

The Past Decade of Paying for Value – From the Affordable Care Act to COVID-19

Hannah Crook, Rebecca G. Whitaker, William Bleser, Robert Saunders, Mark B. McClellan

The Affordable Care Act played a major role in transitioning American health care away from fee-for-service payment. We explore the spread of payment reforms since the implementation of the ACA, both nationally and in North Carolina; the corresponding effects on health care costs and quality; and further steps needed to achieve greater transformation.

Introduction

Health care payment reforms, which have accelerated over the past decade, have been motivated by a recognition that health care costs in the United States are too high and rising—estimated to be almost 18% of the nation's GDP in 2019—and outcomes are lagging in comparison to other high-income countries [1]. The underlying cause of this problem is the predominant payment structure, fee-for-service (FFS), which tends to create system fragmentation and a focus on short-term illness rather than long-term wellness, encourages treatment for later-stage disease instead of shared decision-making about treatment and quality of life, and separates primary and specialty care [2]. Moreover, the ongoing COVID-19 pandemic has further highlighted the failures of volume-reliant FFS payment; yet, health care organizations have been able to repurpose organizational competencies they built for value-based payment (VBP) programs to meet COVID-related needs [3].

While payment reforms started in a limited way in the early 2000s with some pay-for-performance initiatives, early versions of more significant shifts in payment during this time included bundled payments and proto-Accountable Care Organizations [4-8]. The passage of the Affordable Care Act (ACA) in 2010 significantly expanded payment reform in Medicare. The ACA created the Center for Medicare and Medicaid Innovation (CMMI), which has been instrumental in advancing VBP, and also authorized a wide range of new payment models. The ACA has been followed by multiple federal reforms, such as the Medicare Access and CHIP Reauthorization Act (MACRA). The private sector has also been active in introducing its own reforms, especially in the Medicare Advantage market but also in numerous other commercial payer-specific value-based contracts, to move away from FFS payments [9]. Many states have also implemented VBP in their Medicaid programs, through Accountable Care Organizations (ACOs),

Medicaid Managed Care, or other initiatives. While the ACA did not implement or require VBP reforms in Medicaid or commercial insurance, spillover effects have encouraged uptake of VBP by these payers as well. Further, Medicare's VBP efforts post-ACA have encouraged multipayer initiatives, such as the Advanced Primary Care Practice demonstration [10]. Early evidence has shown that the impact of modest reforms was limited, although more recent studies show growing savings among particular reforms where more substantial shifts tend to have larger effects [11-13].

One metric of success for payment reform is the increasing proportion of health care dollars flowing through alternative payment models (APMs). In 2018, about 36% of health care dollars nationally flowed through an APM, up from 23% in 2015 [9, 14]. In 2018, Medicare Advantage had the highest proportion of health care dollars flowing through APMs (54%), followed by traditional Medicare (41%), commercial plans (30%), and Medicaid (23%) [9]. A smaller proportion of money flows through "advanced" APMs, which require more significant and meaningful shifts away from FFS. These advanced models often involve capitated payments and financial risks for health systems and present greater opportunities for savings and care redesign.

Despite the progress made, the majority of health care delivered in the United States is still paid for through FFS reimbursement. Payment reform is now, especially during the COVID-19 era, critical to the long-term viability and stability of our health care system.

Adoption and Results from Early Payment Reforms: Limited Changes Lead to Limited Impact

The earliest payment models tended to be pay-for-performance models, which tied bonuses (or penalties) to achieving certain quality metrics but otherwise continued to pay providers through FFS payments. They represent the smallest shifts away from volume-based payments and are not categorized as APMs. Many Patient-Centered Medical

Electronically published November 2, 2020.

Address correspondence to Hannah Crook, Duke-Margolis Center for Health Policy, 230 Science Drive, Durham, NC 27708 (Hannah.crook@duke.edu).

N C Med J. 2020;81(6):381-385. ©2020 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2020/81609

Homes apply this or a similar model, where the practice receives payments for care coordination and other services and can receive financial bonuses in return for high-quality scores. Pay-for-performance models have been shown to have modest effects on quality improvement, but there is little evidence they impact costs [15].

In the ACO model, a group of providers (or a health care system) agrees to take on financial accountability for the quality and total cost of care for its attributed patient population. ACO models can be either “upside-only,” in which providers receive shared savings for keeping costs under a set benchmark while meeting certain quality thresholds, or they can include two-sided risk, in which providers could be financially penalized if their costs exceed the benchmark. The ACA launched the Medicare Shared Savings Program (MSSP), which now covers approximately 10 million patients in the most recent data (2018) [16]. Across all payers, ACOs covered 44 million in 2018, through 1,588 public and private contracts [17].

The big picture assessment is that ACOs are achieving savings while maintaining high quality of care and good outcomes [11]. On the cost side, while early ACO results were mixed, recent years have shown more promising results, with the MSSP achieving net savings for Medicare in 2017 and 2018 against its own benchmarks [16]. Studies comparing the savings from ACO programs to the counterfactual (if ACOs did not exist) show even higher savings rates [18]. However, overall ACO savings remain modest, especially in upside-only models, although the number of ACOs in more advanced two-sided risk models is increasing [18] and those ACOs are more likely to achieve shared savings [16, 19]. On the quality of care side, the Medicare ACO program in particular is useful for examining the effect of payment reform on care quality changes, given it has had upwards of 30 different quality measures per year over time (spanning population health and some specialty-care-relevant measures). Generally, the average Medicare ACO showed improvements in most measures over time [20]. Preventive health quality measures represented the largest, most consistent improvements, although large improvements were also seen in particular measures in the quality domains of patient safety and care for at-risk populations (screening for fall risk, heart failure admission rates, pneumonia vaccination, and screening/follow-up for clinical depression) [20].

In bundled payments, or “episodes of care” models, all services related to a condition or clinical event are covered by a single payment. To use a popular example, a payer covers a procedure like a hip or knee joint replacement bundled with the hospital care associated with that procedure and 30-90 days of follow-up care. A bundle could include procedures (like our joint replacement example), hospital admissions, or conditions requiring more longitudinal care (such as pregnancy or a behavioral health diagnosis). Medicare’s Bundled Payments for Care Improvement (BPCI) program is a notable example, covering 48 different clinical episodes

through bundled payments from 2013 to 2018. Bundled payment programs have been shown to have positive effects on quality and costs for certain procedures (especially joint replacements), but no impact on others [21].

The least common payment reforms used to date are population-based payments and advanced episodic models. These models include full or partial capitated payments, in which the provider receives a set amount each month to cover a patient’s care before care has occurred. Payers set these payments by estimating the average cost of their patients’ care, often adjusting risk for factors such as age, chronic conditions, and other clinical and sociodemographic factors. Only 5% of all health care dollars flowed through population-based payment models in 2018 [9]. Population-based payment models, which may offer the most promise for cost and quality improvements and for financial resiliency, have seen limited uptake (and therefore, little evaluation) to date. These models effectively cap costs and give providers the most flexibility to deliver services that improve their patients’ health. However, few payers are offering such models, and many providers and health care systems are not yet equipped with the necessary data platforms and care delivery systems to be successful in such models.

Modest payment reforms have only led to modest impacts on cost and care delivery reform. Further shifts away from FFS are needed to see larger savings. More research is needed to determine which APMs offer the most promising changes in cost or quality, or how current APMs should be modified to achieve such goals. This research should also consider how APMs may impact or worsen disparities, since they may discourage providers from caring for high-needs (and therefore high-cost) patients.

North Carolina’s Major Shift to Value

North Carolina has seen substantial innovation through multiple value-based models implemented by public and private payers. While most health care spending in North Carolina currently still flows through FFS, this is scheduled to change significantly due to the variety of payment reform activity in the state. The state has set out on an unprecedented shift to VBP, and is poised to make 65%^a or more of health care payments through APMs over the next five years [22].

On the public sector side, in 2018 the Centers for Medicare and Medicaid Services (CMS) approved North Carolina’s 1115 waiver to implement Medicaid transformation. The waiver aims to move the majority of the state’s Medicaid enrollees to managed care, and requires Managed Care Organizations to take on an increasing proportion of value-based contracts over time. Most notably, the waiver established the Healthy Opportunities Pilots, which, when

^a Figure from authors’ analysis, updated from McClellan et al. [22] with new spending data by payer type.

implemented, will allow Medicaid dollars to cover services related to the social determinants of health in four key areas: housing, food security, transportation, and interpersonal violence.

Commercial payers in North Carolina are also implementing a range of payment reform activities (Table 1). The largest commercial payer in the state, BlueCross BlueShield of North Carolina (BlueCross NC), has developed two notable VBP models: Blue Premier and Accelerate to Value. Blue Premier, an ACO model aiming to cover all of BlueCross NC's patients within five years, will transition providers into progressively higher levels of downside risk by 2022 [23]. The Accelerate to Value program, developed in response to the COVID-19 pandemic, enables independent primary care physicians to remain independent by providing financial stability while offering a pathway to participating in VBP in the future [24]. Other payers in the state are also engaging in payment reform, such as Humana's partnership with Aledade in Medicare Advantage plans to promote more coordinated care [25].

Additional Supports, Time, and Business Cases Needed for Success in Value-based Care

Payment reform alone is not enough to drive changes in care delivery—providers and payers also need to make accompanying infrastructure investments and develop organizational competencies to support the payment model [26, 27]. This is particularly important for more resource-constrained organizations, such as those smaller in size (including many physician-led organizations), those in rural areas, or those serving largely underinsured and uninsured individuals [28].

The need for new infrastructure and new capabilities for providers to succeed in VBP may help explain why it has taken time for payment reforms to show positive results.

For example, organizations have to build care coordination services to ensure patients' medical and social needs are addressed and coordinated. This often necessitates hiring staff devoted to these activities and developing platforms and processes to facilitate them. Data platforms and analytic capabilities are critical for organizations that want to engage in APMs. These capabilities are necessary for identifying high-risk or high-needs patients and developing a robust population health management strategy. Finally, an increasing number of organizations engaged in VBP are maximizing the use of telehealth platforms to deliver home- and community-based care when appropriate.

Investing in new technology and data systems necessary for crucial value-based skills is often the largest financial impediment for more resource-constrained organizations [28]. Some payment reforms have sought to overcome this challenge by providing upfront capital (e.g., grants or advance savings loans) or infrastructure assistance, such as Medicare's ACO Investment Model or the Accelerate to Value model in North Carolina. Smaller and more physician-led ACOs have also found success working with ACO enabler organizations that can assume some of the downside risk and provide upfront capital, resources, and technical assistance in exchange for savings potential [28].

Many alternative payment models have represented only modest shifts from FFS, which makes it difficult to make the business case for the needed investments and workflow changes. Without more prominent changes, it can be difficult to obtain buy-in for VBP from both executive leadership and frontline clinicians. At the same time, it might take at least three years to balance readiness for change with comfort to join these models in order to prevent organizations from leaving them [29]. Finally, the evidence to date has allowed a business case to develop for primary care-focused models like ACOs, but there is a need to better develop the

TABLE 1.
Examples of Payment Reform Adoption in North Carolina

Payer/Purchaser	Examples of Value-based Payment Reforms & Supporting Infrastructure
NC Medicaid and NC DHHS	- Implementing Medicaid managed care with required shifts to APMs (including a Medicaid ACO model, which builds off the state's existing Advanced Medical Home model), slated to start by July 2021. 45% of Medicaid dollars are scheduled to flow through advanced APMs by 2025. - Addressing social determinants of health through the Healthy Opportunities Pilots. - Design and implementation of NCCARE360 – a statewide community resource referral platform.
Commercial Payers	- BlueCross NC's Blue Premier program (an advanced APM model that will require downside risk three years into the program) has eight major health systems participating [26]. - BlueCross NC's Accelerate to Value program will provide upfront capital to independent primary care practices to enable them to participate in Blue Premier. - Humana has partnered with Aledade to provide enhanced care coordination services to North Carolina Medicare Advantage beneficiaries. - Other payers are participating in or expanding accountable care programs (e.g., United, Aetna, Cigna).
Medicare	- Major North Carolina health systems are participating in Medicare ACOs. - About half of major North Carolina health systems have hospitals or affiliates participating in Medicare bundled payment programs.

Source: Updated and adapted from McClellan et al. [22]

business case for involving specialists in population health payment reform programs. Most specialty care is FFS based, and chronic disease requiring specialty care drives a lot of population health, so this could be the next frontier for progress. More work is needed to better integrate specialty care into APMs [30, 31].

Value-based Care Promotes Resiliency to Adapt to Changing Needs (Such as COVID-19)

The COVID-19 pandemic has highlighted the fragility of the FFS payment system. During the height of lockdowns, providers faced unprecedented revenue and utilization drops. Many organizations are still struggling to make up lost revenue. Concurrently, hospitals and health systems in areas with high COVID burden have struggled to handle surges of cases, maintain sufficient health system capacity, and ensure adequate supplies of personal protective equipment and other supplies. VBP models could help ensure a steady stream of revenue through prospective payments and allow flexibility to cover services not typically well-reimbursed under FFS.

COVID-19 has exposed longstanding health inequities—as of June 2020, the COVID-19 case burden of Black Americans was more than twice that of white Americans and the case burden of Latinx Americans was roughly 1.7 times that of white Americans [32]. Other racial and ethnic minority groups similarly faced disparately worse outcomes [32]. In the future, VBP models could help highlight inequities by including quality measures that require providers and health systems to record and report data stratified by race and ethnicity.

Conclusion

The ACA was instrumental in advancing payment reform in the United States health care system. VBP adoption has increased substantially, and it has started to reduce unnecessary health care spending while maintaining quality. However, more aggressive reforms are needed to substantially transform our health care system and improve outcomes. While the ACA and the Center for Medicare and Medicaid Innovation have been foundational to payment reform in the United States thus far, states and the private sector will be critical players in VBP going forward. The COVID-19 pandemic makes the situation all the more urgent, and we should respond to the crisis with provider relief that also builds a more resilient health system for the future. North Carolina is currently in the midst of unprecedented transformation to value while also taking on issues of social needs and health equity. The state is a model for the nation. NCMJ

Hannah Crook, BSPH research assistant, Duke-Margolis Center for Health Policy, Durham, North Carolina.

Rebecca Whitaker, PhD, MSPH managing associate, Duke-Margolis Center for Health Policy, Durham, North Carolina.

William Bleser, PhD, MSPH managing associate, Duke-Margolis Center for Health Policy, Washington, D.C.

Robert Saunders, PhD research director, Duke-Margolis Center for Health Policy, Washington, D.C.

Mark B. McClellan, MD, PhD director and Robert J. Margolis M.D. Professor of Business, Medicine and Policy, Duke-Margolis Center for Health Policy, Durham, North Carolina.

Acknowledgments

Potential conflicts of interest. MBM is an independent board member for Johnson & Johnson, Cigna, Alignment Health Care, and Seer; co-chairs the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor for Blackstone Life Sciences and MITRE. RS has a consulting agreement with Yale-New Haven Health System for development of measures and development of quality measurement strategies for CMMI Alternative Payment Models under CMS Contract Number 75FCMC18D0042/Task Order Number 75FCMC19F0003, “Quality Measure Development and Analytic Support,” Base Period. WB has previously received consulting fees from Merck on vaccine litigation unrelated to this work and serves as Board Vice President (uncompensated) for Shepherd’s Clinic, a clinic providing free health care to the uninsured in Baltimore, MD. RW and HC report no conflicts of interest.

References

- Hartman M, Martin AB, Benson J, Catlin A, National Health Expenditure Accounts Team. National health care spending in 2018: growth driven by accelerations in Medicare and private insurance spending. *Health Aff (Millwood)*. 2020;39(1):8-17. doi: 10.1377/hlthaff.2019.01451
- McClellan MB, Bleser WK, Joynt Maddox KE. Advancing value-based cardiovascular care. *Circ Cardiovasc Qual Outcomes*. 2020;13(5):e006610. doi: 10.1161/CIRCOUTCOMES.120.006610
- Roiland R, Japinga M, Singletary E, et al. Value-Based Care in the COVID-19 Era: Enabling Health Care Response and Resilience. Durham, NC: Duke University Margolis Center for Health Policy; 2020. https://healthpolicy.duke.edu/sites/default/files/2020-07/best_practices_brief_final.pdf. Published June 2020. Accessed September 17, 2020.
- Fisher ES, McClellan MB, Bertko J, et al. Fostering accountable health care: moving forward in Medicare. *Health Aff (Millwood)*. 2009;28:219-231. doi: 10.1377/hlthaff.28.2.w219
- McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES. A national strategy to put accountable care into practice. *Health Aff (Millwood)*. 2010;29(5):982-990. doi: 10.1377/hlthaff.2010.0194
- U.S. Department of Health & Human Services Office of the Assistant Secretary for Planning and Evaluation. An Environmental Scan of Pay for Performance in the Hospital Setting: Final Report. CMS-Premier Hospital Quality Incentive Demonstration. ASPE website. <https://aspe.hhs.gov/report/environmental-scan-pay-performance-hospital-setting-final-report/cms%E2%80%9393premier-hospital-quality-incentive-demonstration>. Published November 1, 2007. Accessed August 12, 2020.
- Kautter J, Pope GC, Leung M, et al. Evaluation of the Medicare Physician Group Practice Demonstration: Final Report. Baltimore, MD: Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation; 2012. Accessed August 12, 2020. <https://downloads.cms.gov/files/cmmi/medicare-demonstration/PhysicianGroupPracticeFinalReport.pdf>. September 2012. Accessed August 12, 2020.
- Nelson L. Lessons from Medicare’s Demonstration Projects on Value-Based Payment. Washington, DC: Congressional Budget Office; 2012. https://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf. Published January 2012. Accessed August 12, 2020.
- Health Care Payment Learning & Action Network. APM Measurement Progress of Alternative Payment Models: 2019 Methodology and Results Report. McLean, VA: The MITRE Corporation; 2019. <http://hcp-lan.org/workproducts/apm-methodology-2019.pdf>. Published 2019. Accessed November 19, 2019.
- Abrams MK, Nuzum R, Zezza MA, Ryan J, Kiszla J, Guterman S. The Affordable Care Act’s Payment and Delivery System Reforms: A Progress Report at Five Years. Commonwealth Fund website. <https://www.commonwealthfund.org/publications/issue-briefs/2015/may/affordable-care-acts-payment-and-delivery-system-reforms>.

Published May 7, 2015. Accessed September 16, 2020.

11. Bleser WK, Muhlestein D, Saunders RS, McClellan MB. Half A Decade In, Medicare Accountable Care Organizations Are Generating Net Savings: Part 2. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180920.604462/full/>. Published September 21, 2018. Accessed October 25, 2019.
12. Center for Medicare & Medicaid Innovation. CMS Innovation Center Episode Payment Models. Baltimore, MD: Center for Medicare & Medicaid Innovation; 2020. <https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf>. Published January 2020. Accessed September 16, 2020.
13. Lewis C, Abrams MK, Seervai S, Blumenthal D. Evidence from a Decade of Innovation: The Impact of the Payment and Delivery System Reforms of the Affordable Care Act. Commonwealth Fund website. <https://www.commonwealthfund.org/evidence-decade-innovation-impact-payment-and-delivery-system-reforms-affordable-care-act>. Published April 1, 2020. Accessed September 16, 2020.
14. Health Care Payment Learning & Action Network. Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs. McLean, VA: The MITRE Corporation; 2016. <http://hcp-lan.org/workproducts/apm-measurement-final.pdf>. Published online 2016. Accessed September 16, 2020.
15. Delbanco SF, Lehan M, Murray R. The Evidence On Pay-For-Performance: Not Strong Enough On Its Own? Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20181018.40069/full/>. Published October 24, 2018. Accessed July 31, 2020.
16. Gonzalez-Smith J, Bleser WK, Muhlestein D, Richards R, McClellan MB, Saunders RS. Medicare ACO Results for 2018: More Downside Risk Adoption, More Savings, and All ACOs Types Now Averaging Savings. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20191024.65681/full/>. Published October 25, 2019. Accessed October 25, 2019.
17. Muhlestein D, Bleser WK, Saunders RS, Richards R, Singletary E, McClellan MB. Spread of ACOs And Value-Based Payment Models In 2019: Gauging the Impact of Pathways to Success. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20191020.962600/full/>. Published October 21, 2019. Accessed July 30, 2020.
18. Chernew ME, Barbey C, McWilliams JM. Savings Reported By CMS Do Not Measure True ACO Savings. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20170619.060649/full/>. Published June 19, 2017. Accessed August 6, 2020.
19. Verma S. 2019 Medicare Shared Savings Program ACO Performance: Lower Costs And Promising Results Under 'Pathways To Success.' Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20200914.598838/>. Published September 14, 2020. Accessed September 16, 2020.
20. Bleser WK, Saunders R, Muhlestein DB, Morrison SQ, Pham HH, McClellan MB. ACO quality over time: the MSSP experience and opportunities for system-wide improvement. *Am J Accountable Care*. 2018;6(1):e1-e15.
21. Agarwal R, Liao JM, Gupta A, Navathe AS. The impact of bundled payment on health care spending, utilization, and quality: a systematic review. *Health Aff (Millwood)*. 2020;39(1):50-57. doi: 10.1377/hlthaff.2019.00784
22. McClellan MB, Alexander M, Japanga M, Saunders RS. North Carolina: The New Frontier For Health Care Transformation. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20190206.576299/full/>. Published February 7, 2019. Accessed March 3, 2020.
23. Rajkumar R. Introducing Blue Premier: Redefining What is Possible in Health Care. BlueCross BlueShield of North Carolina. Blue Cross and Blue Shield of North Carolina Blog. <https://blog.bcbsnc.com/2019/01/blue-premier/>. Published January 11, 2019. Accessed March 2, 2020.
24. Blue Cross NC Launches Comprehensive Program to Help Independent Primary Care Practices Stay in Business [press release]. Durham, NC: Blue Cross NC; 2020. <https://mediacenter.bcbsnc.com/news/blue-cross-nc-launches-comprehensive-program-to-help-independent-primary-care-practices-stay-in-business>. Published June 24, 2020. Accessed September 17, 2020.
25. Finnegan J. Aledade and Humana broaden collaboration into North Carolina. FierceHealthcare.com. <https://www.fiercehealthcare.com/practices/aledade-and-humana-broaden-collaboration-into-north-carolina>. Published February 27, 2020. Accessed March 2, 2020.
26. Japanga M, Crook H, Singletary E, Saunders R, McClellan M. A Roadmap for Effective State Leadership in Value-Based Payment Reform. Durham, NC: Duke University Margolis Center for Health Policy; 2020. https://healthpolicy.duke.edu/sites/default/files/2020-06/a_roadmap_for_effective_state_leadership_in_value-based_payment_reform.pdf. Published February 2020. Accessed August 6, 2020.
27. Japanga M, Sorenson C, O'Donnell J, et al. A Roadmap to Accelerate National Value-Based Payment Reform: Filling in the Missing Pieces. Durham, NC: Duke University Margolis Center for Health Policy; 2020. https://healthpolicy.duke.edu/sites/default/files/2020-06/a_roadmap_to_accelerate_national_value-based_payment_reform_filling_in_the_missing_pieces.pdf. Published February 2020. Accessed August 6, 2020.
28. Gonzalez-Smith J, Crook H, Singletary E, Bleser W, Saunders R. How to Better Support Small Physician-led Accountable Care Organizations: Recent Program Updates, Challenges, and Policy Implications. Durham, NC: Duke University Margolis Center for Health Policy; 2020. https://healthpolicy.duke.edu/sites/default/files/atoms/files/how_to_better_support_small_physician-led_acos.pdf. Published February 2020. Accessed March 2, 2020.
29. Bleser WK, Saunders RS, Muhlestein DB, McClellan M. Why do accountable care organizations leave the Medicare Shared Savings Program? *Health Aff (Millwood)*. 2019;38(5):794-803. doi: 10.1377/hlthaff.2018.05097
30. Joynt Maddox K, Bleser WK, Crook HL, et al. Advancing value-based models for heart failure. *Circ Cardiovasc Qual Outcomes*. 2020;13(5):e006483. doi: 10.1161/CIRCOUTCOMES.120.006483
31. Bleser WK, Saunders RS, Winfield L, et al. ACO serious illness care: survey and case studies depict current challenges and future opportunities. *Health Aff (Millwood)*. 2019;38(6):1011-1020. doi: 10.1377/hlthaff.2019.00013
32. Centers for Medicare & Medicaid Services. Preliminary Medicare COVID-19 Data Snapshot. CMS website. <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot>. Published July 17, 2020. Accessed August 12, 2020.