AMERICAN HOSPITAL ASSOCIATION
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TRENDWATCH

Hospitals and Health Systems Prepare for a Value-driven Future

Hospitals and health systems are actively working to serve their communities in numerous ways, including through the adoption of initiatives that control costs, improve outcomes, and enhance patient-centered care. Many are working with payers to establish value-based payment (VBP) arrangements to support these goals. There is a wide range of approaches to VBP, from programs that incentivize public reporting on quality metrics to prospective payments for all of the health care needs of a given population. With no single VBP "destination," hospitals and health systems are evaluating which models may best support their organizational and community goals. The migration from fee-for-service payment to VBP is well underway. While the Centers for Medicare & Medicaid Services (CMS) has recently promoted increased flexibility for providers in VBP models, many states and private payers also are pursuing and expanding VBP arrangements.

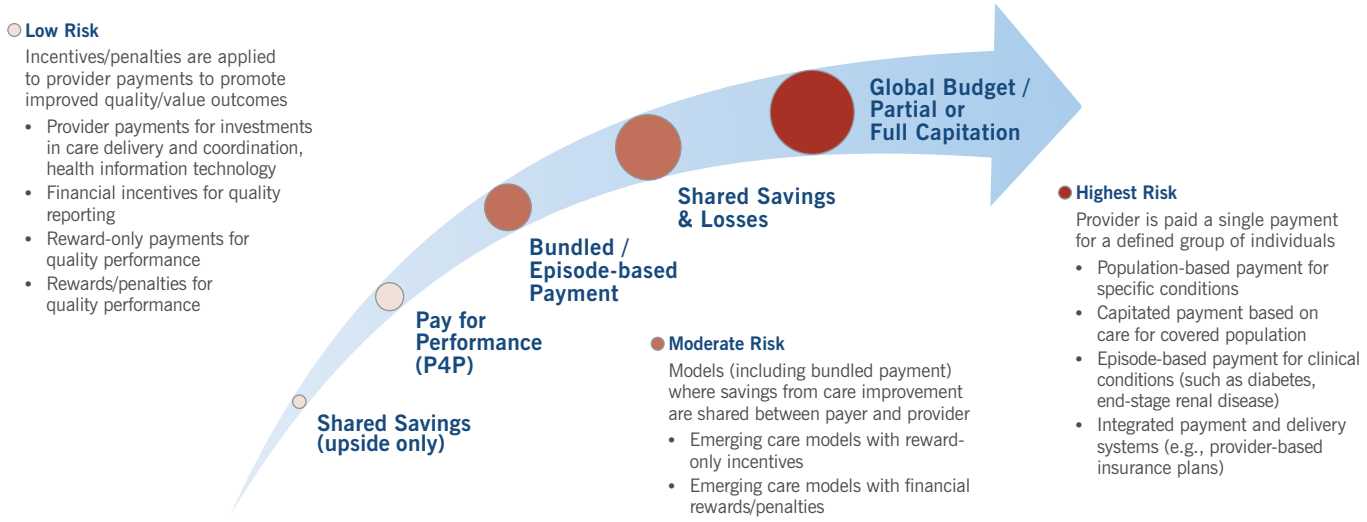
Definition: Value-based Payment

Any payment arrangement that incorporates metrics or factors other than volume of services provided in reimbursement determinations, such as shared savings models or penalties tied to performance metrics. These may include quality, patient experience, cost, utilization and efficiency measures.

"Payment" and "purchasing" are often used interchangeably with regard to value-based services. However, this report uses the "payment" term since hospitals are recipients of this compensation for delivered services.

Hospitals are engaging in a wide range of models along the VBP spectrum; approaches may vary based on community and hospital characteristics.

Chart 1: Spectrum of Value-based Payment Models

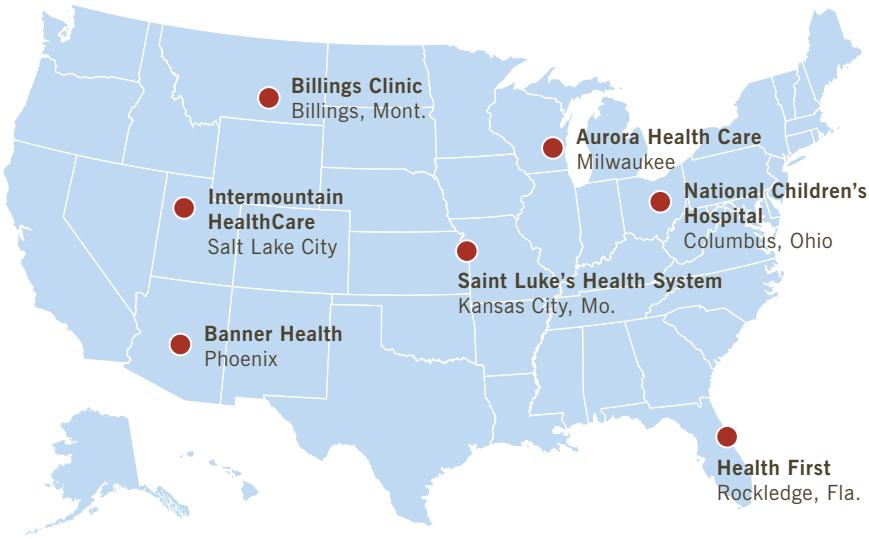


American Hospital Association®

This *TrendWatch* report provides information to help hospitals and health systems evaluate which VBP model(s) may support their organization's goals, and provides insights from seven hospitals and health systems participating in different VBP arrangements. This report examines the drivers and prevalence of VBP arrangements; the conditions and factors that foster, accelerate and — in some cases — stifle VBP transitions; and the tools, capabilities and approaches necessary to succeed. It considers the impact of market dynamics on VBP strategies, as well as the complexities and requirements of transitioning to value. Finally, the report highlights critical issues for hospitals and health systems to consider when evaluating their VBP options. This work is based in part on interviews with hospitals and health systems at different levels of risk adoption. Participating organizations are shown in Chart 2 and listed in the Appendix; profiles of the organizations' VBP experience can be found in a compendium to this report available at www.aha.org.

This TrendWatch report reviews the experience of seven hospitals and health systems that have participated in VBP models.

Chart 2: Profiled Organizations



Key Messages:

- The movement to VBP is being driven by a combination of rising health care expenditures, declining reimbursement for Medicare and Medicaid, federal and state policy, market competition and payer dynamics.
- There is no "one-size" fits all approach to VBP for hospitals and health systems — leaders will need to assess the most appropriate model for their community and organization.
- Past experience with VBP arrangements, organizational capabilities and culture, and market and policy forces influence the ability of hospitals and health systems to succeed in shared savings and population-based VBP models.

Value-based Payment Arrangements: Drivers

Rising expenditures, declining reimbursement for Medicare and Medicaid, federal and state policy, financial stability and access to capital are the key drivers in the movement to a risk-based environment in health care.

Rising Health Care Expenditures

The growth in health care expenditures is driving policymakers, employers and public and private purchasers to explore VBP arrangements that incentivize quality and performance improvements that drive efficient, cost-effective care. Annual health insurance premiums for family coverage more than tripled between 1999 and 2016, while average wages rose by less than 55 percent during this time.[1,2] Annual projected cost growth rates for the nation's two largest purchasers of public insurance, Medicaid and

Definition: Risk-based Environment

A health care market environment in which some or all of providers' payment is based on their ability to deliver high-quality care in a cost-effective manner.

Medicare, are expected to be nearly 6 percent between 2018–2025 and over 7 percent respectively, between 2016–2025.[3] With hospitals representing 32 percent of total health expenditures, they have become targets for cost reduction initiatives.[4]

Reimbursement from Medicare, Medicaid

Hospitals and health systems are motivated to reduce costs to stem losses from the growing portion of patients that are insured through public programs. Reimbursement for publicly-insured patients is generally lower than for those who are commercially insured and often below provider costs. For example, in 2015, Medicare paid 88 percent and Medicaid paid 90 percent of the cost required to provide patient care.[5] The sizable growth of public insurance populations in recent years, driven by Medicaid expansion authorized by the Affordable Care Act (ACA) and the baby boomer transition into Medicare, increases pressure on providers to lower the cost of care. Medicare enrollment grew to over 58 million as of April 2017 — up from 49 million in 2011 — while Medicaid and Children's Health Insurance Program enrollment increased by more than 17 million to 74.5 million between mid–2013 and April 2017.[6,7]

Federal Policy

Medicare is a major driver of the transition to VBP. The ACA created new Medicare pay-for-performance programs, including the Hospital Value-based Purchasing Program, the Hospital-acquired Condition Reduction Program and the Hospital Readmissions Reduction Program. In addition, the ACA encouraged the development and implementation of new payment and delivery models by authorizing the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs) and creating the CMS Center for Medicare & Medicaid Innovation (CMMI), which is tasked with testing "innovative payment and service delivery models to reduce program expenditures… while preserving or enhancing the quality of care" for beneficiaries of federal health care programs, including Medicare.[8]

Building on the foundation set by the ACA, in 2015, the Department of Health & Human Services (HHS) announced new goals to increase the percentage of Medicare payments tied to value and made through alternative payment and delivery models. Specifically, the department's goal was to tie 30 percent of Medicare payments to alternative payment models by the end of 2016 and 50 percent by the end of 2018.[9] In early 2016, HHS announced it had met its first goal via a combination of accountable care models, episode-based payments and primary care initiatives.

Definitions: Emerging Payment Models

Accountable Care Organizations

ACOs are broadly defined as groups of health care providers who voluntarily come together to deliver coordinated care to an attributed patient population, with payment tied to care quality and cost. In 2016, nearly 9 million Medicare beneficiaries were managed within more than 400 Medicare ACOs, representing almost 16 percent of the total Medicare population.

Bundled Payments

CMS has implemented multiple episode-of-care-based bundled payment models. The voluntary Bundled Payments for Care Improvement initiative sets a target price for nearly all services delivered during a single episode-of-care (e.g., congestive heart failure, diabetes, stroke). Provider payment is linked to performance against the target price and on specified performance measures. As of April 2017, 1,295 organizations, including 330 acute care hospitals, participated in one or more episodes through this initiative.

Medicare subsequently launched a separate but parallel, mandatory bundled payment initiative for joint replacements that affects approximately 800 hospitals in 67 select markets. In November 2017, HHS finalized a modification to this initiative that makes participation mandatory in 34 of the original markets and voluntary in the remaining 33 geographic areas.

" " from the field

"Increased adoption of risk resonated with medical staff, as it aligns with the way they want to practice medicine. Clinicians were already asking how do we use our resources to provide the best care possible and keep kids well in the first place."

— Nationwide Children's Hospital

Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) mandated a new physician payment system that further advances adoption of value-based payment arrangements by tying a greater percentage of physician payment to performance and encouraging participation in risk-bearing payment models. Beginning in 2019, physicians who provide services to Medicare beneficiaries will be paid under one of two payment tracks. Under the default payment, the Merit-based Incentive Payment System (MIPS), clinicians who outperform their peers based on performance metrics in four categories will receive a bonus while those who do not will face a penalty. Alternatively, MACRA provides incentives for providers who participate in an advanced alternative payment model (APM) that includes downside risk. Both tracks require participants to report on quality, efficiency, information technology use and other measures. Further information regarding MACRA can be found at *www.aha.org/MACRA*.

Medicare's push toward value may encourage some hospitals to consider engaging more rapidly in APMs, including models that require downside risk. For example, Saint Luke's Health System pursued select VBP arrangements, including commercial upside-only shared savings, but had not opted to participate in other APMs that included significant downside risk. However, changes to federal programs have caused Saint Luke's to consider accepting additional financial risk. Saint Luke's became a participant in the Medicare Comprehensive Care for Joint Replacement (CJR) bundled payment model when CMS selected the Kansas City market as one of the initial mandatory participation markets. More recently, Kansas City was selected as a participating region for the voluntary Comprehensive Primary Care Plus (CPC+) program; Saint Luke's also plans to participate in that program. The ability of CPC+ participants to qualify as advanced APMs under MACRA, with additional payment incentives, prompted Saint Luke's to reconsider more aggressive risk-based arrangements and bolstered the strategic decision to join the CPC+ program.[10]

Perspective on Vermont All-Payer ACO Model

Vermont is establishing an all-payer ACO model to accelerate delivery system reform for its residents, limit health care expenditure growth and achieve three public health goals: 1) improve access to primary care, 2) reduce deaths from suicide and drug overdose, and 3) reduce the prevalence and morbidity of chronic disease. The largest payers in the state — Medicare, Medicaid and commercial payers — will apply a common payment structure for the majority of providers throughout Vermont's delivery system. This initiative will set an all-payer-total cost-of-care target as well as a Medicare growth target and seeks to have 70 percent of beneficiaries across all payers and 90 percent of Medicare beneficiaries aligned to an ACO by 2022. To facilitate Medicaid's participation, CMS approved a five-year extension of Vermont's section 1115(a) demonstration in October 2016.

More recently, CMS has signaled that it may provide additional flexibility in the move to VBP. The agency has issued regulations that reduce the number of hospitals and physicians required to participate in VBP models. In September, CMS solicited input on the future direction of the CMMI, and expressed interest in promoting patient-centered care, market-based reforms, price transparency, and increased choice and competition to improve quality and reduce costs. As part of this shift, CMS requested stakeholder input on a range of VBP arrangements, including models impacting physician specialties, prescription drugs, Medicare Advantage, Medicaid, program integrity and behavioral health.[11]

from the field

"Our care delivery teams have been major champions for value-driven initiatives, particularly our medical group leadership, who play an important role of building care teams and focusing on total cost of care."

— Banner Health

State Policy

States have encouraged VBP adoption through a variety of mechanisms related to Medicaid, including State Delivery System Reform Incentive Payment (DSRIP) programs and through contractual requirements with managed care organizations. Through DSRIP programs, states have funded upfront provider investments in transformation infrastructure and tied provider payments to performance metrics.[12] Some states require Medicaid managed care organizations (MCOs) to adopt rigorous incentive payment programs, such as in New York, where Medicaid MCOs are required to enter into up- and down-side VBP arrangements with providers.[13] Sixteen states have passed Medicaid ACO legislation or enacted ACO-like pilot programs.[14] Up to 22 states have implemented Medicaid pay-for-performance or bundled payment programs.[15] Vermont recently partnered with CMS to establish an all-payer ACO model.[16,17]

Financial Stability and Access to Capital

Hospitals and health systems' uptake of VBP is influenced by financial stability and access to capital. VBP arrangements inherently involve a greater level of financial risk, which may discourage hospitals experiencing financial uncertainty from participating. However, as VBP arrangements become more prevalent, hospitals may seek to standardize clinical processes and align financially and/or operationally with other providers to achieve economies of scale, improve financial stability and enhance access to investment capital.

Health systems and aligned provider networks are more likely to seek oversight of a larger portion of health care spending via VBP. These collaborative networks often result in more integrated health care organizations that combine the functions of traditional hospital systems, provider networks and insurers. For example, there are approximately 90 health plans sponsored by hospitals or health systems ("provider-sponsored health plans" or PSHPs) that covered nearly 18 million lives in 2015, including 7 million in commercial plans, 1.6 million in Medicare Advantage products and 8.9 million in Medicaid plans.[18] However, the risk associated with launching a health plan continues to be significant for hospitals and health systems. Of 17 PSHPs started since 2010 and currently active, none made a profit in 2016 and only two plans made a small profit in the first half of 2017. Three of these 17 PSHPs are now in the process of winding down operations.[19]

Perspective on Risk Exposure: Nationwide Children's Hospital (Columbus, Ohio)

In 1994, Nationwide Children's began accepting sub-capitated payments for the Medicaid population through Partners for Kids (PFK), a joint venture physician hospital organization formed with affiliated physicians. Nationwide Children's determined that it was able to accept this level of risk given that it was already responsible for most of the Medicaid-financed pediatric care in the region. By accepting risk, the organization gained the flexibility necessary to implement care delivery reforms, including enhanced care coordination.

Perspective on Payer Collaboration: Aurora Health Care (Milwaukee)

Aurora formed the Wisconsin Collaborative Insurance Company as a joint venture with Anthem Blue Cross and Blue Shield earlier this year to offer a commercial health insurance product that meets employer demand for both cost containment and a national provider network.

Payer Dynamics & Culture

Many commercial payers also have begun to implement VBP arrangements similar to those being developed by federal and state governments. For example, following Medicare's lead, more than 300 ACOs now manage approximately 20 million individuals with commercial insurance or Medicaid.[20,21]

However, payers differ in their interest and pursuit of VBP arrangements. In some markets, providers may need to initiate discussions with payers on new payment models. Alternatively, in other markets, some large employers are bypassing the traditional insurer intermediary and establishing VBP arrangements directly with providers. Examples include Boeing contracting with providers to offer a Preferred Partnership ACO to 50,000 employees in target markets, Marriott International contracting with local hospitals to provide primary and urgent care through outpatient clinics, and Lowe's and other employers establishing bundled payment arrangements with Centers of Excellence programs for high-volume procedures such as joint replacement and spine surgery.[22]

Value-based Payment Arrangements: Prevalence

VBP arrangements vary in their structure and the amount of financial risk attributable to providers. Chart 3 highlights the prevalence of various VBP arrangements by the associated level of risk and payer type. This information is aggregated at the national level; individual geographies and market segments may experience VBP differently.

The prevalence of each type of VBP arrangement varies by payer and patient population.

Chart 3. Spectrum of Value-based Payment Arrangements

VBP Model & Definition	Prevalence by Payer		
	Commercial	Medicare	Medicaid
Shared Savings (Upside-Only Risk) Upside-only payments comprised of a percentage of any net savings for providers that successfully reduce spending for a defined population **(Lowest Risk)**	• 2% of payments are fee for service (FFS) plus shared savings (2014)[23] • 0.2% of payments are non-FFS shared savings (2014)[24]	• 11.8% of traditional Medicare payments paid through shared savings arrangements as of 2013[25] • MSSP ACOs: ◦ 91% are one-sided shared savings only as of January 2017[26] ◦ Cover 9 million lives, or 15.5% of the entire Medicare population as of 2017[27,28] • 53% of surveyed Medicare Advantage (MA) health plans report having ACOs with shared savings in 2015[29,30]	• Of 43 states surveyed: ◦ 5, or 11%, have implemented ACOs or shared savings ◦ 3, or 7%, are currently implementing shared savings ◦ 20, or 46%, are planning or studying how to implement shared savings (2015)[31]
Pay for Performance (P4P) Financial bonuses and penalties to align payment in areas such as quality, patient experience, or cost; typically tied to existing fee-for-service structure **(Low Risk)**	• 12.8% of in-network payments are FFS-based pay plus P4P (2014)[32]	• 32.8% of traditional Medicare payments are FFS plus P4P via the Hospital Value-based Purchasing and End-stage Renal Disease programs as of 2013[33] • Other P4P arrangements include Hospital Readmissions Reduction, Value-based Payment Modifier, Oncology Care Model and Hospital-acquired Condition Reduction Programs[34,35]	• Of 43 states surveyed: ◦ 15, or 35%, have implemented P4P in their MCOs ◦ 5, or 11%, are in the process of implementing P4P in MCOs ◦ 11, or 25%, are planning or studying how to implement P4P programs in MCOs (2015)[36]
Bundled / Episode-Based Payment Single payment to providers for the expected costs of treating a clinically-defined episode of care **(Medium Risk)**	• 0.1% of in-network payments are bundled with quality incentives (2014)[37] • 34 commercial bundled payment plans across the country (2013)[38]	• 1,244 providers currently participating in the Bundled Payments for Care Improvement Initiative as of July 2017[39] • Approximately 800 hospitals required to participate in the Comprehensive Care for Joint Replacement (CJR) model across 67 designated geographic areas. In November 2017, HHS modified CJR by making participation mandatory in 34 of the designated areas and voluntary in the remaining 33 areas[40] • 33% of surveyed MA health plans report having bundled payment arrangements in 2015[41]	• Of 43 states surveyed: ◦ 7, or 16%, have implemented bundled payments ◦ 3, or 7%, are currently implementing bundled plans ◦ 21, or 29%, are planning or studying how to implement bundled payments (2015)[42]
Shared Savings & Losses (Up- & Downside Risk) Financial bonuses or penalties comprised of a percentage of any net savings or losses in providers' spending for a defined population **(Medium-High Risk)**	• 1% of in-network payments are shared risk (2014)[43]	• 1.9% of traditional Medicare payments are shared risk as of 2013[44] • 121 of the 562 Medicare ACOs are in a risk-bearing track as of January 2017.[45] This includes: ◦ 9% of MSSP ACOs as of January 2017[46] ◦ 8 Pioneer ACOs as of December 2016, down from 19 in April 2015[47,48] ▪ 6, or 50%, of the 12 participating Pioneer ACOs in Performance Year 4 earned shared savings[49] ◦ 45 Next Generation ACOs as of June 2017[50] ◦ A subset of the 37 Comprehensive End-stage Renal Disease Care Model programs as of April 2017[51,52] ◦ 43% of surveyed MA health plans report having ACOs with shared risk in 2015[53]	[See Shared Savings row above]
Global Budget / Partial or Full Capitation Fixed payment to providers for each assigned patient over a defined period of time **(Highest Risk)**	• Of all in-network payments paid to providers, 15% are fully capitated with quality incentives and 1.6% are partially or condition-specific capitated with quality incentives (2014)[54]	• 40% of surveyed MA health plans report having global capitation arrangements with some network providers as of 2015[55] • In Performance Year 2, Next Generation ACOs have the option to participate in a capitated payment model[56]	• Capitation payments are paid to Medicaid MCOs, but MCOs may pay providers on a FFS basis

Organizational Experience with VBP

The timing and process of transitioning to VBP is complex. It requires consideration of both the external factors described above and the organization's internal readiness. The following sections consider critical requirements, reflecting on the challenges and lessons shared by interviewed hospitals related to clinical, technical, financial and organizational domains. In addition to these requirements, one of the most significant success factors relates to experience: providers with more experience tend to perform better in advanced VBP models, including ACOs and health plans.[57,58]

Provider Alignment

Value-based arrangements require buy-in from physicians, as well as alignment of hospitals' clinical leadership and the broader care delivery team.

Some systems seeking to align leadership and engage clinical leaders in finance and risk decisions establish either a dual reporting structure or a dyad management model. In a dual reporting structure, physician leadership reports to both the system's clinical lines and the medical group. In a dyad model, a clinical leader and an administrator are paired to jointly oversee a service line or clinical area.[59] Both models are structured to enable physician leadership to participate in setting the course for strategic direction as well as clinical care.

Aurora Health Care adopted the dual reporting structure and as a result experienced many benefits. For example, Aurora's contracting leaders are better versed in population health and value-based care as a result of their close working relationship with their clinician colleagues. This first-hand experience enables them to negotiate performance metrics with payers that are actionable by their clinicians and effective in measuring the quality of patient care. The Billings Clinic, in addition to having a physician CEO and physician representation on internal and community governing boards, uses a tightly integrated, physician-led and professionally managed dyad model. These management models actively include clinicians, and creates staff champions across the organization that fosters collaboration among administrators and physicians.

While clinical alignment is critical, determinations on operational configuration vary. Ownership of the entire continuum of care is not always necessary, but can produce efficiencies in many cases. Systems use both internal capacity and affiliations to offer the full care continuum — sometimes varying their approach in different markets. Aurora is building a single provider network that includes its visiting nurses agency, pharmacies, behavioral health program, and family service programs, while Saint Luke's is establishing a preferred network of non-owned post-acute care provider partners. Another interviewed organization recently underwent a process to determine whether to build, buy or partner within each area of the care continuum. The Billings Clinic, with half of its hospital patients coming from outside of its flagship hospital in Yellowstone County, is working to closely affiliate with critical access hospitals, invested in telehealth capabilities and utilizes swing beds to meet post-acute care needs closer to patients' homes.

Perspective on Alignment Through Varied Physician Arrangements: Intermountain Healthcare (Salt Lake City)

Intermountain Healthcare is an example of how some organizations may align both employed and affiliated physicians. Intermountain physicians — whether contract or employed — are expected to care for all patients in a consistent way. This consistency is supported by clinical standards that have been adopted across 10 service lines. These standards are based on best practices that are reviewed, discussed and approved by physician leaders, formalized in practice models, and reinforced by Intermountain's clinical information and reporting systems. Physicians who choose alternate care pathways must provide documented justification. All physicians — whether employed or affiliated — must follow these standards.

Furthermore, both contract and employed physicians within Intermountain who participate in small panel shared savings/losses sign a contract, or "citizen agreement," that defines 18 requirements, including complying with evidence-based practices, linking electronic health records (EHRs) to Intermountain, treating other clinicians with respect and providing equal access to all patients, regardless of their payer source.

Technical Capabilities

As providers accept increasing levels of financial risk, they must invest substantial time and resources to develop new capabilities. The technical requirements associated with VBP expand as hospitals and health systems increase their exposure to financial risk. Chart 4 examines major areas of required capabilities across the spectrum of VBP arrangements.

Perspective on Technology Partners: Banner Health (Phoenix)

Banner Health previously sought to develop its own customer-centric care management infrastructure, data analytics and electronic tools (e.g., EHR, registries) but now collaborates with partners — including population health vendors and health plans — for more rapid technical development. This approach allows Banner to focus on quality and outcomes, member satisfaction and affordability. Banner believes it is important to seek partners that offer interoperable approaches, pursue alignment of capabilities and serve as allies in co-developing solutions.

An expanded set of skills and capabilities is needed to be successful under VBP models to effectively manage additional financial risk.

Chart 4: Spectrum of Required Capabilities

*Upside-only shared savings arrangements do not require the same level of capabilities as up- and downside shared savings arrangements.

Low Risk ⟵ VBP arrangements at higher levels of risk require increasing provider capabilities ⟶ *High Risk*

Capabilities	Pay for Performance (P4P)	Bundled Payments & Upside Shared Savings	Up- and Downside Shared Savings	Global Budget/Capitation
Contracting & Provider Network Management	• Contracting with payers • Provider agreements with quality commitment and P4P funds distribution terms/approach	• Contracting with payers • Affiliation and participation agreements with providers • Provisions requiring adoption of protocols, standards of care, shared savings distribution terms/approach		• Payer, provider and group contracts • Fulfillment of network adequacy, division of financial responsibility (DOFR) and provider payment terms
Clinical and Care Management	• Develop and engage patients in quality improvement and disease management programs • Develop registries and performance dashboards, identify and report quality targets with provider network participants	• Care coordination capabilities, including discharge planning • Development of quality and utilization benchmarks and standards, clinical protocols and coordinated work flow processes	• Care management capabilities, including high-risk case management • Clinical integration with affiliated provider network • Targeted disease management programs	• Utilization management and utilization review • Post-acute care management and coordination • Pharmacy benefits management • Prevention and wellness programs
Analytics	• Clinical, financial and patient experience performance reporting • Clinical and administrative data integration • Disease registries; reporting and analysis • Data security infrastructure	• Robust population health capabilities, including: ◦ Risk stratification, identification of high-cost patients (hot-spotting, frequent flyers) ◦ Systems to track utilization, adherence to protocols and guidelines, variations in care and outliers ◦ Identification and connection of high-risk patients to care management ◦ Reporting and analysis of quality, utilization and financial metrics		• Actuarial analytics • Predictive modeling
Financial Management	• Financial and payment modeling of P4P measures • Performance-based funds distribution to affiliated providers	• Financial and payment modeling of P4P measures • Management of funds for distribution to affiliated providers and downside payments (losses) to payers		• Payment processing and claims adjudication capabilities • Underwriting • Reinsurance • Maintenance of reserves
Governance and Organization	• Medical direction and oversight of quality improvement (QI) programs • Provider engagement in QI program development • Change management expertise	• Medical oversight of and provider engagement in quality, care coordination, protocol and standards development programs and processes	• Medical oversight of care and disease management programs • Clinical integration governance • Legal and antitrust evaluation	• Corporate governance with clear role for board, executive, medical direction, state regulatory reporting, compliance, management and operations

Financial Requirements

Organizations meet the requirements described in Chart 4 by building internal capabilities, establishing partnerships with others or procuring services from vendors. The financial investments to build new competencies can be significant. For example, ACO start-up costs, much of which are attributable to information technology and other systems infrastructure, were estimated to be $4 million in 2013 while provider-sponsored plan start-up costs were estimated to be $9 million in 2014.[60,61] A majority of interviewed organizations funded their own investments, opting not to seek capital from external sources. However, a 2016 survey of hospital executives found that small hospitals, defined as those having fewer than 200 beds, were five times less likely than larger hospitals or systems to have sufficient capital to build the infrastructure necessary to succeed in risk-based contracting.[62] Acknowledging these limitations in accessing capital for small and rural hospitals, CMS announced the ACO Investment Model in March, which provides pre-paid shared savings to participating hospitals to support investment in ACO operations.[63]

Systems can complement their own operations by leveraging partners' capabilities. For example, in its new joint venture insurance company, Aurora provides strong risk management proficiency and leverages Anthem's predictive modeling and service center capabilities, which enables Aurora to focus on customers and enhancing responsiveness to patients.

Perspective on Organizational Change: Health First (Rockledge, Fla.)

Health First has undergone a comprehensive, multi-year effort to transition from a siloed holding company with internally competing interests to a fully integrated health system in which the health plan functions as the organizer of care. Health First applied integration science lessons from the aerospace and defense industries, specifically using Capability Maturity Model Integration which is an approach to performance management [that]…helps integrate traditionally separate organizational functions, set process improvement goals and priorities, provide guidance for quality processes, and provide a point of reference for appraising current processes. Through this approach, Health First developed new feedback loops across the organization by forming overlapping governing councils (strategic, operating, clinical, etc.) to compensate for the loss of immediate — yet siloed — feedback that it experienced in its linear reporting model.

Culture and Organization

Ensuring that an organization's culture and institutional supports align with delivering value is essential for success in VBP models. Hospital executives surveyed in 2016 reported that cultural alignment on quality was key to impacting value-based care success, second only to analytics.[64] Integrating the network of providers and care sites to deliver coordinated services to patients across the care continuum requires particular consideration. The organizational transition to become a truly integrated delivery system can be challenging.

Strong leadership and consistent incentives across management, operation, and clinicians along the care continuum is critical. Leaders must establish clear definitions and measurements of success that apply throughout the organization. Health First no longer tracks net operating performance of individual units and, instead, established a single system-wide bottom line with rigorous attention to key performance indicators. It also migrated away from an annual budgeting processes toward financial forecasting. These changes stimulated a cultural shift among Health First's executive leaders from silos independently seeking to drive change to an effective and cooperative team. Banner Health also maintains common performance metrics across all areas of institutional leadership, combining annual short-term measures and longer term measures that rotate on three-year cycles.

from the field

"We learned a lot through participation in bundled payments, leading us to re-evaluate our post-acute care strategy, increase coordination with critical access hospitals and expand our social service capabilities."

— Billings Clinic

Conclusion

Hospitals and health systems — influenced by both policy and market forces — are increasingly moving away from fee-for-service payments towards value-based arrangements. There is no single model that will work for every organization. Hospital and health system leaders should assess the personnel, infrastructure and other capabilities required for success in each model when considering the most appropriate path for their organization.

The breadth of competencies necessary to succeed at VBP increases as a hospital or health system moves up the risk spectrum. Depending on the model, organizations will need skills and infrastructure to support provider contracting and network management, clinical and care management, analytics, and risk/financial management. Organizations need to decide whether to partner, purchase or develop these capabilities in-house. Such decisions depend on available resources, timing issues, and existing internal and external capabilities. Some have found that success in VBP models has required an intense and focused effort on evolving the culture of the organization to align with new incentives. These efforts may include changing the organization's governance and reporting structures and ensuring that clinicians are engaged and represented in leadership roles.

Hospitals and health systems may find that their value-based "destination" evolves over time as policy, market and organizational forces change. Leaders will want to frequently revisit their vision and objectives to assess which model may best help them achieve organizational goals and understand the tools, information, resources and delivery network required to succeed in a particular model.

POLICY QUESTIONS

1. How can federal and state policies drive alignment across public and private VBP efforts to reduce challenges associated with managing many different forms of value-based payment?
2. What financial mechanisms should the federal and state governments make available to support providers in the transition to VBP?
3. Are there instances — for example, in sparsely populated regions — in which VBP is not appropriate?

Appendix A: Hospital and Health System Interviewed

Institution	Interviewee Name & Title	Position on VBP Spectrum & Relevant Activities
Aurora Health Care *Milwaukee*	Richard G. Klein *Executive Vice President, Enterprise Business Group*	Shared Savings & Losses: • Partnering with national health plans to establish Medicare Advantage ACOs • Created joint-venture insurance company with payer partner
Banner Health *Phoenix*	Chuck Lehn *President, Banner Health Network*	Shared Savings & Losses / Capitation: • Partnering with national health plans to establish ACOs across all market segments
Billings Clinic *Billings, Mont.*	Nicholas Wolter, M.D. *Former Chief Executive Officer*	Bundles / Shared Savings: • Discontinued Medicare bundles and Medicare Advantage health plan • Positioning for commercial ACOs
Intermountain Healthcare *Salt Lake City*	Gregory P. Poulsen *Senior Vice President & Chief Strategy Officer*	Capitation: • Formed health plan that offers commercial, Medicare Advantage, Medicaid and exchange products
Health First *Rockledge, Fla.*	Steven P. Johnson, PhD President & Chief Executive Officer	Capitation: • Developing a fully integrated delivery system and health plan
Nationwide Children's Hospital *Columbus, Ohio*	Timothy C. Robinson *Executive Vice President, Chief Financial/ Administrative Officer*	Capitation: • Accepts full risk sub-capitation from Medicaid managed care plans as part of a joint-venture physician hospital organization formed with affiliated physicians
Saint Luke's Health System *Kansas City, Mo.*	Leonardo J. Lozada, M.D., MBA *Chief Physician Executive*	Bundles: • Participates in Medicare bundles arrangements • Considering participation in CPC+ program after Kansas City was selected as target region

ENDNOTES

1. Kaiser Family Foundation. Health Research and Educational Trust. (14 September 2016). Employer Health Benefits 2016 Annual Survey. http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey.
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