AIS's
VALUE-BASED CARE NEWS

Volume 7, Number 2 • February 2016

Accountable Care • Medical Homes • Bundled Payments • Shared Savings • Global Payments

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CMS's Next Generation ACOs Cite Waivers, Shared Learning as Reasons for Joining Up

CMS launched its Next Generation accountable care organization model with a bumper crop of 21 new ACOs, many of which said they were attracted by the care enhancements built into the program's design and by the opportunity to share learnings with other ACOs on the cutting edge of Medicare value-based payment.

The program, which is run by CMS's Center for Medicare & Medicaid Innovation (CMMI), allows more advanced ACOs to take on significantly more risk while providing them with better tools to manage care.

Erik Johnson, vice president for network and population health consulting at Optum, Inc., says he's encouraged by the number of organizations that joined NextGen. "It's a good sign for the program," he tells *VBC*. "If you have any confidence in your ability to do this, the NextGen upside is considerably higher than the upside" for the Medicare Shared Savings Program (MSSP).

With the advent of NextGen, CMS now has four different types of accountable care models in operation: the Medicare Shared Savings Program (see story, p. 3), the Pioneer ACO Model, NextGen and the Comprehensive ESRD Care Model *(VBC 11/15, p. 4)*.

Combined, these programs comprise a total of 477 ACOs and serve nearly 8.9 million beneficiaries, according to CMS. Just 64 of these ACOs are at downside risk, the agency said. MSSP remains the largest Medicare ACO program by far.

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Real-Time Data Can Help Providers With Value-Based Care, but Only in Some Cases

As the shift toward value-based care continues, technology companies are developing a wide range of tools to help providers offer the most efficient care possible. One burgeoning area in health care services is analytics companies that offer real-time data. And while insurers are pushing for data-driven outcomes in a series of new pilots with these companies, it remains to be seen how useful providers find the data.

The hope is that by eliminating the lag time in the transmission of patient information from one care provider to another, from the patient to the physician, or from the physician to the insurer, the care coordination team can close existing gaps in care while simultaneously reducing costs and improving outcomes.

Companies like Vheda Health, Lumiata, GNS Healthcare and MedeAnalytics are working to deliver solutions such as smart devices that track biodata or predictive analytics to identify women at risk of premature labor. But while insurers may find the data useful, providers' perspectives — as is often the case — may vary somewhat, depending on the situation.

"Real-time data can be very useful in some cases," maintains David Muhlestein, senior director of research and development at Leavitt Partners. "If providers can learn, in real-time, which of their covered patients are receiving care, they are in a position to

potentially intervene and more effectively manage the patients."

However, Muhlestein points out that "In many cases,…real-time data may not be necessary if providers are more interested in focusing on variation of treatment between providers, network design or other activities that can use retrospective data. Also, many providers are not well-positioned to use real-time data, as they do not have the protocols and processes in place to respond. More important than real-time data is timely data — this, though, could be daily, weekly or even monthly data. Having real-time capabilities is nice, but it may not be necessary."

According to Muhlestein, "Very few providers that I am aware of are using real-time data analytics. There are a variety of analytic platforms, but the vast majority rely on post-hoc analysis of data that is brought in from a variety of systems."

Muhlestein tells *VBC* that "providers usually are responsible for the cost of the analytic systems they use. Sometimes payers will provide analytic services, but the challenge is that those are usually unique to that payer, while the provider needs analytics that work across all payers, so even if the payer provides a platform, the provider must still integrate it into their broader technological approach to managing their covered population."

AIS's Value-Based Care News (ISSN: 2378-9352) is published 12 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Senior Writer, Jane Anderson; Editor, Angela Maas; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Director, Andrea Gudeon.

Subscriptions to *VBC* include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *VBC* content and archives of past issues.

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As far as whether the tools are useful enough for insurers to invest in, Muhlestein says that "developing real-time applications typically involves a different technological framework than other data, and the benefits for most organizations are such that it may not be worth the investment."

Smart Devices Aid Medicaid Patients

Here's a look at four companies innovating in the real-time data arena:

(1) Vheda Health is a mobile software company that partners primarily with Medicaid health plans to reduce medical costs in members with chronic conditions. Members track their health via a comprehensive app — that Vheda can ship to them preloaded — which automatically collects data from more than 250 smart devices like fitness trackers, glucose monitors and weight scales. Vheda can send these devices to the member on behalf of the insurer, along with the smartphone, which also allows the member to video chat weekly with a dedicated health coach.

CEO Shameet Luhar cofounded the company after Anthem, Inc. bought his first analytics start-up, Resolution Health. Luhar says Vheda has the potential to save insurers $17,000 per member per year, which is what happened in the case of a diabetes population in South Carolina. The program recorded care plan compliance rates of 84% and reduced hospitalizations by 71%, which Luhar says is outstanding, particularly considering the fact that he was lucky to see compliance rates of 5% to 10% when he worked with commercial populations. The key is simplicity, he says, and so Vheda designed the app in a way that allows a member to become completely familiarized within 60 seconds. Vheda also offers in-depth product reviews with member compliance in mind — an average fitness tracker battery lasts three to five days, Luhar says, so Vheda recommends the Garmin vivofit, which lasts for a full year. Less time charging means less for the patient to remember, making compliance with care plans more likely.

Insurers can also text and video chat with members, and are alerted in real time when members are falling out of range in various metrics. "If you want to be successful in developing behavior change, you have to develop trust, and you can't do that through a traditional telephone call," Luhar says.

(2) Lumiata provides predictive analytics at an individual level, focusing on backing up its projections in clinical terms rather than in statistics. Chief Commercial Officer Anthony Jones, M.D., tells *VBC* sister publication *Health Plan Week* that Lumiata can give payers and providers evidence of a patient's health trajectory based on medical studies and his or her lab results, instead of statistical projections. Lumiata can also predict a patient's

health status based on six-month intervals, which Jones says helps care givers prioritize interventions.

"That ability to really speak in clinical terminology versus statistical terminology is a real big differentiator in getting providers engaged," Jones says, adding that doctors don't see statistical similarities as clinically meaningful. "That's not terribly convincing to a provider."

Lumiata's data are organized into a graph, combining things like diagnoses and prescriptions and comparing them to factors such as age and social determinants. Primary care physicians (PCPs) can access data from other points of care — which Jones says amounts to three-quarters of the patient's medical profile — in real time through a Web portal. The company partnered with Independence Blue Cross and Penn Medicine last year and is about halfway through gathering and compiling the data to fully implement the software.

(3) GNS Healthcare, a portfolio company of Cambia Health Solutions, Inc., the parent of Regence Blues plans, develops personalized predictive models for different subsets of the patient population. GNS most recently partnered with Inova Translational Medicine Institute, a branch of Inova Fairfax Hospital, to develop software that can identify pregnant women at risk for premature birth, which affects one in every nine babies. The software now is in its validation stages, and cofounder and CEO Colin Hill tells *Health Plan Week* the company plans to involve other health systems to strengthen the database. GNS's software products use artificial intelligence to predict risk and intervention value on an individual basis, using data from genomics, medical and pharmaceutical claims, behavioral health claims, socioeconomic metrics and geographic factors.

"One of the keys is who to touch, who to attach resources to because there are certainly not resources to intervene with everybody," Hill says of the product, which he claims is the first for premature births.

In 2012, GNS partnered with Aetna Inc. to build a predictive model for metabolic syndrome, or people who are at risk of developing diabetes, heart disease or stroke. In an Aetna and Newtopia study published last month in the *Journal of Occupational and Environmental Medicine*, 76% of the 421 participants who reported their weight before and after the 12-month program lost an average of 10 pounds. The program saved $122 on average per member per month in medical costs.

(4) MedeAnalytics, founded in 1994, launched its population health suite around 2010 for the Medicare Shared Savings Program, and it is fully compatible with Epic Systems Corp.'s electronic health record (EHR) platform, so providers can access both internal and external data through a system they already have. The platform incorporates individual analytics for different accountable care organizations, identifying gaps in care and tracking quality metrics. Dan West, associate vice president of product marketing at MedeAnalytics, says the company is working on integrating with other popular EHR platforms AllScripts and NextGen.

West says the company's "flagship case" is with Blue Cross & Blue Shield of Rhode Island, which launched the product with its providers last September, and is continuing to roll out the platform with the intention of incorporating all the PCPs in the state. West says the Blues plan and MedeAnalytics eventually will expand the platform to specialists, and currently are working on integrating the state's four health systems to input admits and discharges into the system in real time.

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Portions of this article were excerpted from the Jan. 25 issue of Health Plan Week. *For more information, visit the MarketPlace at www.AISHealth.com.*

MSSP Gains More ACOs Than It Loses in Class of 2016

The Medicare Shared Savings Program (MSSP) added 100 new accountable care organizations as of Jan. 1 and saw nearly 150 ACOs out of 220 renew their expiring contracts for another three-year term. Including the class of 2016, CMS will have 434 ACOs participating in the MSSP, serving more than 7.7 million beneficiaries.

CMS's announcement means that the worst-case scenario of widespread dropouts from MSSP didn't come to pass. Overall, enough new ACOs joined the MSSP program to more than offset the attrition from ACOs that didn't renew their contracts.

The dropouts represent "a sizeable number," says Leavitt Partners LLC Director of Research David Muhlestein, but they don't necessarily impact the program significantly. "There were some drop-outs, but the vast majority have stayed," he tells *VBC*. "That speaks to people taking this as an opportunity."

Erik Johnson, vice president for network and population health consulting at Optum, Inc., agrees. He tells *VBC* that with no downside risk, ACOs might as well stay in the program for the time being. He expects the count of MSSP ACOs to stabilize for the next two to three years.

For organizations just starting out on the ACO journey, "MSSP Track 1 is still the best deal they're going to get," Johnson tells *VBC*.

continued

Overall, Medicare now has a total of 477 ACOs in operation serving nearly 8.9 million beneficiaries, including ACOs in the MSSP, Next Generation Accountable Care Organization Model (see story, p. 1), Medicare Pioneer demonstration project, and Comprehensive ESRD Care Model *(VBC 11/15, p. 4)*.

The new ACOs joining MSSP don't include "a lot of really name brand organizations," says Muhlestein. "We're getting to a lot of these middle-market and smaller systems, which is the kind of progression you would expect. We're starting to move towards the followers."

A total of 39 of the MSSP ACOs will be participating in the ACO Investment Model (AIM), which provides payments to assist new ACOs forming in rural and underserved areas and to encourage current ACOs to transition to higher levels of risk. The up-front payments distributed through this program are intended to pay for improvements in infrastructure and to redesign care processes.

CMS made up to $114 million available as part of the AIM program, unveiled in late 2014 *(VBC 11/14, p. 2)*. Both new and existing ACOs were eligible to apply for the funds. Applicants had to have fewer than 10,000 patients attributed to them and to meet several other requirements.

In addition, 22 ACOs opted for either Track 2 or Track 3, both of which require downside risk. Combined with the Medicare Pioneer program's remaining nine ACOs and the Medicare Next Generation ACO program's 21 ACOs, that means 52 ACOs are taking downside financial risk. The Comprehensive ESRD Care Model's 12 ACOs also are at downside risk.

Almost 70 MSSP ACOs are leaving the program, representing about a one-third dropout rate.

Many cite the difficulty achieving shared savings as a primary reason for leaving; only about one-quarter of ACOs have earned a payout in each of the last two years *(VBC 9/15, p. 1)*, which means most have spent money on ACO infrastructure and care management, but haven't seen a return on their investment. Many also cite administrative burdens imposed by CMS.

Nonetheless, a few of the ACOs that are counted as drop-outs actually still are in the program as part of larger ACOs, while others moved over to Next Generation.

However, Muhlestein points out that there were some "very optimistic" partnerships launched among providers to join MSSP that since have decided they took on too great a task. "They were going to work together to transform health care, and a lot of these newly formed entities weren't in a position to do this."

MACRA Could Push More ACOs to Downside Risk

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) could be the spur many providers need to move to two-sided risk.

The law repealed the much-maligned Medicare Sustainable Growth Rate (SGR) formula and replaced it with two separate types of incentive payments *(VBC 5/15, p. 1)*. Physicians who participate in Alternative Payment Models will be eligible for a 5% annual bonus from Medicare, while physicians not participating in APMs will instead have to participate in the complex Merit-Based Incentive Program, which offers bonuses based on quality, use of resources, use of electronic health records and practice improvement.

Under MACRA, provider groups can qualify as an APM if they take downside risk for at least 25% of their payments (the 25% figure will increase to 50% in 2021). It's assumed that ACOs participating in the Medicare Shared Savings Program (MSSP) Track 1 will not qualify for this alternative program, but CMS hasn't said that for certain.

Last fall, CMS sought comment from stakeholders on how eligible APMs should be defined. The agency also asked for feedback on the establishment of new Physician-Focused Payment Models. The proposed rule is due out by spring, and the final regulations on MACRA implementation should be released next fall.

MACRA will drive downside risk acceptance in the ACO industry, predicts Leavitt Partners LLC Director of Research David Muhlestein. For 2016, there's no penalty for not participating in a downside risk arrangement. But ACOs that make the jump into downside Medicare risk before they're truly ready for it could owe money back to CMS. So most organizations are sticking with MSSP Track 1.

CMS will see a few ACOs move into downside risk arrangements in 2017 and a few more in 2018, he says. But the real bulk of ACOs will begin to take on downside risk in 2019, when MACRA will force them to choose either APMs or the Merit-Based Incentive System, he says.

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All this just points up the fact that transforming health care is very difficult and is a multiyear job.

Muhlestein notes that 22 ACOs now are participating in Track 2 or Track 3, so "CMS has more than there used to be in downside risk. But that's still not a lot of ACOs."

Success in Track 1 didn't predict which ACOs would move to higher risk levels. For example, some in the industry had predicted that Memorial Hermann Accountable Care Organization, the top-performing MSSP ACO over the last two years with $51.06 million in total shared savings payments from CMS, would switch into a program that would allow a potentially greater share of savings, such as MSSP Track 2 or NextGen.

However, Memorial Hermann stayed put in Track 1, and Johnson says he understands why: "There's no reason for them to do anything different — they're doing so well now." The ACO didn't respond to a request for comment.

National Association of ACOs (NAACOS) CEO Clif Gaus notes that among Pioneer, MSSP and NextGen, CMS has added only 16 downside risk-bearing ACOs in four years, for 52 in total. "While many believe two-sided risk ACOs are the future, this very slow adoption brings that into question and signals the importance of maintaining a robust group of Track 1 ACOs," he contends.

The vast majority of Medicare ACOs begin with MSSP Track 1. For nascent ACOs to move successfully up the risk ladder, NAACOS believes that CMS should focus on Track 1 and continue to foster growth there, Gaus says.

"The good news is the program is still growing, albeit slower, but it's a long heavy lift for many ACOs to achieve success in Track 1 before they are ready to migrate into higher risk tracks. We need to ensure Track 1 becomes more appealing for organizations evaluating whether to join or remain in the program," he says.

Few organizations are feeling confident enough in their ability to take on risk to join a program such as MSSP Track 2 or 3, or NextGen, Muhlestein points out. But this will change as the 2019 deadline approaches for satisfying the value-based demands contained in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (see box, p. 4).

"Congress has essentially set the target date" for moving to downside risk," Muhlestein notes. "Progress towards risk is not moving as fast as people would have hoped, but it's moving faster than people on the ground thought was possible."

"At some point we have to decide what Medicare ACOs are going to be when they grow up," says Johnson. CMS has set impressive goals for value-based payment — the agency wants to have 30% of all payments in alternative payment models by the end of this year and 50% in alternative payment models by the end of 2018. But "that's coming up, and we're still kind of far away from it. There are still a lot of people on the sidelines, who say, 'The next model CMS creates is the one that's going to work for me.'"

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Study Highlights Challenges of Coordinating Health Care in U.S.

Almost one-quarter of U.S. primary care physicians maintain they are not well prepared to care for people who have complex health care needs due to having multiple chronic conditions. That's one of the findings of a study from The Commonwealth Fund based on surveys of primary care doctors in 10 countries. In addition, only 16% of U.S. respondents said they were prepared to care for people with severe mental health problems. As the U.S. health system continues its shift to value-based care, various challenges contribute to providers' issues with managing and coordinating care for patients. While there are approaches that can counter those problems, some may be easier said than done, say providers.

"The need to bolster primary care in the United States is critical," concludes the article, titled "Primary Care Physicians In Ten Countries Report Challenges Caring For Patients With Complex Health Needs" and published in the December issue of *Health Affairs.* "Among the ten countries in this survey, the United States has the youngest population, yet it has the highest incidence of chronic disease and spends 50–150 percent more on health care per capita than the other nine countries in the survey."

VBC spoke to multiple physician leaders for feedback on the findings, including how primary care providers can coordinate care and how they can get over potential barriers to these approaches.

Chronic conditions and serious mental health issues "are both huge in primary care," maintains R.W. Watkins, M.D., senior physician consultant for Community Care of North Carolina. These are "medically complex patients" who have "different types of issues" that "sometimes overlap," explains Michael Barr, M.D., executive vice president, quality measurement and research group at the National Committee for Quality Assurance (NCQA). Mental health issues can be "contributors to chronic conditions," and, conversely, people with multiple chronic conditions can develop mental health issues because of those conditions.

Barr says that the question of whether physicians are prepared to handle these patients comes down to how physicians define "prepared." Is it in "terms of clinical knowledge?" In terms of the practice's organization contributing to its ability to handle the needs of patients? In terms of whether the physician has a referral network that he or she feels comfortable sending patients to for care? With chronic medical conditions, it's less likely that a primary care doctor would be uncomfortable with his or her network, but with mental health issues, "finding resources may be difficult." Additional complications in the U.S. include the fact that "primary care doctors are asked to do a lot more psychiatry services than they thought they would and than they feel confident doing," says Watkins. And Barr points out that "things that used to be treated through inpatient care are now managed on the outpatient side."

"It's really about managing those populations" proactively, Watkins asserts. For example, perhaps a person with high blood sugar isn't managing her condition very well, which eventually lands her in the emergency room. "We have the opportunity with electronic health records to do patient registries" for diabetic patients that allow physicians to identify certain types of patients, such as those who haven't been into the physician's office in six months. That information allows the practice to contact those patients and schedule them for checkups. "The key is being able to find the impactable patients before they get sick," he tells *VBC*.

But identifying those people "who need an extra level of support…sounds easier than it is," maintains Barr. A "skill set that's really important" is "knowing who your patients at risk are, the 'hot spotters'…who are at the most risk of their health deteriorating," says David Ehrenberger, M.D., chief medical officer for Avista Adventist Hospital and Integrated Physician Network.

U.S. Health Care Culture Is an Issue

The study's focus across multiple countries highlights the fact that the U.S. health care culture is quite different from other countries' approaches. In the U.S., we have a "let's get a prescription and fix the problem culture" and have "neglected the idea of supporting lifestyle issues," contends Cynthia Ambres, M.D., national lead advisory partner for KPMG LLP's provider segment. She notes that many conditions, such as type II diabetes, are tied to lifestyles, and that managing patients by addressing factors such as nutrition and exercise can help ultimately eliminate these conditions. "The adage of 'you are what you eat' is actually true" in situations such as this, she says.

"That said, people are going to become ill," Ambres says, and will need to navigate the health care system. At this point, "how we manage people is a quagmire" for primary care providers. Some of that stems from providers' inability "to spend the appropriate amount of time" with patients. "Addressing culture and lifestyle

falls through the cracks when you're spending 10 to 15 minutes with a patient." Primary care providers are "not reimbursed for spending the necessary time with patients," which should be longer than 10 to 15 minutes for people with comorbidities.

Because providers cannot address all of a patient's concerns in one visit, options such as home care or telehealth can help, says Ambres. Patient-centered medical homes and accountable care organizations are "making care more organized" through a group health approach. A patient-centered medical home can "provide a roadmap to practices for the simplest to the most complex patient," says Barr.

But even when there is "the opportunity to get a lot of information on patients,…how do we coordinate and aggregate that data?" asks Ambres. She maintains there is a "lack of coordination of data and usefulness of data.…Are we able to use data in a meaningful way?" She tells *VBC* that the "biggest and most important" question is "how do we really coordinate care to the benefit of the patient?"

A huge difference exists between "a plan of care versus a multisiloed plan of care," says Ehrenberger.

Making certain that people are getting the best care they can includes making sure that medications prescribed by one provider aren't contraindicated by ones that another doctor prescribes. This can be addressed by involving pharmacists in patients' care, Ambres says. Ensuring that patients are adherent to their treatment regimens also is critical. Ambres says that providers may assume that patients will take their medications as directed, but there is "a lack of follow-up" to confirm this.

Ambres tells *VBC* that "we're trying to look at how to get the best use of data." That includes "aggregating claims data" and using analytical tools to place patients in baskets ranking them from low to high risk. This allows providers to identify and then intervene with specific groups of patients. For instance, doctors can flag which patients are at highest risk of not following through with their care plans because of costs — "patients that will fall through the cracks" — perhaps because they have a high-deductible health plan. In the U.S., "are we looking

Home Visits Can Help Identify Potential Patient Care Issues

The idea of a doctor making a home visit may seem like a quaint notion in the U.S. But this step can help providers get a more complete picture of potential barriers to care for their patients, regardless of who in the practice conducts the visit.

"For primary care providers to become effective in addressing the needs of complex patients, they and their team need to reach patients where they're at," says David Ehrenberger, M.D., chief medical officer for Avista Adventist Hospital and Integrated Physician Network. He points out to *VBC* that researchers from The Commonwealth Fund found that only 6% of U.S. respondents said "practice staff frequently make home visits." That finding was only one of many aspects of health care systems in 10 countries identified in surveys of primary care doctors, published in the December issue of *Health Affairs*.

"If we go to where the patient is at, we can see their support or lack of support," as well as any other problems that could impact their care, he says. For this reason, home care "is absolutely essential." The "nuance" to this, though, is whether it is "essential for the doctors themselves to go" to patients' homes, Ehrenberger explains. The answer is "yes and no. It depends on the situation. What do physicians have to bring to the table" with people, and can they achieve this from their offices? "Physicians can be entirely effective" in building a relationship with patients and their family, which creates "trust and empathy," and having the technical knowledge to know how to treat a patient by remaining in the office.

But it can be difficult "to understand the nuances…of people's lives unless you go" to their homes, asserts Ehrenberger. He tells *VBC* of a former patient who was obese, diabetic, hypertensive and suffered from coronary artery disease. The patient "had worked hard to take control" of his situation but "fell off the radar," prompting Ehrenberger to first call him and then ultimately go to his home. It was at that point that "I realized just how poor he was and that it was a struggle for him to meet me at my office," he says. "I realized what kind of help he really needed." When nurse practitioners and physician assistants make home visits, "they can do a lot to extend my reach" and "inform me about the issues going on in patients' homes.…A home visit is essential for the health care team to have as a method, a tool, an approach to being effective in helping patients who need extraordinary help."

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at the socioeconomic situation of the patient aligned with their actual physical needs?" asks Ambres. "If not, we are missing the boat."

In "traditional Western medicine," says Ambres, "we've left everyone to their own resources." But "what happens in the interim around wellness" and other approaches to try to keep people well is important, as seen in the Netherlands and Sweden, which have a "more longitudinal approach" to care. In the U.S., we need "proper prevention [efforts] and education around being well." That should be combined with what patients need to do when they find themselves needing to navigate the health care system, including assisting with psychosocial issues. Much of what impacts patients' care does not happen in a doctor's office, Watkins says, such as issues with transportation, education and poverty, including food and shelter. Home visits may give a better view into these factors (see box, p. 7).

A group health approach, where a patient may come into a practice and see multiple people, such as a physician, nurse, nutritionist, pharmacist and podiatrist, is an option. But this "one-stop-shopping environment" also is "challenging with the reimbursement structure," says Ambres. That's because "only one or two problems a patient has can be addressed during one visit," forcing patients with multiple issues to return to the office so all the providers can be reimbursed — which is "not a very efficient form of care," she notes.

Perhaps instead when a patient has an appointment with his or her primary care doctor, that could include a "concurrent telehealth call" with a specialist, says Ambres. This also helps when it's difficult to get appointments with specialists, whether it's because there aren't many in a patient's geographic area or there are few options but high demand.

With so many care providers potentially involved in one person's care, it's critical that there is seamless communication among them. However, the study reveals that 62% of U.S. primary care doctor respondents "always or often" receive "timely and relevant information" from specialists who see their patients. And only 31% of doctors said they are notified when their patients are discharged from the hospital, while 32% are always told when their patients are seen in the emergency department.

That's unfortunate because out of all the stakeholders involved in a patient's care, primary care doctors are in the best position to take the lead on managing a patient's care, experts tell *VBC*.

"This goes back to what was proposed almost two decades ago" with HMOs, Ambres says, in which the "primary care doctor would be the gatekeeper." That, however, "fell apart mainly because we weren't ready to provide primary care providers with the data to make it work."

"All health care, like politics, is local," says Watkins. When a patient sees a particular primary care physician, that doctor has a relationship with the patient and his or her family, giving them a deeper insight into the situation beyond simply what the patient's chart reveals. That physician also "knows the team that's tied into the local resources" and likely has relationships with them.

"To manage these complex patients, it takes a village," contends Ehrenberger. "It takes a regional organization" that has an "understanding of the various people" involved in a patient's care, including not only other physicians but also social workers, mental health providers and home health care providers.

But, says Watkins, "the key is getting paid for" patient oversight and care, much of which providers are already doing. In the "fast-paced fee-for-service environment, you need time and space in the practice" to coordinate care, including making sure that patients and their families are involved in their care.

Practices need to provide "better access to people who need care," says Barr. This means they "see who they need to see, and they don't see those who don't need to be seen." But since most "practices only get paid when they see a patient," this can pose a problem.

Barr points to "fee-for-service hybrid models" with which some payers are experimenting, such as ones that add infrastructure payments, some shared savings and merit-based payments. And coordinated care management codes now are available for patient-centered medical homes. A per-member per-month management fee "can fund the extra work required in order to effectively coordinate care," Ehrenberger says.

However, while payments for quality are happening, the shift is slow going at this point, says Ehrenberger.

Selected Recent Health Plan ACO Arrangements, Collaborative Agreements

Health Plan Affiliates	Provider Affiliates	Service Area	Launch Date
Anthem Blue Cross and Blue Shield	Ohio Independent Collaborative	OH	Effective Jan. 1, 2016
Cigna	WakeMed Key Community Care	NC	Effective Jan. 1, 2016
UnitedHealthcare	Brown & Toland Physicians	CA	Announced in January 2016

SOURCE: Compiled by AIS from health plan press releases in January 2016.

"Reimbursement that rewards quality and efficiency of care is moving in that direction, but the vast majority of primary care reimbursement is still fee for service."

View the *Health Affairs* article at http://tinyurl.com/h3pjpl7.

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Insurers Expand Palliative Care As Industry Conversation Grows

Health insurers are increasingly targeting palliative care in their ongoing mission to improve quality and bring down costs associated with the most expensive aspects of care, partnering with specialty providers and launching pilot programs aimed at the terminally ill.

On Jan. 1, CMS began reimbursing physicians for conducting end-of-life conversations with their patients, a provision proposed for inclusion in the Affordable Care Act that was buried in 2009 when former Alaska Gov. Sarah Palin (R) accused President Obama of creating "death panels." The new billing code encourages advanced care planning and would allow the government to track how much time doctors spend discussing a patient's care goals and final wishes. Some insurers, however, began reimbursing for these conversations on their own, a task that has been difficult to push with providers mostly because of technical issues, according to Regence BlueShield Executive Medical Director Bruce Smith, M.D.

"Even though we're paying for these visits separately in addition to their regular visits, and lots of our docs are really committed to doing this, the challenge has been to try and educate them that they can actually send us a bill for that," Bruce Smith tells *VBC* sister publication *Health Plan Week*. "Yes, we want you to do this. Yes, we'll pay you. Yes, please send us a bill." Regence has been requesting end-of-life discussion claims since November 2014, but Smith, a former hospice and palliative care doctor, says so far the insurer has seen relatively few.

End-of-Life Conversation Is Growing

The conversation has been snowballing in the last several years. In 2015, California became the fifth state to enact a "Death With Dignity" law, allowing terminally ill patients the right to end their lives on their own terms. Insurers and palliative care advocates see this as a separate conversation, but it brings more attention to the idea of patient choice in end-of-life care. Aetna Inc. is well-known for its palliative care initiatives, and UnitedHealth Group on Jan. 7 announced a support program for caregivers that provides them with guidance on medical care, financial tips and a marketplace for commonly needed products and services like home safety devices and delivered meals.

Aspire Health, a palliative care services provider that launched in 2013, has built an impressive array of large payer clients in the three short years the company has been in operation. One is Highmark Health, which partnered with Aspire in July 2015 to offer free around-the-clock support to in-home members.

"We feel the economic value of the program with decreased hospitalizations and increased hospice utilization more than covers the cost of the program, so we're passing that along to our members," Tim Lightner, Highmark vice president of products and marketing for senior products, tells *Health Plan Week.*

The partnership is an expansion of Highmark's current palliative care efforts. The company has offered its Advanced Illness Services program for several years, providing its Medicare Advantage members up to 10 palliative care consults per year. That program has seen a 48% decrease in ICU admissions and a 39% decrease in emergency room admissions in the last month of life. Ninety-five percent of members said they would refer friends and family to the program.

Aspire CEO Brad Smith says its program reduces hospitalizations by an average of 52% to 76%, depending on the control group used in the analysis. Furthermore, the patient satisfaction rate averages 4.9 on a five-point scale, he says. Aspire contracts with payers in value-based arrangements, receiving bonus payments for achieving goals in metrics such as reduced hospitalizations, patient satisfaction and transitions to hospice. Aspire's service typically lasts eight or nine months per patient.

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This article originally appeared in the Jan. 11 issue of Health Plan Week. *For more information, visit the MarketPlace at www.AISHealth.com.*

CMS Has Oversized NextGen Class

continued from p. 1

The 21 NextGen participants all are at risk for shared losses. Ultimately, they will have the opportunity to take on even higher levels of financial risk — up to 100% risk in the third year of the program as part of global capitation. Coupled with this increased risk come richer information and program benefits (see box, p. 11).

The third year of NextGen will allow organizations to move to a per-member per-month global capitation payment methodology, which could prepare ACOs to

start their own Medicare Advantage plans or to acquire properties and expand their footprints, Johnson says.

Leavitt Partners LLC Director of Research David Muhlestein notes that CMS originally was aiming to have between 15 and 20 ACOs participate in the NextGen program in its first year and instead wound up with a robust 21 participants. The agency had signaled in November that it expected the number of NextGen ACOs to come in at the top end of its original range and had noted that interest in the program was higher than anticipated, albeit welcome *(VBC 12/15, p. 4)*.

"I was interested to see how many people moved from Pioneer to NextGen," Muhlestein tells *VBC*. "That's the progression CMS wants to see. But it's also interesting to see who didn't join."

He points to three former Pioneer ACOs. Brown & Toland Physicians in the San Francisco Bay area did not join the NextGen program, nor did Dartmouth-Hitchcock Medical Center in Lebanon, N.H., or Mount Auburn Cambridge Independent Practice Association in Massachusetts. For its part, Dartmouth-Hitchcock said it was still evaluating the program and would make a decision about whether to join in the second round of applications later this year.

Despite that, Muhlestein says, with 21 participants, "the program is ready to go." NextGen includes six ACOs that formerly were Pioneer ACOs (see table, below).

With the NextGen program starting, the Medicare Pioneer program is left with only nine participants:

- ***Allina Health*** (Minnesota and western Wisconsin),
- ***Atrius Health*** (eastern and central Massachusetts),
- ***Banner Health Network*** (Phoenix),
- ***Beth Israel Deaconess Physician Organization*** (eastern Massachusetts),
- ***Fairview Health Systems*** (Minneapolis),
- ***Michigan Pioneer ACO*** (Detroit area),
- ***Monarch Healthcare*** (Orange County, Calif.),
- ***Montefiore ACO*** (Bronx and Westchester County, N.Y.), and
- ***Partners HealthCare*** (eastern Massachusetts).

Medicare Next Generation Accountable Care Organizations

Next Generation ACO Name	Location	Pioneer Participation	MSSP Participation
Accountable Care Coalition of Southeast Texas Inc.	Houston	No	No
Baroma Accountable Care LLC	Miami	No	Joined in January 2013
Bellin Health Partners	Green Bay, Wis.	Yes, as part of Bellin-ThedaCare HealthCare Partners	No
Cornerstone Health Enablement Strategic Solutions (CHESS)	High Point, N.C.	No	Joined in January 2015
Deaconess Care Integration	Evansville, Ind.	No	Joined in July 2012
Henry Ford Physician Accountable Care Organization	Detroit	No	No
MemorialCare Regional ACO	Fountain Valley, Calif.	No	No
Optum Accountable Care Organization	Phoenix	No	No
OSF Healthcare System	Peoria, Ill.	Yes	No
Park Nicollet Health Services	St. Louis Park, Minn.	Yes	No
Pioneer Valley Accountable Care	Springfield, Mass.	No	Joined in January 2013
Prospect ACO CA	Los Angeles	No	No
Regal Medical Group	Northridge, Calif.	Yes, as Heritage California ACO	No
River Health ACO	Harrisburg, Pa.	No	Joined in January 2014
Steward Integrated Care Network	Boston	Yes, as Steward Health Care System	No
ThedaCare ACO	Appleton, Wis.	Yes, as part of Bellin-ThedaCare HealthCare Partners	No
Triad HealthCare Network	Greensboro, N.C.	No	Joined in July 2012
Trinity Health ACO	Livonia, Mich.	No	Four separate MSSP ACOs
UnityPoint Health Partners (Iowa Health Accountable Care)	Des Moines, Iowa	Yes, as Trinity Pioneer ACO	Four separate MSSP ACOs
WakeMed Key Community Care	Raleigh, N.C.	No	Joined in January 2014

MSSP=Medicare Shared Savings Program.
SOURCE: Compiled by AIS from data supplied by CMS and NextGen ACOs.

This isn't unexpected, Muhlestein points out: "There's not a general understanding of the Pioneer model as a demonstration." In fact, the program was intended to run for only five years — the three initial years, plus an option for Pioneers to keep going for two additional years. Pioneer is slated to end at the close of 2016.

However, the participants in NextGen say they expect to keep the collaborative spirit of Pioneer alive: They cite the chance to share best practices with other participants and with CMMI as a major reason to join the program, just as they had done in Pioneer.

For example, Aric Sharp, vice president for accountable care at UnityPoint Health Partners ACO, stresses this as a primary reason for UnityPoint to get involved in NextGen. UnityPoint's NextGen ACO has about 84,000 Medicare patients attributed to it, spread over six markets: Des Moines, Fort Dodge, Waterloo and Cedar Rapids, Iowa, and Quincy and Peoria, Ill. The ACO has in excess of 1,500 primary care physicians — a mix of employed and independent doctors — and about 5,000 physicians overall, Sharp says.

Pioneer Was 'Great Learning Ground'

UnityPoint cut its teeth in both Medicare Pioneer and the MSSP — it had a Pioneer program in its Fort Dodge market, and most of its other NextGen markets in MSSP. The ACO is merging the programs together for NextGen.

"Pioneer was a really great learning ground," Sharp says. "We did generate savings. It wasn't always enough to get a share of the savings, but we were able to generate savings." UnityPoint's MSSP ACO didn't earn shared savings, he adds. It will be challenging for UnityPoint to quickly unify the six markets it has placed into NextGen, Sharp says. "If you look anywhere in the country, when you start getting into programs approaching 100,000 beneficiaries, you will find practice variation. The wide geography will pose a challenge for us, but we're ready to step up to the challenge." The ACO will focus on giving its physicians the tools they need to reduce practice variation, he explains.

UnityPoint was attracted to NextGen when the program first was announced, but nonetheless made a careful, analytical decision, Sharp says. "We looked at all of our options — everything from [MSSP] Track 1 to Next Generation. We certainly did an analysis."

The cutting-edge ACO elements of NextGen appealed to UnityPoint, he tells *VBC*, including prospective attribution, more progressive risk score adjustment and the waivers for telehealth, post-discharge home health visits and SNF use.

In addition, the shared learning environment — carried over from the Pioneer program, where participants collaborated and shared best practices — truly appealed, he says. "In Pioneer, we learned a lot and contributed a lot. We didn't want to lose that."

Sharp adds, "It was attractive to be at the forefront of the program design. We believe we both can benefit from the design and contribute to the learning environment."

UnityPoint is pressing ahead with at least some of the waivers for care now permitted under the NextGen program. The three-day SNF waiver was a part of the Pioneer program, and UnityPoint already had implemented it with success in its Fort Dodge market, Sharp says. "We'll be migrating that to our other markets." In addition, "we certainly will do work in telehealth and in post-discharge home visits."

The UnityPoint health care system now is using telehealth for some behavioral health and specialty consults, and recently launched e-visits, Sharp says. However, it's too early for the ACO to have determined exactly what it will do in the realm of telehealth as part of NextGen.

Sharp tells *VBC* that CMS has worked hard to "continue to evolve the ACO programs. They're listening to folks in MSSP and Pioneer, and even those sitting on the sidelines, to see how the programs could be enhanced."

continued

NextGen ACOs Enjoy More Perks

The 21 Next Generation accountable care organizations will enjoy a range of perks from CMS in exchange for accepting higher levels of financial risk. The model reflects many of the "wish list" items that the ACOs participating in Medicare Pioneer and the Medicare Shared Savings Program have said they wanted. These benefits include:

- ***A waiver of the three-day inpatient hospital stay rule*** before skilled nursing facility coverage kicks in, so ACO physicians can refer patients directly into SNFs.
- ***Expanded use of telehealth services.***
- ***A waiver to allow home visits*** for non-homebound beneficiaries.
- ***Prospective beneficiary assignment.***
- ***"Opt-in" beneficiary attribution*** to allow Medicare members to choose to enroll themselves in the ACO.
- ***The potential for direct payments to Medicare beneficiaries*** if they receive a certain percentage of their care from a NextGen provider.
- ***Medicare benchmark calculations that are more predictable.***

With any new payment system, "you can expect there to be some lumps and bumps and learning along the way," he says. "There's a good understanding that this is a partnership with CMMI. That, and being able to exchange learning with other NextGen participants, gives us the confidence that we'll be able to make a difference for our patients."

Trinity Health Accountable Care Organization, another NextGen ACO, also participated in MSSP before joining NextGen, says Sheila Johnson, vice president of population health and clinical operations. "Participating in the Next Generation ACO Model is the next step in transforming care for the communities we serve," she tells *VBC*.

The organization, which combined four MSSP ACOs and a private medical group to create the NextGen ACO, will include about 64,000 attributed patients and 1,032 primary care physicians, she says. The groups involved include Affinia Health Network in Michigan, Lourdes Health Network in New Jersey, Summit Medical Group in New Jersey, Health Collaborative of Central Ohio and Loyola Physician Partners in Chicago.

"This is our first foray into having a national ACO," Trinity's Johnson says, adding that the ACO didn't consider joining MSSP Track 3 as an alternative to joining NextGen.

Trinity was attracted to the NextGen model in part because of the waivers, and will be moving quickly to implement some of them: The SNF and home health beneficiary enhancements take effect this month. She says the ACO is "reviewing the telehealth waiver to decide if and when we might implement this enhancement."

Universal American Corp. also is joining the NextGen program with a new ACO: the Accountable Care Coalition of Southeast Texas. This ACO, which will have approximately 12,500 Medicare beneficiaries attributed to it and 118 providers, includes physicians from TexanPlus, Universal American's four-star Medicare Advantage plan in southeast Texas.

Like other NextGen ACOs, Universal American cites the availability of waivers for SNF care, plus the promise of telemedicine, as strong reasons for joining the program. "We are excited to team up with our providers and CMS to develop more flexible payment models, take on more risk and ultimately improve the health of Medicare beneficiaries while cutting costs," says Universal American Chairman and CEO Richard Barasch.

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NEWS BRIEFS

◆ **Brown & Toland Physicians and UnitedHealthcare have established an accountable care organization (ACO) that will serve more than 15,000 members in UHC's employer-sponsored health plans in California.** Physicians participating in the ACO are reimbursed based on patients' health outcomes and "for encouraging services that are proven to deliver consistent, high-quality care," says the insurer. UHC will provide support that includes "technology and information that will help the group's 1,500 physicians take specific actions that improve quality and lower costs," according to a press release. "Actionable data can include patient profiles, identifying specific gaps in care, and receiving real-time information about emergency room and inpatient admissions. Patient navigators may also be used to support community-based care coordination, such as helping with transition plans after a patient is discharged from the hospital and scheduling follow-up appointments." Visit http://tinyurl.com/z8lwg7v.

◆ **Use of a pediatric ACO decreased inpatient days and reduced hospital costs among more than 28,000 patients studied from Sept. 1, 2013, to May 31, 2015,** according to an article in *JAMA Pediatrics*. Published online Dec. 14, the article, titled "Effect of Attribution Length on the Use and Cost of Health Care for a Pediatric Medicaid Accountable Care Organization," also noted that there were increases in office and emergency department visits, as well as in the use of medications. According to the researchers, "these findings suggest significant and durable reductions of inpatient use and cost of health care resources associated with longer attribution to the ACO, with attribution as a proxy for exposure to the ACO's consistent primary care. Consistent primary care among the pediatric Medicaid population is challenging, but these findings suggest substantial benefits if consistency can be improved." View the article at http://tinyurl.com/hn4lmbj.

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