



# Health Centers in the Era of Accountable Care

Insights from AltaMed Health Services

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## Acknowledgments

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JSI is a public health research and consulting organization with a focus on vulnerable populations.

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## Introduction

An accountable care organization (ACO) can be defined as an entity that is responsible for the cost and quality outcomes of its assigned or attributed patients.<sup>1,2</sup> Providers have played leadership roles in established ACOs to date, with 51% of ACOs in a recent national survey reporting being physician-led.<sup>3,4</sup> As the Affordable Care Act has elevated the need for increased accountability for cost and quality outcomes, clinical leaders, thought leaders, and policymakers have recognized that primary care can and should play a central role in accountable care. Primary care has ongoing contact and established trust with patients, and represents a cost-effective health home and care integrator across systems compared to other settings.<sup>5</sup>

ACOs consisting of multiple health centers or health center networks have formed in several places, yet many health centers have not participated in or led ACOs for a variety of reasons, including lack of startup capital and lack of experience collaborating with hospitals in sharing financial risk.<sup>6-8</sup> Nevertheless, health centers are increasingly interested in pursuing accountable care strategies to improve cost and quality outcomes for the individuals they serve. In some states, state policy change is promoting formal ACOs.<sup>9-12</sup> However, even in the absence of state-level policy facilitators, health centers are well positioned to participate actively in accountable care payment and delivery system reforms, whether as part of formal ACOs or as networks of providers.

Health centers have a set of competencies and characteristics that position them to potentially play leadership roles in accountable care in Medicaid. Health centers serve a large proportion of the Medicaid population, practice a form of culturally competent primary care that addresses health and behavioral health concerns within the context of the social and economic challenges that patients face, and have a history of and explicit commitment to advancing population health within a geographically defined community.<sup>13</sup> With this foundation, successful health center participation in accountable care will require rethinking geographic accountability, refining the health center care delivery model, and diversifying financial contracts to include risk-based payments. Such changes hold promise to improve population health in the communities that health centers serve, and to promote health center financial sustainability.

## Purpose

The purpose of this white paper is to describe a unique path to accountable care for health centers that leverages their historic strengths and social commitments and addresses key challenges.

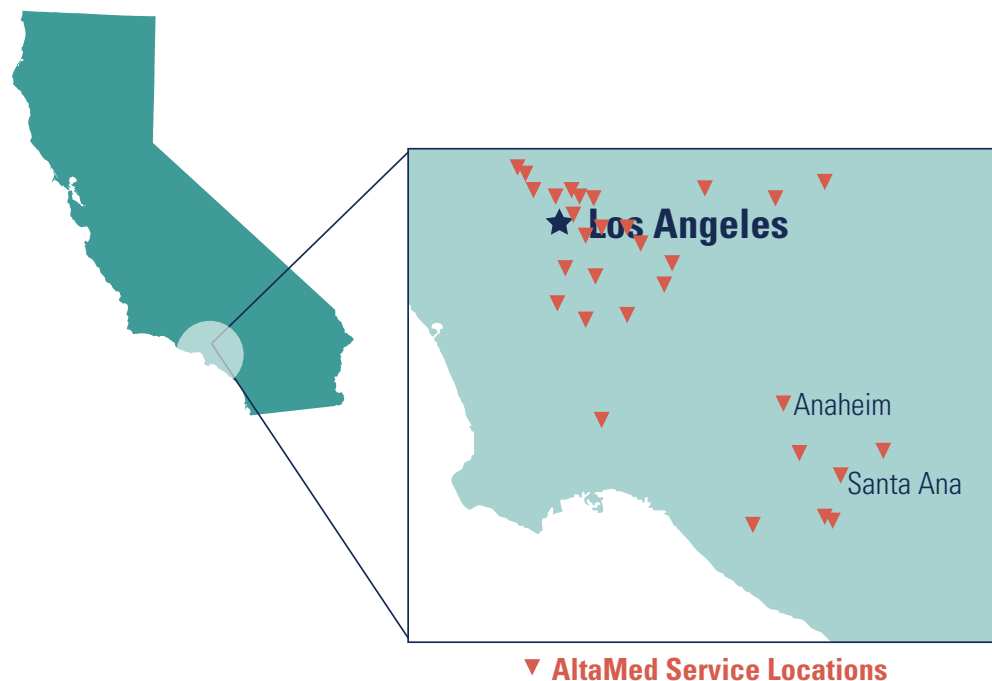
By focusing on the experience of AltaMed Health Services (AltaMed), a large federally-qualified health center (FQHC) and independent practice association (IPA) in Southern California, this white paper will:

- » Outline our research methodology;
- » Provide background on the history and trajectory of growth of AltaMed;
- » Explore three key findings regarding how health centers can leverage their geographic accountability to achieve population health and financial stability, refine their care model to increasingly reflect a whole-person focus as a strategy for meeting the Triple Aim, and benefit from assuming financial risk incrementally;<sup>14</sup> and
- » Address how leadership and size can serve as cross-cutting and mutually supporting key facilitators for health centers participating in and succeeding under accountable care.

## Methodology

JSI Research and Training Institute, Inc. (JSI) conducted case studies of AltaMed and three other emerging ACOs serving Medicaid populations from March 2013 through March 2015 under a Robert Wood Johnson Foundation (RWJF) grant. We have drawn insights from a synthesis of the AltaMed case study—derived from a robust review of documents, three site visits conducted over a 2-year period, and over 25 interviews with AltaMed leaders—and JSI’s recent research on safety-net ACOs and work with health centers nationwide on the topics of payment reform and delivery system transformation.<sup>15-19</sup> This white paper seeks to use the AltaMed experience as a lens through which other health centers might see opportunities, and is complementary to an AltaMed case study written by the Integrated Healthcare Association as part of the same RWJF grant.<sup>20</sup>

**Figure 1. AltaMed Service Locations**



## Background on AltaMed as a “Virtual ACO”

AltaMed was one of the first federally qualified health centers (FQHC) to be established under the federal Urban Health Initiative in 1977. FQHCs provide care to predominantly low-income individuals and are considered the safety-net providers in their communities because of a mission to serve all patients, regardless of their ability to pay. One key requirement for all FQHCs is having a governing board where 51 percent of members are from the community that the health center serves.

In AltaMed’s case, the community served includes a population that is 82 percent Hispanic/Latino and 80 percent below the federal poverty level. While historically, approximately a third of patients were uninsured, this number has been declining with Medi-Cal expansion.<sup>21</sup> For over 30 years, AltaMed has been under the same leadership and has grown from an organization earning \$15 million a year in revenues to a \$423 million enterprise. By our last site visit in 2014, AltaMed was operating 43 FQHC clinics in Los Angeles and Orange Counties, making it the largest FQHC in the country.<sup>22</sup> AltaMed’s vision is to be the “leading community-based provider of quality health care and human services” while also maintaining financial health as a key ingredient in its overall strategy.

AltaMed is unique as a safety-net organization not only in size but in its contracting arrangements. AltaMed moved relatively early into risk-bearing contracts and managing care for assigned members that extends well beyond

primary care services. Since 2007, AltaMed has operated a separate, professionally capitated Independent Practice Association (IPA), which now manages 146,610 Medi-Cal and 34,102 commercial and senior lives (see Table 1).

AltaMed’s Medi-Cal membership has grown significantly with the Affordable Care Act, from 82,367 in 2013 to 146,610 in 2015. While AltaMed employs providers in a “staff model” within 43 of its own clinics, its IPA contracts with both its own clinics and a growing network of primary care and specialty care providers. As an IPA, AltaMed also recently entered into six shared risk contracts with hospitals and health plans for individuals dually eligible for Medicare and Medi-Cal under California’s Coordinated Care Initiative (CCI).

Finally, AltaMed has a relatively unique business line in that they accept global capitation for the Program of All-Inclusive Care for the Elderly (PACE), which allows Medicare and Medicaid patients eligible for skilled nursing care to receive appropriate health care and supportive services in community-based settings rather than nursing homes or other facilities.

Like all FQHCs, AltaMed FQHC clinics ultimately receive per-visit prospective payment system (PPS) payments for all Medi-Cal visits with qualified providers. Established in federal legislation, PPS payments are prospectively set based on reasonable costs (see sidebar on page 19).<sup>23</sup> PPS payments are designed to allow FQHCs to use their federal grant dollars

## Background on AltaMed as a “Virtual ACO”

to care for the uninsured rather than to cross-subsidize low Medicaid reimbursement.<sup>24</sup>

While PPS payments are bundled, per-visit rates based on historical costs of medical services and wrap-around services such as translation, transportation and enrollment assistance, they ultimately function as a fee-for-service payment that creates a financial incentive to render a higher volume of visits with billable providers. AltaMed’s visit rates per patient reflect both a high level of access to care and a response to this financial incentive, which is typical of other FQHCs in the state as well.<sup>25</sup> AltaMed sees patients 3.7 times per year, which is higher than the rate for typical Medicaid HMO patients in California.<sup>26</sup>

As an organization, AltaMed accurately foresaw insurance expansion and increasing competition for Medi-Cal expansion and exchange members. In order to compete successfully on quality and member experience with other large medical groups, AltaMed committed to becoming the “provider of choice” rather than “provider of last resort” in their communities. This transformation included investing heavily in improving clinic infrastructure, organizational leadership, data analytics, quality outcomes, and customer service. In 2012-13, AltaMed also attempted to forge an accountable care network (ACN), which did not move forward due to leadership challenges, competition between hospitals, and a lack of agreement among partners on making investments in shared initiatives, such as care management and information technology.

Despite an absence of any state intervention or policy facilitator, AltaMed’s evolutions in care delivery and payment show it has grown into a **“virtual ACO,”** which we define as an entity that practices most, if not all, of the competencies and risk-based payment arrangements of an ACO without having a formal ACO governance structure or explicitly named ACO contracts with payers. AltaMed possesses the key competencies of an ACO through holding upside and downside risk-bearing contracts with payers; making investments in systems and health information technology with the intent of coordinating care within and across systems; and making strategic changes in delivery system transformation with the goals of improving quality outcomes, patient experience, and total cost of care.

Table 1. AltaMed Enrollment 2013-2015

Enrollment by Product Line	April 2013	April 2014	April 2015
Total Medi-Cal	82,367	106,199	146,610
AltaMed Clinics	72,739	97,639	122,236
Network IPA	9,628	10,381	25,963
Total Commercial & Senior	25,712	32,137	34,102
AltaMed Clinics	19,852	24,174	27,234
Network IPA	5,860	7,963	6,868
Total Duals			2,269
AltaMed Clinics	-	-	745
Network IPA	-	-	306
Total PACE	1,406	1,597	1,688

## Findings for Health Centers in the Era of Accountable Care

AltaMed represents an interesting health center to study because of its size, growth, and experience with financial risk. The future of U.S. health care will increasingly require that providers assume more financial risk and accountability for the Triple Aim for populations, a trajectory that AltaMed embarked on voluntarily as part of a concerted growth strategy in a competitive environment. Based on analysis of AltaMed's experience growing from a single health center into a virtual ACO competing with other large provider groups, coupled with our team's experience researching and working with health centers and safety-net hospitals during the same 2013-2015 timeframe, we have identified four generalizable insights for health centers looking ahead in the era of accountable care:

1. Health centers can leverage their geographic accountability to achieve population health and financial stability.
2. To meet the Triple Aim in the safety net, care models and the delivery system will need to change to reflect a whole-person focus.<sup>27</sup>
3. Health centers can benefit from assuming financial risk incrementally.
4. Leadership and size represent facilitators for success in accountable care, and there are multiple ways for health centers to achieve the benefits of size.

### Leveraging geographic accountability for population health and financial stability

#### **Summary Finding: Health centers can leverage their geographic accountability to achieve population health and financial stability.**

Health centers have long known—and vanguard community health initiatives are increasingly recognizing—that when a single entity holds clinical and financial responsibility for a large portion of the people in a community, that entity has more incentive to make community-level investments in health services, to engage in health promotion, and to address social determinants of health both directly and indirectly. AltaMed's initiatives that aim to serve a majority of individuals in a community and to serve individuals over the course of a lifetime highlight how one FQHC has increased the organizational incentive to deliver on health centers' mission to promote community health.

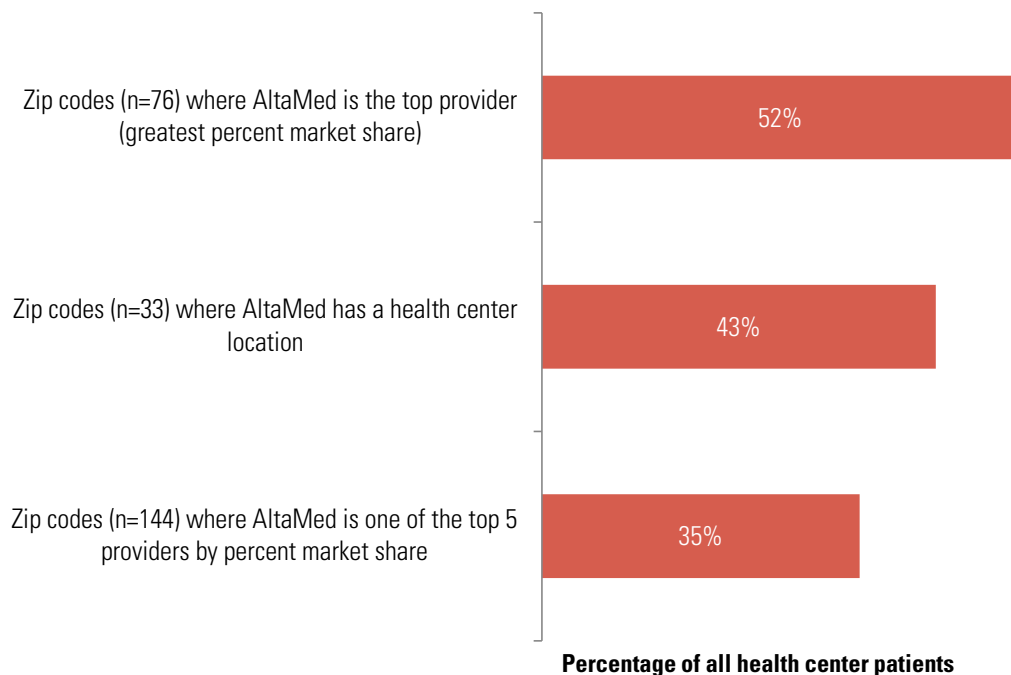
As state Medicaid programs have grappled with delivery system transformation and payment reform, accountability for population health and cost outcomes is evolving in some vanguard states to focus on geographically defined communities. This geographic accountability is part of a strategy to target interventions at the clinical and community levels simultaneously while also involving stakeholders from health, behavioral health and other sectors that influence health outcomes. Oregon's regional Coordinated Care Organizations, Minnesota's Integrated Health Partnerships,



and Colorado's Regional Care Collaborative Organizations are all examples in which state policy has accelerated Medicaid programs by taking a regional approach to coordinating and integrating care for low-income populations. Such geographic accountability very much aligns on a smaller scale with health centers applying to the federal government to care for a defined population within a circumscribed geographic area. As part of the process to become an FQHC, an applicant must rigorously describe and quantify the need and patient population in a defined community, demonstrate an ability to work with existing organizations and providers within the area, and have the capacity and plan to meet the identified need of the geographically defined population (along with meeting numerous other requirements).<sup>28</sup>

Unlike other primary care providers, accountability to the community is also systematic for health centers. All health centers are required to have majority (51%+) community boards to help the health center respond to community needs. AltaMed recognized how geographic accountability could serve as a cornerstone of both its business strategy and its mission to improve community health. In essence, they recognized that by being the provider and risk-bearing entity for a large proportion of individuals in a given community, the incentive to engage in population health improvement at multiple levels increases. Reviewing data from 76 Los Angeles and Orange County zip codes where AltaMed is the top provider (i.e. greatest percent market share) revealed that AltaMed has an average of 52% health center market share, seeing a range of 2% to 100% of all health center patients and 0.2% to 28% of all low income individuals in these areas (see Figure 2).

**Figure 2. Percentage of All Health Center Patients Served by AltaMed in Top AltaMed Service Areas**



Source: Uniform Data System Mapper, 2015. Note: N = 144 zip codes. Zip codes were selected in Los Angeles and Orange Counties, corresponding to the major areas that AltaMed serves. Zip codes were only selected if AltaMed was within the Top 5 Health Center Providers by Market Share.

Furthermore, when bearing financial risk for a large portion of individuals in a community, investments and coordinated efforts to improve patient, member, and community health result in financial benefits to the organization. Benefits increase if customers remain loyal over time. AltaMed's CEO, Cástulo de la Rocha, also highlighted the fusion of their health center mission and business strategy when he recounted that the "birth" of their eventual PACE program was prompted by a community board member asking, "What are you doing for old folks in East LA?"

### **Versions of population health: patient, member, community**

While not alone, AltaMed represents a health center that is systematically advancing three "versions" of population health: the health of a patient population, the health of a prospectively assigned membership population, and the population of an entire community. The organization has also made explicit connections between its patient population goals and community health goals.

Pairing patient-level and community-level efforts is a strategy in the early stages of implementation. Nevertheless, aligning efforts to address community-level obesity and patient-level diabetes is an example of a health center fusing clinical efforts with community-level initiatives. Within AltaMed, at the patient population level, care teams flag all pre-diabetes patients to meet with health educators using the Diabetes Prevention Program, an evidence-based intervention to improve HbA1c levels, systolic blood pressure, cholesterol levels, and body mass index (BMI). The Quality Department also maintains registries of patients who need certain follow-up activities. To bridge the gap between patient health and community health, AltaMed maintains registries for three years and considers any patient seen in past two years to be an "attributed patient," regardless of their managed care assignment. At the membership level, leaders expressed plans to make BMI an internal quality measure, while pushing external organizations to adopt BMI as a measure of quality performance. At the community level, the organization aims to conduct community-level BMI measurement and is hiring more culturally and linguistically competent health educators, called *promotoras*, based on evidence that *promotoras* can positively influence dietary and physical activity habits that prevent obesity and diabetes.<sup>29</sup>

Simultaneously, to advance population health at the community level, AltaMed is partnering with RAND, a nationally known research organization, to conduct a National Institute of Health study in which *promotoras* survey parks to determine if they are being used for physical activity in an optimal way. Based on data collected, the health center provides free exercise classes in underserved community parks. In another example, AltaMed conducted a 5-mile radius survey of East LA, resulting in a partnership with Mothers of East LA and the Sheriff's Department; the partnership established a walking track in cemeteries, where "gangs don't go," and community members continue to use the path. AltaMed has also worked to establish a farmers' market in the local community, creating increased access to fresh, healthy food for an underserved community. It is notable that the alignment of clinical and community-level strategies around a health outcome represents an emerging practice in accountable care efforts to improve population health.<sup>30,31</sup>

One unique aspect of AltaMed's approach to community health is that efforts designed to influence a health outcome are not limited to medical services and factors. AltaMed is simultaneously working to address the social determinants of health in the communities it serves. Recognizing that factors such as employment status and education can impact health outcomes as much if not more than health services, AltaMed has established a grant writing program that attracts approximately \$20 million each year for projects inside and outside the clinics. For example, in 2011, AltaMed received one of four Department of Labor grants for a 4-year program that mentors young, low-income parents to stay in school, graduate, and enter the health care profession.<sup>32</sup> As providers and payers struggle to improve cost and quality outcomes over the long term in Medicaid populations, there will likely be increasing attention to the social determinants that affect health outcomes and costs of care.<sup>33,34</sup>

### **Caring for individuals as they age**

AltaMed exemplifies one of few health centers that have adopted a clinical and business strategy that encompasses caring for individuals and families over a lifetime, which further incentivizes the organization to invest in long-term population health strategies. National health center data shows that only a small portion (8.4%) of all health center patients are insured by Medicare. By building capacity to care for dual-eligible individuals and the frail elderly through PACE, AltaMed is increasingly offering communities that it serves the unique prospect of being a "lifetime" provider.

Simultaneously, having PACE and duals contracts diversifies AltaMed's financial portfolio, bringing the organization a unique type of stability in the short and long term. In fact, because many investments in preventive health care accumulate over the course of many years, when a single provider bears financial risk for a population over a lifetime, it creates an increased incentive to make long-term investments in health. For AltaMed, the long-term returns on being a provider across a lifetime can accrue when individuals for whom they have long provided preventive health services become Medicare or dually eligible and remain loyal patients under capitated contracts.

### **Implications for health centers**

As more and more Medicaid programs and Medicaid managed care plans move towards population-based payment and accountability strategies, FQHCs will need to re-orient themselves to the notion of population health for assigned members even though most FQHC accountability systems to date (such as the Uniform Data System) only require reporting on quality processes and outcomes for patients seen in clinic. Health centers also stand to benefit vis-à-vis their mission and their financial goals if they can become providers for a large portion of individuals in their community, including those who are—or will become—Medicare eligible. Such strategies can incentivize and reward health centers for short- and long-term investment in population health initiatives.

## Primary Care Delivering Whole-Person Care to Meet the Triple Aim

### **Summary Finding: To meet the Triple Aim in the safety net, care models and the delivery system will need to change to reflect a whole-person focus.**

Whole-person care has been defined as “the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.” Whole-person care is increasingly considered an especially important accountable care strategy to achieving cost and quality outcomes for individuals whose non-medical issues greatly influence, if not trump, medical issues affecting their health.<sup>37-39</sup> As trusted providers of primary care with an appreciation for addressing non-medical needs of vulnerable populations, health centers are well positioned to be the integrator for precisely this type of patient-centered delivery system transformation. Health centers could also benefit from continuing to refine their delivery model. The results of such efforts hold promise to improve patient experience, access, and quality outcomes and allow health centers to compete most effectively and succeed financially in risk-based environments.

AltaMed, like most health centers, has always recognized that social determinants of health—or the constellation of environmental, social and economic factors that shape health—affect access to care and health outcomes for its patient populations. By providing enabling services such as transportation, translation, and referral to community-based social services, health centers have long worked to address some of these needs within the health center payment framework. However, for provider organizations assuming increased responsibility for the cost and health outcomes of Medicaid populations, there is increasing attention to whole-person care strategies to best achieve health outcomes and reduce total costs of care through better addressing social determinants of health. Table 2 outlines six accountable care strategies, their alignment with whole-person care, and an explanation of how health centers’ competencies and delivery model position them well to use such strategies. AltaMed’s path to delivery system transformation reveals a movement toward more whole-person care and illustrates some notable challenges.

**Patient-Centered Medical Home (PCMH):** Similar to some FQHCs, AltaMed’s care model hinges on an interdisciplinary team of physicians, midlevel providers, nurses, medical assistants, and health educators. AltaMed also went the extra step of becoming PCMH-recognized by the National Committee for Quality Assurance (NCQA) earlier than most health centers. “PCMH is just what AltaMed’s model is. Re-accreditation is checking boxes in some way,” commented one Medical Director. Built on the health center mission to serve all patients, regardless of their ability to pay, AltaMed embraces a “payer-agnostic” care model where clinical algorithms and quality goals are universal rather than being dictated by a patient’s insurance status or specific payer.<sup>42</sup> All staff model primary care providers (PCPs) are evaluated on a common set of quality measures which are prioritized primarily for having a strong clinical evidence base and secondarily on

**Table 2. Accountable Care Strategies that Leverage Health Center Competencies**

Whole-Person Care Activity	Accountable Care Strategy	How strategy could leverage health center competencies
Patient-centered care within PCMH	<ul style="list-style-type: none"> <li>» PCMH is a key feature of most accountable care delivery models, including empanelment with a care team and a commitment to measuring and improving quality.</li> <li>» Patient-centered care includes culturally competent, linguistically appropriate care and assessment of non-medical needs and coordination with services for non-medical factors that influence health outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>» CHCs use care teams and serve as the medical home and coordinator of behavioral health and other social services.</li> <li>» CHCs have linguistically and culturally competent staff and providers.</li> <li>» CHCs address common barriers to health and other services, including limited English language and literacy, cultural taboos, and transportation.</li> </ul>
Enrollment	<ul style="list-style-type: none"> <li>» Like whole-person care, accountable care starts with enrollment in insurance as a critical “gateway” to health, behavioral health and other social services. Enrollment in Medicaid can simultaneously mean coverage for health, substance use, and mental health services.</li> <li>» Newly insured populations need education regarding how to use insurance and health, behavioral health and social services for optimal health outcomes and prevention of avoidable hospitalization.</li> <li>» Medicaid eligibility criteria also often overlap with programs to assist with housing, income support and food assistance.</li> </ul>	<ul style="list-style-type: none"> <li>» Unlike many providers, CHCs are allowed to both enroll and provide services to patients.</li> <li>» As trusted primary care providers, CHCs educate newly insured on appropriate health system use.</li> <li>» CHCs assess non-medical needs, establish relationships with community-based providers of social services and make appropriate referrals for social services</li> </ul>
Patient Engagement & Activation	<ul style="list-style-type: none"> <li>» Patient engagement and activation strategies at the clinical and community levels in accountable care take the form of technological tools, use of motivational interviewing, and expanding care teams to include non-traditional health workers.</li> </ul>	<ul style="list-style-type: none"> <li>» CHCs are implementing online patient portals to engage with members.</li> <li>» CHCs train providers and staff in motivational interviewing.</li> <li>» CHCs support non-traditional health workers (e.g., promotoras) conduct activities such as outreach and case management.</li> </ul>
High-cost case management	<ul style="list-style-type: none"> <li>» Risk stratification and concentrated care management and care coordination for those in the highest risk strata are a key strategy for any organization bearing financial risk for a population.</li> <li>» Recent research on high-risk care management has supported this model, “High-risk care management programs are most effective when they are anchored in the practices where patients receive their care.”<sup>40</sup></li> </ul>	<ul style="list-style-type: none"> <li>» CHCs establish the critical trust necessary to engage high-risk patients.</li> <li>» Challenge: health centers may need external data from an IPA or health plan to accurately identify high-risk cases.</li> <li>» High-cost case management is a novel role for health centers and will form an increasingly important service as assume more financial and clinical accountability for total health system utilization and outcomes.</li> </ul>
Behavioral Health Integration	<ul style="list-style-type: none"> <li>» Addressing health and behavioral health concerns in concert —frequently via integration of behavioral health services into primary care—is a key strategy for improved quality outcomes and appropriate health system utilization.</li> </ul>	<ul style="list-style-type: none"> <li>» CHCs employ behavioral health staff and do “warm handoffs” while a patient is in clinic.</li> <li>» Challenge: Some states do not pay for two visits on a single day and/or do not reimburse for non-licensed BH providers.</li> </ul>
Collaboration with social services	<ul style="list-style-type: none"> <li>» Addressing social determinants of health becomes a higher-stakes strategy when operating as part of a risk-bearing organization like an IPA or an ACO.</li> </ul>	<ul style="list-style-type: none"> <li>» Health centers have long provided enabling services to address non-medical barriers to services and outcomes.</li> <li>» CHCs have partnerships with community-based organizations to address social factors, such as housing instability and food insecurity.<sup>41</sup></li> </ul>

alignment with payer objectives. While many health centers embrace a team-based care model and are required to have a quality improvement program in order to meet federal requirements, AltaMed built upon these foundational health center elements to be competitive as a “provider of choice” as more patients gain insurance coverage.

**Enrollment:** It is significant that AltaMed enrolled more people in Medi-Cal and Covered California (the Exchange) than any other enrollment entity in the state. Not all beneficiaries whom AltaMed enrolled chose AltaMed as a provider, although many did. Embracing this role of enroller helped fulfill both “mission and margin” goals for the health center and served as a “gateway” to connect patients to both healthcare services and services to address the multitude of non-medical factors that influence health outcomes and costs. Gaining newly enrolled managed care Medi-Cal members has also been a challenge. For example, 40 percent of patients assigned to AltaMed IPA by health plans have no listed address, and AltaMed has had to invest heavily in processes to identify contact information for these members and connect them to primary care services.

**Patient Engagement and Activation:** On the patient engagement front, AltaMed has the benefit of knowing for whom it is responsible for prospectively; managed care plans assign beneficiaries to the AltaMed IPA, which, in turn, assigns individuals to a primary care physician in their staffed health centers or network of providers. Providers are responsible for panels of patients and are held accountable for quality metrics for their panels. Empanelment of members has been an iterative process of achieving buy-in with clinicians who had traditionally worked in an acute care model. Empanelment has involved building providers’ trust in the quality process and outcomes data. As state Medicaid programs expand Medicaid managed care and push for increased levels of accountability, health centers will have to make the same philosophical shift that AltaMed has—from focusing just on patients who come to the clinic, to caring for an entire assigned membership.

In terms of patient activation, AltaMed is pursuing clinical and community strategies that could be embraced by other health centers. One medical director developed training for physicians in “motivational conversation,” a shortened version of motivational interviewing (MI), which recognizes the importance of the skill and addresses the challenge providers voiced about having insufficient time to do MI. AltaMed has also made sizable investments in a patient portal to enhance self-care and out-of-clinic engagement with patients who increasingly have access to internet and mobile phones despite being low income.<sup>43,44</sup> Furthermore, AltaMed employs *promotoras* to do outreach and education outside the clinic, to build trusting relationships with patients, and to help understand disease processes and self-care. “*Promotoras* in the community really make a difference,” commented one Medical Director.

**High-Cost Case Management:** With the impetus of being a professionally capitated IPA and a CMS Community-based Care Transitions Program grantee, AltaMed has made a concerted effort to do high-cost case management for the highest risk of their general population (AltaMed also does

intensive case management of PACE patients).<sup>45</sup> AltaMed employs a risk-stratification methodology based on prior hospitalization and emergency department use to identify the top 1 percent highest risk assigned members. Both staff model and contracted network primary care providers can also refer patients into care management. For the highest risk patients, nurse care managers and licensed clinical social workers provide specialized case management and care coordination. For a second tier of individuals at high risk for hospital and emergency department utilization, AltaMed has co-located behavioral health specialists and care managers on the clinical interdisciplinary teams in their health centers.

High-risk case management has also been an evolving challenge. Determining whether care managers optimally reside within the clinics or at the IPA level has been challenge that AltaMed has confronted along with many other ACOs.<sup>46</sup> Providing care management and coordination that is integrated with clinical care is more seamless for patients assigned to AltaMed's own clinics compared to patients assigned to contracted network practices, many of which have not yet adopted EHRs. For AltaMed clinic patients, care managers are considered part of the interdisciplinary team and work from the same electronic health record and care plan as the clinical team. By contrast, for patients within the contracted network, AltaMed IPA-level care managers do solely telephonic care. Given that patients tend to trust advice from their "doctor" but tend to be skeptical of "management by their health plan," for IPA-level care management and coordination of clinic patients, AltaMed benefits from having the same brand for their IPA and their health centers. While IPA-level care managers and coordinators will continue to be necessary for the contracted network's patients, AltaMed plans to study outcomes for clinic patient populations managed by staff-model-health-center-level and IPA-level care managers and case coordinators to determine the optimal path moving forward. They will also have to negotiate with some health plans that have been reluctant to delegate the dollars and responsibility for the high-risk care management and coordination function. In another part of the evolution of the care model, AltaMed is striving to build in high-risk identification at the point of care rather than depend on the current method of retrospective risk stratification.

**Behavioral Health Integration:** Integrating mental health and substance use services has been a key challenge for AltaMed. Similar to many safety-net providers, AltaMed clinical leaders estimate that 60-70 percent of primary care visits have a behavioral health dimension. Furthermore, national research on all-cause hospital admissions among Medicaid super-utilizers revealed "mood disorders, schizophrenia and other psychotic disorders, and alcohol-related disorders were the first, second, and sixth most common reasons for hospitalization, respectively."<sup>47</sup> Yet at first, AltaMed moved slowly into embracing behavioral health integration as a core part of its care model. Once AltaMed did adopt it as a strategy and began seeking behavioral health providers for their health centers, the organization had difficulty finding sufficient numbers of bilingual, bicultural licensed clinical social workers to meet the needs of their population. California is also one of a small number of states that does not reimburse health centers for marriage and family therapist visits or



two visits on the same day, creating a financial hurdle to integrating care. Despite these challenges, AltaMed recognizes the pivotal role of treating behavioral health as part of an individual's care plan as a strategy to achieve quality outcomes and reduce avoidable hospitalization.

**Collaboration with Social Services:** For AltaMed, collaboration with social services as part of a whole-person care approach is still early in development. Coordinating with frequently overburdened county systems has been a challenge in better addressing social determinants of health. Specific hurdles have included referral networks of community-based social service providers not being ready to receive referrals and not “closing the loop” once a need is met. While clinical leaders are committed to screening for a variety of social issues, including domestic violence and substance use, AltaMed is moving slowly into this effort, wanting to ensure that screening processes have high-quality internal or external referral pathways in place to address needs uncovered by screening. While AltaMed continues to try to hire additional internal licensed clinical social workers and establish internal processes to address select psychosocial needs, organizational leaders still foresee ongoing gaps in county social service referral and communication networks.

### **Implications for health centers**

With the foundation of the health center mission and payments that can include medical, behavioral health, and enabling services, health centers are well situated to be a trusted center of an accountable care entity focused on the whole person. AltaMed's case illustrates how efforts in PCMH, enrollment, patient activation, high-cost case management, behavioral health integration, and collaboration with social services are evolving in a whole-person care model. Challenges of whole-person care remain. Safety-net systems will continue to need to forge effective referral networks and communication practices with entities that address social determinants of health, while internalizing some of these functions to meet member needs. Challenges aside, health centers could benefit from viewing the health center care model as both a foundation of a competitive quality and patient experience strategy and an advantage for providing whole-person care as a path to achieving cost and quality outcomes under financial risk in Medicaid.



## Incrementally Assuming Financial Risk as an Opportunity and Eventual Responsibility

### **Summary Finding: Health centers can benefit from assuming financial risk incrementally.**

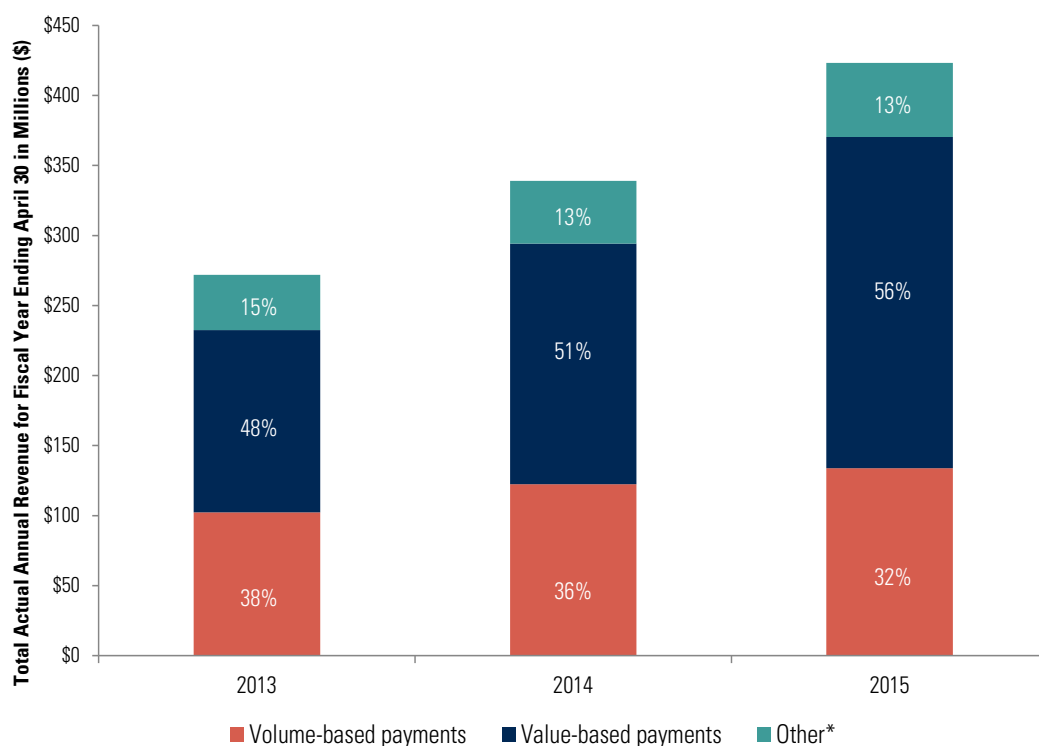
Many health centers view financial risk as unnerving and unsafe. Yet taking on small amounts of risk or taking on just upside risk for a period before assuming downside risk can help health centers to make desired changes to their care models and systems. Health centers are increasingly seeing a need for more flexibility in delivering primary care to meet increasing patient demand, to compete effectively for Medicaid and exchange patients, and to transform care models to meet whole-person needs. Partial-risk and global contracts have been helpful, if not essential, for advancing and transforming care models. By gaining expertise in whole-person care delivery through participating incrementally in risk, health centers can gain experience under financial risk models that are likely to be models for health care payment in the future.

### **The National Shift Toward Value-Based Care**

In recent years, the critique of the fee-for-service model of payment for health services has grown into a national call to action. It is significant that CMS announced a commitment to tying at least 50 percent of all Medicare payments to quality or value through alternative payment models, such as ACOs, by 2018.<sup>48</sup> While payment reforms are not a panacea for all that is flawed with the U.S. health system, a move away from volume-based payments continues to be held up as one necessary and inevitable aspect of a health system that is incentivized and accountable for outcomes, not just services rendered.<sup>49</sup>

Many health centers are already participating in payment reforms that provide additional dollars for transformation and upside risk arrangements in the form of performance-based pay through managed care plans, but only a small number have moved toward accepting downside financial risk.<sup>50</sup> Some health centers are beginning to participate in shared savings contracts by being part of ACOs in which health center partners have the chance to earn significant financial reward for helping to reduce overall health system costs and improve outcomes.<sup>51-53</sup> In select instances nationally, health centers have operated their own health plans or IPA networks. However, most health centers still ultimately depend on volume-based PPS payments for the majority of their revenue. Amidst this landscape, AltaMed exemplifies a health center that is experimenting on multiple fronts with payment reforms that are likely to shape the value-based payment landscape of the future. Figure 3 shows AltaMed's portfolio of revenue as it has evolved from 48% to 56% of revenues being tied to value over the last three years. By experimenting incrementally in payment reforms for some populations and in full risk-based contracts for other populations, AltaMed offers an example of how other health centers might contemplate incremental adoption of payment reforms that enables delivery system transformation to meet the Triple Aim.

**Figure 3. AltaMed Revenue Growth 2013-15**



Note: Value-based payments include all capitated payments across business lines (Medi-Cal and commercial, and duals professional capitation, PACE), and other risk-based and pay-for-performance payments (~1% of total revenue). Volume-based payments include all Medi-Cal capitation, wrap around, and reconciliation payments received by AltaMed clinics. "Other" includes \$8 million in 330 grants, other grants, payments for deliveries and other carved out services from Division of Financial Responsibility, and revenues from HIV, Drug Treatment and Long Term Care programs.

### Moving to "Risk" Within the FQHC System

Like most health centers, the majority of AltaMed clinics' core Medicaid revenue continues to be tied to the volume of face-to-face visits with a limited set of billable providers. AltaMed is also an anomaly among health centers in that as an IPA, a PACE provider, and a risk-bearing provider for dual-eligible beneficiaries, it derives an increasing proportion of revenue from capitated contracts.

Building on its experience delivering care flexibly under per-member-per-month payments, a few AltaMed sites are part of an effort led by the California Primary Care Association and the California Association of Public Hospitals and Health Systems to pilot a novel, non-volume-based payment reform under an Alternative Payment Methodology (see sidebar on pg. 22). On the one hand, PPS payments, which tend to be higher than non-FQHC Medi-Cal reimbursement rates, have provided AltaMed with a level of revenue that has enabled clinics to provide services to uninsured and Medi-Cal patients consistently over their 45-year history, even as California has cut non-FQHC Medi-Cal reimbursement to one of the nation's lowest rates.<sup>54,55</sup> On the other hand, as AltaMed strives to provide population health management, the PPS system poses a barrier because it only reimburses for a subset of care that could support Triple Aim goals. The PPS system also poses

barriers to integrating behavioral health with primary care, using a broader group of providers as part of medical home teams, and interacting with clients in non-face-to-face ways, such as email and phone-based care. In the face of these barriers, a payment reform pilot in California will enable a voluntary set of health centers to move cautiously toward value-based pay for their core revenue stream.<sup>56</sup> Participating in such a pilot would put AltaMed among a small group of innovative health centers nationally that are experimenting with moving from volume-based care to primary care capitation within the FQHC payment framework. These health centers view this shift as an opportunity that may eventually become a responsibility as the nation moves toward value-based payment.

### **Providing Care Under Financial Risk Outside the FQHC System**

AltaMed participates in multiple risk-bearing contracts as an IPA and through two significant CMS projects. Together, these give the organization helpful, if not essential, experience with building the delivery system infrastructure and business expertise necessary to practice and thrive under risk-bearing contracts.

AltaMed has learned on multiple fronts from their experience running an IPA. By accepting professional risk capitation payments for almost 149,000 managed care Medi-Cal and dual-eligible beneficiaries and over 34,000 commercial lives, AltaMed has established specialty referral networks, utilization management functions, and contracting capabilities. They have had to learn to manage specialty care for staff

## **The FQHC Payment System as a Protection, a Barrier and an Opportunity**

Under Federal law health centers are entitled to receive a prospective payment system (PPS) payment that is tied to historical costs increased by an annual federal inflation factor known as the Medical Economic Index (MEI). PPS payments are essentially per-visit payments that FQHCs receive when a billable provider—defined as a physician, certified nurse midwife, nurse practitioner, physician’s assistant, psychologist, psychiatrist, or licensed clinical social worker—renders a face-to-face visit with a Medicaid beneficiary. Federal law also allows health centers to be paid under an Alternative Payment Methodology (APM) as long as payments received at least equivalent to what the health center would have been paid under PPS and the APM is agreed to by the State and the FQHC.<sup>a,b</sup>

As of 2014, select Oregon health centers had adopted an APM pilot that gives health centers more flexibility to deliver services to patients while moving them away from a volume-based incentive under an APM. Under this pilot, health centers receive a per-member-per-month (PMPM) payment from the state that can be used more flexibly to deliver health center services via traditionally non-billable care team members and via non-face-to-face modalities.

a Social Security Act 42 USC §1396a(bb)(6). Available at: <http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXIX.htm>

b January 2001 State Medicaid Directors Letter (SMDL #01-014)

model clinic members and both primary and specialty care for members in the contracted network under fixed budgets.

Participating in multiple risk-bearing contracts as an IPA has also given the organization experience with negotiating and performing under upside risk contracts and risk pools with as many as eight different payers in Los Angeles and Orange Counties. Such contracts provide incentives to reduce hospitalization and total costs of care, often times gated by quality and patient experience. AltaMed also participates in two large CMS projects under which the organization assumes either partial or full financial responsibility for a defined group of assigned members: PACE and CalMediConnect, California's dual-eligible demonstration project. AltaMed's experience as a PACE provider is notable because PACE is a full-risk program, where AltaMed receives a global payment for an individual who would have been eligible for nursing home care. Such full-risk global payments tend to be considered as the most advanced type of value-based pay.

PACE has provided AltaMed with the opportunity to manage a large revenue stream within a fixed budget, to practice working under risk, and to establish a robust care model for one high-risk population. Under a global capitation payment for approximately 1,700 members, PACE represents approximately over a quarter of AltaMed's \$423 million annual revenue stream. AltaMed runs eight PACE centers and is responsible for all care across the health system that these members receive.

Through the PACE program, AltaMed PACE centers must provide adult day services for a defined service area, primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals at a physical site location.<sup>57</sup> Because AltaMed receives a single, global payment, they have had to develop a network of providers and to negotiate contractual payments with hospitals, community-based organizations, and specialists and to provide all Medicare and Medicaid services, "regardless of frequency or duration of services."<sup>58</sup> When a patient is admitted to a hospital, PACE physician leaders work closely with a hospitalist team and hospital staff to ensure patients are discharged into the care of outpatient PACE providers as soon as is medically safe. AltaMed has also established a way for patients to access a physician 24 hours per day as a strategy to prevent ED visits, which more often than not result in hospital admissions for the frail elderly. AltaMed has also decided to incur additional costs to have PACE patients see specialists if it prevents a visit to the hospital. All of these care strategies have the Triple Aim benefit of keeping overall costs down, reducing risk for hospital-acquired infection, and improving patient experience by allowing patients to spend more time in the safety and familiarity of their home and adult day service centers.

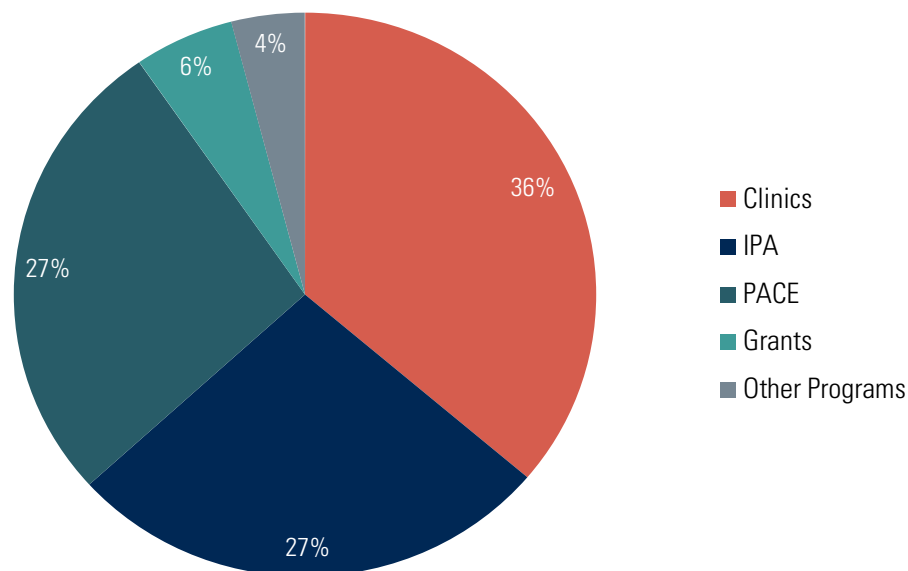
Under CalMediConnect, AltaMed has been able to leverage the care delivery and financial risk experience with PACE to accept partial risk and responsibility for approximately 2,200 dually eligible individuals (projected to grow to over 5,000 by the end of 2016). Even though duals represent approximately 1 percent of AltaMed's covered lives, they are projected to account

for almost 4 percent of organizational revenue in 2015-16. Additionally, shared-risk contracts with hospitals make AltaMed eligible to receive bonus payments if inpatient costs are less than anticipated while also meeting quality benchmarks. Participation as a CalMediConnect provider further increases AltaMed's ability to design care models for high-risk beneficiaries and to invest in opportunities that will reduce total cost of care to the health system and improve quality outcomes and patient experience. On the care side, this includes using interdisciplinary teams and working with hospitalists to ensure inpatient to outpatient care transitions occur smoothly, including information transfer and timely follow up in the outpatient setting. On the payment side, this includes negotiating contracts and sharing risk with six local hospitals.

IPA, PACE and CalMediConnect contracts give AltaMed a much more diverse financial portfolio than most health centers, creating both financial risk and a unique financial stability. Risk-based contracts constitute well over half of all organizational revenue (Figure 4) and have provided AltaMed with significant experience managing within a fixed budget and using upfront dollars to invest in infrastructure, leadership, and care transformation.

By moving incrementally into risk (Figure 3), AltaMed has also had to adopt, learn, and adapt analytic tools to look carefully at the data on their members both within the primary care setting

**Figure 4. AltaMed Total Actual Annual Revenue - 2015**



Note: Reflects actual annual revenue for Fiscal Year ending April 30, 2015. Fiscal year ending 2015 did not have 12 months of payments. Revenue for duals is included in IPA.

and extending well beyond into member use of the broader health system. Within primary care, a Medical Director for Quality explained that developing reports and sharing with providers quality metrics regarding their panels frequently was an intensive and iterative process of first building provider trust in the data. Trusted data then served as a foundation for effecting quality improvement efforts. Through such data-driven improvement efforts, AltaMed has seen their Medicare star rating go from 1.5 to 4 stars. The organization also centralized data analytics for clinical quality analysis and business intelligence and hired a Vice President of Enterprise Services. When they realized health plan data was inconsistent and untimely, they built data systems and processes to understand hospital utilization quickly enough to allow risk stratification and intervention. Also, by studying the professional claims for their IPA and PACE members, AltaMed was able to make informed decisions regarding the probability of being able to manage under proposed CalMediConnect rates.

#### **Already a Next Generation ACO?**

While AltaMed technically holds no formally defined “ACO” contracts, its financial and care delivery experience as an IPA and as a PACE and CalMediConnect provider reveal that it is functioning as a virtual ACO for multiple member populations in a manner that will likely be the way of the future. For example, AltaMed is managing populations of assigned members rather than attributed patients. While member assignment is a key feature of managed care systems, it is only now being acknowledged as a key feature of accountable care moving forward. In fact, the

#### **FQHC Payment System Proposed in California**

California’s health centers have proposed to pilot a payment reform for select health center sites under which sites would receive a per-member-per-month payment for all assigned managed care Medi-Cal members in certain population groups. Health center revenue would come in the form of site-specific, aid-category-specific PMPM PPS-equivalent rates paid by the managed care plan for all assigned Medi-Cal members in the adult, child, seniors and persons with disabilities and eventually Medi-Cal expansion population categories of aid. Under the proposed pilot, select California health centers would also accept some degree of increasing risk for more utilization compared to a historical period in exchange for the flexibility to see both a behavioral health visit and a health provider on the same day and to serve patients with non-traditional providers and alternative modalities, such as phone, email, and group visits.

The pilot seeks to align health centers with the managed care infrastructure of assigned members (not just patients who come to clinic), to provide pilot sites more flexibility in using care teams and using alternative methods of caring for and providing access for patients, to create incentives for population management, and to measure progress on Triple Aim outcomes. Such a pilot would mark a significant departure from the status quo of health center volume-based pay, while still honoring key federal payment protections under an APM.

CMS Next Generation ACO model, designed to respond to some of the criticisms of the Medicare Shared Savings Program and Pioneer ACO models, has outlined how it will attempt to clarify which members are assigned to the ACO rather than attributing patients retrospectively.

The Next Generation ACO model has also outlined that providers can receive some upfront investment payments for transformation that can make achieving savings more likely. By virtue of having global and partial capitation payments, AltaMed has been able to leverage portions of these payments for upfront investment in data analytics, leadership, and transformation that will, in turn, make them more likely to succeed under such risk payments.

As more Medicaid programs gravitate toward systems that increase accountability through payment reforms, thought leaders have predicted that future Medicaid ACOs will develop underneath the managed care infrastructure, using models of prospective payment and patient assignment. Thus, in some ways, AltaMed represents a health center and IPA whose experience places it in a small group of safety-net providers experiencing payment and delivery system change that will likely characterize accountable care models of the future.

### **Implications for health centers**

Moving into risk-based contracts incrementally can represent an opportunity and will likely be a responsibility in the future. AltaMed's experience reveals a couple of key lessons for health centers as they explore upside and downside financial risk. First, gaining experience with risk in an incremental fashion that allows one set of delivery system changes and financial experience to build upon another is a "safe" way to build risk expertise and confidence. Having experience with PACE and professional capitation as an IPA allowed AltaMed to feel confident in accepting dual-eligible contracts. Second, access to good total health system utilization and price data and investing in the analytics to understand such data is essential if moving into financial risk. Whether it is through an IPA that pays all professional claims or gaining access to state Medicaid or health plan data, understanding the historical utilization and costs for a health center's population is critical for negotiating fair upside risk contracts and for entering into safe downside contracts.

Finally, health centers need to use data to strategically assess where opportunities for benefiting under upside or downside financial risk contracts are greatest. This can include studying past spending and quality outcomes for populations relative to benchmarks. For example, AltaMed has been able to reap financial reward from reducing hospitalization rates for PACE patients whose global capitation rates are set based on high historical costs. AltaMed hopes to have a similar experience with the dual-eligible population, where capitation rates to plans are approximately 3.75 times larger than adult rates and 27% greater than rates for seniors and persons with disabilities.<sup>59-60</sup> While it is oversimplifying to only pursue shared savings or risk-based contracts in higher-cost populations, health centers in regions of the country that have had higher than average total costs and utilization of health care might benefit from entering into shared savings contracts as part of ACOs [see Appendix A for select state Medicaid expenditures compared to national



averages].<sup>61</sup> In all cases, health centers interested in financial benefits associated with total health system cost savings and improved quality outcomes would be savvy to assess the probability of being able to achieve such results for their populations in their region.

While health centers in different regions may diversify their financial portfolio based on regional context, AltaMed's experience with incrementally taking on financial risk demonstrates that health centers can take an active role in shaping their future payments—both inside and outside the FQHC payment system.

## Leadership and Size as Facilitators for Success under Accountable Care

The findings above describe how leveraging geographic accountability to meet mission and business goals, refining care delivery to more intensively address social, behavioral and health needs in concert, and moving incrementally into risk-based payment models represent three key strategies for health centers interested in participating successfully in accountable care. The case of AltaMed also illuminates how a growth strategy and strong, visionary leadership served as cross-cutting and mutually reinforcing facilitators of success.

### **Leadership and size facilitate spreading practice transformation efforts**

Leadership has played a critical role in AltaMed's growth strategy with a mission and business focus. As AltaMed recognized, in a competitive environment of drastically increased insurance coverage, health centers must move from being providers of last resort to providers of choice that can empirically prove quality, patient service and the capacity to impact total health system costs for both Medicaid and Exchange patients. Connecting this strategic insight to the history of the community health center movement has guided AltaMed's transition into accountable care. During our first year of interviews when ACOs nationally were still early in development, Cástulo de la Rocha, AltaMed's CEO, stated: "ACOs remind me of PCMH...[PCMH] is what we have always been doing as an FQHC—committed to our community's health and always interested in keeping people healthy and in managing cost. We have invested in EHR, case managers, *promotoras*, medical management systems... In the civil rights movement, we learned to be militant about continuing to push and push on an important issue. In a PCMH, we are militant about keeping people out of hospital." Since this comment in 2013, this "resistance movement" has increasingly shaped the work of all ACOs.

AltaMed's case also illustrates how a growth strategy can facilitate investment in building a strong internal leadership structure, which in turn, sets the stage for further growth, creating a virtuous cycle for a health center and the population it serves. It is significant that AltaMed recognized that growing successfully within communities and into new communities would require both physician leadership and business acumen on the executive team and throughout the organization. Like



industry leaders such as Kaiser Permanente, AltaMed recognized that physicians would be most likely to respond to other well-respected physician leaders. For example, the Medical Director for Quality splits time in an academic appointment at USC. A Chief Medical Officer with experience leading a large medical group oversees medical directors who, in turn, lead all major business functions. While top leadership set audacious goals and provided resources to align systems and incentives, this robust clinical leadership infrastructure helped AltaMed move from a 1.5-star CMS rating to 4 stars in one year. AltaMed also recognized that the contract negotiations and relationship building inherent in establishing shared risk or full risk contracts would require experience-based managed care savvy and hired a business leader with experience leading a large IPA and ACO. AltaMed's strong leadership has catalyzed and supported growth. Growth has in turn facilitated execution on strategies of improved population health at the individual and community levels, delivery system change, and payment reforms.

AltaMed's growth strategy provided the organization with a number of benefits of size. Size can be beneficial for spreading delivery system transformation efforts over a large population while being a reasonable investment relative to total revenues. For instance, AltaMed's size allowed it to institutionalize its growth strategy in corporate infrastructure. With its size and strong balance sheets, the organization was able to secure a \$70 million bond to invest in physical infrastructure improvements. Two years prior to Medicaid expansion, AltaMed also made a strategic decision to invest in the Baldrige Performance Excellence Program, a leadership and performance management framework that carries a price tag that would be perceived as too hefty for most health centers.<sup>62</sup> The idea was that by investing in quality and service improvements, the health centers would be best situated to be a "provider of choice" for Medicaid expansion and exchange populations. Having a sizeable enough revenue stream and number of lives that would benefit from such an investment provided the economies of scale to make such an investment possible. The Baldrige program provided AltaMed with a corporate framework for advancing its goal of competing on quality and patient experience. It was notable that almost all leaders and key director-level staff interviewed cited the same core set of outcomes as guiding their work. AltaMed's size also facilitated investment in large capital projects, such as health information technology (HIT) and data analytics to support its payment and practice transformation efforts. Where other health centers adopted off-the-shelf EHRs with frustration, AltaMed paid to customize its system to align with its business and practice model. AltaMed estimates it has invested over \$1 million in data management software, \$1.2 million in a patient portal, and \$2-3 million in a call center to allow improved access for patients to schedule appointments or contact their providers.

### **Leadership and size facilitate financial risk-taking and forging partnerships**

Leadership dedication to a growth strategy can also facilitate entering into risk-based contracts and leveraging that experience for future risk taking. Basic risk-bearing principles require having a large enough pool of members that the cost impact of any given individual can be spread across a large population. Depending on the state, regulatory rules sometimes require that entities bearing

financial risk have a requisite level of capitalization such that they can withstand a number of financial blows without failing.<sup>63</sup> In California, this regulation is known as a Knox-Keene license. As an IPA accepting professional risk, AltaMed has a limited Knox-Keene license and is considering applying for a full Knox-Keene license which would allow the organization to accept global capitation for a non-PACE population. Taking financial risk as an IPA and PACE provider allowed AltaMed to invest in data capabilities and analysis, creating a sound foundation for taking on future risk. AltaMed was able to analyze its members practice patterns in primary care, specialty care and hospital settings as the payer of professional claims. The organization could then use this information to make sound calculations about whether or not new financial arrangements are safe bets to take, to identify high-quality, low-cost referral pathways, and key referral partners.

Being responsible for over 146,000 Medi-Cal lives in concentrated geographic areas has also facilitated AltaMed's ability to negotiate contracts and forge relationships with hospitals, specialists, and community-based organizations. For example, during CalMediConnect contracting discussions, health plans required that provider groups and hospitals contract as risk-sharing partners. A total of six local hospitals ended up agreeing to contract in partnership with AltaMed for CalMediConnect. AltaMed's size is also beneficial for contracting with rarefied Medi-Cal specialists since maintaining a volume of referrals can mitigate low Medi-Cal payments. The organization has also been able to leverage its size in establishing relationships with social services in the community. Leaders cited the importance of being able to build upon relationships established by the PACE program with housing agencies and transportation providers when they began accepting professional risk for seniors and persons with disabilities and dual eligibles. Indeed, AltaMed's leadership and size have facilitated progress toward a community health mission and further business growth.

### **Implications for health centers**

**There are multiple benefits to size and multiple ways to achieve it.** Most health centers are not as big as AltaMed and never dream to be. For health centers interested in realizing the benefits of size for financial risk taking and delivery system transformation, it is important to recognize that AltaMed's trajectory is not the only path to increasing health centers' ability to be large enough to facilitate success under accountable care. Having responsibility for cost and quality outcomes can be a facilitator for advancing population health within a defined community. For some health centers, this might mean striving to become a dominant provider in a given geographic area, not necessarily being big but "big in a small pond." There are also multiple ways for health centers to achieve "size" benefits besides the growth strategies of AltaMed. Such approaches could include: associating with a larger voluntary health center coalition that can negotiate terms of contracts and data sharing agreements with payers for individual health centers; joining a network or health-center-led IPA for shared risk; forging formal collaborations in order to have a chance of earning shared savings as part of a Medicare or Medicaid ACO; or affiliating with a non-health center provider network or hospital entity for contracting clout.

**Strong, visionary, and adaptable leadership is essential for effecting change.** The future of value-based health care in the U.S. will likely require health centers to consider novel collaborations and affiliations for the purposes of delivering care, contracting, and risk taking. Moving into accountable care delivery and payment constitutes significant change for health centers. For some health centers, changing their payment and delivery model will be voluntary while for others it may be forced upon them. The case of AltaMed highlights how strong, visionary leadership can set the course for transformation, facilitate necessary changes to succeed under financial and delivery system models that demand increased levels of risk and accountability, and help health centers achieve their community health mission and long-term financial viability.

## **Conclusion: Health Centers Looking Ahead into a Future of Accountable Care**

The case of AltaMed illustrates that there is a path for health centers interested in participating in accountable care that both leverages and challenges health center geographic accountability, care delivery and payment structures. AltaMed also demonstrates that it is possible to participate actively in and shape accountable care payment models and delivery system transformations, even in the absence of state policy change or a formal ACO governance structure. For AltaMed, this has included aligning business goals and their community health center mission in a concerted effort to care for an increasing proportion of individuals within the communities they serve.

AltaMed's path to becoming a virtual ACO also provides insights for health centers regarding delivery system and payment transformation that may lie ahead. On the delivery system side, becoming operational patient-centered medical homes, using robust data systems to support risk stratification and care management, integrating behavioral health in primary care and partnering with social services are some key competencies health centers will need in order to perform under accountable care models. On the payment side, health centers could benefit from leveraging the stability of a federally-ensured level of reimbursement in Medicaid to adopt a more diverse portfolio of payment models. This includes assuming financial risk incrementally in select business lines, since ultimately achieving the Triple Aim depends, in part, on having flexibility and an incentive to reduce hospital utilization. Finally, identifying strategies to achieve the benefits of size represents a potentially important step for health centers that anticipate a future where they may voluntarily or be required to bear increased risk and accountability as part of the national move from volume to value-based care.

In many ways, in 2015, the United States is experiencing a tectonically shifting health care payment and delivery system. To emerge strong and financially viable from this turbulent time in health care, health centers will need to make concerted efforts to affect and implement change on both the payment and delivery system fronts. As cost-effective primary care providers with a commitment to population health, health centers are also well suited to emerge successfully. Rooted in community-based leadership and a mission to advance community health, health centers can be a fulcrum of accountable care in the safety-net, delivering cost-effective, whole-person-centered care and working with partners to improve the patient, member, and population health of underserved communities. AltaMed is clearly working to be this fulcrum. In the words of the AltaMed CEO: "I want to invest this DNA about growth and put it into quality and eliminating disparities." The challenge for other health centers is how they might do the same.



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### Appendix A. Total Medicaid Payments per enrollee, 2010

State	Elderly and disabled individuals, 2010	Difference from National Average	Parents and children, 2010	Difference from National Average
<b>United States (average)</b>	<b>\$14,946</b>		<b>\$2,596</b>	
Florida	\$10,510	-30%	\$2,049	-21%
California	\$12,906	-14%	\$1,354	-48%
Texas	\$12,985	-13%	\$3,058	18%
Colorado	\$19,297	29%	\$2,759	6%
Minnesota	\$22,063	48%	\$3,311	28%
New York	\$26,347	76%	\$3,538	36%

Source: The Pew Charitable Trusts State Health Care Spending Project. State Health Care Spending on Medicaid: A 50-state study of trends and drivers of cost. July 1, 2014. Available at: <http://www.pewtrusts.org/en/Multimedia/Data-Visualizations/2014/Medicaid-Spending-Growth>

