PROMISING PAYMENT REFORM: RISK-SHARING WITH ACCOUNTABLE CARE ORGANIZATIONS

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ABSTRACT: The Medicare Shared Savings Program, a component of the Patient Protection and Affordable Care Act, has accelerated the creation of accountable care organizations (ACOs), payer–provider alliances meant to deliver lower-cost but still high-quality health care via new payment models, particularly ones that reward efficiency. This paper describes and reports on the implementation of eight private ACOs that use, or are planning to deploy, a shared payer–provider risk payment model. Still in an early developmental phase, these payment models vary not only in their design and in how they define shared risk. The authors note that providers currently lack the infrastructure required to take on and manage risk successfully, though some payers are providing such support. Providers will need more data and analytic capabilities to manage the patient populations for which they take on financial risk and to negotiate appropriate risk-sharing arrangements with payers.

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act is serving as a catalyst in health care for new approaches to measuring performance and value, promoting wider adoption of health information technology (HIT), and developing models for delivering and paying for care more effectively and efficiently. In particular, the Medicare Shared Savings Program created by the legislation establishes financial incentives for accountable care organizations (ACOs) to provide coordinated, well-integrated care. Anticipation of the program has caused a flurry of activity among providers, purchasers, and payers.

Providers and payers recognize that for ACOs to reach their potential, there is a need for payment models other than the fee-for-service approach dominant today. As the new ACOs form, payers are establishing shared-savings programs and other payment models in an effort to create financial incentives for high-quality care. Payers are also considering payment methods that confer a portion of the financial risk to the provider, seeking to create stronger incentives than shared savings only; in fact, the proposed rule for the Shared Savings Program includes a shared-risk component. But while many providers and payers prepare to participate in ACOs, there is minimal evidence about what it takes for ACOs to succeed, including the payment models—shared-risk or otherwise—that will most appropriately support them.

This report summarizes research on ACO shared-risk payment models conducted by Catalyst for Payment Reform and Booz Allen Hamilton. The focus is on private sector payment models that meet criteria along three dimensions: provider risk, inclusion of services, and incentives for quality. Models of interest are those that include a provider risk-sharing component, address the broad array or full continuum of patient care/services, and provide meaningful quality incentives. While we found dozens of ACO initiatives, only eight met the criteria for inclusion in this study.

The research uncovered several key findings:

- Payer–provider shared-risk models are in an early developmental phase; there are few operational shared-risk models aside from the traditional capitated HMO model.
- There are varying definitions of shared risk, and shared-risk initiatives use a variety of program designs.

- Providers do not currently have the infrastructure required to take on and manage risk successfully, though some payers are providing infrastructure and other support to providers.
- Shared-risk models have typically evolved from shared-savings programs.

It is particularly important to note the very early stage of development of these population-based, shared-risk contracts. We found few operational shared-risk payment models; most are in development or at an early stage of implementation. Of those that are operational, many launched only in the first quarter of 2011 (three of the eight models). A variety of approaches to shared risk exist. Exhibit ES-1 summarizes the four main approaches we found.

Exhibit ES-1. Shared Risk Payment: Four Approaches

Risk Model	Definition	Examples
Bonus Payment at Risk	Provider is at risk of not receiving a bonus payment based on quality and/or efficiency performance	Blue Cross Blue Shield of Minnesota Preferred One
Market Share Risk	Patients are incentivized by lower copays or premiums to select certain providers so providers are at risk of loss of market share	Buyers Health Care Action Group
Risk of Baseline Revenue Loss	Built on a fee-for-service "chassis"; providers face a financial or payment loss if they fail to meet certain cost or quality thresholds, and/or if actual costs exceed a target cost	Blue Cross Blue Shield of Massachusetts AQC Blue Cross Blue Shield of Illinois–Advocate Health Care
Financial Risk for Patient Population (Whole or Partial)	Providers manage patient treatment costs for all or a designated set of services within a predetermined payment stream and are at risk for costs that exceed payments (e.g., partial/full capitation, global budget)	State Employees Health Commission (State of Maine) *(planned)* Anthem/WellPoint *(planned)*

While this work focused on shared-risk models that fall into the definitions in the bottom two rows of this table, it is the models in which providers take on whole or partial financial risk for a patient population—and move away from the fee-for-service "chassis"— that are arguably of greatest interest. All of the studied models include the fee-for-service "chassis"; we were unable to find any models currently in place that both move away from fee-for-service and include financial risk to the provider for a patient population.

The fact that providers lack the infrastructure they need to take on and manage risk successfully was also a common theme among the initiatives we studied. Providers

do not have the data they need about the clinical or financial experience of their patients to manage patient care and financial risk effectively—the HIT structure necessary to coordinate care among providers is at varying levels of implementation. Providers also face operational and structural challenges related to the ACO model of care, which demand more coordinated, efficient processes. Many of the initiatives we studied try to mitigate some of these challenges by providing case management, disease management, and risk management support to providers.

Although this research uncovered several key findings about the development of ACOs and the payment models to support them, it is too early to identify which payment models best align incentives for ACOs with high-quality, high-value care. The majority of the payment models we studied have a fee-for-service foundation; however, shared risk combined with other base payment approaches can be even more robust. Capitation, bundled payments, and global budgets place the responsibility for managing financial risk more squarely on the shoulders of providers. Though we did not uncover any existing initiatives that employ one of these payment methods and meet the other research criteria, some initiatives anticipate more aggressive shared-risk payment models in their future. These burgeoning models and the experiments they embody will inevitably instruct us.

While many unknowns remain, this research advances our collective understanding and identifies several elements of ACO development to monitor and learn from over time. Through the Center for Medicare and Medicaid Innovation, there might even be opportunities to build on these experiments with public–private partnerships, strengthening the power of the pilots and making it potentially easier to detect their impact. Alignment between Medicare and the private sector will be critical to strengthen the impact of each other's reforms, sending consistent signals to and intensifying incentives for health care providers to improve quality and reduce costs. It is also critical to assure that Medicare reforms do not simply lead providers to shift additional costs from Medicare to private purchasers and payers but, instead, make health care more affordable for all. It is unlikely that there will ultimately be a "one size fits all" solution; it will be important to learn which models work best in which situations.

PROMISING PAYMENT REFORM: RISK-SHARING WITH ACCOUNTABLE CARE ORGANIZATIONS

INTRODUCTION

Policy Context

The need for innovation in the U.S. health care system continues to accelerate as costs stay on their upward trajectory while quality remains stagnant. The March 2010 passage of the Patient Protection and Affordable Care Act has been a catalyst for change, producing innovations in the measurement of performance and value as well as payment and care delivery models, and increasing the use of health information technology (IT). The payment and care delivery reforms of the Affordable Care Act provide the impetus for providers and payers to move the U.S. health care system beyond the predominant, yet fragmented, fee-for-service (FFS) approach to payment and powerful momentum for private sector purchasers to make their own reforms. Alignment between Medicare and the private sector will be critical to strengthen the impact of each other's reforms, sending consistent signals to and intensifying incentives for health care providers to improve quality and reduce costs. It is critical to assure that Medicare reforms do not simply lead providers to shift additional costs from Medicare to private purchasers and payers but, instead, make health care more affordable for all.

One reform initiated by the Affordable Care Act that has created a significant amount of interest and activity is the establishment of a Medicare shared savings payment model for providers that are participating in accountable care organizations (ACOs). While the specifics of organizational structure and defining characteristics of ACOs will continue to evolve as the Centers for Medicare and Medicaid (CMS) moves from the proposed rule to the final rule for the Shared Savings Program, the broad definition of an ACO is a group of providers that work together to provide and coordinate care for a specified patient population. The provider members of the ACO collectively take accountability for providing and coordinating care for their patients across the care continuum.[1] Accountable care organizations promise better-coordinated care (and, therefore, higher-quality and more efficient care at a lower cost), fostered through concerted collaboration among providers. CMS has established a series of associated programs within the Center for Medicare and Medicaid Innovation to foster and support the development of ACOs.

[1] Definition of ACO adapted from CMS's Proposed Rule on the Medicare Shared Savings Program: Accountable Care Organizations, released March 31, 2011.

To realize their full potential, ACOs will require other reimbursement models than the traditional FFS common today, so the private sector has been investigating payment models to meet this need. Many of the models being implemented or developed for ACOs in the private sector are similar to the planned Medicare initiative in their use of a shared savings approach.[2] While shared savings helps create incentives for efficiency and quality, other payment models are being explored that may create even stronger incentives. Such alternative models involve shared risk whereby ACOs share in some of the losses when costs or spending exceed an established target.

Research Scope and Understanding of Payment Models

An understanding of emerging private sector shared-risk ACO payment models, whether currently operational or in development, will be beneficial as CMS and the private sector contemplate ACO payment models beyond the Medicare Shared Savings Program.[3] Using a grant from The Commonwealth Fund, Catalyst for Payment Reform teamed with Booz Allen Hamilton to identify innovative ACO payment models and to use this report to present findings related to each model.

The primary objective of the research was to identify commercial insurers or payers with ACO payment models that met criteria along three dimensions: provider risk, inclusion of services, and incentives for quality. Models of interest were those that include a provider risk-sharing component, address the broad array or full continuum of patient care/services, and create meaningful quality incentives. The research focused on payment models that include both upside and downside risk; we defined shared risk for this effort as "payment models in which providers share in a portion of the savings they achieve (upside), but are also at risk for a portion of spending that exceeds a target (downside)." Shared risk within the providers' payment structure was of specific interest, as opposed to, for example, market-share risk wherein poor performance may cause a provider a loss of market share.

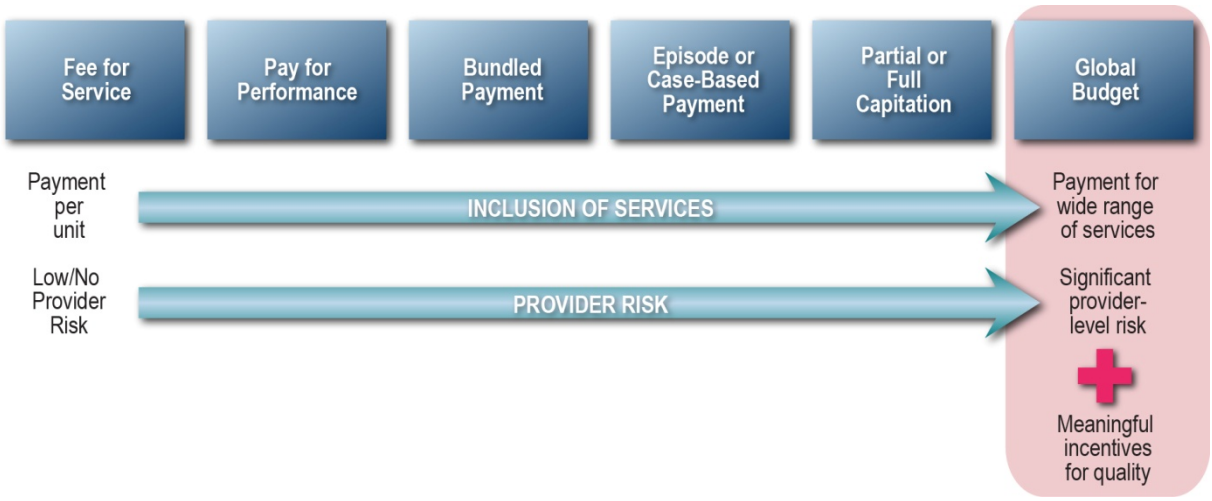
There are many existing payer–provider risk arrangements, but in most cases these payment models involve a narrow scope of services, and/or have no quality component, and/or are associated with Medicare Advantage or other traditional staff-model HMOs; these were not the focus of this research. Exhibit 1 illustrates the spectrum

[2] The shared savings approach to ACO payment allows ACOs potentially to retain some portion of savings they are able to demonstrate over a specified time period; eligibility to retain some of the savings is often dependent on achieving specified quality targets. ACOs have an incentive not only to provide care efficiently in order to demonstrate savings but also to maintain quality.

[3] CMS's Proposed Rule on ACOs indicates ACOs must include a shared risk model of payment by their third year of participation.

of payment models along the three dimensions of interest noted above; the pink shaded portion denotes the area in which this research focused. The payment models noted are examples across the respective spectrums shown and are not meant to be an exhaustive list.

Exhibit 1. Dimensions of Interest



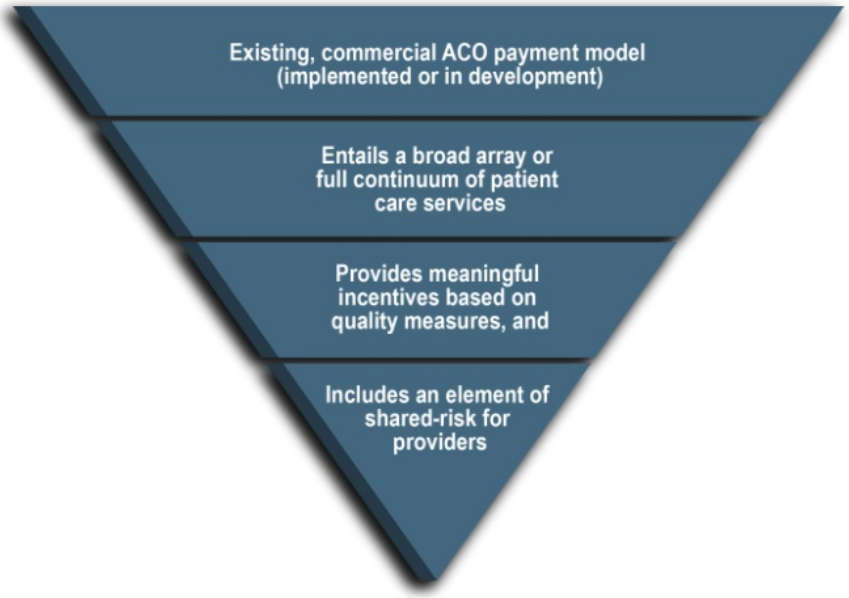
This report is one of several projects funded by The Commonwealth Fund to document alternative payment models. Another project being conducted in parallel by Bailit Health Purchasing, LLC, will identify and document shared savings (upside only) programs in the public and private sectors. As we describe below, the two project teams collaborated in their respective work.

The two following sections describe the approach we used for this study and key findings. Included are details on discussions with the representatives from the initiatives that met the research criteria, organized alphabetically by payer, with details on the initiative in both a summary table and narrative format. The development of shared-risk models is in its infancy and many models are still under development; these findings represent a snapshot in time.

HOW THIS STUDY WAS CONDUCTED

At the outset, the project team defined the criteria by which to assess payment initiatives for inclusion and the key elements of each initiative to explore through the research. Exhibit 2 illustrates how the criteria described above narrowed the universe of initiatives to be included in this work. To identify initiatives for potential inclusion, we first conducted informal interviews with subject matter experts from the provider and payer communities and from the broader public and private sector health care industry. In addition, the Blue Cross Blue Shield Association (BCBSA) and America's Health

Exhibit 2. Criteria for Initiatives Included in This Report



Insurance Plans helped us to understand activity among each organization's member plans. The research turned up dozens of initiatives; 16 met the criteria for interviews.[4]

The key elements of interest included general information about the initiative, such as provider, purchaser, and payer participants and respective market share; type of payment model including range of financial risk and performance-based revenue; performance metrics; and stage of implementation. The project team developed an interview guide (available from the authors on request) to serve as the framework for 60-minute interviews. The guide aligns with the one used by Bailit Health Purchasing so as to gather, where possible, comparable information across the two projects. Catalyst for Payment Reform, Booz Allen Hamilton, The Commonwealth Fund, and BCBSA reviewed and provided input on the guide and the project team field-tested the guide internally before putting it to use. Two members of the project team conducted each interview, completing a total of 16 interviews. (See Appendix A for a list of organizations we interviewed.)

On completion of the interviews, the project team reviewed the information gathered, confirmed which initiatives met the criteria for inclusion in the white paper, outlined the key findings or themes from the research, and designed a template for presenting succinct summary-level information about each risk-sharing payment model. We present the results of this synthesis in the following sections.

[4] Initiatives identified for research may not reflect a comprehensive list due to limitations on the project timeline and/or willingness of identified initiatives to participate in the study; additional risk-sharing payment models may exist.

KEY FINDINGS

Based on information from the 16 interviews, the project team identified eight initiatives that involve shared risk as defined above. Exhibit 3 presents the implementation status of the shared-risk payment models. The highlighted payers have existing arrangements with ACOs (or burgeoning ACOs), but for some the shared-risk components of some arrangements are still in development. More specific information about each initiative is in the section, Shared-Risk Payment Model Summaries.

Exhibit 3. Payers with Existing Shared-Risk Payment Models or with Shared-Risk Payment Models in Development

Payer Name	Existing Shared-Risk Payment Model?	Shared-Risk Payment Model in Development?
Aetna (Nationwide)		X
Anthem/WellPoint (California)		X
Blue Cross Blue Shield of North Carolina		X
Blue Cross Blue Shield of Illinois	X	
Blue Cross Blue Shield of Massachusetts	X	
Horizon Blue Cross Blue Shield of New Jersey	X	
Medica	X	
State Employees Health Commission (State of Maine)	X	

The following themes emerged based on initial research and information from the interviews:

- Payer–provider shared-risk models are in an early developmental phase; there are few operational shared-risk models aside from the traditional capitated HMO model (excluded from this research).
- There are varying definitions of shared risk, and shared-risk initiatives use a variety of program designs.
- Providers do not currently have the infrastructure required to take on and manage risk successfully, though some payers are providing infrastructure and other support to providers.
- Shared-risk models have typically evolved from shared-savings programs.

Payer–provider shared-risk models are in an early developmental phase; there are few operational risk-sharing models aside from the traditional HMO and capitation model. Through the initial research and subsequent interviews, the project team identified few operational shared-risk payment models; of the initiatives we identified, most are in early development stages. One interview revealed that only letters of agreement were in place and that the model will be launched in the near future; another has an initial agreement in place while a longer-term contract is under negotiation. Of those that are operational, many were only launched in the first quarter of 2011 (three of the eight models). The longest-standing shared-risk model involves Medica Health Plan, launched in 2008, followed by the Blue Cross Blue Shield of Massachusetts (BCBS MA) Alternative Quality Contract (AQC), which launched in 2009.

There are varying definitions of shared risk, and shared-risk initiatives use a variety of program designs. The term "shared risk" was interpreted in various ways by interviewees. Exhibit 4 summarizes the definitions of shared risk we found during our research and interviews.

Exhibit 4. Provider Risk Models

Risk Model	Definition	Examples
Bonus Payment at Risk	Provider is at risk of not receiving a bonus payment based on quality and/or efficiency performance	Blue Cross Blue Shield of Minnesota Preferred One
Market Share Risk	Patients are incentivized by lower copays or premiums to select certain providers so providers are at risk of loss of market share	Buyers Health Care Action Group
Risk of Baseline Revenue Loss	Built on a fee-for-service "chassis"; providers face a financial or payment loss if they fail to meet certain cost or quality thresholds, and/or if actual costs exceed a target cost	Blue Cross Blue Shield of Massachusetts AQC Blue Cross Blue Shield of Illinois–Advocate Health Care
Financial Risk for Patient Population (Whole or Partial)	Providers manage patient treatment costs for all or a designated set of services within a predetermined payment stream and are at risk for costs that exceed payments (e.g., partial/full capitation, global budget)	State Employees Health Commission (State of Maine) *(planned)* Anthem/WellPoint *(planned)*

This study focused on shared-risk models that fall into the definitions in the bottom two rows of Exhibit 4: those that included the direct downside risk of potential baseline revenue loss or overall financial risk based on how well a patient population is treated and managed. Of these two types of risk models, we found only models that

include potential baseline revenue loss to be currently implemented; the models that include provider financial risk for a patient population were under development.

The shared-risk models we researched vary in their program design. Five of the implemented models include risk of revenue loss based on quality and/or efficiency results; each of these five is implemented in a slightly different way. Four of the five models share a common design element in that they measure providers' "savings" or "losses"; providers are at risk to lose some of their baseline revenue if they demonstrate a loss based on this measurement. However, both the method for measuring the loss (or savings) and the financial impact on the providers varies across the four initiatives. Two of the models measure loss (or savings) as actual cost experience compared against a prenegotiated target cost, one model assesses actual cost against the market average medical cost trend, and one model compares provider actual cost to costs of a peer group. The models also vary in how they implement the financial impact to providers. For example, the AQC model requires providers whose actual costs exceed the target or budgeted costs to reimburse BCBS MA some percentage of the loss; the Horizon Blue Cross Blue Shield of New Jersey model has a similar reimbursement process. With the BCBS Illinois–Advocate model, however, the provider feels the financial impact in the future (i.e., if Advocate experiences a loss, it is subject to callbacks in unit pricing for the following year). In two of the models, providers prospectively set aside funds to be "at risk"; the providers earn back or lose some or all of these funds based on their attainment of quality and efficiency metrics. None of the models disclosed the amount of revenue at risk, thus it is not possible to compare the revenue at risk across models.

Providers do not have the infrastructure required to take on and manage risk successfully, though some payers are providing infrastructure and other support to providers.

Across all initiatives, interviewees discussed the infrastructure providers need to take on and manage risk successfully. Interviewees frequently mentioned the need for data, the analytic power to turn those data into actionable information, and the need for robust health IT infrastructure. Currently, providers do not have sufficient data about the clinical or financial experience of their patients; these data are important to manage patient care and financial risk effectively as well as to support rapid-cycle performance evaluation and targeted improvement efforts. Many of the initiatives we interviewed include some level of provider quality and/or efficiency data feedback to providers, and many offer frequent sharing of utilization and cost information so providers can correct course on a near real-time basis. However, to participate in the design of appropriate risk arrangements—and to manage risk effectively—providers require these and other data as

well as analytic and modeling capabilities. Some interviewees noted that many providers are at a disadvantage in negotiating and managing shared-risk arrangements because of their lack of experience in understanding the overall financial risk of their populations and actuarial modeling to support negotiating and managing shared-risk contracts. There may be a role for other entities, including payers, in helping providers meet these needs. Without such support, providers may enter into contracts that are not sustainable.

In addition, interviewees noted the importance of interoperable health IT across participants in ACOs, but they reported varying levels of health IT preparedness among provider groups. Some interviewees highlighted the development of IT infrastructure as an area of focus for support to providers. This IT infrastructure will be important to support clinical functions across providers (e.g., to support care coordination and care transitions; to provide screening reminders and wellness communication to patients). In addition, an IT infrastructure that better integrates financial and clinical systems—such as through interoperability with external data sources (e.g., payers, ancillary services)—will further enhance ACO efficiency and effectiveness in managing care delivery and financial risk.

Providers are also faced with operational and structural challenges related to the ACO model of care, which demands more coordinated, efficient processes. Some provider groups are more prepared for coordinated care delivery than others. Many interviewees discussed the tools and resources they are making available to support providers in some of these challenges, including case management, disease management, and risk management. See the "Provider Support" section of each model's summary table in the Shared-Risk Payment Model Summaries section for specifics about the various ways payers are supporting provider groups in the eight highlighted models.

Shared-risk models have typically evolved from shared-savings programs.
Instances of payment models evolving (or intending to evolve) from a shared-savings-only model to include shared risk are common among interviewees. For example, Anthem/WellPoint plans to make this transition over a three- to five-year period under the notion that there must also be downside risk for a payment model to create incentives to improve cost and quality. Additionally, Aetna foresees expanding its shared savings models to include more shared risk or some level of capitated provider payment in the future, depending on the providers' willingness to accept this type of risk and their patient case mix. In their collaboration, the Maine State Employees Health Commission and MaineGeneral Health also anticipate using shared savings as a stepping stone to broader shared-risk arrangements. Although in many of these models shared savings are

intended to be a stepping stone to shared risk, the result may reflect a bias in the sample as the interviews focused on shared-risk models. The research on shared-savings models conducted by Bailit Health Purchasing provides an additional perspective on how payers view shared savings initiatives within their overall payment strategy.

SHARED-RISK PAYMENT MODEL SUMMARIES

The following eight initiatives used a payment model that aligned with the research criteria and definition of shared risk.

1. Aetna

Goals Associated with the Payment Model

Through development and implementation of ACO models, Aetna primarily seeks to create value for its various stakeholders—members, providers, and purchasers—by aligning incentives to help reduce medical costs and improve quality and care outcomes. It describes its approach as "holistic," including not only payment redesign but also supporting providers with care management and other decision-support systems. Recent health reform legislation has also motivated Aetna to develop innovative care delivery and payment models. Aetna is developing a variety of ACO models in collaboration with health systems throughout the country and customizes its approach to payment, performance measurement, or provider support for all of these ACO partnerships.

Provider and Patient Participation

A variety of providers are participating or planning to participate in Aetna's ACO models, including independent physician associations, multispecialty physician groups, and multispecialty physician groups with a contracted hospital(s). According to Aetna, factors that motivate providers to participate include improved care coordination through clinical integration technology, and a realization that change is needed to improve outcomes, reduce waste, and increase efficiencies with care delivery.

With some of its ACO initiatives, Aetna members have the opportunity to choose an ACO-based product (as opposed to an open network PPO product, for example), which prospectively attributes them to the ACO and its participating providers. In other cases, where an ACO is affiliated with a PPO, for example, members are retrospectively attributed to the ACO based on utilization history or claims data. In this type of model, patients are not locked in to receiving care from the ACO. However, if members seek care outside of the ACO, or if there is evidence of a significant lack of care management, there may be an impact on providers' payment under the shared-savings model.

Aetna at a Glance	
General Information	
Payer/Purchaser	Aetna
Provider Participation	• Implementing ACO initiatives and payment models with multiple health systems • Collaborating with health systems throughout the country to design and implement additional ACO models
Status as of May 2011	Three ACOs launched in early 2011
Geographic Reach	Existing models: one in the Midwest, one in the West, and one in the Southeast (unable to provide specific geographic/market information)
Market Share	Unable to provide
Products	Unable to provide
Payment	
Payment Summary	Varies by health system
Payment Mechanism and Eligibility	Varies by health system and currently includes FFS with bundled payments for some services, and shared savings models; may broaden risk with some level of capitation in the future
Measurement	
Specific Conditions Addressed	Full continuum of care
Quality Improvement Domains	Varies by health system
Efficiency	Varies by health system. Examples include measuring hospital admissions that could have been avoided, and potentially avoidable ER visits
Implementation	
Provider Support	Types of support vary by health system, and include care management/case management support and tools, provision of data on efficiency and quality, and other consultative services to support health systems achieving quality and efficiency goals

Payment and Risk-Sharing Arrangement

Aetna's ACO models involve an array of payment arrangements including FFS, bundled payment, and shared savings; Aetna aims to implement increased provider risk with some level of capitation for ACOs in the future. The ability to implement shared-risk models will depend on the provider's patient population and desire to assume such risk.

The shared-savings models are based on efficiency metrics, whereby providers are eligible for up to half of the total amount saved; providers earn a share of these savings based on their performance on quality metrics.

Performance Measurement

In Aetna's shared-savings models, providers are eligible for a portion of the savings if they meet efficiency thresholds related to (for example) avoidable inpatient admissions and ER visits. Once providers achieve these efficiency thresholds, they must meet a set of clinical quality measure benchmarks to receive any of the savings.

In efforts to assist providers with improving their performance over time, Aetna provides data feedback and support tools to educate them about specific areas of care. Aetna also promotes case management services to ensure improved outcomes. On a quarterly basis, Aetna assesses data on efficiency results, while they assess data on clinical measures semiannually.

Looking Ahead

Aetna recognizes it is increasingly important to engage the provider community and facilitate discussions for health system improvement. As it begins a journey down this alternative path, Aetna intends to support ACOs actively to ensure a collaborative partnership to accomplish the Triple Aim.

2. Anthem/WellPoint

Goals Associated with the Payment Model

Anthem/WellPoint and the participating provider organizations initiated the ACO payment model jointly, agreeing that a change in the current reimbursement system was necessary to promote the goals of higher quality and reduced cost. Providers, it was determined, had to have more "skin in the game" and accountability with respect to the costs and quality of care. Quality and efficiency metrics will be used to ensure that providers do not achieve savings by rationing care. Depending on the success of the ACO pilots, the relationships and payment model may expand both in duration and geographic reach.

Provider and Patient Participation

To participate in an Anthem/WellPoint ACO arrangement, a provider group should serve an attributed population of 15,000 PPO members, offer the full complement of medical services (with the exception of transplants), have demonstrated a plan for reducing the cost of medical care, have an IT platform for the capture and electronic exchange of clinical information, be financially stable, and have a formal legal structure and commitment from its leadership. The provider group must also be willing to enter a five-year contractual relationship.

Patients are attributed to the ACO by looking at two years of retrospective claims data; however, once a patient is attributed to an ACO, s/he is considered part of that ACO for the following year. The four participants in the Anthem/WellPoint pilot requested a 50 percent threshold for a patient to be attributed to the ACO—patients who receive 50 percent or more of their care with a given provider (based on two years of claims data) are attributed to that provider's ACO. Once attributed, a patient is considered to be in that ACO for a year; therefore, the attribution can be considered prospective. Although

patients are in the ACO for a year, they are not locked in to seeing only providers within the ACO and providers can refer patients outside of the ACO. However, if patients seek care outside of the ACO, the ACO is still accountable for their care and costs. Anthem/WellPoint performs the attribution every six months for new additions to the membership and deletions every two weeks for members who lose Anthem/WellPoint coverage, select another Anthem/WellPoint product, such as the HMO, or move to a geographic location not covered by the ACO.

Anthem/WellPoint communicates with its members, employers, and brokers an overview of the ACO model of care, emphasizing also that benefits have not changed. Communications also indicate that, in the future, members may be incentivized to enroll in this ACO as a type of insurance product.

Anthem/WellPoint at a Glance	
General Information	
Payer/Purchaser	Anthem/WellPoint
Provider Participation	• Monarch—IPA • Health Partners—IPA • Sharp Reese—IHS • Sharp Community Medical Group—IHS
Status as of May 2011	• Three of the models launched in January 2011 under five-year shared savings contracts, and the fourth model's contract is in-process • Contracts will implement shared risk in three to five years
Geographic Reach	Pilots are located in Orange County, Los Angeles County, and San Diego County, California
Market Share	Information not provided; varies by market
Products	Commercial PPO
Payment	
Payment Summary	FFS with shared savings based on actual costs compared to a medical cost target; intent is to evolve to a global budget with shared risk
Payment Mechanism and Eligibility	In addition to FFS, the ACOs are eligible for up to 50 percent of any savings they achieve if they meet a quality gate (threshold). Their performance on efficiency metrics provides the basis for the amount of their shared savings payment
Measurement	
Specific Conditions Addressed	Full continuum of care with the exception of transplants
Quality Improvement Domains	Acute care processes and outcomes; chronic care processes and outcomes; patient safety; patient experience; includes both physician and hospital metrics
Efficiency	Costs are estimated by service utilization rates (e.g., Spine MRIs per 1,000)
Implementation	
Provider Support	Plan engages in robust data exchange with providers and produces reports on providers' performance against benchmarks. The reporting and data exchange frequency varies from monthly to annually

Payment and Risk-Sharing Arrangement

The ACOs are paid on a FFS basis with the potential for a share of savings based on performance against a medical cost target. If savings are achieved, the upside for providers is to receive a share of those savings; to share in savings, the ACO must pass a "quality gate" based on clinical quality measures. If the ACO meets the minimum quality threshold, it is eligible for up to 50 percent of the savings generated. The amount received (up to 50 percent of the total savings) depends on performance on efficiency measures.

Caps on high-cost cases are part of the contract discussion with each ACO, and most ACOs carry reinsurance (stop-loss insurance). The goal is to evolve to a global budget in the future. Most provider groups are interested in moving to a global risk arrangement that would include risk corridors for both the upside and downside.

Performance Measurement

Anthem/WellPoint measures both clinical quality and efficiency at participating ACOs. More specifically, the providers must pass a quality gate or minimum performance threshold on clinical measures specific to physician care (e.g., breast cancer screening and nephropathy monitoring) and hospital care (e.g., the Joint Commission's AMI, pneumonia, cardiac heart failure, and Surgical Care Improvement Project [SCIP] measures). The quality gate threshold and benchmarks are currently being established. Once the ACOs meet the quality gate threshold, they must meet certain efficiency criteria to receive a percentage of the savings for which they are eligible. Such efficiency metrics include avoidable emergency department visits per 1,000; prescriptions per 1,000 and generic prescribing rate; imaging (spine MRIs per 1,000); and inpatient admissions per 1,000 and all-cause readmissions.

Defining Success

Anthem/WellPoint believes the success of an ACO depends on robust data exchanges, which allow providers to have better data to improve the quality and reduce costs of the defined population. With this model, the financial risk or incentives will aim to promote high-quality, coordinated care. Anthem/WellPoint is using local control groups to understand how quality and efficiency of care within the ACOs compare to that being provided elsewhere in the market. Anthem/WellPoint will also examine success at the enterprise level and employ criteria other than financial ones.

3. Blue Cross Blue Shield of Illinois

Goals Associated with the Payment Model

The arrangement between Blue Cross Blue Shield of Illinois (BCBS IL) and Advocate Health Care (Advocate) was spurred by the ACO provisions of the Affordable Care Act. BCBS IL and Advocate had a previously established information exchange, so the transition to managing Advocate's attributed PPO population was described as "straightforward." Currently, the arrangement is overlaid on a broad PPO design. However, it is anticipated that a product may eventually be made out of the arrangement, once the final ACO regulations are released.

Blue Cross Blue Shield of Illinois at a Glance	
General Information	
Payer/Purchaser	Blue Cross Blue Shield of Illinois
Provider Participation	Advocate Health Care, encompassing 10 hospitals and 2,700 physicians across all specialties
Status as of May 2011	Agreement was signed in October 2010, and the three-year contract period began in January 2011
Geographic Reach	Greater Chicago area
Market Share	Advocate is the largest health system in Illinois and represents approximately 20 percent of the market
Products	Commercial PPO
Payment	
Payment Summary	Baseline payment is FFS; includes an upside risk in the form of shared savings and a downside risk in the form of potentially lower unit pricing in the future
Payment Mechanism and Eligibility	If Advocate's actual costs are lower than the risk-adjusted average medical cost trend, it is eligible for a percentage of the difference; if costs are higher than the average medical cost trend, it may face lower unit pricing in out years. In addition, Advocate may be penalized financially for declines in performance metrics
Measurement	
Specific Conditions Addressed	Full continuum of care
Quality Improvement Domains	Preventive care; acute care processes and outcomes; patient safety; patient experience
Efficiency	Utilization is compared to medical cost trends
Implementation	
Provider Support	Support is provided on a monthly basis and includes performance feedback on HEDIS measures and costs/spending, and patient attribution updates

Provider and Patient Participation

The arrangement encompasses the entire Advocate health system, which includes approximately 10 hospitals and 2,700 physicians across all specialties. Advocate is the largest health system in the state of Illinois, and includes nine of 10 hospitals in Chicago.

The patients participating in the model are all commercial PPO members, but they have not been formally notified of their participation. BCBS IL describes the patient attribution as "prospective based on retrospective utilization." The threshold for attribution to Advocate is approximately 50 percent and is based on claims data from the previous two years. There is no patient lock-in—patients are free to receive care from any provider or health system (within their current benefit design). However, Advocate is ultimately responsible for the care of all its attributed patients, even if these patients elect to receive their care elsewhere.

Payment and Risk-Sharing Arrangement

Advocate is paid FFS and has the opportunity for shared savings (upside risk) and the potential for reduced unit pricing in the future (downside risk) based on performance against specific quality, safety, and patient satisfaction measures. To determine if savings are achieved, BCBS IL compares Advocate's medical costs to the network average. The comparative measures are risk-adjusted, so patient costs are not truncated. If Advocate provides high-quality care at a lower threshold cost than the aggregate (minus Advocate) medical cost trend, it shares in the total amount of savings generated. If Advocate's costs are higher than the threshold, BCBS IL will call back future unit pricing. Advocate is a fully integrated system, so the risk and savings are allocated at a system level. Advocate is responsible for managing the risk and distributing savings among the providers. BCBS IL conducts final payment reconciliation annually once the savings or losses have been evaluated.

The arrangement also includes additional risk-sharing: Advocate is at risk for significant payment reductions if patient quality, safety, and satisfaction metrics decline; and BCBS IL is subject to financial penalties if it fails to provide timely data on performance and cost to Advocate.

Performance Measurement

Advocate's payment from BCBS IL is partially determined by Advocate's performance on patient quality, patient satisfaction, and efficiency metrics. These metrics include some HEDIS measures, as well as numerous other domains including never events, readmissions, ambulatory care, hospital-acquired infections, avoidable hospital days, appropriateness of advanced imaging utilization, and patient access to outpatient visits.

Across these domains, Advocate must maintain a baseline in the first year of the agreement. To participate in shared savings (and avoid reduced unit pricing in the future), Advocate must demonstrate improvement during the second and third years. Under the contract, BCBS IL must evaluate Advocate's performance on the HEDIS measures and

report their patient attribution and cost of care on a monthly basis. This information allows Advocate to monitor its progress and remain in contact with its attributed members as to better coordinate patient care.

4. Blue Cross Blue Shield of Massachusetts

Goals Associated with the Payment Model

The Alternative Quality Contract (AQC) was the result of Blue Cross Blue Shield of Massachusetts' (BCBS MA) 10-year vision (beginning in 2006) to "cross the quality chasm." The two aims of the AQC are to reduce medical spending growth and improve quality of care and patient outcomes. BCBS MA established the AQC as an alternative (as opposed to mandatory) model of payment for provider organizations. While BCBS MA did not necessarily conceive it as a pilot, the AQC was tested on a smaller scale in the beginning with expectations that only 15 percent of contracted providers would participate. By end of year one, 23 percent of the contracted providers were involved.

Blue Cross Blue Shield of Massachusetts at a Glance	
General Information	
Payer/Purchaser	Blue Cross Blue Shield of Massachusetts
Provider Participation	Multispecialty groups, IPAs, PHOs, integrated systems
Status as of May 2011	Launched in January 2009
Geographic Reach	Massachusetts, statewide
Market Share	44 percent of commercial product business
Products	Commercial HMO and POS
Payment	
Payment Summary	Global budget with upside and downside risk sharing (50% to 100%), in addition to bonus PMPM incentives for improved quality
Payment Mechanism and Eligibility	BCBS MA allocates provider groups an annual budget (risk-adjusted) with a payment differential based on surplus or deficit; BCBS MA will also pay groups a PMPM bonus if they meet certain quality thresholds on ambulatory and inpatient quality measures
Measurement	
Specific Conditions Addressed	Full continuum of care
Quality Improvement Domains	Ambulatory: chronic care process and outcomes; acute and preventive care process; patient experience. Hospital: acute and surgical care process and outcomes; patient experience
Efficiency	Efficiency is measured by assessing actual costs against a negotiated annual budget
Implementation	
Provider Support	Types of support include: provision of data and information that inform provider groups about budget management and potential savings opportunities based on their performance on quality metrics; general best practices forums three times per year, as well as facilitation of user group dialogue related to more specific topics; consultative services that support provider groups and troubleshoot based on performance goals

Providers were eager to be a part of the AQC, acknowledging that payment reform was inevitable, and that it would be advantageous to participate in a payment reform initiative on a smaller scale before facing broader changes in payment and expectations regarding care delivery.

Provider and Patient Participation

Provider organizations participating in AQC include large multispecialty groups, independent practice associations (IPAs), or physician–hospital organizations (PHOs). To participate, the organization must collectively care for at least 5,000 members of BCBS MA's commercial HMO or point-of-service product. Contract durations for each provider group span five years because of provider demand for more consistent payment levels over time and the need for sufficient time to develop necessary capacity and organizational structures to be successful within the model.

Based on their selection of a primary care physician, BCBS MA prospectively assigns patients to an AQC-participating provider group. There is no formal process for notifying patients of whether their provider participates in the AQC. For patients that choose to seek care outside of the AQC provider arrangement, the AQC-contracted provider remains responsible for the patient's care, including quality and costs associated with that care.

Payment and Risk-Sharing Arrangement

Providers participating in the AQC are paid FFS and have a prenegotiated per member per month (PMPM) budget. Providers are exposed to both an upside (in the form of a share in savings should costs be below budget) and downside risk (in the form of sharing in losses with BCBS MA should costs be higher than the budgeted amount). There is also a separate financial incentive based on quality of care. Currently, provider organizations may elect to take on between 50 percent and 100 percent risk; the aim of the AQC is to evolve to a standard of 80 percent risk across all providers. For those providers that assume risk between 50 percent and 100 percent, they share savings and losses with BCBS MA; providers that assume 100 percent risk keep all savings and are responsible for all losses.

Each provider organization negotiates a baseline PMPM budget for the first year and annual budget changes for the remainder of the five-year contract period. Groups with high baseline budgets are typically given lower annual budget increases; budget trajectories over the five-year contract period are intended to reduce disparities between provider groups with higher or lower baseline rates. Providers must purchase reinsurance

so as to manage high-cost patients (e.g., when costs exceed $100,000). In some cases, an overall cost trend corridor allows the budgets of provider organizations to increase based on patient expenses.

Provider organizations may also receive an incentive payment based on their performance on quality measures, independent of any share in savings or losses. The bonus system is based on absolute (as opposed to relative) performance, is the same for all groups for the contract period, and depends on an overall quality score that is created by aggregating quality scores from each measure. Currently, participating providers are eligible for up to 5 percent of their PMPM amount in incentive payments for ambulatory care measures and up to 5 percent PMPM for performance on inpatient care measures.

Performance Measurement

For provider organizations to qualify for the financial incentive payments, they must perform at a certain level on 32 ambulatory care and 32 inpatient care measures. There is a range of performance targets or "gates"; bonus payments vary based on the gate they achieve (i.e., by achieving gate 5, providers receive the full 5% bonus payment). Metrics include access, process, outcomes, and patient experience-of-care measures.

Successes and Challenges to Date

Since it introduced the AQC in January 2009, BCBS MA has improved its control of spending and quality. Participation in AQC has caused providers to reorient the way they provide care and engage patients, as seen, for example, through increased chronic care case management and home health visits. Some of the AQC's successes may be attributable to the transparency of expectations and results with the contract, which enables providers to plan appropriately for care delivery. In addition, the AQC support team has been instrumental in engaging providers effectively and supporting them in improvement efforts.

There have also been challenges with establishing and engaging certain providers in the AQC. For example, the existing national payment system continues to reward more care and more services without attention to quality or efficiency. Until we address this on a national scale, providers may prefer to continue with this payment model. Patients' financial incentives in seeking care and level of awareness about costs are not well aligned with some of the newer payment models, which hold providers accountable for the patient's care regardless of where patients seek care. Additionally, provider collaboration in the patient's interest is a challenge, especially in cases where a physician group and a hospital are not joined by the same AQC arrangement and are not incentivized to collaborate for a given patient.

5. Blue Cross Blue Shield of North Carolina

Goals Associated with the Payment Model

The Model Practice is currently being developed through collaborative discussions and funding from Blue Cross Blue Shield of North Carolina (BCBS NC) and the University of North Carolina Health Care System (UNCHCS). Both BCBS NC and UNCHCS recognized an opportunity to work together in efforts to enhance health care quality, efficiency, and effectiveness, and ultimately to reduce health care costs.

Provider and Patient Participation

The Model Practice will be a small, primary care practice that will employ a full-time medical director in addition to a number of full-time primary care physicians, as well as additional providers ranging from physician assistants and nurse practitioners to nutritionists and mental health providers. The practice will have established relationships with specialists who will work with them consistently to enhance communication. The practice will also focus on coordination and communication among local hospitals and providers for transitional care.

It is expected that the practice will serve approximately 5,000 adult patients with chronic conditions in the Research Triangle area, and will be available for all underwritten BCBS NC PPO members and a number of administrative-services-only (ASO) groups. BCBS NC plans to identify and incentivize patients with multiple chronic conditions to participate. One approach will be the implementation of voucher-type incentives to attract patients. Other incentives will involve the use of advanced technology to allow patients easier and better access to their physicians, medical records, and test results.

While members will be free to select whether or not to visit the practice, they will be retrospectively attributed to it based on their record of visits over the course of the year. BCBS NC and UNCHCS are currently analyzing data to determine an attribution model.

Payment and Risk-Sharing Arrangement

During the development of the Model Practice, its costs will be borne by BCBS NC and UNCHCS equally. Once operational and caring for patients, the Model Practice will submit claims to BCBS NC and BCBS NC will reimburse the Model Practice for care delivered. The total medical expenses of the patients will be compared to a control group of patients to determine whether medical expense savings are payable to the Model Practice in addition to the fee-for-service payments. The providers at the Model Practice will be salaried and eligible for a bonus incentive based on clinical quality metrics.

The specific details surrounding medical expense savings are currently under discussion. However, one fundamental principle is protection of the Model Practice providers against catastrophic patients to ensure that the practice is not unfairly penalized for a catastrophic case.

Blue Cross Blue Shield of North Carolina at a Glance	
General Information	
Payer/Purchaser	Blue Cross Blue Shield of North Carolina (BCBS NC) and the University of North Carolina Health Care System (UNCHCS)
Provider Participation	• Model Practice, a primary care practice, is capitalized through a newly created LLC formed by BCBS NC and UNCHCS • Model Practice will employ a care team approach to include, but not be limited to, nutritionists, mental health providers, and pharmacists • Relationships with area specialists for enhanced and coordinated care delivery
Status as of May 2011	A signed letter of agreement is in place, and the practice plans to open in late 2011 with three-year agreements for the providers
Geographic Reach	Approximate 25-mile radius of the Model Practice including Durham County, Orange County, and Wake County, North Carolina
Market Share	Approximately 5,000 chronically ill members will participate—a small percentage of the over one million people in the Research Triangle area
Products	PPO
Payment	
Payment Summary	Initial start-up capital jointly funded by BCBS NC and UNCHCS; ongoing operating budget funded by FFS payments from BCBS NC for care the Model Practice delivers with an outcomes-based quality and medical expense savings payment arrangement in development
Payment Mechanism and Eligibility	The Model Practice will bill and be paid by BCBS NC on a FFS basis for care it delivers. Providers will be salaried and eligible for a bonus incentive based on clinical quality metrics.
Measurement	
Specific Conditions Addressed	Primary care with a focus on chronic conditions and chronic care for asthma, cardiac disease, congestive heart failure, hypertension, and hyperlipidemia, among others
Quality Improvement Domains	Access; preventive care; chronic care process and health outcomes; acute care process and health outcomes; total medical expense savings; member education and self-directed care; patient safety; patient experience
Efficiency	Efficiency/utilization
Implementation	
Provider Support	The Model Practice and providers will receive regular feedback regarding any appropriate metrics as they are available; assistance with information regarding transitions in care; notifications and data of member treatments by other facilities and organizations; in-depth member health data sharing; and advanced technology such as an online system for patients to make appointments, receive information, and communicate with the practice

Performance Measurement

Performance on clinical metrics will be a bonus arrangement with the Model Practice providers. BCBS NC and UNCHCS plan to rely on existing standard and nationally endorsed measures, so the practice may be analyzed against a proxy group. The clinical informatics staff for each organization is examining the most appropriate proxy.

Defining Characteristics

In designing the Model Practice, BCBS NC and UNCHCS describe several essential characteristics they expect will set the practice apart. An online registration and communications system will allow patients to schedule appointments online and provide access to their detailed medical information. This innovative feature offers increased patient access and control, and adds to efficiencies in the administrative process for the practice. The practice will also conduct previsit analyses in advance of patient visits, making providers more prepared to answer potential questions and provide clinical decisions in a timely manner. Providers within the practice will receive intensive data for real-time analyses of their care and clinical effectiveness.

6. Horizon Blue Cross Blue Shield of New Jersey

Goals Associated with the Payment Model

As part of a broader strategy to address quality and affordability issues in innovative ways, Horizon Blue Cross Blue Shield of New Jersey (BCBS NJ) created a wholly owned subsidiary called Horizon Healthcare Innovations (HHI), LLC. Horizon Healthcare Innovations pursues new reimbursement and care delivery models with the ultimate goal of reducing waste in health care spending and reducing the total cost of care. ACO Pilot, a product of HHI, has as its specific goals improving quality and reducing the cost of care.

Provider and Patient Participation

The ACO Pilot comprises a large multispecialty group and several of Horizon BCBS NJ's national accounts are participating as purchasers. The multispecialty group includes primary care, specialty care, ancillary services, and some ambulatory and surgery services. The Pilot interacts with its choice of hospitals; these hospitals are not contractually included in the Pilot, but their costs are included in the Pilot's total cost of care calculations.

Participation in the Pilot is restricted to 1,000 to 2,000 patients with commercial self-insured PPO coverage. Retrospectively, HHI attributes patients to the Pilot based on a percentage of their total visits. It conducts the attribution calculation at the conclusion

of the Pilot, so the patients and physicians are blind to the patients' participation. This arrangement places responsibility on the providers to "delight" their patients by providing great care and encouraging them to consider the participating multispecialty group as their sole source of care.

Horizon Blue Cross Blue Shield of New Jersey at a Glance	
General Information	
Payer/Purchaser	Horizon Blue Cross Blue Shield of New Jersey
Provider Participation	Large, multispecialty medical group; the identity of the medical group was not disclosed
Status as of May 2011	Pilot launched with two-year contract during the 4th quarter of 2010
Geographic Reach	North of Atlantic City, New Jersey
Market Share	Pilot is limited to 1,000 to 2,000 patients
Products	Pilot is available to commercial self-insured PPO patients
Payment	
Payment Summary	Base payment is fee-for-service with shared savings and shared losses
Payment Mechanism and Eligibility	Providers must spend equal or less than the projected total cost of care, or they risk losing up to a double-digit percentage of their fee schedule in future years. If providers spend less than the projected total cost of care and they meet a quality threshold, they are eligible to receive up to a prenegotiated percentage of the savings generated
Measurement	
Specific Conditions Addressed	Full continuum of care
Quality Improvement Domains	Access; patient experience; preventive care; chronic care processes of care; chronic care outcomes; efficiency/utilization of care; patient safety; population health
Efficiency	Total cost of care
Implementation	
Provider Support	Types of support: ongoing dialogue, collaboration and meetings focusing on key metrics; care coordination support; informatics; monthly meetings with lead executives from participating accounts.

Payment and Risk-Sharing Arrangement

The ACO Pilot accounts for upside and downside payment risk. HHI provides the Pilot with a base fee schedule aligned against a projected total cost of care. If the Pilot exceeds the projected total cost of care, it is responsible for reimbursing HHI and the participating accounts a prenegotiated percentage of the excess costs. HHI did not disclose the exact percentage that must be returned, but noted it is in the double digits. To protect the providers, the total cost of care is risk-adjusted, and a mechanism is in place to eliminate outliers that may skew results for the population. The amount of money at risk is also capped, so even if the Pilot must reimburse HHI and national accounts for excess costs, it is guaranteed a baseline of revenue.

If the Pilot is able to provide care at a reduced cost while meeting a quality threshold, it is eligible to share in the savings achieved (the delta between the projected costs and actual costs). The savings are shared between the participating accounts, HHI, and the Pilot; the Pilot's percentage of the savings share is set at a prenegotiated amount. The Pilot is also eligible for additional payment if it performs within the top 10 percent of all the quality metrics.

Performance Measurement

To share in any savings achieved, the ACO Pilot must meet a quality threshold. This threshold comprises HEDIS measures addressing diabetes care, cardiovascular care, oncology treatment, BMI assessment, and numerous quality domains. The variety of measures is intended to be wide ranging, but not so broad that performance (or lack of performance) in one measure dilutes the impact of the others.

Annually, HHI's internal analytics team will measure the Pilot's performance in a straightforward, retrospective evaluation. As agreed on in the Pilot contract, a third party will also validate the evaluation.

Looking Forward

The ACO Pilot reports early indications of success, primarily concerning improvements in total cost of care. HHI attributes this success to the Pilot's structure, and its impact on the providers' view of management and approach to care. HHI has not speculated on the Pilot's performance on quality improvement metrics, but the findings will impact HHI's decisions on how to move forward. Specifically, the Pilot's performance on quality metrics will determine if it will be scaled and replicated, or adjusted and improved.

As HHI awaits the findings from the Pilot's first annual performance evaluation, it has begun focusing on consumer engagement. HHI recognizes a lack of patient knowledge concerning patient-centered medical homes and ACOs and intends to focus on consumer engagement in the coming months to help patients understand the benefits of being involved in an ACO.

7. Medica Health Plan[5]

Goals Associated with the Payment Model

Medica's alternative payment model stems from discussions among leadership regarding escalating provider payment rates and the need for aligned incentives to reduce costs.

[5] The summary for Medica Health Plan was also informed by an interview with Fairview Health System, a contracted provider participating in the shared-risk arrangement.

These discussions were the genesis of Medica's Total Cost of Care contracts, which were conceived as a long-term yet evolving payment model, as opposed to a pilot. Each of the six Total Cost of Care contracts is unique in its exact payment methodology, but follows a similar structure that includes shared savings and some amount of revenue at risk based on performance. Medica also aims to encourage delivery system changes with participating providers, such as less frequent use of the emergency department (ED) and increased coordination of care after a hospital or ED discharge.

Medica Health Plan at a Glance	
General Information	
Payer/Purchaser	Medica Health Plan
Provider Participation	• Five integrated health systems: Allina, Fairview Health System, Health East, North Memorial, Park Nicollet • One physician clinic: North Clinic
Status as of May 2011	Launched in July 2008
Geographic Reach	Minnesota Twin Cities region
Market Share	30 percent of commercial market
Products	Commercial PPO and POS products; recently expanded to Medicaid product
Payment	
Payment Summary	Shared savings with either a withhold arrangement or prospective adjustments to FFS payments in which providers are eligible for withheld funds when they achieve the performance threshold (cost and quality); with the withhold, if providers do not achieve performance thresholds, they must return a portion of their payments
Payment Mechanism and Eligibility	Providers must meet PMPM cost targets in comparison to a peer group to be eligible; provider performance is compared on an acuity-adjusted PMPM basis. If providers attain savings compared to the peer group, they are eligible for up to 50 percent of the savings they generate. Providers must also meet performance benchmarks on specified quality measures to be eligible for a share in savings or earn the amount withheld
Measurement	
Specific Conditions Addressed	Full continuum of care with the exception of behavioral health and dental services
Quality Improvement Domains	Preventive care; chronic care processes of care; chronic care outcomes; efficiency and utilization of care
Efficiency	PMPM risk-adjusted costs
Implementation	
Provider Support	Types of support: performance data feedback; clinical advisory support; patient cost data; and supplemental health coaching (as needed)

Provider and Patient Participation

There are currently six providers—five integrated health systems and one physician clinic—participating in Medica's Total Cost of Care contracts. These providers are located in Minnesota's Twin Cities region, and Medica is anticipating expansion to other parts of Minnesota (e.g., Duluth and St. Cloud) and North Dakota.

Medica retrospectively assigns patients to a primary care provider based on claims history. Initially, patients could be assigned to hospitalists, rather than primary care physicians, based on their admission to a hospital. Medica has recently improved the method of attribution so that it now assigns all patients to a primary care provider in an outpatient setting.

Payment and Risk-Sharing Arrangement

The Total Cost of Care contracts entail a "risk and reward pool" funded through a withheld amount (which is held either by Medica or by the provider) or through prospective adjustments to providers' FFS payment schedule. A given amount is withheld at the beginning of the contract year, and providers must achieve an established cost and quality threshold in order to receive payment from the withheld amount. Cost performance (80%) and quality performance (20%) determine eligibility for some of or the entire withheld amount. Between 2 percent and 8 percent of provider revenue is at risk under these arrangements. Providers are also eligible for additional payment based on savings they achieve; specifically, providers are eligible to keep up to 50 percent of any savings they earn.

Performance Measurement

The quality metrics used to determine performance include the Minnesota Community Measurement program and include measures of preventive care, chronic care, and utilization. Medica establishes targets for select procedures (e.g., reduction in ED visits, reduction in elective labor inductions) and works with the providers to establish other thresholds for improvement. Medica also assesses efficiency by measuring the overall, risk-adjusted PMPM cost. Performance on the various metrics is assessed annually for payment adjustments; however, providers receive feedback at least quarterly from Medica regarding their performance. Medica also gives the providers a "prospective risk-adjustment perspective" so the providers can understand which of their patients is high cost and manage patient care more efficiently.

Successes and Considerations Moving Forward

Since 2008, a number of successes and lessons learned have allowed Medica to improve the cost trend and offer its provider partners a more data-rich environment. Medica has seen lower FFS rate increases as a result of their Total Cost of Care contracts, and they have recently initiated similar contracts that involve the Medicaid population. There have been challenges with the withhold method of payment, including a concern that the withhold model does not adequately support Medica's goal to eliminate overuse. In some cases, Medica has found providers deliver more care under FFS systems with large

withhold arrangements. There is also an administrative burden associated with processing individual checks to self-funded groups in situations when providers earn only a portion of the withhold. As an alternative to the withhold method and as a means of funding the risk and reward pool, Medica is exploring a PMPM fee (similar to a medical home payment) that could be increased or decreased based on the provider's cost and quality performance. Another alternative could include a network management fee that would be assessed as part of the premium.

8. State of Maine/MaineGeneral Health Collaboration

Goals Associated with the Payment Model

The overall goal of the collaboration between the Maine State Employees Health Commission (SEHC) and MaineGeneral Health is to improve patient care by aligning payment to quality and efficiency of care. The collaboration is unique and is the most mature of several similar pilots under way in Maine. These pilots are collaborations convened by the Maine Health Management Coalition (MHMC) and bring together providers, payers, and consumers to consider ways to align structures and incentives for higher quality and coordinated care. MHMC has led public reporting efforts in Maine and the SEHC uses this publicly reported data as the basis for a tiering structure that creates incentives for patients to choose higher-tier providers. The collaboration between MaineGeneral and the SEHC began when the SEHC challenged MaineGeneral to come up with an innovative approach to make strides in advancing quality and reducing cost; if successful, SEHC would place MaineGeneral in a tier of its own. The innovative approach under development includes both a change in care delivery and the use of payment models to support it. Payers have been invited to participate; to date, they have not become involved. Rather, the SEHC and MaineGeneral are engaging in direct contracting arrangements to support the new payment model.

Provider and Patient Participation

All providers within the MaineGeneral system are participating. This includes one hospital (on two campuses), 116 primary care providers in 26 practices, and 112 specialists. MaineGeneral is working with its various primary care practices to enhance their ability to provide well-coordinated care; the philosophy behind the initiative is that primary care is the foundation for success. The 26 primary care practices are in various stages of preparedness and range in ability to provide this foundation. Five of the 26 are designated as patient-centered medical homes. MaineGeneral has established a Primary Care Transformation Committee to address needs around care management, administrative support, and support in use of health IT.

Participation in the initiative is open to all SEHC employees and their dependents in the market; MaineGeneral is also opening the initiative to the approximately 4,400 individuals in its self-insured population. Currently, SEHC has approximately 8,000 of its insured population (excluding retirees) in a MaineGeneral primary care practice, which represents approximately 26 percent of its membership statewide.

State of Maine/MaineGeneral Health Collaboration at a Glance	
General Information	
Payer/Purchaser	State Employees Health Commission (SEHC)
Provider Participation	MaineGeneral Health
Status as of May 2011	Implementation began February 2010
Geographic Reach	Central Maine
Market Share	Covered lives equal approximately 5 percent of MaineGeneral market share
Products	Not applicable; direct contract between SEHC and MaineGeneral
Payment	
Payment Summary	Currently paid FFS with risk-sharing based on performance on quality/efficiency metrics. Negotiations under way to move to partial capitation; also considering shared savings model as step toward partial capitation
Payment Mechanism and Eligibility	MaineGeneral is paid FFS with up to $250,000 at risk based on achievement of quality/efficiency metrics
Measurement	
Specific Conditions Addressed	Full continuum of care
Quality Improvement Domains	Access; patient engagement; patient experience; clinical quality
Efficiency	Utilization and financial metrics
Implementation	
Provider Support	MaineGeneral is supporting its primary care practices in various ways, depending on need. Examples include care management support, health IT, and administrative support

Payment and Risk-Sharing Arrangement

The initiative launched in early 2010 with downside risk: MaineGeneral will continue to be paid FFS and a separate pool of funds has been set aside from which MaineGeneral may be required to pay SEHC up to $250,000 based on whether it achieves specific quality targets on five domains of measurement, detailed below. SEHC and MaineGeneral describe this first step as "symbolic" in the progression toward more robust shared risk. Active negotiations are under way to implement a five-year plan to move from the downside risk of the first year to some type of partial capitation. They may implement a shared savings model as part of this progression; however, both entities have discussed that shared savings may not be enough to support coordinated, high-quality, efficient care.

To align incentives across stakeholders, SEHC is also considering implementing financial incentives for enrollees to participate in the MaineGeneral network.

Performance Measurement

In the first year, measurement is based on five domains of performance: access, patient engagement, clinical quality, utilization, and financials, and incorporates performance measurement initiatives under way under the leadership of the Maine Health Management Coalition. The access metric is focused on expanding primary care workforce capacity. Patient engagement includes achievement of MHMC "Blue Ribbon" status based on MaineGeneral's performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. For full achievement of the patient engagement metric, MaineGeneral must also develop Patient Advisory Councils at all five of its patient-centered medical home practices. The clinical quality domain relies on MHMC measures of care for heart attack, heart failure, pneumonia, and surgical infection. Utilization is measured by reduction in nonurgent emergency room visits as compared to the previous years; the financial domain metric requires MaineGeneral to maintain current cost trends (with an increase of no more than 5%) for the SEHC population over the year.

Looking Ahead

As noted above, the initiative as currently deployed is the first step of a five-year plan. Many details of the future payment model, including performance measurement and incentive structure, are under development. Although initially conceived as a pilot, both SEHC and MaineGeneral are committed to this collaboration as a mechanism to create permanent change in care delivery and payment. In addition, discussions are under way to include additional purchasers in the arrangement. One limitation to developing a robust risk-sharing arrangement is the need for better data and financial modeling. Without the involvement of payers—or access to their data and actuarial analyses—SEHC and MaineGeneral lack easy access to some of the building blocks of a truly sophisticated risk-sharing arrangement. This model, and the collaborative process through which it is being developed, is becoming a model for others throughout the state. MHMC is helping convene several other pilots throughout Maine that are developing similar models.

CONCLUSION

Despite the flurry of activity to understand and establish ACOs since the passage of the Affordable Care Act, the development of ACOs and the payment models to support them are still their infancy. While some provider groups are well positioned and already deliver coordinated care across the care continuum, it is too early to know whether independent providers can or will reorganize themselves to deliver coordinated care. Moreover, there are many unknowns about the requisites for success and the payment models that will most appropriately align incentives while providing burgeoning ACOs with the resources to manage their patients successfully.

Throughout the industry there is interest in population-based shared-risk contracts as a way to help align incentives for high-quality and coordinated care. The proposed rule for the Medicare Shared Savings Program creates incentives for providers forming ACOs to move quickly toward accepting financial risk. Taking on financial risk for a patient population has the potential to provide stronger incentives for providers to coordinate and streamline care delivery than other payment models, such as shared savings. However, very few payment models exist today that can provide evidence-based guidance on program design or evidence of the impact of shared-risk arrangements.

This lack of experience also leaves unknowns about what providers need to be successful under shared-risk arrangements. One element highlighted through this research is providers' need for more data and analytic capabilities to aid both in their management of the patient population for which they take on financial risk and in their negotiation of appropriate risk-sharing arrangements with payers. Although the payers we interviewed had typically introduced elements of support for providers, the limited experience with risk-sharing models and the developmental stage of many of the initiatives causes them to fall short of offering an understanding of what providers need to be successful. However, it is likely that concerted partnership between payers and developing ACOs will be an important element of success. The types of support providers need as they organize into and begin operating as ACOs is an area for further study.

At this early stage of development, there is not a single, "one size fits all" approach to shared-risk contracts; the approaches are unique to each payer. On the other hand, many of the design concepts align to the approach to shared risk that CMS outlines in its proposed rule: to impose a financial penalty if spending exceeds the threshold. The initiatives we studied implement this financial penalty as reimbursement from the provider for some portion of excessive cost (e.g., Horizon Blue Cross Blue Shield of New Jersey/Horizon Healthcare Innovations; Blue Cross Blue Shield of Massachusetts AQC) or as reductions in future pricing (e.g., the Blue Cross Blue Shield of Illinois and Advocate Healthcare partnership). However, shared risk can be more robust than imposing a financial penalty for exceeding a cost target; capitation, bundled payments, and global budgets place the responsibility for managing financial risk more squarely on the shoulders of providers. None of these initiatives employs these financial penalties or addresses the full array of services, even as they attempt to put in place meaningful quality incentives. But some of them, including Anthem/WellPoint and the SEHC/MaineGeneral collaboration, anticipate including these more aggressive shared-risk payment models in the future.

The varying approaches to shared risk create both opportunities and challenges as the health care system continues to seek payment and care delivery models that promote high-quality, high-value care. Many unknowns persist about payment models that will most appropriately align incentives for high-value care. In the meantime, however, providers will potentially face many different signals and incentives from the various public and private payers with whom they do business. Providers' attempts to respond to these different incentives may confuse or dilute the results and are an important area to monitor over time.

Regardless, this research helps to familiarize us with an important component of today's landscape of health care delivery and payment reform. The findings from the developing initiatives we studied—and others that may also exist—will inform our collective understanding of which approaches are most successful. The research also identifies for us a series of experiments to monitor and learn from over time. Through the Center for Medicare and Medicaid Innovation, there might even be opportunities to build on these experiments with public–private partnerships, strengthening the power of the pilots and making it potentially easier to detect their impact. It is unlikely that there will ultimately be a one size fits all solution; it will be important to learn which models work best in which situations.

Appendix A. Interviewee Organizations and Contacts

No.	Organization	Organization Type	Individual(s) Interviewed
1	Aetna	Payer	Elizabeth Curran Director, National Contracting Policy
2	Anthem/WellPoint	Payer	Rome ("Skip") Walker, M.D. Medical Director
3	Buyers Health Care Action Group (BHCAG)	Purchaser coalition	Ann Robinow Former Executive Director, Care Systems and Finance, BHCAG
4	Blue Cross Blue Shield of Illinois	Payer	Steve Hamman Vice President, Network Management
5	Blue Cross Blue Shield of Massachusetts	Payer	Dana Safran, Sc.D. Senior Vice President, Performance Measurement and Improvement
6	Blue Cross Blue Shield of Minnesota	Payer	James W. Eppel, Jr. Senior Vice President, Commercial Markets and Health Management
7	Blue Cross Blue Shield of North Carolina	Payer	Troy Arnold, M.B.A., M.H.A. Strategic Advisor, Strategic Development Don Bradley, M.D., Chief Medical Officer and Senior Vice President, Health Care
8	Fairview Health Services*	Integrated health system	R. Andrew McCoy Vice President, Revenue Management
9	Horizon Blue Cross Blue Shield of New Jersey	Payer	Richard Popiel, M.D., M.B.A. President and Chief Operating Officer of Horizon Healthcare Innovations
10	Integrated Healthcare Association	Nonprofit leadership group	Dolores Yanigahara, M.P.H. Director, Pay for Performance Program
11	Medica	Payer	Mike Lenz Vice President of Health Management Finance and Provider Strategy
12	PreferredOne	Payer	Darcee Weber Vice President, Network Management

No.	Organization	Organization Type	Individual(s) Interviewed
13	State of Maine/MaineGeneral Health Collaboration	Payer/purchaser	Elizabeth Mitchell, Chief Executive Officer, Maine Health Management Coalition Barbara Crowley, M.D. Executive Vice President, MaineGeneral Health Frank Johnson Executive Director, Office of Employee Health & Benefits, State of Maine
14	State of Minnesota State Employee Insurance Program	Payer/purchaser	Nathan Morroco Director, State Employee Group Insurance Program
15	ThedaCare**	Integrated health system	Jeff Squier Executive Director, Northeast Wisconsin Health Value Network
16	United Healthcare	Payer	Sam Ho, M.D. Executive Vice President and Chief Medical Officer

* Fairview Health Services was interviewed to gain an increased understanding of their payer–provider arrangements to the extent it involved risk-sharing.

** ThedaCare was interviewed to gain an increased understanding of their payer–provider arrangements to the extent it involved risk-sharing.

Appendix B. Additional Sources Used to Inform This Report

"Achieving Better Care at Lower Costs Through Accountable Care Organizations." Public forum sponsored by the Engelberg Center for Health Care Reform and the Dartmouth Institute for Health Policy and Clinical Practice, Feb. 1, 2011, Washington, D.C.

"Proposed Rule on Medicare Shared Savings Program: Accountable Care Organizations," Centers for Medicare and Medicaid Services, released March 31, 2011.

M. E. Chernew, R. E. Mechanic, B. E. Landon et al., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract,'" *Health Affairs,* Jan. 2011 30(1):51–61.

E. C. Schneider, P. S. Hussey, and C. Schnyer, "Payment Reform: Analysis of Models and Performance Measurement Implications." Study conducted by RAND Health and sponsored by the National Quality Forum, Feb. 22, 2011.