain their correlation with success in the cost, quality or patient experience domains. Findings are mixed, although several sources suggested that hospital integration is not necessary to achieve savings.

Size

The review included analyses of correlations related to ACO size. Select findings demonstrated that larger ACOs in the Pioneer program (determined by person months associated with ACO-aligned beneficiaries) had better patient experiences,¹⁷⁷ while ACOs with more covered lives had higher quality scores in the MSSP program.¹⁷⁸ Larger ACOs are not necessarily correlated with more savings, however¹⁷⁹, and smaller organizations participating in MSSP were shown to have higher shared savings rates in 2016 than larger organizations.¹⁸⁰

¹⁷⁶ Takach, M., Townley, C., et al. (2015). "Making Multi-payer Reform Work: What Can Be Learned from Medical Home Initiatives." *Health Aff (Millwood)* 34(4): 662-672.

¹⁷⁷ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹⁷⁸ Leavitt Partners. (2016). "Ten Early Takeaways from the Medicare Shared Savings ACO Program." Available at: <https://leavittpartners.com/whitepaper/ten-early-takeaways-from-the-medicare-shared-savings-aco-program/>

¹⁷⁹ Ibid.

¹⁸⁰ Saunders, R., Muhlestein, D, McClellan, M. (Nov. 21, 2017). "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time." *The Health Affairs Blog*. Health Affairs. Accessed at <https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171120.211043&format=full&> on July 19, 2018.

Hospital Integration

Numerous articles suggest that hospital integration is not necessary to achieve savings, including a 2015 analysis of Pioneer ACOs¹⁸¹ and MSSP program studies written in 2016¹⁸² and 2017.¹⁸³ Two reviews of MSSP results also observed that physician group-led ACOs were more likely to achieve shared savings and that savings in Medicare spending were larger among independent primary care groups compared to hospital-integrated groups.^{184 185} For spending reductions related to post-acute care, researchers speculate that ACO-attributed patients may represent a small portion of admissions, potentially leading to weak incentives for hospitals to adopt widespread efforts to curtail post-discharge costs.¹⁸⁶ The final Pioneer ACO program evaluation, however, found that an ACO that owned a hospital “tended to have higher levels of satisfaction on improved provider communication, overall rating of physician, and shared decision-making.”¹⁸⁷ Another study analyzing whether MSSP ACOs were meeting public reporting requirements found that ACOs with hospitals intended to share a larger percentage of the savings with PCPs, specialists, and/or hospitals versus ACOs without a hospital.¹⁸⁸ Additionally, the researchers found that “ACOs distributing over 60% of savings to PCPs were more likely to have generated savings.”¹⁸⁹

¹⁸¹ McWilliams, J. M., Chernew, M. E., et al. (2015). "Performance differences in year 1 of pioneer accountable care organizations." *N Engl J Med* 372(20): 1927-1936.

¹⁸² McWilliams, J. M., Hatfield, L. A., et al. (2016). "Early Performance of Accountable Care Organizations in Medicare." *N Engl J Med* 374(24): 2357-2366.

¹⁸³ McWilliams, J. M., Gilstrap, L. G., et al. (2017). "Changes in Postacute Care in the Medicare Shared Savings Program." *JAMA Internal Medicine* 177(4): 518-526.

¹⁸⁴ Saunders, R., Muhlestein, D, McClellan, M. (2017). "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time." *The Health Affairs Blog*. Health Affairs. Accessed at <https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171120.211043&format=full&> on July 19, 2018.

¹⁸⁵ McWilliams, J. M., Hatfield, L. A., et al. (2016). "Early Performance of Accountable Care Organizations in Medicare." *N Engl J Med* 374(24): 2357-2366.

¹⁸⁶ McWilliams, J. M., Gilstrap, L. G., et al. (2017). "Changes in Postacute Care in the Medicare Shared Savings Program." *JAMA Internal Medicine* 177(4): 518-526.

¹⁸⁷ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹⁸⁸ Schulz, J., DeCamp, M., et al. (2015). "Medicare Shared Savings Program: Public Reporting and Shared Savings Distributions." *The American Journal of Managed Care* 21(8): 546-553.

¹⁸⁹ Ibid.

Experience

Some health plans use provider experience in alternative payment or risk arrangements as a criterion for eligibility in an accountable care contract.¹⁹⁰ Several studies offer support for this approach. In analyzing 2016 MSSP results, researchers found that average quality scores were similar "regardless of the ACO's age," but that experienced ACOs were more likely to achieve shared savings.¹⁹¹ In a study of post-acute care changes in the MSSP program, "reductions in SNF spending grew with longer ACO participation, and later entrants required more time to achieve reductions than did early entrants."¹⁹² Pioneer participants also point to the strong advantage that previous experience in care coordination, risk contracting, and CMS demonstration projects played in implementing their ACOs.¹⁹³

NGACOs all reported prior experience in value-based care, and several noted that participation in the Pioneer or SSP model, for example, laid the groundwork for NGACO participation. Prior experience in risk also informed NGACO decisions on acceptable levels of risk.¹⁹⁴ Premier Inc. underscores the need for provider organizations to have knowledgeable people who understand APM program elements and can effectively negotiate two-sided risk contracts.¹⁹⁵ Finally, Leavitt Partners evaluated associations between an ACO's number of contracts and its outcomes, determining that, "[t]he more contracts an ACO had correlated with higher quality but not greater savings."¹⁹⁶ Conversely, a 2016 study of MSSP and Pioneer ACOs suggested that the magnitude of spending and utilization reductions "was not significantly different by the start date of ACOs, though further exploration revealed slight increases in spending with longer ACO participation."¹⁹⁷

¹⁹⁰ Higgins, A., Stewart, K., et al. (2016). "Health Plan—Provider Accountable Care Partnerships: How Have They Evolved?" *The American Journal of Accountable Care* 4(1): 43-46.

¹⁹¹ Saunders, R., Muhlestein, D, McClellan, M. (2017). "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time." *The Health Affairs Blog*. Health Affairs. Accessed at <https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171120.211043&format=full&> on July 19, 2018

¹⁹² McWilliams, J. M., Gilstrap, L. G., et al. (2017). "Changes in Postacute Care in the Medicare Shared Savings Program." *JAMA Internal Medicine* 177(4): 518-526.

¹⁹³ L&M Policy Research, LLC. (2016). "Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report." Available at: <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>

¹⁹⁴ NORC at the University of Chicago. (2018). "Next Generation Accountable Care Organization Model Evaluation First Annual Report." Available at: <https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf>

¹⁹⁵ Hiller, M., Ireton, B. et al. (2018). "Ready, Risk, Reward: Keys to Success in Bundled Payments." Premier Inc. Available at: <https://learn.premierinc.com/white-papers/ready-risk-reward-keys-to-success-in-bundled-payments-white-paper>.

¹⁹⁶ Leavitt Partners. (2016). "Ten Early Takeaways from the Medicare Shared Savings ACO Program." Available at: <https://leavittpartners.com/whitepaper/ten-early-takeaways-from-the-medicare-shared-savings-aco-program/>

¹⁹⁷ Colla, C. H., Lewis, V. A., et al. (2016). "Association Between Medicare Accountable Care Organization Implementation and Spending Among Clinically Vulnerable Beneficiaries." *JAMA Internal Medicine* 176(8): 1167-1175.

Limitations of the Background Research

The targeted journal and gray literature review, combined with stakeholder discussions, provide a strong overview of key issues surrounding APM design and implementation. The HCP-LAN team selected medical and health care journals that were likely to discuss important areas of APM development. The gray literature search largely focused on identifying and analyzing publications about APM implementation from stakeholder and industry organizations, such as reports that offered best practices and lessons learned. The sources consulted included documents obtained through internet searches; articles and suggestions provided by a multi-stakeholder work group created to guide the development of the Roadmap (the “APM Roadmap Work Group”); internal MITRE staff recommendations; and publications from the HCP-LAN. HCP-LAN team members also reviewed a selection of CMMI model evaluations and drew heavily upon their own knowledge and contacts, and those of the APM Roadmap Work Group, to identify individuals with expertise for stakeholder discussions.

While the combined list of resources is extensive, it does not reflect the full body of knowledge about APMs, and this review was intentionally limited in scope. Research efforts on correlates of success largely focused on providing a solid foundation for interviewing payers and providers about best practices and building a knowledge bank against which to validate the findings from these interviews.

Conclusion

This focused research effort describes an extensive level of APM activity across the U.S., as health plans, providers, patients and purchasers work together to move the health care system towards value-based payment. The literature and interviews provide a rich discussion of the strategies that APMs are employing to improve care, lower costs, and enhance patient and provider experiences. These sources also illustrate the complexities of APM design and implementation and highlight challenges for APM implementers as well as some solutions to overcoming barriers. While the evidence on many correlates of success is lacking, the literature offered well-informed perspectives from those who are studying design and implementation features, interactions among stakeholders, and APM outcomes related to cost and quality. The stakeholder discussions enabled the HCP-LAN team to hear directly from those implementing APMs and gain detailed insights about what reformers on the ground believe is working.

Together, the literature and interviews allowed the HCP-LAN team to discover both consistencies in viewpoints about success factors as well as areas of disagreement and skepticism. While many findings are familiar, such as the agreement about providing flexibility in APM risk framework, the research allowed the HCP-LAN team to test whether the conventional wisdom remains relevant and to discern important nuances in some thematic areas. The knowledge gained through the research augmented the HCP-LAN’s current expertise and provides a detailed foundation for subsequent phases of the APM Roadmap project.

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Appendix A. Methodology

Literature Review

The literature review comprised two parts, including a limited review of five medical and health care journals and a review of selected gray literature sources. Each part is described below.

Medical and Health Care Journals

The journal search was targeted to five specific publications selected by HCP-LAN team members with broad knowledge of the medical literature based on their record of publications in this topic area. The selected journals include *Health Affairs*; the *Journal of the American Medical Association (JAMA)*; *New England Journal of Medicine (NEJM)*; *American Journal of Accountable Care (AJAC)*; and the *American Journal of Managed Care (AJMC)*. The search terms listed in Table 1 were used to identify articles published in the last five years about Category 3 and 4 APMs that addressed potential correlates of success or lessons learned. A custom research analyst within MITRE’s Information Services department performed the initial search through PubMed and by searching the journal websites directly. After removing duplicates and extraneous articles that were off-topic, about 375 articles were selected for further review. A principal health policy analyst at MITRE subsequently screened the titles and abstracts for relevance, and prioritized articles for further analysis. Ultimately, information from approximately 28 articles was included in this report.

Gray Literature

The gray literature search largely focused on identifying and analyzing publications about APM implementation published by stakeholder and industry organizations, such as reports that offered best practices and lessons learned. The sources consulted during this phase of the research included documents obtained through internet searches; articles and suggestions provided by a multi-stakeholder work group created to guide the development of the APM Roadmap (the “APM Roadmap Work Group”); internal MITRE staff recommendations; and publications from the HCP-LAN. HCP-LAN team members also reviewed a selection of CMMI model evaluations, including models that have demonstrated success in reducing cost and improving quality. The below [List of Publications](#) contains the sources included in the gray literature search.

Table 1: Selected Journals and Key Search Terms

Journals	Search Terms
Health Affairs JAMA NEJM AJAC AJMC	Accountable care organizations (ACO), accountable care, alternative payment, attribution, benchmark, bundle AND payment, bundled payment, BPCI or bundled payment for care improvement, comprehensive end stage renal disease care (CEC) model, comprehensive primary care, downside risk, episode-based, episodes of care, global budget, global payment, innovation, lessons learned, multi-payer, pioneer, prospective payment, population-based, PCMH OR patient-centered medical home, shared savings, total cost of care, value-based purchasing (VBP).

List of Publications Included in Gray Literature Search

1. Accelerating and Aligning Population-Based Payment Models: Data Sharing (HCP-LAN, 2016)
2. Accelerating and Aligning Population-Based Payment Models: Financial Benchmarking (HCP-LAN, 2016)
3. Accelerating and Aligning Population-Based Payment Models: Patient Attribution (HCP-LAN, 2016)
4. Accelerating and Aligning Population-Based Payment Models: Performance Measurement (HCP-LAN, 2016)
5. Accelerating and Aligning Primary Care Payment Models (MITRE, 2017)
6. Alternative Payment Model (APM) Framework Refreshed. (HCP-LAN, 2017.)
7. Arkansas Health Care Payment Improvement Initiative 3rd Annual Statewide Tracking Report (May 2017)
8. Building Successful Two-Sided Risk Models (Premier Inc., November 2017)
9. CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report (Lewin Group, October 2017)
10. Comprehensive End Stage Renal Disease Care (CEC) Model Performance Year 1 Annual Evaluation Report (Lewin Group, October 2017)
11. Early Results from the Enhanced Personal Health Care Program: Learnings for the Movement to Value-Based Payment (Anthem Public Policy Institute, March 2016)
12. Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Final Report. (L&M Policy Research, LLC, 2016)

13. Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report. (Mathematica Policy Research, 2018)
14. Evaluation of the Maryland All-Payer Model: Third Annual Report. (RTI International, 2018)
15. Levers of Successful ACOs: Insights from the Health Care Transformation Task Force (HCTTF, November 2017)
16. Measure Applications Partnership: Maximizing the Value of Measurement, MAP 2017 Guidance, Final Report. (National Quality Forum, 2017).
17. Measuring Success in Health Care Value-Based Purchasing Programs (RAND Corp., 2014)
18. Medicare Shared Savings Program: Accountable Care Organizations Have Shown Potential for Reduced Spending and Improved Quality (OIG, August 2017)
19. Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis. (The Commonwealth Fund, 2015)
20. Next Generation Accountable Care Organization Model Evaluation – First Annual Report. (NORC at the University of Chicago, 2018)
21. Principles for Patient- and Family-Centered Payment (HCP-LAN, April 2016)
22. Ready, Risk, Reward: Keys to Success in Bundled Payments (Premier, April 2018)
23. Rewarding High Quality: Practical Models for Value-Based Physician Payment (Premier Inc., April 2016)
24. Status Report on Medicare Accountable Care Organizations (MedPAC meeting transcript, January 2018)
25. Ten Early Takeaways from the Medicare Shared Savings ACO Program (Leavitt Partners, April 2016)

Stakeholder Interviews

Drawing on recommendations from the HCP-LAN Guiding Committee and the APM Roadmap Work Group, HCP-LAN staff interviewed 30 experts with diverse stakeholder perspectives on APM implementation (please see Table 2).

Table 2: Stakeholders Interviewed

Stakeholder Group	Number
Payers	8
Providers	4
Academics and consultants/vendors	6
Multi-stakeholder collaboratives	3
Purchasers (states and private employers)	4
Patients and consumers	5

Each stakeholder responded to a different set of questions, designed to address topics that most closely reflected their respective experience. For example, providers and practice transformation consultants were asked what they did to achieve success and how payers could better support their efforts; representatives from multi-stakeholder collaborations were asked about best practices for multi-payer APMs and measure alignment; and state representatives were asked about successful state-based initiatives to drive successful APM implementation. Stakeholder interviews typically lasted 45 minutes.