COLLABORATION UNDER VALUE-BASED PAYMENT:

Lessons Learned

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ABOUT THIS REPORT

The National Partnership for the Health Care Safety Net is committed to improving vulnerable patients’ access to high-quality health care. In past years, the National Partnership facilitated cooperation among local providers to navigate and adapt to the system-wide policy changes and accountability standards generated by the Affordable Care Act (ACA). Its more recent work has progressed with the changing health care landscape under the ACA and moved into the exploration of safety net partnerships in value-based payment.

In 2016, the National Partnership began investigating value-based payment partnerships between hospitals and health centers. This included preliminary research to assess the current state of value-based payment arrangements nationally, case studies of mature partnerships implementing a collaborative value-based payment model, developing and curating educational resources for future payment reform partnerships, and disseminating findings.

This report serves as an overview of themes that emerged from our preliminary research, as well as our planning, execution, and analysis of the case studies. The following discussion includes a high-level synopsis of the current value-based payment landscape, particularly as it pertains to the context of the case study research, lessons learned from both case study recruitment and analysis, and guidance for moving forward with value-based payment specific to collaboration between safety net providers and future policy recommendations.

More information about the National Partnership, value-based payment models, and safety net collaborations can be found at safetynetpartnership.org.
CURRENT LANDSCAPE

As health care continues to shift from volume to value, health care organizations have increasingly implemented alternative payment models. For example, data from 2016 identified 838 active accountable care organizations (ACO) across the United States. Additionally, the Center for Medicare & Medicaid Innovation (CMMI) reported a total of 1295 participants in the Bundled Payments for Care Improvement (BPCI) initiative as of April 2017.

The National Partnership’s preliminary research into successful cases of value-based payment arrangements validated that this is a proliferating area across the field of health care, including safety net providers. Within the memberships of America’s Essential Hospitals and the National Association of Community Health Centers, over a dozen value-based payment models were identified. This included high-profile cases such as Cambridge Health Alliance (Cambridge, MA) and Hennepin Health (Minneapolis, MN).

CASE STUDIES AND LESSONS LEARNED

The National Partnership sought to conduct a series of case studies of established, collaborative payment arrangements as part of its efforts to investigate value-based payment partnerships between hospitals and health centers. The case studies were intended to explore the following domains:

- **Federal and State Policy Context** – How do federal- and state-level policies facilitate or hinder collaborative value-based payment arrangements, and how can providers leverage such policies?
- **Collaboration** – What are the parameters of the partnerships (e.g., how are they governed), and what are the facilitators and barriers to working collaboratively (e.g., prior history, building trust)?
- **Financial Structure** – What payment arrangements are in place, how were these arrangements established, and what incentives are involved?
- **Care Management** – How have delivery systems or processes changed to compliment the payment arrangement?
- **Quality Improvement/Clinical Performance** – How are the provider partners approaching and measuring quality of care across settings?
- **Infrastructure** – How have provider partners established connectivity between sites for information sharing?

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Several inclusion/exclusion criteria were used when identifying potential case studies. The criteria aimed to focus the case studies on the following:

- Partnerships that included at least one member of America’s Essential Hospitals and one member of the National Association of Community Health Centers
- Partnerships beyond the National Partnership’s previous community collaboration work (i.e., Atlanta, Cleveland, Denver, Richmond)
- Partnerships beyond those of highly published case studies (e.g., Cambridge Health Alliance or Hennepin Health)
- Partnerships that involved collaborative work arrangements as well as shared financial investments/risk

Using these criteria, America’s Essential Hospitals and the National Association of Community Health Centers led the recruitment efforts, reaching out to both members and state affiliates.

**Recruitment: Challenges Identified**

Following the inclusion/exclusion criteria, the number of potential case studies was smaller than anticipated. The following summarizes the primary challenges identified while recruiting from eligible case studies:

- Some cases were not mature enough to warrant informative case studies. This may indicate that establishing collaborative value-based payment arrangements between hospitals and health centers is still a developing area for these providers.

- Local market dynamics are so unique that it is not easy to identify models that can be easily replicated. In some cases, a payment arrangement had been established between a hospital and health center, yet was too specific to the providers and local market in terms of scale, buy-in, and standardization to be replicated elsewhere. However, such homegrown initiatives may serve as strong precursors to more broadly available value-based payment models (e.g. Medicare or Medicaid ACOs).

- Some of the arrangements between hospitals and health centers involved either collaborative work arrangements or shared financial investments/risks, but not both. For example, a hospital and health center may establish a financial incentive to redirect patients who present in the ED to primary care without establishing care coordination between sites. In other cases, a hospital and health center may enter into an affiliation or collaboration without necessarily making shared financial investments or taking on shared financial risks.

These issues highlight the evolving nature of value-based payment and the challenges that safety net hospitals and health centers are facing as they work on transformation.

**Case Studies: Overview**

Because of these challenges, only two case studies of accountable care, shared savings models between hospitals and health centers were completed. The two case studies comprise data collected from 24 interviews, as well as reviews of quality reports, annual reports and other community and quality assessments. Below is a short summary of each ACO case study.
**Adirondacks Accountable Care Organization:** The Adirondacks ACO was established in 2014 under the Medicare Shared Savings Program (MSSP). The ACO serves patients across Vermont and northern New York through the hospital and community health center partners - Champlain Valley Physicians Hospital (CVPH), owned by University of Vermont Health Network (UVMHN), and Hudson Headwaters Health Network (HHHN).

The collaboration between CVPH and HHHN predates the ACO and was established through a 2010 New York state Patient-Centered Medical Home (PCMH) pilot funded by CMMI’s Multi-Payer Advanced Primary Care demonstration project. This PCMH demonstration project - the Adirondacks Medical Home Demonstration – was fundamental to the development of the ACO collaboration, leadership, and delivery system infrastructure. Specifically, the ACO leadership leveraged the systems established within the PCMH project to develop the ACO – first as a Medicare shared savings demonstration and later as a risk-based model of care.

Participants hope that with buy-in from commercial payers and Medicaid, the ACO will be able to continue their work and share both upside and downside risk. The ACO currently only serves Medicare patients as part of the MSSP. However, the built infrastructure of the PCMH project, as well as contracts with local and regional payers, provides care to commercial, Medicaid, and Medicare beneficiaries.

**Medical Home Network (MHN) Accountable Care Organization:** MHN ACO is a Medicaid Accountable Care Organization involving three hospitals, their affiliated medical groups and nine community health centers on the South Side and West Side of Chicago, Illinois. It is a partnership between providers and CountyCare, a Medicaid managed care plan run by Cook County Health and Hospitals System (CCHHS). The ACO is operated by MHN, a healthcare provider collaborative founded to improve services for Cook County’s vulnerable Medicaid population with the support of Chicago’s Comer Family Foundation in 2009.

In 2011, the MHN provider collaborative became a Medicaid pilot project, working with the Illinois Department of Healthcare and Family Services (HFS) to test service delivery and payment innovations. MHN was designated as a “care coordination innovations project” by HFS in August 2013. In July 2014, the ACO formed as a provider-owned limited liability corporation (LLC) and CCHHS took on the new role as payer for the ACO (after initially participating as a provider in the MHN provider collaborative). MHN ACO seeks to build on the successes of the MHN provider collaborative and take the next steps toward value-based payment and delivery system transformation.

Please see Appendix A and Appendix B for full reports of each case study.

*Case Studies: Lessons Learned*

The small number of cases included in this research, as well as differences between the two ACOs that agreed to participate, limits the ability to draw generalizable conclusions from the case studies. However, the following highlights challenges and successes, and identifies cross-cutting lessons (as seen in Figure 1) generated from each case’s experience with implementing value-based payment.
Lesson 1: Aligned Mission and Vision – In both case studies, partners are committed to shared goals of delivery system and payment transformation to improve population health, even at the potential expense of individual organizations. In both ACOs, tensions or competition between health centers and hospitals were mitigated by a shared mission of improving quality and efficiency.

Lesson 2: Trust, Transparency and Equal Partnership – Partners in both case studies emphasized the importance of extensive discussion and negotiation during the decision-making and development process of the ACOs. Given the high stakes of shared financial risk, trust, transparency and open communication were essential, particularly as individual organizations sometimes had competing objectives that needed to be addressed.

For example, for the Adirondacks ACO, tensions around the competing financial priorities of the hospitals, health clinics and primary care practices created challenges at the beginning of negotiations. However, continued communication, frank discussions of the challenges faced by each institution, transparency in how transformation would occur and trust in the shared mission and vision of the model have helped mitigate many of the challenges. The MHN ACO used transparent quality data to foster friendly competition and sharing of best practices between partners.

Importantly, both ACO governance arrangements sought to build trust between partners by involving hospitals and health centers as equal partners. For the Adirondacks ACO, HHHN and CVPH are both equal equity partners in the PCMH pilot and now the ACO. For the MHN ACO, hospitals and health centers contributed equal financial investments and have equal representation on the board.
Lesson 3: Leveraging Prior Partnerships, Strengths and Resources – In both case studies, implementation of the ACO was facilitated by previous collaborative demonstration projects, where the partner organizations had already committed significant resources. Leveraging the strengths and successes of these existing partnerships was critical to the development of the value-based payment partnerships.

The Adirondacks ACO exists because of the early successes of a PCMH pilot in which both partners saw the opportunity to take the strengths of the built care management and health information technology (HIT) infrastructure and leverage it into a value-based payment model. Moreover, both partners had important resources that have contributed significantly to the success of the partnership. CVPH/UVMHN brings considerable experience with value-based payment, as well as strong financial backing, while HHHN brings a strong patient base and payer mix to the partnership.

The MHN ACO built on the MHN provider collaborative, in which many of the same partner organizations had already worked together, to develop HIT capacity and shared information for several years before pursuing the opportunity to become an ACO. The Medicaid managed care organization that served as payer for the ACO was also part of the provider collaborative, which facilitated communication and trust between payer and providers to support the transition to the ACO model.

Lesson 4: Developing Delivery System Infrastructure and HIT Systems – Participants in both case studies emphasized the importance of having a strong delivery system infrastructure and HIT systems to track the delivery of care, quality outcomes and cost. For the Adirondacks ACO, a locally driven approach to care management developed as part of the PCMH pilot helped build an effective and efficient approach to clinical care, while the HIT systems identify gaps in care and population needs. MHN ACO’s care management approach builds on MHNCOnnect, a care coordination exchange already developed by the MHN provider collaborative, to share real-time utilization data and guide care coordinators in performing health risk assessments and developing care plans for ACO patients.

Lesson 5: State Resources and Local Context – In each case, partners considered closely how the local context plays an important role in the success of value-based models. For the Adirondacks ACO, the geographic dispersion of healthcare across the Adirondack Northern region and the fragmented network of small, independent practices were challenges for the partnership. It took several years and hard work to successfully build the PCMH project with many mistakes along the way. Moreover, leaders in the PCMH have also leveraged the infusion of New York Delivery System Reform Incentive Payment (DSRIP) funds for Medicaid to build the primary care infrastructure in the area. Finally, leaders in the area were nimble negotiators both with each other and the state, making sure they had the support to implement innovative practices that worked for their area, including obtaining an anti-trust exemption to allow for a multi-payer demonstration. Despite these successes, the economic reality for the hospitals in the North Country remains a problem.
The partner organizations in MHN ACO were less dispersed given their urban location relative to Adirondacks’ rural setting, and many of them had already begun working together under the MHN provider collaborative to serve Cook County’s Medicaid population with the support of a local foundation in Chicago. The ACO partners were also in a position to take advantage of a statewide shift to Medicaid managed care with designated medical homes and an emphasis on care coordination in Illinois by building on the care coordination efforts of the provider collaborative and working with CCHHS as its Medicaid managed care payer.

Lesson 6: Barriers and Limitations of Value-Based Care Still Exist – As evidenced by both case studies, barriers to collaboration are reduced, but not eliminated, in high-performing value-based payment arrangements. In both cases, partnering providers continued to struggle with navigating relational tensions and competing financial incentives and are trying to negotiate terms that will increase the potential for shared savings and reduce risk. In the Adirondacks ACO, participating hospitals feel their positions are precarious in any type of value-based payment model. In the MHN ACO, the partners are still working to find the best ways of documenting care and sharing information across organizations given that they have different electronic health record systems that share limited information with the ACO information exchange. Moreover, all partners report concern around the need for substantial upfront resources to bend the cost curve enough to qualify for shared savings.

GUIDANCE FOR MOVING FORWARD
The challenges in recruiting case studies, coupled with lessons throughout the two completed case studies, lend themselves to larger hurdles in the implementation of collaborative, value-based payment arrangements between hospitals and health centers. However, these challenges may be mitigated by addressing specific facilitators to collaboration as well as larger policy considerations.

Facilitators to Collaboration
The following seven factors are key elements of successful collaboration. As hospitals and health centers move forward in partnering in value-based payment, additional efforts are needed to ensure sustainable collaboration between partners.

- **Aligned Mission and Vision** – Establishing a shared mission and vision between partners can mitigate traditional competition for resources and facilitate the development of mutually beneficial initiatives.

- **Unique Purpose of Safety Net Providers** – Understanding the partners’ collective role as safety net providers can drive motivation for collaboration. Particularly with respect to influencing policy and pursuing opportunities for outside funding or support, working together can be more powerful than working alone.

- **Complementary Capacities Across Organizations** – Essential hospitals and community health centers both contribute unique strengths, capacities, and resources. Partnering organizations must understand and leverage these assets to promote success in care coordination, population health, and policy issues.
> **Know Your Partners and Mobilize Support** – External stakeholders play a key role in supporting collaborative initiatives, especially in value-based payment arrangements. Third parties, such as health plans or care management organizations, can help facilitate collaboration and take on responsibilities which may otherwise overburden provider partners.

> **Leadership Time** – Collaboration and value-based payment partnerships fail without leadership buy-in. CEOs or other high-level administrators must consistently be at the table with their partners.

> **Building Relationships and Defining Decision Making** – Partnering hospitals and health centers must establish processes for distributing responsibilities and decision making for their value-based payment arrangement. This can be facilitated by building relationships through face-time and getting to know the goals and priorities of each partner.

> **Data and Information** – Sharing and leveraging data is an important tool for fostering collaboration and supporting value-based payment models. Additionally, the care coordination needed to reduce the use of expensive services and achieve shared savings is greatly facilitated by integrated data systems.

**Policy Considerations**

Value-based payment holds several considerations for safety net providers and their collaborative payment arrangements, as highlighted by the six lessons learned in this report. The following policy areas should be considered as health care continues to move toward value-base care and alternative payment models.

> **Sustainability** – Safety net organizations are making progress in value-based payment. These providers see the changes they have made (e.g., staff/team changes, care management approaches, new infrastructure, risk stratification of ACO patients) as improvements that they can and want to retain. Both state and federal policies are needed to support these efforts as long-term transformations, and could include a continuation of existing demonstration projects and grants, as well as new funding mechanisms that incentivize sustainability. Public policy solutions can translate into scalability on the ground. For example, safety net providers recognize the need to keep refining their models and make improvements, but are most interested in scaling to include other patients and other payers because of the widespread benefits they are seeing.

> **State Levers & Local Engagement** – What is possible for safety net partnerships is shaped by the policies and initiatives within a given state (e.g., DSRIP, PCMH, care coordination and payment model demonstrations, ACOs, Medicaid expansion, transition to Medicaid managed care). As implementation is further shaped by local market dynamics, it is important that states engage stakeholders in the development and implementation of value-based care models. This will enable policymakers to gain a better understanding of how potential changes could impact local communities and accelerate transformation of the health care delivery system.

> **Alignment** – Adoption and implementation of value-based care can be significantly facilitated by aligning alternative payment models with population health incentives. Future value-based
payment policies should move in a direction that enables and rewards the care team for meeting the needs of patients and achieving population health goals.

Overall, the transition to value-based payment is still a developing area for most of the health care sector, and especially for collaborative initiatives between safety net hospitals and health centers. Payers and policy makers will want to carefully consider the resources, infrastructure, and technical assistance that are needed to support safety net providers in making this transition, encourage provider collaboration and care integration, and avoid any disruption of progress made so far in moving towards value in population health.
APPENDIX A:
Collaborations Between Safety Net Hospitals and Health Centers around Value-Based Payment Strategies: A Case Study of the Medical Home Network ACO
INTRODUCTION

Medical Home Network ACO (MHN ACO) is a Medicaid Accountable Care Organization owned by 3 hospitals, their affiliated medical groups and 9 community health centers on the South Side and West Side of Chicago, Illinois. The hospitals and affiliated medical groups include Rush University Medical Center (RUMC, Rush Children’s, Rush Oak Park Physicians’ Group, and Rush University Medical Group); Sinai Health Systems (Sinai Hospital, Holy Cross Hospital, Schwab Rehabilitation Hospital, and Sinai Medical Group); and La Rabida Children’s Hospital. The community health centers, all Federally Qualified Health Centers, are Alivio Medical Center, Aunt Martha’s Health & Wellness, Chicago Family Health Center, Erie Family Health Center, Esperanza Health Centers, Friend Family Health Center, Lawndale Christian Health Center, PrimeCare Community Health and PCC Community Wellness Center. Since its inception in 2014, the ACO and its participating organizations have undertaken a transformation of health care delivery for their Medicaid population, including significant investments in medical homes, care coordination, real-time connectivity and data sharing between providers. The ACO has been successful in achieving shared savings since its first year, which has enabled its participating organizations to continue improving and expanding their services through ongoing investments in infrastructure and programming.

HISTORY

The MHN ACO is operated by Medical Home Network, a 501(c)3 not-for-profit healthcare organization founded in 2009 in partnership with a local foundation, the Comer Family Foundation, to improve healthcare for the Medicaid population and to address health inequities uncovered in a Comer-funded needs assessment:

- 40% of residents were uninsured or reliant on public insurance
- A high rate of immigration and migration of poor residents from city to suburbs caused increased demand for health services
- Providers had reduced access to services in some cases (e.g. closing pediatric/obstetric services, limited Medicaid referrals for specialty care)

The consulting group that conducted the needs assessment recommended the formation of public/private provider partnerships to address primary care, urgent care, outpatient specialty care and hospital care needs for Medicaid patients in each of 3 regions (Southeast, Southwest, and Far South). Rallying safety-net providers around a common cause to address disparities, MHN launched a Medicaid pilot project in 2012, working with the Illinois Department of Healthcare and Family Services (HFS) to test service delivery and payment innovations for more than 120,000 patients assigned to 12 partner safety-net organizations. MHN worked with partners to form the MHN ACO in July 2014 as a provider-owned limited liability corporation (LLC) with the goal of building on the successes of the pilot and taking the next steps toward value-based payment and delivery system transformation as Illinois made large-scale shifts of its Medicaid population to managed care. Medical Home Network, the 501(c)3, continued to provide managed services, leveraging the organization’s expertise and proven track record established during the original pilot.

The ACO includes a subset of the hospitals involved in the MHN pilot, and its community health center members include both organizations that had participated in the pilot as well as some that joined with
the formation of the ACO. At the time, the ACO partners had varying degrees of experience with value-based or pay-for-performance arrangements—some had extensive experience, while others were relatively new to value-based care.

**LEADERSHIP & COLLABORATION**

The MHN ACO partners with CountyCare, a Medicaid managed care plan run by Cook County Health and Hospitals System. CountyCare started in December 2012 as a demonstration project under an Illinois state 1115 waiver, which allowed HFS and Cook County to enroll newly eligible Medicaid beneficiaries prior to the official opening of the Medicaid expansion on January 1, 2014. CountyCare also aligned with the state’s goal of shifting its Medicaid program from fee-for-service to managed care, with 50% of Medicaid recipients required to be in “care coordination” programs by 2015. The founding of the MHN ACO coincided with the launch of the CountyCare health plan as a County Managed Care Community Network. Since Cook County Health & Hospitals System was part of the MHN provider collaborative, it had been “around the table” with the ACO partners for a long time already when it took on the new role as payer for the ACO.

The MHN ACO is provider-governed. Its governance structure is purposefully egalitarian: the Board of Managers includes an equal number of hospital and community health center partners, and the role of board chair switches back and forth between hospital and community health center representatives. Hospital and community health center partners also made equal financial investments in the ACO at the outset. The board helps to ensure protection for smaller partners by requiring a supermajority (¾ of the owners) for certain key decisions. The Board of Managers is responsible for strategic decision-making, and the ACO Clinical Committee, which also includes representatives of each partner organization, is responsible for programmatic decision-making. Representatives of CountyCare (mostly at the director/manager level) interact most directly with the Clinical Committee—interactions include weekly technical calls, monthly data reporting meetings, and quarterly/yearly strategy meetings (which include executives from both the ACO partner organizations and CountyCare).

**STRUCTURE & OPERATIONS**

*Medical Homes*

Most Medicaid recipients in Illinois are enrolled in a Medicaid Managed Care Organization (MCO), and are assigned to a primary care medical home. The medical home model has the same requirements for all enrollees, regardless of the specific managed care plan in which they enroll, although there is some variation in how different MCOs and providers/medical homes meet the state requirements.

CountyCare recipients are attributed to the ACO if they choose a PCP/medical home that is part of the ACO—either at one of the community health centers or primary care practices affiliated with Rush, Sinai, or La Rabida—when they enroll. Many MHN ACO patients were already patients of MHN ACO providers when Medicaid managed care was rolled out. They likely chose CountyCare (vs. other Medicaid managed care plans) because their existing providers were part of the CountyCare network, and they may or may not know that they are part of an ACO. The CountyCare network also includes providers who are not part of the ACO, so the ACO is not a “closed system”—patients can be (and sometimes are) referred to providers or hospitals who are part of the CountyCare network but not part of the ACO.
Care Coordination

Care coordination is a key aspect of the medical home model required by the Illinois Department of Healthcare and Family Services. As part of the MHN model of care, CountyCare delegates care coordination to MHN ACO providers; in other words, it pays a per member per month (PMPM) rate to ACO providers based on the composition of each provider’s enrollee population (percentage of low-income women and children, “expansion adults”, and disabled). The provider organizations themselves conduct care coordination activities such as health risk assessments (detailed below), following up with patients who have been hospitalized or visited the emergency department, connecting high-risk patients with community resources, etc. This contrasts with centralized care coordination, where the health plan itself conducts care coordination activities, with health plan staff contacting patients and providers via telephone or email. In the delegated care coordination model, care coordination staff are members of the care team, and they are able to meet with patients in person and participate in “warm handoffs” between providers (e.g. from primary care to behavioral health or social work). One clinician described MHN’s delegated care coordination model as critical to the success of the ACO:

“Here what happens, because care management is part of your care team, is that the patient walks in and now they’ve lost their housing, OK? It’s not like, what am I supposed to do? I open the door, the care manager comes in, and I give them a warm handoff...So I think having the support of the care coordinator, the care manager, right there in the practice is really key.”

Care coordination staff members include unlicensed care coordinators (sometimes medical assistants or other unlicensed clinical staff who have been reassigned to work on care coordination) and clinically licensed care managers (nurses or social workers). MHN ACO medical homes vary in the ways they structure practice-level care teams, at one medical home, for example, care coordination staff work in “triads” of one unlicensed/lay care coordinator or “navigator”, one nurse care manager and one social worker care manager. Unlicensed care coordinators conduct health risk assessments (described below) and track/contact patients, while nurse care managers work on (e.g.) transitions of care for patients who have been hospitalized and social work care managers work on (e.g.) behavioral health needs or social determinants of health—housing, food security, etc. One case study participant noted that having licensed staff members as part of the care coordination team was especially helpful for building trust with hospital staff members, who feel more comfortable working on transitions of care with clinically licensed rather than unlicensed staff.

Some medical homes have internal mechanisms for care coordination staff to escalate particularly complex cases when needed, and all medical homes have access to a centralized complex care coordination (“4C”) program for patients with severe needs. The 4C team for patients is housed at Rush, but they can take referrals from any care coordination staff members across the ACO. The team provides services ranging from phone consultations for care coordination staff to temporarily taking on care coordination for patients whose needs are too complex to be addressed at the medical home. Even with this extra support, some participants reported that their care coordination teams sometimes felt overstretched and struggled to address all of their patients’ needs even with maximum resources.

Health Risk Assessments

Another key aspect of the MHN model of care is its health risk assessment (HRA) tool, which it uses to risk stratify ACO patients according to their health status and social determinants of health. The state
required all medical homes to develop and use a screening tool, and MHN leaders decided to take a “very comprehensive” approach to risk assessment. In addition to assessing health and healthcare history, the HRA also considers 11 socio-economic and behavioral health factors (e.g. how patients view their own health, food scarcity, housing, transportation, depression, and substance use) that are predictors of engagement with care coordination and healthcare utilization (“who we will see” in the medical home, as one participant described it). It is built into MHN’s care coordination platform (described below), and it uses an algorithm to stratify patients into high, moderate, low and “low with social determinants” risk categories.⁶

In alignment with IL DHFS requirements, the ACO has a stated goal of conducting health risk assessments (usually by unlicensed care coordination staff) for all ACO patients within 60 days of enrollment, and it tracks the completion of HRAs in real time in its care coordination platform (described below). Patients who are identified as moderate and high risk receive comprehensive risk assessment care plans. Care coordination staff members conduct monthly care planning with patients identified as high risk, and quarterly care planning with patients identified as moderate risk. More than 85% of ACO patients have been assessed and risk stratified using the HRA—higher than any other MCO in Illinois.⁷

MHN has tested and validated the HRA tool as a predictor of utilization for the ACO’s “expansion adult” ACA population, and it is revising it for testing in the low-income, family health plan adult population. Its leaders are also looking to add disease-specific risk assessments in the future. They have begun implementation of a depression-specific care management program that builds off of the depression screening embedded in the HRA and triggers the involvement of behavioral health care managers and therapists for patients who screen positive for depression above a specific threshold.

Connectivity, Data Sharing & Analytics
MHN ACO uses MHNConnect, a cloud-based care coordination exchange developed and operated by Medical Home Network and Safety Net Connect. MHNConnect supports the ACO with its data sharing and analytics capabilities and provides the entire care team with a “360 degree” patient view by integrating multiple disparate data sources into one, actionable system. MHNConnect virtually integrates the healthcare ecosystem, connecting to over 22 hospitals in the Chicagoland area to receive real-time alerts as patients move throughout the system, and supplementing them with historical claims, prescriptions, and care management data. ACO members use MHNConnect as the central hub of care management activity, acting on specially designed worklists to carry out requisite care management programming (such as HRAs), to coordinate follow-up care after emergency room visit, and inpatient admissions, as well as to understand pharmacy utilization for their patients. Medical Home Network supplements MHN ACO members’ efforts with ACO clinical integration dashboards, which include a variety of care coordination measures (e.g. care plan completion, follow-up within 7 days, patient outreach), health risk assessments, as well as data needed for external quality reporting (e.g. NCQA, HEDIS). In the spirit of transparency, MHN makes facility-level data visible to its members, which leads to friendly competition and best-practice sharing between ACO members, further contributing to achievement of quality indicators.⁸

MHNConnect is not an electronic health record (EHR); it can share some information with EHR systems, but does not replace the use of EHRs. MHN ACO members are not required to have the same EHR system, so MHNConnect is the common information vehicle between and among partners. Medical Home Network has undertaken an interoperability project to more seamlessly integrate information
into clinical workflows so that the right information is always accessible in the right place; an important step in mitigating the pain point caused by duplicate entry between two systems.

Care coordination and care management staff members are the main day-to-day users of MHNConnect at most MHN ACO provider organizations. They document health risk assessments and care plans in the platform, which feeds back information to guide care management workflows. The system also integrates resources to help identify community-based organizations that can help patients with particular social determinants of health raised in their health risk assessments.

The use of MHNConnect as the central hub for care management has evolved over time as State of Illinois oversight and requirements for delegated care management have grown more sophisticated. The guidance on where the detailed information about care coordination “lives” (MHNConnect vs. EHRs) has changed since the ACO began and first received HFS approval for delegated care management: care coordination staff originally documented the details of care plans in their organizations’ EHR systems and only noted their existence/completion in the MHNConnect platform. However, in response to new feedback from HFS auditors, requiring that care management be done in the context of real-time alerts and historical claims, like those available in MHNConnect, the MHN has developed workflows and technical capabilities that enable care coordination staff to fully document care management within MHNConnect. The new workflows also help to streamline and standardize care coordination staff members’ activities across facilities and updates to the MHNConnect system provide functionality with a focus on actionable and automated care management process flows that are not typical within EHRs.

While most participants reported that providers do less of their daily work in the MHNConnect platform compared to other care team staff, the platform includes other modules that are a part of Medical Home Network’s suite of care management tools, such as an “e-consult” function, which enables primary care providers to obtain electronic specialty consultations from over 40 specialties at CCHHS. One participant estimated that for their MHN ACO patient population, 35% to 40% of specialty consultations were initially conducted using the eConsult function in the platform. He gave the example of a dermatology consultation—instead of waiting months to make an in-person appointment for a patient, a primary care provider could send a photo and information to a dermatologist and receive a response within 48 hours in the platform, potentially replacing the need for a face to face specialty visit entirely.

**Distribution of Shared Savings**

CountyCare conducts quarterly reconciliation to determine the amount of shared savings the ACO has achieved. Medical Home Network distributes any earned savings to the ACO member organizations using a methodology that accounts for clinical and financial performance. In addition to total cost of patient care, each organization is also evaluated on a set of measures (one for hospitals and one for primary practices), many of which are tied to the data and care management processes that flow through the MHNConnect system. Organizational performance on these measures has downstream impact on their shared savings earnings. For example, one of the key performance indicators measures the percentage of hospital inpatient discharge patients who have a follow-up appointment at their medical home within 7 days. To achieve this, care coordination staff leverage real-time MHNConnect data to track patient discharges, coordinate with hospitals, and engage with patients. The ACO providers only receive shared savings for this measure if they initiate “transitions of care” back to the medical home for at least 35% of ACO patients within 7 days. The ACO hospitals are also evaluated on
how patients rate their discharge process, and they must achieve a specified target (relative to the “market”—all of the hospitals on the MHNConnect platform) to receive a portion of the shared savings for this measure.

A significant percentage of shared savings are also held at the ACO level to help maintain the egalitarian investment and governance of the ACO. MHN leadership structured it this way to ensure that funds are available at the ACO level for future capital investments so they would not have to go to the “deep pockets” (hospitals) for funds, thereby offsetting the balance between hospitals and community health centers in investment and decision-making. This has resulted in clinical program investment, such as the launch of a Collaborative Care Model for integrated depression management as well as the funding of robust risk reserves to provide a financial “cushion” as the ACO advances into a value-based model that accepts downside risk.

Shared savings earned by and distributed to ACO members are unrestricted and cycle dollars directly back into the safety-net delivery system; some ACO providers have used shared savings to add or improve services for all of their patients, not only ACO patients.

**CHALLENGES & SUCCESSES**

*Challenges*

The ACO partners have faced several challenges in transforming their care models and building information sharing capacity to support the ACO goals. One case study participant likened the process to “building the plane while flying” since the partners had no preexisting model to draw from, other than the Medical Home Network pilot, and have largely had to learn by trying/doing all while maintaining their current operations and adapting the MHN model and tools to their organizations.

Some of the challenges faced by the ACO partner organizations are related to the difficulty of serving a high-need Medicaid population. While they have been able to make contact with and engage a large percentage (more than 85%) of their assigned patients, the remaining ~15% of ACO patients have not responded to care coordination staff’s efforts. Many of these are previously institutionalized or homeless patients who may not have stable housing and/or reliable methods for care coordination staff to contact them. One participant pointed out that while the medical home-based care coordination model was closer to patients than a health plan-driven centralized care coordination model, it may not be able to meet the neediest patients where they are—in their homes, on the streets, or moving between provider locations. (“Boots on the street” are still in the healthcare facilities rather than actually “on the street”.)

In addition to the difficulty of tracking and contacting some ACO patients, participants also noted several other destabilizing factors that made their efforts to provide coordinated care more difficult. Illinois Medicaid recipients are required to “redetermine” their eligibility for Medicaid annually. The process is currently conducted using a paper form, so ACO partner organizations are constantly working to identify patients up for redetermination in given month and make sure they complete the paperwork to remain eligible for Medicaid (and the ACO). They also must determine how to handle care coordination and other ACO-specific services for patients who lose coverage due to gaps in the redetermination process (or for other reasons).
Medicaid redetermination is only one source of “churn” or complexity for ACO partner organizations to manage. At all partner organizations, ACO patients are only a subset of all patients seen by ACO providers—ACO providers see ACO and non-ACO patients, and sometimes ACO patients are a very small percentage of their overall service populations. Also, the ACO is not a “closed system” of providers, so there are still elements of ACO patients’ care they cannot manage directly even with the MHN’s enhanced care coordination and data sharing tools. The CountyCare network includes both ACO and non-ACO providers, so patients—who are allowed to switch primary care providers up to once a month—could switch to a different primary care provider who is still in-network but not part of the ACO. (One participant noted that the average patient is on CountyCare for 9 months.) Patients can also move in or out of the ACO if they switch between CountyCare and another Medicaid managed care plan, which HFS allows patients to do once a year during an open choice period. Providers could also refer to specialists or hospitals that are in-network for CountyCare but not part of the ACO. Most local healthcare organizations are both connected to and have access to MHNConnect, so they are able to share real-time data—but in instances where patients utilize facilities or services not connected to MHNConnect, the care coordination staff does not get the benefit of real-time data or “warm handoff” transitions of care that MHNConnect affords.

Other challenges relate to the information sharing and documentation needed to support the ACO. For example, the MHN’s medical home-based care coordination model means that multiple organizations with different EHR systems have to work together and share care coordination and utilization information with each other—and as recently instructed by HFS Auditors, this must take place in a centrally accessible system that streamlines workflows and provides actionable views of key data inputs, like claims and real-time alerts, which today’s EHRs do not provide—because the ACO has not required individual organizations to be on the same EHR system (there are 6+ EHRs in operation across the ACO). Instead, the ACO uses MHNConnect as the central hub to share ACO patients’ care management data (health risk assessment, risk stratification, care plans, etc.) along with real-time hospital data and the historical claims and prescription data that provide context. As a result of using the cloud-based MHNConnect system for the care management programming—and EHRs for day-to-day clinical operations—at each ACO organization important information “lives” in both the EHR and MHNConnect. While MHNConnect can share some data, like care plan summaries, with EHRs, data sharing overall is limited. Also, different care team members may do their work in one or the other depending on their role—e.g. care coordinators do much of their work in MHNConnect, but clinicians may only access the EHR regularly. One participant suggested that the lack of seamless data exchange between MHNConnect and the various EHR systems at different partner organizations could be a source of frustration for some clinicians:

“I think one of the challenges is that our care management solution is cloud based, but is not part of their EHR. They would love to do work completely in their EHR. It’s just that the interoperability isn’t there yet, and...what you hear time after time is why can’t this all be in my EHR? Well, your EHR is not going to take in all the claims there like MHNConnect can. We’re getting daily pharmacy feeds, you know, we’re getting all the HRA in MHNConnect. The EHR is not really built to do care management, but it’s still a frustration for them.”

Again, as HFS’s thinking regarding delegated care management grew more sophisticated, MHN was instructed by auditors that a centrally accessible repository for care management data was necessary
and MHNConnect fulfills this requirement. Another participant expressed the difficulty associated with only being able to document care management activity in the MHNConnect system for their ACO patients because it results in dual processes: one for ACO patients and one for all other patients.

Participants reported a few other challenges related to quality measurement and the calculation of shared savings. They noted that even with all of the added resources for ACO patients it is difficult to “keep all of the balls in the air” with respect to quality metrics. Instead, partner organizations may focus on a specific measure at a time and show significant progress, which then drops off when they shift focus to a different measure. They did not believe this was due to lack of resources, although they acknowledged that it would be easier to see sustained improvement if they had the resources and incentives for all of their patients (not only those in the ACO). Also, they noted that the long lag time required for the collection of claims data and the calculation of shared savings made it difficult to link current care coordination efforts or other process changes to past performance outcomes and shared savings. They hoped the turnaround time for claims data would improve and one noted that they were able to use real-time utilization data and reporting from MHNConnect to predict performance in the meantime.

**Successes**

Despite these challenges, case study participants universally described their experiences working with MHN ACO as a dramatic step toward integrated, coordinated care for a needy patient population, and they felt that that the investments that their organizations had made in the ACO—hiring new staff, building information sharing infrastructure, etc.—were worthwhile and valuable. Several noted that they wished they could provide the same services they offered to ACO patients to all of their patients, regardless of payer.

CountyCare staff members also spoke positively about the relative ease of working with a single entity—the ACO—rather than the 12 partner organizations as separate entities. They reported a strong working relationship with MHN leadership, and noted that the MHN ACO structure simplifies decision-making and alignment between the health plan and the providers and enables them to work together to maximize their impact on patients’ health outcomes.

MHN’s medical home-based care coordination model—including the integration of care coordination staff into medical home care teams, health risk assessments and stratification, and real-time information sharing through MHNConnect—has led to several key successes on critical ACO benchmarks:

- **High rate of patient engagement:**
  - More than 85% of MHN ACO patients have completed health risk assessments (2.5 times the rate at other Illinois medical homes).

- **Lower utilization of expensive services:**
  - MHN ACO patients had 493 inpatient days per 1000 (vs. 547 per 1000 by patients at other medical homes) in Year 1 and 521 per 1000 (vs. 693 per 1000) in Year 2.
  - MHN ACO patients had 729 emergency department visits per 1000 (vs. 885 per 1000 by non-MHN patients) in Year 1 and 658 per 1000 (vs. 770 per 1000) in Year 2.

- **Shared savings:**
  - $17.7 million in shared savings during Year 1
  - $10.8 million in shared savings during first half of Year 2
In addition to its performance on these ACO benchmarks, participants noted that the MHN ACO had achieved several other key successes. They described the infrastructure and workforce investments made possible by participating in the ACO as durable and long-lasting—not like short-term grant funded projects that might disappear after the grant ended. One participant also suggested that participation in the ACO had pushed its primary care partners (community health centers and hospital-affiliated primary care practices) to grow into their roles as medical homes—not thinking of themselves as specializing in a certain population or condition, but instead learning to manage “cradle to grave” needs of their patients:

“I definitely see that the provider groups, the medical homes themselves, have had to grow to address a broader scope of clinical needs and coordinating clinical needs. I truly believe that it was possible to pick and choose the areas that you do well before [the ACO]. So it was possible that a community health center was able to say we’re really going to take on comprehensive diabetes care, but...we’re not strong on pediatrics. [Or] we can see the kids, but we don’t have any programs built out or vice versa. [Or] very strong maternal child health programs and a bit of avoidance of complexity in other populations. This [ACO] has required each of the organizations to grow their clinical care coordination capacity...they’ve all grown in terms of their generalist ability to manage cradle to grave needs...I think they’ve also had to grow in their ability to see other parts of the health system.”

Another participant described several workforce development efforts that both support the needs of the ACO partner organizations and provide opportunities for community members to pursue healthcare careers. These included a BMO Harris Bank grant-funded partnership between Rush/MHN and Malcolm X College (a City College of Chicago) to provide training for community health workers/care coordinators, along with several scholarship, fellowship and training opportunities. Participants described this relationship as mutually beneficial for MXC, which was designated as a destination for healthcare education in City Colleges of Chicago’s “Colleges to Career” initiative, MHN and the students who would have new opportunities for education and work as a result of the initiative. One described the care coordinator training program as an “entry level pathway” to healthcare employment:

“We would really like to see some of these folks go to Malcolm X and go through the -- it’s called community health worker, but care coordinator [course]. We believe that if they get their two-year degree, then they might then look at some of their colleagues and say, ‘I’d really like to be nurse or a social worker or something else in healthcare.’ And then they might go on and get a four-year degree, and then maybe a master’s degree as well. So, it provides that entry level pathway.”

Participants also described several other workforce development efforts, including MHN developed training & certification for care coordinators/managers, which these staff members can use on their resumes, as well as other training efforts for unlicensed care coordinators (including topics like health assessments/diagnoses, behavioral health, social determinants, and social justice).
LESSONS LEARNED FROM THE MHN ACO EXPERIENCE

Case study participants noted several factors that were critical to the success of MHN ACO in developing unified approaches to care coordination, information sharing and quality improvement across a large and varied group of partner organizations.

**Aligned mission and vision:** The most prominent and frequently mentioned key to successful implementation of the ACO transformation was the egalitarian relationship and sense of shared mission between the participating hospitals and community health centers. The ACO includes some very large organizations and some very small ones, which could set up an unequal power dynamic, and the community health centers have sometimes considered each other to be competitors. However, strong existing relationships and equal financial investments from all partners has led to “leveling” of relationships between hospitals and community health centers. As participants noted, “nobody [has] a louder voice than anyone else”, and partners “check institutional identity at the door” in working toward the shared goal of improving the health of the ACO population.

**Trust and relationships:** Many of the partner organizations had already worked together for a long time, whether through the MHN provider collaborative or other collaborations, so they trusted each other’s commitment to the mission of the ACO. They also had a strong working relationship with Cook County Health & Hospitals System, which meant that CCHHS and the ACO partner organizations were known entities to each other when CCHHS, through the CountyCare health program, moved into the role of as a payer partner for the ACO.

**ACO leadership and personnel:** Participants cited several key choices about the specific people or roles involved in developing and launching the ACO that have been critical to its success:

- Engaging stakeholders using a diverse team for ACO operations/clinical integration implementation—experienced in a variety of settings and perspectives.
- Cultivating provider champions—clinical leaders from each organization who are members of the ACO Clinical Committee and help lead ACO aligned cultural change and practice transformation initiatives within their practices.
- Establishing a shared vision and commitment amongst CEOs of partner organizations; MHN ACO collaboration requires the right people at the table.

**Aligning incentives for engagement:** While partner organizations learn and adjust as they implement the ACO model, participants also emphasized the importance of starting to act and make change sooner rather than later. Even “small wins” are helpful for demonstrating the potential of the model and keeping partner organizations motivated and “at the table”. MHN ACO members have remained motivated because they have been actively engaged in practice transformation from the beginning and because MHN created incentives for practice redesign that ensure their ongoing commitment to success.

**Engaging clinicians and staff:** Participants also noted the importance building leadership within their organizations, especially clinicians, to lead change efforts that accompany the roll out of the MHN model. Some said they have framed the practice changes in the context of the ACO and the collaboration with CountyCare, while others said they tried to build them “into the DNA” of the
community health center, hoping to extend changes brought about by implementing the MHN model of care to all patients.

**Tracking both process and outcome indicators:** Because MHN ACO includes so many partner organizations, using a health IT platform that allows for data sharing between and among providers is paramount. Participants noted that it was especially important to track process indicators in addition to outcomes. Heterogeneity is to be expected with a decentralized, medical-home based care coordination model, especially when the organizations are as disparate as those in the MHN ACO. While partner organizations may use different approaches/workflows to pursue the ACO goals, having a central care management hub for population level health management and tracking standard process indicators makes it possible to understand and evaluate processes (e.g. how a particular workflow is or is not helping to reach an ACO goal).

**Understanding a changing environment:** Finally, participants emphasized the importance of ACO partner organizations understanding how to be flexible and accommodate changes to programs and obligations—amidst a changing and challenging Medicaid environment. This has been a new experience for some community health centers and hospitals, but their participation in the ACO has helped to steady their footing on the uncertain healthcare landscape, allowing each organization to grow and evolve alongside partners like CountyCare, and setting the ACO up for success in the value-based marketplace.
REFERENCES


APPENDIX B:
Collaborations Between Safety Net Hospitals and Health Centers around Value-Based Payment Strategies: A Case Study of the Adirondacks ACO
INTRODUCTION
The Adirondacks Accountable Care Organization (ACO) was established in 2014 under the Medicare Shared Savings Program (MSSP). A hospital-community health center (CHC) partnership between Champlain Valley Physicians Hospital (CVPH), owned by University of Vermont Health Network (UVMHN), and Hudson Headwaters Health Network (HHHN), the ACO serves patients across Vermont and northern New York. The collaboration between CVPH and HHHN predates the Adirondacks ACO and was established through a 2010 New York state Patient-Centered Medical Home (PCMH) pilot funded by the Centers for Medicaid and Medicare’s Innovation Center’s (CMMI) Multi-Payer Advanced Primary Care (MAPCP) demonstration project. The PCMH was fundamental to the development of the ACO collaboration, leadership and delivery system infrastructure. Transformation and organizational systems were translated into the ACO framework with the idea that once the medical home pilot was completed, much of the work accomplished and patients served would continue through the ACO. The built infrastructure of the PCMH project, as well as contracts with local and regional payors, provides care to commercial, Medicaid, and Medicare beneficiaries; the ACO currently only serves Medicare patients as part of the MSSP ACO.

The two equity partners of the Adirondacks ACO are CVPH/UVMHN and HHHN. UVMHN is a highly integrated, five-hospital network across northern New York and Vermont. The hospitals included in the health system are The University of Vermont Medical Center in Burlington, VT, Alice Hyde Medical Center in Malone, NY, Central Vermont Medical Center in Berlin, VT, Champlain Valley Physicians Hospital in Plattsburgh, NY, and Elizabethtown Community Hospital in Elizabethtown, NY. UVMHN aims to centralize care to improve purchasing power, health information technology, academic opportunities for physicians, regional strategic planning, local access to care, and joint quality and clinical initiatives. Since 2011, UVMHN has been developing relationships with physicians within the catchment areas of each hospital, and currently employs “a significant proportion” of the physicians in each community, according to one study participant. Champlain Valley Physicians Hospital (CVPH) initially led the development of the Adirondacks ACO and was one of the principal stakeholders along with HHHN in the New York PCMH initiative. CVPH joined the UVMHN health system in 2013. Though a system within the larger UVMHN system, CVPH is the primary hospital leading the collaboration and governance of the ACO.

HHHN is a large not-for profit system of 17 community health centers that serve upstate New York. A Federally Qualified Health Center (FQHC), HHHN aims to improve quality and access to care for everyone in their communities, regardless of income or insurance. HHHN employs almost 180 providers and cares for over 100,000 patients. Currently HHHN spans a large geographic area that is inhabited by a small population (5000-6000 square miles with ~300,000 people). The payer mix reflects the Adirondacks North Country and Glen Falls region, and is largely comprised of commercial and Medicare patients. Medicaid is the third largest payer in the network. HHHN is the dominant and largest medical practice in the Adirondacks, providing “60% of the primary care in the area according to one participant. In certain rural areas of the region, HHHN is the only medical center, or only safety-net provider. HHHN is focused on continuing to expand its “footprint” in the community. These partners have come together in the Adirondacks ACO to reach the triple aim for their respective communities.
HISTORY OF AND NEED FOR HEALTH CARE COLLABORATION IN THE ADIRONDACK REGION

The history of the partnership between CVPH (UVMHN) stems from a shared need to address primary care capacity in the North Country of the Adirondack Region of upstate New York and goals to improve population health. The North Country comprises a group of rural counties with significant geographic dispersion, which has resulted in a fragmented primary care network and inefficient health care usage with substantially higher avoidable admissions than other counties in the lower Adirondack area, according to study participants. These negative conditions were exacerbated by the economic depression in 2007, low Medicaid reimbursements and low volumes of patients, all of which have created disincentives for primary care physicians to stay in the region. As a result, the North Country has experienced a significant exodus of primary care physicians, which has made the already fragmented network of care even more fragile. According to one interviewee, the area lost 22% of its primary care workforce across an 18-month period, setting off a ripple effect of reduced access, increased cost and lower quality of care.

Under a rural network grant from the Health Resources and Services Administration (HRSA), health care providers in the area counties came together to discuss the health care crisis and potential solutions through collaboration. Health care leaders in the region realized that the departure of primary care physicians, low number of patients, lack of income to incentivize physician retention, and limited capacity of care in the rural area, could be improved by collaboration. In 2010, a coalition of 3 community and critical access hospitals and an FQHC came together to form a PCMH pilot project as part of the New York State MAPCP demonstration initiative. HHHN and CVPH led the formation of the PCMH, which was a five-year multi-payor pilot program focusing on improving access to and quality of primary care in the area. The PCMH program included a $7 per member per month prospective payment to incentivize primary care provider (PCP) retention, increase care management to improve quality, and build the administrative and health information technology (HIT) data needs to track care, increase efficiency and reduce costs. The PMPM payment was contingent on the successful transformation of care in the area and meeting specific quality and cost goals, as well as attaining National Committee for Quality Assurance (NCQA)-recognition. For the Northern Adirondack collaborative, leaders of the medical home pilot used half of the payment to build the infrastructures needed and half for physician incomes to incentivize retention. To increase collaboration on the payor side, New York State granted the MAPCP project antitrust immunity allowing eight payers, as well as Medicaid and Medicare to participate in the PCMH multi-payor pilot.

The PCMH pilot was extremely successful in building an extensive care management infrastructure through health care pods across the region, using data to coordinate and keep track of health measures, such as score cards for chronic illnesses to help manage populations, and creating care management teams to coordinate around patient needs. In addition, all practices participating in the PCMH pilot successfully achieved NCQA-recognized medical home status. According to participants in the study, the PCMH pilot dramatically impacted quality and cost of care, as evidenced by both quality reports and Medicaid cost savings, which were reported to be approximately 15-20%. Furthermore, the PCMH pilot served to solidify the partnership between safety net and rural health care institutions across the region.

5 The North Country of New York is comprised of Clinton, Essex, Franklin, Jefferson, Lewis, St. Lawrence, Hamilton, and Warren County.
including HHHN and CVPH. The partnership has been a springboard for other initiatives, including a residency program rotation at HHHN for UVM residents and a new HHHN community health center site in Plattsburg, funded in part by UVMHN, to increase access to primary care in an especially poor community, as described by study participants, where access is limited. These initiatives have built up the partnerships and collaboration that were integral to the foundation for the development of the Adirondacks ACO.

TRANSITION TO THE ADIRONDACK ACCOUNTABLE CARE ORGANIZATION

Based on the success of the PCMH pilot, HHHN and CVPH, along with the other hospital and provider members, understood the benefit of collaboration in improving quality and access to care, and incentivizing physicians to stay in the area. As the completion date for the PCMH pilot approached, the partners began to explore new sources of support and funding to sustain progress that had been made. UVMHN had recently established an ACO, OneCare Vermont, and was interested in establishing a similar value-based model of care in upstate New York with CVPH as the lead. The Adirondacks ACO started in 2013 as part of CMS’ Medicare Shared Savings Program (MSSP).

HHHN was involved in the initial ACO development as a member, but quickly transitioned to an equity partner with UVMHN/CVPH in 2014-2015. The induction of HHHN as an equity partner was based on the need to have a highly integrated approach to care based on a strong primary care base. As an FQHC, HHHN is uniquely situated because of its strong commercial payor mix, which was an important feature for the Adirondacks ACO. Thus, given HHHN’s strong presence in the Adirondack community, their care management approach and the high number of attributed lives they bring to the partnership, they were an ideal partner for the Adirondacks ACO.

The impetus behind the Adirondacks ACO stemmed largely from a desire to continue the impact of the PCMH pilot project, but also from the shared goal of both CVPH and HHHN to improve population health, advance quality of care, and increase both financial and clinical accountability among the providers in the area. As one participant noted:

“From an overall philosophy and vision - we believe strongly that the way to develop the highest quality, most efficient delivery system is to move away from the current FFS world where there is bifurcation of accountability for clinical decision making and outcomes, that would be us on the provider side, and accountability for the financial aspects of funding healthcare which now rests traditionally with the payers. And we’re very driven to bring those accountabilities together, and to take that accountability on the provider side.”

Both UVMHN/CVPH and HHHN saw the Adirondacks ACO as an opportunity to create a framework and infrastructure that would bring the provider community together around these goals and to ultimately share the risk and the savings for an attributed population, which has initially been the Medicare population. While still in its infancy, the Adirondacks ACO transitions the PCMH program with the same attributed membership to a risk-based contract administered by the ACO. In addition, the Adirondacks ACO has brought in additional providers that were not originally in the PCMH project, and are still interested in functioning as independent practices. And although the ACO currently is only a Medicare Shared Savings Program, leadership is working with all of the payers included in the PCMH pilot to transition their patients into the ACO. On the Medicaid side, the ACO is also seeing the benefit of the
New York state Delivery System Reform Incentive Payment Program (DSRIP) funding to help build infrastructure, such as the new HHHN site in Plattsburg. The purpose of the DSRIP funding is to “restructure the health care delivery system by reinvesting in the Medicaid Program” by promoting community level collaborations.4

LEADERSHIP AND COLLABORATION WITHIN THE ADIRONDACKS ACO

UVMHN and HHHN share equal equity of the Adirondacks ACO. In the partnership, each entity brings important elements to the Adirondacks ACO. CVPH, backed by UVMHN, brought the necessary initial investment into the ACO and the experience and lessons learned of establishing the OneCare Vermont ACO. In addition, CVPH brings economies of scale in terms of building the informatics, the care management infrastructure and the actuarial and financial expertise of operating an ACO. HHHN brings a “highly functioning, integrative primary care base,” according to one study participant, which is critical for the success of any ACO. As one participant representing UVMHN noted, “The cost and time involved in developing that when you have HHHN right there in the environment, it was not even a contest. So it made all the sense in the world to reach out to the leadership of HHHN and say ‘Hey what’s your plan? Do we want to do this together?’”

Given the shared goals and the mutually beneficial partnership, the executive leadership of both organizations came together and agreed to include HHHN as an equity partner. While at times the ACO may appear to exacerbate tensions between the hospital and the FQHC, the dynamic of the partnership is successful based upon open communication to ease competing motives, prevent manipulation or harm of one another, and share learnings, according to study participants. The tensions inherent in the hospital-FQHC partnership revolve around competing bottom-lines. In the Adirondacks region, some tension initially existed between perceived threats that the FQHC was hoping to overhaul hospital outpatient services and that the hospital wanted to drive higher utilization rates. The reality was that neither organizations was motivated to succeed at any expense. Both organizations understood the necessity of new, evolving approaches to improve population health, and a genuine desire to engage in collaborative work towards achieving the triple aim. Early communication helped HHHN and CVPH detect those commonalities so that both providers in the community could come together and openly communicate their goals for the population. There was a shared culture and value system that supported and promoted this collaborative model. Currently all tensions are mitigated by thoughtful consideration of how internal decisions may impact the partnering organization and the health of the population. This is done by strong working relationships across the leadership board.

STRUCTURE, OPERATIONS AND FINANCIAL ARRANGEMENTS

Given the early stages of the ACO, the primary operational goal is to transition the care management, data infrastructure and other population health initiatives of the PCMH pilot into the ACO structure. The PCMH pilot provided infrastructures that accelerated the transition into risk associated, value-based contracts. However, the transition of the medical home pilot into the ACO also allows for expansion of providers and benefit plans that were not participating in the PCMH pilot.

One of the early challenges of the structure of the Adirondacks ACO was the perception among local providers that the ACO was financed by UVMHN and operated by CVPH with the intent of subsuming smaller hospitals and primary care providers in the Adirondack area. The hospital has worked hard in the early stages of the Adirondacks ACO development to adjust that view and position the ACO as a
provider run model of care that is not driven by one single provider. The partnership with HHHN has helped to alleviate much of that concern.

In addition, the partnership is looking at how to transition from a shared savings model to a risk-based model and negotiating with both Medicaid and commercial payers who have been involved in the PCMH to participate in the ACO. From a financial perspective, the two equity partners finance the operation of the ACO equally, in line with their 50-50 equity partnership. Because there is no revenue currently flowing into the ACO, and no shared savings as of yet, there is no division of profit. From an operational standpoint, the PMPM that had been paid to each practice will now, as of January 1, 2017, be made to the Adirondacks ACO. In the Adirondacks ACO model, funds will still be distributed evenly between physician incentives and central infrastructure support, but will be allocated to each of the regional care pods established under the PCMH pilot. This arrangement will only last until the expiration of the PCMH pilot project. The Adirondacks ACO has applied for and been granted another 3-year MSSP period with upside risk only, allowing the ACO to continue to build clinical care and payment structures in preparation for taking on downside risk arrangements.

The ACO employs an interim CEO to help with the transition and to continue to negotiate with payers. In 2018-2019, the risk parameters that are established may change the payment structure. The Adirondacks ACO leadership is actively negotiating with commercial payers to participate in the ACO and the shared risk model. Each payer, however, differs in the amount of risk they are willing to take, and the ACO is working to maintain consistency across all commercial payers. As a key informant explained, current negotiations are aimed to ensure consistent risk bearing arrangements: “New York state aims for 80% of payments to be value-based by 2020. As a result, the goal is to move towards a multi-payer ACO as an avenue to succeed in ’18 and ’19 with new data infrastructures that reduce total cost of care so that the ACO is prepared for value based payments by 2020.”

In 2014, New York state received an 1115 Medicaid DSRIP waiver, which also adds to the financial structure of the ACO, though indirectly. The main purpose of the federal and state-sponsored DSRIP program is to fund an overhaul of the Medicaid health care delivery system, focusing specifically on infrastructure and system redesign. DSRIP funding is being used to support and promote collaborative provider networks with the goal of reducing unnecessary hospital admissions by 25%. The Adirondack Health Institute (AHI) is the regional body managing DSRIP funds in the Adirondack region. Approximately $187 million have been allocated to the region across the span of five years. Funds flow through AHI and are distributed to participating organizations in the Adirondacks region as performance metrics are met. The funds are project-driven and support delivery system re-design (rather than care managers’ income, etc.). While the ACO itself does not directly receive funding from DSRIP, many of the providers who are members in the ACO are participants in the DSRIP funding, and the two initiatives run parallel in terms of their goals of value-based care. Thus, the Adirondacks ACO sees the benefit of improved effectiveness and efficiency among those providers working on the DSRIP project, and the DSRIP program sees performance enhancement from the achievements of the Adirondacks ACO.

CLINICAL CARE
The approach to clinical care in the Adirondacks ACO relies on the care delivery structure and care management approach developed as part of the PCMH project and the transformation of care to achieve NCQA medical home recognition. The medical home pilot organized care into three regional pods: Lake George (which is overseen by HHHN), Northern Adirondacks (overseen by CVPH) and Tri-
Lakes (overseen by AHI). Each pod makes decisions on care and operations based on the circumstances of the patient and provider population in that region. Using some of the resources from the medical home PMPM, providers in these pods have invested in building the infrastructure for care management and improved clinical care.

The Lake George pod houses HHHN, which is a closed system where decisions on expansions and allocation of funds are made internally by HHHN leadership. All care management is team-based, because care managers are embedded in the HHHN clinic sites and able to see patients during clinical visits. The immediacy of having a care manager on-site helps eliminate the disconnect of the services provided by care managers, and reframes care as a team-based approach rather than siloed services. The care management team has also been expanded to include social workers and community advocates to help identify community resources that can address many of the social determinants of health. The program, which began with 5-10 case managers, has expanded to over 50 nurses, social workers, and community resource advocates.

According to participants in the study, the investment in building the care management infrastructure has transformed how care is delivered at HHHN, resulting in improved quality, better patient experience and cost savings. In addition to the increase in care providers, HHHN focused on building the health information technology (HIT) as part of the infrastructure to transform care. HHHN uses AthenaHealth to track and measure performance and utilization. HHHN’s analysis of the data has identified other areas for quality and cost improvement, including ED overuse, behavioral health management and transitions in care from the hospital to home.

By comparison, the Northern Adirondacks region, which includes CVPH, as well as a network of independent physician practices, has set up a central services model where CVPH serves as a management services organization for the network of providers in the region. Through an essential services agreement, CVPH used a portion of the PMPM resources to develop an extensive care management network, which now comprises 25 FTEs, including registered nurses, social workers, pharmacist and a director. CVPH serves as the centralized management of these providers and their employer of record. For practices that are interested in care management services, care managers are deployed to the practice to address patient needs on site as needed. Some practices are large enough and the need is consistent enough that care managers are fully embedded into the care teams. For many smaller practices, however, the interest and ability to fully embed care management workers into the care process is more challenging as it is difficult to ensure patients will want or need the services. Thus, care managers are utilized on an as needed basis with a rotation of managers that may not have the continuity of a fully embedded care manager. CVPH’s approach stems from the desire to reduce duplication of services and the creation of care that is not warranted or wanted. As a result, their model facilitates the connection of patients to readily available services within the community. This not only lowers the costs of building infrastructures, but also supports community organizations reach into their target population.

The care management of the PCMH across all pods has been very successful in increasing quality of care and improving patient experience. According to a Report to the Legislature from the New York State Department of Health on the Adirondacks Medical Home Demonstration, 2012-2013 EHR data supports an improvement in quality across almost all domains, including management of coronary artery disease, diabetes, and hypertension for adults. The report noted improvements in patient satisfaction scores...
across all domains—communication with patients, follow up on test results, respectful and courteous office staff—except for access to care. Utilization rates did not improve, but remained stable from 2009-2012. One explanation for the lack of improvement in utilization rates is the demonstration enabled increased utilization of primary care services. The report shows the number of providers increased by 16 between 2011 and 2013, and the number of attributed patients across all payers increased from ~87,000 in 2011 to ~96,000 in 2013. The success of the approach has served as both the motivation and foundation of the Adirondacks ACO approach to care. Given the MSSP structure, the Adirondacks ACO leaders needed to ensure they would be able to improve care and reduce cost enough to ultimately create savings. The delivery system infrastructure of the PCMH is robust enough to transition to a risk-based model, according to participants.

HIT AND PERFORMANCE MEASUREMENT

Each pod also differs in the health information technology it utilizes to measure and track performance. HHHN uses AthenaHealth, a robust HIT system that allows advanced data analytics. The system tracks performance on approximately 100 different clinical quality indicators and has been used for years to track and improve population health. For example, the HIT system can identify high risk groups, gaps in care, and outreach priorities by subpopulation. UVMHN/CVPH currently utilizes the EPIC system, but not all independent practices in this pod have the same HIT, which is a challenge for quality improvement.

When attempting to create an interface between AthenaHealth and EPIC, the ACO decided to follow the direction of UVMHN’s other ACO, OneCare VT, and adopt Health Catalyst. Health Catalyst provides timely data but still has a month delay, so the ACO continues to struggle with real time data. In order to deal with the gap, the ACO has developed a model where the hospital in which a patient is admitted will alert care managers in real time if a patient enters the ED. This information on the patient’s location is not in the HIT system, but passed between the local hospital, Hudson Headwaters and physician practices across multiple provider levels and data interfaces. ACO collaborators continue to struggle with providing timely data reports across these complex channels for data sharing.

Through the medical home pilot, providers have been measuring process and clinical care outcomes of chronic diseases, such as diabetes, as well as patient experience, meaningful use, and utilization rates. The partners utilize Hixny, a health information exchange, to gather these data from the primary care physicians. The data are stored in the EHR data warehouse within Health Catalyst. The aim of measurement is to improve physician satisfaction and retention, quality of care, population health and reduce per capita costs of care. In the ACO, providers also track prevention, chronic disease, behavioral health/substance abuse, patient-reported care, appropriateness of care, and total cost of care measures. The established health information technology network provides the opportunity for providers to improve health outcomes, reduce unnecessary utilization, care management, transitions in care, and behavioral health management.

CHALLENGES AND SUCCESSES

In considering the overall progress of the Adirondacks ACO, it is important to focus on both the successes and the challenges. In this case study, we examine the impediments of the Adirondacks ACO, as well as its accomplishments in order to learn best practices that may be useful for other safety net organizations as they consider embarking in ACO partnerships.
Challenges

One of the biggest challenges voiced by participants stems from the uncertainty of engaging in an ACO and value based payment strategies, particularly when it’s unclear which models are working and which ones are not. Study participants emphasized the importance of payment policy that supports initial investments, understands the local context, and has realistic expectations in terms results.

With multiple partners and different levels of risk, study partners voiced concern about how to ensure the patients get what they need and institutions still make a profit. As one interviewee noted, the partnership has had “one to two years of transformation under its belt,” resulting in lower health care costs in the region. As a result, their margin to begin with is smaller making it harder to qualify for shared savings and see a real fiscal benefit to the ACO. According to participants, the effort and resources that would be needed to really bend the cost curve would be substantial and if the partners are not sharing in any of the savings, participants questioned whether “that cost is even worthwhile?”

In addition, the different levels of risk make it challenging for the ACO members to forecast expenditures and savings. In a diffused system, it is difficult to track referrals and know the value of care when there are multiple entry points into the system. As one study participant noted,

“You expect us to go at risk, but we need to know what we are at risk for or what the terms are. So we need to know, for example, if we’re at risk for the total cost of care and we have, as we do, three places where patients find their way for coronary bypass surgeries, we want to know where the best value is. We want to know what the quality measures are for those three programs; we also want to know what you’re paying. Because you can’t very well put up a financial risk if we don’t know or we’re playing blind man’s bluff in terms of who is, in terms of who we’re sending to whom by way of specialist or hospitals.”

Further, the ACO partners are still negotiating with commercial payers to join the ACO in order to have enough covered lives to enter into any value-based payment with downsize risk. According to one participant, the ACO would need to have a patient base of at least 10,000 patients to be comfortable with a risk-based arrangement. Because none of the commercial plans have more than 5 or 6 thousand covered lives, the ACO needs most of them to participate. In addition, the partnerships is very aware of its need to work with other practices that are committed to quality transformation and value-based care to build this patient base.

Finally, competing financial incentives are the biggest barriers to the success of the ACO. Even with the history of partnership between HHHN and CVPH/UVMHN study participants noted the difficulty in negotiating and doing what is best for the ACO especially when it might not be what is best for their individual institution. For the FQHC and other primary care physicians, there is a concern that the hospital systems are more financially positioned for ACO transformation and risk sharing and that “they are usually the ones that get funding and the PCs are kind of left outside.” Even with the diffusion of DSRIP dollars into Medicaid and primary care services, the concern that the large hospital systems will appropriate funding and try to drive utilization up is “a big barrier to doing what we need to do,” according to interviewees. In addition, study participants noted that PC practices must reinvent their business models in order to survive, which many are resisting. As one participant explained,
“Independent docs cannot survive...They will either [need to] be part of a hospital system or be part of an FQHC or some other larger network.”

On the hospital side, the concern around “demand destruction” and reducing hospital utilization, as well as the encroachment of larger PCP networks into the hospitals’ outpatient space has led to challenges during negotiations of the ACO. In addition, the fundamental differences between the economic drivers of area hospitals and local PC practices has at times derailed negotiations. As one interviewee explained:

“I think you need to sit down with potential partners and understand what you each value. And what your vision is. If somebody’s vision is we really want to do everything we can to improve health of the population. And somebody else is we really want to grow and be the strongest Community hospital in our region that provides all of the services that we can possibly provide. Those are both very reasonable visions. But if one group is trying to improve the population- reduce the ER visits, reduce the need for care for people with the complications of chronic conditions. And the other organization is trying to build specialty services and make sure that they all the latest imagining technology, and all of that. You will see the world very differently and it will be very, very difficult to come together.”

Thus, when the hospital economic model is based on utilization the mindset must change dramatically, and likely to the hospital’s detriment, to make value-based payment work. And while there is significant upside in improving efficiency and quality of care, the downside is the disequilibrium that results and who loses in this equation, as both the hospitals and the clinics are at risk. Furthermore, “coopetition” is a series of balancing acts. Organizations that were once competitors are now collaborators because “you can’t do this alone.” But participants agreed that to make value-based care work, there will be losers, and its unclear to them how to soften this blow and ensure the hospitals do not disappear. As one participant noted, “the last thing we want as PCPs is to see our hospitals go away.”

Successes
As a safety net partnership serving a highly fragmented, rural community, CVPH/UVMHN and HHHN have achieved substantial success in better integrating care, creating a much needed care management approach, building and integrating HIT infrastructure, rebuilding the primary care workforce and improving overall quality and efficiency. Though most of this success is attributable to the PCMH pilot and the care pod structure created under that initiative, the Adirondacks ACO is well-positioned to take this progress and translate it into value-based care that brings both clinical and financial accountability to the provider. The 2014 and 2015 quality performance reports from the Adirondacks ACO show the organization performs very well in comparison to the national average ACO scores in providing immunizations, cancer screenings, drug therapy for Ischemic Vascular Disease and management of high blood pressure and diabetes. Adirondacks ACO also exceeds average performance from 2014-2015 in providing health promotion and education and preventative care and screenings, including tobacco use assessment and cessation and weight screenings. The approval rating of doctors by patients remained high in 2014 and 2015, and the Adirondacks ACO receiving a score of 93.66 out of 100 in 2015 for how well providers communicate. As one study participant noted, “we achieved top decile in quality in the country, which for a rural, fragmented medical community is pretty amazing. [We] achieved 98.3 of a quality score of 100.”
The CVPH/UVMHN and HHHN partnership has also demonstrated how very different care providers can work together to become something bigger than just the sum of their parts. Though each organization has internal objectives, some of which may be competing with each other, the collaboration between CVPH and HHHN has been successful in building trust and communication and learning how to leverage each other’s strengths for the betterment of the health of their community. The two organizations have come together to not only provide a better, more robust health care delivery system, but also to learn best practices and make gains for their collaborative unit. HHHN provides a strong patient base and primary care network, while CVPH/UVMHN contributes important financing, a commitment to broadening PC infrastructure and the experience of their work in the OneCare Vermont ACO.

Moreover, while in the PCMH project, the two organizations shared the common mission of improving quality and decreasing cost. Their approaches to doing so operated in tandem and not necessarily in partnership, as payment was prospective and the success of one pod was not reliant on the success of the others. The Adirondacks ACO, however, demonstrates a willingness to share in the liability of a risk bearing arrangement where both organizations could lose. Thus, the two organizations have a stake in the delivery system innovations, infrastructure development and patient care strategies of all of the organizations in their ACO unit, which facilitates and strengthens the connections between hospitals, clinics and physician practices, as they each learn what works and what doesn’t work.

In addition, part of the success of the PCMH pilot and now the MSSP Adirondacks ACO is due to leadership’s ability to leverage important resources. For example, the inclusion of commercial payers in the PCMH project would not have happened without the support of the state department of health which shepherded the anti-trust exemption. In addition, the smart decision to split the medical home PMPM payment to both increase physician income and build the delivery system has served to increase both the provider network and infrastructure for care that will continue to result in better quality and efficiency. Finally, the infusion of state DSRIP money has helped to solidify delivery system change at the Medicaid level, further setting the stage for continued success as all providers and payers move toward value-based care. As one study participant noted:

“This is fairly particular stuff unique to our environment. But it's our unique response to the forces at play everywhere in US in terms of: How do we move away from FFS, how do we get to better value, how do we integrate across PC practices to be more efficient and effective, how do we integrate the very PC enterprises with other parts of the sector, including hospitals, nursing homes, post-acute care givers, and hospices and all the rest. So this is our version of that. Taking all those building blocks and parts and moving them around for optimal value in terms of reimbursement environment, and policy environment, and grant environment in the state of New York.”

LESSONS LEARNED FROM THE ADIRONDACKS ACO EXPERIENCE

The Adirondacks ACO offers a unique look at a safety net partnership that has a long-history of working together on population health, quality of care and cost efficiency and that has evolved into a value-based payment model. The Adirondacks ACO’s development provides examples of factors that both support and impede implementation of these types of models. The leadership, clinical care, information technology and financial planning necessary for the ACO to succeed are extensive and ever-evolving to adapt to the unique factors of the health care community, payer market and patients. Served a geographically dispersed and extremely rural safety net population makes this undertaking even more challenging but also more impactful on the community.
Given the unique characteristics of the Adirondacks ACO, it is difficult to generalize factors that can be widely adopted by other safety net partnerships that are embarking on value-based care. However, some overarching lessons can be garnered from the partners’ experiences along the journey.

**Aligned Mission and Vision:** Both HHHN and CVPH/UVMHN are committed to delivery system and payment transformation to improve population health, even at the expense of their own organizations. CVPH in particular, which feels its position is precarious in any type of value-based payment model, noted the importance of prioritizing the larger mission of improving community health over its own bottom line.

**Trust and Communication:** HHHN and CVPH/UVMHN both noted the extensive negotiations that occurred during the decision-making and development of the Adirondacks ACO. As discussed, tensions around the competing financial priorities of the two organizations created challenges at the beginning. However, continued communication, an understanding of the challenges faced by each institution, transparency in how transformation would occur and trust in the shared mission and vision of the model have helped mitigate many of the challenges.

**Strong commitment, delivery system infrastructure and HIT system:** All study participants emphasized the great importance of having a strong delivery system infrastructure and HIT system to track care and ensure patients are getting the services they need. Interviewees attributed the success of the PCMH to the care management systems and the use of HIT to identify gaps in care and population needs. The success of these systems would not have occurred without the strong commitment from all levels of care.

**Leveraging strengths and resources:** The Adirondacks ACO exists because of the early successes of the PCMH pilot and both partners saw the opportunity to take the strengths of the built care management and HIT infrastructure and leverage it into a value-based payment model. Moreover, both partners have important resources that have contributed significantly to the success of the partnership. CVPH/UVMHN brings considerable experience with VBP, as well as strong financial backing, while HHHN brings a strong patient base and payer mix to the partnership. Partners noted that HHHN’s position as an FQHC with such a strong commercial payer mix has had a unique benefit for the PCMH and Adirondacks ACO that many FQHC’s cannot bring to the table. In addition, the Adirondacks ACO is negotiating with commercial payors in the region, most of whom participate in the PCMH under an anti-trust exemption shepherded by the NY DOH, to further strengthen the patient base.

**Understanding the limitations of value-based payment:** While the Adirondacks ACO has had stellar quality scores since its inception, it still has not seen shared savings. One of the challenges of the value-based model for these partners is the success they have seen under the PCMH pilot. The efficiencies they have achieved have lowered cost of care to a point that it has been difficult to bend the cost curve any further and qualify for shared savings under the ACO. Study participants consider this both a win and a loss and hope that CMS and value-based payment policy is adaptable enough that when the ACO takes on downsize risk it will not be penalized for its early successes.

**Considering local context and how it impacts the success of the value based model:** While value-based payment appears to be the path forward in health care, the experiences of the Adirondacks ACO and the PCMH before it strongly suggests the importance of understanding how an area’s local context can significantly impact the ability to develop, implement and succeed in value-based care. The geographic
dispersion of healthcare across the Adirondack Northern region and the fragmented network of small, independent practices were challenges for the partnership and it took several years and a lot of hard work to successfully build the PCMH project with many mistakes along the way. Moreover, leaders in the area were nimble negotiators both with each other and the state, making sure they had the support to implement innovative practices that worked for their area. Despite these successes, the economic reality for the hospitals in the North Country still remains a problem. The success of the PCMH and the Adirondacks ACO could likely undermine their ability to stay viable. This is becoming more and more of a problem in rural areas and other safety net communities. As CMS considers the successes and failures of value-based models, it must also consider the winners and losers within the local health care system.

Engaging all payers in a market: The PCMH pilot has evidence that their efforts are improving quality for both Medicaid and Medicare patients, and, have data showing significant cost savings for Medicaid. However, as noted above, because of these initial efforts, the ACO costs were lower than the national average for health care spending so it did not benefit from shared savings. Moreover, leadership noted it will be difficult to qualify for shared savings or engage in downside risk without engaging commercial payers. The commercial plans increase the patient base substantially, which is necessary for risk sharing. While HHHN as an FQHC is unique in its high commercial payor mix, other safety net providers should consider how to partner with practices that bring covered lives to the collaboration. In return, safety net providers can share best practices around cost containment, prevention, and quality, which are strategies they are well versed in. Moreover, FQHCs bring other funding mechanisms to the table, including their Section 330 Health Center grant funding and higher reimbursement rates for Medicaid and Medicare.
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