Commercial ACO Growth May Continue Rapid Rise as Insurers Promote Contracts

As the accountable care industry moves into 2014, major insurers say they intend to push for additional provider groups to move into value-based contracts.

However, evidence suggests provider groups may be waiting to see whether existing ACOs are successful in controlling costs and improving quality before jumping into the field — a survey published in Health Affairs in November showed growth in ACO agreements slowed in the last several months of 2013 (ABN 12/13, p. 5).

Ultimately, it could take real proof of concept from those existing ACOs to jump-start growth in the field. But for major insurers, the future remains in accountable care, whether it’s ACOs, bundled payments or global risk, representatives say.

UnitedHealthcare Executive Vice President and Chief Medical Officer Sam Ho, M.D., says United wants to push for value-based payments in all its contracts. “Our view on value-based payments is to focus on all providers” — not just ACO-ready providers, but those all along the continuum, Ho told attendees Nov. 5 at the National Accountable Care Congress in Los Angeles, sponsored by Global Health Care, LLC. “We have a value-based continuum on quality and cost outcomes that ranges from individual primary care physicians to large integrated delivery systems.”

continued on p. 17
All told, United has 600 hospitals, 1,100 medical groups and 100,000 physicians under value-based contracts, with 8 million covered lives, Ho said. In the next four years, that’s expected to double, he added.

Results in value-based payment models have been impressive, Ho said. “We find quality improvements across the board,” including reductions in hospital readmissions and emergency room visits, along with improvements in diabetes control and adherence to pharmaceutical regimens. In addition, United is seeing a 2% to 5% reduction in the cost trend. That leads to a return on investment of 2-to-1 or 3-to-1, he said.

Meanwhile, Aetna Inc.’s approach to accountable care and ACO formation will continue to focus in part on investments in support tools for ACOs, said Joseph Zubretsky, the insurer’s senior executive vice president.

“We don’t believe that owning brick-and-mortar or owning physician contracts does anything to improve the system,” Zubretsky told attendees at the ACO Congress. “Our strategy is payer-agnostic — it has to be. If you are fundamentally installing a new business practice in an institution, then how can five payers each have their own different business practice?”

Aetna has made a $1.5 billion investment in clinical support tools for accountable care, he said, adding that “the key to this is clinical and financial information being interpreted in a way that can influence the outcome at the point of care.” Provider groups, with Aetna support, can make the move into accountable care and be successful. “We’re finding that the boldness of the move made by the provider group is commensurate with the money that’s saved and the quality improvement,” Zubretsky said.

That doesn’t mean Aetna doesn’t want more contracts with provider groups for ACO alliances — it does. Some 15% of Aetna’s medical costs are running through value-based contracts now, and “we want to triple that,” Zubretsky said. “It’s transformational. Everyone knows we need to do it.”

To build its own ACO brand, Woodland Hills, Calif.-based Anthem Blue Cross is using the strategy of partnering with well-known provider groups, such as Cedars-Sinai Medical Care Foundation (see story, p. 7), HealthCare Partners and Heritage Provider Network, to treat commercial members within its PPO plans, said Aldo De La Torre, vice president, provider engagement and contracting. The number of Anthem’s PPO members in ACO programs is growing rapidly, from about 200,000 in late 2013 to an anticipated 500,000 in mid-2014, he said.

“In 2014 to 2015, the ACO will become the product you sell,” he said. “I fully expect membership will be purchased rather than attributed.” PPO benefit structures allow members the choice to go out-of-network, and partnering with highly regarded provider groups will help to drive “stickiness” of the ACO, De La Torre told attendees at the ACO Congress. “Engagement jumps significantly,” from 14% to 75% in one Anthem survey.

**Shared Savings May Have Short Shelf Life**

ACOs that are willing to take full insurance risk could begin offering their own products on public health insurance exchanges as soon as next year (see story, p. 6), while at the same time, other ACOs — potentially aided by ACO-specific tools supplied by insurers — could move beyond shared savings into more global risk arrangements. Ultimately, shared savings — the cornerstone of most early ACO contracts — may go by the wayside as partnerships between ACOs and commercial insurers mature, industry observers say.

ACOs will need to decide if they want to move into full risk — and potentially become Medicare Advantage plans or HMOs — or if they want to partner with insurers and only accept partial risk, says Leavitt Partners LLP Director of Research David Muhlestein. This will result in a split in the industry between risk-bearers and “those who consciously choose not to do so,” he tells *ABN*, and likely will be market-specific and market-dependent.

Muhlestein, who authored the *Health Affairs* survey showing slowing growth in the industry, says he expects
a significant number of ACOs to offer products on health care exchanges over the next several years. “Providers are going to see a real opportunity there,” he says. He also expects to see more partnering with insurers.

More competition is coming in the ACO world, Zubretsky says, and provider groups that form an ACO should not be the only ACO in the area. “We’ve already seen it in markets where we’ve established a beachhead ACO with a premier institution — within weeks, two more ACOs get announced,” he says.

The push for ACO formation is playing out among other trends in the health care industry, and industry insiders say those trends are another reason to build ACOs.

Health care spending moderated over the last few years due to the recession and its aftermath, but once people start feeling more financially secure, “demand is going to come back, just as we’re in the midst of implementing value-based systems,” Zubretsky said.

“Bold” provider groups that jump wholeheartedly into accountable care tend to do well in this practice environment, he says, adding, that the health care industry needs value-based payments to keep a lid on overall medical spending. At the same time, “the consumer needs to be more informed and engaged — we need to invest more, mainly in consumer engagement tools,” Zubretsky said.

All providers should expect to see consolidation over the next several years, and “consumers are going to expect more for less,” Ho says. “Core competencies are going to have to be leveraged more extensively than ever.”

Ten years from now, Zubretsky expects the lines to blur between health systems and health insurers, with partnerships between the two and with providers depending on insurers to supply them with the data they need to manage care. This will allow providers to do what they do best — take care of people — while insurers help them manage more global risk, he says.

Contact Ho via UnitedHealth Group spokesperson Tyler Mason at (714) 226-3530, Zubretsky via Aetna spokesperson Sherry Sanderford at sanderfords@aetna.com, De La Torre via Anthem Blue Cross spokesperson Ben Singer at (818) 234-0749 and Muhlestein via Leavitt Partners spokesperson Jordana Choucair at jordana.choucair@leavittpartners.com.

**Premier Adds Seven Hospitals to Bundled Payment Initiative**

Hospital and provider alliance Premier Inc. has added seven new members to its Bundled Payment Collaborative, which now includes 17 health care provider systems with more than 45 hospitals, all of which are working towards bundled payment arrangements in both public and private markets.

The collaborative, launched in July 2012, offers providers analysis of claims data, insights into cost reduction opportunities, care redesign guidance, legal and financial templates, contracting and application support for both commercial and public programs, and peer-to-peer support.

Members share best practices and data with each other across seven specific clinical areas:
- Hip/knee joint replacement,
- Lumbar spine fusion,
- Coronary artery bypass,
- Heart valve replacement,
- Congestive heart failure,
- Percutaneous coronary intervention, and
- Colon resection.

Most collaborative members still are in the early stages of exploring bundled payments, although Premier spokesperson Morgan Bridges says some have already signed contracts for multiple bundles with payers. None of the collaborative members currently are participating in the Medicare Bundled Payment Initiative (ABN 3/13, p. 1), but some are considering whether to join that program in 2014, Bridges says.

Bridges says that claims analysis provided by Premier is proving to be the most valuable to collaborative members. “We’re looking at post-acute utilization and spend such as in skilled nursing facilities, long-term care facilities, inpatient rehabilitation facilities and readmissions to other acute hospitals,” she says. “However, internal cost savings analyses have also been very important, and our members are looking at things such as blood utilization, implant cost, length of stay and the level of care.”

The seven hospitals joining the collaborative are Adventist Health in Roseville, Calif.; Centra Health Inc. in Lynchburg, Va.; El Camino Hospital in Mountain View, Calif.; Regional Health in Rapid City, S.D.; Regional Medical Center in Orangeburg, S.C.; Rockford Memorial Hospital in Rockford, Ill.; and Southwestern General Health Center in Middleburg Heights, Ohio.

Contact Bridges at (704) 816-4152.
Almost Half of Hospitals Have No Plans for ACO Involvement

While some hospital organizations are jumping into accountable care with both feet, others are reluctant to take the plunge: 46% of hospital groups say they have no intention of starting an ACO in the near future.

The survey of 206 hospital executives, conducted for West Lafayette, Ind.-based Purdue Healthcare Advisors, found many of those executives view ACOs as unstable and potentially financially risky. (See highlights from survey findings below.) More than half of those who don’t have plans to start an ACO believe there are too many unknowns, and want to see stronger evidence and consistently successful models before jumping in.

In addition, almost half of those in the group without ACO plans believe their hospitals are too small for an ACO-like model. Respondents also cited challenges with financial investments, quality standards, performance benchmarks and the transformation process. The 7% who chose “other” provided the following answers:

- “Chosen to implement clinical integration with medical staff”;
- “Currently in turnaround and can’t focus on that initiative”;
- “Government facility”;
- “State facility”;
- “There are state specific ACO-like changes taking place”;
- “VA reimbursement not based on ACO structure at this time”;
- “We are a state hospital.”

Even though almost half of hospitals say they won’t be forming an ACO anytime soon, 89% of executives say they’re concerned about their hospital’s ability to address cost pressures, and most are taking steps to deal with diminishing patient volume and decreased reimbursement rates.

For example, 60% are focused on reducing waste and inefficiencies, 19% are considering staff and salary reductions, and 15% are working to improve quality of care.

Almost all the hospitals surveyed are implementing electronic medical records (EMRs), and 49% are working on or have completed Stage 2 Meaningful Use, the survey found. Hospital executives’ top concerns surrounding EMRs include: interoperability with other providers; data retrieval and analytics; on-going staff readiness and training; and infrastructure and technology needs.

### Have you adopted an ACO-like model, or do you plan to in the next year?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
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<tr>
<td>Yes, we have already started/implemented an ACO-like model</td>
<td>20%</td>
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<tr>
<td>No, but we plan to in the next year</td>
<td>28%</td>
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<tr>
<td>No, and we have no plans to in the near future</td>
<td>46%</td>
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<tr>
<td>Not sure</td>
<td>5%</td>
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### Why don’t you plan to adopt an ACO-like model in the near future?

- There are still too many unknowns and I want to see stronger evidence and a consistency of successful models | 52% |
- My hospital is too small | 49% |
- The financial investment outweighs the potential incentives/bonuses | 26% |
- The performance benchmarks are not realistic for my hospital at this time | 13% |
- The transition would overwhelm my staff | 4% |
- Other (Please specify) | 7% |

SOURCE: Purdue Healthcare Advisors. Contact Purdue spokesperson Cristina Bortner at cristinab@imre.com.
2014 Outlook
Medicare, Medicaid ACOs Grow as Early Outcomes Results Trickle in

Public program accountable care should continue to grow in 2014, with the Medicare Shared Savings Program (MSSP) expected to add up to 100 ACOs this month and at least two states pushing ahead on Medicaid ACOs.

Meanwhile, CMS is expected to release long-anticipated results indicating which MSSP ACOs have been successful in boosting quality and cutting costs, providing a window into the models that could work for other provider organizations. The results, which already have been given to the MSSP group that kicked off the program in April 2012, are expected to be “mixed,” says Clif Gaus, CEO of the National Association of ACOs.

“I think it says this has a very long runway to success,” Gaus tells ABN. “Mixed results, to us, are understandable. What ACOs are trying to accomplish with new organizations and trying to redesign clinical care undoubtedly will take multiple years.” The early success stories, which include Geisinger Health System and the Mayo Clinic, show “it’s a long process,” he says.

Nonetheless, Gaus says he expects the ACO industry to continue to grow, with perhaps 75 to 100 new Medicare ACOs approved to start in the MSSP program as of Jan. 1, although “we may have some consolidation and a few dropouts.” He also anticipates an additional 50 to 75 private payer ACOs (see story, p. 1).

“This is a very substantial growth rate,” he says. “I think most providers understand the long runway that’s needed. But I’m not saying everyone who’s in now will be here in two years — there will be some churning.”

New MSSP Groups Prefer One-Sided Risk
Leavitt Partners LLP Director of Research David Muhlestein says he expects the new provider groups joining MSSP this month to be much smaller, on average, and to overwhelmingly select the one-sided risk model.

“Medicare can be seen as an enabler for smaller physician groups to become ACOs,” he says. “The more innovative, larger-scale models are going to happen outside of Medicare,” in part because “Medicare is continuing to be less flexible.”

Muhlestein tells ABN he expects the average savings from the MSSP program to come in below those of the Medicare Pioneer ACOs. In the Pioneer program results, released in July (ABN 8/13, p. 1), CMS reported that costs for the more than 669,000 beneficiaries aligned to Pioneer ACOs grew by 0.3% in 2012, compared to 0.8% for similar beneficiaries enrolled in fee-for-service Medicare.

Overall, the Pioneer program saved $87.6 million before shared savings payments were deducted, CMS says. Out of that, 13 of 32 Pioneer ACOs shared more than $76 million, and Medicare pocketed nearly $33 million in savings. Two Pioneer ACOs wound up with shared losses totaling about $4 million, CMS says.

“We will see consistently improved quality metrics, and progressing to year two, we should see even better cost savings,” Muhlestein says. However, because of the program’s design, year two of the MSSP program should represent the peak year for ACO cost savings, he says.

The larger question for Medicare ACOs, Gaus says, is what will happen to MSSP once the first three-year contracts are up for renewal (see story, p. 1). Since the first group of MSSP ACOs started in April 2012, they would end their contract periods in April 2015 — just 15 months from now.

Colo., Ore. Medicaid ACOs Show Results
Meanwhile, numerous states are considering implementing some form of accountable care — ACOs, bundled payments or patient-centered medical homes — in their Medicaid programs, reports Jennifer Flynn, director of state affairs at Premier Inc. Colorado and Oregon, the two state frontrunners in Medicaid ACO programs, are starting to show results.

Colorado Medicaid’s program reported in November that it had achieved $44 million in gross savings or cost avoidance with its Accountable Care Collaborative (ACC) program in fiscal year 2013 — more than double the amount of cost avoidance achieved by the program in fiscal year 2012. After accounting for payments to providers and regional care organizations, the program’s total net savings for both state fiscal years, 2012 and 2013, was about $6 million, the state said. “In terms of savings, the program has exceeded our expectations,” Deputy Medicaid Director Laurel Karabatsos said in a statement.

The Colorado program also reduced hospital readmissions by 15% to 20% and high-cost imaging services by 25%, the state said. Emergency room utilization increased 1.9%, compared with 2.8% for Medicaid beneficiaries not enrolled in the ACC program.

Oregon’s Medicaid ACO program has been in place for approximately 16 months, and 90% of Medicaid beneficiaries receive their care through a Coordinated Care Organization, says Jeanene Smith, M.D., chief medical officer for the Oregon Health Authority.

Next, Oregon intends to integrate key elements of the program into its state employee health plan for the 2015 plan year, and ultimately will include similar elements, metrics and accountability into plans sold on the Oregon insurance exchange, Smith says.

In New Jersey, the Division of Medical Assistance and Health Services (DMAHS) has finalized regulations to establish ACOs in the Medicaid program and move
most Medicaid beneficiaries into the program. The next step is a 60-day ACO application period, which DMAHS spokesperson Nicole Brossoie says should begin early in 2014. New Jersey ACO applicants must be non-profit organizations serving a minimum of 5,000 Medicaid beneficiaries within a designated region. In addition, ACOs must contract with 100% of the hospitals, 75% of primary care providers and at least four mental health providers within the service region, Brosoie says.

After New Jersey, Alabama could be the next state to implement an ACO program within Medicaid — its state legislature approved a bill last spring calling for ACOs to be up and running in 2016. “Alabama will be very aggressive in how they move forward,” Flynn says.

Meanwhile, policymakers in North Carolina, Ohio, California, Washington state, Texas and Arkansas are considering ACO or bundled payment models for their Medicaid programs, she says.

Contact Gaus at cgaus@naacos.com, Muhlestein via Leavitt Partners spokesperson Jordana Choucair at jordana.choucair@leavittpartners.com, Flynn via Premier spokesperson Alven Weil at (704) 816-5797, Karabatos via Colorado Medicaid spokesperson Rachel Reiter at (303) 866-3921 and Brossoie at Nicole.brossoie@dhs.state.nj.us.

ACOs Loom Large on Exchanges, But Form, Risk Model Aren’t Clear

Accountable care organizations are likely to play a large role on health insurance exchanges, and actually are uniquely suited to do well in a market dominated by narrow-network plans competing in large part on price, ACO insiders say.

However, it’s not clear what form ACOs will take on the exchanges — some expect them to evolve into full risk-bearing entities with their own insurance products.

Representatives of ACOs, research firms and regulators, who spoke Nov. 5 at the National Accountable Care Congress in Los Angeles, sponsored by Global Health Care, LLC, outlined how they expect ACOs to fit into the national health care exchanges, and how large a market share they might eventually represent.

“We’re seeing plans actually present real choices to consumers,” said Tom Latkovic, senior partner for consulting and research firm McKinsey & Co. “We think an awful lot of people are going to pick the narrower [network] configuration, and that represents a pretty big change in the industry.”

Research is hinting that consumers will choose narrow networks if it helps them save money, Latkovic said. “Some 60% to 70% of consumers are willing to concede some significant restrictions on access in exchange for premium reductions.”

Back in the 1990s, HMOs “were forced down the throats of consumers,” said Joel Ario, managing director of Manatt Health Solutions and former director of HHS’s Office of Health Insurance Exchanges. “This time around, they will be offered as an option on the exchanges. They are offered as one choice, and you don’t have to take it.” However, ACO products will have a “better price point,” he said.

“Maybe consumers won’t necessarily take it the first time,” he said. But over time, Ario said he anticipates less-expensive narrow network exchange products — some of which will be ACOs — to do well on the
exchanges, in large part because of lower prices. Those networks that excel in quality measures will do especially well, he said, noting that “narrow networks often do better on quality.”

There could be a backlash from consumers several years from now, just as took place after HMOs had been in place a few years, Latkovic said. But that backlash isn’t guaranteed, since this time, consumers can choose to pay more and have access to a broader network.

In addition, the ACOs themselves can avert a backlash through member education. Lipeles cited Heritage’s policy of building brand awareness through member engagement (ABN 11/13, p. 1) as an important strategy “to make sure we’re getting a large population and not just sick people who know about us.”

It’s also important to have the right narrow network for your population, Lipeles added — a network optimized for a Medicare dual-eligible population would look quite different than a network optimized for a young commercial population. He anticipates that 75% of providers will be bearing risk within five years.

**Regulators Will Scrutinize Some ACOs**

ACOs considering taking on insurance risk in the exchanges need to consider several factors, said Jacob Garn, chief examiner for the Utah Insurance Department. For example, they will need to determine what reserves they will need, and to set rates based on their assessments about the population in the network.

To accomplish these insurer tasks, ACOs will need to either build the actuarial infrastructure in-house or rent it from an insurance company, Garn said. “That’s something that needs to be thought about.”

ACOs also need to consider state regulations. Right now, ACOs aren’t really on regulators’ radar, but that will change if the entities get more involved in insurance risk. “There may be interest on the part of the states that now regulate insurance companies where states will take more of an interest in ACOs and maybe pass some regulations in order to ensure a level playing field,” he said.

Provider networks operating in more than one state will need to take into account differing state insurance regulations when deciding whether to offer products on the exchanges, Lipeles said. For example, Heritage operates in three states — Arizona, California and New York — and all have different requirements for reserves and licenses.

Ultimately, private exchanges may eclipse the public exchanges in sheer size, and ACOs should consider participating in those as well, Ario said. Currently, there are 160 million people in the group insurance market, and “if only one-quarter of those moves to private exchanges, that’s 40 million lives. It could well be more than that in the next five to 10 years.” In comparison, about 30 to 35 million people are eligible for the public exchanges.

“The exchanges are the laboratories under which all this experimentation happens,” Ario added. “They’re just conducive to it.”

Contact Latkovic at (216) 274-4000, Ario at (212) 790-4588 or jario@manatt.com, Lipeles via Heritage spokesperson Janet Janjigian at janjigian@carmengroup.com, and Garn at (801) 538-3800.

**Cedars-Sinai Pinpoints Targets In Anthem’s Commercial PPO**

It’s obvious that a commercial PPO patient population will differ from a Medicare population. But Cedars-Sinai Medical Care Foundation, which is in the second year of a partnership with Anthem Blue Cross in California on a PPO-based commercial accountable care organization, is finding out just how significant those differences can be.

“You really need to customize the patient engagement strategy — it’s much different than a high-risk senior population,” said Cynthia Litt, vice president of medical network development for Los Angeles-based Cedars-Sinai. “These patients chose the Anthem PPO product for what it offered them, choice-wise. It’s not a one-size-fits-all, and it’s not the same as reaching out to high-risk seniors.”

Cedars-Sinai was interested in partnering with the WellPoint, Inc. subsidiary because the PPO model “is dominant in our community, [and] this was our opportunity to apply our years of managed care experience in our community,” Litt told attendees Nov. 5 at the National Accountable Care Congress in Los Angeles, sponsored by Global Health Care, LLC. “We did have the infrastructure in place for the care management model.”

In addition, “we saw this as a next phase” in the organization’s long-standing, valued relationship with Anthem. Finally, forming the ACO “improves our ability to compete in the marketplace and in new benefit models,” Litt said, adding, “this is the new benefit plan — ACO is going to be a product, and we want to be in that market.”

Cedars-Sinai employs 134 physicians in a multispecialty medical group and also is associated with a primary care independent practice association (IPA), Cedars-Sinai Health Associates, with more than 500 physicians, for approximately 650 physicians in total, Litt said. Cedars-Sinai has approximately 44,000 lives under management in an HMO.

The ACO started small: the initial ACO contract between Anthem and the Cedars-Sinai Medical Care Foundation included 43 primary care physicians — 30...
employed physicians and 13 private attending physicians in the associated IPA, Litt said. Cedars-Sinai intends to add physicians to the ACO as of the beginning of 2014. It provides the care management infrastructure in collaboration with Anthem, which supplies claims data and monthly reports.

A total of 5,108 attributed patients are assigned to the ACO. Litt noted that once Anthem and Cedars-Sinai dug into the data on patient and physician visit patterns, they found many patients were attributed to ACO primary care physicians — but these patients actually were followed by specialists who were not affiliated with Cedars-Sinai. “How do we deal with that? Relationship-building,” she said. “We try to engage the specialists, try to get the patient back in, and try to make better decisions about who we’re referring to.”

**MEDICARE ACO PROFILE**

Memorial Hermann ACO Unites Independent MDs via Data Initiatives

One of the stickiest problems facing accountable care organizations with multiple independent physician groups is how to integrate a variety of different electronic medical record (EMR) platforms. Houston-based Memorial Hermann ACO solved that problem by choosing one EMR, and then ultimately requiring most of its physicians to use it.

Memorial Hermann’s physicians are nearly all in private practice — only 200 out of the 2,000 physicians in the ACO are employed by the hospital organization. With that many private practice physicians — many of whom happen to be in very small practices — Memorial Hermann’s ACO risked a patchwork with two dozen or more EMRs. But it took steps to prevent the problem.

“We pretty aggressively supported eClinicalWorks,” says D. Keith Fernandez, M.D., president and physician-in-chief, MHMD Memorial Hermann Physician Network, and chief medical officer, Memorial Hermann ACO. The ACO does support a few other EMRs for its 2,000 doctors — Allscripts and GE Healthcare’s Centricity are two examples — but new practices must implement eClinicalWorks.

By limiting the potential number of EMRs, Memorial Hermann curbs data interoperability problems, making data mining and analytics that much easier to accomplish, Fernandez tells *ABN.*

The EMR compatibility issue is only one part of Memorial Hermann’s health IT strategy. The health system, which joined the Medicare Shared Savings Program in the second round in July 2012, also is in an “aggressive build phase” of a health information exchange system — currently, 15% to 20% of patients have information on the exchange, he says.

Finally, Memorial Hermann is investing in a doctor-to-doctor communications app, and is looking to invest in a clinician-to-clinician HIPAA-compliant app “so that doctors and nurses can communicate,” Fernandez says. Memorial Hermann’s hospital electronic health record platform is supplied by Cerner Corp.

In its first year, Memorial Hermann had about 22,000 lives attributed to its MSSP program. That number has grown to about 40,000 beneficiaries, says Chris Lloyd, CEO of MHMD Memorial Hermann Physician Network and Memorial Hermann ACO.

Memorial Hermann also manages about 15,000 to 20,000 Medicare Advantage (MA) beneficiaries, Lloyd tells *ABN.* The organization uses the same management techniques with all its Medicare patients, even if they’re not in the MA plan or not currently attributed to the ACO, he says. “The ones who see our doctors are likely to become part of the ACO down the road.”

Data, in fact, is the cornerstone of Memorial Hermann’s ACO efforts, and the hospital system has made significant investments in health IT, says Fernandez. For example, Memorial Hermann co-developed a hospital quality reporting tool with Crimson, now a part of The Advisory Board Co., Fernandez says. In addition, Memorial Hermann works closely with the Advisory Board on population management and care management tools. “What we’re really good at doing is providing data to doctors about how their patients are doing — we want to make them all equally fantastic.”

The ACO structure allows the physicians to negotiate as a group in ways they had not been able to do before, Lloyd says. But even before the ACO’s formation, Memorial Hermann sought to clinically integrate the physicians, Lloyd says. “They sign contracts to participate together, to collaborate together to improve quality,” he says. The organization includes 27 different specialty and subspecialty committees that seek to improve quality of care, he says.

There’s no detriment to having an ACO that’s made up mainly of independent physicians, Lloyd adds. “The independent physicians have results that...
Of those patients attributed to the ACO, 8% are pediatric patients, and “we haven’t focused too much attention yet on the pediatric population.” In addition, “obstetrics is a large driver of cost, but is not considered a chronic illness,” she said. “When we looked at the population, we realized we had a lot of opportunity in obstetrics.”

Meanwhile, patients with two or more chronic illnesses make up 32% of the total and are twice as expensive as the average patient, Litt said. That’s where Cedars-Sinai focused its initial efforts, sending an engagement letter to all patients who were identified as having two or more chronic illnesses to engage them in care management.

When Anthem sent over the first file of claims data, “we had insight into a whole world of claims we had never seen before,” Litt said. “It was incredibly eye-opening to see from a payer’s perspective what’s going on.”

The case management team realized almost immediately that it needed to screen out certain chronic conditions, she said. “It was not necessarily the right tone for some of the chronic illnesses on the list. We quickly learned that patients with sinusitis don’t want or need a care manager.”

MEMICARE ACO PROFILE

are at least as good, if not better, than the employed physicians.”

To encourage collaboration and improved performance, Memorial Hermann requires its physicians to work together. The ACO has organized its physicians into regional groups of about 50 each, and those groups meet regularly to work on quality of care issues, Fernandez says. Memorial Hermann supplies each group with unblended comparative data on patients and quality metrics, he says.

“Every doctor knows every other doctor’s data,” Fernandez says. “We hold quarterly meetings where all the data is presented, and our chief medical officer for population management counsels them.” In addition, specialists come to the meetings to present specialty-specific data, he says. “There’s a lot of pressure on all the doctors to make sure they’re doing the very best they can.”

Memorial Hermann also uses risk stratification tools in its hospitals to determine which patients are most likely to be readmitted or to have complications, Fernandez says.

The ACO employs 30 care management nurses (expected to increase to 50 in 2014), along with social workers, schedulers and pharmacists to assist with care management, says Fernandez. Care management personnel can meet with patients as needed at primary care offices, he says. Other care management initiatives include wellness programs and telephonic interventions, he says.

Memorial Hermann has been working on accountable care for years, Lloyd says. “The Medicare ACO was not the driving influence for us,” he says. “With 2,000 physicians, we had done a lot of the underlying work on population health already,” investing in multiple tools prior to MSSP. “We’ve been moving down the path of population management for many years. For us, [MSSP] was just a natural extension of what we had been working on for many years.”

Memorial Hermann, which owns 12 acute care hospitals, two rehabilitation hospitals and numerous specialty care centers, is pursuing a variety of commercial accountable care agreements, Lloyd says. Currently, it has an ACO co-branded with Aetna Inc., and hopes to win similar pacts with other players, he says. “When you think about population management, you think about applying it to every population, and for us, the Medicare ACO becomes an extension of that.”

The ACO has spent “in the multiple seven figures” to create the tools and structure it needs to manage its population, Lloyd says.

But “if we had not built our clinical integration program the way we built it — a real, functional clinical integration with lots of demands on us and the doctors — then we would be likely to fail,” Fernandez adds.

Memorial Hermann’s ACO physicians must report quality and billing data to the ACO, collaborate on quality and safety initiatives (both inpatient and outpatient) and abide by the ACO’s compact. Meanwhile, the ACO has committed to being honest with its doctors and helping them meet the ACO’s goals.

In addition, “we’ve provided them with some financial support — we’ve had shared-savings programs on a number of contracts, and we’ve been able to deliver bonuses,” Fernandez says. “They’ve had to work for it, though.”

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ACO Adopts ‘Choosing Wisely’ Guidelines

Cedars-Sinai is relying heavily on the “Choosing Wisely” guidelines, said Scott Weingarten, M.D., senior vice president and chief clinical transformation officer for the provider. Choosing Wisely, a project of the American Board of Internal Medicine (ABIM) Foundation, highlights 120 medical tests that do not benefit patients.

Strategies for reducing costs included transparent data sharing with the primary care physicians; specialty-specific initiatives in oncology, behavioral health, joint diseases and rheumatoid arthritis; and new clinical decision support modules in the electronic medical record, she says.

In one specialty-specific initiative, Cedars-Sinai leveraged its access to medical center pharmacists to develop and then help oncologists comply with new anti-emetic guidelines that emphasized lower-cost drugs, Litt said. Prior to the initiative, compliance with the guidelines was at 48%, while following implementation of the guidelines, compliance was 83%. This resulted in lower spending for the more expensive anti-emetic drug options.

In another specialty-specific initiative, Cedars-Sinai created a pilot spine clinic with an orthopedic surgeon and a physical medicine doctor, and directed its primary care physicians to send back pain patients to the spine clinic, Litt said. The pilot resulted in a significant reduction in the number of spine surgeries performed.

Many of the Choosing Wisely recommendations apply to chronic diseases, and specialty-specific data compiled by Anthem and Cedars-Sinai resulted in some interesting observations that ran counter to the recommendations in specific instances, he says.

For example, in a comparison of four urologists, one ordered ultrasound imaging for more than half of patients with benign prostatic hyperplasia, while other urologists ordered it rarely. In addition, primary care physicians varied dramatically in the number of DEXA bone density scans ordered for women younger than age 65. In both cases, ACO leaders addressed the disparities directly with the physicians involved, and implemented clinical decision support modules at the point of care.

In another initiative, Cedars-Sinai physicians about to prescribe benzodiazepines or other sedative-hypnotics in older adults as the first choice for insomnia, agitation or delirium are cautioned that Choosing Wisely advises against those medications, Weingarten says. “Physicians can override it — it’s a soft stop,” he adds. But the alert resulted in a 31.5% drop in prescriptions for the medications in patients older than age 65, he says.

Claims data shows that benzodiazepine prescriptions for older patients vary dramatically by physician, Weingarten notes. With the 31.5% reduction in benzodiazepine use, medical study data indicates that Cedars-Sinai could expect 5.6 fewer fall-related injuries, 3.2 fewer emergency department visits, 0.8 fewer hospitalizations, and 0.5 fewer deaths from falls over three months.

First-year quality results were strong, bettering Anthem’s benchmarks in most metrics, Litt says. For example, Cedars-Sinai physicians measured cholesterol in coronary heart disease patients more than 93% of the time, compared to a benchmark of about 85%, and avoided prescribing inappropriate antibiotics for acute adult bronchitis patients nearly 54% of the time, compared to an Anthem benchmark of around 25%.

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SGR Fix May Push Two-Sided Model

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Physician fees were scheduled to be cut by nearly 25% on Jan. 1, but just before the holidays, the House approved a three-month patch for the SGR to keep fees level while negotiations continue on legislation to replace the Medicare physician fee schedule with rules that favor value-based payment arrangements. The Senate was expected to act on the three-month patch before going home for the holidays.

The permanent proposals under consideration would repeal the SGR payment update mechanism,

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reform the fee-for-service payment system through a greater focus on value over volume, and encourage participation in “alternative payment models.” Fee-for-service payments would be frozen, but providers could earn bonuses by participating in these APMs, according to the “discussion draft” prepared by the House Ways & Means and Senate Finance committees.

The problem, according to Gaus, is that under the current legislative proposals, only providers who participate in two-sided risk models would be eligible for these bonuses. One-sided models currently are far more popular with provider groups, especially those that haven’t participated in ACOs before, and forcing ACOs to accept two-sided risk in Medicare will put a tremendous damper on ACO programs, Gaus says.

In addition, two-sided risk models might not save more money, NAACOS said in a Nov. 12 letter sent to lawmakers.

“There is no evidence that two-sided financial risk models produce more savings than one-sided models,” the letter said. “Even if two-sided ACOs produced greater savings per Medicare beneficiary, they will produce substantially less in the aggregate than one-sided programs as far fewer organizations will agree to participate in a two-sided APM. A two-sided APM would exclude every physician that otherwise would participate in a one-sided APM.”

NAACOS noted that even in the Medicare Pioneer ACO program — designed for organizations with more experience in value-based payment — some ACOs found success elusive in a two-sided risk model. Nine Pioneers dropped out of the program after the first year, and seven of those said they would apply to join the Medicare Shared Savings Program under the MSSP one-sided risk model (ABN 8/13, p. 1).

“Limiting the APM to two-sided risk models may exclude even the most advanced physician organiza-

Anthem, Cigna See Higher Quality in First-Year ACO Results

More first-year commercial accountable care results are beginning to trickle in: Both Cigna Corp. and WellPoint, Inc. unit Anthem Blue Cross in California reported improved quality for ACOs in their networks, and Cigna also reported a lower medical cost trend.

Anthem said last month that its four ACO partners — HealthCare Partners, Santa Clara County IPA, Sharp Community Medical Group and Sharp Rees-Stealy Medical Group — saw a 35% year-over-year increase in the number of mammograms performed and a 44% increase in appropriate prescribing of antibiotics for bronchitis treatment. The insurer did not provide data on other metrics collected, which included cholesterol screening for diabetics, Chlamydia screening for women, and strep throat testing and antibiotics for sore throats in children.

Through the four medical groups, more than 140,000 fully insured PPO members were attributed to ACOs, Anthem said. The program is expected to be available for self-insured clients beginning this year.

Meanwhile, Cigna said first-year results from its initiative with Granite Healthcare Network (GHN), a partnership among five independent charitable health organizations in New Hampshire, indicate a cost trend that was 1.2 percentage points better than the cost trend in Cigna’s overall New Hampshire market.

GHN’s cost trend in the first year of the ACO was 3.7%, while in the overall New Hampshire market, costs rose by 4.9%, Cigna said. The ACO’s emergency room cost trend fell by 8%, emergency room use dropped 4%, the advanced imaging cost trend dropped by 4%, and advanced imaging use fell by 7%.

Cigna said that GHN’s performance on quality metrics prior to the ACO’s formation was level with other providers in New Hampshire. One year later, GHN has improved quality results by 1%, and now performs better than the market.

Those results were driven by improvements in a number of quality measures, including better-than-market quality results for cervical and breast cancer screening, adolescent well care, diabetes care and child access to primary care doctors, Cigna said. In addition, during the first year of the ACO initiative, GHN improved its rate for closing gaps in care by 2%.

Cigna provides compensation to GHN for care coordination services, and the organizations are rewarded through a “pay for value” structure if they meet their targets for improving quality and lowering medical costs.

The Granite Healthcare Network is made up of Concord Hospital, Elliot Health System, LRGHealthcare, Southern New Hampshire Health System and Wentworth-Douglass Hospital. About 30,000 patients are attributed to the ACO.

Contact Anthem spokesperson Darrel Ng at (916) 403-0528 and Cigna spokesperson Mark Slitt at mark.slitt@cigna.com.
tions, let alone the vast majority of the remainder of Medicare participating physicians,” NAACOS said. The organization cited an informal poll of roughly 100 one-sided risk model ACOs, which it said showed fewer than 10% would have applied to participate in the program if the only option was two-sided risk.

“Further, the one-sided MSSP organizations already bear substantial risk due to the enormous investment they are making in first-year start-up costs,” NAACOS said. “This is substantial risk, in many cases born exclusively by small physician medical groups, with little assurance they will begin receiving savings 18 months later. This investment alone will drive the one-sided ACOs to work hard on redesigning care and achieve savings.”

It’s still not clear if legislation permanently fixing the SGR problem and encouraging alternative payment methodologies will clear Congress this winter, though. Under lawmakers’ budget rules, the full cost must be covered by cuts or revenue increases, and neither the House nor the Senate committees considering the legislation have specified where to find the $116.5 billion needed to repeal and replace the payment formula.

If lawmakers do pursue a permanent fix, it’s likely that some form of value-based payment will play a role in it. But proponents of an ACO one-sided risk model — as opposed to two-sided risk — may have an uphill battle, since Medicare provider payment experts say they want to see ACOs take on more risk.

For example, Medicare Payment Advisory Commission (MedPAC) members said last fall that ACOs should move toward a two-sided risk model following the initial three years of the Pioneer and Medicare Shared Savings Program (ABN 12/13, p. 1).

Still, other experts say it’s too early for Congress to determine which alternative payment methods warrant increased reimbursement. Gail Wilensky, Ph.D., a senior fellow at Project HOPE and former MedPAC chair, noted in an opinion piece published Dec. 11 in the *New England Journal of Medicine* that it’s unclear whether early savings in some ACOs and patient-centered medical homes can be replicated.

“This is clearly a stretch goal, at least in the near term,” Wilensky says.

Contact Gaus at cgaus@naacos.com.

**NEWS BRIEFS**

- **Regional HealthPlus and Humana Inc. are forming an accountable care relationship to improve health outcomes for Humana Medicare Advantage (MA) members in South Carolina**, the companies said on Dec. 12. The ACO will coordinate care for Humana’s HMO and PPO MA members with Regional HealthPlus’ Spartanburg Medical Center, Village Hospital and Spartanburg Hospital for Restorative Care, as well as its four ambulatory surgery centers and more than 500 physicians. Visit http://tinyurl.com/mdjhh5.

- **Humana on Dec. 3 said it has entered into an accountable care agreement with St. Luke’s University Health Network that will benefit Humana Medicare Advantage members throughout eastern Pennsylvania**. For the first time, Humana will offer HMO and PPO plan designs featuring St. Luke’s hospitals and affiliated facilities under the agreement. The value-based arrangement is intended to produce more cost-effective, evidence-based, high-quality care through value-based incentives and care coordination. Humana says it now has 900 accountable care relationships in 40 states and Puerto Rico with more than 1 million members and 33,000 primary care physicians. Visit http://tinyurl.com/l9q2l6v.

- **Aetna on Dec. 2 said it is forming an accountable care relationship with PinnacleHealth System in central Pennsylvania**. The program is intended to improve the quality of care while reducing costs for Aetna members seeing PinnacleHealth physicians. Aetna will launch a product based on PinnacleHealth’s care systems for employers with more than 51 employees on April 1, 2014, and for employers with two to 50 employees on July 1. Visit http://tinyurl.com/mvwbwbfq.

- **The Society of Actuaries on Dec. 16 issued a report finding that risk adjustment can be used to help evaluate how effectively ACOs manage factors not related to patient health, such as physician practice patterns and patient preferences**. “Evaluating ACO Efficiency: Risk Adjustment Within Episodes” found that the patient’s diagnostic history explains “relatively little of the differences” in utilization rates or service costs within an episode. This suggests that factors such as patient preferences, physician practice patterns and delivery system structure may “account for the unexplained wide cost and utilization variance,” and thus represent an opportunity for ACOs seeking to reduce unnecessary spending. To view the report, visit http://tinyurl.com/ksu6igg.
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