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The Voice of Accountable Physician Groups

CAPG's Guide to Alternative Payment Models:

Case Studies of
Risk-Based
Coordinated Care

2016

A CAPG WHITE PAPER



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Welcome to *CAPG's Guide to Alternative Payment Models*. In this special CAPG publication, several of our members share their firsthand experiences with existing, tested, and proven alternative payment models (APMs). By learning about their experiences, you will gain valuable insights into how these models work—and how you can succeed with them.

This knowledge is critical. Medicare is engaged in a concerted push toward risk-based coordinated care. Last year, Health and Human Services Secretary Sylvia Burwell announced goals to transform Medicare from volume to value by increasing physician participation in APMs. President Obama later signed the Medicare Access and CHIP Reauthorization Act (MACRA), which includes a 5 percent incentive payment for participating in advanced APMs. The nation is now clearly on its way toward risk-based APMs.

This guide is designed to help you understand these new models. The case studies illustrate the payment foundation for risk-based coordinated care across a variety of payer types, including Medicare, Medicaid, and commercial health plans. Each vignette explains the form of payment from the payer to the physician organization, and then the payment from the physician organization to the individual physician or provider.

You'll also learn where each model is successful and strong, and where each has room for improvement. Key areas where CAPG members are demonstrating success in APMs include:

- Improving the quality and efficiency of care for patients. These APMs align physician payment to the achievement of performance objectives.
- Encouraging team-based care and a commitment to primary care.
- Innovating to better meet the needs of patients, particularly those with chronic conditions.

In addition to the significant progress our members are making in improving patient care and innovation, several themes have emerged where there is room for improvement:

- Improving data sharing with payers to continue to drive care improvements.
- Engaging patients in new payment approaches, particularly in accountable care organizations (ACOs).
- Aligning quality measures across programs. This will play an important role in reducing the burden on physician practices and getting actionable information to consumers.

As physicians across the nation embark on this journey toward risk-bearing arrangements, we hope you find this paper a practical, helpful, and invaluable guide. We would like to offer a special thank you to the CAPG members who so generously shared their experiences.



Don Crane, President and CEO, CAPG

Mara McDermott, Vice President of Federal Affairs, CAPG

Alternative Payment Methods Summary Chart

MODEL	HOW THE GROUP IS PAID	HOW THE PHYSICIAN IS PAID
Medicare Shared Savings Program Accountable Care Organization (ACO), Track One John Muir Health	Shared savings	Fee-for-service, care management fee, and shared savings
Commercial Accountable Care Organization (ACO), PPO Platform DaVita HealthCare Partners	Care management fee and shared savings	Fee-for-service and shared savings or salary and performance incentive
Medicare Pioneer Accountable Care Organization (ACO) Monarch Healthcare	Shared savings	Fee-for-service, shared savings, and care coordination fee
Commercial Accountable Care Organization (ACO), HMO Platform Physicians Medical Group of Santa Cruz	Capitation	Capitation or fee-for-service, plus performance incentive
IPA, Professional Risk Sharp Community Medical Group	Capitation	Capitation plus performance incentive
MSO, Medicaid Managed Care, Professional Risk MedPoint Management	Capitation	Capitation or fee-for-service, and performance incentive for PCPs
Medical Group, Percent of Premium Capitation Pioneer Medical Group	Capitation	Salary and performance incentive
Staff Model Medical Group, Global Capitation Sharp Rees-Stealy	Capitation	Salary and performance incentive
Health Plan-Owned Group Cigna Medical Group of Arizona	Budget	Salary and performance incentive
California Hospital Foundation Model MemorialCare Health System	Capitation or fee-for-service	Capitation and performance incentive or salary and performance incentive
Medicare's Bundled Payment for Care Improvement (BPCI) Catholic Health Initiatives	Fee-for-service and shared savings	Fee-for-service and shared savings
Medicare's Comprehensive Primary Care Initiative (CPCI) Providence Health & Services	Shared savings and care management fee	Productivity payment and performance incentive
Behavioral Health Integration UCLA Medical Group	Fee-for-service	Salary

THE MODEL

Accountable care organizations (ACOs) are groups of physicians and other healthcare providers who come together to provide coordinated care to patients. ACOs exist in Medicare, Medicaid, and commercial payment arrangements. Terms vary, but in general, provider reimbursements and financial incentives are tied to quality performance and reductions in the cost of care.

The Medicare Shared Savings Program ACO was established under the Affordable Care Act. The program offers three payment tracks, each with a different level of risk. This vignette details the experience of John Muir Health (JMH) in a Track One ACO. Track One is an “upside only” model, which means that ACOs share in savings, but they are not at risk for downside losses.

SUCCESS

“ We credit the program with starting us on a path of increased accountability, as we move toward assuming greater levels of financial risk.”

SUGGESTION FOR IMPROVEMENT

“ We do not definitively know which patients the ACO was accountable for until after a performance period has ended.”

Medicare Shared Savings Program Accountable Care Organization (ACO)

TRACK ONE

Contributed by: Keith Pugliese, Vice President of Contracting and Risk Operations, John Muir Health

How it Works

Medicare pays shared savings to the ACO. The Centers for Medicare & Medicaid Services (CMS) compares our ACO's financial "spend" for the year with our three-year historical spend under traditional Medicare. If we saved money—performing within the CMS benchmark, exceeding the minimum savings rate, and meeting quality requirements—we receive a share of the savings (about 50 percent).

Medicare pays physicians fee-for-service, and the ACO pays physicians shared savings. Medicare pays fee-for-service reimbursements to our ACO physicians. Our ACO then distributes 70 percent of our savings to physicians who participated in ACO educational programs and who helped develop potential new ACO care programs. We pay the majority of the shared savings to primary care physicians (PCPs), while also paying a portion to affiliated specialists.

Primary care physicians receive a flat care coordination fee twice a year. PCPs receive this payment regardless of our ACO's performance. Our Care Coordination program plays a key role. Case managers are assigned to PCPs and provide patient assessments and population health and disease management support. Patients needing special services are identified by PCP referrals, case reviews, or risk stratification analyses. This effective Care Coordination program has now been expanded to our Medicare Advantage patients.

CMS used 33 (now 34) traditional Medicare quality metrics. Physicians provide their scores on these quality measures to the ACO. Our ACO then reports them to CMS. The quality scorecard affects the percentage of savings our ACO can receive. In the program's first year, if an ACO successfully completed its quality reporting requirements, it received a score of 100 percent. For the second year, the quality program was a blend of pay-for-reporting and pay-for-performance.

Why It's a Success

We can coordinate care for previously fragmented patient populations. The program encourages ACOs to focus on care coordination and "de-fragmentize" care. It also enables us to focus on quality of care processes and outcomes. This has direct, positive effects on achieving the Triple Aim: improving patients' experience of care, improving the health of populations, and lowering per-capita costs.

It started us on the journey to greater risk. We credit the program with starting us on a path of increased accountability, as we move toward assuming greater levels of financial risk in our relationships with other payers, including Medicare Advantage plans. We feel the ACO program has been a positive program in terms of engaging our physician network and our system as a whole to coordinate patient care across the continuum—whether that care is provided at a hospital, office, or patient home.

Suggestions for Improvement

Make the financial model more predictable. One drawback of the program is the unpredictable financial model and how information is shared with participants. The methodology for developing the benchmark is also complex, and determining the ACO's financial performance mid-year is difficult.

Engage and incentivize patients. Patient engagement is difficult. Physicians actively participate in the program, but patients do not. Instead, patients are passive participants; they are included if they receive a certain amount of their primary care from the ACO's participating physicians. Patients are free to obtain care from any provider, which makes it difficult to manage care and costs.

In Track One, patients are included under the ACO in a retrospective fashion. In other words, we do not know which patients the ACO was accountable for until after a performance period has ended. One improvement would be to assign patients at the beginning, with complete and timely financial, utilization, and quality data, as well as a benefit structure that incentivizes patients' decision-making in accessing care.

We will continue to engage in value-based arrangements with payers, and we continue to consider applying for additional government-directed accountability initiatives. Thanks to our experience in the Medicare Shared Savings Program ACO, we are applying patient engagement and population health programs to commercial and Medicare Advantage plan members.

John Muir Health (JMH) is a healthcare system with two acute care hospitals, one behavioral health hospital, a medical foundation physician group, and an independent practice association (IPA). The JMH Medicare Shared Savings Program ACO is led by physicians. JMH participated in the Track One model beginning in July 2012. The ACO achieved shared savings in its first two performance years; results for the third and final year of the program are not yet available.



THE MODEL

Accountable care organizations (ACOs) are groups of physicians and other healthcare providers who come together to provide coordinated care to patients. These arrangements exist not only in Medicare, but also with commercial plans. Terms vary, but in general, provider reimbursements and financial incentives in ACOs are tied to quality performance and reductions in the cost of care.

This vignette details the experience of DaVita HealthCare Partners medical group (HealthCare Partners, or HCP) with a commercial ACO on Preferred Provider Organization (PPO) platforms in Nevada and California. HealthCare Partners participates in these ACOs with two health plans: Anthem and Cigna.

SUCCESS

“ Our centralized team of care coordinators and care managers provides direct outreach to high-risk patients and connects them with appropriate resources.”

SUGGESTION FOR IMPROVEMENT

“ It's been a challenge to engage patients and educate them about our ACO and how it improves their care.”

Commercial Accountable Care Organization (ACO) – PPO Platform

Contributed by: George Hong, MD, National Medical Director, HealthCare Partners; Rajesh Gade, MD, Corporate Medical Director, HealthCare Partners; Hela Mahgerefteh, ACO Director, HealthCare Partners; Ariel Huhn, RN, ACO Regional Care Manager, HealthCare Partners

How it Works

Health plans pay our medical group a care management fee and a share of savings. Commercial health plans (in our case, Anthem and Cigna) compare our “spend” for the year to a benchmark amount. This benchmark is calculated based on what we have spent historically and what the local market spends.

If we spend less than the benchmark amount, we receive a share of the savings. We retain a portion of the total earned shared savings and use it to administer our ACO. These are “upside only” arrangements, which means that we are not at risk for financial losses.

Our medical group receives a care management fee. This is a “per-member, per-month” payment for the patients in our ACO. Our health plan contracts determine the amount of this fee, as well as which patient populations the fee covers. For example, Anthem pays care management fees for chronically ill patients, but Cigna pays care management fees for all patients in the ACO.

Our medical group pays a salary to employed physicians and shared savings to contracted physicians. Anthem and Cigna pay fee-for-service reimbursements to our independent practice association (IPA) physicians. In addition, we distribute shared savings payments to these contracted physicians, based on a formula that takes into account a physician’s ACO patient membership. We pay our employed physicians a salary. Shared savings are indirectly incorporated in these salaries.

Each ACO contract includes quality metrics. In general, achieving quality performance targets is necessary for us to be eligible to share in savings. (The contracts contain a quality “gate” that must be met before shared savings will be earned). Anthem includes 13 Healthcare Effectiveness Data and Information Set (HEDIS) measures, while Cigna includes 18 measures (16 evidence-based, one patient experience, and one pharmacy).

Why It’s a Success

We can better identify and help high-risk patients. We created an ACO Unit, a centralized team of care managers and care coordinators. This team coordinates care for ACO patients, manages transitions out of the hospital, and provides post-discharge planning and follow-up. The team uses predictive modeling to identify opportunities to engage high-risk patients before an inpatient admission. We target these patients by using ambulatory care sensitive condition (ACSC) status (medical conditions where optimal care can prevent a condition from worsening and resulting in a hospitalization), as well as emergency room utilization and health plan risk score indicators.

Our ACO Unit provides direct outreach to these patients and connects them with appropriate resources, including high-risk programs, disease management, and health enhancement classes.

We have more access to actionable PPO patient health information. Being an ACO enables us to use health plan data and reports, as well as our own proprietary reporting tools, to improve patient care.

For example, we use health plan data to generate our Opportunity Patient Listing report. This report identifies high-risk ACO patients and estimates risk—such as a patient's risk of a hospital admission within a specific time frame. The data helps us target complex case management to high-risk individuals.

We also include health plan data in our Patient Intervention Report (PIR), which identifies gaps in care for our ACO patients. For example, if a patient is overdue for a preventive screening, the report will flag it for the physician. This type of proactive information sharing and reporting is not available in a fee-for-service environment.

Suggestions for Improvement

Make ACOs more visible to patients. In the PPO environment, patients are free to see any preferred provider in the plan's network; they are not constrained to the ACO network. However, it's been a challenge—particularly initially—to engage patients and educate them about our ACO and how it improves their care.

To overcome this challenge, we continue to work with our health plan partners to make our ACO more visible to patients. For example, we created an ACO-branded sleeve for the patient's insurance card.

Engage physicians. Our health plan contracts define the physicians—both primary care and specialists—who are part of our ACO network. In one arrangement, contracted HCP physicians are automatically included in the ACO network if they meet certain criteria, but in the other, affiliated physicians must actively join. One challenge has been making the case that it is worthwhile for individual physicians to participate in the ACO.

Increase consistency across multiple plans. We contract with two health plans for commercial ACO arrangements, and we participate in a Medicare Shared Savings Program ACO. Each of these relationships has different rules around attribution, benchmarking, payment, shared savings calculations, and other requirements. This inconsistency across health plans creates additional complexities for provider organizations, even for organizations like ours with sophisticated risk-contracting capabilities.

DaVita HealthCare Partners is a leading medical group with both employed and contracted physicians in eight states. We participate in commercial Preferred Provider Organization (PPO) ACO arrangements in Nevada and California, with a total of approximately 115,000 enrollees across two health plan relationships (Anthem and Cigna).



THE MODEL

The Centers for Medicare & Medicaid Services (CMS) Innovation Center began testing the Pioneer Accountable Care Organization (ACO) model in 2012. The Pioneer ACO model was designed for providers who are already experienced in coordinating care for patients across care settings. Pioneer generally has higher levels of shared savings—and higher levels of risk—than the Medicare Shared Savings Program.

This case study examines Monarch HealthCare's experience in the Pioneer ACO.

SUCCESS

“ We have reduced unnecessary hospital stays because we are allowed to directly admit ACO patients to a skilled nursing facility without a prior three-day acute hospital stay.”

SUGGESTION FOR IMPROVEMENT

“ To maximize care coordination and care improvements, Medicare and ACOs must figure out how to increase patient engagement.”

Medicare Pioneer Accountable Care Organization (ACO)

Contributed by: Ray Chicoine, President and Chief Operating Officer, Monarch HealthCare

How it Works

Medicare pays shared savings to the ACO. The Pioneer model compares our “spend” in a performance year with our historical spend. If we spend less than we did in prior years—and meet quality metrics—Medicare pays us a share of the savings. We then invest this savings in care management, infrastructure, quality reporting, and disease management. We also use the savings to provide physician incentives.

We are at risk for downside losses in the Pioneer model. For example, if we overspend compared with our historical benchmark, we would have to repay a portion of the difference to Medicare.

Physicians receive fee-for-service and shared savings payments. Under this model, Medicare pays individual physicians fee-for-service reimbursements, just as it does in traditional Medicare. On top of those payments, Monarch pays physicians a portion of our shared savings. We do this in two ways:

1. **Care coordination fee.** We pay ACO physicians a flat fee per patient, per year—if physicians complete an annual patient wellness visit, access the patient profile in our proprietary physician portal, and submit a completed Annual Senior Health Assessment (ASHA) form. We pay an additional fee to physicians who improve care for patients with specific chronic conditions.
2. **Year-end shared savings.** Physicians who achieve established thresholds on quality and cost metrics are eligible to share in year-end savings. The higher their performance on the metrics, the higher the payment. This payment is made in the fall following the performance year.

The program uses 33 traditional Medicare quality metrics. Monarch reports quality performance using the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO). Physicians provide quality information to us; we then enter it into the Medicare reporting system.

Monarch uses internal quality and cost metrics to assess physician performance to determine the amount of the year-end shared savings payment.

Why It's a Success

We've improved quality. The Pioneer ACO program has enabled us to improve quality for our fee-for-service Medicare patients. We have used our managed care experience, including in Medicare Advantage, to apply proven care coordination, disease management, and population health approaches to our Pioneer patients.

However, the tools available in the Pioneer ACO do not go as far as the tightly managed, capitated model available in Medicare Advantage. As a result, the quality improvements in the Pioneer ACO program have not yet risen to the levels we've achieved in Medicare Advantage (see following chart).

Inpatient Performance: Pioneer ACO vs. Medicare Advantage

KEY OPERATING INDICATORS	2012 (ACO Year 1)	2013 (ACO Year 2)	2014 (ACO Year 3)	Medicare Advantage (2014)
Acute Admits/thousand	283	239	230	195
Acute Days/thousand	1,414	1,131	1,125	835
SNF Admits/thousand	136	104	90	70
SNF Days/thousand	4,249	2,908	2,334	1,100

Our physicians have access to new tools and more patient information. For example, we have implemented the ASHA form, a comprehensive list of patient screenings and ACO quality metrics. Patients complete the form during the annual wellness visit. The form helps to identify gaps in care and is incorporated in the electronic medical record. This tool was previously unavailable for fee-for-service Medicare patients, and it has been enormously popular with our ACO physicians.

In addition, we created a Patient Profile using the CMS claims data available on our ACO patients. The profile gives physicians a long-term view of their fee-for-service patients' care experience. Access to this type of information has been a game changer for our physicians.

Medicare waives some restrictive rules. In the Pioneer ACO, Medicare waives some of its more restrictive fee-for-service rules. For example, we have reduced unnecessary hospital stays because we are allowed to directly admit ACO patients to a skilled nursing facility without a prior three-day acute hospital stay. This waiver has created a tremendous benefit for our physicians and patients.

Suggestions for Improvement

Change how patients are aligned in the ACO. In general, Medicare aligns or “assigns” patients to the ACO if they receive a certain amount of primary care services from an ACO provider. However, these patients remain free to see any Medicare provider.

In addition, the patient population changes annually as new patients become part of the ACO, and previously aligned patients are “de-aligned” (dropped out of the ACO).

These two issues pose significant challenges for disease management and care coordination. Although CMS began implementing voluntary patient alignment in the Pioneer program, this option has been limited to patients who previously or currently were in the ACO. Significant changes to the alignment model are needed to make the Pioneer ACO more successful.

Increase patient engagement. In the Pioneer program, there is limited patient engagement or knowledge about the ACO—including what the ACO does and how it benefits patients. The federal government has tightly controlled communications with patients about the ACO model. To maximize care coordination and care improvements, Medicare and ACOs must figure out how to increase patient engagement in this model of care.

Monarch HealthCare is an independent practice association (IPA) that encompasses all of Orange County, with 2,500 private physicians and 20 hospital affiliations. It serves 200,000 patients (commercial, Medicare Advantage, Medi-Cal, and Pioneer ACO).



THE MODEL

Accountable care organizations (ACOs) are groups of physicians and other healthcare providers who come together to provide coordinated care to patients. These arrangements exist in Medicare and with commercial plans. Terms vary, but in general, provider reimbursements and financial incentives in ACOs are tied to quality performance and reductions in the cost of care.

This case study describes the experience of Physicians Medical Group of Santa Cruz (PMG) with the Blue Shield ACO on an HMO platform. PMG is an independent practice association (IPA) and has approximately 4,500 patients enrolled in this ACO. There are upside and downside risks for the group in this model, but there are limits on the risks.

SUCCESS

“ Because of the ACO model, transitions of care—between the hospital, skilled nursing facility, and home care—have become smoother.”

SUGGESTION FOR IMPROVEMENT

“ Although behavioral health conditions frequently impact other areas of care, such as emergency department visits, PMG cannot access this information.”

Commercial Accountable Care Organization (ACO) – HMO Platform

Contributed by: Marvin Labrie, CEO, Physicians Medical Group of Santa Cruz; and Cindy Martin, Chief Operations Officer, Physicians Medical Group of Santa Cruz

How it Works

The health plan makes a capitated payment to our independent practice association (IPA). Our ACO arrangement involves our IPA, Blue Shield, and a hospital partner. Under this arrangement, Blue Shield makes a capitated payment to our IPA in the normal fashion for HMO contracts. A separate arrangement with the hospital covers hospital services.

The hospital and our IPA can each qualify for shared savings or shared losses. The ACO's performance on cost is measured in five areas or "segments": hospital, professional, mental health, pharmacy, and ancillary. Blue Shield, PMG Santa Cruz, and the hospital negotiate financial targets for these five segments, as well as each party's upside and downside risk in each area.

At the end of the year, there is a financial reconciliation for each segment. This determines if the hospital and our IPA spent more or less than the financial targets for each area. If we spent less, we qualify for shared savings. If we spent more, there are shared losses. The hospital and the IPA can each qualify for these shared savings or shared losses separately. It's important to note that there are limits to both the upside and downside risks.

For the first two years in the program, PMG Santa Cruz and our hospital partner each achieved shared savings. We are now in our third performance year.

Primary care physicians receive capitated payments and some fee-for-service. Primary care physicians generally receive capitated payments. However, our IPA also pays primary care physicians a fee-for-service payment for certain desired services, such as immunizations.

In addition to their base compensation, primary care physicians are eligible for incentives in three areas: "citizenship" (e.g., patient satisfaction, attending meetings); surplus distributions; and performance incentives based on metrics (e.g., emergency department utilization, meaningful use of electronic health records, and statewide pay for performance metrics). To date, these metrics apply to all of these physicians' patients, not just their ACO patients.

Specialists receive fee-for-service and incentive payments. Specialists are paid fee-for-service and are eligible for the incentives for surplus distributions, citizenship, and meaningful use of electronic health records. These three bonus categories constitute approximately 17 percent of specialist compensation.

Why It's a Success

It has improved relationships between healthcare providers in the community. The ACO has improved communication and alignment on care initiatives between our IPA and our hospital partner. The increased transparency and shared goals across the ACO

network have also led to stronger relationships between the hospital, the IPA, and the health plan. These strengthened relationships and aligned goals have resulted in improved care management and better outcomes for patients.

Care transitions are smoother. Because of this ACO model, transitions of care—between the hospital, skilled nursing facility, and home care—are now a shared focus for the hospital, PMG, and the health plan. This shared focus has resulted in smoother transitions of care for our patients.

Better data helps us target sicker patients. A defining feature of the HMO ACO is the access we have to actionable data from the health plan. Specifically, we have access to information about the risk of our patient population, and we can use that information to target the most appropriate care interventions to the sickest patients, including those with multiple chronic conditions.

Suggestions for Improvement

Integrate behavioral health information. PMG Santa Cruz has a high percentage of patients with behavioral health conditions, but there is a firewall between medical and behavioral health information. This largely stems from the California Mental Health Parity Act.

In other words, although behavioral health conditions frequently impact other areas of care, such as emergency department visits, PMG cannot access this information. The health plan has called a committee of medical directors from different ACOs to develop a solution to this challenge, but so far there has been no resolution.

Engage patients. Although patients enroll in the HMO product, they do not specifically enroll in the ACO model. This has posed challenges in terms of outreach to patients about care coordination activities and other benefits of the ACO model. We are working with the health plan to address and improve this area for the future.

Physicians Medical Group (PMG) of Santa Cruz is an independent practice association (IPA) in Santa Cruz County. PMG contracts with 59 primary care physicians and 200 specialists and serves nearly 20,000 patients. Most of our business is with commercial payers, but we also serve 1,100 Medicare Advantage patients. We have participated in capitated arrangements for more than 30 years.



THE MODEL

An independent practice association (IPA) is an organization of physicians who come together as independent contractors, not employees. These physicians maintain their autonomy and their own practices. The IPA provides them with infrastructure support and capabilities. IPAs are owned and led by physicians.

This vignette details the experience of Sharp Community Medical Group (SCMG) in a professional-risk IPA. This IPA model is built on a capitated—or “per member, per month”—payment model.

SUCCESS

“The IPA model is attractive to physicians who want to maintain independent practice but still have the support of a larger entity.”

SUGGESTION FOR IMPROVEMENT

“One challenge is keeping pace with the growing and shifting performance metrics used across health plans, Medicare, and other types of payers.”

Independent Practice Association (IPA), Professional Risk

Contributed by: Paul Durr, CEO, Sharp Community Medical Group

How it Works

Health plans make capitated payments to the IPA. We enter into risk contracts with health plans, which then make capitated payments to our IPA. In commercial plans, this payment is calculated as a fixed, per-member, per-month amount. In Medicare Advantage (MA) plans, the amount is calculated as a percentage of what Medicare pays the plan. (This is called “percent of premium capitation.”)

Sharp Community Medical Group negotiates with each plan and agrees on which professional services are covered in the capitated payment. Some high-cost procedures may be carved out of this amount.

Our IPA makes capitated payments to individual physicians. In general, we make capitated payments to the physicians in our IPA. The amount is determined through negotiations with each doctor. In limited circumstances, some physicians, especially specialists, may be paid fee-for-service (usually paid as a percentage of what Medicare pays).

All physicians are eligible for performance incentives. These incentives are on top of the capitated payments. Incentives make up a substantial portion of a physician's compensation (approximately 15 percent for primary care physicians and 10 percent for specialists).

We participate in quality initiatives. Our IPA participates in various external quality measurement and improvement initiatives, including the Medicare Advantage (MA) Five Star Rating System and California's Value Based Pay for Performance Program (VBP4P).

Internally, we use a dashboard of approximately 15 measures to determine physician incentive payments. These measures are aligned to the VBP4P and the MA Five Star Rating System.

Why It's a Success

Incentives are aligned for better care, not more volume. While fee-for-service rewards quantity of care, capitated payments allow us to align physician incentives with high-quality care that is primary care–focused and team-based. Our performance incentive program encourages physicians to achieve quality performance standards. Fixed capitated payments also provide us with the upfront resources to invest in quality reporting infrastructure and provide reliable information to physicians. This translates to better care and better outcomes for patients.

There is flexibility to innovate. The IPA model offers the flexibility to innovate to meet the challenges of a rapidly changing healthcare environment. For example, in response to the recent push by health plans toward “narrow networks,” we are developing a “High Value Network.”

In the High Value Network, physicians receive additional incentive payments for significantly higher performance on quality metrics. Physicians are eligible for as much as an additional 10 percent of their capitated payment if they are in the top tier of quality performance (the 90th percentile for the majority of quality measures and the 50th percentile for all quality measures). The pre-selected quality measures are tracked on a scorecard, which is available online at a secure website.

It supports community physicians. In an IPA model, physicians remain independent contractors, not employees. This hybrid model is attractive to many physicians who want to maintain independent practice but still have the support of a larger entity with infrastructure capabilities. An IPA is a strong option for physicians considering how to respond to an increasingly demanding environment.

Suggestions for Improvement

Make it easier to integrate new payment approaches. This IPA model is built on a capitated payment infrastructure, but the new payment models for traditional Medicare—such as accountable care organizations (ACOs) and bundled payments—are based on a fee-for-service structure. Because of this difference, professional-risk IPAs have struggled to integrate these alternative payment models.

The Medicare Access and CHIP Reauthorization Act (MACRA) places greater emphasis on alternative payment models (APMs) in traditional Medicare. This exacerbates the challenge for organizations like ours that have not found APMs based on fee-for-service to be a good fit.

Consolidate the number of quality measures. We assist our contracted physicians in meeting health plans' quality and resource use requirements. One challenge is keeping pace with the growing and shifting performance metrics used across health plans, Medicare, and other types of payers. Overall, we report around 150 quality metrics.

Address overall funding pressures. One of the biggest obstacles we have is the cost pressure that is passed through from health plans to the IPA. There are numerous examples of this: the health plan tax, cost of specialty drugs, and cost of new technologies.

Essentially, any reduction in payment to the health plan or requirement to cover and pay for new services is directly passed to us. We then have to adapt to meet these funding cuts. These relatively common events can significantly reduce overall funding and impede our work to improve healthcare for our patients.

Sharp Community Medical Group (SCMG) is an independent practice association (IPA) of more than 200 primary care physicians and 500 specialists in San Diego County. Our physicians care for more than 130,000 HMO patients, as well as 15,000 commercial ACO patients.



THE MODEL

Management services organizations (MSOs) contract with medical groups or independent practice associations (IPAs). MSOs do not provide medical care, but they do provide a wide variety of services to support physician practices, including clinical quality services and administrative functions. Physician practices pay the MSO for these services.

This vignette describes the experience of MedPoint Management with “professional-risk” Medicaid managed care arrangements. These involve physicians and ancillary care services, but not hospital or pharmacy services. MedPoint’s clients are independent practice associations (IPAs) and healthcare networks, and it contracts with five Medicaid managed care plans.

SUCCESS

“Health information technology infrastructure is aligned with care management to improve the management of high-risk patients.”

SUGGESTION FOR IMPROVEMENT

“One of the most significant issues facing this model is the underfunding of Medi-Cal.”

Management Services Organization (MSO), Medicaid Managed Care – Professional Risk

Contributed by: Derek Schneider, Chief Financial Officer, MedPoint Management

How it Works

The Medicaid plan pays capitation to the MSO. As an MSO, MedPoint accepts payment from Medicaid managed care plans on behalf of our independent practice association (IPA) clients. This payment is capitated (a fixed, per-member, per-month amount) and risk-adjusted. The physician services covered by the payment are negotiated beforehand in a “division of financial responsibility” (DOFR).

However, Medicaid adjusts this capitated payment for populations that require greater healthcare resources. For example, Medicaid uses aid code adjustments to differentiate between populations, such as adults and children, and seniors and people with disabilities.

The health plan's arrangement with the hospital varies depending on the payer. More than half of our clients have hospital partners that also take capitated payments. These arrangements allow for a higher degree of collaboration and result in better care for patients.

The MSO pays physicians capitated payments or fee-for-service. While there are various payment models for physicians, the most common model is to pay a capitated rate to primary care physicians and pay fee-for-service to specialists. Primary care physicians are also eligible for performance incentives, typically around Healthcare Effectiveness Data and Information Set (HEDIS) measures, reducing readmissions, and improving access. We pay physicians on behalf of the IPA.

The MSO offers quality management services. These services help evaluate and improve quality for Medicaid patients. The specific quality metrics and incentives depend on the challenges facing the population.

Some of our IPAs use specific incentives around access, reducing readmissions, or bending the cost curve. Others focus on such areas as adult immunizations or readmissions, where they can apply resources and make a measurable impact. For example, one of our IPA clients, which has a capitated hospital arrangement, lowered readmissions by more than 20 percent.

However, in general, the underfunding of California's Medicaid program, Medi-Cal, continues to pose challenges to implementing robust quality measurement and reporting programs.

Why It's a Success

It ensures access to high-quality, coordinated care. We provide a comprehensive coordinated care infrastructure to clients, including health information technology, care management, and performance measurements. For example, our health information technology infrastructure is aligned with care management to improve the management of high-risk patients, resulting in better quality and outcomes.

The MSO helps coordinate transitions of care. When a patient is admitted to the hospital, we notify the primary care physician of the hospital stay, including all relevant procedures performed there and the recommended medications and specialist follow-up visits. We then work with the patient, the primary care physician, and the specialists to schedule these appointments and ensure the patient receives the care necessary to achieve the optimal health outcomes.

Our Utilization Management and Case Management processes and initiatives have demonstrated a 15 percent reduction in non-emergent ER visits and a 60 percent reduction in avoidable readmissions.

Physicians can focus on medicine, not administrative headaches. The MSO streamlines systems for physicians participating with multiple Medicaid managed care plans. We serve as a liaison between HMOs and providers, advising physicians of new policies and procedures as they become available.

In addition, we provide physicians with “one-stop shopping.” Rather than a physician office calling five different health plans to ask about authorizations, the office calls us and immediately gets an answer. This allows physicians to focus on the practice of medicine. We also give smaller physician groups access to more sophisticated services than they would be able to support on their own.

Suggestions for Improvement

Address Medicaid funding challenges. One of the most significant issues facing this model is the underfunding of Medi-Cal (the Medicaid program in California). While we have found ways to innovate and drive quality improvement for the population, the razor-thin margins in Medi-Cal pose challenges for access in the future.

Improve the flow of patient data to enable more proactive outreach. In many cases, the contact information for patients is inaccurate or non-existent, making it very difficult to identify patient populations and conduct proactive outreach to provide primary care and preventive services. The data issues appear to persist at both the state and the health plan level, and there are opportunities at both levels to improve the flow of data to the physician and physician group.

MedPoint Management (MPM) is a management services organization (MSO) that provides services to independent practice associations (IPAs) and healthcare networks. Founded in 1996, we represent a client base of more than 3,500 contracted physicians and are responsible for coordinating care for more than 745,000 patients through commercial HMO, Covered California, Medicaid, Medicare Advantage, and dual eligible products. We contract with five Medicaid managed care plans.



THE MODEL

Capitation means that providers are generally paid a fixed, “per-member, per-month” fee. In “percent of premium capitation,” this fixed fee is a percentage of what Medicare pays Medicare Advantage plans.

The following vignette describes the experience of Pioneer Medical Group with Medicare Advantage plans and a percent of premium capitation model. Pioneer contracts with six Medicare Advantage plans.

SUCCESS

“ This model focuses on primary care, appropriate utilization, and patient satisfaction.”

SUGGESTION FOR IMPROVEMENT

“ When Medicare reduces the amount it pays to health plans, we also receive lower reimbursements.”

Medical Group, Percent of Premium Capitation

Contributed by: John Kirk, CEO, Pioneer Medical Group

How it Works

The Medicare Advantage plan pays capitation to our medical group. The amount of this fixed, per-member, per-month payment is a percentage of what Medicare pays to the health plan. This is called “percent of premium capitation.”

Pioneer Medical Group negotiates this percentage with each Medicare Advantage (MA) plan. We also negotiate which physician services are covered by this capitated rate; these services are detailed in a division of financial responsibility (DOFR). However, the amount we receive can fluctuate based on increases or decreases in what Medicare pays the health plan.

Our medical group pays a salary and incentive to physicians. In general, we pay our physicians a salary and a performance incentive. In addition to customary productivity metrics, physicians receive a performance incentive based on three sets of measures: appropriate utilization management, clinical quality, and patient satisfaction. Approximately 10 percent of a physician's salary is tied to this performance incentive bonus.

Our medical group participates in multiple quality measurement programs. These include California's Value Based Pay for Performance Program (VBP4P), CMS Medicare Advantage (MA) Five Star Rating System, Healthcare Effectiveness Data and Information Set (HEDIS), and meaningful use of certified electronic health records. In all, we are responsible for 66 core quality measures and several sub-measures.

Why It's a Success

Everyone has an incentive to achieve high-quality, coordinated care. These incentives are aligned for physicians, the physician group, and health plans. For example, if high quality results in an incentive payment from the MA Five Star Rating System, these bonus funds are paid to the plan, to the group, and then to the individual physicians. This alignment encourages all parties to focus their achievement on the same quality metrics—resulting in better care for seniors.

We focus on primary care, prevention, and slowing the progression of disease. Unlike a fee-for-service model, where physicians are paid for each service they provide, in a capitated model, physicians are held accountable and have incentives for keeping patients healthy. This model focuses on primary care, appropriate utilization, and patient satisfaction. Each category is measured, and physician performance incentives are tied to these metrics.

Suggestions for Improvement

Improve payment accuracy and consistency. One key factor in percent of premium capitation is that the amount associated with a given patient is “risk-adjusted” to reflect that patient’s health. In other words, Medicare Advantage plans pay us more for patients with complex health needs because it takes more resources to care for those patients. When risk adjustment is accurate, the payments we receive reflect the needs of the population and the health of the seniors served.

However, in recent years, the risk adjustment model has not accurately reflected the resources needed to treat patients with chronic diseases. One area for improvement is to correct this risk adjustment model to appropriately pay for these patients.

In addition, when Medicare reduces the amount it pays to health plans, we also receive lower reimbursements. This is problematic because these circumstances may be outside our control, and they can create an imbalance between the revenue we receive and the medical costs we are responsible for.

Share more data between health plans and providers. To continue to improve this model, we need to increase data sharing between physician groups and health plans. For example, a health plan may have additional data about providers, such as hospitals, in a given market. Sharing this information with the physician group can lower costs for health plans and improve quality for patients.

Pioneer Medical Group is a multispecialty medical group with 54 employed providers, including 30 primary care physicians. Pioneer has been capitated for its Medicare Advantage (MA) patients for 15 years, and 85 percent of our total revenue is capitated.



THE MODEL

Under global capitation, the physician organization receives capitated payments. Typically, the payment is a prepaid, per-member, per-month amount. The organization then pays its physicians.

This case study details the experience of Sharp Rees-Stealy Medical Group with global capitation. Sharp Rees-Stealy is a staff model medical group that employs 475 physicians in San Diego County.

SUCCESS

“ Because the majority of our revenue is prepaid, we have the resources to invest in innovations that improve patient care.”

SUGGESTION FOR IMPROVEMENT

“ The lack of alignment of quality metrics across payers represents a costly burden and an opportunity for improvement.”

Staff Model Medical Group, Global Capitation

Contributed by: Stacey Hrountas, Senior VP and CEO, Sharp Rees-Stealy Medical Group; and Alan Bier, MD, President, Sharp Rees-Stealy Medical Group

How it Works

Health plans make capitated payments to our medical group. We work with our partner Sharp hospitals to jointly negotiate capitated payments with health plans. The rate varies depending on the health plan. With commercial plans, we receive a per-member, per-month fee, and with Medicare Advantage plans, the payment is a percentage of what Medicare pays to the health plan.

In addition, we have an exclusive partnership with one health plan based on a long-standing track record of providing high quality healthcare services. The capitated model allows us to more effectively focus on the community's health needs and the cost of services.

Our medical group pays physicians a salary and performance incentives. The salary makes up 75 percent of a physician's total compensation. The remaining 25 percent comes from performance incentive payments. These incentives are paid from a pool funded by medical group and hospital savings.

Performance incentives reward individual quality and patient satisfaction metrics, meaningful use of electronic health records, access, and group utilization performance. (Our hospital partner also receives funds from this pool of savings.)

We participate in external and internal quality programs. External quality measurement and improvement initiatives include the Medicare Advantage (MA) Five Star Rating System and California's Value Based Pay for Performance Program (VBP4P). As a group, we are tracking and reporting more than 100 quality measures.

Internally, we use a quality performance program. The number of measures depends on the physician specialty, but it's generally capped at 10 measures. The measures are aligned to the external programs, including VBP4P and the MA Five Star Rating System.

Why It's a Success

It provides upfront resources for innovation. Because the majority of our revenue is prepaid, we have the resources to invest in innovations that improve patient care.

For example, our physicians can request an e-consult for patient convenience, or when there are access issues for a certain subspecialist. These are high-quality, connected visits that enable care in a format simply unavailable in a fee-for-service model.

Prepaid capitation not only provides the upfront funding for this infrastructure and technology, but it also means that physicians in our system are free to use the technology. (Under a fee-for-service model, they would not be reimbursed for it, which would greatly limit its use.)

We have a multidisciplinary care team. This model also provides the upfront dollars to invest in what is right for our patients along the continuum of care. For example, we hire disease managers and case managers to assist with the care plan for patients with specific conditions. We also offer a hospitalist team that cares for patients who are admitted to the hospital. This frees up our physicians to focus on their office workloads, rather than running back and forth from the hospital to the office.

Our physicians like it. In addition to offering better patient care, the global capitation model receives high marks from our physicians. They like that they are supported by a care team and can focus on practicing medicine, rather than billing, contract negotiation with health plans, and other administrative tasks. We handle all these tasks at the medical group level.

Suggestions for Improvement

Improve the system for encounter data. In our capitated model, we must submit “encounter data” to health plans. Similar to a claim form, this is detailed information about all the medical services provided to patients. Encounter data is used for different purposes, including risk adjustment, performance measurement, incentive programs, consumer cost-sharing, and improving transparency.

The existing encounter data system poses significant challenges. First, encounter data must be submitted from individual physicians to our medical group, and then on to the different health plans. But each plan often has a different process for verifying the data’s accuracy, and plans may use a different intermediary to review and filter the data.

Like most other prepaid medical groups, we find that complexities and flaws in the encounter data verification system cause certain encounters to be lost or deemed “invalid.” This potentially creates an inaccurate portrayal of the patient population, especially when high-risk or other resource-intensive encounters are not recognized across the patient population. Inaccuracies in encounter data can cause a population to look healthier than it actually is.

As encounter data plays a bigger role in negotiations with health plans, these issues will be exacerbated.

Align quality measures across health plans. We participate in multiple Medicare quality reporting systems. The total number of measures we are responsible for creates a costly burden for us, and thus represents an opportunity for improvement. There should continue to be a concerted effort by plans, consumers, and purchasers to agree on a smaller set of metrics that truly improve patient care.

Sharp Rees-Stealy is a staff model medical group with 475 employed physicians. Approximately one-third are primary care physicians. We offer services in 22 locations throughout San Diego County. We entered into our first capitated contract 30 years ago; today, approximately 70 percent of our total revenue stream is prepaid capitation.



THE MODEL

Management services organizations (MSOs) contract with medical groups or independent practice associations (IPAs). MSOs do not provide medical care, but they do provide a wide variety of services to support physician practices, including clinical quality services and administrative functions.

This case study examines the experience of SynerMed, an MSO, with full-risk Medicaid managed care plans. “Full-risk” arrangements involve all care services—including physicians, hospitals, ancillary providers, and pharmacy.

SUCCESS

“ In markets where we have a capitated hospital and capitated physician organizations, we can use this joint funding to create innovative models of care delivery.”

SUGGESTION FOR IMPROVEMENT

“ One challenge is that behavioral health and substance abuse treatments are often funded through separate streams and entities.”

Management Services Organization (MSO), Medicaid Managed Care – Full Risk

Contributed by: Peter Winston, Executive Vice President, SynerMed

How it Works

Medicaid managed care plans make capitated payments to the MSO. As a management services organization (MSO), SynerMed negotiates health plan contracts on behalf of our physician groups, independent practice associations (IPAs), and hospitals. Health plans then make a capitated (fixed, per-member, per-month) payment to SynerMed.

This payment covers both the physician and hospital services. In general, the rate is risk-adjusted for certain Medicaid eligibility categories, including Temporary Assistance for Needy Families (TANF), seniors and people with disabilities, childless adults, and certain low-income children. The rates are risk-adjusted to reflect the estimated resources needed to treat these patient populations.

The MSO pays physicians capitation or fee-for-service. We pay individual providers on behalf of each of our physician groups and IPAs. Each of these clients determines how it will pay its physicians, so there are a variety of different payment models. Primary care physicians are paid either risk-adjusted capitation or fee-for-service. Again, Medicaid adjusts the payment for populations that require greater healthcare resources. In general, specialists are paid fee-for-service.

IPAs and medical groups pay the MSO. The IPAs and medical groups that use our services pay us a contracted rate. This rate varies depending on the scope of services we provide for them; it's typically a percentage of the client's capitated payment.

Our MSO assists clients with meeting quality goals. Our IPA clients use different quality metrics and incentives, depending on the challenges facing their specific populations. For example, our clients may want to focus on initiatives around increasing vaccination rates or reducing readmissions. We assist IPAs in measuring and achieving their specific quality improvement goals.

Why It's a Success

We can invest in health for vulnerable populations. In markets where we have a capitated hospital and capitated physician organizations, our MSO can use this joint, prepaid funding to create innovative models of care delivery.

One example is the Downtown Coordinated Care Clinic (DC3). Located in downtown Los Angeles, the DC3 is dedicated to providing personalized, quality care to the most complex patients. The clinic provides services to Medicare and Medicaid patients and uses population analytics, advanced care coordination, care management, and team-based care to improve health and lower costs.

The benefits to patients are numerous. The DC3 prides itself on innovative strategies to meet patients' total healthcare needs. It often provides socioeconomic services not covered by the health plan—such as temporary housing for a homeless patient or transportation services for needy populations. This program has been very successful and has reduced high-risk patient costs from an average of \$30,000 per-member, per-month, to \$6,000 per-member, per month—a 6:1 return on investment.

We can build the infrastructure needed for complex care management. The MSO model works for physicians and patients because it affords an opportunity to organize physicians into sophisticated groups, with an infrastructure to support population health.

While low reimbursement rates in Medi-Cal for any single provider may serve as a barrier to coordinated care, the MSO model allows physicians to combine resources to build the infrastructure needed for complex care management. This is particularly true in a “full-risk” model—which has prepaid capitation for both physician and hospital services. The combined prepaid funding can be used to invest in sophisticated care management tools to provide better care for patients.

Suggestions for Improvement

Integrate behavioral health. One challenge is that certain services are carved out or offered separately by the health plan or county, rather than by SynerMed and its clients. In particular, behavioral health and substance abuse treatments are often funded through separate streams and entities, due mostly to California’s 1999 Mental Health Parity Act.

This makes it difficult to achieve a “whole person” orientation, as behavioral health plays a key role in overall clinical health. A more integrated funding and care delivery approach would better serve Medicaid patients.

Expand successful models. There are barriers to expanding or replicating the success of the Downtown Coordinated Care Clinic (DC3) in new markets. First, it’s difficult to identify and deploy the startup funding to create this type of model in different geographic locations without scale.

Second, additional work must be done to identify other global-risk partners in the delivery system—such as hospitals or health plans—that may be interested in pursuing the DC3 model. The model’s success depends on participation from multiple entities in healthcare delivery. This is the only way to provide the funding and care systems to meet the needs of complex populations. More robust participation in the future will be key to expanding and building on the success of the DC3.

SynerMed is a leading management services organization (MSO). It contracts with independent practice associations (IPAs), physician groups, and hospitals covering more than one million members to provide high-quality healthcare services for Medicaid, Medicare Advantage, and dual eligible beneficiaries.



THE MODEL

A health plan–owned group is a medical group owned by a health plan. In these arrangements, the health plan sets a defined budget for the medical group, which then operates like a department or division of the plan. Physicians, including specialists, are typically paid salaries plus performance incentives.

The following case study looks at the experience of Cigna Medical Group of Arizona, a multispecialty practice group owned by Cigna Healthcare of Arizona.

SUCCESS

“ This model provides a predictable budget, which allows us to take a thoughtful approach to leveraging community partnerships.”

SUGGESTION FOR IMPROVEMENT

“ An area for improvement would be to make timely, dynamic informatics available in a consistent manner across all product lines.”

Health Plan–Owned Group

Contributed by: Edward Kim, President and General Manager, Cigna Arizona

How it Works

The health plan provides a fixed budget. Cigna Healthcare of Arizona sets a defined budget for our medical group expenses. In essence, we operate as though we are a department of the health plan, under a prescribed budget. Our medical group is at full risk for both physician and hospital services for our Medicare Advantage patients. We are delegated for all professional services and provide quality and care management services.

Our medical group pays physicians—both primary care and specialists—a salary plus incentives. The incentive payment can be as much as 15 percent of a physician's total compensation. The incentive is based on the physician's and the medical group's overall performance on quality and resource use metrics.

We participate in quality measurement programs. These include the Medicare Advantage (MA) Five Star Rating System, as well as various commercial and Medicaid quality measurement programs. In 2016, our medical group assisted the health plan in achieving MA five-star status.

Why It's a Success

Our symbiotic relationship leads to better quality for patients. Because the financing and care delivery systems are under one roof, the plan and our medical group share the same goals and can focus on achieving them. The financial and clinical departments meet regularly to evaluate performance and how to deliver better care at a lower cost and in a targeted and consistent manner.

For example, in our quest for MA Five Star Rating System status, our medical group worked with the health plan to identify internal barriers to achieving the highest possible quality rating. Together, we developed a plan to focus on key areas and address sticking points.

Claims data helps us provide more efficient care. Our model allows both the plan and the medical group to improve patient care by combining financial and clinical data, expertise, and experience. One key to making this happen is the availability and integration of Medicare Advantage Part A, B, and D claims data. This data helps our medical group to provide efficient clinical care and population health management.

We can better leverage community partnerships. This model provides a predictable budget, which allows us to take a thoughtful approach to leveraging community partnerships. Together with the health plan, we determine which clinical capacities to build internally and where to seek opportunities to collaborate with other organizations. For example, after careful review with the health plan, we decided to subcontract with an outside hospice provider to offer services for our patients.

Suggestions for Improvement

Refine the division of labor between the plan and our medical group. One area for potential improvement is to better identify and allocate duties between the plan and the medical group. For example, we have capabilities in population health, and the health plan may need similar capabilities to support other health plan providers. In such instances, there are ongoing opportunities to share and allocate resources to maximize the strengths of both parties.

Enhance data sharing and communication. Our group's access to plan data varies by the type of insurance coverage. The most effective and complete clinical information sharing is provided for Medicare Advantage patients, but data are less available for commercial members. An area for improvement would be to make timely, dynamic informatics available in a consistent manner across all product lines.

Cigna Medical Group (CMG) is a multispecialty group practice that is a division of Cigna Healthcare of Arizona. CMG has 150 providers in 23 medical offices, six multispecialty centers, and three urgent care centers in Arizona, as well as 20 onsite pharmacies and refill centers. We offer vision, hearing, and pediatric services, have an accredited Ambulatory Surgery Center, and offer an after-hours nurse triage telephone line.

We provide care to the majority of patients in the Cigna Medicare Advantage (MA) plan in Arizona (about 53,000 patients). We participate in commercial, MA, and Medicaid arrangements.



THE MODEL

California law generally precludes corporations, including hospitals, from directly employing physicians. To still achieve the benefits of physician employment, some California hospitals use nonprofit medical foundations. In this model, the foundation contracts with health plans and pays physicians.

This vignette describes the experience of MemorialCare Health System, whose nonprofit foundation, MemorialCare Medical Foundation, works with two physician groups: MemorialCare Medical Group, which employs physicians, and Greater Newport Physicians IPA, which contracts with physicians.

SUCCESS

“ We’re able to offer different options to physicians, depending on whether they want to be employed or maintain their independence.”

SUGGESTION FOR IMPROVEMENT

“ In our shared-risk contracts, we don’t have sufficient data from health plans to accurately measure and manage the total cost of care.”

California Hospital Foundation Model

Contributed by: Jennifer Jackman, Chief Operating Officer, MemorialCare Medical Group; and Regina Berman, Vice President, Population Health, MemorialCare Health System

How it Works

All revenue flows through the Foundation. MemorialCare Medical Foundation contracts with different health plans under different arrangements—either shared risk or global risk. The Foundation then pays its two physician groups under both capitated (fixed, per-member, per-month fees) and fee-for-service arrangements. For Medicare Advantage plans, the Foundation pays “percent of premium capitation” (a percentage of what Medicare pays the health plan).

The physician groups pay physicians. In MemorialCare Medical Group, physicians are employees who are paid a salary. For these physicians, approximately 15 percent of their compensation is a bonus for quality, productivity, and patient satisfaction.

In the Greater Newport Physicians independent practice association (IPA), all physicians are independent contractors. The IPA pays primary care physicians capitation and a bonus for encounter data, quality, and patient satisfaction. Specialists also typically receive capitated payments, although some are paid fee-for-service.

The Foundation uses a subset of five quality metrics. These metrics are a focus for the overall MemorialCare Health System and are used to determine physician bonuses.

Why It's a Success

Physicians can be employees or contractors. Using the foundation model, we're able to offer different options to physicians, depending on whether they want to be employed or maintain their independence. This gives our patients broad access to physicians in the community.

We have the flexibility to respond to an evolving industry. The diverse tools of the foundation model have enabled MemorialCare to successfully respond to the rapidly evolving healthcare delivery system. For example, we've used this model with both employed and contracted physicians to respond to new alternative payment approaches, including commercial ACOs and Medicare's Next Generation ACO.

We take a team-based approach to care. Our Foundation employs clinical pharmacists, nurse practitioners, dietitians, and other health professionals to support comprehensive medical management for complex, high-risk patients in both physician groups. These programs receive high patient satisfaction scores. For example:

- The ACTIVE Diabetes Program provides comprehensive individualized care and education to help patients meet their diabetes treatment goals. When compared with a similar patient cohort, medical costs for ACTIVE participants were \$1,200 less per patient, per year.
- An Anticoagulation Center staffed by pharmacists resulted in 53 percent fewer inpatient admissions and 41 percent fewer emergency room visits.
- A post-discharge Special Care Clinic for senior patients uses a hospitalist, clinical pharmacists, nurse case manager, social worker, and a medical assistant to support positive transitions of care. The program provides patients with test results, discharge plan information, and medication adherence education before they return to their primary care physician. The clinic resulted in a 30-day readmission rate that was 60 percent lower than the national average.

Suggestions for Improvement

Simplify and streamline administration. One challenge is that internally we have two separate sets of agreements: one for MemorialCare Medical Group and one for Greater Newport Physicians IPA. For example, the division of financial responsibility (DOFR) differs for each group, and the groups have separate care management programs. We are working to integrate these two separate approaches to the extent possible.

Improve data sharing with health plans. Another issue is incomplete data. For example, we participate in the Integrated Healthcare Association's program to reduce the total cost of care. However, in our shared-risk contracts, we don't have sufficient data from health plans to accurately measure and manage this total cost of care. We look forward to working closely with health plans to develop information-sharing processes that support improvements in population health.

MemorialCare Health System is a nonprofit integrated delivery system that includes six nonprofit hospitals, a health plan, and MemorialCare Medical Foundation. The Foundation has two physician divisions—MemorialCare Medical Group and Greater Newport Physicians IPA—with more than 700 primary care providers and 1,500 specialists. In addition, the Foundation operates multiple urgent care centers, imaging centers, surgery centers, and dialysis centers.



THE MODEL

The Bundled Payment for Care Improvement (BPCI) initiative is Medicare's voluntary bundled payment program. While fee-for-service models pay for care "a la carte," under BPCI, a bundled price is set for each episode of care. An episode encompasses the clinical services for a patient for a particular condition over a set period of time. Different types of providers are included, and organizations assume financial and clinical accountability.

BPCI has four different models. Episodes of care and payment structures are different in each model. This vignette describes the experience Catholic Health Initiatives (CHI) has had with BPCI model two.

SUCCESS

“As a result of our participation in bundled payment initiatives, we have reduced readmissions by 46 percent and reduced utilization of skilled nursing facilities by 45 percent.”

SUGGESTION FOR IMPROVEMENT

“The limits on sharing savings with physicians are a barrier to achieving maximum collaboration in care improvement initiatives.”

Medicare's Bundled Payment for Care Improvement Initiative (BPCI)

Contributed by: Chris Stanley, MD, Vice President, Population Health, Catholic Health Initiatives; and Tamara Cull, National Director, Population Health Account Management, Catholic Health Initiatives

How it Works

Medicare sets a “bundled” price. To set this price under BPCI model two, Medicare looks at the hospital's historical claims for Medicare Part A and B for specific patients for episodes of care. An episode includes an inpatient stay in an acute care hospital, plus post-acute care and related services, up to 90 days after hospital discharge. After looking at these historical claims, Medicare applies a two percent discount to the “episode cost.” This results in the target “bundled” price.

Medicare pays shared savings to the hospital. During the year, traditional Medicare continues to make fee-for-service payments to providers. At the end of the year, the Medicare Part A and B spend for specific patients is compared against the target price. If the actual spend is less than the target price, we receive a share of the savings. We then invest this savings in infrastructure, quality reporting, and care management processes. We also use the savings to provide physician performance incentives.

Physicians are paid fee-for-service and shared savings. In addition to fee-for-service payments, individual physicians are eligible to receive a share of the savings we achieve (depending on each physician's agreement with the hospital). The amount of shared savings physicians receive depends on how they perform on quality and efficiency metrics. We also pay our physicians a share of the internal cost savings that come from efficiency improvements, such as reduced lengths of stay.

However, the Centers for Medicare & Medicaid Services (CMS) imposes a cap on the amount of savings that can be shared with physicians.

We use quality measures to assess performance. In general, Medicare uses—and therefore, we use—four quality and efficiency measures to assess performance in BPCI. These metrics include reduction in readmissions, completion of pre-operative patient education, and completion of the discharge transition process.

Why It's a Success

It improves quality and efficiency. To implement the BPCI program, we use three teams:

1. A pre-admission team assesses and coordinates with the patient and the patient's care team prior to the hospital admission.
2. An acute team works to improve hospital efficiency and reduce lengths of stay.
3. A post-acute team focuses on transitioning the patient out of the hospital and on continuing to be accountable for the patient in the community.

As a result of our participation in bundled payment initiatives and this focus on care redesign in collaboration with hospital teams, physicians, and post-acute providers, we have reduced readmissions by 46 percent and reduced utilization of skilled nursing facilities by 45 percent.

We have greater access to data. Under BPCI, we have access to the episode-related data from Medicare. We receive this data once a month. We then analyze this data to see how our physicians and hospitals are managing patient progress, readmission rates, and other indicators of health improvement.

We also have broader access to information about where our patients are receiving care—both inside and outside of our own system. This type of visibility is very valuable.

Suggestions for Improvement

Allow more savings to be shared with physicians. Medicare regulations limit the amount of savings we can share with our providers. However, sharing savings with our physicians is one way that we work to advance care improvement initiatives. The regulatory limits on sharing savings are a barrier to achieving maximum collaboration and results in these initiatives.

Clarify rules around post-acute providers. Our success in bundled payment initiatives has depended on our ability to collaborate with post-acute providers, including skilled nursing facilities. We have worked to establish preferred provider relationships with post-acute providers, to the extent permitted by Medicare. However, we would like Medicare to give us greater flexibility and opportunity to assist our patients in selecting appropriate post-acute providers.

Catholic Health Initiatives (CHI) has 105 hospitals and 12 clinically integrated networks across 19 states. We actively participate in Medicare's delivery system reforms. We have 10 Medicare Shared Savings participants, 18 teams working on the Bundled Payment for Care Improvement (BPCI) initiative, and 17 hospitals that will be impacted by Medicare's Comprehensive Care for Joint Replacement Model (a mandatory bundled payment initiative).



THE MODEL

Primary care is critical for patients' health, but historically, it has been underfunded in the United States. Medicare's Comprehensive Primary Care Initiative (CPCI) was created in 2012 to test new ways to fund and strengthen primary care—with the goal of improving patient care and lowering costs.

Under this four-year, multi-payer program, the Centers for Medicare & Medicaid Services (CMS) collaborates with payers in seven regions across the country. The program offers care management fees and shared savings to support specific primary care functions. (Note: In April 2016, CMS announced a new initiative, Comprehensive Primary Care Plus, which will build on the lessons learned in CPCI.)

This case study details the experience of Providence Health & Services in CPCI in Oregon. Providence participates in two ways: Providence Health Plan participates as a payer, and 13 Providence Medical Group clinics participate as providers.

SUCCESS

“ Participating in CPCI has improved our care coordination, quality, and efficiency.”

SUGGESTION FOR IMPROVEMENT

“ There have been some challenges aligning the CPCI project with the larger medical group infrastructure.”

Medicare's Comprehensive Primary Care Initiative (CPCI)

Contributed by: Cindy Klug, Director of Innovation, Providence Medical Group; Ben LeBlanc, MD, Chief Medical Officer, Providence Medical Group; and Christa Shively, Director, Federal Regulatory Affairs and Engagement, Providence Health & Services

How it Works

Clinics receive a care management fee and shared savings. Our clinics work with multiple payers: traditional Medicare, Medicare Advantage, fee-for-service Medicaid, Medicaid managed care, and commercial plans. These payers pay a “per-member, per-month” care management fee to an individual clinic for a specific patient population. Providence clinics use this fee to improve care coordination, quality, and efficiency.

In addition, clinics are eligible for a share of the savings generated (when compared with a historical baseline “spend”). CMS calculates these savings at the regional level, which includes other practices in Oregon selected for the CPCI program.

Physicians are paid through a value-based arrangement determined by the medical group. Our value-based plan combines three criteria: clinical quality performance metrics (15 percent), primary care panel size (10 percent), and traditional RVU (relative value unit) production. Quality performance and panel size (number of patients) are measured across a physician's entire patient population.

Quality measures play a key role. CMS uses nine milestones to evaluate providers. These include financial performance, after-hours advice by a clinician with access to patient records, care management, and behavioral health integration. In addition, clinics report on 13 measures that evaluate clinical quality at the practice level.

Why It's a Success

There's flexibility in achieving performance milestones. The nine performance milestones have reinforced team-based care within our clinics and provided a useful framework for building population health infrastructure. Clinics have the flexibility to achieve the milestones through different strategies; this creates opportunities to share what they learn and meet the needs of unique patient populations.

We're more proactive in coordinating patient care. Participating in CPCI has improved our care coordination, quality, and efficiency. For example, in the past, our care managers carried workloads across multiple clinics. Under CPCI, thanks to the care management fees, we've placed a care manager at each clinic.

As a result, each care manager can now take a more proactive approach to coordinating care—evaluating the stratified population for high-risk patients and helping to address any barriers to care. They also assist with coordinating care across multiple providers and ensure patients are up to date on their appointments and necessary tests.

It gives us more resources to improve care. CPCI has allowed individual practices to focus on population health and improving patient care. For example, we've improved depression screening and follow-up care. The CPCI project has given our practices the resources to follow up on the results of depression screening and empowered physicians to better address each patient's total care needs.

We've kept costs flat. The CMS evaluation has shown that Providence Medical Group and other participants in the region have been able to keep their costs flat in this program, after factoring in the care management fee. In other words, the care management fees have essentially paid for themselves, resulting in a program that is budget-neutral.

Suggestions for Improvement

Improve data flow from payers. One challenge has been getting information from multiple payers in a timely, complete, and consistent manner. Clinics work with multiple payers and patient populations, and they rely on payers to transmit timely information to help inform our interventions.

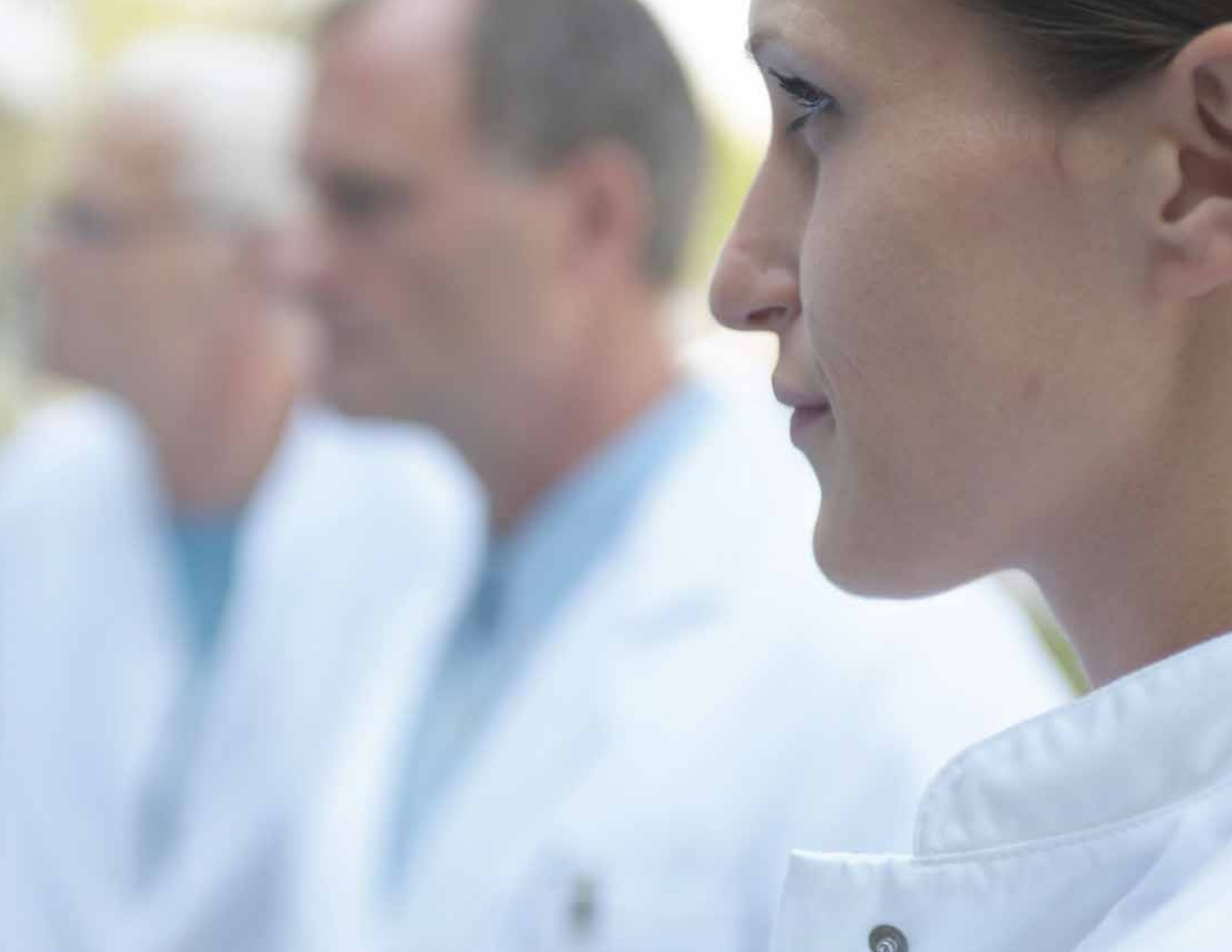
We would like CMS to provide participants with information to improve the care delivery model—for example, using the more robust and frequent claims data feeds in the Medicare Shared Savings Program. Practices should be able to use claims data to produce custom reports to better identify quality improvement and care coordination opportunities.

Streamline interactions between all entities. CPCI focuses on care improvements at the clinic or individual practice level. But in a highly integrated system like Providence, much of the infrastructure and support for these improvements exist at the medical group level.

There have been some challenges aligning the CPCI project with the larger medical group infrastructure. Data reports flow to individual clinics and not to the centralized medical group administration—which may slow down the analysis and response to these reports. We see future opportunities to streamline the interaction between the CPCI project, the individual clinics, the medical group, and the various participating payers.

Integrate CPCI with other new payment models. Today, practices that participate in CPCI are prohibited from also participating in Medicare accountable care organizations (ACOs). The rationale has been to prevent practices from “double dipping” in shared savings. However, there are ways to ensure against double payment of savings and achieve greater results by integrating CPCI's performance milestones and care management fee model into the ACO environment.

Providence Health & Services is one of the largest not-for-profit health systems in the United States. We operate 34 hospitals, a health plan, 475 physician clinics, 22 long-term care facilities, 19 hospice and home health programs, and 693 supportive housing units in 14 locations. Our not-for-profit health plan issues or administers health coverage for more than 500,000 members through commercial group, Medicare Advantage, Medicaid, and individual/family plans in Oregon and Washington.



THE MODEL

California's 1999 Mental Health Parity Act led to health plans shifting mental health services from group professional-risk contracts to managed behavioral health organizations. As a result, physician groups had to refer patients needing mental health services to external provider networks that were contracted with the health plans. Many groups expressed concerns with the quality, continuity, communication, and access to care for these services.

This case study describes the experience of UCLA Medical Group, which contracts with managed behavioral health organizations to make behavioral health services available within their network.

SUCCESS

“ Incorporating behavioral health with primary care and other clinical services allows us to offer integrated, coordinated care to patients with diagnosed behavioral health conditions.”

SUGGESTION FOR IMPROVEMENT

“ Our system has had to subsidize this integrated model beyond what the managed behavioral health organizations pay for services.”

Behavioral Health Integration

Contributed by: Sam Skootsky, MD, Chief Medical Officer, UCLA Faculty Practice Group and Medical Group

How it Works

Managed behavioral health organizations make fee-for-service payments to UCLA. To navigate the complexities in California law, we contract with managed behavioral health organizations. This allows us to make behavioral health services available within our network. In this arrangement, the managed behavioral health organizations reimburse us for this care with fee-for-service payments.

UCLA pays a salary to behavioral health associates (therapists and psychiatrists). To achieve the appropriate compensation level for these providers, we have to supplement the fee-for-service reimbursement we get from the managed behavioral health organizations. Over time, providers' compensation incentives will be tied to clinical quality metrics.

We take an innovative approach to quality measurement. This is based on our UCLA Behavioral Health Check Up, a tablet-based screening exam for depression, anxiety, substance abuse, and other conditions. The tool—which is integrated with electronic medical records—provides a personalized, real-time report to support clinical decision-making and care processes.

These results are tracked and trended at the point of care for each visit. In addition, we monitor patients' results to identify those who have not reached the target improvement in symptoms for depression or anxiety. These patients receive additional interventions. The early results show improved symptoms of depression and anxiety compared with the baseline.

Why It's a Success

It integrates behavioral health into a patient's overall care. Incorporating behavioral health with primary care and other clinical services allows us to offer integrated, coordinated care to patients with diagnosed behavioral health conditions. Approximately 25 percent of our patients have a diagnosed behavioral health condition, most often depression and anxiety. When these conditions are untreated, it results in higher utilization of acute facilities.

By embedding behavioral health providers and incorporating their payment stream into our overall funding system, we've improved and integrated the behavioral health care of these patients, while maintaining confidentiality and privacy protections around sensitive information.

Suggestions for Improvement

We need a long-term, stable funding mechanism. To date, our system has had to subsidize the development of this integrated model beyond what the managed behavioral health organizations have paid for services. And not every contracted plan has come to the table to bring together the behavioral health component.

Going forward, UCLA continues to work to deliver behavioral health services more efficiently and secure more stable sources of funding to provide this important service for the community.

By embedding behavioral health providers and incorporating their payment stream into our overall funding system, we've improved and integrated the behavioral health care of these patients, while maintaining confidentiality and privacy protections around sensitive information.

UCLA Medical Group is part of UCLA Health, an integrated, academic medical center affiliated with the David Geffen School of Medicine at UCLA. We've held partial- and full-risk capitation contracts for commercial and Medicare Advantage members for over 30 years. UCLA Health includes four hospitals, more than 300 primary care physicians, and 1,200 medical and surgical specialists. We have more than 20 behavioral health specialists, who see more than 2,000 new patients and 12,000 patient visits a year.



Accountable Care Organization (ACO)

Accountable Care Organizations are groups of physicians and other healthcare providers who come together to provide coordinated care to patients. ACOs exist in Medicare, Medicaid, and commercial payment arrangements. The payment model varies depending upon the ACO's contract with the health plan or Medicare.

- **Medicare Shared Savings Program ACO.** The Medicare Shared Savings Program (MSSP) was established under the Affordable Care Act. It offers three payment tracks:
 1. Track 1 is an “upside only” model. (The ACO may share in savings, but it's not at risk for losses.)
 2. Tracks 2 and 3 have “downside risk.” (The ACO must repay if it spends more than the benchmark.)
 3. Tracks 2 and 3 have different design elements. For example, Track 2 has retrospective beneficiary alignment (assigning patients at the end of the year), whereas Track 3 has prospective beneficiary alignment (assigning patients at the start of a year).
- **Pioneer ACO.** A Medicare model that is being tested by the Center for Medicare & Medicaid Innovation (CMS Innovation Center). Designed for providers who are already experienced in coordinating care for patients across care settings, it allows these organizations to move from shared savings to population-based payments. Pioneer generally has higher levels of shared savings and risk than the Medicare Shared Savings Program ACO.
- **Next Generation ACO.** The Next Generation ACO is a Medicare model that is being tested by the CMS Innovation Center. It's intended for ACOs that are experienced in coordinating care for their patient populations. It allows higher levels of financial risk and reward than the Pioneer or MSSP ACO. The goal is to test whether strong financial incentives and more patient engagement tools can improve health outcomes and lower costs for traditional Medicare patients.

Beneficiary Alignment

This refers to the way in which beneficiaries (patients) are attributed or “assigned” to a particular model, such as an accountable care organization (ACO). For example, instead of patients choosing to enroll in an ACO, in many models they are assigned to one—usually based on their use of physician services.

Bundled Payments for Care Improvement (BPCI)

A voluntary Medicare initiative in which a bundled or “package” price is set for an entire episode of care. Different types of providers are included, and organizations assume financial and clinical accountability for these episodes. There are four different models in this initiative, and episodes of care and payment structures are different in each one.

Capitation

A fixed, “per-member, per-month” payment for care—without regard to the quantity or frequency of services provided. The provider assumes the financial risk for providing services.

- **Global Capitation.** A two-sided risk arrangement involving a contract for all care services, including primary care, specialty care, hospital facilities, and ancillary services. Typically, the organization receives a prepaid, per-member, per-month payment.
- **Professional Capitation.** A two-sided risk arrangement involving a contract for primary care and specialty care professional services only (typically, physician services and certain ancillary services). These arrangements exclude other types of services, such as hospital and pharmacy. The physician organization is prepaid, usually “per-member, per-month” in these arrangements.
- **Percent of Premium Capitation.** This form of capitation is most commonly used in Medicare Advantage plans. In this model, providers are paid a percentage of what Medicare pays the health plan.

Delegated Model

In the delegated model, a health plan contracts with a physician group, which agrees to provide the full spectrum of specific medical services to patients. The physician group is also responsible for utilization oversight, quality improvement processes, paying claims, organizing the provider network, health information technology, and clinical quality and resource use measurement and reporting. The health plan typically prepays for these services upfront (capitation).

Division of Financial Responsibility (DOFR)

A tool used in the contracting process between health plans and physician organizations in capitated arrangements. It defines which party is financially responsible for specific services.

Episode of Care

Encompasses the clinical services for a patient for a particular condition, such as a stroke, over a set period of time (defined in advance). For example, an episode might start at the inpatient admission and end 90 days after discharge. Episodes involve different types of providers.

Independent Practice Association (IPA)

A physician-led organization in which physicians are independent contractors, rather than employees.

Per-Member, Per-Month Payment

A payment made to a provider each month for each of the members of a health plan who are assigned to that provider. This form of payment does not vary based on the frequency of services provided; it is a fixed, flat amount determined in advance.

Risk (for physician groups)

The physician organization agrees to take financial responsibility for the delivery of healthcare services to a patient population.

- **One-sided risk.** One-sided risk arrangements typically have upside only. In other words, physician organizations can share in savings that they achieve, but they are not at risk for downside losses. (In the event of overspending, they do not have to repay the health plan or Medicare.)
- **Two-sided risk.** In two-sided arrangements, providers are typically eligible to share in savings they achieve, but they are also accountable for overspending. If the provider overspends its benchmark, it must either repay the health plan or Medicare, or, in capitated arrangements, it must absorb financial losses.

Total Cost of Care

The amount that one or more payers spend on healthcare services for a group of patients.

Value Based Pay for Performance Program (VBP4P)

This California program enables physician organizations to earn incentive payments based on their performance on quality and efficiency measures. The results are publicly reported, and top performers are publicly recognized annually. The Integrated Healthcare Association (IHA) administers this program.

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