

HEALTH MANAGEMENT ASSOCIATES
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Health Care Providers and Value-Based Reimbursement

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HEALTH CARE PROVIDERS AND MANAGED CARE

Most of the attention on the Affordable Care Act has focused on the controversial expansion of insurance coverage. A more subtle but important aspect of the ACA is that it is accelerating a market trend that was already set in motion by the Medicare Modernization Act – a movement away from fee-for-service health care towards a reimbursement system that rewards improved outcomes and cost efficiency. Movement of patients into some type of managed care is a significant part of the transformation. Some providers may have little previous experience with managed care companies but are now working hard to understand, design, and implement a new way of doing business that positions them for success in the new world. Others have historically contracted with managed care companies, as they have with indemnity insurance companies, but are now being asked to be financially and clinically responsible for results. The opportunity is great, but the transition path is challenging.

Medicare beneficiaries who are choosing Medicare Advantage plans are growing quickly and steadily. More state Medicaid agencies have expanded Medicaid managed care to include populations with complex health care needs. The number of states with managed long term care programs doubled from 8 to 16 between 2004 and 2012¹ and increased to 19 in 2014.² The past trend of carving out behavioral health services or excluding special populations, like those with developmental or intellectual disabilities, foster children, or other “waiver” populations, is being reversed. Virtually every segment of the population being served by a government program is being enrolled into managed care.

As state Medicaid managed care programs continue to grow and expand in terms of services and populations covered, states are shifting their focus to developing more sophisticated quality metrics and performance measures to ensure that care is being delivered effectively and efficiently, many fashioned similarly to the Medicare Advantage Stars quality program that started as a demonstration project but is now a permanent and powerful driver of quality for Medicare beneficiaries. States are adding new quality metrics and reporting requirements, adding or enhancing pay-for-performance requirements, and increasing the portion of managed care payments withheld or at risk, based on managed care performance on quality measures. In some states, a new quality focus will be on the integration of care across physical and behavioral health as well as between acute and long-term care.

While the managed care community is being pressed to improve overall cost and quality performance, it is relying heavily on the provider community – where the care actually happens – to engage in the new vision. This paper serves as a starting point for providers who are exploring the move to managed care and value-based reimbursement options; it is designed to help providers understand the flow of money and associated payment models and how to thoughtfully move through this transition.

¹ Medicaid.gov: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

² <http://files.kff.org/attachment/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers-issue-brief>

THE FLOW OF MONEY

Many providers who serve the Medicaid, Medicare, or dual eligible populations are being paid on a fee-for-service basis by states and the Center for Medicare and Medicaid Services (CMS). The cost of this fee-for-service system is unsustainable and is driving the current trend of states moving more of their Medicaid populations into managed care. At the same time, CMS is working with states to align Medicare and Medicaid for dual eligibles through managed care. CMS is making Medicare Advantage business attractive for managed care. CMS and states are turning to managed care for their beneficiaries for two major reasons: to systematically improve quality and outcomes, and to contain costs. Their current volume-based model of paying a fee for each visit, service, procedure, or admission (fee-for-service), regardless of its value to the patient, has failed to accomplish these two goals.

States and CMS pay managed care organizations (MCOs) per-member-per-month (pmpm) capitation payments – one lump sum per month for all of a patient’s care. No payment is made to MCOs for any specific service, visit, procedure, or admission.

For Medicaid, states expect MCOs to provide services more efficiently by reducing unnecessary spending; therefore, the capitation rate is set at several percentage points lower than the actual historical costs that have been incurred by the state in paying fee-for-service directly to the medical providers. By doing so, the state reaps immediate cost savings and financial predictability.

For Medicare and in some Medicaid programs, a percentage of capitation payment to MCOs is tied to achieving certain quality thresholds. A portion of the MCOs capitation is withheld and must be earned by achieving quality standards. This deters MCOs from using inappropriate methods of reducing medical costs at the expense of member access or clinical outcomes. MCOs must figure out how to better manage care and quality in order to have financial success.

MCOs bear financial risk for the cost of their patients’ care: if the sum of the patient’s total medical costs and the MCO’s administrative costs are more than the capitation payment from the state or CMS, then the MCO incurs a financial loss. If the patient’s total medical costs and the plan’s administrative costs are less than the capitation amount, then the MCO makes a profit.

Although the MCO is paid on a capitation basis, the payment from the MCO to providers is often maintained as fee-for-service. MCOs will impose new rules and guidelines on providers to better manage quality and cost, but in the fee-for-service model, the provider will realize none of the financial benefits that result from the changes that they will have to make in the managed care environment.

Many providers are not in a position to take on financial risk and are smart not to do so if they are unprepared. Unfortunately, however, many providers fear value-based payment options that do not require them to take on risk, such as those that provide financial rewards for quality and allow providers to keep a share of the money that they save through efforts to appropriately contain costs. Pay-for-performance and upside-only shared savings reimbursement models have no financial risk associated with them. MCOs are willing to do these kinds of deals in an effort to move

the provider community along a continuum that will help them to take ever-increasing responsibility for care and assuming more financial accountability.

Fee-for-Service Model

The fee-for-service system is a source of many inefficiencies. It does not encourage innovation and practice redesign that improves patient access and care at a reduced cost. For instance, a primary care office (PCP) may want to have some services delivered by a member of the care team other than a physician, such as a nurse or dietician, who is qualified to deliver high-quality, appropriate services in certain situations. The hourly costs of these alternative providers are less than a physician's, and employing their skills frees up physician time for patients who need their unique skills and expertise, creating improved access. Unfortunately, the fee-for-service system may not pay for visits with a dietician or a nurse, even though they are well qualified to deliver the care. The FFS reimbursement rules require that the care be delivered by a physician. Yet better use of lower cost ancillary staff results in better provider, staff, and patient satisfaction at lower costs.

Giving patients access to care through electronic patient portals, secure email, and telephonic nurse triage are effective methods of creating efficient, convenient, appropriate care for routine conditions that do not require an exam, such as a urinary tract infection. Unfortunately, fee-for-service does not recognize or pay for these virtual interactions even though patients may prefer to have a virtual "exam" without the inconvenience of an office visit. Without a source of revenue to underwrite the additional cost of providing this "non-billable" service, providers are dissuaded from offering it.

The ability to reward providers who create value by preventing expensive services, such as hospital admissions, is also missing from the fee-for-service model. For example, nursing homes could manage some acute conditions with IV hydration, antibiotics, nebulizer treatments, or other simple therapeutic services without admitting the patient to the hospital. But providing these services consumes staff time and resources, both of which are unrecognized in the usual per diem reimbursement. Using another example, it takes more effort for an emergency room physician to contact a patient's PCP to discuss a patient's condition and arrange for timely next-day follow-up than to admit the patient. It consumes nursing staff time to follow-up on a patient the next day after inpatient discharge to be sure that transition back home is unfolding as planned. These steps may improve care, but again are often not recognized as billable or reimbursable.

Many providers recognize that U.S. health care in its current form is inefficient, overly expensive, and not sustainable, but under a fee-for-service model they have little financial incentive to transform the way medicine is practiced. Not only are they not rewarded for economizing; they are penalized if they provide fewer services or lower-cost services. And although MCOs work hard to manage care and costs, their impact is limited since they do not make the day-to-day diagnostic and treatment decisions that determine costs. In the typical fee-for-service arrangement, providers make these decisions, and MCOs have only limited ways to influence them.

To correct these deficiencies, MCOs and other direct payers are moving to value-based payment models designed to reward providers for implementing health care transformation that results in

better clinical outcomes, improved member satisfaction, and cost containment. The key elements of value-based payment models are:

- Financial incentives are not based on the volume of services, and payment is not limited to billable encounters traditionally reimbursed on the fee-for-service schedule.
- Financial rewards are paid for by the achievement of quality standards, overall management of care, and eliminating unproductive costs from the system of care.

VALUE-BASED PAYMENT MODELS

Value-based payment structures are gaining popularity for many reasons.

1. Financial incentives can be designed to reward behavior and promote practice changes needed to successfully implement more efficient and effective models of care.
2. Financial incentives can help providers pay for investments in technology, process improvements, staff training, and culture changes needed for practice transformation.
3. Value-based payment promotes the delivery of the right care in the most timely and cost-effective setting. Patient portals, secure email, and nurse triage can be deployed without a negative impact on the provider's revenue. Routine care issues that may not require an exam can be handled more quickly and conveniently for the patients, and early intervention may prevent a costlier level of visit or an adverse event.
4. The use of alternative members of the care team becomes practical. In many instances, nurses, medical assistants, pharmacists, dietitians, patient navigators, and others can deliver certain types of care or assistance more efficiently and effectively.
5. Providers are remunerated based on the value they produce, even if the volume of services is reduced.

The model can align incentives to encourage disparate providers to collaborate to achieve objectives. Cost savings can be shared with nursing homes, behavioral health providers, specialists, hospitals, home and community based providers, and others who are creating value for the beneficiary and the system as a whole. A well-structured model draws attention to the full continuum of healthcare services including long-term services and supports (LTSS) and behavioral health services, which have traditionally been of little interest to providers not directly involved in providing these services. Coordinating the full range of services is a key focus for CMS' Medicare-Medicaid Alignment Initiative (MMAI). High-cost, complex dually eligible individuals have historically suffered suboptimal outcomes because of inadequate coordination among primary care, LTSS, and hospital providers. MMAI creates the imperative for better rationalization of these services and improved handoffs as members transition from one type of provider to the next.

Value-Based Payment Methodologies

There are several value-based payment methodologies that can be used alone or in combination. They form a continuum that tends to increase in potential value to the provider as it increases accountability for outcomes, including cost of care. It is important to match the model with a provider's ability to manage any financial risk. With the exception of capitation (partial and full), payment structures build on fee-for-service payments with a goal of eliminating the incentives to provide services of low value. Methodologies include the following:

- Payments for specific activities, services, or procedures that are not traditionally reimbursable, such as care coordination or Patient Centered Medical Home functionality.
- Pay-for-performance programs.
- Shared savings but with no risk when savings are not realized.
- Partial risk, where the provider is entitled to enhanced upside potential coupled with a limited amount of responsibility for cost overruns (downside risk).
- Partial capitation
- Full capitation

The level of reward is linked to the level of accountability: greater accountability, including in some cases financial risk, is associated with greater potential financial reward.

Certain types of value-based payments such as pay-for-performance or payment for specific quality activities can be applied to an individual primary care physician, specialist, or other practitioners, regardless of how many or how few patients they have on their panel who are eligible for the reimbursement. On the other hand, reimbursement, such as shared savings and partial or full capitation, are contingent on providers' having a minimum patient panel size to ensure that the risk pool is large enough to spread risk – that is, to offset the effect of high-cost patients whose care will be costly no matter how well-managed (insurance risk) and to avoid rewarding savings that occur by chance alone. An individual practitioner or a small group of physicians who has a large panel of the same type of patients may be eligible for this type of payment. Independent Physician Associations (IPAs), Physician Hospital Organizations (PHOs), and health systems can negotiate value-based payment on behalf of a large patient population that is on the panel of many member practitioners.

Throughout this article, the term “provider” is used in a general sense for purposes of simplification. “Provider” can mean individual doctor, practice, IPA, PHO or Health System, depending on the context.

Transitioning to Value-based Care

Some providers may want to transition to a new, innovative model of care but not know how to “get from here to there,” concerned that they could be taking on a financial risk that might jeopardize

their viability. Providers should decide which value-based payment model is appropriate for them based on an assessment of their volume of patients, sophistication of practice processes, ability to monitor and improve financial and quality performance, and the cultural readiness for managing relationships with MCOs and taking financial risk. As a provider achieves success on the more basic versions of payment models, the earnings and learnings can be used to build more sophisticated capabilities and to continue to assume more accountability with the potential for greater financial rewards.

Components of Value-based Payments

At the center of value-based payments are the patients and their primary care providers. Care coordination fees, pay-for-performance rewards, and shared savings or capitation are based on the number of patients assigned to PCPs.

Federally Qualified Health Centers, individual PCPs, PCP group practices, IPAs, PHOs, and health systems with medical groups need to consider several things as they work with MCOs on establishing a value-based payment contract:

- How many patients are included in a particular value-based payment methodology; is the number (and thus the prospect of financial gain) enough to warrant practice redesign and the building of care management processes, reporting capabilities, and financial management?
- To what degree are the PCPs integrated with hospitals, specialists, and other providers who are serious about pursuing value-based payments? The inclusion of hospitals, long-term services and supports (LTSS) providers, specialists, and behavioral health providers can be important, particularly for shared savings or capitation methodologies where these providers have a major say in utilization, cost, and meeting quality thresholds. Provider partners who are still focused on maximizing fee-for-service revenue can present a barrier to success. If an integrated delivery system involves contracting as a single entity, it is important that each provider group member has an active role in decision-making, and that each member's contribution to overall performance is recognized when value-based incentives are distributed.

Some PCPs have a substantial number of members enrolled in a particular MCO, but many have contracts with multiple MCOs. The frequent result is networks with a large number of PCPs, with each PCP having only a small number of patients from any one MCO. This limits the ability of the individual PCP to organize around quality and key activities required for the management of specific populations. The effectiveness of incentives for small patient panels is marginal because the potential reward is so small, and some structures, such as shared savings and capitation, are not applicable to providers serving a small number of an MCO's patients.

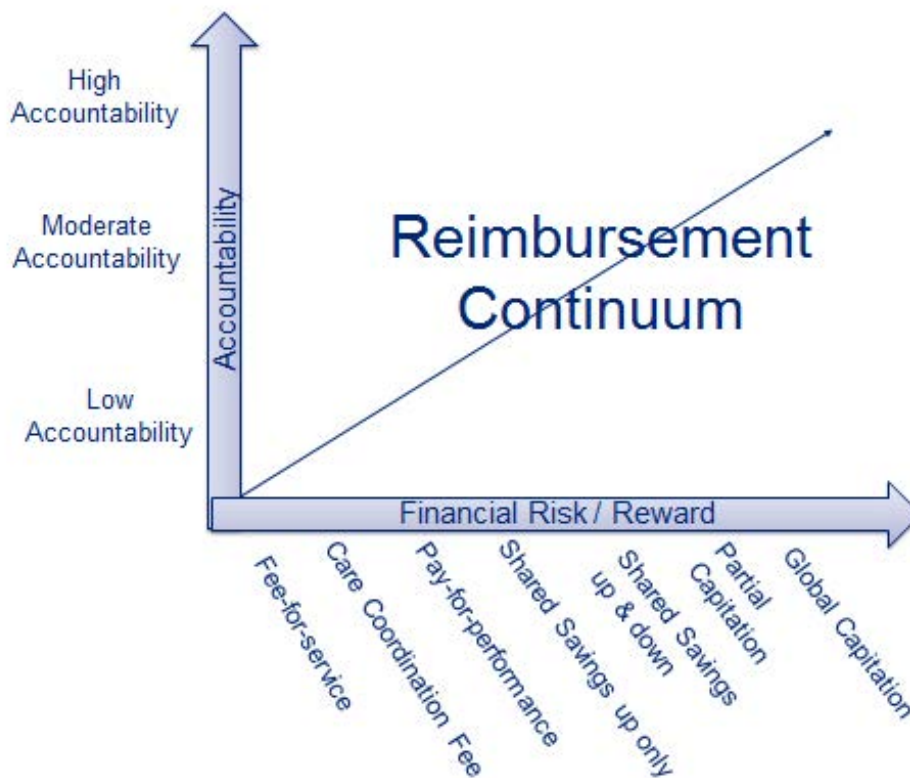
Participating in PHOs, IPAs, and health systems offers individual providers and small provider groups the opportunity to aggregate patients into larger panels that qualify for more lucrative and accountable reimbursement programs. These organizations can form a common system of governance that can contract with MCOs as a single entity and distribute outcomes-based

payments. The organization can, depending on its nature, include specialists and hospitals that collaborate to improve care delivery under an aligned incentive system. The organizations can spread the overhead expense of developing the technology, guidance, and reports needed to improve care and outcomes. These organizations can aggregate payment from multiple payers and reward individual practitioners based on performance of a larger portion of their patients. If these providers do not organize themselves, an MCO may choose to create “pods,” which are, in essence, an informal, MCO-sponsored IPA.

The Reimbursement Continuum

Approaches that are designed to give providers more responsibility for controlling costs and improving quality in exchange for the prospect of greater financial rewards can be thought of as a continuum, where greater responsibility is matched with greater potential financial payment, as shown in Figure 1 below.

Figure 1: Reimbursement Continuum



The reimbursement continuum (Figure 1) is the mechanism by which the transition can be made over time:

- At the low end of the continuum is fee-for-service, where providers are paid for each visit, service, or procedure.

- Care coordination fees, pay-for-performance, and shared savings earnings are all in addition to fee-for-service payments. The revenue that is earned through the additional payments can be used to offset or replace any fee-for-service revenue that is sacrificed or additional expenses that result from practice redesigns. These mechanisms have no financial risk associated with them, so providers have a safe environment and time in which to figure out how to transform their care, master financial management, respond to MCO's data that gives a new perspective on their performance, and achieve culture shifts in their own organizations.
- When the provider is ready for some level of financial risk, which can be taken through partial risk, partial capitation, or full capitation, the positive revenue potential becomes greater, based on the premise that operates in all parts of the free market system – with greater risk comes greater reward. Providers can choose to never take financial risk, or they can accept it along with the added responsibility and control.

The table on the next page describes how each of the payment methodologies works and the implications for the provider.

	Fee-for-Service	Care Coordination Fee	Pay for Performance	Shared Savings Upside Only	Shared Savings Upside & Downside	Partial Capitation	Global Capitation
How it works	<ul style="list-style-type: none"> -Starting point is Medicaid or Medicare fee-for-service rates -May be negotiated up or down by a few percentage points 	<ul style="list-style-type: none"> -PMPM payment for specific populations -May have no contingencies attached to payment -May be contingent on PCMH accreditation, certain facility enhancements for persons with disabilities, or other parameters 	<ul style="list-style-type: none"> -Usually tied to performance metrics required of MCOs by CMS or states, such as: <ul style="list-style-type: none"> -HEDIS measures -State-specific quality measures -CAHPS -Cost/quality drivers such as readmission rates 	<ul style="list-style-type: none"> -Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved -Allows more flexibility in practice redesign, innovative care and financial incentives for overall appropriate cost management and premium management 	<ul style="list-style-type: none"> -Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved or pays a percentage of the deficit -Step one of financial risk -With risk comes enhanced reward opportunities – higher percentages on upside along with responsibility for downside -Even more flexibility for providers to influence their own practice redesign, innovative care 	<ul style="list-style-type: none"> -A percentage of premium is paid for one area of care; PCP, Part B, Parts A/B, Part D -Total financial responsibility within limited area of care -Provides maximum flexibility for that area of care 	<ul style="list-style-type: none"> -Percentage of premium for total care -Can be accompanied by delegation of care management, claims and other functions -Total financial risk and reward for high quality care and cost management -Maximum Flexibility
Implications to Provider	<ul style="list-style-type: none"> -Encourages volume-based vs. value-based medicine 	<ul style="list-style-type: none"> -Helps to fund people, processes, and technology for upgraded care -Sometimes can be used only for care and cannot be used for reserves 	<ul style="list-style-type: none"> -Helps to fund upgraded care -Helps to focus on specific areas of improvement -May be used to build reserves 	<ul style="list-style-type: none"> -Perfect way to gain understanding and control of holistic financial performance without taking any financial risk -Allows provider to get ready to take financial risk, if desired -Shared savings money can be distributed in ways that incent desired behavior changes -May be used to build reserves 	<ul style="list-style-type: none"> -A good method to take on limited financial risk with opportunity for more financial gain -Shared savings money can be distributed in ways that incent desired behavior changes -May be used to build reserves 	<ul style="list-style-type: none"> -Allows provider significant flexibility and financial responsibility in an area of strength without having financial responsibility for total care -Excess money beyond the cost of care can be used for anything the provider deems important: reserves, incentives, people, processes, technology 	<ul style="list-style-type: none"> -Provider gains significant leverage with payers, total control of practice design, incentives & investments in people, processes, technology -Provider can take financial risk directly from government programs and share nothing with MCOs

Care Coordination Fees

Care coordination fees are pmpm payments based on the number of patients that are assigned to primary care physicians. Fees may vary by patient complexity. No minimum number of patients is required to qualify for a MCO's care coordination fee program. The care coordination fee may be based on formal accreditations such as NCQA accreditation for a patient centered medical home (PCMH), a set of criteria set forth by the health plan, or some specific action of value to the health plan. Some examples include:

- The MCO pays a pmpm care coordination fee for PCMH accreditation, such as \$5 for level 1, \$7 for level 2, and \$9 for level 3.
- The MCO pays \$8 pmpm for a provider's dual eligible population, if the provider has high level of ADA accessibility.
- The MCO pays \$25 for each completed health risk assessment.
- The MCO pays \$6 pmpm based on the completion of a site audit checklist, systems capability, and encounter data compliance.

The value of care coordination fees to providers:

- Care coordination fees provide up-front cash that is typically paid monthly. This money is not associated with payment for a specific service. Care coordination money should be used to implement care coordination staffing, technology, and processes. Care coordination money should not become part of the operating budget.

Pay-for-Performance

Pay-for-performance (P4P) programs are financial rewards for good performance based on a set of quality metrics. MCOs may establish P4P programs to help them generate good scores on state-specific, CMS-driven, or national NCQA measures. Performance above a certain threshold may allow a MCO to earn back part or all of a premium withhold. P4P programs can be designed to reward process measures that address inappropriate utilization and cost, such as PCP follow-up within seven days after an inpatient discharge to reduce readmissions. P4P can reward achievement in reducing cost drivers such as non-emergent visits to the emergency room or unnecessary admissions.

Pay-for-performance payments may be made quarterly, bi-annually, or annually. Ideally, the MCO will establish a manageable number of quality metrics so that providers can focus on their quality improvement efforts and set thresholds that are challenging but achievable. Thresholds do not need to be uniform; a threshold that recognizes individual improvement can be individually set for different provider types. However, whenever possible, providers, MCOs, and payers should collaborate to choose metrics and thresholds that are aligned across populations and plans as much as possible so that providers have clear priorities and the ability to organize around the accomplishment of a reasonable set of quality targets.

Types of pay-for-performance programs:

- MCOs may reward providers with a one-time payment each time the provider delivers a service that contributes to a quality score, for example, provision of a mammogram. This does not incentivize accountability for population health, per se, but it does provide an immediate reward for certain behaviors in treating the patients assigned to a PCP group. In some cases, as with Medicare Advantage, timing is also a consideration for the bonus payment. For example:
 - For each claim that is submitted for an HbA1c screening, a \$25 fee is paid as part of the bonus program.
 - The provider is paid \$50 for every mammogram that is completed on an appropriate patient between the months of January and July.

The P4P model can promote provider engagement, since almost any provider can earn some reward. However, this also limits the ability of P4P to drive system transformation, since providers can earn payment with little additional effort to change their practice behaviors.

- MCOs may designate quality measurements for the program and pay providers per-member-per-month for achieving targets for their membership, helping providers to focus on priority areas for population health. For example:
 - Nine quality measurements could be designated each year. If the provider achieves the target of 75th percentile compliance on at least six out of nine measures, the MCO would pay \$9 pmpm for all of the patients in a PCP's panel.
 - The pmpm could be on a sliding scale contingent on the number of targets that are achieved. For instance, if a provider achieves three out of nine targets, the pmpm would be \$3; six out of nine would earn \$6 pmpm; and nine out of nine would earn \$9.

The value of pay-for-performance programs to providers:

- Pay-for-performance programs offer money to pay for the people, processes, and technology that are needed to improve quality care.
- Although the PCP is the basis for the P4P program, the earnings can be distributed among various types of providers based on who is creating the value and their success in achieving the quality targets, which expands the potential for savings or quality improvements. For example, an IPA may form relationships with specialists, hospitals, or nursing facilities for the purpose of promoting care coordination and sharing the financial rewards for doing so.

Shared Savings

Shared savings models reward providers for managing overall costs and in some cases, revenue. Providers are given the opportunity to share the positive financial result of their work to contain medical costs or enhance premium revenue for the MCO in cases where premium is risk adjusted

(to be explained later). Shared savings may apply to institutional services, professional services, prescription drugs, subsets of all of these categories, or any combination.

Shared savings can take several forms. In one approach, shared savings are based on a medical loss ratio (MLR), which is defined as the medical expenditures divided by the premium revenue. Earnings are achieved when the actual MLR is less than the target MLR. For example, if the MLR target is 85 percent and the provider achieves an 83 percent MLR, then the shared savings is two percent of the premium.

A contracted “shared savings split” determines what percentage of shared savings is distributed to the provider and what percentage is kept by the MCO. If the total savings is two percent and the shared savings is 50 percent, then the provider receives one percent and the MCO retains one percent.

The same concept applies to providers who are willing to take some financial responsibility for a deficit, which is called downside or partial risk. In upside-only shared savings, the provider receives a split of any positive financial results that they achieve. In upside/downside shared savings or partial risk the provider is also responsible for splitting the cost of any deficit between the MLR target and actual MLR.

For a Medicaid population, Table 1 shows the total financial potential, positive and negative, assuming 3,000 patients, an average premium of \$175 pmpm, and a 50 percent shared savings split.

Table 1: Example of Medicaid Earnings or Deficits driven by an Upside/Downside or Partial Risk Arrangement, Membership=3,000; Average premium=\$175; Shared savings split=50%

Rate 1							
Shared Savings (50%)							
Contracted MLR		82%	83%	84%	85%	91%	92%
Actual MLR	80%	\$63,000	\$94,500	\$126,000	\$157,500	\$346,500	\$378,000
	81%	\$31,500	\$63,000	\$94,500	\$126,000	\$315,000	\$346,500
	82%	\$0	\$31,500	\$63,000	\$94,500	\$283,500	\$315,000
	83%	-\$31,500	\$0	\$31,500	\$63,000	\$252,000	\$283,500
	84%	-\$63,000	-\$31,500	\$0	\$31,500	\$220,500	\$252,000
	85%	-\$94,500	-\$63,000	-\$31,500	\$0	\$189,000	\$220,500

For a Medicare population, Table 2 shows the total financial potential, positive and negative, assuming 3,000 patients, an average premium of \$900 pmpm and a 50 percent split.

Table 2: Example of Medicare Earnings or Deficits driven by an Upside/Downside or Partial Risk Arrangement, Membership = 3,000; PMPM Premium = \$900; shared savings split = 50%

Target MLR		82%	83%	84%	85%
Actual MLR	80%	\$324,000	\$486,000	\$648,000	\$810,000
	81%	\$162,000	\$324,000	\$486,000	\$648,000
	82%	\$0	\$162,000	\$324,000	\$486,000
	83%	-\$162,000	\$0	\$162,000	\$324,000
	84%	-\$324,000	-\$162,000	\$0	\$162,000
	85%	-\$486,000	-\$324,000	-\$162,000	\$0
	86%	-\$648,000	-\$486,000	-\$324,000	-\$162,000
	87%	-\$810,000	-\$648,000	-\$486,000	-\$324,000
	88%	-\$972,000	-\$810,000	-\$648,000	-\$486,000
	89%	-\$1,134,000	-\$972,000	-\$810,000	-\$648,000
	90%	-\$1,296,000	-\$1,134,000	-\$972,000	-\$810,000
	91%	-\$1,458,000	-\$1,296,000	-\$1,134,000	-\$972,000

- The revenue side of the MLR is the capitation paid to MCOs by the state or CMS. The cost side is a total of the fee-for-service cost of medical services actually delivered.
- The revenue side may be adjusted for quality performance or for the risk profile of the population (higher revenue for sicker-than-average members).
- Shared-savings payment models are on top of fee-for-service payments. Pay-for-performance programs and care coordination fees may be included in the payment model. Sometimes access to shared savings is dependent upon meeting certain pay-for-performance targets. The costs associated with care coordination and pay-for-performance components of the pay structure are typically included in the cost side of the MLR calculation.
- Shared savings may be paid quarterly, biannually, or annually. MCOs usually set a minimum number of patients for shared savings to create a risk pool that is large enough so that cost outliers do not have a disproportionate effect on the financial results.
- MCOs may make shared savings contingent on achieving a set of quality targets, or they may change the provider share based on quality performance. For example:
 - Twelve quality measurements are designated each year. Shared savings MLR targets are predicated on the number of quality measures that have been achieved. If three to five measurement goals are achieved, the MLR target is 82 percent with a 30 percent split. If six to eight targets are achieved, the MLR target is 83 percent with a 35 percent split. If nine or more targets are achieved, the MLR target is 84 percent with a 40 percent split. At least three metrics must be met before the shared savings program applies.

Providers generally start by taking upside-only deals, where they have access to shared savings based on when savings are generated but are not financially responsible for losses. The shared savings split on up-side only deals are usually 50 percent or less. Some MCOs will offer a higher

shared savings split but set a lower MLR target. The provider receives a larger portion of their savings, but the savings have to be greater. Since the MCO continues to take all of the financial risk, they are entitled to a sizeable portion of the reward. Once a provider agrees to take some level of downside risk, the target MLR and/or shared savings split is greater.

The shared savings split and MLR targets are more favorable for providers if they are willing to take a portion of the downside risk. Providers with downside risk may receive 75 percent or even 90 percent of the savings. The MCO is willing to share more of the provider's financial improvements if the provider is willing to pay a portion of the deficit if they do not perform well. This reduces the MCO's financial risk and increases the provider risk, thereby entitling the provider to more of the money in the case of good performance.

In order to limit financial risk, providers can adopt several strategies:

- Maintain reserves so that money is available to pay the deficit, should one occur.
- Negotiate or purchase stop-loss provisions to manage insurance risk – that is, the providers' loss cannot exceed a specified amount or percentage. Individual member stop-loss and risk corridors are two means by which a risk-bearing provider may secure some financial protection from insurance risk. Generally MCOs will offer stop loss provisions (reinsurance), but in some cases providers are allowed to choose to purchase their own reinsurance from another company. Examples include:
 - Stop loss for individual members places a limit on the provider's financial liability for claims for any one member. For instance, during a certain time period, a provider may be financially responsible for a member's claim up to \$80,000. Reinsurance pays 80 percent of the costs that exceed \$80,000, and the provider pays 20 percent.
 - Total costs for a population may also be limited through risk corridors. For instance, if the risk corridor is from 100 percent to 110 percent and the MLR of a population reaches 110 percent, reinsurance pays 80 percent of the costs between 100 percent and 110 percent (which constitutes the corridor) and the provider is responsible for 20 percent. If the cost surpasses 110%, the provider is responsible for all of the costs.

Providers need to be certain that the MCO is offering an MLR that is achievable. Some MCOs set an MLR that requires the provider to reduce costs compared to previous experience. For instance an MCO may set an MLR target of 88 percent for a provider whose current MLR is 90 percent, with the understanding that each year improvement will need to be made in order to continue this type of payment structure. Although the MCO will not necessarily make a profit in the first year or two, they will lose less if the provider is successful in improving the MLR. MCOs are, of course, intent on setting a target that will help them stay profitable in the market as a whole. But this can be problematic. If they negotiate upside-only share savings arrangements, they are in the position of paying for gains of those providers who perform well while also paying the deficits of those

providers who are not good performers. This can have significant negative financial impact on the MCOs.

For-profit MCOs are accountable to shareholders, and they need to be able to justify to shareholders the financial advantages of any arrangement. All MCOs need to at least break even, so they want to establish payment relationships that achieve that objective. At the same time, providers are looking for ways to cover the added cost of the practice redesign needed to improve performance; so there is something of a conflict of interests. Providers need to carefully weigh the value of the deal each MCO in the provider's market is offering. This assessment is an important business function and warrants careful attention. Once contracting decisions are made, it is essential to build positive collaborative relationships with the contracted MCOs by sharing information and ideas.

When discussing MLR targets with MCOs, the provider group should ask the MCO to share their data on total cost and revenue for the population for which the contract is being negotiated. If that information is not available, then a similar population's cost and revenue numbers should be shared. In addition, a provider should ask the MCO for cost and revenue data for the specific provider's population, since insurance companies have much more complete data than providers. This information will help the provider make informed decisions about assumption of risk as well as informing negotiations for an appropriate MLR target.

Providers who want to dip their toe into the water may want to opt for partial shared savings arrangements. For example, the provider may take 50 percent downside risk on professional services only. Taking some down-side risk on the services for which a provider has control is a way to build clinical integration and financial management capabilities that create success, while assuming only a limited amount of risk. As providers gain experience and generate reserves, they may choose to assume risk for additional services.

To earn shared savings, providers need to implement practice redesigns focused on care coordination, transitions of care, and other initiatives that will reduce cost, enhance revenue (in some cases), and meet quality thresholds. Providers should also engage in financial management, quality management, and relationship management that is robust and organized.

The Value of Shared Savings Models to Providers

The money that is earned through shared savings gives the provider more flexibility to redesign the primary care practice, build processes or technology to support more innovative ways of practicing, and invest in enhanced delivery capabilities. The shared savings revenue may offset reductions in fee-for-service revenue, and time-saving efficiencies may free up capacity to serve additional individuals, thereby creating the potential for additional revenue.

The shared savings model makes it possible to distribute incentive payments among all of the providers who are creating value (which is not the case with the fee-for-service model). The earnings, which are paid in a lump sum, may be distributed to hospitals, behavioral health providers, nursing homes, community-based organization, and others who have contributed to the achievement of the earnings.

The shared savings model can also benefit providers who can help MCOs that serve Medicare Advantage and dual eligible demonstration patients maximize premium payments. Medicare premiums are adjusted for patient illness severity and for the MCO's achievement of quality targets. The premium can be significantly higher if providers help the plan accurately code for illness severity and meet quality targets. The shared savings model gives providers incentives to reduce costs, which, of course, affects the profitability of Medicare Advantage plans. Providers have incentives to get organized around charting, coding, and submitting encounter data to the MCO. They are also rewarded for their efforts to help the MCO achieve star ratings, which also affects premium.

Providers can be rewarded for similarly helping MCOs achieve premium and performance targets in serving dual eligibles in the Medicare-Medicaid alignment initiatives. Some Medicaid premiums are also contingent on appropriate coding and the achievement of quality metrics.

Shared savings is a good starting point for providers who want to start down the path of financial management, premium management, or care management.

Capitation

Under capitation payment systems, each provider group is paid a fixed monthly amount for each person enrolled with the group. The payment is the same regardless of how much or how little care the enrollee uses. The capitation may cover all services—hospital, outpatient, professional and prescription drug— typically referred to as global cap, or it may cover only a more limited category of services, such as professional services only, which may be called sub-cap, part B cap, or partial cap.

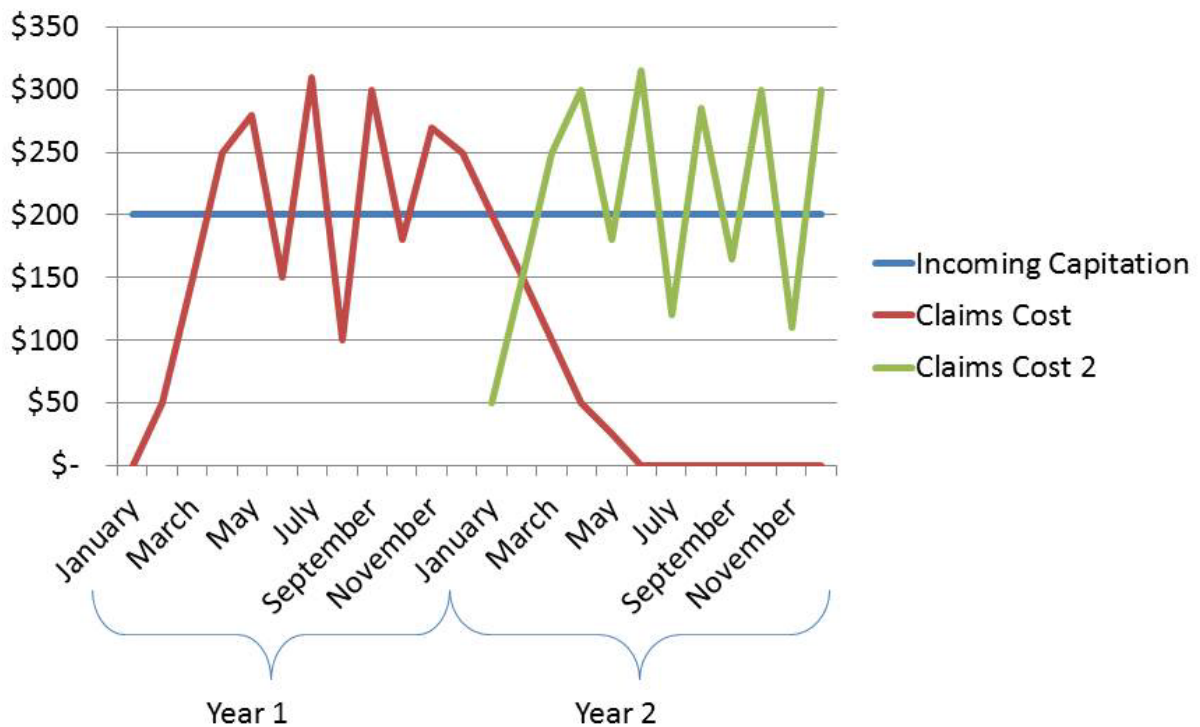
Capitation has the potential to be the most lucrative value-based payment structure for providers, but only if the provider is sophisticated and prepared to deliver effective care management, eliminate low-value services, appropriately maximize risk-adjusted premium, and closely monitor medical costs. Full capitation makes costs completely predictable for the MCO because the cost to them for the year of the contract will be whatever rate was contracted with the provider for that group of patients. For instance, if the “cap deal” is for 85 percent of premium, then 85 percent of premium is the cost to the MCO, whether the medical claims come in below or above 85 percent. The provider absorbs any losses and realizes any gains. If the MCO realizes an increase in premium because of more accurate coding of patient risk or achieving quality targets, the provider realizes 85 of the increase and the MCO realizes 15 percent.

The provider is given full responsibility for the clinical and financial management of that population. MCOs may delegate to the provider the care coordination functions and, in some cases, claims payment, if the provider wants to control that part of the business as well. The provider has maximum flexibility to manage costs. Providers can use the capitated payment to build processes and technology, hire alternative levels of people, redesign the way that care is delivered, and do anything else that they believe will have a significant positive impact on the management of costs and the premium.

At the same time, the provider must have financial reserves and the capability to manage the volatility of medical claims. Capitation requires the assumption of true financial risk: if the medical costs are higher than the capitation, the provider group must be able to absorb the losses. They must be capable of managing premium and medical costs that can fluctuate considerably.

The graph below (Figure 2) shows the relationship between capitation payments and medical costs. The provider receives the same capitation payment each month, but medical expenses—and thus claims payments—can vary widely from month to month and by season or because of illness epidemics. Moreover, there can be a delay between provision of services by external providers and claims submission. Claims for services provided in year one may not be submitted until the following year, so the financial implications of a one year cap continue for as much as 18 months or two years. Money must be reserved to pay these claims. The provider’s financial manager must be aware of this and help clinical and administrative staff plan accordingly.

Figure 2: Relationship of Capitation Payments and Medical Costs



Once providers start to take on any financial risk, they must set aside a significant portion of payments to build up reserves and invest in technology, enhanced services, new expertise, and processes that will improve future performance.

Capitation is a viable approach only if the PCP provider group has a relatively large membership base over which to spread the risk. The minimum panel size depends on stop loss provisions, reserves, risk appetite, historical ability to manage shared savings arrangements, and health plan preferences. Risk can be mitigated when the provider can spread it over other capitated contracts,

so that losses from one contract may be offset by gains from another. By having a large enough risk pool, the provider group mitigates the effects of costs that are beyond their control, such as paying for treatment of a patient with very costly and prolonged illness (insurance risk). The MCO wants risk partners to be successful and will reserve risk deals for those who meet their minimum member panel size thresholds.

To manage capitation, providers need the experience, qualified staff, technology, and desire to financially manage the business, recognizing that multiple factors must be monitored regularly, including medical costs, revenue, and quality. Most providers are wary of taking financial risk. Many remember the 1990s when they were unprepared to assume capitated risk and experienced significant financial losses. Under capitation, financial performance can be volatile; high-cost outliers can adversely affect an entire year's financial performance. Proper reinsurance can mitigate but not eliminate the risk.

Capitation contracts with MCOs should specify all of the following:

- The percentage of premium or pmpm amount that will be paid each month to the provider.
- The Division of Financial Responsibility (“DOFR”), which defines which services are included in the provider’s financial responsibility and which remain the responsibility of the managed care organizations.
- Stop loss provisions.
- Fiscal reserve requirements including plan oversight procedures.
- Delegation of responsibility for claims authorization and payment, care coordination, utilization management, and appeals.
- Access and quality standards to guard against inappropriate restriction of member services.

Care management is delegated to the provider who can take full advantage of established doctor-patient relationships. The MCO may delegate the claims processing function to the provider with plan oversight. The delegation of claims gives the provider more control over the entire financial situation, assuring that only authorized services are paid. However, many MCOs are reluctant to delegate claims processing because accurate and complete encounter information may not be shared with them. This lack of complete data hinders the MCO’s ability to understand the provider’s costs, quality metrics, risk adjustment, and other important data-based items. It also hinders their ability to meet their contractual reporting requirements with the state or CMS.

When the capitation amount is a percentage of premium, providers have a strong incentive to code claims with complete diagnostic information for Medicare Advantage contracts, since enhanced premium revenue is shared with the provider group. The premium is member-specific based on diagnosis codes. Certain diagnoses are recognized as increasing the likelihood that a member will experience higher medical costs in the coming year. These “HCC” diagnoses increase the annual premium by an average of \$3,000 annually, a 25 percent incremental revenue on top of the average

Medicare Advantage pmpm capitation of \$900 to \$1000. Providers can also help health plans achieve high star ratings based on achieving high performance on HEDIS quality measures and patient satisfaction, which translates into higher future premiums. Health plan provider partnerships are enhanced when the health plan and the provider collaborate to increase premium and subsequent profitability.

The Value of the Capitation Model

Because the capitation model pays a fixed amount per member regardless of medical expense, it creates a strong incentive for the capitated providers to keep members healthy, and gives providers flexibility to achieve this goal in the way they think most effective. The provider organization can, in turn, contract with their individual provider members to provide incentives for high-value care that result in improved patient outcomes and higher levels of satisfaction. When the capitation is for the full continuum of care, an impetus is created for the range of participating providers (PCPs, hospitals, specialists, behavioral health providers, long-term services and supports providers) to collaborate on new models of care that result from their newly aligned interests. As they improve clinical outcomes and member satisfaction and eliminate wasteful, unproductive costs, they are able to distribute the entire savings among themselves. This is in distinction to shared savings where a portion of the savings is allocated back to the health plan. MCOs value providers who perform well on risk deals, which can translate into leverage in contract negotiation and innovative joint ventures.

Partial Capitation

Partial capitation offers advantages similar to full capitation, but the capitation amount covers a more limited set of services, usually those for which providers feel best prepared to manage the financial risk. A pmpm or percentage of premium is paid to reflect the portion of total premium that is usually spent on those services. It is common, for example, for PCPs to accept partial capitation for just the services provided directly by the PCP. As they gain experience with PCP partial capitation or as they add non-PCP provider partners, they may choose to assume partial capitation for additional services. The Division of Financial Responsibility specifies which services are included in the provider's capitated financial responsibility and which remain the responsibility of the managed care organizations.

- Sometimes the partial capitation is combined with shared savings for the services not included in the capitation, e.g., capitation for Medicare plans for Part B with upside-only shared savings for Parts A and D. Shared savings may be upside-only or partial or full upside/downside.
- Depending on the risk arrangement, care management may still be delegated to the provider, where it can be more effectively deployed. Health plans are often reluctant to delegate care management if providers do not face any financial consequences for poor performance.
- Because capitation is a lump sum, the provider group has more flexibility compared to fee-for-service payment to introduce practice innovations, as described under the discussion of full capitation. Provider organizations taking partial capitation can restrict membership to

certain provider types but must realize that providers who do not share in any capitation-derived profits will have no incentive to collaborate to generate those profits.

- The potential financial gains from partial capitation are less than from full capitation, but so are the risks. The incentives to control costs are greater than under a fee-for-service payment arrangement, but because the capitated providers' financial gains or losses are not affected by non-capitated costs, they have no incentive to control those costs. This can cause problems for the managed care organization since it can result in cost shifting and elevated overall costs. For example, a provider organization that is accepting only PCP capitation may choose to refer members to an emergency room rather than expanding evening or weekend hours. Creating a shared savings opportunity for non-capitated services can help remedy this situation.

Providers on partial capitation must still have a level of sophistication, although they will have fewer total dollars at risk:

- Although there is less money at risk, partial capitation is a true financial risk arrangement. Similar to the requirements for global capitation, providers need to have reserves, the financial capacity to pay for deficits, and the capabilities for financial management.
- A fairly large population of the MCO's patients is still necessary under partial capitation (usually at least 300). The smaller the population, the more risky the financial proposition.
- The MLR should be attainable, or the pmpm payment should be actuarially sound.
- The provider groups must have the experience, people, and technology described in capitation.
- Providers must have the capability and desire to maximize premium through charting, coding, and submitting data while staying on top of quality targets and performance. They must be willing to create multi-year operational plans to achieve quality targets and risk scores.

CONCLUSION

The health care landscape in the United States is rapidly changing to include value-based payment structures that produce better quality outcomes and cost performance for defined populations. As providers work to achieve the triple aim of high-quality care, cost containment, and patient satisfaction, value-based payment models can be used to receive financial rewards for good performance and to pay for clinical integration efforts. The required transformation is challenging, but with appropriate resource investment, well-defined strategies that apply proven best approaches, and firm commitment to transformation, providers can succeed in moving to a system that rewards value over volume.

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Since joining Health Management Associates, Deborah has connected the payer and provider communities in transformative and innovative initiatives including Medicaid and Medicare managed care strategies for providers who are clinically integrating; the creation of new provider-owned Medicare Advantage plans; provider strategies for health plans serving Medicaid and dual eligibles beneficiaries; and the design of a state health care innovation plan aimed at the creation of integrated delivery systems with supporting payment reforms.

Prior to joining HMA, Deborah was president of Humana's Medicare business for the Great Lakes Region where she was responsible for profitability and growth of 35 Medicare Advantage plans in Illinois, Michigan, and Wisconsin. She oversaw complex provider relationships, community relations, revenue enhancement, and cost containment.

While at Humana, Deborah created and ran a new performance organization accountable for integrated, enterprise-wide Medicare performance management, process engineering, and planning to create an exemplary consumer experience for 4.5 million Medicare members.

Prior to joining the healthcare industry, Deborah enjoyed working in the airline industry. As director of airport administration, she was responsible for directing the administration of 100 airports and 10,000 employees. She held numerous leadership positions during her time with U.S. Airways.

Deborah is certified as a Six Sigma Green Belt. She earned her Bachelor of Science degree in business administration from the University of Maryland University College. She recently completed an intensive 16-month program, "Healthcare Leaders 2020."

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A pioneer in the accountable care organization movement, Dr. Arthur Jones has 27 years of "boots-on-the-ground" experience as the founding physician and CEO of Lawndale Christian Health Center — a large urban community health center on Chicago's west side.

Dr. Jones helped establish Lawndale as a model managed care organization in the forefront of delivering Medicaid services under a near global capitation payment system. During his tenure, the organization earned top ratings for financial performance and invested in innovations to improve the health of the uninsured. Its redesigned delivery model capitalizes on the efficiencies of electronic medical records, and its care coordinators are creating fully integrated medical homes. Dr. Jones has also served as chief medical officer for a Medicaid managed care company.

Work is his home, and community health is his passion. Dr. Jones has lived in the disadvantaged community he has served since 1980. He "moonlights" as the chief medical officer for Medical Home Network — a foundation-funded demonstration project to improve the health status of low-income Chicago area residents by organizing providers to elevate quality, improve access, reduce costs and reinforce the medical home.

Dr. Jones earned his MD from the University of Illinois and bachelor's degree from Taylor University. He completed his internal medicine residency, chief residency and cardiology fellowship and continues to serve as a clinical associate at the University of Chicago.

At HMA, Dr. Jones focuses on advancing Medicaid accountable care organizations and helping federally qualified health centers transition to managing health care risk and reap some of the downstream financial benefits from operating as a well-functioning, patient-centered medical home.

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Dr. Margaret Kirkegaard provides client consulting focusing on physician engagement in health care reform, medical education, community health and medical care integration, primary care development and transformation, population-based health care delivery and underserved and vulnerable populations. Dr. Kirkegaard has particular expertise in the implementation of the patient-centered medical home model. For over six years, she served as the Medical Director of a state-wide, start-up primary care case management program for 1.8 million Medicaid clients. She was responsible for network development, physician recruitment and practice transformation to the medical home model for 5700 primary care providers and 2300 specialist providers. During her tenure, the program developed multiple clinical quality management tools and a pay-for-performance program and achieved provider approval and client satisfaction ratings over 90%.

Prior to her work in Medicaid, Dr. Kirkegaard held several academic positions teaching in both graduate and undergraduate medical education institutions. In 2005, she was selected from among nominees from all American medical schools for the National Golden Apple Teaching Award sponsored by the American Medical Student Association.

Dr. Kirkegaard is a board certified family physician. She received her M.D. from the University of Minnesota and completed her Family Medicine residency at Hinsdale Family Practice Residency. She holds a Masters of Public Health with a concentration in Health Policy and focus on Quality Improvement.

As a third-generation family physician with over twenty years clinical experience, Dr. Kirkegaard continues to teach medical students and residents and provide clinical care to patients at the Hinsdale Family Medicine Residency. As an advocate for underserved and vulnerable patients, she has also been a long-term volunteer at local free clinics serving uninsured patients.

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As administrator of HMA's Accountable Care Institute (ACI), Meghan Kirkpatrick focuses on building and expanding the Institute and its reach through new educational programs and leadership development. Meghan facilitates seminars and workshops including large-scale training sessions for providers with a focus on the organization of care for underserved populations. She assists in the writing and production of products and tools focused on the transformation of health care delivery to integrated and accountable systems of care, and is responsible for developing business and marketing strategies. In addition to strategic planning and business development, Meghan plays a significant project management role, overseeing four ACI teams that focus on the development of new, innovative approaches to delivery system and payment reform.

Meghan has a wide array of project experience, including working with the State of Illinois and key stakeholders to develop their State Health Care

Innovation Plan (SHIP), which proposes new and sustainable health care innovations for Illinois; and working with the State of Iowa on their application to the Centers for Medicare and Medicaid Services (CMS) to receive funding to test and implement their SHIP over the next five years. Meghan has also worked with a health system in Illinois to develop a model that integrates Advanced Practice Nurses and Physician Assistants into large practices, has experience helping local health systems achieve PCMH accreditation, and has developed strategic recommendations related to provider networks for a national health plan.

Prior to joining HMA, Meghan worked for both corporate and non-profit organizations and attended a Global Business graduate program in Washington, D.C. in order to gain more experience working on development and foreign aid projects. In addition to taking classes in international relations, she worked for a non-governmental organization that helped to advance trade, economic, and commercial development overseas.

HEALTH MANAGEMENT ASSOCIATES ACCOUNTABLE CARE INSTITUTE

ACI

SYSTEM REDESIGN

NEW MODELS OF CARE

INFORMATION AND TECHNOLOGY
INNOVATIONS

FEDERAL AND STATE POLICY
CONNECTIONS

OBJECTIVE/MISSION OF
THE ACI: *Transform the
current healthcare delivery
system to ensure greater
effectiveness, value,
transparency, and
accountability.*

Health Management Associates (HMA) has amassed a wealth of on-the-ground experience that is important to share more widely as the nation undergoes the dramatic changes anticipated over the next several years. To that end, it is forming the Accountable Care Institute (ACI). The ACI will:

- provide a venue in which to share experiences and best practices from across the country related to the development of community-specific integrated delivery systems, new financial strategies to incentivize value, and innovative partnerships between providers and payers to ensure effective care for the unique populations they are both trying to serve;
- develop and offer resources to others to help spread lessons learned in the development of these new approaches to the delivery of accountable care;
- facilitate the training of new leaders in health system change; and
- translate delivery system lessons learned on the ground into policy and policy into change at the delivery system level, whether financial, legal, clinical or organizational.

Over the past decade, HMA has been assembling a growing practice of senior health care clinicians and administrators, finance experts, behavioral health professionals, managed care leaders, long term care innovators and others committed to developing new approaches to delivering health care services, particularly to populations and communities that have traditionally been underserved. HMA has worked for large health systems, consortia of providers, individual hospitals and ambulatory providers, states and counties, foundations and managed care plans to assess current delivery of care, plan new approaches and assist in implementation. This work has been growing in volume as the country has started to seriously grapple with how to assure access and quality—and the improvement of health status—while rolling back the cost trajectory which is universally agreed to be unsustainable. Expertise in integrated and accountable care as it applies to the delivery of care to those funded by public dollars is in demand; it is anticipated that the ACI will provide a vehicle for meeting that demand.