

Trustee Insights

NEW DELIVERY MODELS



Editor's note: Excerpted from “[Evolving Care Models](#),” a Market Insights report from the AHA Center for Health Innovation that provides an overview of the successes and challenges providers have experienced in aligning care delivery models with alternative payment models, and that provides lessons for those in the midst of this transition. As payers shift financial risk to providers through more advanced payment models, trustees will need to help their organizations build new capabilities for succeeding under these payment arrangements.

Aligning Care Delivery to Emerging Payment Models

Boards can employ a “maturity framework” to help their organizations evolve

BY THE AMERICAN HOSPITAL ASSOCIATION

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

The payment landscape for health care services has evolved to support providers’ transition to new care delivery models. Over the past 10 years, payers have

transitioned a growing portion of payments made to providers from traditional fee-for-service to alternative payment models (APMs). Also, commonly referred to as value-based payment models, APMs incent providers for quality and value, rather than volume.

The AHA Center for Health Innovation based this report on information and insights from a number of sources, including interviews with hospital and health system leaders and other health care experts, surveys of hospitals and health systems, and a number of health care reports and research articles.

Evolution in Care Delivery Models

Among other key points, the report's collaborators have observed that:

- APMs vary in the degree of financial risk they transfer to providers, but most providers today still assume relatively low levels of risk. This approach provides stability to providers as they build up the required capabilities for taking on higher levels of risk.
- APMs have gained traction in recent years, driven in large part by government payers. Activity across commercial payers varies geographically but is also accelerating. In certain cases, public and private payers are working together — at both the national and state levels — to align payment models.
- Providers are juggling the challenge of developing the capacity to operate successfully in shared-risk payment models, while still caring for significant numbers of patients in fee-for-service arrangements.

Four Most Common Alternative Care Delivery Models

Various service-delivery and payment models that aim to achieve better care for patients, smarter spending and healthier communities are still evolving and being tested. Health systems are implementing and refining a wide array of care delivery models. Alternative approaches have clustered around four specific models: accountable care organizations (ACOs), medical homes, integrated service lines (bundled payment programs) and provider-sponsored health plans, see chart on page 3.

According to the report, health systems without previous experience in alternative care delivery models chose to adopt one of the most common care models for the first time, and those with experience were adopting new processes and/or technologies to make the models more effective.

The Four Most Common Alternative Care Delivery Models

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

1 | ACCOUNTABLE CARE ORGANIZATION

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

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

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

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



2 | MEDICAL HOME

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

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

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

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



3 | INTEGRATED SERVICE LINES

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

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

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

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



4 | PROVIDER-SPONSORED HEALTH PLANS

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

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

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

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



Maturity Framework for APMs




While government payers have sparked a paradigm shift during the past decade around how to pay for health care, they have allowed for a transition, granting providers time to build new capabilities without significant exposure to downside risk. Many health systems now find themselves with one foot in more traditional fee-for-service payment systems and the other in alternative-reimbursement models. They want to transform their care models, but struggle to finance the required changes to their networks, processes and support systems.

Boards can help their organizations evolve toward value-based payment models by employing a “maturity framework” in discussions with their leadership team, see pages 5-6.



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

Maturity Framework for New Care Models/Risk-sharing Arrangements

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

| CAPABILITY | MATURITY LEVEL | | |
|--|--|---|--|
| | BASIC | FOUNDATIONAL | ADVANCED |
|  <p>Care Continuum and Provider Network Management</p> | <ul style="list-style-type: none"> ● NETWORK Significant gaps in assets across care continuum (outpatient — inpatient — post-acute) ● AFFILIATION REQUIREMENTS Limited criteria for affiliation ● QUALITY IMPROVEMENTS No link to quality/value | <ul style="list-style-type: none"> ● NETWORK Robust network (either owned or affiliated). Health systems can address most patient care needs across continuum through owned or affiliated providers. ● AFFILIATION REQUIREMENTS Contracts require commitment to shared quality/utilization metrics ● QUALITY IMPROVEMENTS Portion of payment to physicians tied to performance/value | <ul style="list-style-type: none"> ● NETWORK Comprehensive, clinically integrated network ● AFFILIATION REQUIREMENTS Affiliation relationship contingent on meeting quality and cost-management objectives ● QUALITY IMPROVEMENTS Strong alignment of physician compensation with clinical objectives through use of incentives |
|  <p>Clinical and Care Management</p> | <ul style="list-style-type: none"> ● CLINICAL PROTOCOLS No standardization of clinical protocols ● CARE MANAGEMENT Limited, if any ● QUALITY IMPROVEMENTS Quality-improvement and disease-management programs exist but are not coordinated across different parts of the health system | <ul style="list-style-type: none"> ● CLINICAL PROTOCOLS Shared clinical protocols and standards of care ● CARE MANAGEMENT Integrated care teams, including nonphysician providers; dedicated care managers for high-risk patients ● QUALITY IMPROVEMENTS Shared quality measures | <ul style="list-style-type: none"> ● CLINICAL PROTOCOLS Process for updating protocols with latest evidence and monitoring adoption ● CARE MANAGEMENT Population-health and disease-management programs, including use of telehealth and new technologies, where appropriate; assessment of social determinants of health and referrals to community-based organizations ● QUALITY IMPROVEMENTS Culture of continuous process improvement with progressively evolving performance standards |
|  <p>IT Infrastructure and Analytics</p> | <ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Functional EHR but little interoperability with affiliates ● POPULATION HEALTH MANAGEMENT TOOLS Use of disease registries/reporting ● PERFORMANCE ANALYTICS Some ability to track performance against quality/utilization benchmarks | <ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Strategy in place to integrate EHR and analytics platforms across network, though not necessarily common platform ● POPULATION HEALTH MANAGEMENT TOOLS Population health-management system to identify high-risk patients ● PERFORMANCE ANALYTICS Integration of clinical, administrative and care management data at patient-level; practice-level dashboards to track performance against quality/utilization targets | <ul style="list-style-type: none"> ● ELECTRONIC HEALTH RECORD Common EHR, analytics and care management platform used across network ● POPULATION HEALTH MANAGEMENT TOOLS Ability to identify defined subpopulations for targeted interventions; use of predictive modeling to identify at-risk members; ability to facilitate and track closed-loop referrals to community-based organizations ● PERFORMANCE ANALYTICS Near real-time visibility into quality and cost performance <p style="text-align: right;"><i>Continued on page 6</i></p> |

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

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

Road Map to Advance Along the Maturity Model

Health system leaders who have embarked on care delivery change say they are committed to continuing the evolution toward value-based care because the approach is better for patients, but they caution that there is no silver bullet that can substitute for: setting an inspiring vision for care delivery; engaging clinicians to agree on evidence-

based protocols and care plans; retraining staff to support the new approach; and building feedback loops to measure organizational performance and adjust accordingly.

The following “road map” on page 8 offers leadership lessons for those wishing to transform their care models.

Road Map to Advance Along the Maturity Model

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

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

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

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

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

3 Develop a proof of concept.

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

4 Build financial-management capabilities to manage risk contracts.

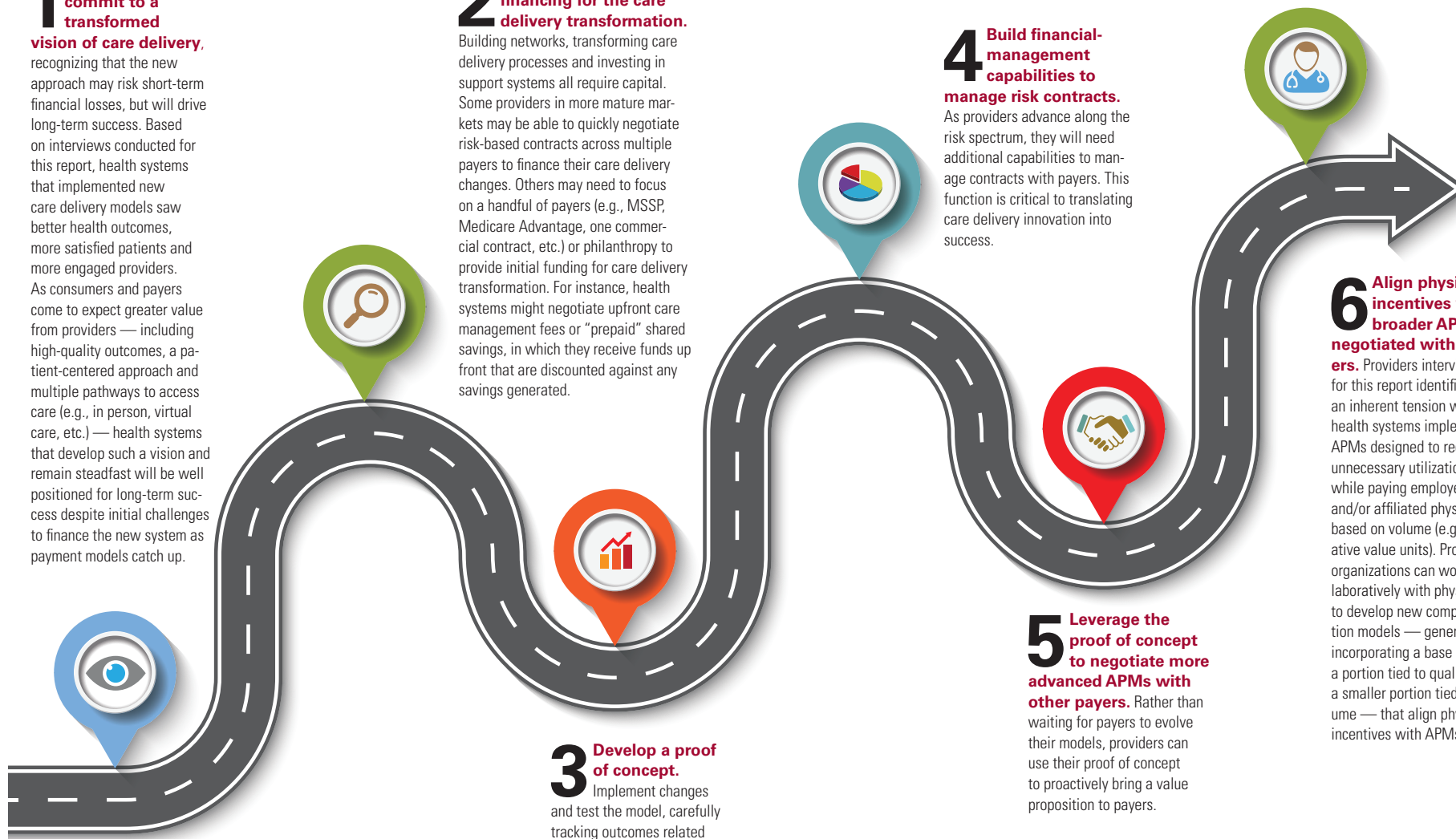
As providers advance along the risk spectrum, they will need additional capabilities to manage contracts with payers. This function is critical to translating care delivery innovation into success.

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

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

6 Align physician incentives with broader APMs negotiated with payers.

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



Conclusion

By building care delivery prototypes, testing their models and bringing a value proposition to payers, health systems can achieve greater alignment among reimbursement from government and commercial payers, thereby further accelerating care delivery transformation. Such an approach creates a virtuous cycle where initial successes in care delivery and payment reform provide feedback to drive bolder care model changes and increased levels of financial risk. As payers continue to shift higher levels of risk onto

providers, hospitals and health systems that can leverage this positive feedback loop to transition a substantial portion of their payment stream to APMs will be well positioned for success. Through the hard work of changing their care models, providers are poised to lead care delivery change to improve patient outcomes.

The report was collaboratively prepared with insights from Benjamin Chu, Naomi Newman and Avi Herring from Manatt Health.

Questions for Board Discussion

1. How has our organization gained experience with alternative care delivery/payment models? Which models have we adopted and what have we learned?
2. What are the key challenges we have faced in gaining experience with new care delivery/payment models (for example, engaging staff and clinicians, financing the transition to these models, acquiring the technology, tools and capabilities needed to make the change, etc.)? How has our organization addressed these challenges?
3. Will experience with alternate care delivery and payment models require us to change our risk appetite/tolerance and, if so, how?
4. Where does our organization fall on each dimension of the maturity framework shown above?
5. What steps along the above road map might our organization take to continue to advance our capabilities to effectively engage in value-based care delivery and payment?
6. How should our board continue to monitor our organization's progress toward adopting value-based care and payment models?