Best Practices in Value-Based Payment
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Making the shift from fee-for-service to value-based care is perhaps the most transformative change a healthcare organization will ever make.

It impacts every aspect of your operations: care delivery, governance, technology, human resources, compensation, and beyond. And with increased accountability for managing the costs of care while improving patient health, it’s essential to get it right.

AMGA guides organizations through this evolution like no other group.

AMGA was founded in 1950 to empower the delivery of health care that is coordinated, patient-centered, high-quality, and value-driven. Our promise is to be an indispensable partner in advancing high performance health.

Our vision: a transformed healthcare system that partners with engaged communities to promote healthier lives.

Today we represent 450 medical groups and health systems serving 1 in 3 Americans, from California to the Carolinas. We leverage this unprecedented reach to convene healthcare leaders in solving the vital issues of the day and to promote patient-centered care, accountability, care coordination, physician leadership, and achieving the Triple (and now Quadruple) Aim.

Our members learn from each other, especially in the complex endeavor of undertaking risk. Through in-person conferences, multi-year campaigns and collaboratives, webinars, peer-to-peer exchanges and more, they share their experiences, challenges, triumphs, and lessons learned. Read on to see highlights from five models and 10 cutting-edge organizations—and a sample of how AMGA membership and programs can benefit you.

Contact Bill Baron, vice president, membership, at 703.838.0033 ext. 336 or wbaron@amga.org today to learn more.
Pay for Performance

The pay for performance risk model delivers just that: financial incentives for meeting specific quality and/or utilization measures. It’s where many organizations start in assuming risk.
Holston Medical Group: Saving Money Through Segmenting Care

Pay for performance models take different forms, one of the most common of which is an accountable care organization (ACO). In 2012, only 29 of 114 Medicare ACOs generated savings in their first year. In 2013, Qualuable Medical Professionals, the new ACO for Holston Medical Group (HMG), reported a Medicare savings of $10.8 million, according to Jason Tipton, HMG’s director of value operations and informatics and chair of data aggregation and analytics.

The physician-owned, multispecialty group achieved these results through focusing its efforts on highest-risk patients: driving down hospital admissions and readmissions, identifying inefficiencies (such as duplicated tests and high-spend services), and driving services to high-quality, low-cost facilities and providers.

The journey started with data. A Health Information Exchange established in 2012 gave HMG the analytics to stratify its patients into three risk levels:

- **Level 3 (5+ chronic conditions):** This group was responsible for 54% of overall medical costs. HMG case managers educated these patients about their health and care, kept them in contact with HMG, and removed obstacles standing in the way of appropriate care.

- **Level 2 (2-4 chronic conditions):** To reduce readmissions for these medium-risk patients, HMG focused on transitions of care after hospitalization, improving these outcomes through follow-up calls and close monitoring after discharge.

- **Level 1 (0-1 chronic conditions):** To keep low-risk patients healthy, HMG used routine care protocols during office visits to address gaps in care, and closed 81% of these gaps in 2013 alone.

### Pay for Performance Lessons Learned

*Because inpatient care can be a significant cost area for patients with multiple chronic conditions, Tipton recommended that organizations use outpatient settings to deliver these patients advanced care conveniently and cost-effectively. HMG uses its Extensivist Clinic in this manner for conditions such as atrial fibrillation, acute renal failure, and COPD exacerbation.*
Mayo Clinic:  
Change Starts with Governance

Fewer dollars for healthcare services. An expanded population in need of care. Market disruptors such as payer and employer carve-outs and narrow networks. This convergence of trends led Mayo Clinic to a plan for a patient-centric healthcare experience across its four regions, 18 hospitals, and the 525,000 patients it serves each year, as well as an academic research center serving another half-million patients annually.

The obstacles were many: daily management challenges, past experience with contracts and payments, inertia, and “provider angst,” said Brian Whited, a regional CEO for Mayo Clinic Health System.

Delivering a “right care, right time, right location” patient experience started with governance: moving from a confusing, multi-layered set-up of independent practices to a lean system led by a new Midwest Executive Operating Team.

With the patient always at center focus, the team worked through committees to launch parallel integration efforts for benefits and compensation, privileging and appointments, information management, and more.

In just four years, from 2007 to 2011, Mayo Clinic moved from a holding company model to operating as an integrated organization. According to Whited, integration prepared Mayo Clinic for its move to shared risk and yielded several practice benefits, including improved recruitment in difficult specialties and a community practice “learning lab” for product development.

He attributed success to engaging leaders from practice groups, making adjustments for culture and expectations, focusing on a common baseline goal, and engaging site leaders in roles with system responsibility. And throughout, he advised, remember that the needs of the patient come first.

Pay for Performance Lessons Learned

“To gain optimal buy-in and minimize push-back, be reasonable in how you time the process,” Whited advised. “And engage leadership from your practice groups. They are critical to helping deliver the message throughout the practice.”
Track 1 ACO: Medicare Shared Savings Program (MSSP)

As the name implies, an Accountable Care Organization (ACO) is held accountable for the quality, cost, and care experience of an assigned population. Through CMS’ multi-track Medicare Shared Savings Program (MSSP), participants nationwide explored the ACO model with Medicare fee-for-service beneficiaries. In Track One, ACOs share savings but don’t incur losses.
Crystal Run: Data Accelerates Progress

Physician-owned multispecialty medical group Crystal Run Healthcare was one of the first participants in the MSSP program, joining in 2012 as one important step in its overall journey from volume to value. In AMGA’s webinar series, Chief Quality Officer Scott Hines advised AMGA members to prioritize data and be proactive about making the change from volume to value. “Don’t wait for the market to move and then catch up,” said Hines. “Be a leader in your market because there is a first mover advantage, particularly if risk-based contracts benchmark you in the market.”

By mining claims information, Crystal Run identified three major cost centers: acute and subacute rehabilitation, admissions and readmissions, and overuse of specialists and labs. With these insights sharpening its focus, Crystal Run reconciled in-home medications for the sickest patients, which reduced hospital readmissions, and educated primary providers about the unnecessary use of specialist and labs. In addition, they had patients go to physical therapy prior to surgery to increase strength and flexibility for easier post-op recovery.

With multiple quality measures to report, finite windows of time to do so, and the ever-present possibility of a CMS audit, robust information management is critical to MSSP success. Crystal Run got ahead of the situation by writing the code for data collection over nine months in advance. The organization had the foundation to do so, as an early adopter (since 1999) of electronic health records and the first New York practice to achieve Joint Commission accreditation. Since Performance Year 1 (PY1) pays for reporting, as long as a group reports data accurately and completely, it will get full credit regardless of their performance. Hines suggests that groups use PY1 to grow their capabilities to perform well on the measures, since PY2 and beyond are pay for performance, and it takes time to build those competencies.

Involving physicians and IT specialists in the effort was key. “It was important to have providers show the business intelligence team where to look in the chart,” Hines said.

MSSP Lessons Learned

Because the MSSP program is an opportunity to engage and re-engage patients, the required CMS notification letter should only be the beginning of MSSP patient outreach, according to Hines. Crystal Run sent out a brochure to explain what an ACO is and to raise awareness about patient-centric ACO features like the online patient portal and support groups.
Memorial Hermann Health System:
Care Integration Delivers Powerful Results

With an estimated 323,000 lives covered by its ACO, Memorial Hermann Health System reported millions in savings in per-employee, per-year claims costs over four years. Meanwhile, its rates for avoidable ER visits and readmissions fell below the averages for the Houston market where the organization operates.

D. Keith Fernandez, Memorial Hermann’s then president, physician in chief, and CMO, credited much of this success to clinical integration.

“Physicians must be integrated on a clinical basis to determine and commit to the right and best ways to practice medicine, commit to mutual accountability, and develop active performance improvement programs to enhance healthcare quality and efficiency,” Fernandez told AMGA members.

As an MSSP participant, Memorial Hermann segmented patients by risk and delivered care based on matching intensity levels: from wellness and prevention programs for healthy patients to chronic disease management, telemedicine, and home visits for the smaller number of sickest (but most costly) patients.

MSSP participation has laid the groundwork for future transformation, he said. “Clinical integration provides the foundation for risk-based contracting, population health management, and an ACO within a hospital or hospital system.” It’s a necessary journey for Texas’ largest not-for-profit health system. “Employers are bearing more risk, turning to providers as allies. They want a reliable product with predictable and stable costs.”

MSSP Lessons Learned

“Physicians must see data to be informed,” according to Fernandez. He advised exploring the full range of traditional and emerging sources: points of care, registries, wearables, concierge medical services, networks, and beyond.
Next Generation ACO

For organizations experienced in population health, the Medicare Next Generation ACO model offers greater opportunities for financial risk and reward. Participants can use payments for incentives, infrastructure, and revenue-sharing.
UnityPoint Health: 
Next Gen as a Logical Next Step

MACRA and the promise of 105 million patients by 2020 drew UnityPoint Health to the ACO model, Aric Sharp, vice president of Unity Point Accountable Care, told attendees at AMGA’s annual conference. After Pioneer ACO and MSSP participation, a number of other factors led the organization specifically to the Next Gen model, including:

- Prospective, rather than retroactive, patient attribution
- 80% risk sharing
- Waivers in areas like skilled nursing, telehealth, and home visits
- The opportunity to collaborate with peers and the Center for Medicare and Medicaid Innovation (CMMI) as the ACO model evolves

UnityPoint Health had 84,000 lives in its Next Gen ACO and $1 billion in medical spend in agreements with downside risk. To guide its clinical transformation, it created its own trademarked care model. This model is grounded in five foundational processes (common care plans, clinical care pathways, care transitions, and utilization and referral management) and guides the use of analytics, risk stratification, platforms, and services across the organization.
For success in the Next Gen ACO model, Sharp advised:

- Spreading risk out over a sufficient volume of lives, and keeping care within network to better manage costs
- Prioritizing physician training and coaching to manage change and reduce outliers and variations in care
- Focusing on risk coding, and on favorable and fair contract terms. “Work on sharing risk with your network partners in amounts that are both meaningful and palatable.”

UnityPoint Health’s Care Model

Next Gen ACO Lessons Learned

“Don’t underestimate the importance of keeping low-risk lives attributed to you,” Sharp advised. “Losing the attribution of healthy lives will impact your calculus.”
Trinity Health: Making the Right Thing the Easiest Thing

When sharing Next Gen ACO success stories at a recent AMGA conference, Barbara Walters, executive vice president and chief population officer of Trinity Health, relayed the story of Rodney, a 54-year-old patient. Before receiving care through the ACO program, Rodney visited the ER 80 times over a 10-month period for pain, numbness, nausea, and stroke-like symptoms.

Then a care manager met with Rodney. Discovering behavioral health and socioeconomic components to Rodney’s illnesses, the care manager referred him to specialists in behavioral health and pain management, as well as medical services. This helped him achieve compliance with his appointments and medications and gain coping mechanisms for his anxiety disorder. After these interventions, Rodney only visited the ER twice over a two-month period.

Trinity Health, a 22-state diversified network, began its three-year Next-Gen ACO journey in 2016 as a move to replace its Medicare Shared Savings Program with an enhanced model similar.

Collaborative Model

The collaborative model will drive improved performance in achieving better health, better care, and lower cost.

- Effective Trinity Systems Office Support
- Effective Local ACO/CIN Execution
- Collaboration Drives Improved Performance
- Shared Governance

Collaborative Model
to Medicare Advantage. The organization set up Trinity Health ACO (THACO) as a separate legal entity, working through five participating organizations that it refers to as “chapters.”

The Next Gen ACO model aligns with Trinity Health’s mission, “Making the right thing to do the easiest thing to do,” Walters said. The Next Gen ACO model removes the perverse incentives and limitations of the fee-for-service world by refocusing care teams on the patient’s needs at and away from the visit.

**Next Gen ACO Lessons Learned**

Although health care is an inherently local service, organizations can ease their administrative burdens by performing some tasks centrally. “All of us move down this path faster and more effectively together rather than separately,” said Walters.

**Next Gen ACO Lessons Learned**

Given the variety of Medicare beneficiaries in THACO’s attributed population, success has depended on its five chapters working together to:

- Understand aligned beneficiaries and their clinical conditions
- Implement resources for care management
- Use data and analytics to understand and measure performance, then share best practices in population health
- Document care for chronic conditions
- Engage beneficiaries and providers
- Proactively manage the use and total cost of care
Medicare Advantage

In recent years, as many as half of new patients joining Medicare have chosen Medicare Advantage plans through private companies for their Part A (institutional services like hospitals) and Part B (professional services like doctor’s visits) benefits. Provider groups and hospitals have been partnering with insurance plans in shared savings plans and other shared risk models to move away from fee-for-service payments and collectively drive costs down.

Organizations can take on risk for professional services alone, or they can increase their potential payments by taking on risk for both professional and institutional services. This latter arrangement is known as global capitation.
HealthCare Partners: 
**Homing In on Chronic Conditions**

This AMGA member currently serves more than 600,000 patients under risk-based contracts in the Los Angeles area and more than 900,000 nationwide. While most organizations only accept professional risk, HealthCare Partners accepts professional and institutional risk, with most patients falling under this global capitation arrangement.

Managing population health has been key to making it work, National Medical Director Donald Rebhun told AMGA annual conference attendees. This involves delivering appropriate levels of care, reducing unnecessary utilization, leveraging technology and data, and building patient trust.

**Investment in Patient-Centered Care**

HealthCare Partners focuses on MA patients with high-cost chronic conditions. These patients are supported with personalized disease plans and multidisciplinary onsite teams of internists, clinical pharmacists, and social workers. To reduce unnecessary hospitalization, the biggest cost burden, these teams educate patients and their families, communicate with primary care physicians and specialists, and assist with discharge from hospitals and other facilities.

For the highest-risk patients, HealthCare Partners’ home care program provides a 24-hour hotline for at-home visits. At the patient’s home, the team conducts a comprehensive assessment of medical services, behavioral health services, medications, safety and living conditions, and social and financial needs.

**Medicare Advantage Lessons Learned**

“As organizations take on more risk, they’re going to have to address the psychosocial needs of patients,” Rebhun said. “This includes transportation, housing, food, medication costs, and behavioral health.”
WellMed Medical Group: A Senior-Focused Group Delivers Award-Winning Care

WellMed Medical Group provides care for more than 320,000 older adults in Texas and Florida. One key goal for this senior-focused, physician-led healthcare delivery system: decreasing unnecessary readmissions and ER visits.

Its award-winning disease management program unites social workers, hospitalists, primary care providers, and transition managers. These interdisciplinary teams meet weekly to review inpatient transitions and ER visits and revise care plans to better coordinate services, reconcile medications, ensure safe transitions home, and follow up with patients in a timely manner.

“The success of the risk adjustment program depends on primary care physician engagement,” Senior Medical Director Laura Huete told AMGA members. WellMed has introduced resources, like reporting tools for tracking progress, to educate and support primary care physicians. The organization also factors risk adjustment, quality performance, and healthcare cost control into its compensation incentives.

**Illness Pyramid – the Rosetta Stone**

78% of admissions were for members in bands 1 and 2

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<th>Percent of Cost</th>
<th>PMPM Cost</th>
<th>Illness Burden Range</th>
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Source: CareFirst HealthCare Analytics – 2012 Data

**Medicare Advantage Lessons Learned**

“Risk coding is key to success,” Huete said. WellMed enlists clinical coders to review every chart. This highlights issues like suspect codes, codes that don’t meet applicable guidelines (AHIMA, ICD-9, CMS), and insufficient documentation.
Commercial Capitation

Under capitation, assuming financial risk for the cost of care can yield a variety of potential benefits: upfront cash flow, the ability to invest in infrastructure and care model redesign, and increased capacity to move physician incentives away from volume, to name a few. It’s one of the most advanced risk payment models, and AMGA’s membership includes some of its most skilled and experienced practitioners.
Atrius Health: 
**Strong Partnerships Power Success**

With roots in the HMO staffing model, multispeciality group Atrius Health has a long history of managing global capitation payments, which today represent 75% of the organization's $1.9 billion in annual revenue.

Here's how it works: A health plan pays a monthly amount for patients who have an Atrius Health primary care provider—regardless of whether services have been delivered that month. Payments are made on a “per member per month” basis, with services from outside providers and for medications deducted from the gross amount.

Engaging the right partners, like lower-cost hospitals, has been critical to capitation's success, Chief Contracting Officer Beth Honan told participants in an AMGA regional meeting. Also critical: supporting these relationships with robust performance measures, IT interoperability, and collaborative risk arrangements.

As partnerships hit key milestones, “think long and hard about budget adjustments,” Honan advised. How might your population's demographics, health status, or mandated benefits change? Make sure you have the right provisions in place with health plans to make adjustments as needed. And make sure any prospective partner has strong actuarial capabilities.

Strategic collaboration has lowered the cost of care for patients across age groups. Over a 12-month period, Atrius Health reduced total medical expense by 10% among its pediatric Medicaid patients by hiring care facilitators to handle social, emotional, and community needs. And when the organization brought its own clinicians to manage patient discharge in skilled nursing facilities, the savings amounted to nearly $4,000 per case.

**Atrius Health Payment Model Mix**

![Atrius Health Payment Model Mix Chart](chart.png)

- **25% Fee-for-Service** (~$500K)
- **75% Capitation** (~$1.4b)
MemorialCare Health System:
*Aligning Strengths with Capitation*

Capitation is a prevalent payment model in California. MemorialCare Health System in the southern part of the state turned to commercial risk when commercial HMO membership flattened and the organization needed new ways to protect and grow membership among large employers like Boeing.

Today, MemorialCare provides care for 265,000 at-risk lives: 148,000 HMO patients and 107,000 ACO patients. To do so, it aligns the efforts of 261 employed providers, 1,500 contracted specialists, and more than 1,000 independent primary care physicians and specialists.

Accurate coding for risk adjustment is a must, particularly for Medicare Advantage capitation, CEO Mark Schafer told attendees at AMGA’s 2017 Annual Conference. MemorialCare enlists coders and auditors to ensure appropriate documentation and a physician champion for peer education.

He also cited the importance of shifting care from hospitals to ambulatory facilities. MemorialCare offers 10 imaging centers, nine ambulatory care centers, 13 dialysis centers, and 12 urgent care facilities across its network. The organization also leverages partnerships for services like dialysis and sends emergency department patients to skilled nursing facilities, rather than hospitals, when possible.

*Sample Cost Trend Analytics*
Capitation Lessons Learned

According to Schafer, organizations pursuing commercial risk need:

- **Data analytics** for modeling and understanding cost trends, stratifying risk, and identifying patients for care management, chronic disease management, and special clinics

- **Robust infrastructure** for care management and coordination, special clinics (e.g., discharge, intensive outpatient care, high-risk, diabetes), provider contracting, and network management

- **Information at the point of care** for adjusting risk and addressing gaps in prevention, chronic disease management, and overall care

- **Strong, aligned physician leadership**, representing specialties and primary care, to implement panels, conduct risk adjustments, manage quality initiatives, and tackle variations in care
AMGA: Unrivaled Resources and Relationships for Managing Risk

Wherever you are on the risk continuum, the move from volume to value can feel like uncharted territory.

What’s the best way to manage high-risk patients, engage providers, leverage data and technology, and align payer contracts? How should you adjust your leadership and governance structures?

The questions are complicated. But with AMGA, you’re not answering them alone.

Through our programs, resources, and valuable peer-to-peer networks, you’ll find methodologies for process improvement and models for care and compensation. You’ll hear firsthand about tips for success—and impediments to progress—from groups like yours.

AMGA: Your Partner for Value-Based Care

Contact Bill Baron, vice president, membership, at 703.838.0033 ext. 336 or wbaron@amga.org to take the next step or visit amga.org/risk.
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