

ROADMAP

for Driving High Performance
in Alternative Payment Models



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Executive Summary

Introduction and Overview

Building on the Health Care Payment Learning and Action Network's (HCP-LAN) previous work, the purpose of the *Roadmap for Driving High Performance in Alternative Payment Models (APM) (Roadmap)* is to offer payers—as well as providers and other stakeholders—specific promising practices used in APMs that have achieved success improving quality and lowering costs. The *Roadmap* is a pilot study based on information gathered through 22 interviews with payers and providers participating in 10 APMs. Promising practices highlighted in the *Roadmap* fall into three domains—APM Design, Payer-Provider Collaboration, and Person-Centered Care—each of which include several themes that contain related promising practices. The *Roadmap* also includes a “Path Forward” section with key areas where significant progress is needed to support payers and providers on their APM journey.

The HCP-LAN encourages using the [online tool](#) to further explore the many promising practices collected via the development of the *Roadmap*. The following high-level summary describes select practices for the three domains.

Payers are designing APMs by...

- Establishing a variety of payment structures (which include base payments, infrastructure investments, and incentive payments for quality) in population- and episode-based models for providers based on their readiness to implement. Payers are also designing strategies to support providers in moving gradually toward APMs and taking on both historical and regional benchmarking methodologies for population-based APMs, while sometimes using other utilization-based benchmarks to establish financial accountability without exposing providers to insurance risk.
- Predominantly using HEDIS measures in population-based models, while recognizing the need to use measures that better assess patient outcomes and reduce clinician burden. In episode-based models, payers use both core measure sets and episode-specific measures.
- Implementing prospective and retrospective patient attribution methodologies in population-based models and setting attribution in episodes of care based on episode initiation criteria.
- Working with stakeholders to develop multi-payer models and driving alignment on priority model design aspects. Strong leadership from states and dominant stakeholders in a market can help accelerate multi-payer alignment.

Payers are collaborating with providers using the following practices

- Engaging providers in APM design (e.g., provider advisory councils), assessing provider capabilities for population health management (e.g., via joint operating committees), and implementing strategies for effective communication and collaborative learning across providers, including learning and diffusion systems.

- Sharing data and information (e.g., gaps in care, cost and utilization trends, and quality performance) with providers on timelines that are relevant and appropriate to how providers are using this information, and tailoring their level of analytic support to providers' capabilities.
- Establishing care management support strategies for providers along the spectrum of population health management capabilities, including types of centralized teams that perform core functions. They are also leveraging data analytics to identify process improvements for specific provider organizations.
- Assessing an organization's leadership capabilities and engaging with both clinical and executive leadership in provider organizations to promote success in APMs.

Payers are focusing on person-centered payment models by...

- Promoting shared decision making and health literacy, executing alignment campaigns, and requiring providers to establish care contracts with patients outlining provider and patient roles.
- Offering global payments and care management fees for providers to engage patients.
- Using social workers to help providers establish linkages with community resources along with multidisciplinary teams to supplement providers' efforts to address social determinants of health.
- Starting to integrate benefit design in APMs to guide patients toward high-quality, low-cost providers.

Provider Perspectives

In addition to highlighting promising practices for payers, the *Roadmap* offers provider perspectives on current strategies to address changes in care delivery and to implement APMs successfully via APM Design, Payer-Provider Collaboration, and Person-Centered Care.

APM Design

- Downside Risk – Strategies include demonstrating success in upside-only models and ensuring appropriate access to data.
- Quality Measurement – Strategies include redesigned workflows for seamlessly integrating quality data and engaging clinicians on quality performance.
- Multi-Payer Alignment – Providers note a lack of alignment on quality measurement and data sharing as a significant burden.

Payer-Provider Collaboration

- Preparing for APMs – Providers build data capabilities, redesign staffing models, and collaborate with external stakeholders when preparing for population health management.
- Data Analytics – Providers work with electronic health record vendors to integrate and aggregate payer data and use data to develop care coordination and engagement processes.
- Care Coordination – Strategies include foundational outreach, engagement, and education efforts, and using data to manage population health.
- Leadership and Culture – Providers note leadership is essential to success in APMs and describe financial and non-financial incentives (e.g., quality performance incentives and internal performance reports) to engage clinicians in APMs.

Person-Centered Care

- Patient Engagement – Providers implement various patient engagement strategies, including communication through patient portals and convening patient advisory councils.
- Health Equity – Providers described extensive efforts to address various socioeconomic needs.

The Path Forward

The *Roadmap* acknowledges there are topics, such as quality measurement, patient engagement, downside risk, multi-payer alignment, and benefit design, where the challenges still outweigh the strategies and solutions, making it difficult to address specific barriers to wide adoption of APMs. Although the *Roadmap* does not offer consensus recommendations to solve current challenges in these five topics, it does identify key concerns and offers short- and long-term suggestions for how payers and providers can advance APM adoption in these areas.

Introduction & Overview: *What is the APM Roadmap?*

Purpose

Health care experts and stakeholders—payers, providers,¹ patients, and purchasers—have long agreed that the current health care system is financially unsustainable largely because of the predominant fee-for-service (FFS) payment model. The work of the [Health Care Payment Learning and Action Network \(HCP-LAN\)](#) on the APM Framework and Measurement Effort, as well as its recommendations on model design, have advanced the shift in recent years toward alternative payment models (APM) that pay providers for value, not volume. To accelerate this transition toward holding providers increasingly accountable for high quality and lower cost care, the HCP-LAN created this *Roadmap for Driving High Performance in Alternative Payment Models* as a tool to identify best practices for implementing successful APMs that achieve favorable cost and quality outcomes.

Based on 22 interviews with payers and providers, the *Roadmap* provides a sound foundation for future learning. In addition to the *Roadmap's* operational guidance, it supplements such other resources supporting care delivery transformation as:

- The core competencies in the Accountable Care Learning Collaborative's (ACLC) [Accountable Care Atlas](#)
- The strategies in the Health Care Transformation Task Force's (HCTTF) [Levers of Successful ACOs](#)
- The capabilities of America's Physician Groups [Standards of Excellence Survey](#)

The operational guidance in the *Roadmap* also reinforces the tailored technical assistance of health care improvement organizations that help provider organizations that are transforming care delivery for greater success in APMs.

Why Is the Roadmap Important?

At present, payers have little guidance on approaches for working with providers with varying capabilities² and other stakeholders to design and implement successful APMs, such as payment arrangements in Category 3 (shared savings/risk APMs) and Category 4 (population-based APMs). Although key lessons learned and insights into promising practices for APM implementation are widely dispersed throughout the field, they are often siloed in organizations and not synthesized for broader dissemination. Notably, few resources bring together practices that payers and providers use to achieve success in APMs of the HCP-LAN's [APM Framework](#) to identify important points of

¹ Throughout the *Roadmap*, the term “provider” refers to both health care delivery organizations and/or clinicians more broadly, while the term “clinician” specifically refers to individual physicians, nurses, and other medical professionals.

² Throughout the *Roadmap*, provider “capabilities” refer to human resources, information technology, established processes, and other assets available to manage the health and health care costs of patient populations.

collaboration as well as potential disconnects that warrant additional attention. Making this information widely available is critical for the field to make it possible that payers at different stages of the implementation process can navigate common challenges and work more effectively with providers who participate in their models.

Scope and Constraints of the Roadmap Methodology

The *Roadmap* is a pilot study focused on a small sample of APMs. Given the complexities of payment model design and implementation, the *Roadmap* is not intended as a step-by-step implementation guide. The promising practices detailed in the *Roadmap* reflect current activities the pilot payers and providers perform in the field and are based solely on information captured during the payer/provider interviews. These 22 interviews focused on 10 APMs nominated by 8 regional and national plans, including the Center for Medicare and Medicaid Innovation (CMMI). The HCP-LAN selected payers to participate in the *Roadmap* based on the payers' previous involvement in APM development, support for the mission of the HCP-LAN, and willingness to provide detailed information regarding their APM(s) for the study. The *Roadmap* consists of insights from nine payers, representing roughly 135 million covered lives, and 13 providers participating in the 10 APMs. **Error! Reference source not found.** presents details about the sample of payers, providers, and APMs. The accompanying [Methodology Report](#) offers additional details about the methods used to develop the *Roadmap*.

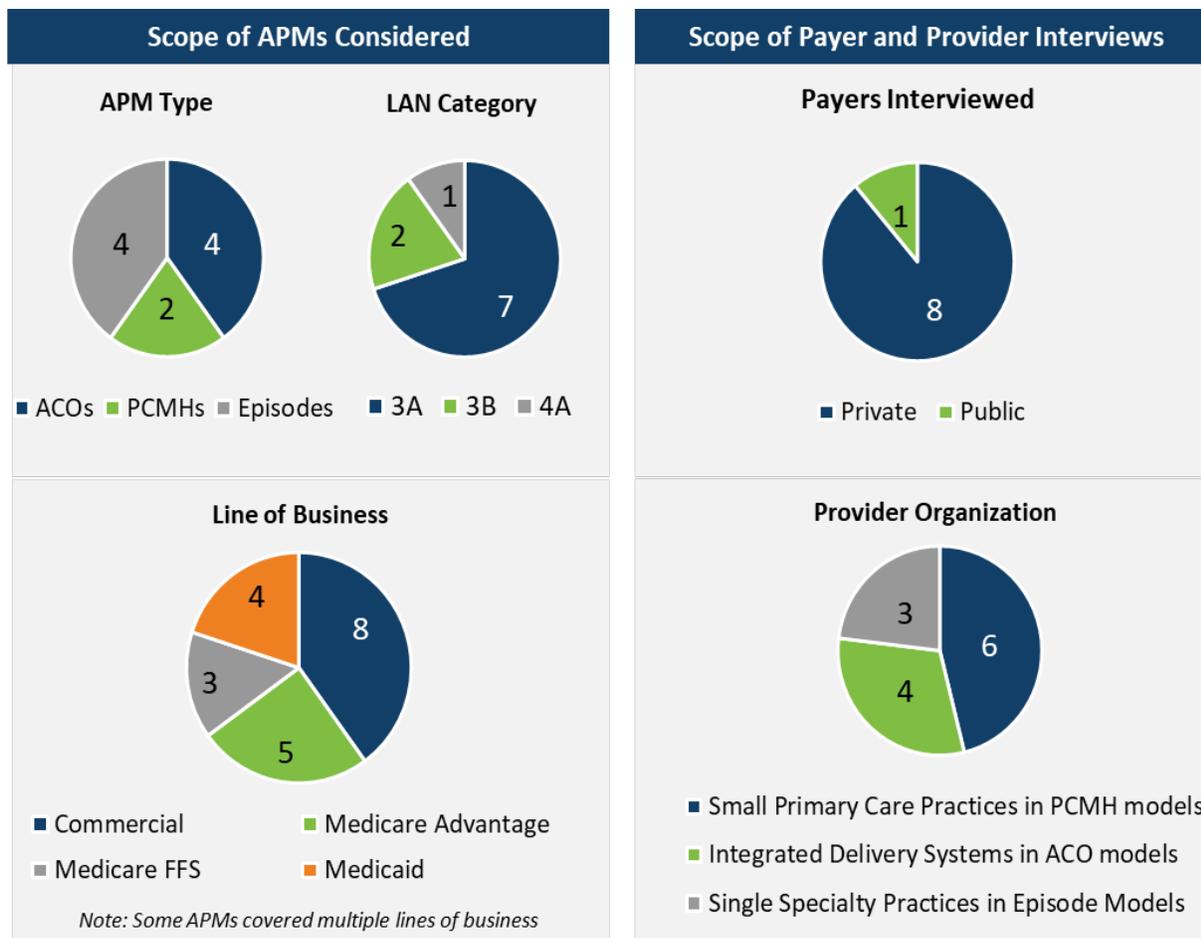


Figure 1: Scope of the Roadmap

* Accountable Care Organization (ACO) and Primary Care Medical Home (PCMH)

Given the limited number of APMs investigated, the promising practices described in the *Roadmap* do not reflect the full range of payer and provider experiences, approaches, and challenges with APM implementation. For example, APMs investigated in the *Roadmap* focus mostly on adult and senior populations, which likely reduces its applicability to pediatric populations. In addition, the modest scope of the *Roadmap* makes it difficult to determine whether the promising practices described here represent the universe of promising practices, let alone the “best practices” used in the field. As a pilot study, the *Roadmap* was unable to fully examine or describe the complexities of practices essential for successful APM implementation, such as approaches to succeeding in downside-risk arrangements, implementing multi-payer APMs, integrating behavioral health, or collecting and using patient-reported outcome measures. In the Path Forward section, the *Roadmap* offers HCP-LAN suggestions on important areas for additional work to further efforts to promote value-based care.

How to Use the Roadmap

Based on an analysis of qualitative data gathered through 22 payer and provider interviews, the HCP-LAN determined that promising practices fell into three domains, with several themes in each domain. The *Roadmap* presents descriptions of promising practices organized by domain and nested themes.

Readers can focus on sections that are most relevant for them (Figure 2). Promising practices often span domains and themes; in these cases, the *Roadmap* provides links to other relevant sections.

APM Design	Payer-Provider Collaboration	Person-Centered Care
Payment Structure & Financial Risk	Collaboration on APM Design & Provider Engagement	Patient Engagement
Benchmarking & Utilization	Data Sharing & Analytics	Health Equity
Quality Measurement	Care Management Support	
Patient Attribution	Leadership & Organizational Culture	Benefit Design
Multi-Payer Alignment		
DESIGN	IMPLEMENTATION	

Figure 2: Domains and Themes in the Roadmap

The *Roadmap* is primarily intended for public and private payers in all lines of business (i.e., commercial, Medicare FFS, Medicare Advantage, and Medicaid) and at different stages in APM implementation. Readers should gain a better sense of which approaches have worked for payers through the lens of promising practices that promote collaboration and partnership.

The *Roadmap* also offers useful information for other stakeholders. Clinical leaders, for example, can gain a better understanding of the design and implementation decisions that payers encounter and a sense of the types of activities other providers undertake to succeed in APMs. Patient and consumer advocates may find useful the catalog of payer and provider practices to engage patients. These practices may help advocates pinpoint specific areas for more actively engaging patients to improve patient experiences and outcomes. Finally, purchasers can benefit from a deeper understanding of the APM design and implementation process for more effective engagement in the design and administration of value-based insurance products.

APM Design

Theme 1: Payment Structures & Financial Risk

Note: In the APM Design section only, each theme offers promising practices for population-based models and clinical episode models separately.

Population-Based Payment Models



Promising Practice #1: Establish a payment structure for population-based models that is appropriate for providers with a range of capabilities for successfully implementing APMs.



For Providers with Emerging Capabilities

- Providers with emerging capabilities may have difficulty moving directly from pay-for-performance to global payments without the opportunity to gain experience in shared savings/risk arrangements.
 - Note that the continued use of fee-for-service (FFS) can limit the flexibility of more advanced providers to allocate resources among patients with different levels of health needs and to perform functions that are not compensated on the fee schedule.
- Payers can employ utilization-based shared savings models in which providers receive FFS payment and care management fees as well as at-risk incentive payments for quality and utilization.
- Payers implementing accountable care organization (ACO) models can use enhanced FFS or per-member-per-month (PMPM) fees to cover care coordination and management costs. It is not uncommon for providers to forego care management fees in favor of additional opportunities for shared savings.
 - Generally, these ACO models do not offer additional at-risk incentive payments in addition to shared savings opportunities, but rather, use scores on performance measures to adjust shared savings rates.
 - These types of utilization-based shared savings models provide a more gradual transition from pay-for-performance into shared savings.



For Providers with Advanced Capabilities

- Payers use a risk-adjusted, global, upfront payment for most primary care services. These payments retain FFS payment for underutilized services (e.g., immunizations, vaccinations, and wellness visits), including regular incentive payments for quality and cost. These payments are reconciled at year-end to fully reflect updated claims and adjustments.
- Payers believe these Category 4A arrangements are effective because:
 - Global payments free providers from the revenue cycle and from performing services simply to maintain financial viability.

- Global payments reduce uncertainty about cash flow and give providers greater flexibility to focus on patients with greater health needs and goals for population health.
- They encourage clinicians to practice to the top of their licenses.
- They allow providers to invest in nonmedical services that would otherwise not be reimbursed through FFS (please refer to [Health Equity](#)).



Promising Practice #2: Make sustainable and effective investments in primary care delivery infrastructure.

Providers in early stages of APM implementation rely on support from payers to invest in infrastructure, but these investments are generally not provided indefinitely. A common resource stream is care management fees, which are used to invest in population health management infrastructure. Another strategy is for payers to offer opportunities for shared savings.



Care Management Fees: Provider Perspective

- Providers prefer consistent care management fees to offset the costs of care delivery transformation, but payers and purchasers prefer to introduce accountability mechanisms and limit the duration of care management fees.
- Where possible, providers combine care management fees from multiple payers to fully support new clinical and administrative functions and staff.
- Providers may prefer risk-adjusted fees because they more accurately reflect care coordination costs and help providers focus on the sickest patients.



Care Management Fees: Payer and Purchaser Perspective

- Payers may use Joint Operating Committee meetings to ensure that providers are using care management fees to responsibly invest in care delivery transformation (please refer to [Provider Engagement](#)).
- Payers may place restrictions on how care management fees can be used and/or make care management fees contingent on the implementation of person-centered care delivery functions, such as:
 - Improving access through expanded office hours, 24/7 clinician availability, same-day appointments, online scheduling, and allowing for urgent care walk-ins
 - Improving care delivery by creating and refining practice workflows
 - Improving care coordination by staffing a care coordinator
 - Improving person-centered care by undertaking initiatives to address social determinants of health or high-risk populations
 - Improving health equity by developing initiatives that address health disparities
 - Participating in disease registries to improve clinical care
- For payers and purchasers who do not want to maintain care management fees indefinitely, other payment mechanisms (e.g., shared savings) can provide incentives for providers to invest effectively in infrastructure. Once providers have consistently generated shared savings, payers can transition their care management fees into additional opportunities for shared savings.



Promising Practice #3: Use timely incentive payments that reward improvement and attainment.



Timeliness

Incentive payments can have greater impact on clinical behaviors and decisions when they closely follow the incentivized activity. When annual incentive payments are too delayed or too infrequent, they will not effectively influence providers' activities or maintain cash flow.

- To tie performance to payment, some payers use quarterly or semiannual incentive payments, based on projections about what providers are expected to earn as shared savings.
- Another approach is to prospectively pay incentive payments and recoup payments in the event of poor performance. Providers caution that it can be difficult to pay back prospective incentive payments because they have already spent those funds on overhead and staff.



Reward Improvement and Attainment

- Payers use several approaches to link cost and quality performance to incentive payments (please refer to [Quality Measurement](#)), such as:
 - **Quality Gates:** Payers establish all-or-nothing, minimum-quality gate thresholds for providers to be eligible for shared savings (i.e., providers receive 0 percent of shared savings if they fall below the threshold and 100 percent if above).
 - **Scaling Shared Savings Based on Quality:** In addition to establishing all-or-nothing, minimum-quality gate thresholds for shared savings eligibility, payers also scale shared savings payments according to quality scores above the minimum threshold; certain payers base shared savings on reduction of preventable utilization measures relative to historic trends.
 - **Quality Monitoring for Improvement:** Payers work with providers who consistently fail to meet quality measurement thresholds and reconsider their continued participation through corrective actions.
- Payers set realistic goals for short-term improvement (e.g., one to two years) and aspirational goals for improvement over the medium to long term (e.g., three to five years) and work closely with providers to identify opportunities to drive improvement. Payers' medical directors work directly with providers to ensure that providers consider these goals fair, and payers share score calculations and their impact on payment in the interest of transparency (please refer to [Data Sharing and Data Analytics](#)).
- When constructing total quality scores from results on individual measures, payers set annual improvement and attainment benchmarks for providers to meet longer-term quality goals. Scores on each metric are compared to benchmarks and a scoring system is used to calculate a total quality score, which determines whether providers receive incentive and shared-savings payments and how much they receive (please refer to [Payment Structure and Financial Risk](#)).



Promising Practice #4: Give providers a smooth glide path for assuming financial risk and moving into downside-risk arrangements.



Glide Path for Cost Accountability

To give providers a smooth glide path for assuming financial risk, payers can design seamless models that gradually move providers from pay-for-performance to shared-savings arrangements. These models establish incentive payments for high performance on quality and utilization measures and gradually introduce opportunities for shared savings, based on individualized assessments of their capabilities and performance (e.g., infrastructure, leadership, and past performance) (please refer to [Provider Selection](#)).

- It is critical for payers to gradually increase the level of financial risk in an APM so providers can gain the necessary experience to confidently and successfully assume financial risk. Providers prefer to gain experience and confidence in upside models and are reluctant to participate in downside-risk models until they do so.
- Risk frameworks should be designed to be flexible for providers depending on their capacity to manage population health.



Downside Risk

Some providers are hesitant to assume downside risk (i.e., accountability for excessive costs within providers' control) due to concerns about their financial viability, their ability to control and manage risk, and other organizational factors. Payers use several strategies to address these concerns as shown in Table 1.

Table 1: Payer Strategies to Address Provider Concerns with Downside Risk

Topic	Provider Concerns	Payer Strategies
Financial Viability	<ul style="list-style-type: none"> • Margin of Error and Capital Reserves – Low margins of error in revenue targets and lack of capital reserves to cover losses above the costs of investing in care delivery redesign • High Costs for Small Patient Panels – Costs associated with redesigning care for a small portion of a patient panel 	<ul style="list-style-type: none"> • Limit Risk – Establish limits on financial risk • Asymmetric Risk – Use asymmetric risk corridors (i.e., greater opportunities for savings than losses) and provide additional shared savings opportunities
Span of Control	<ul style="list-style-type: none"> • APM Design – Lack of opportunities to participate in downside models with sufficiently favorable terms (i.e., approaches to financial risk, benchmarking, and other aspects of 	<ul style="list-style-type: none"> • Model Design Flexibility – Give providers more flexibility in downside-risk arrangements (e.g., by allowing selection of attribution methodologies and waiving certain prior authorization requirements)

Topic	Provider Concerns	Payer Strategies
	<p>APM design that give providers confidence they can succeed)</p> <ul style="list-style-type: none"> • Access to Data – Inability to access raw claims data • Attribution Methodologies – Being accountable for patients they are not aware of or do not actively care for, and not being able to easily change patient attribution status • Benefit Design – Open access benefit designs that offer no patient incentives to choose a high-value provider or to remain within the ACO provider network • Benchmarking – Being evaluated on previous performance and not being able to make additional improvements after reaching a certain threshold 	<ul style="list-style-type: none"> • Access to Data – Establish contractual reporting agreements and let providers access payers’ claims data (including paid amount from care delivered outside the provider organization (please refer to Data Sharing and Data Analytics)

Payers and providers noted several additional considerations about implementing downside-risk APMs:

- Medicare Advantage APMs may be well suited for taking on downside risk because they often offer more opportunity to address cost and quality of care in that population (e.g., by addressing care gaps) and the population can be easier to engage.
- In some cases, government regulations prohibit downside-risk arrangements (e.g., state laws prohibiting payers from holding providers financially accountable for care they do not deliver).
- It is essential to link payment to quality measures and patient experience survey results in downside-risk models.



Provider's Perspective: Preparing for participation in downside-risk models

Small practices and large provider organizations both noted the steps they would take to succeed in downside-risk models were very similar to those they have used to succeed in upside-only models. Some steps include:

Operations:

- Ensuring internal financial incentives for individual clinicians are aligned with provider organization incentives in the APM
- Before participating in downside models, ensuring existing care delivery programs (e.g., quality and risk programs) have demonstrated success in shared savings arrangements, and would therefore be more likely to be successful in downside arrangements

Contracting:

- Understanding the risk modeling in downside-risk contracts
- Making access to raw claims data a prerequisite for participation
- Making access to patient attribution lists and adequate processes for modifying patient attribution a prerequisite for participation

Business Strategy:

- Developing long-term growth strategies that account for shifts in care from hospital to ambulatory facilities and shifts from specialty to primary care utilization
- Using payouts from quality programs to offset revenue losses associated with decreased hospital utilization in integrated delivery systems
- If needed, involving conveners and support organizations to provide technical assistance for assuming financial risk



Promising Practice #5: Scale APMs to preserve core features of the model (e.g., base payment mechanisms and types of risk) while also allowing for flexibility and customization in different markets and for different types of providers.

When introducing modifications to core payment methodologies and/or scaling APMs in new markets, payers consider payer and provider mix as well as state regulations. Payers balance foundational APM design elements with the need to reflect market-level customization when designing, expanding, or scaling an APM. Market-level considerations in APM design fall into two categories:

- Payer/Provider Mix
 - In markets with smaller or independent practices, payers implement patient-centered medical home (PCMH) programs with different risk adjustment and savings opportunities based on the market and line of business.

- In markets with particularly high fee schedules and where contracts are structured in terms of medical loss ratio (MLR), not total costs (please refer to [Benchmarking and Efficient Utilization](#)), payers create models based on MLRs³ rather than setting cost targets such that providers share savings if they come under the MLR benchmark.
- Gaining and promoting multi-payer alignment on APM design aspects (e.g., provider portals and data analytics reports) may help attain provider buy-in in a given market (please refer to [Multi-payer Alignment](#)).
- In certain markets where payers have set precedents with certain APM design aspects, it can be difficult for other payers to come into the market with different design elements (e.g., care management fees and benchmarks based on improvement relative to market).
- State Regulations
 - Payers evaluate regulations in different markets that could interfere with model components or value-based payments more generally. Some states have stricter regulations than others, which can limit creativity and timeliness of new programs.
 - Medicaid APMs must consider state guidelines on provider reimbursements (e.g., provider eligibility for gain sharing) and the challenges of modifying value-based programs year to year to align with state requirements and priorities.

Clinical Episode Models



Promising Practice #1: Establish base payments for procedural episodes.



Suitability for Episode Payments

Payers consider episodes for high-volume, high-cost procedures (particularly those with significant cost variation) as ideal targets for bundled payments. Payers are less likely to design bundles for procedures without much variation in care delivery, even if the episodes are high volume and costly.



Base Payments

- Payers use at least two approaches to make base payments for procedural episodes:
 - Prospective professional and facility payments, effective either at the beginning of the episode or at the time of the procedure (if the procedure occurs in the middle of an episode). Unpaid claims are used to track services provided in the episode. This approach is used in downside-risk models and reduces the burden of processing claims.
 - Fees for services rendered during the episode and use of retrospective reconciliation to reflect shared savings or losses based on agreed-upon financial benchmarks.
- The appropriate approach to base payments in clinical episodes will depend on the payer's payment system configuration—and which is easier to implement—as well as the preference of providers who are recruited to participate in the model.

³ MLR measures the amount of money a payer spends on claims for health care and quality improvement, relative to the amount of money the payer receives in premiums.



Promising Practice #2: Ensure timely incentive payments.

As with population-based models, long lags between activities and incentives can diminish the saliency of these payments:

- Procedure-based episodes: Shared savings payments can be provided quarterly or semi-annually.
- Condition-based episodes: Prospective payments can be used when longer episodes of care would result in a significant lag between services rendered and incentives paid.



Promising Practice #3: Establish a risk framework appropriate for providers who will participate in the models.

As with population-based models, participating in episode models with downside risk can be difficult for providers, particularly if fee schedule negotiations have engendered distrust.



Glide Path

Providers in clinical episode models may not initially assume downside risk. This builds trust (by allowing the two stakeholders to work closely to generate savings for both parties) and helps providers gain the capabilities needed to succeed in APMs.



Downside Risk

To drive greater efficiencies in care delivery, payers use downside-risk arrangements with providers who are affiliated with more sophisticated delivery systems with advanced practice management systems in place. Payers may also make participation in downside-risk arrangements mandatory for providers who receive payments for services covered in the payers' episode models.

Theme 2: Benchmarking and Efficient Utilization

APMs use financial benchmarks and other methods to assess providers' cost and utilization performance. This section describes how payers establish benchmarks to limit the amount of insurance risk that providers assume.

Population-Based Payment Models



Promising Practice #1: Establish a methodology for basing and rebasing benchmarks that ensures the right level of accountability for costs.



Basing and Rebasement Benchmarks

- Payers use historical benchmarks to drive year-over-year improvements. Alternatively, they use regional benchmarks to reduce random variation in regional medical prices and to drive greater efficiencies in care delivery.
 - Payers set global primary care rates at levels above historical spending to spur additional investments in primary care.
 - Payers use efficiency adjustments in historical benchmarks (e.g., holding spending targets close to constant year over year) to reward efficient providers for maintaining low costs.
 - Payers take regional cost performance into account when setting prices and determining the risk structure in contracts with historical benchmarks (e.g., minimum and maximum thresholds for savings and risk).
- When establishing regional benchmarks, payers construct comparison groups based on logically equivalent patients and providers in the same geographic region who do not participate in the APM.
 - Some payers establish rolling, cohort-controlled comparisons based on logically equivalent peer groups, instead of basing benchmarks on a provider's historical costs.
 - Other payers construct comparison groups of patients who are not attributed to an APM.
 - Payers ensure providers included in comparison groups are in the same geographic region. They also include pharmaceutical costs but control benchmarks for pharmaceutical benefits because benefit structures influence utilization and prescription patterns in ways that are beyond providers' control.



Cost Measures

- Many payers use total cost of care (TCOC) measures when constructing benchmarks, but others use different measures, such as:
 - MLR to determine cost performance when providers work in high-cost markets and/or participate in Medicaid APMs.
 - Total medical cost trend, which holds providers accountable for improving overall trends (e.g., holding medical cost increases to 1 percent or lower).



Promising Practice #2: Use nontraditional benchmarks that do not expose providers to insurance risk.

Payers use utilization indices as a proxy for total cost of care, sometimes in combination with virtual panels across providers, to establish cost accountability while minimizing providers' exposure to insurance risk. This is vital for small practices.



Utilization Indices



To ensure cost reductions do not derive from reductions in appropriate care, payers set utilization targets in Category 3A APMs for ACOs that are actuarially sound and risk adjusted, and they base eligibility for shared savings on providers' ability to reduce preventable events (e.g., readmissions or emergency department utilization) relative to historical trends. This is important in Medicaid APMs because of historical access issues in this population.



In Category 4A APMs for primary care, payers establish a utilization index covering high-cost areas outside of the primary care setting (e.g., specialists, radiology, hospital, and pharmacy costs) and base incentive payments on how well providers perform on the index.



Virtual Panels



In Category 3A APMs for primary care, payers combine patients across smaller practices in the same region into virtual panels, which are used to calculate aggregate performance scores. Using advanced utilization and quality metrics as a proxy for total cost of care, payers set overall targets for the virtual panel. If the panel beats the target, payers share savings with all panel providers.

Clinical Episode Models



Promising Practice #1: Establish a methodology for basing and rebasing benchmarks that limits insurance risk and ensures the right level of accountability for costs.



Establishing and Updating Benchmarks

- **Set and Update Historical Benchmarks:** Payers use the most recent data available, anticipate changes to the fee schedule, and run regression models to establish average, practice-level cost targets for each provider, which determine rates of shared savings or shared losses. When setting or updating cost targets in episode models, payers retrospectively define populations that would have been attributed to a practice, project the costs associated with those patients, and set cost targets consistent with cost goals (i.e., in terms of reducing costs or reducing cost trends).
- **Use Benchmarks to Reduce Unnecessary Services:** When clinical episodes can entail higher- or lower-intensity services (e.g., C-sections versus vaginal deliveries in maternity episodes), payers use a blended rate that reflects utilization goals for each type of service to incentivize providers to appropriately utilize lower-intensity services. Similarly, payers set utilization targets (e.g., readmission rates) to goals for reducing unnecessary care and factor savings from reduced utilization into a benchmark that is lower than one based solely on historical utilization.

- **Use Efficiency Adjustments for Efficient Providers:** As in population-based models, efficient providers in clinical episode models may not have much room for improvement. Payers account for this by setting targets that are close to historically efficient spending rates.
- **Set Minimum Episode Thresholds and Exclude Outliers:** To reduce random variation in bundle rates and exposure to insurance risk, payers require providers to perform a minimum number of episodes to be eligible for shared savings and shared losses. Payers also exclude patient outliers from bundles to set more reasonable cost targets.



Case Mix Adjustment

- **Adjust for Risk at the Practice Level:** When safeguarding against incentives to deny care to high-acuity patients, payers prefer practice-level, case mix-adjusted targets. This is because patient-specific risk adjustments are complicated for payers and opaque for providers, and because regional, statewide, or national targets mask variation in case mix and the costs of local providers.
- **Adjust for Risk Based on Episode Length and Initiation:** In certain cases, payers make further adjustments to target costs, depending on initiation and length of the episode, because risks may vary based on when a patient presents to the provider. For example, in prenatal episodes less than nine months, payers consider whether patients have had prenatal care before the initiation of the episode. For coronary artery bypass grafts, payers consider whether the procedure was elective.
- **Provide Transparency in Risk Adjustment:** Although methodologies used for case mix adjustment can be complicated, payers have found that providers are satisfied if they know that relevant factors have been accounted for in the adjustment, even if they do not fully understand the specific algorithms.



Including and Excluding Services from an Episode

- When designing new clinical episode models, some payers use proprietary groupers to specify services related to the episode, while others use homegrown groupers tied to clinical models used in provider organizations.
 - Payers find proprietary episodes useful because they are standardized and maintained by an independent entity; however, they can also be overly complicated and require simplification to implement.
 - Conversely, episodes developed in-house can be harder to maintain because they need to be manually updated.
- When payers create a new clinical episode model, it can be analytically challenging to clearly distinguish services related to the episode from those that are not.
 - To ease analytic and administrative burden, payers set benchmarks based on all services rendered during the episode period.
 - Payers consider this approach sufficiently reliable for setting cost targets because similar rates of unrelated services can be expected in the future.
 - Providers can be uncomfortable assuming risk for costs that are outside of their control (e.g., a hospitalization not associated with a clinical episode), and they noted that including costs for all services can lead to unintended consequences (e.g., delaying a

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procedure because a patient already received a high-cost service within the episode period). Nevertheless, providers recognize that excluding certain costs is administratively difficult and time consuming and note that excluding outliers can mitigate risk.

Theme 3: Quality Measurement

APMs use quality measurement systems to hold providers accountable for high-quality care and outcomes. This section describes how payers select measures for APMs and the approaches they use to reduce reporting burden.

Population-Based Payment Models



Promising Practice #1: Select a parsimonious set of measures that covers prevalent and costly conditions in the patient population and uses common, endorsed measures.

Payers engage providers in varying degrees in the selection and maintenance of quality measures and the updating of quality measure sets (please refer to [Collaboration on APM Design](#)).



Core Measure Sets

- In primary care models and ACO models, payers use a core set of Healthcare Effectiveness Data and Information Set (HEDIS) metrics, focusing on accountability for management of common conditions or areas in which providers are best able to address care gaps (e.g., cancer screenings, medication management, or immunizations).
- Payers also develop TCOC composite metrics based on areas of high cost, such as specialty care, radiology, inpatient/outpatient hospital services, pharmacy, and emergency/urgent care (please refer to [Benchmarking and Utilization](#)).
- Measures sets range from 5 to 20 measures, with little overlap between APMs from different payers.⁴



Measurement Set Customization

- Payers complement HEDIS measures with utilization measures, such as preventable admissions and readmissions, which cover areas of high spend.
- When building on applicable CMS quality measure sets (e.g., Medicare Shared Savings Program), payers supplement with pediatric measures (e.g., adolescent well-care visits) in private and Medicaid APMs and with state-required quality measures to attain a five-star National Committee for Quality Assurance (NCQA) Medicaid rating.
- Providers are more likely to participate in APMs if required measures align with measures they are already tracking.

⁴ Please refer to Additional Resources in the tool for lists of measures used in population-based and clinical episode models.

Moving Beyond HEDIS

Payers and providers agree that...

It is important to move beyond HEDIS measures when evaluating quality in APMs, and some providers do not regard Category 3 and 4 APMs as valid quality programs if less than 10 percent of incentive payments are based on patient health outcomes (as opposed to HEDIS process and utilization measures).

Experience of Care Measures

- Payers include patient experience measures, such as [Clinician and Group Consumer Assessment of Health Providers Survey \(CG-CAHPS\)](#), and tie them to payments in ACO and primary care models. Patient experience survey results are used to identify opportunities to better engage patients in their care.
 - Payers link patient experience scores to payment based on improvement as well as achievement, compared to a benchmark of patients not attributed to an APM.
 - Payers use third-party vendors to administer patient experience surveys and share survey results with providers, who are generally eager to know how patients rate them.
 - Where providers are unfamiliar with patient experience measures or uncomfortable tying them to payment, payers start with an attestation that providers are fielding their own surveys and acting on the information (please refer to [Payment Structure and Financial Risk](#)).
- Payers are considering working with employers and providers to administer homegrown surveys in addition to CG-CAHPS, particularly when piloting models. Payers are also developing methodologies to tie net promoter score (NPS) survey results into CG-CAHPS results specific to ACOs.



Promising Practice #2: Reduce the burden on providers of reporting data for quality measures.

- **Use Claims-Based Measures:** To reduce provider burden and minimize technical challenges associated with collecting data from EHRs, payers rely on process measures (HEDIS measures in particular), which can often be calculated using claims data.
- **Make Certain Measures Optional:** When specifying a set of measures that impact payment, payers identify a core set of mandatory measures and allow providers to select additional measures that are most relevant to their practice from a set of optional measures. This approach can reduce measure fatigue and help align quality measures used by different payers.
- **Use Common Specifications:** Payers use standard measure specifications to support alignment with measures used by other payers.



Provider's Perspective: Approaches to quality improvement in population-based payment models

Providers take different steps to improve the quality of the care they deliver to patients.

Engage clinicians

- Hold weekly staff meetings to identify areas for improvement, monitor progress on metrics, review guidelines for care, refine data collection techniques, and discuss opportunities to enhance patient engagement.
- Develop best practices for improving measure scores and leverage physician champions to disseminate these practices throughout the organization.
- Furnish regular reports for individual clinicians to help them improve their performance (e.g., utilization, care retention, and quality measure performance compared to both peer and best in class benchmarks).

Develop quality improvement strategies

- Conduct data-driven analyses to assess the burden of disease in a patient population.
- Focus on widely accepted metrics where there is room to improve and that impact a significant number of patients in a provider's panel.
- First prioritize quality measure performance, then address utilization and appropriate sites of care, and finally develop programs to address social determinants of health.
- Monitor patients on the verge of becoming high risk for critical preventive care needs.

Improve data use and optimize data reporting mechanisms

- Use registry platforms to collect and report data.
- Redesign workflows to increase the ease of data entry in EHRs and provide information about clinical and cost guidelines at the point of care.
- Establish a cross functional analytics team to aggregate and integrate data from multiple payers with internal EHR data

Clinical Episode Models



Promising Practice #1: Select a parsimonious set of measures that assesses outcomes across episodes as well as processes, outcomes, and experience that are unique to a specific episode.



Clinical Measures

- Payers work closely with providers to select measures that focus on outcomes (instead of process measures), and they reduce the number of measures used in bundle payment models (please refer to [Collaboration on APM Design](#)).
- When developing measure sets for bundled payment models, payers use a core set across episodes (e.g., readmissions and extended use of opioids) as well as a small set of episode-specific measures that focus on key outcomes (e.g., adenoma detection rate in colonoscopy bundles).



Patient-Reported Measures

- Where applicable and possible, payers incorporate patient-reported outcome measures in clinical episode models (e.g., pre- and post-operative functional status for orthopedic procedures).
- Payers assess patient experience of care across the entire episode, rather than in a specific site of care.
- Payers account for the uniqueness of each episode when interpreting patient experience measure results. For example, ratings for oncology episodes are generally poor by virtue of the treatments, while ratings following joint replacement are generally more positive because pain is alleviated.



Promising Practice #2: Establish assurances that quality is not diminished by economic incentives in bundled payments.

Payers monitor performance on quality measures before tying performance to shared savings payments. Payers use at least two types of linkages between quality performance and payment: Quality Monitoring and Link to Payment.



Quality Monitoring

- When working with providers with advanced capabilities, payers may rely heavily on providers' own quality improvement initiatives and do not use additional measures to assess performance.
- These payers also use their own measures to assess performance and identify improvement opportunities. They make continued APM participation (and potentially inclusion in a payer's network) contingent on performance.
- These payers also place a strong emphasis on annual evaluations to flag safety issues, as well as informal mechanisms for fielding concerns about poor quality outcomes in the episode (e.g., via patient surveys and hotlines).



Link to Payment

- Payers tie quality performance to eligibility for shared savings, but they allow flexibility in the measures used.
- Some providers noted they would prefer greater financial incentives for maintaining high levels of quality performance, especially when achieving quality outcomes increases costs in a clinical episode (please refer to [Payment Structure and Financial Risk](#))



Promising Practice #3: Reduce the burden on providers of reporting data for quality measures.

- **Align Measures:** Payers align measures with ones that providers report to national specialty societies.
- **Standardize Clinical Data Collection:** When necessary for calculating quality measures, payers use portals to collect clinical data from providers. They also work with providers to standardize EHR data submission when expanding episode models or developing multiple clinical episode model types (please refer to [Data Sharing and Data Analytics](#)). Otherwise, payers calculate quality measures from claims.
- **Sample Data:** For high-volume episodes, payers allow providers to report on a random sample of episodes, instead of requiring providers to report data on all episodes performed.



Provider's Perspective: Approaches to quality improvement in clinical episode models

Integrated delivery systems and specialty practices use several tactics to improve the quality of care in clinical episodes, such as:

Data Entry and Analytics

- Clinicians report process (e.g., beta blocker pre-op) and outcome (e.g., transfusions) data real time or monthly.
- Clinicians receive regular reports (quarterly or monthly) to help them monitor compliance with clinical processes.
- Integrated delivery systems regularly refine EHRs to mitigate the burden of intrusive data collection and to achieve the promise of clinical decision support and monitoring.

Compliance with Clinical Guidelines

- Providers condense complicated clinical guidelines into simple algorithms that providers can use to make care decisions, such as picking the right lab test or prescribing the right drug.
- Providers use "clinician ambassadors" to champion guidelines in individual practices.
- Providers monitor compliance with clinical guidelines and intervening with individual physicians who deviate from the guidelines, or whose quality performance scores are significantly lower than national standards. These interventions can take place individually or during regular meetings where physicians meet to discuss performance data and results.

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Theme 4: Patient Attribution

APMs use patient attribution to assign patients to providers who assume responsibility for their care and care outcomes. This section describes how payers establish prospective and retrospective approaches to attribution in population-based models and how they use claims to attribute patients in APMs.

Population-Based Payment Models



Promising Practice #1: Deliberately select a prospective, retrospective, or hybrid approach to patient attribution.



Attribution Options

- **Prospective Attribution:** Payers attribute patients to primary care physicians before the annual performance period, based on claims or patient attestation. Prospective attribution makes it easier for providers to manage patients because providers know their patient's profile in advance.
 - Prospective attribution seems to be more successful for primary care providers—as opposed to specialists—given the primary care physician's role in coordinating care.
 - If payers are unable to attribute based on claims, they engage in alignment campaigns, in which they send a letter to all members informing them of the importance of selecting a primary care physician. If patients do not select a primary care physician, one is selected for them, and both patient and provider have an opportunity to decline the alignment.
 - Private payers marketing ACO networks as Health Maintenance Organization (HMO) products require members to select a primary care physician, either with open access to specialists or referral requirements.
 - Prospective patient attribution is inconsistent with purchasers' demands for insurance products with open networks, which can create misaligned incentives for patients and providers (please refer to [Benefit Design](#)).
- **Retrospective Attribution:** Payers attribute patients to primary care providers or specialists based on claims. Retrospective attribution more accurately assigns patients to the providers who are most responsible for the patients' care based on utilization of services. When there is not a direct link to a primary care provider, payers use claims-based attribution to specialists. These payers ensure that either provider type has an adequate opportunity to intervene with attributed patients.
- **Flexible Attribution:** For providers who assume downside risk, payers offer a flexible option between prospective or retrospective attribution methodologies.



Adjudicating Attribution Lists

- Many payers give providers monthly reports on their attributed population, which account for changes in enrollment and additional claims runout (Please refer to Data Sharing and Data Analytics).
- They also give providers opportunities to discuss and adjust lists of attributed patients.

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- A significant area of concern for many providers is the difficulty they experience in obtaining monthly attribution lists through payers' portals.
- Providers noted the inability to easily adjust attribution lists is a significant impediment to movement into downside-risk arrangements.
- Provider experience difficulties recouping payments when patients were erroneously assigned to another provider for a period of time.



Promising Practice #2: *Adopt an algorithm that attributes patients to providers who can meaningfully impact patients' health.*

- In primary care models, payers attribute patients based on 12 rolling months of evaluation and management (E&M) billing codes for services rendered in a site (e.g., outpatient visits in an office setting) such that patients are attributed to the provider who delivered the most services. In the case of a tie, they attribute patients based on the most recent date of service or the highest FFS allowed amount. Other payers attribute patients based on most recent visits, not the largest number of visits.
- For the purposes of global payments for primary care models (Category 4A), payers attribute patients even if they are only seen once for an annual wellness visit. This allows providers to use some of the payment they receive for healthy patients on patients with greater health needs (please refer to Payment Structure).

Clinical Episode Models



Promising Practice #1: *Use straightforward, consistent approaches when attributing patients to clinical episodes.*

Attribution of patients in clinical episodes is more straightforward than in population-based models because there is a clearer link between a patient and a discrete episode of care.

- In procedural episodes, payers attribute patients to physicians and facilities that perform designated "triggering events" (e.g., attribute Chronic Obstructive Pulmonary Disease (COPD) episodes to hospitals where patients were initially seen in the emergency department).
- In condition-based episodes, payers attribute patients to providers based on "day-one" criteria, which initiate an episode for a patient. Day-one criteria are identified by claims logic (e.g., two claims with a diagnosis of heart failure that are at least 30 days apart or a hospitalization with a specific diagnosis). The selection of day-one criteria can be arbitrary. This is not problematic if the specifications for day-one criteria are consistent and make clinical sense to providers.

Theme 5: Multi-Payer Alignment

In some cases, payers work together and with other stakeholders to implement multi-payer APMs, which establish similar conditions and payment approaches for providers who see patients from different payers. In other cases, payers adopt strategies to increase alignment of APM design and implementation across distinct APMs operated by different payers. This section describes how payers and other stakeholders collaborate to increase multi-payer alignment.

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Promising Practice #1: Establish forums and shared understanding to facilitate discussion and promote collaboration.

Payers noted that collaboration with other payers can be difficult, but their efforts result in concrete benefits for patients and providers, and each other. Multi-payer models also can increase provider participation in APMs.



Catalysts for Multi-Payer Alignment

- According to payers, having a smaller number of payers in a market, leadership and support from state agencies, and preexisting collaboration among payers and providers, makes it easier to collaborate on multi-payer models.
 - With sufficient leverage in a market, providers can expedite the development and deployment of multi-payer models by demanding that payers align on quality measures and other programmatic requirements.



Design and Execution

- Stakeholder Engagement
 - Payers engage a wide range of stakeholders when designing and executing multi-payer models, including:
 - Academic and community physicians
 - Nurses
 - Clinic managers
 - Behavioral health specialists
 - Patients and patient advocates
 - Patient engagement can improve APM design and implementation. It is essential to include patients in planning and designing multi-payer models to benefit from their unique insights on areas important for care delivery transformation and its specific impact on patients and families.
 - Payers maintain consistent expectations for stakeholders, including who is involved in the collaboration.
- Meetings
 - Payers obtain initial buy-in from providers in town halls and similar open forums.
 - Payers meet regularly in person to improve collaboration and trust and facilitate coordination and decision making.



Promising Practice #2: Reach consensus on priority topics and specific approaches to priority topics.

- Consistency and Flexibility: Payers have created multi-payer APMs that keep some design facets consistent (e.g., eligibility and attribution), while also allowing flexibility to address the needs of different patient populations (e.g., pediatrics and seniors). Using similar requirements across payers reduces administrative burden for providers.

- **Quality Measurement:** Establishing consensus on quality measurement can be done by partnering with other payers and working closely with providers to select measures as well as measure specifications for use in an APM.
- **Data Sharing:** Payers create a standard format for data sharing to ensure providers receive the same type of report by using aligned data elements for attribution, quality measurement, and cost performance.
 - If a single, common report is not feasible, payers strive to standardize reporting formats and specifications across payers. For example, payers use sharable, editable files with drill-down functionality to allow providers to aggregate patient-level data across payers on the back end.
 - Payers use a common portal for sharing data with providers within and across different models. These portals are used for claims submission, technical assistance, and determining eligibility. Providers note that common portals significantly reduce administrative burden.
- **Investments in Common Infrastructure:** Multi-payer models give payers a shared interest in improving common health care infrastructure for patients living in the same geographic area, even when patients move between payers. Payers have found that coordinating payer investments in priority areas (e.g., through care coordinators or data-sharing capabilities) while avoiding antitrust issues is helpful for implementing successful multi-payer models.



Provider's Perspective: Challenges working with multiple payers

Providers noted the following challenges with working with multiple payers:

Lack of Quality Measure Alignment

- Use of different quality measures and conflicting thresholds in numerators and denominators, which substantially increase reporting burden for providers, makes it difficult to implement standard processes for all patients. It also significantly contributes to provider burnout.

Lack of Alignment on Required Documentation

- Misaligned documentation requirements for care plans and care plan transfers between payers create administrative inefficiencies.

Lack of Alignment on Data Sharing

- Inconsistent and insufficient data sharing (e.g., claims feeds with different data-mapping systems) makes it difficult to aggregate payer data and integrate it with EHR data.

Lack of Flexibility in Model Design

- Lack of flexibility by national payers when implementing national APMs at the local level, and the inability of payers' regional representatives to secure modifications for providers, creates misalignments in local APM implementation.

Lack of Alignment on Episode Design

- In clinical episode models, payers' use of similar episode definitions but different technical approaches (e.g., risk adjustment, outlier expenses, and shared savings methodologies), result in burdensome calculations that do not directly impact patient care.



Payer-Provider Collaboration:

Theme 1: Collaboration on APM Design and Provider Engagement

Payer-provider collaboration—both on APM design and delivery transformation—is a critical factor for implementing successful APMs. This section describes how payers collaborate with providers on APM design and engage providers in delivery transformation.

Collaboration on APM Design



Promising Practice #1: Establish venues, processes, and shared understanding to facilitate discussion and promote collaboration with providers.

Iteratively Engaging an Expanding Group of Providers in APM Design

- When designing and piloting APMs, payers work closely with staff physicians and a small cohort of advanced practices to resolve programmatic details and capture provider feedback before rolling out a pilot model.
 - When applicable, payers draw on lessons learned and precedents from Medicare APMs, such as the Medicare Shared Savings Program or state pilots.
- Payers develop APMs iteratively through multiple refinements to design and implementation and establish mechanisms to collect and incorporate feedback into the program (e.g., primary care services that may be included in a global payment, timing of incentive bonus payouts, and approaches to adjusting incentives for absolute and historical performance).

Establish Formal Forums for Experienced Providers

- Payers anticipate providers will become more knowledgeable about APM design as they gain experience in the model.
- Once the models have matured and developed, some payers convene provider advisory councils—generally C-suite, executive, or management-level thought leaders—to meet regularly during the year to provide guidance on APM design and implementation.
- Other payers establish quarterly meetings with a cross-section of the highest performers to identify opportunities to improve the program (e.g., approach to quality measure selection).



Promising Practice #2: Reach agreement on foundational elements of APM design.

Formal Evaluations of Population-Based Models

- Identifying Refinements: Payers implementing population-based models emphasize that robust program evaluation is essential for understanding APMs from multiple dimensions and separating their impact from broader industry trends. Payers closely examine APM operations to identify opportunities for improvement that would be beneficial to all parties—patients, providers, employers, and payers.
- Provider Advisory Councils: Several times a year, teams of payer analysts bring research findings and recommendations for redesigning APM elements (e.g., attribution, trending and risk adjustment methodologies, and sustainability factors) to provider advisory councils. Input from provider advisory councils has a significant impact on changes to the model. Payers view this input as invaluable. Providers also view collaboration with payers on APM design as productive and that payers are receptive to feedback for program simplification.

Close Collaboration with Specialists to Align Payments and Clinical Models

- Discussing Intent: Payers discuss episode models and their intent with providers (drawing on the expertise of vendors who developed the episodes as needed), including which episodes to tie to gainsharing.
- Feedback on Technical Elements: Payers meet regularly (e.g., biannually) with each specialty in an episode to gather feedback on issues, such as payment algorithms, quality metrics, list of services related to a procedure, patient exclusions, and thresholds for clinical indicators.
- Initial Flexibility: For providers new to bundled payments and how they operate, payers may offer multiple options (e.g., retrospective versus prospective payment, inpatient-only versus inpatient and outpatient care, or different risk-adjustment approaches) and then limit the options as payers get a better sense of what works and what does not.
- Consistent Changes: When modifying episode definitions, payers ensure that changes are made for all providers, rather than using different model definitions for providers in the same episode.
- Success Through Collaboration: Providers participating in clinical episode models express a high degree of satisfaction with payers’ approaches to collaborating on episode design and noted this collaboration has led to improvements in the model.

Provider Engagement



Promising Practice #3: Use flexible tools to assess provider capabilities and select providers for APM participation.

Because not all providers are ready to participate in APMs, payers carefully select the ones who are.

- Payers use a multidisciplinary team to design flexible capability assessment tools, which evaluate providers on different dimensions, including:
 - Experience**
 - The organization’s leadership, culture, and commitment to value-based care.

- Performance or experience, either in other models or based on a review of the provider’s historical data.
- The organization’s current relationship with the payer and their position in the network in a market.

Resources

- Existing transformation investments and workflows.
 - Information technology (IT) capacity and infrastructure.
 - Adequate staffing in large organizations (e.g., quality managers and financial reporting teams).
 - Staff capabilities (e.g., use of dashboards or data mining, quality improvement, understanding of quality measures, and care coordination functions).
- Assessment results have a material impact on how or whether payers collaborate and engage with specific providers. Payers acknowledge it does not make business sense for a provider to invest in redesigning clinical workflows and additional staff until APM penetration reaches a critical mass.



Provider’s Perspective: Preparing to participate in population-based APMs

Both small and large practices enter population-based APMs because:

- They believe value-based care is the future of health care and the right thing to do for patients and for health care system sustainability.
- They see immediate opportunities to increase revenue and to improve job satisfaction for their staff.
- They are required by law to enter these arrangements.

For smaller provider organizations with emerging population health management capabilities

Some providers in smaller practices use the NCQA guidelines and certification process to prepare to participate in population-based models. While providers characterize this as meticulous and difficult, they saw it as crucially important for establishing care processes appropriate for APMs. In addition to using the NCQA guidelines and certification process, providers took additional steps to prepare, such as:

Building Data Capabilities and Automatic Processes

- Identifying data needs for quality monitoring, tracking measures used in the APM, setting and tracking goals, and determining opportunities for performance improvement
- Implementing EHRs that allow providers after-hour access to medical records
- Setting up systems to automatically refill medications
- Establishing processes for fielding after-hours calls

Staffing Changes and Increased Responsibilities

- Establishing regular meetings with office staff to examine individual cases and identify ways to engage patients
- Adding additional staff (e.g., care coordinators) and using them to schedule additional preventive visits
- Delegating greater responsibility to care coordination staff
- Retraining nurses to better understand social services and care management (sometimes with the assistance of programs offered by payers)
- Redesigning staffing models and scheduling systems (e.g., so that physicians work with rotating teams of nurses and patients only receive care from a single team)
- Purchasing vehicles that can be used by nursing staff to conduct home visits

Stakeholder Collaboration

- Collaborating with other providers or community organizations on promising practices for population health management
- Establishing patient/family advisory councils

For larger provider organizations with advanced population health management capabilities:

Larger provider organizations typically make use of existing care management programs when first participating in an APM. For example, they use existing programs to see patients for their annual wellness visits and address patients' needs while they are in the office (please refer to [Patient Engagement](#)). Larger provider organizations also begin stratifying, targeting, and tracking new patient populations, while ensuring sufficient staffing and care coordination support to meet APM objectives.



Provider's Perspective: Preparing for participation in clinical episode models

When preparing to participate in commercial clinical episode, providers noted one of the most important steps is to establish privileges to perform surgeries at low-cost surgical centers rather than the hospital. Other actions included:

- Leveraging in-network providers to reduce costs
- Minor, targeted changes to clinical protocols, such as ordering labs
- Having clear conversations with patients about when to use the ED
- Ensuring that guidelines are automatically implemented through standing orders.

In the Bundled Payments for Care Improvement model, clinical episodes were triggered by an inpatient admission or surgery, and performance strategies were different than for commercial models. Participants within the BPCI model pursued strategies including:

- For elective surgical episodes, developing “prehab” programs to optimize patients before surgery, streamlining care protocols, and carefully managing post-acute care
- For medical episodes, focusing on care coordination, early post-discharge follow-up, and carefully managing post-acute care
- Please refer to the [BPCI Tool Kit](#) for more information.



Promising Practice #4: Identify an overarching strategy for scaling an APM and leverage regional personnel when entering new markets.



Scaling Strategies

Payers scale payment models by incorporating additional providers and by expanding into new lines of business. Scaling strategies depend on specific objectives and payment structures.

- Some payers look to scale rapidly and learn quickly about what is working in value-based payment, initially onboarding providers into a payment model with minimal selection criteria before moving gradually toward more selective models.
- Other payers begin with stringent criteria to select providers, ensuring that participating providers have shifted away from the FFS mentality and acquired necessary health IT capabilities to transform care delivery. These payers test a payment model design thoroughly before expanding to new providers.



Regional Staff

When scaling payment models broadly, payers leverage regional staff to establish provider relationships for value-based payments in each market. These individuals possess insight into market-level factors and what has been successful. They can identify and assess providers' population health management capabilities.

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Promising Practice #5: Strategically and effectively communicate with providers to gain and maintain engagement.



Communicating Effectively

Payers noted that effective communication is important for gaining initial provider buy-in and engagement in APMs.

- Payers use many strategies to communicate with providers and secure their engagement. For example, they:
 - Strive for simplicity in model design for algorithms to assess performance and the data and information sharing.
 - Educate clinicians about the model and provide them with simulations that show how providers might fare better in value-based contracting versus FFS.
 - Ensure buy-in and support of practice transformation efforts from physician leaders and corporate representatives of multi-practice organizations before initiating or changing agreements.
 - Give providers an effective outlet for expressing frustrations with the program, including those that are not directly related to the APM (e.g., billing processes).
- Payers try to quickly investigate questions and address concerns that providers raise; however, providers express frustration that they are not able to obtain prior authorizations after business hours, which can lead to unnecessary hospital utilization.



Learning Collaboratives

Providers benefit from venues where they can share best practices with and learn from their peers.

- Payers establish learning collaboratives—often two to three per year—that can be topic specific (e.g., opioid epidemic), APM specific (e.g., changes to incentives or quality measures), or care delivery specific (e.g., behavioral health integration). Topics ideally interest clinicians as well as office/management personnel.
 - Payers in multi-payer models bring in academics to educate clinicians about health literacy and motivational interviews, and they work with medical schools to teach students about team-based approaches to health literacy.
 - Other learning collaboratives focus on problem-solving in small groups and clinicians have found this format helpful.
- Payers schedule learning collaboratives during evening hours to increase attendance.
- Providers find it helpful to organize their own learning collaboratives with other providers in the area, which can focus on issues unique to their city or region; these local collaboratives provide insights that may not be addressed in more general forums run by national payers.
 - Providers also organize learning collaboratives within their practices to share best practices for specific clinical episodes.



Promising Practice #6: Execute Joint Operating Committee (JOC) Meetings that drive provider engagement and improvements in care delivery.



Timing of JOC Meetings

Payers establish monthly or quarterly JOC meetings with practices to discuss data and areas for improvement in detail.

- Payers tailor the timing of JOC meetings to reflect the needs of specific providers—advanced providers need fewer meetings while providers with emerging capabilities may need more.
- Payer teams who work closely with provider organizations are well positioned to understand providers' relative need for support to strategically invest engagement resources in provider groups that can make the most of the assistance.



JOC Meeting Agenda

Payers focus JOC meetings on mutually agreed actions, areas of focus, and ways to restructure workflows to meet improvement goals.

- The purpose of JOC meetings is to empower practices to make changes by identifying specific steps to close gaps in care (e.g., opportunities to switch certain patients to generic drugs).
- Payers create tailored care transformation action plans, especially for less experienced providers, based on provider-specific analytic data. Payers then discuss improvements to detailed workflow processes (e.g., specific approaches for engaging patients when they call or come into the office).



Payer Support for and Between JOC Meetings

Establishing trust and close personal relationships between payer and provider teams between JOC meetings is key to leveraging the JOC to improve provider performance.

- Payers send team members with different functions, including analysts, network liaisons, and clinical transformation consultants, to JOC meetings to ensure the teams can respond a range of provider questions and concerns.
- Payers establish training programs for providers' analytic staff to address frequent turnover in these positions.
- To build trust with providers, payers explain and simplify APM parameters, as needed, and they share transparent data.
- Payers strive to maintain consistency in the payer team to ensure providers always have a contact who can support supplemental drill-down reporting.
- Providers find it helpful to have easy access to dedicated teams. They also value their connections to senior leaders in payer organizations who can mediate relationships with other providers in their network and can act on information they receive directly about provider experience in the APM.



Assessment of Provider Engagement

Payers use JOC meetings to evaluate provider engagement with APM requirements (e.g., outreach to high-risk populations and extended office hours) as one factor for deciding whether providers should continue to participate in the APM.

- Payers maintain open and honest communication with providers about their performance.
- Payers place providers on a corrective action plan when they are not engaged (e.g., by decreasing care coordination fees and making continued participation contingent on improvement).
- Payers manage low-performing providers and do not allow chronic underperformers to continue with the model, especially if they do not have the right leadership or are not making the right investments to be successful.



Promising Practice #7: Establish learning and diffusion systems to disseminate information and to share best practices for APM success among providers.

When payers are unable to establish personal relationships with individual provider organizations because of the number of providers participating in an APM, payers establish learning and diffusion systems to engage providers, provide personalized feedback, and help them succeed.

Learning and Diffusion Platforms: Payers who establish learning systems create multifunctional platforms for communicating and accessing information.

Three-Way Communication: These platforms allow for three-way communications (i.e., from the payer to providers, from providers to the payer, and between providers) along with resources, webinars, podcasts featuring subject matter experts, and portals for posing programmatic questions.

Affinity and Action Groups: Within these platforms, payers create focused groups for provider collaboration to implement specific organizational changes or to share information and best practices on a topic.

- Groups focus on various topics, such as:
 - Telehealth
 - Using EHRs
 - Fall reduction programs
 - Approaches to care coordination and wraparound services
- These groups meet monthly and sometimes biweekly and often last up to six to eight months.
- Payers using these platforms find that clinicians readily pose questions, reach out to their peers for advice, and access written resources and webinars. Payers examine the types of interests and information that providers seek and use this information to consider changes to the learning system and programmatic features of the APM.

Sharing Best Practices and Lessons Learned: Payers operating learning systems also collect information from providers about their challenges and the implementation approaches they have found effective.

- Payers collect this information through interviews with targeted providers on focused areas that are developed into formal case studies and compilations of best practices.

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- Where possible, payers present this information in toolkits and driver diagrams, which give different types of providers (e.g., hospitals and single-specialty practices) strategic and operational guidance for succeeding in clinical episode models (e.g., standard operating procedures, job descriptions, governance structures, performance measures, and roadmaps).
- Generally, payers find it easier to engage care and finance teams than to engage physicians directly.

Theme 2: Data Sharing and Data Analytics

Sharing data and analytic reports with providers is a core function that payers perform when implementing successful APMs. This section describes how payers establish data architectures, provide analytic support, and share timely and actionable information.



Promising Practice #1: Identify and access data sources needed to operate an APM effectively and give providers access to claims data.



Data Architecture

Payers find it challenging to construct a data architecture to store and transmit data, and use dedicated analytics teams to:

- Establish a data architecture before to implementing an APM.
- Receive data from claims, EHRs, and other sources.
- Assess and compare provider cost and quality performance.
- Share raw data and analytic reports with providers.
- Distinguish the impact of the APM from broader economic trends.



Sharing Claims Data

- Some payers do not give providers access to raw claims data. These payers share other information on an interim basis when it is not possible to share a complete set of claims data.
- Some payers share claims data on a rolling basis before it is fully adjudicated.
- Payers with advanced data-sharing capabilities offer comprehensive data on fully adjudicated claims, including medical/pharmacy data, and information on care delivered outside the APM.
- Providers with advanced data analytic capabilities prefer direct access to raw claims data (both processed and pre-processed). If providers only desire claim extracts, payers produce raw flat-file claim extracts to help providers integrate the information into their internal systems along with data from other payers.



Sharing Clinical Data

- When payers need clinical data to calculate measure scores or assess provider compliance with other APM requirements, providers share EHR data.
- Payers with advanced capabilities employ bidirectional health information exchange (HIE) tools that allow providers to obtain a longitudinal view of a patient's care and health status.

- Payers and providers have had good experience entering data through online portals, especially when portals are shared by multiple payers. Nevertheless, payers face significant challenges with interoperability when scaling APMs to larger numbers of providers with different EHRs.
- Considering the various data sources required, payers capture clinical data that can be used to calculate hierarchical condition category (HCC) scores, risk adjustments, and CMS star ratings.
- When building capabilities for sharing clinical data, payers focus early partnerships on advanced and large providers who have the resources and staff to support the effort.



Third-Party Data

- Payers connect to HIEs or third-party data aggregators to obtain clinical data and use this data in analyzing performance and identifying care improvement opportunities (although this can present challenges with data integrity and validation).
- Payers collect data on social determinants of health and use it to inform the risk model and prioritize member needs. For example, some payers can identify patient needs and flag this information for care managers.



Promising Practice #2: Provide the right level of data analytic support.

Providers vary considerably in their level of analytic sophistication and their ability to understand and process health data (please refer to [Data Sharing and Data Analytics.](#)) Therefore, it is important for payers to adopt a flexible approach to make information as actionable as possible.



Provider Preferences

Payers recognize that provider preference for data will vary.

- **Raw Data:** Some providers prefer to run their own tailored reports based on raw data. Too much data, however, can be overwhelming for inexperienced providers.
- **Aggregated Reports:** Other providers prefer to use standard aggregated reports and may not know how to manipulate raw data for their unique purposes. Aggregated data can be frustrating for providers who want to drill down to the patient or provider level.



Payer Approaches

Some payers create customized approaches for each provider.

- **Communicate Regularly:** Some payers hold regular calls or office visits with each office or organization. Typically, a health plan staff member or team will be assigned to several provider offices.
- **Provide Direct Access to Payer Analysts:** Payers ensure providers have a direct line to dedicated analysts on the payer side who can answer questions about reports or model specifics (e.g., episode exclusions).
- **Help Providers Understand Data:** Payers use dedicated teams to help providers access and analyze data. Teams can offer data-training opportunities as well as individualized assistance to teach providers how to work with the data, such as how to sort information to prioritize the high-risk

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population, target specific populations in need of improvement, or target specific quality metrics (please refer to Care Management Support). In addition, payers task health plan staff with using the data and analytics to identify opportunities for improvement within provider practices or organizations.

- Consider Use of Population Health Analytics Vendors: Sometimes, payers encourage practices to engage with a population health analytics vendor who can create an ongoing information flow between providers, payers, and the vendor, with the goal of tailoring the insights to specific sites.



Promising Practice #3: Share actionable and timely data analytic reports to ensure providers have information to drive improvements.

Payers aspire to communicate timely, parsimonious, and actionable data (e.g., patient reports, gap lists, performance data, bonus estimates, and peer comparisons) to providers to promote data-driven decision making for improvement. To assure the most effective use of data, payers create data-sharing frameworks that provide specific information in specific intervals.

Although information contained in the following reports may overlap, [Table 2](#) presents the common reports.

Table 2: Payer Data Reports

Reports	Content and Purpose	Common Frequency
Admission and Discharge	Notify providers of patients admitted to or discharged from a hospital to ensure providers can schedule follow-up visits within 7–14 days to avoid potential readmissions.	Daily
Attribution	Give providers a list of patients currently attributed to them in the APM to ensure they understand for whom they are accountable.	At least monthly (especially on the first of the month)
Gaps in Care	Identify patients who require additional follow-up. Providers find it helpful when payers update these reports through their EHR portals, which makes it possible to access reports on an ongoing basis.	At least monthly or ongoing through EHR portals
Performance	Provide information about quality performance, utilization, and costs according to specialty and type of service to permit providers to track progress on quality improvement initiatives.	At least quarterly
Utilization	Identify frequent ED utilizers; benchmark against peers on utilization metrics in different categories (e.g., early scanning for low back pain and specialty care utilization); identify prescription management issues; and highlight opportunities to reduce unnecessary utilization.	At least monthly
Care Variation	Identify variation in care or service setting among similar patients to identify improvement opportunities (e.g., less expensive or higher quality sites of service for procedures or unnecessary tests), ideally with data at the individual clinician level.	At least quarterly
Cost Opportunity	Illustrate savings or incentive payments from reducing inappropriate care (e.g., by improving 5 percent, you can save \$X.XX).	At least monthly or as close to real time as possible
Predictive Analytics	Consider risk factors (e.g., conditions, health care utilization, behavioral health, and medication complexity) and predict negative outcomes (e.g., readmissions, acute care and ER events) before they occur.	At least monthly, or ad hoc

Reports	Content and Purpose	Common Frequency
Ad Hoc Analytics	Target specific opportunities for improvement (e.g., identifying patients who use the ED on the weekend or at night) to help providers understand the value of having extended hours. Many payers have internalized the analytics function (versus using a vendor) to reduce time lags needed to demonstrate the impacts of changes made by providers.	Ad hoc and as quickly as 6-8 weeks from request
Episode-Specific Analytics	Detail a provider's included and excluded episodes, costs associated with components of the episode, quality measure performance, utilization metrics, and benchmarking reports compared to their peers.	At least quarterly



Additional Considerations

- **Timeliness of Claims-Based Reports:**
 - Providers commonly express frustration that claims-based reports are less actionable because they are up to six months old.
 - In addition to making efforts to share pre-adjudicated claims data to address this concern, payers note that broad-scale trends are well represented in analytic reports, even if the underlying data are several months old.
 - Payers and some providers noted that providers can use claims-based reports to make successful delivery transformations, even if the data are old.
- **Reporting Data at the Provider and Patient Level:**
 - Payers suggest reporting data at the individual provider (National Provider Identifier) level and at the practice level to identify variations in practice within an organization.
 - In some cases, payers produce patient- and clinician-level reports and conduct supplemental analyses (e.g., cost reporting by disease) to make reports more actionable.
- **Data Integrity:**
 - Data integrity issues erode trust between payers and providers (especially attribution mistakes); reconciling minor inaccuracies (e.g., an admission listed on the wrong day) is time consuming.
 - Both payers and providers recognize the importance of data accuracy but they also understand that actions can be taken based on data that are less than perfect.



Provider's Perspective: Small practice approaches to data integration and aggregation

Challenges with EHR Configuration

- Smaller primary care practices experience difficulties abstracting reliable information from their EHRs due to discrepancies in data entry or because of incorrectly configured requirements used by EHR vendors (e.g., excluding blood pressure readings from a nurse-level visit).
- Primary care practices address these issues by working closely with vendors to modify requirements and develop new functionalities. These efforts are resource intensive and often lag payers' requirements for data reporting.

Acting on EHR Data

- Providers in smaller practices can generate feedback reports, such as gaps in care (e.g., annual wellness visits or mammograms), patients needing follow-up appointments (e.g., for diabetic eye exams or routine lab tests), and reports that flag patients with high risk clinical indicators (e.g., HbA1c greater than 9.0).
- Using results from these and other reports (e.g., discharge alerts), providers can stratify patients, prioritize outreach from care coordinators, and make hiring decisions (e.g., nutritionists).
- These providers also report electronic clinical quality measure (eCQM) performance directly through payers' EHR portals and run gap reports and performance reports as often as weekly.

Acting on Payer Analyses

- Primary care providers in smaller practices note that payers have made great strides in their data analytic reports over the years, and that trend reports provide good information about the success of improvement initiatives.
- Providers use gaps in care reports; however, the reports do not usually reflect care a patient received before they joined the payer's plan. Providers find it can be challenging to get claims data to reflect their EHR data. Providers must manually identify erroneous information in reports. Correcting these errors with payers is resource intensive.
- Providers express frustration that payers are unable to run claims reports to calculate clinical quality measures. Providers must repackage clinical data captured in case notes to conform to data elements used to calculate quality measures. Providers believe that payers should be able to perform this function.

Cost Reports

- Some small practices do not pay close attention to cost reports; instead, they rely on processes and clinical protocols to optimize utilization and see few opportunities to reduce costs without withholding necessary care. Other providers scrutinize cost reports, and express frustration with granular reports that are difficult to interpret as well as higher-level analyses that they could not disaggregate (e.g., specialty cost reports that did not break out costs by specialty or patient).

- Providers consider patient-level data on specialty costs especially important for managing costs. They also desire multi-payer reports so they can determine when their patients see providers in different plans.
 - Providers note that many reports are up to nine months old and that more timely cost data would be more actionable.
 - Providers also recognize that pre-processed claims are not especially accurate and therefore less helpful for cost management. They found great value in quarterly prescription cost reports to identify patients on expensive medications. These providers credited HIT as a significant contributor to their success because it reduced the resources required to manage a practice.



Provider's Perspective: Integrated Delivery System approaches to data integration and aggregation

Sophisticated Analytic Capabilities:

Integrated delivery systems employ sophisticated data architectures, which allow them to collect and aggregate data from EHRs, registries, claims, and other sources, to ensure actionable information is available at the point of care.

- Some providers internally generate monthly analytic reports and use them, instead of analytic report from payers, to manage care coordination activities.
- Large provider organizations find value in reports that identify missed opportunities to provide services or referrals that would have improved quality measure scores. These organizations use this and other information (e.g., risk stratification data and discharge alerts) to prioritize resources for outreach to individual patients.
- Large provider organizations note that individual clinicians can be overburdened and overwhelmed by reporting and receiving too much data and believe the key to reporting registry data efficiently is to incorporate it into existing workflows.

Sharing Claims Data:

Large provider organizations express frustration that they are unable to access payer claims data, which they noted as a limitation for population health management, particularly when providers are unable to generate attributed patient lists.

- Large provider organizations highlight different mappings that payers used to structure their claims feeds (e.g., approaches to patient identification and matching), which complicates aggregation. They also express frustration that payers are unable to generate a single claims report for the entire health system, and instead can only generate unique reports for each tax identification number in the system.
- Even without claims data from a specific payer, large provider organizations can rely on other data in their system (including claims data from other payers) to guide population health management activities.

- In the absence of claims feeds, summary, and patient-level reports based on rolling claims, data can be sufficient to monitor payer-specific trends and priority areas.
- Payers support providers' efforts to develop and share standard EHR files (to eliminate manual data entry); however, providers note that payers face challenges loading EHR data from providers with different systems into a common data warehouse.

Theme 3: Care Management Support

Payers support providers in APMs by helping them manage the care of their patient population by establishing new care processes and executing those processes to coordinate patient care.



Promising Practice #1: Create care transformation teams to work closely with data analytic staff to provide tailored recommendations on process.



Care Transformation Teams

Payers create care transformation teams that work closely with payers' analytic teams to identify and capitalize on opportunities for improvement (please refer to [Provider Engagement](#)), such as reducing cost, enhancing quality, and transforming care delivery. These teams can be essential for providers with emerging capabilities, although both small and large provider organizations indicate that payers' care transformation teams have helped them achieve success in their APMs. Some providers with advanced capabilities appreciate a hands-off approach that identifies higher-order priorities and does not attempt to manage their internal processes.



Core Functions

- **Develop Action Plans:** Payers develop action plans leveraging analytics to identify specific modifications to existing work plans and potential new processes and resources to help providers achieve their goals.
- **Provide Innovative Ideas:** Payers provide innovative ideas about how to meet program requirements, such as how to form patient and family advisory committees. Practice transformation teams support providers' transformation efforts and are a "go-to" resource throughout the life of the agreement.
- **Assist with Case Management:** For each provider, practice transformation and analytic teams implement a process for identifying attributed patients with the highest needs, such as using "triggers" for case management activities. Practice transformation teams help providers develop plans to prioritize and address patient needs and they collaborate with providers on medical management.



Promising Practice #2: Create teams of centralized payer care coordinators to interface with provider care coordinators to more directly assist with case management.



Care Coordination Teams

Payers create centralized care coordination teams that perform several functions for providers who participate in APMs and those who do not. These teams provide more direct care coordination and case management assistance than care transformation teams, whose function is to identify plans and processes for improving care delivery.

- For Providers with Emerging Care Coordination Capabilities: Payers offer a centralized team of care coordinators to collaborate with, or serve as, care coordination staff. These teams can facilitate care transitions and help patients navigate the health care system as well as engage in case management for complex cases.
- For Providers with Advanced Care Coordination Capabilities: Payers customize their care coordination support to avoid duplicating provider efforts. When patients are identified as needing case management, centralized care coordination teams ensure that health plan case managers coordinate with provider-based case managers to avoid confusing patients with duplicate calls. If a provider has a care coordination program, the payer's team helps them analyze strengths and gaps to complement but not duplicate their programs.



Core Functions

- Connecting Providers to the Community: Centralized payer care coordination teams engage community navigators to link providers to local resources or connect them to health plan case managers if they need specific help. Teams often include social workers to enhance case management support for members and/or provider practices.
- Enhancing Provider Care Management Teams: Some payers use centralized care coordination teams to train, educate, and enhance care manager capacity in provider offices. In some cases, centralized care coordination teams engage case management vendors for their most complex members.
- Utilization Management:
 - ER Utilization – Payer care coordination teams ensure providers are notified when their patients go to the ED. They review whether urgent care appointments are available within the practice or whether urgent care centers are available in the community, with the goal of identifying more efficient alternatives for non-emergent situations.
 - Specialty Utilization – Payers share information with providers about specialists and their corresponding quality and efficiency scores. Payers review specialty referral patterns to help providers understand whether they are referring patients to the highest-value clinicians.

- Incorporating Behavioral Health: Payers are running pilots to test complementary services in APMs, including subsidies for high-impact, low-cost interventions and services (e.g., programs focused on meditation to reduce anxiety). Payers recognize the importance of managing behavioral health in an integrated way and have begun including behavioral health services into traditional medical benefits.



Provider's Perspective: Foundational care coordination functions

Small practices rely heavily on dedicated care coordinators (either employed or subcontracted) to establish and track performance metrics, meet APM requirements, and engage with patients. Small practices can use revenue from increased utilization of wellness visits to support care coordinators.

Outreach, Engagement, and Education

- Execute efforts to increase annual wellness visits, either through outreach (e.g., via phone, text, or email) or by reminding patients who visit the clinic for other reasons to schedule a wellness visit.
- Over the phone, in the office and in after-hours classes, care coordinators educate patients on topics such as diabetes and wellness management (please refer to [Patient Engagement](#)).

Data and Analysis

- Set care management goals for patients at different levels of risk.
- Monitor progress toward established goals.
- Identify gaps in care and develop and execute processes to close them.
- Identify patients who use disproportionate health care resources.

Managing Utilization

- Use home visits, phone calls, and patient education to reduce hospitalizations and ED use.
- Hold regular meetings with home health agencies to manage home care and discharge patients when appropriate.

Thorough Patient Assessments

- Speak with patients, review patient charts, ensure that treatment plans are feasible for the patient; identify barriers to care for patients; and assess and address socioeconomic challenges, such as food insecurity and housing.
- Perform extensive risk assessments, including home visits to assess factors that interfere with care plans, such as cognition or safety issues within the home.

Integrating Care Delivery

- Reach out to patients who require follow-up and schedule visits with patients to close as many care gaps as possible.

- Present information to clinical care teams so they can adjust care plans accordingly and develop pre-visit protocols to ensure that medical assistants and physicians are aware of gaps in care and emergent needs before the visit, which increases the potential to make the clinical encounter more efficient.
- Health systems can use in-house pharmacy staff to improve rates of medication adherence, for example, by ensuring asthma patients receive the proper education about how to use inhalers.
- Work with urgent care centers to maintain continuity of care and exchange of patient health information.

Challenges with Scale. Small practices noted difficulties scaling care coordination activities with limited staff, and that the demands of effective care coordination can contribute to physician burnout.

- Although integrated delivery systems rely on teams of specially trained nurses who provide extensive care coordination support, a single physician in a smaller practice can find it challenging to be on call for patients with emergent issues. It is easier when many physicians or physician extenders share these responsibilities in larger group practices.



Provider's Perspective: Targeted Approaches to Care Coordination

Integrating primary care and behavioral health

Shortages. Smaller primary care practices find it difficult to integrate behavioral health with primary care partly because of shortages of behavioral health specialists and transportation issues.

- Some clinicians address shortages by contracting with licensed social workers, who treat patients in the office several days a month or by phone, or by hiring licensed professional counselors.
- Other clinicians receive supplemental behavioral health training, which allows them to provide additional behavioral health services in-house, or institute automatic screenings and established referral processes when patients screen positive for behavioral health issues.

In-House. Integrated delivery systems support in-house behavioral health units, which provide substance abuse and mental health services, and coordinate behavioral health care with primary care physicians. Like small primary care practices, in-house behavioral units proactively screen patients for behavioral health issues and have automatic referral processes in place if needed.

Preventing unnecessary hospital utilization

Collaboration with hospitals. Small primary care practices face challenges coordinating with hospitals to receive notifications of patient admissions and often rely on patients to notify them if they have been admitted.

- Some small primary care practices address these issues by gaining hospital privileges and access to hospital EHRs.

- Alternatively, care coordinators work with hospitalists to ensure that primary care practices receive discharge notifications and summaries, either electronically through a HIE, by fax, or by setting up a follow-up visit with the primary care practice and relying on patients to relay discharge information by hand.
- When hospitalists see patients in the ED instead of primary care physicians, providers find that patients are more likely to be admitted. Therefore, small practices establish relationships with ED physicians, who call them when their patients come to the ED to avoid duplicative testing and unnecessary admissions.

Follow-up on hospital discharge

- Once notified of discharges, small primary care practices obtain records from the hospital encounter. If possible, their EHRs automatically pulls discharge reports into the patient's record, and the appropriate staff in the practice receive an automatic notification.
- Care coordinators contact patients within 24 to 48 hours to understand why they were hospitalized, discuss medication changes or other issues patients face in obtaining the medications and equipment they need, and schedule follow-up visits with the primary care practice within a day to a week.
- Care coordinators place weekly calls to discharged patients to ensure continuity of care in the following weeks, schedule rapid visits to address emergent issues, and provide education on when it is or is not necessary to go to the ED. These activities are supported in part through transitional care management billing.

Managing utilization of specialty and post-acute services

Partnerships between primary care and specialty providers. Small primary care practices note difficulties establishing a process for automatically receiving detailed reports from specialists.

- Some rural primary care clinicians rely on established relationships with the few specialists in the area. These clinicians can monitor referrals to ensure that appointments are completed and receive patient records from the specialist encounter.
- Other primary care clinicians can be more selective about which specialists they select for referrals and base referrals on information about cost, quality, and utilization. In these cases, primary care clinicians establish care compacts that stipulate that specialists will see their patients within a certain amount of time when there is an emergency and that specialists will share consult notes on a predetermined schedule.
- Some practices lease space to specialists so they can periodically see patients in the primary care office.
- Health systems facilitate care coordination with specialists by offering them EHR access or through their involvement in common HIE portals. They also negotiate narrow networks with payers to give primary care providers more control over the specialists that their patients see.
- Managing utilization of skilled nursing facilities (SNF). Some specialists make recommendations to inform decisions about post-acute care, but patients ultimately decide and many prefer to recover in SNFs. Hospitals may refer patients to SNFs that they own, which makes it difficult for specialists to discuss less costly options.

Theme 4: Leadership and Organizational Structure

Payers and providers both note that provider leadership and organizational culture can be the most important factor for implementing successful APMs. This section describes how payers evaluate and engage provider leadership on multiple levels.



Promising Practice #1: *Assess and characterize the leadership of provider organizations participating in or planning to participate in an APM.*

Payers assess whether provider leaders are committed to transitioning away from FFS to value-based payments (and acknowledge that providers' revenue mix may still include significant FFS payments). Payers look for several leadership characteristics and activities when establishing and maintaining partnerships in APMs (please refer to [Provider Engagement](#)).

Payers note that provider leadership should:

- Invest in Value-Based Care: Ensure care coordination fees are invested in value-based transformation (e.g., quality managers, financial reporting teams, and clinical transformation).
- Promote Value-Based Care: Continuously promote standardized workflow processes that support person-centered care transformation.
- Engage Clinicians in Value-Based Care: Engage all clinicians in performance improvement plans and ensure they are aware of cost and quality targets (e.g., requiring individual clinicians to sign a commitment to value-based care or making performance data transparent and public within the organization). Payers also engage clinicians by cascading physician incentives for clinicians who work with patients in APMs (e.g., bonus payments for providing high-quality, low-cost care).



Provider's Perspective: Approaches to financial and non-financial incentives

Some providers use financial incentives to engage clinicians in meeting organizational or model goals, although incentive structures vary. For example:

- **Incentives tied to quality performance:** The provision or the amount of the incentives can be based on meeting specified quality metrics selected by the provider organization. For example, providers develop a core set of 10–25 measures and tie clinician or clinical group financial incentives (such as a bonus or portion of salaries) to performance on the core set. In some bonus structures, individual clinicians received a set dollar amount for each metric met every quarter.
- **Incentives tied to shared savings:** Financial incentives can be based on whether the organization itself receives shared savings. In this approach, team members receive a percentage of the savings if goals are met.
- **Distribution of Incentives:** Financial incentives can be paid out to individual clinicians or staff members, clinical groups, or entire departments.
- **Timing of Incentives:** Incentives can be quarterly, bi-annual or annual, which recognizes the importance of avoiding a significant lag between performance and rewards.

Providers also use a variety of non-financial incentives, including:

- **Performance Reports:** Publishing internal “report cards” on clinician performance to benchmark against their peers.
 - Report cards can be fully transparent to allow clinicians to see how their colleagues perform.
 - Alternatively, report cards can benchmark an individual’s performance against a blinded comparison group.
 - Both report cards target clinicians’ internal motivations to be high performers among their peers.
- **Performance Recognition:** Workplace events aim to celebrate successful performance on quality metrics and reward individual clinicians for meeting established goals.
- **High-Performer Distinctions:** External physician “finder” tools for patients that highlight high-performing clinicians for quality and cost.

Several providers mention that clinicians are often incentivized because they know patients are receiving better care and achieving better outcomes because of care delivery transformations. When clinicians can do a better job of taking care of patients, morale and buy-in increase.

In addition to financial and non-financial incentives, providers integrate physician ambassadors to help peers understand the value of the model and support organizational culture change (please refer to [Leadership and Organizational Culture](#)).



Promising Practice #2: Identify provider champions and effectively engage provider leadership participating in an APM.

Payers note that to ensure APM success, it is critical to identify and engage provider champions.



Payers

- **Identify and Engage Provider Champions:** Strategically approach the APM as a payer-provider partnership by identifying and engaging clinical and executive champions in leadership positions, both within practices and across provider organizations. Payers maintain close connections with provider champions to maintain support for the APM and to ensure alignment, engagement, and a shared understanding of what it will take to be successful.
- **Leverage Provider Champions to Attain Buy-In:** Leverage provider champions to attain buy-in and culture change within the provider organization. When assessing the pace of organizational change, payers recognize that in larger organizations culture change can be more challenging and take longer because these organizations have longer review processes and require greater coordination to implement systemic changes.



Provider’s Perspective: Approaches to Leadership and Team-Based Care

Leadership

- Providers consistently believe that leadership is essential to their success in APMs and that lack of leadership often explains others’ lack of success.
- Often, chief medical officers and clinical leaders establish goals and policies for quality and cost improvement, ensure senior leadership support for clinical initiatives, relay initiatives to clinical staff, and obtain staff buy-in.
- Many senior clinical leaders are invested in population health management as the future of health care and a key to financial success. They outline organizational strategies for delivering value-based care based on population health management approaches.
- Clinical leaders use performance data to motivate clinicians to change practices and disseminate a value-based organizational culture. Clinical leaders have found that simplifying performance reviews by focusing on a small number of key metrics makes it easier to channel clinicians’ efforts.
- Specialty physicians are committed to efficient and effective care delivery by adhering to evidence-based clinical models. Specialty physicians are less likely than primary care physicians to believe that leadership is critical to their success.

Team-Based Care

- Primary care providers work in multidisciplinary teams to facilitate care coordination and care management, and to ensure that staff are performing functions appropriate to their role.
- One tactic to promote team-based care is the “morning huddle,” where teams discuss immediate care management and care coordination goals, along with the patients on the

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schedule and their needs. Each member of the team leaves the meeting with specific tasks to accomplish during the day.

- Practices focus monthly team meetings on specific topics and objectives (e.g., complex case management, APM performance, and reinforcing practice values). If executed properly, these meetings can be fun and boost morale.
- Some clinicians establish care teams in which physicians are paired with rotating teams of nurses who perform outreach phone calls. In this way, even if patients cannot be seen by their physician, they can be seen by a clinician on the same team. Rotating nurses ensures that multiple individuals can address a physician's needs for patient care. This can help prevent physician and nurse burnout, because physicians see fewer patients and practice medicine as they want to, and nurses can undertake a range of activities.
- Clinicians note organizational changes can take place more rapidly in smaller practices than in larger provider organizations.
- Practices participating in procedural episode models adopt a team-based approach to care but may not coordinate workflows around care management and care coordination.
 - Surgeons lead teams of support specialists (e.g., anesthesiologists) and facility staff (e.g., operating room physicians and nurses). These teams follow pre-established surgical routes in the clinical care model.
 - In private episodes, it is important to establish access to low-cost, outpatient surgical centers and work effectively with their staff to reduce episode costs relative to performing the surgery in a hospital.
- Specialists in health systems use a team-based approach for procedural bundles, which involves nurses, care managers, and the different types of physicians who are involved in the patient's care (e.g., cardiac surgeons, cardiologists and anesthesiologists for coronary artery bypass grafting). These teams closely follow clinical protocols that have been developed and approved by clinical leaders in the organization. Processes ensure that the episode is warranted from a clinical perspective (e.g., second opinions from other specialists), and provider organizations use internal prior authorization processes to manage the utilization of post-acute care.

Changing Culture

Individual clinicians may already have bought into a value-based approach to care delivery, and culture change may occur at the grassroots before it reaches leadership. In some cases, however, leaders must let clinicians go if they are unable to operate in value-based organizational cultures.

Person-Centered Care

Theme 1: Patient Engagement

Patient engagement is essential for delivering high-quality, person-centered care and is a critical component for successfully implementing APMs. Providers and payers engage patients in their care, with providers often taking the lead. To a lesser extent, payers and providers engage patients in early decisions about APM design and implementation. Recognizing that payers and providers still struggle to maximize patient engagement (please refer to [Path Forward](#)), this section describes the activities payers and providers are undertaking to engage patients.



Promising Practice #1: Implement direct and innovative approaches to further engage patients in their care.



Standard Tool

- Payers use a range of strategies and tools for engaging patients, including:
 - Online patient portals
 - Provider directories to identify high-quality providers
 - Patient notifications about potential gaps in care and appointment reminders
 - Tools to provide transparent information about cost and quality (e.g., drug and procedure pricing breakdowns)
- Payers often incorporate these strategies for all members, regardless of their participation in an APM.



Additional Engagement Approaches

Beyond these standard tools, payers undertake additional activities to engage patients in their care and, to a lesser extent, in the design and implementation of APMs. For example:

- Patient Engagement in APM Design: Payers generally do not engage patients directly in APM design, although a few payers include patient representatives in stakeholder advisory meetings. Patient representatives can be included in stakeholder discussions about multi-payer APMs and can be influential in recommending changes in that context. Some payers host patient advocacy groups to gather views on payment and delivery models, in addition to reviewing patient feedback. Payers also gather patient feedback extensively through model evaluation surveys and incorporate this information into subsequent iterations of models. Still, payers note it is challenging to gather patient feedback on payment models because patients often are unaware of their participation in the models.
- Building Staff and Patient Awareness: Payers supply APM information (e.g., brochures) to providers to raise patient awareness about value-based care. Payers discuss the APM with providers' front office and phone staff to ensure they understand the APM and its goals because these staff members are generally the first point of contact for patients. Payers note that if phone calls are redirected or front office staff are not aware of the goals of value-based care, effective engagement can break down before it even begins.

- **Shared Decision Making:** Although payers generally encourage the concept of shared decision making, they do not necessarily place requirements on a formalized approach. Some payers emphasize shared decision making in episode-based payment models, particularly in the context of appropriateness of initiating an episode. Specifically, providers in the model are required to inform patients of appropriate indications for surgeries before initiating the bundle. In certain instances, shared decision making and care planning in episodes may not be feasible (e.g., trauma cases vs. elective surgeries). Other payers noted that a shared decision-making requirement can be challenging to implement, given significant variations in how providers approach the issue, especially with different patient populations.
- **Emphasizing Health Literacy:** Payers noted health literacy (e.g., understanding prescriptions) is particularly important in geographic areas with lower literacy rates. To improve health literacy, payers can partner with local universities to train students across multiple disciplines (e.g., medical, nursing, and pharmacy) on techniques to address patient barriers to understanding important issues related to their health.
- **Care Compacts:** Some payers require providers to discuss with patients a description of the APM, the provider's role, and the patients' responsibilities in their care, particularly when patients choose a high-value network product. In addition to requiring these discussions, payers have started implementing care compact arrangements that delineate provider and patient expectations from one another. Compacts explain levels of provider commitment to the patient (e.g., office hours and phone calls from care managers) and patients' responsibilities in their care (e.g., seeking guidance on appropriate care settings based on the severity of their need rather than going to the ED). These have been implemented in both population-based and episode-based payment models. For example, patient compacts in population-based payment models may emphasize that the primary care provider leads efforts to establish care plans and coordinate care delivery, while a patient compact in a surgical bundle may emphasize medication adherence or methods to decrease infection rates.
- **Patient Alignment Campaigns:** Payers implement patient alignment campaigns to engage patients. Payers conduct outreach to members who could not be attributed to a primary care provider through claims to inform them that they will be attributed to providers based on proximity if they do not respond. Payers implement direct communication programs that inform unaligned members of APM providers in their region and create a welcoming environment to engage those members if they choose to align. Payers also examine patients' utilization of ACO specialists and work with those specialists to align those patients to a primary care physician.
- **Multi-Disciplinary Care Management Teams:** Payers implement extensive care management approaches with social workers and behavioral health care management resources in local communities. These care management teams work to engage patients who are difficult to reach, focusing on how to address social determinants of health (please refer to Health Equity). Payers develop mobile capabilities for local care management teams (e.g., access to a utilization management platform with real-time data and bidirectional texting), so they can better understand when and how best to engage with high-risk or at-risk members. Payers noted that bidirectional texting is effective in member engagement because patients commonly respond to text messages.



Additional Considerations

- Payers take patient populations into account when designing patient engagement strategies as follows:
 - Medicare Advantage patients may be easier to engage in care management and to address gaps in their care.
 - Some populations may be more difficult to engage due to social circumstances (e.g., housing stability) and innovative approaches may be needed.
 - Some populations may be more critical to engage to address specific issues, such as ED utilization or opioid use disorder.
- Regulatory limitations may affect financial or other types of incentives payers can use to engage patients (e.g., financial amount, type of incentive, or social service).



Promising Practice #2: Use global payments or care management fees to allow providers flexibility in how they manage and engage high-risk populations.



Delegated Approach

- Certain payers enable providers to engage patients by providing greater flexibility in using funds beyond medical expenses, either through global payments or care management fees.
- Payers in these arrangements note providers are often better positioned to implement successful patient engagement strategies, given their closer relationship with patients.



Supporting Engagement with Global Payments

- Payers implementing global payment arrangements allow providers greater flexibility to use funds for patient engagement—particularly for complex patients—because funds can be used to perform services that are not compensated on the fee schedule. This frees providers from the demands of performing services to maintain solvency.
- By leveraging providers in patient engagement, payers may see more creative and invigorated efforts to engage members in care (e.g., providers offering gift cards for patients who complete the recommended course of preventive care or who use an outpatient mammogram center versus the hospital).



Supporting Engagement with Care Management Fees

- Payers often establish care management fees to assist providers in value-based care transformation (please refer to [Payment Structure and Financial Risk](#)).
- Payers may make care management fees contingent on providers managing and engaging high-risk populations as well as improving access to care, such as:
 - Requiring extended hours
 - Monitoring weekend or evening ED utilization
 - Requiring same-day appointments
 - Requiring online scheduling
 - Requiring urgent care walk-ins



Provider's Perspective: Approaches to Patient Engagement

Providers describe several office and community-based communication and education strategies (please refer to [Health Equity](#)):

Engagement Modalities

- Patient Portals and Smartphone Apps:** Providers use patient portals and smartphone apps, which offer benefits to providers and patients. By providing easy-to-use tools for patients to ask questions, request appointments and prescription refills, print immunization reports, and view lab results, for example, providers and care management staff can spend more time on care coordination and care delivery. Providers note that uptake of patient portals can be difficult given the need to sign up online and remember passwords. Therefore, providers incentivize patients to use the portal by offering such things as monthly contests and prizes (e.g., blood pressure monitors for the most engaged patients). According to providers, smartphone applications make it easier for patients to engage, particularly through HIPAA-compliant texting. In addition to communication from patients, providers send out communication blasts through direct messaging systems in the portal, reminding patients to come in for flu shots or other preventive services.
- Social Media:** Providers use social media to post general information on maintaining a healthy lifestyle or other health topics of importance, and to promote health fairs or other events.
- Mail:** Providers send mailers to patients who are due for certain appointments or screenings, or for general patient education. Providers or care coordinators may follow up a patient visit by sending patients information such as treatment plans to review at home.

Direct Engagement through Communication and Education

- Targeted Outreach:** Providers conduct focused outreach for patients to address gaps in care (please refer to [Care Coordination](#)). Providers emphasize the significance of care management in the context of a medical home. For patients who may not be consistently adhering to care plans, providers work to understand and address underlying reasons, (e.g., assumptions that a service is not covered or unmet social needs).
- Direct Engagement in the Office:** Providers emphasize direct patient engagement during office visits as more efficacious than other modes of communication. Small primary care practices encourage patients to attend relevant classes offered in the office. They proactively schedule wellness visits or screenings when patients are in the office rather than scheduling the appointment later. Providers acknowledge medication adherence as particularly important for direct communication.
- Engagement through Community Initiatives:** Small primary care practices offer health fairs in partnership with local communities (e.g., schools, local health departments, foundations, nonprofits, and home health agencies) to engage with patients. Many offer free preventive screenings. They also visit organizations in the community to discuss specific health conditions, and care coordinators run classes within the office. These practices collaborate with health plans and the community to focus on certain patient populations and encourage

them to come in for a visit. They also offer entertainment for children and gift cards for completing annual wellness visits.

- **Education on Post-Surgical Care:** Clinicians in episode-based payment models emphasized education on expectations post-procedure to avoid unnecessary ED utilization (e.g., expectations for pain, guidelines for keeping hydrated, and emergent versus non-emergent scenarios). These clinicians also offer 24/7 phone lines if patients or families are unsure whether an ED visit is necessary.
- **Shared Decision Making:** Patient engagement requires an understanding of patient preferences, values, and goals to tailor medical care appropriately. Clinicians emphasize that a patient's goal is not always to meet all of a provider's quality measures. While providers generally encourage shared decision making and patient engagement, many highlight challenges with standardized shared decision-making tools, noting:
 - Insufficient time to explain care options thoroughly when patients do not understand their options.
 - Some patients do not want to engage in health care decision making and believe that is the role of the provider.
 - Standardized shared decision-making tools or paperwork can become a barrier to patient interactions, with patients preferring a conversation to reach a shared understanding of their personal care preferences.

Patient and Family Advisory Councils

- **Patient/Family Advisory Councils (PFAC):** Providers convene patient/family advisory meetings, generally monthly or quarterly, in which they solicit patient input to drive improvement (e.g., approaches to afterhours phone access). Some committees are independently run, while others are run by providers' offices or care coordinators. Providers note the importance of having adequate representation across their patient population to generate ideas that are responsive to a variety of needs. Providers offer several examples of changes implemented as a result of patient input, including reducing paperwork (e.g., completing information online to expedite check-ins), and offering transportation for appointments to those in need (please refer to [Health Equity](#)).

Patient Engagement and Access

- **Extended Hours:** While increasing access to care does not necessarily drive patient engagement, providers note that a lack of access, or perceived lack of access, may be a barrier. Providers feel it is important to expand night-time hours and after-hours phone access. Providers also find that while extended hours may have been offered prior to APM participation, the APM further incentivized them to use extended hours and after-hours phone lines better, especially to avoid unnecessary ED utilization.
- **Telemedicine:** Some providers offer telemedicine options via virtual visits through phone applications. While virtual visits need to meet certain criteria for reimbursement, providers note they can be particularly helpful in engaging patients with access issues.

Theme 2: Health Equity

Deliberate approaches are critical for improving health equity and payers and providers both have important roles to play in this vital area. Recognizing that many payers and providers are still learning how to most effectively address health disparities as well as social determinants of health, this section describes the current activities of payers and providers in health equity.



Promising Practice #1: Provide data to identify gaps in care and allow providers flexibility in using funds to address health disparities and social determinants.

Using Data Analytics to Identify and Address Care Gaps: Payers may take a global approach to using data analytics to identify existing disparities in health or in care delivery among their members, seek to understand potential root causes, and identify appropriate strategies and solutions that can be addressed.

Providing Flexible Funds to Address Patient Needs: Payers often take a hands-off approach to addressing health disparities and social determinants of health, allowing providers flexibility to use funds in ways that work best for their patient population. For example, prospective payments can be used to cover social supports, such as transportation to medical appointments.



Promising Practice #2: Leverage community resources to address health disparities and social determinants.

Identifying Community Resources: Payers use social workers and case managers to assist primary care practices in identifying community resources for patients. For example, payers create uniform community resource guides and work with providers' care coordinators to make the guides readily available in their offices.

Multi-Disciplinary Care Management Teams: Multidisciplinary care management teams can be helpful in addressing complex medical and social needs and engaging patients who may be hard to reach. These teams work to determine specific issues contributing to disparities in health and health care and seek out potential solutions (e.g., behavioral health care management resources).



Provider's Perspective: Approaches to social determinants of health

Providers emphasize that health outcomes are impacted by social determinants of health. They develop strategies, mostly in partnership with communities, to address them.

Assess Social Needs

Providers note it can be difficult to attain community data on socioeconomic needs, although they use several approaches to assess needs.

- **Social Needs Assessments:** Many providers offer social needs assessments and questionnaires during patient visits to assess patients' needs. In addition, many providers seek to understand these needs through conversations with patients.

- **Care Management:** Providers emphasize the importance of care coordinators, care managers, and social workers in identifying high utilizers of the health care system (particularly the ED) and reaching out to these patients to understand root causes. Small practices note difficulties hiring social workers, and often work with larger hospital systems to requisition a social worker periodically to identify and address socioeconomic needs. Providers note challenges in reducing unnecessary ED utilization among Medicaid patients, especially when the ED becomes the default health care provider. Providers emphasize the importance of explaining emergent versus non-emergent needs to these patients and probing further for issues that could be driving that use.

Address Social Needs

Several providers engage patients through the community—including schools, health fairs, local health departments, hospitals, foundations, nonprofits, and churches—to address health equity and social determinants of health.

Uniform resource guides can help connect patients to important and useful community resources. Some providers distribute their resource guides to other offices (e.g., local health departments and the courthouse) to reach as many individuals as possible. The following section describes provider strategies to improve access to basic needs, such as food, transportation, housing, and health care.

- **Food:** Providers emphasize that access to nutritious food benefits is essential for health outcomes. In some cases, providers supply food in the office through food banks (e.g., through partnerships with local hospitals) and refer patients to community resources (e.g., food banks at local churches) for supplemental nutritional assistance. Providers can educate patients on applying for food stamps, connect them to local government agencies for nutritional assistance, and partner with local schools and community gardens.
- **Transportation:** Providers cite a lack of reliable transportation as one of the most significant barriers to health care, and therefore, many offer some form of transportation services. Providers work with case managers to provide certain transportation services, sometimes with assistance from payers or community organizations. Providers note that without reliable transportation, some patients may by necessity call an ambulance for non-emergent situations. Providers highlight two common barriers to facilitating transportation. First, transportation services are often unreliable and may need to be scheduled well in advance. Second, regulations may necessitate that providers seek legal counsel to determine if and under which circumstances they may offer transportation services.

Other potential options to address transportation issues include purchasing vehicles to conduct home visits; providing gas cards for patients to travel to specialists; and establishing mobile clinics. Small practices also partner with schools to more efficiently and effectively meet the needs of their pediatric patients.

- **Housing and Utilities:** Providers mention lack of housing and utilities as significant issues, although few providers offer concrete strategies to address them. Some providers strengthen relationships with housing authorities to ensure patients understand housing options. These providers also offer social work services to inmates (primarily jailed short-term for drug/alcohol-related issues) and conduct screenings and assist with housing applications. Some providers have worked with utility companies during bad weather to ensure utilities are restored for certain patients.

- **Language Barriers:** Some providers offer language services to patients, including telecommunication tools and interpretation services. Others with large Spanish-speaking populations work to ensure sufficient office staff are bilingual and that individuals staffing the after-hours phone line are bilingual as well.
- **Health Care Affordability:** A key barrier to health care is affordability for services and medications. Several providers work with social services to ensure patients get the care and medicines they need. Providers can help patients to optimally manage limited funds and can help patients access care in free clinics when eligible. Providers also work through pharmacies to identify patients who do not adhere to their medications and determine if more affordable options are available.

Theme 3: Benefit Design

In principle, benefit design can be used to guide patients to high-performing providers and to proactively manage their health and health care. Recognizing that benefit design as a complement to APM design is still evolving (please refer to [Path Forward](#)), this section describes the steps payers are taking to better align patient and provider incentives in APMs.

Promising Practices



Promising Practice #1: Integrate APMs and benefit design to guide patients toward high-quality, low-cost providers.



Approaches to Benefit Design

- **Emerging Approaches at Present:** While several payers note that tying benefit design to APMs is a significant and evolving issue, most are not yet implementing benefit design strategies specifically around their APMs.
- **Product Strategy:** Payers are anchoring insurance products around high-performing ACOs (where there is adequate coverage) to guide patients to high-value providers.
 - Payers may require primary care provider selection in these products to emphasize the role of primary care in population health management. Beyond PCP selection, payers offer both open access and referral requirement options.
 - Payers note that to guide members to high performing providers, there must be a meaningful cost differential (e.g., lower copays) to make the choice palatable.
 - Payers highlight the value of integrating center for excellence (COE) programs and streamlining COE referrals, as well as offering enhanced benefits (e.g., telehealth) in such products.
- **Challenges in Benefit Design:**
 - As benefit design evolves, payers note that either PCP referrals will be required, or payers will need to implement other benefit design strategies to emphasize the role of PCPs in patients' care.
 - Purchasers are not interested in placing limitations on insurance benefits (e.g., exclusive networks) unless they are directly associated with higher-value care.

»» APM Roadmap: The Path Forward

Five key topic areas—quality measurement, patient engagement, downside risk, multi-payer alignment, and benefit design—came up repeatedly in interviews with payers and providers and during discussions with the HCP-LAN Guiding Committee and APM Roadmap Work Group. Based on the *Roadmap* findings on promising practices currently used to implement successful APMs, the Guiding Committee and Work Group considered it important to signal to the field the importance of making progress in these five areas. Although the *Roadmap* was not designed to develop consensus on the best path forward, this section identifies key issues and barriers as well as suggestions for immediate (1–2 years) and longer-term (2-plus years) action.

Quality Measurement

The current state of quality measurement in population-based models reflects a lack of measures to meaningfully assess health and quality-of-life outcomes. Progress on quality measurement will require a significant shift away from clinical process measures and a greater focus on measure alignment and standardization across a wide range of APMs.



Immediate Actions

Stakeholder	Action
Payers	Incorporate existing patient experience measures (e.g., CG-CAHPS) into APMs to establish greater accountability for patient experience.
Providers	Move beyond narrow quality improvement initiatives and establish foundational improvement systems that can address a range of quality issues.



Long-Term Actions

Stakeholder	Action
All Stakeholders	Design new measures based on what patients say is important to them to measure patient experience more directly than CG-CAHPS.
All Stakeholders	Develop seamless ways to collect patient-reported outcomes (PRO) as part of the patient-clinician interactions.
All Stakeholders	Develop and implement PRO-performance measures (PRO-PM).
All Stakeholders	Leverage professional societies to develop measures that can be used across population- and clinical episode-based models.

Patient Engagement

Stakeholders across the health care system agree that APM design and implementation efforts would benefit from greater patient engagement, but the necessary resources are often not available. Stakeholders agree that additional progress can be made to support patients in making health care

decisions that are consistent with their personal preferences, values, and goals. Authentic patient engagement will require support for physician training in effective communication skills and engagement strategies that reflect patient preferences, cultural norms, and social determinants of health.



Immediate Actions

Stakeholder	Action
All Stakeholders	Leverage the PCORI model to engage patients in their care as well as the design of payment and care delivery models.
Providers	Establish compacts with patients in APMs, which establish mutual responsibilities that both parties need to fulfill to effectively manage the patient's care.
Payers and Providers	Operationalize HCP-LAN's Principles for Patient- and Family-Centered Payment into concrete criteria for APM design and implementation.
Payers and Providers	Invest in patient feedback to inform the design and implementation of APMs and recognize that patient expertise warrants compensation.
Payers, Providers, and Purchasers	Examine other industries for strategies on effectively engaging consumers and improving patients' understanding of benefit designs.
Payers and Medical Schools	Support communication skills training programs for providers.

Downside Risk

According to the HCP-LAN's [2018 APM Measurement](#) effort, only 12.5 percent of health care payments were made through downside models in 2017. Challenges to moving into downside risk include provider hesitation to assume financial risk and perceived lack of readiness and/or experience; lack of viable options for provider organizations that want to participate in downside-risk arrangements; and operational challenges that complicate population health management (e.g., provider access to raw and/or preprocessed claims data). Progress on downside risk will require modifications to APM design and greater efforts on the part of providers and others to develop strategies for controlled risk taking.



Immediate Actions

Stakeholder	Action
All Stakeholders	Establish clear goals and timeframes for moving health care payments into downside-risk models that establish greater accountability for outcomes without exposing them to insurance risk.
Payers	Set levels of risk relative to the size/readiness of a provider organization and establish steeper glide paths to downside risk.
Payers	Consider making downside-risk models mandatory when proper provider supports have been established (e.g., predictive analytics and access to claims data).
Smaller Practices	Partner with other small practices or with ACOs to spread financial risk.
Payers and Purchasers	Couple downside-risk arrangements with benefit designs that align patient incentives with care delivered in the APM.
Payers, Providers, and Other Organizations	Develop strategies for controlled risk taking, such as reinsurance, stop-loss, or risks focused on areas providers can best influence (e.g., hospitalizations).

Multi-Payer Alignment

Although there is no consensus yet on whether multi-payer models are advantageous or essential, several pragmatic steps can be taken to increase operational alignment between APMs. Efforts should focus on addressing inconsistencies between APMs operated by different payers; differences in payers' proprietary approaches to APM implementation; differences between local and regional approaches to APM implementation; and the lack of resources and infrastructure to support local collaboration on APM implementation.



Immediate Actions

Stakeholder	Action
Dominant Payers in a Market, State-Based Agencies, and Multi-Stakeholder Collaboratives	Take the lead in establishing greater operational alignment among a critical mass of payers in a region or market.

- Low hanging fruit for alignment include:
 - Common definitions for data elements used to calculate quality measures.
 - Common measure specifications and reporting formats for quality measures.
 - Aligned reporting periods.
 - Common discharge and admission notifications.
 - Aligned infrastructure for two-way data flow.

Benefit Design

Many in the field recognize the importance of designing health benefits to support care delivery in an APM. However, there is a general lack of alignment in incentives for providers and patients (and especially for patients) to choose high-value providers. One common vehicle for better aligning is to offer consumers narrow provider networks. Purchasers, however, may be less inclined to limit benefit design without demonstrated value for them and their employees. Similarly, patients and consumers often prefer more expansive plans with broader networks.



Immediate Actions

Stakeholder	Action
All Stakeholders	Operationalize and implement HCTTF's Guiding Principles on Consumer Engagement in Benefit Design to better align benefit incentives and experience with value-based payment and delivery.
Payers	Understand purchaser perspectives and preferences for plan features, and work on developing products that appeal to all stakeholders.
Payers and Purchasers	Educate patients on the value of receiving care from a defined high-performance network and how patients can help improve outcomes and reduce costs by seeking out high-value providers.

Appendix: Core Concepts

The core concepts described in this Appendix are intended to clarify key terminology and ideas that covered in each section of the *Roadmap*.

APM Design

Payment Structure and Financial Risk

APMs can include a variety of different payment mechanisms and entail different levels of financial risk for providers. Payers and providers both emphasized the importance of making payments simple to increase transparency and give providers clear targets for succeeding in the model.

Payment Model Types

APMs can be population-based or based on clinical episodes. Some payers implement both strategically.

- **Population-Based Models:** Establish payments and provider accountability for the health of a patient population across the care continuum. These models are used to manage the health of a population but can be less well suited for incentivizing the delivery of high quality, low cost specialty care.
- **Clinical Episode Models:** Establish payments and provider accountability for delivering high quality, low-cost care during a clinical episode. These models incentivize specialists to improve quality and address costs during a clinical episode and can be less well suited for addressing cost and quality outside the episode. These models typically do not address the appropriateness of initiating an episode.

Payment Mechanisms

APMs use various payment mechanisms. Each serves a distinct purpose. APMs typically use one of two base payments, sometimes in combination with infrastructure and/or incentive payments.

- **Base Payments**
 - (1) ***Fee-for-service (FFS)*** can encourage use of underutilized preventive services (e.g., vaccinations). In combination with spending or utilization targets, FFS can serve as a bridge to population-based payments.
 - (2) ***Population-based*** payments can be used in lieu of FFS to give providers flexibility to direct resources to patients with the greatest need. FFS carve-outs may also be used for underutilized preventive services.
- Infrastructure payments, which are typically care management fees for attributed patients, can be used to add clinical and support staff and to invest in care delivery infrastructure such as health information technology.
- Incentive and shared-savings payments can be used to encourage providers to deliver efficient and effective care. Various methods can be used to tie performance to different payment mechanisms; for example, a certain threshold of quality performance can serve as a gateway for shared savings or determine the magnitude of incentive payments.

Financial Risk

Providers' financial risk in APMs gradually increases as they participate in shared-saving opportunities, then opportunities for shared risk, and finally in transitioning from FFS to population-based savings.

Benchmarking and Utilization

Financial benchmarks are used in APMs to establish accountability for costs and health care resource utilization.

Basing and Rebasement Cost Targets

Several methodologies are used to set and reset cost targets. One approach is to base benchmarks on a provider's historical spending levels. Another approach is to base benchmarks on regional cost trends.

Non-Traditional Benchmarks to Calibrate Financial Risk

There are several approaches for using benchmarks to calibrate the amount of financial risk that providers assume, and to ensure they are not subjected to insurance or actuarial risk. Common approaches include using virtual panels and/or proxy measures for total cost of care.

Quality Measurement

Quality measurement systems consist of measures that have been selected according to criteria, along with methodologies for calculating total quality scores and establishing linkages to payments. APMs link performance on quality measures to payment, but some payers monitor quality in episodes without explicitly linking payment to quality.

Measure Selection

Payers select measures for inclusion in APMs based on patterns of illness experienced in the targeted patient population, and they focus on areas of high costs and disease burden. Payers use outcomes measures where possible and rely on core sets and endorsed measures to increase alignment and ensure validity. Coverage across measure types is also a consideration when constructing APM measure sets.

Types of Measures

There are at least five types of quality measures used in APMs:

- **Structural Measures:** Performance is based on the presence of procedural or organizational characteristics of the provider organization.
- **Process Measures:** Performance is based on the provision of services that adhere to evidence-based clinical guidelines.
- **Utilization Measures:** Performance is based on the efficient use of health care resources (e.g., avoidance of hospital admissions).
- **Experience of Care:** Performance is based on patients' assessment of their experience of care.
- **Outcome Measures:** Performance is based on the achievement of patient outcomes (e.g., mortality or improved functional status or clinical indicators that are strongly tied to patient outcomes (e.g., HbA1C control).

Total Quality Scores

Provider scores on individual measures are assessed using various methods (e.g., comparisons to national or regional benchmarks, or to improvement goals), and individual measure scores are weighted and aggregated using a variety of algorithms.

Provider Burden

Reporting data for quality measures can be burdensome for providers. Payers use different approaches for reducing burden, such as limiting the number of measures reported or relying on derived or claims-based measures that do not require additional efforts to report.

Patient Attribution

Several methods are used to attribute patients to different types of providers, either prospectively, retrospectively, or a combination of both.

Prospective Attribution to a Primary Care Physician

Patients are assigned to an accountable primary care physician before the performance period, either through a patient selection process or based on claims data.

Retrospective Attribution to Primary Care Physicians or Specialists

Patients are assigned to an accountable primary care provider or specialist after the measurement period for an APM using a claim-based attribution algorithm.

Multi-Payer Alignment

Multi-payer models involve arrangements between payers and providers in which multiple payers implement common approaches in their APMs. Alternatively, payers may adopt strategies to align APM design and implementation approaches with approaches used by other payers in distinct APMs. When payers and other stakeholders collaborate on APM design and implementation, they focus on areas of APM design and/or implementation. Consistent data sharing is important to reap the benefits of alignment on APM design.

Collaboration Forums

Stakeholders who collaborate on multi-payer models convene regularly and share common conceptual frameworks that outline goals and objectives. Stakeholders focus their discussions and activities on specific areas of APM design and implementation. Collaborations can be long or short term.

Data Sharing in Multi-Payer Models

Providers benefit when payers align on common approaches to APM design and implementation in multi-payer models. Effective data sharing is of unique benefit to providers because it allows them to analyze their entire patient panel according to a common set of data elements, irrespective of payer.

Payer-Provider Collaboration

Collaboration on APM Design and Provider Engagement

Payers work closely with select providers to establish and improve APM design. Payers use a range of approaches to engage providers and help them succeed in APMs.

Collaboration on APM Design

Payers collaborate with provider groups to establish overarching features of an APM's design:

- Collaboration Forums – Collaboration on APM design involves specific types of interaction between payers and providers (and occasionally patients and purchasers), and common understandings of goals and objectives.
- Agreement on APM Design – Payers and providers reach agreement on specific areas of APMs, in either the short or long term.

Provider Engagement

Payers engage provider organizations by offering guidance and support for improving APM performance:

- Strategic Communication: Payers communicate effectively with providers to gauge and secure their commitment to the APM, and to convey information that providers need to succeed in the model.
- Joint Operating Committee Meetings: Payers use Joint Operating Committee meetings to provide formal guidance on operational approaches to improve performance and to establish formal agreements on goals and initiatives.

Data Sharing and Data Analytics

Payers share performance and other data with providers. They provide data analytic support to ensure that providers can better act on the information they receive.

Data Sources and Access

Payers use a variety of data sources to operate APMs. They apply several approaches to access data sources and give providers access to payer data.

Timely Data Analytic Reports

Payers produce reports to help providers identify and act on improvement opportunities. These reports have different use cases, and payers produce them on different schedules to enhance their value as actionable data.

Data Analytic Support

Payers give providers various levels of data analytic support, depending on provider preferences and internal data analytic capabilities.

Care Management Support

Payers staff internal teams that work closely with providers to support care delivery transformation and to care coordination.

Care Transformation Teams

These teams work closely with providers to improve care delivery processes to drive APM success and improve patient care and experience.

Centralized Care Coordination

These teams work closely with providers' existing care coordination teams to facilitate care transitions, fill care gaps, and establish relationships between providers that see the same patient.

For many payers, care management and care coordination functions are the same across the network, whether a provider participates in an APM or not. Practice transformation and care coordination functions may be consolidated in a single team of payer organizations.

Leadership and Organizational Culture

Many payers and providers agree that commitment to value-based care within the leadership of a provider organization is the most important factor for implementing successful APMs. Providers must have staff engagement at all levels of the organization to drive culture change.

Leadership Assessment

Payers use various approaches to assess a provider organization's leadership, which influences how payers engage providers on specific aspects of the financial arrangement.

Leadership Engagement

Payers use several approaches to successfully engage with a provider organization's leadership and work with them to establish a value-based culture.

Person-Centered Care

Patient Engagement

Payers note that actively engaging patients in value-based payment design continues to be challenge. Payers acknowledge difficulties engaging patients and consumers in the technical aspects of APM design and implementation. Payers have historically engaged patients in direct care through online tools and patient portals, and payers also leverage these tools in APMs. Although some payers delegate patient engagement to providers to tailor approaches on the ground, others implement innovative approaches to both directly and indirectly engage patients in APMs.

Direct Approaches to Patient Engagement

With the transition to value-based care, payers are implementing several direct and innovative strategies to engage patients:

- Patient engagement in APM design
- Engaging all staff in APM goals
- Shared decision making
- Emphasizing health literacy
- Care compacts
- Patient alignment campaigns
- Multidisciplinary care management teams

Use of Payments to Allow Providers Flexibility in Patient Engagement

Some payers delegate patient engagement to providers, including by providing flexibility in global payments, or by making care management fees contingent on managing high-risk populations.

Health Equity

There is considerable variation in how providers address health disparities. Payers implementing APMs have introduced several strategies to assist providers in this space. In many circumstances, however, payer strategies may be independent of the payment model itself.

Use of Payments to Allow Providers Flexibility in Approaches to Health Equity

In certain circumstances, payers give providers flexibility in using funds to address health equity and provide data on health disparities and social determinants that may highlight care gaps for providers.

Engaging Patients in Local Communities

Payers provide additional indirect or direct assistance in identifying community resources to address social needs, integrating behavioral health benefits and services, and using multidisciplinary care teams to assist in engaging patients in local communities.

Benefit Design

Payers acknowledge the importance of aligning incentives for physicians in APMs with benefit design (e.g., narrow networks, tiered networks, and Centers of Excellence) to best guide patients toward higher-quality, lower-cost providers. Purchasers may be less inclined to limit benefit design without demonstrated value for them and their employees. Similarly, patients and consumers often prefer more expansive plans with broader networks.

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