2016 Outlook

Providers Get No Rest as CMS Rolls Out CJR, NextGen Program, New MSSP Class

2016 might have represented a logical “pause point” for CMS to stop and evaluate the results of its extensive efforts to quickly move providers into value-based programs for Medicare. But the agency shows no signs of slowing its wholesale push into population health and value-based payment strategies.

“Certainly, value-based purchasing continues to ramp up — Medicare continues to accelerate the pace of new types of programs,” says Rich Bajner, managing director for Navigant Healthcare, Inc.

If Medicare is going to reach its goal of having half of all spending in value-based programs by 2018, CMS needs to continue to maintain this push, he tells VBC. “I think we’re going to see more of this. Medicare will continue to be the force behind the movement to value-based payment models, forcing providers to develop value-based clinical models.”

Meanwhile, it’s going to be a busy winter as CMS works to implement the programs the agency already has announced.

First, CMS is set to release the list of accountable care organizations joining the Medicare Shared Savings Program (MSSP) in 2016. This list will include new MSSP ACOs and — for the first time — ACOs signing a second contract with the program after having completed their first three-year contract period.

It’s the re-contracting group that will draw the most scrutiny, since the number of renewed MSSP contracts will indicate whether MSSP program veterans believe the program is worth participating in.

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2016 Outlook

Commercial Insurers, Medicare Advantage Operators Continue to Push Value, Risk

Commercial insurers will continue to work aggressively in 2016 to move providers into value-based arrangements, but are starting to have a better understanding of what types of contracts and partnerships will be most successful for both parties.

That’s the word from top executives at leading insurers, along with analysts who follow the value-based health care industry. They say value-based care, done well, potentially can offer both insurers and providers a significant market advantage, regardless of whether the market in question involves employer-based insurance, Medicare Advantage plans or products on the public health insurance exchanges.

“We expect continued experimentation, with insurance plans really pushing these programs onto providers,” Leavitt Partners LLC Director of Research David Muhlestein tells VBC. “I think that we’re now just beyond pure experimentation,” and payers will ratchet up the pressure on providers to accept risk-based agreements, he adds.

continued
Erik Johnson, vice president for network and population health consulting at Optum, Inc., notes that this expansion may not be easy, given the traditional animosity between payers and providers. “Stakeholders have to overcome longstanding historical bitterness,” he tells VBC, although he says this is more prevalent in some markets than in others.

“The emphasis and rhetoric out of the big payers is that they’re still very committed to the ACO concept,” he says. “They’re looking at what’s going on in Medicare, and they’re going to follow, potentially in a way that’s more nimble and more tailored to local markets.”

He cites Inova Health System’s partnership with Aetna Inc. in northern Virginia, under which the plan and the health system formed Innovation Health Plans, a jointly owned health plan that now serves more than 80,000 individuals.

Muhlestein also anticipates more partnerships between health plans and large hospital-based health systems like Vivity, a group of seven top Los Angeles-area hospital systems that have banded together with Anthem Blue Cross (VBC 5/15, p. 1) to offer value-based products to employers. Those types of partnerships represent a way for providers to join together to take on risk, broaden their market reach and provide population-based care.

Humana Inc. now contracts with about 44,000 physicians who are working with about 1.3 million members, Roy Beveridge, M.D., senior vice president and chief medical officer, told attendees Nov. 16 at the National Accountable Care Congress, sponsored by Global Health Care, LLC.

Beveridge noted that the average Medicare Advantage patient sticks with a Humana plan for more than seven years, so it makes sense for the company to invest in value-based care. “If you know you’ve got them for seven years, you can make tremendous amounts of money by getting them all screened for cancer, getting them all to lose 10 pounds. We as plans are talking much more about health these days.”

And that investment in population health has led to a significant improvement in HEDIS scores and Medicare Advantage star ratings, he said.

“We’ve learned a significant amount about how to work with providers so they don’t fail” in the transition to value-based care, Beveridge said. For example, “if you move people through this quickly — you don’t give them three or four years — they’re more likely to fail. And if you don’t work on the clinical mindset [of the physicians], you’re going to fail. To help physicians, you’ve really got to get them in the right mindset.”

**United Is Seeing ‘Very Strong’ ACO Results**

Added Sam Ho, M.D., executive vice president and chief medical officer for UnitedHealthcare: “Payment reform is necessary but insufficient to drive value.” United has about 40% of its medical spending in value-based payment contracts, but that’s “just one of the value levers,” Ho said at the meeting. Nonetheless, he added, ACO results “are coming in very strong — up to 6% lower total cost of care” depending on the market and the age of the ACO.

However, United “is not that enamored with bundled payment,” Ho said, adding that although it could be useful in oncology and in certain cardiac procedures, long term he didn’t expect bundles to be sustainable. “Bundled payment is a sophisticated case rate — it’s not population health.”

United, which has contracts with more than 450 ACOs, around 160 patient-centered medical homes and 180 capitated organizations, now is working on the consumer side on value-based insurance design, he said.

Aetna, which agreed to buy Humana (VBC 8/15, p. 1) in part to accelerate the move toward value-based purchasing, has 71 ACOs under contract and 6 million patients in value-based arrangements, Charles Kennedy, M.D., chief population health officer for Healthagen, an Aetna subsidiary, told meeting attendees. “We want to get to 75% of members being in value-based [care] by
2020, so there’s some really aggressive re-contracting going on,” he said.

Like Humana, Aetna has sought to create a collaborative environment “where there’s some degree of trust,” Kennedy said. And the health insurer has gained some perspective on which provider organizations are most likely to succeed.

Organizations where everyone is committed to care transformation and has a clear perspective on what that means are much more successful, he said. Meanwhile, organizations that treat value-based agreements like just another contract, and which don’t involve the leadership, are more likely to fail.

Aetna has realized that it needs to give provider organizations some incentive to move to a value-based contract, Kennedy said. “The first thing we say is, we’re going to launch products to bring you more patients.” About one-quarter of large provider organizations in contracts with Aetna are taking downside risk, he added, but once you get beyond large organizations, many less take downside risk.

More Payers Look to Partner With Providers

More and more commercial payers are exploring ways to pay care management fees to providers as a way of encouraging reluctant providers to take on more risk, says Rich Bajner, managing director for Navigant Healthcare, Inc. He tells VBC, “There’s a lot of talk about payer-provider partnerships. Payers and providers are all of a sudden going to become really good friends.”

Deals can include new products that pledge to restrict growth in health care expenses significantly — to a 2% trend, a 1% trend or even zero growth, he says. These types of partnerships will be better suited to some markets than others, Bajner explains.

For example, in markets where there is one main payer but multiple providers, “the payer is probably trying to test out different kinds of partnerships while keeping a very broad network,” he says.

In markets where there are multiple payers and providers, meanwhile, you might see more narrow networks, Bajner adds. And in markets where there has been more provider consolidation, you may not see the same use of narrow networks, “except maybe for specific populations, like exchange populations.”

The trend towards narrower networks — driven by the formation of insurance exchanges — will continue, says Andrew Croshaw, president of Leavitt Partners Consulting. He tells VBC that he expects to see more evidence of networks being marketed on value, rather than on price.

This hasn’t happened to date, he notes: “Health plans have been primarily interested in getting premiums to look attractive.” But “there are obvious plays into the ACO movement,” and “payers will begin to use provider brands on the exchanges.” However, Croshaw says he doesn’t expect significant ACO inroads into exchanges this year; this trend, he maintains, will take some time to develop.

Growth in Bundles Is Expected

Bajner also anticipates growth around bundles in the commercial market. “It’s about controlling the cost per unit, and going to employers as a design mechanism,” he says. Possible commercial care bundles can include maternity care, joint replacement, cardiac, oncology and maybe even asthma in pediatrics, he adds.

The trend of physician consolidation will continue, although there may be less of an emphasis on hospitals buying physician groups and more of an emphasis on physician groups joining with each other to create larger multispecialty groups, Croshaw predicts. Meanwhile, Bajner says he expects ACOs to continue to struggle with how to align with specialists.

“The value-based payer landscape is expanding to focus beyond ACOs to episode-based payments,” says Croshaw. “Also, the business world is adapting to help providers optimize processes” so that they are better equipped to move to value-based payments.

Both Aetna and UnitedHealth Group are building and marketing tools to providers that can help them cope with the data analytics needed for population health, Johnson points out. “The focus on patient and consumer engagement is really, really high,” he adds. “Commercial payers are spending more time on consumer engagement than CMS.”

Of course, some advanced provider organizations may want to consider doing away with insurers altogether. “I see an opportunity in provider-owned plans for them to try to take full risk,” says Muhlestein. “A lot of providers across the country already have [insurance] plans, and those will continue to expand.” Commercial ACOs will work to bypass the role of the payer and take the risk themselves.

Finally, Croshaw anticipates more pressure on specialty pharmacy companies to partner with plans and ACOs on value-based programs. “I have to believe we’re going to see new models emerge on how payers and pro-

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Calif. Blue Shield Saves $325M Via ACOs, but Experts Question Details

Blue Shield of California on Dec. 8 said it had seen a $325 million reduction in medical costs through its accountable care programs since first launching the initiatives in 2010. But the figure doesn’t account for the added expense of administering the programs, and experts say several factors aside from the ACO likely contributed to the savings.

The insurer’s ACOs are primarily open to commercial HMO enrollees, with some PPO and Medicare membership. California Blue Shield is looking into expanding value-based care to its exchange population through Covered California, where it now has only a slim portion of its accountable care membership.

The savings figure is a measure of the insurer’s actual medical costs versus its projected costs had the ACO not been in place. ACO Performance Director AnaLisa Luippold tells VBC the insurer successfully reduced its health care cost trend from between 7% and 8% to between 3.5% and 4% over the past five years. Luippold says the company did not factor in the cost of the program but notes the cost was only a “small fraction” of its recorded savings.

While the ACO savings don’t typically reach the consumer just yet, Frank Williams, CEO of Evolent Health, LLC, says he believes the money eventually will be passed down. In the meantime, simply controlling costs after years of double-digit increases leading up to the passage of the Affordable Care Act is an accomplishment in and of itself. “If you’re cutting that growth rate, I think that’s a significant achievement,” he says.

While the reduction in medical spending is notable, David Muhlestein, senior director of research and development for Leavitt Partners, tells VBC, it isn’t necessarily a result of their value-based agreements.

“That’s a very significant change, though I question whether that has been driven by their ACO,” he says, citing “externalities” such as the historically low growth the industry has seen in the past five years. “It’s exciting that they’ve seen that, but I would be very hesitant to attribute it to the ACO. Maybe the ACO has contributed a part of it, but there’s this broader trend that’s going on at the same time.”

Furthermore, the impact in terms of their overall revenue is relatively small, Muhlestein points out. Because Blue Shield of California is a $13 billion company, $325 million over five years amounts to 0.5% of its annual revenue. “What does that mean? Does that mean they’re making a difference? Yes, that’s great,” he says. “But the net impact is relatively modest. So really when I think of an ACO, hopefully we’re going to see some cost savings, hopefully we’re going to pay for some of the infrastructural investments, but the better or more likely outcome that’s valuable to people is if the quality of care improves.”

Hospitalist Program, ER Diversion Improved

California Blue Shield reduced hospital readmissions by 13% and hospital bed days by 27%. The biggest improvements overall varied by region, but came primarily through hospitalist programs, emergency room diversion and home care services, Luippold says. Participating health systems hold daily meetings between the hospital and outpatient staffs to review each patient’s care and discharge plan, and hospitals added more workers to improve staff-to-patient ratios. The greatest success came through partnerships between medical groups and health systems.

“It’s the deepening of a relationship between these two parties that are providing care to the same members in the same communities, where in the past they were not necessarily incentivized in those partnerships to make sure the members get the right care at the right location and at the right time,” she says. “That’s the biggest win that we are consistently seeing — year-over-year too, so even with our older ACOs and then with our new ones that we’re bringing on.”

Going forward, the insurer will continue working to expand its technology platform, partnering with Cal IN-DEX, a nonprofit health data exchange, to advance data analytics and provide real-time information to physicians and hospitals at the point of care. Blue Shield of California gives participating providers daily reports on the inpatient admissions and ER visits of its PPO members.

Luippold said the Blues plan and its providers will focus on automating some processes to make them more efficient, developing metrics on site-of-service costs, practice variation and frequency of specialty referrals. The insurer will also concentrate on locating members who “fall through the cracks.”
“These are the members that are at home,” Luippold says. “These are the members that can’t make it into the hospital on a regular basis. These are the members that are in skilled nursing facilities, that are in nontraditional settings. We’re trying to make sure we’re getting care to them. We’re developing systems of cross-functional resources such as social workers and nurse practitioners and pharmacists so that those resources are more aware about these members and their conditions so that we bring care to them versus wait for that member to come to us.”

One key component of a successful value-based agreement is the transparency in discussions with providers, she says.

“Greatest lesson learned is to put everything on the table and be fully transparent and clear with the goals of all of the parties, and make sure your incentives are aligned from the very start,” Luippold says. “And be transparent about where there may be known barriers. In some cases some of our hospital systems are still struggling with the effort to improve affordability and reduce length of stay and ER visits and some of their typical breadwinning strategies. And to know that they’re struggling with that and be aware of it, it’s kind of good to have that out on the table so that we can work together and make sure we’re taking the time to be transparent about our data, taking the time to be transparent with our strategies and how they will work in the end so that we will hopefully calm any concerns that they have.”

California Environment Contributed to Success

In 2014, Blue Shield of California was one of the few insurers to profit through the public exchanges. In fact, three of the state’s insurers — including Anthem Blue Cross in California and Kaiser Permanente — accounted for half of the $362 million in profits through the risk corridors program, according to the Los Angeles Times. California’s reputation as a health care pioneer is a major reason the Blues plan has seen such success in its accountable care deals, Luippold says.

“Certainly our providers are willing to engage in new initiatives — again with the economy and the pressure that we have here to keep our health insurance premiums and costs as low as possible,” she says, “while also having a very public environment where quality scores and patient satisfaction scores are so public and readily available.”

Doctors are also more comfortable with handling risk than in some other parts of the country, Williams says. “I think in California you do have some structural benefits that allow you to experience some physicians that are well organized,” he says. “They’re used to managing in risk-based arrangements, and I think you’re able to get to more competitive costs from a delivery perspective than in some markets where the physicians really aren’t organized, there is no experience with risk, and people aren’t used to it.”

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First Year of United Deal With IHN Results in Improved Care

Results from the first year of an accountable care partnership between Integrated Health Network of Wisconsin (IHN) and UnitedHealthcare indicate the beginning of a promising relationship, the two entities say.

Launched in 2010, IHN is the first multisystem, clinically integrated accountable care network in Wisconsin, consisting of eight major health systems that serve as network owners, with more than 6,300 physicians and providers, 1,027 clinics and 49 hospitals. The deal with United began in 2013. Now more than 114,000 United employer-sponsored health plan participants can access care through the collaboration, and IHN physicians treated 60,000 of them in 2014. The insurer has more than 1.5 million members in Wisconsin.

When compared with IHN clinical data from 2012, the relationship produced the following results in 2014:

◆ An almost 7% increase in breast cancer screenings.
◆ A more than 5% jump in colorectal cancer screenings.
◆ A rise of more than 4% in diabetic screenings.
◆ A decline of 4% in unnecessary emergency room use.
◆ An increase of more than 2% in generic prescription drug use, when compared with 2013 clinical data.

“We are especially proud of how each IHN system embraced the improvement opportunities and acted upon them,” says Kurt Janavitz, CEO of IHN. “The results indicate to us that our care model has been effective in closing gaps in care for patients, supporting our shared commitment with UnitedHealthcare to more affordable and effective care that results in better health.”

IHN and United, he says, “are working together to shape a relationship and processes that make the most sense for consumers, employers, payers and providers.”

Janavitz tells VBC that United “has complemented our own care management and data systems by supporting us with resources and information that helps us improve quality and lower costs.” Specifically, says Dustin Hinton, CEO of UnitedHealthcare of Wisconsin, that support “included technology and information that helps the network’s thousands of physicians and providers take specific actions that improve quality and lower...
costs, actionable data that helps identify specific gaps in care that require action, and real-time information about emergency room and inpatient admissions to better manage a patient’s ongoing care.” In turn, says Janavitz, “IHN provides clinical data elements to UnitedHealthcare that helps them get a [clearer] snapshot of population health.”

UnitedHealthcare has more than 750 nationwide accountable care arrangements, and more than 13 million members receive care through physicians in them. Over the last three years, payments tied to these collaborations have tripled to $43 billion. The insurer says it expects that amount to rise to $65 billion by the end of 2018.

**United Has Three-Pronged Approach to Care**

Hinton says the insurer focuses on three things in its approach to accountable care: “improving population health and the patient experience, delivering the best possible health outcomes and reducing medical costs. We believe value-based care provides the best path to better health, better care and lower costs for everyone.”

On United’s decision to work with the accountable care network, Hinton points out that “IHN has a huge reach throughout the state of Wisconsin.” In addition, he tells VBC, “They were also very open to a collaborative relationship in which we mutually use data and information to enhance the care coordination for the patients we both serve. We felt they were the perfect partner to introduce our first commercial ACO in Wisconsin....In IHN, we have a partner also committed to the industry’s transformation in how quality health care is delivered, paid for and rewarded. IHN shares our vision of shifting from fee-for-service to value-based models that reward quality health care.”

The deal expanded in early 2015, when United added its AARP MedicareComplete Medicare Advantage plans to the relationship, says Hinton. Through that arrangement, IHN is managing the care of more than 30,000 of United’s Medicare Advantage members in Wisconsin.

The two organizations meet “regularly to review how the relationship is performing and to ensure we’re on target to achieve the goals we established in terms of improved health outcomes for our members,” Hinton explains. “The expansion of the ACO relationship earlier this year to include UnitedHealthcare’s Medicare Advantage health plan members is a testament to the strong performance we’ve seen to date.”

“This is only year one in a three-year relationship with IHN, and we anticipate having more detailed information on how the ACO slowed rising health costs later in the relationship,” maintains Hinton. “Our ACOs are multiyear partnerships designed to align the interests and incentives of providers, employers and consumers, focusing on innovation and value, rather than price negotiation and utilization.”

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**More Docs Are OK With ACOs, But ‘Spectrum’ Still Exists**

Providers are more and more willing to participate in value-based care programs, according to a Dec. 9 roundtable of Blues plan executives at the Blue Cross and Blue Shield Association (BCBSA) in Washington, D.C. While a “spectrum” of physician engagement still exists, one executive said he never thought he would see the day when so many doctors and insurers were actually excited about collaborating on accountable care.

In October, BCBSA unveiled Blue Distinction Total Care, a nationwide network of accountable care programs for national employer clients, comprising 450 programs in 37 states. When insurers were attempting to launch the first accountable care organizations, some doctors were receptive to collaborating with insurers, while others weren’t. That dynamic still holds true today, but the tables are quickly turning.

“There were practices that were absolutely on board, couldn’t wait. ‘Teach us, give us data.’ And there were practices that said, ‘Get out of my office. What do you know?’” said Donald Fischer, M.D., chief medical officer at Highmark Inc. “There’s still a spectrum. I would say we’re moving things along, but we’ve chosen practices that we thought were going to be most receptive to working with us and using these resources in a way that was actually going to make their lives easier.”

According to Fischer, value-based care has resulted in a 0.5% decline in costs for Highmark’s participating members, which translates to $2.37 per member per month (PMPM). “It’s nibbling at the edges, but it’s real,” he said. Highmark’s trends in hospital readmissions, emergency room visits, medical utilization and prescription drug use are all down relative to the market, and the insurer has seen a 2.3% reduction in costs by integrating functions within the physician’s office.

“I believe that’s a beginning for where we will be,” he said. “Health plans have done a lot of this stuff by default, but the clinical functions in the plans rightly belong out in the practice.”

One major reason physicians are more interested in accountable care is the improved data the insurers bring, and another is the extra help. Providers are increasingly comfortable with letting health plans embed nurse care...
coordinators in their practices, said Joann Schaefer, M.D., chief medical officer of Blue Cross and Blue Shield of Nebraska.

“We still have a large number of rural practices across the state that are largely still independent,” she said. “So for an independent family practitioner that takes care of a large area, they see this as an opportunity to help them stay independent.”

Donald Liss, M.D., vice president for clinical programs and policy at Independence Blue Cross, said the

Maryland Global Payment Shows Promising Early Results

Initial cost results are promising for a two-year-old Maryland experiment in which all health care payers, including Medicare, have agreed to move hospital revenue into global budgets. Still, the state has work to do in order to bring down high utilization rates, according to an analysis of the program.

Growth in per-capita hospital costs in 2014, the first year of the program, was limited to 1.47%, 2.11 percentage points lower than the original, agreed-upon growth rate of 3.58%, the program’s architects reported in the Nov. 12 New England Journal of Medicine.

“Costs were contained despite the expansion of health insurance under the Affordable Care Act (ACA), including growth of approximately 21% in Medicaid enrollment after implementation of the state’s Medicaid expansion,” said the authors, who are CMS and Maryland officials.

“We believe Maryland’s cost growth was below the target because of a combination of lower-than-anticipated growth in adjusted costs per admission and changes in care delivery under the global budget model,” the analysis said.

In 2014, Medicare’s per-capita hospital costs grew by 1.07% nationally, but fell by 1.08% in Maryland. The state’s overall total per capita costs of care dropped by 0.64%, almost entirely because of the reductions in hospital expenditures.

“Given these trends, Maryland has already saved Medicare $116 million,” the study authors wrote. The state had committed to saving Medicare a total of $330 million by 2019 as part of the program.

The Maryland all-payer rate-setting system for hospital services is a joint initiative run by CMS and the state of Maryland designed to test whether a new payment system can improve care and reduce costs.

It’s made possible by a quirk in Medicare policy — a 36-year-old Medicare waiver that makes Maryland the only state with an all-payer hospital rate regulation system. Under the waiver, all third parties pay the same hospital rates.

As the new program began in January 2014, Maryland had committed to shift hospital payments away from the fee-for-service system to global payments, but the shift happened more quickly than expected — by July 1, 2014, hospitals had agreed to move more than 90% of the state’s aggregate revenue into global budgets.

“The speed of that transition demonstrates hospitals’ commitment to the new model and to value-based care,” the authors wrote in the analysis.

Maryland hospitals also have improved the quality of care as part of this initiative. Payers and hospitals implemented a quality incentive program in which hospitals’ global budgets were adjusted on the basis of all-payer performance on quality measures.

The state was able to reduce the rate of potentially preventable conditions by 26.3% between 2013 and 2014, the first year of the global budget program. State hospitals also agreed to bring the high rate of all-cause readmissions among Medicare patients in line with the national rate.

Although Maryland has reduced its rate of inpatient admissions per 1,000 beneficiaries by nearly 5% (a greater reduction than the national average), its overall rate of hospital admissions and its per capita spending for Medicare patients remain among the highest in the country, the analysis said. Meanwhile, hospitals’ most recent patient experience rates are among the lowest in the country.

In addition to fixing these deficiencies, the next step will involve expanding the all-payer payment models beyond hospital care, CMS and Maryland officials say. Hospitals potentially can offer providers incentives such as per-member per-month payments, shared savings, or capital funding for investments in care redesign, they said.

“CMS is committed to working with Maryland to design and launch new all-payer payment models that connect all health care providers, hospital and non-hospital, through value-based care models that are appropriate for the state’s rate-setting system,” the study authors concluded.

plan’s medical directors visit each participating primary care physician (PCP) to go over cost and quality metrics in a variety of areas, including specialty referrals. Independence partnered with DaVita HealthCare Partners, Inc. in 2014 to launch Tandigm Health, which works with primary care practices to improve quality and lower costs. Tandigm is growing at a slightly faster clip than Independence expected, and now comprises 15% of its members. “The engagement is clear and palpable,” Liss said.

Independence provides each primary care physician (PCP) with regular metrics reports on the specialists in their area in regard to cost and frequency of referrals. Outcomes data, however, is still something insurers and doctors are working on. Fischer likened it to Zagat, which rates restaurants not only on their cost and food quality, but service and atmosphere as well.

“You should be able to do that with orthopedics,” he said. “We don’t have sophisticated metrics yet to be able to tell people, what’s the difference between going to Orthopedist A versus Orthopedist B, with regard to return to work for your hip replacement, with regard to infection rates, with regard to cost. That’s where it should be, and I predict it will be.”

Furthermore, an orthopedist could excel in shoulder replacements, but not so much in hip replacements, said Thomas Schenk, M.D., chief medical officer for BlueCross BlueShield of Western New York. That is the sort of information PCPs could use.

“You’re inundated by, say, eight or nine different views of your effectiveness from an efficiency point of view,” he says. “Physicians in general are waiting for us to give them information that will make that relevant to them because historically, say, for the last 10 years, you would see that number and ask, ‘Well, how can I make that better?’ and get unsatisfying responses. So finally we’re at a point where we can start to transmit some actual satisfying responses to those things.”

Future of Outcomes Data Is Promising

The future looks bright for outcomes data if the burgeoning friendship between insurance companies and physicians continues to grow.

“I never thought my professional career would span this moment — where doctors and hospitals are looking forward to these visits, looking forward to these meetings, and going over the results,” Glenn Pomerantz, M.D., vice president and chief medical officer for Horizon Blue Cross and Blue Shield of New Jersey, said. “And then every year we’re setting the bar to try and improve together. The whole conversation has changed.”

Trent Haywood, M.D., chief medical officer for BCBSA, says the Blues accountable care model is scalable, but not one-size-fits-all. Forty-two million Blues members are enrolled in value-based care programs, accounting for 38% or $145 billion in medical claims. Plans have seen an average net savings of $6 to $9 PMPM, but the association hasn’t yet examined the impact on premiums.

The next step is integrating patient-reported outcomes — a survey of how well patients feel or are able to function, without interpretation by a physician. Haywood said Blue Distinction is starting to incorporate patient-reported outcomes in knee and hip care.

“One once we get agreements with providers to be able to incorporate those,” he said, “then I think you’ll see much more uptake on the consumer side in terms of the quality measures.”

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Vermont Single ACO Plan Moves Forward, but Questions Remain

Vermont continues to move forward on its all-payer model, which would include a single statewide accountable care organization (ACO). That’s the word from Al Gobeille, chair of the Green Mountain Care Board, when he gave an update on the model to the Vermont House Committee on Health Care on Nov. 30.

The Vermont legislature created the board in 2011, charging it with “ensuring that changes in the health system improve quality while stabilizing costs.”

The law creating the Green Mountain Care Board called on it to create a single-payer system for the state. But in late 2014, state officials conceded the single-payer system would have been too expensive to implement. The new proposal, the all-payer model, would put the state in charge of Medicare along with Medicaid and commercial insurance.

The update specifically covered negotiations between the Green Mountain Care Board and CMS’s Center for Medicare & Medicaid Innovation (CMMI) on the planned Vermont model. According to Gobeille’s presentation, CMMI can allow “states to test and evaluate systems of all-payer payment reform for the medical care of residents of the state.” He maintained that “a necessary element” to convince CMMI to OK the state’s plan “is demonstrating that Vermont is serious about testing a truly innovative delivery model.”

The presentation noted that “As we finalize a term sheet we will learn more about how much detail CMMI needs about the ACO to approve the model agreement.” According to VT Digger, a nonprofit statewide news website, Gobeille said “he expects to have the terms for
an all-payer model agreement with the federal government in December.”

The presentation did, however, include a breakdown of issues that are between Vermont and CMS and those that are between the state and the ACO. According to the presentation, the following are matters in the model agreement between Vermont and the ACO:
◆ “Payment rates and methods”
◆ “Risk arrangements”
◆ “Attribution methodology”
◆ “Structure of payments to ACO providers”
◆ “Rates of payment to ACO providers”
◆ “Quality measures for the ACO”
◆ “ACO governance”

Three ACOs now operate in the state: OneCare, which is the largest ACO, and two smaller ones, Community Health Accountable Care and Healthfirst. Critics of the health reform plan have questioned whether the smaller ACOs actually would join the single statewide ACO, and so far, those ACOs have not indicated what they will do. The issue of governance of that ACO remains a concern as well.

The all-payer system is scheduled to go live on Jan. 1, 2017.

According to an Oct. 22 VT Digger article on the ACO landscape in the state, “We’ve gone a long way in Vermont, farther, I would argue, than anyone else in North America, but we have only just stepped into the swamp that lies between current reality and the sustainable system that supporters see on the horizon.”


PCMH Incentives Are Growing, But Larger Payments Are Needed

Across the country, financial incentives that motivate primary care physicians and practices to become patient-centered medical homes (PCMHs) are on the rise. But the bulk of the incentives are not enough to continue to support the move to this patient-care model, according to an analysis of these initiatives by the National Committee for Quality Assurance (NCQA).

Researchers analyzed all 50 states, Puerto Rico and Washington, D.C., for PCMHs that receive financial support, excluding ones in which clinicians and practices are penalized for not participating. That research shows a tremendous increase in these programs — more than 160 today, as opposed to only 26 in 2009. “The increased focus on accountability at the provider level supports the trend in the increasing number of financial incentive-based initiatives,” says Kristine Thurston Toppe, director of state affairs, public policy at NCQA.

The 26 initiatives in 2009 were across 18 states, while the current initiatives are in 48 states, Puerto Rico and Washington, D.C. The two states without such programs are Utah and Mississippi, and Toppe tells VBC that “we can only speculate why those two states do not have financial incentives for PCMH.”

Another finding is that “the majority of incentives are tied to a national PCMH recognition program,” and such recognition is “recognized or required” by many initiatives. “At least 24 programs explicitly require NCQA recognition; another 88 recognize NCQA recognition as meeting programmatic goals.”

The research showed that a variety of incentives are provided. The most commonly used approach is per-member per-month (PMPM) payments, and researchers found that “payments often increase, based on recognition level, to cover the cost of PCMH activities not traditionally reimbursed, such as care coordination or enhanced patient access.” Toppe points out that the analysis “did not address nonfinancial incentives that may also be provided to support transformation, such as a shared care coordinator, EHR [electronic health record] consultant services or other forms of practice transformation support.”

Two-Thirds Do Not Have Adequate Support

Among the initiatives studied, only one-third “provide adequate financial support,” which NCQA defined as $6 to $8 per patient, based on a recently published study in the Annals of Family Medicine (see chart below). “Many of those initiatives provide additional or risk-adjusted payments to account for complex patient populations,” explained Toppe when asked about similarities among them. “Others offer additional payment to prac-
tices for certain PCMH activities like extended hours. We also found that the most sophisticated initiatives phase in Shared Savings or other types of comprehensive payment to incentivize continuous quality improvement beyond the initial implementation period."

While some programs may use one form, and others may use a combination of incentives, the one-third with adequate financial support tended to offer a “significantly” larger number of incentives.

Other qualities of the programs offering adequate financial support include the following:

◆ “They are spread across the country from Idaho to New York,” says Toppe. “There is, however, a high density of well-funded initiatives in New England.”

◆ They have “not necessarily” been in existence for a longer period of time than most others. “Many of them are more recent,” she points out. “The landscape is evolving very rapidly, and the initiatives are very much reflective of that.”

According to Toppe, “One-time, lump sum transformation payments are common but were considered among the ‘insufficient’ initiatives. PCMH transformation requires ongoing commitment to evolving how practices deliver care, and thus a one-time payment may help to get a practice started but is not adequate to continue the process. Practices need regular, sustained incentives. We also don’t typically see the Shared Savings structures in the ‘insufficient’ initiatives.”

NCQA President Margaret O’Kane says that “it’s gratifying to see more insurance plans recognizing the value of PCMHs.” However, she maintains in a press release that “ongoing support” for the offerings is “critical…in order to sustain transformation and attain full return on the investment of $6 in savings for every $1 spent, starting in year three.”

Toppe points out that the industry is not static: “Initiatives come and go depending on the organizing/funding entity (e.g. federal initiatives), duration of a pilot initiative or changes in the expectations of practices (i.e., moving from a PMPM to shared savings model).”

So how can participants make sure incentives are aligned? “The federal State Innovation Model grants are the biggest lever toward creating standardization/alignment on a model to reward practices since the SIMs are intended to be multipayer,” says Toppe. “It typically starts with Medicaid and [tries] to engage the private insurers in the development and planning.”

Contact Toppe and O’Kane through Cindy Pena at pena@ncqa.org.

**CMS Pushes Value-Based Care in ’16 continued from p. 1**

Data on new contracts also will reveal which ACOs will increase their risk level by moving to Track 2, Track 3 or the Next Generation ACO program. Specifically, CMS officials expect the class of NextGen ACOs to be larger than initially anticipated when the program was announced (VBC 12/15, p. 4).

“The ACO Class of ‘16 will tell us about the maturing of the program and what additional changes might be needed,” says National Association of ACOs (NAA-COS) CEO Clif Gaus.

Second, the proposed regulations implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are due out from CMS at any time (VBC 5/15, p. 1), and NAACOS is watching closely to see exactly how ACOs will be treated in advance payment models.

**Medicare SGR Formula Has Been Replaced**

MACRA repealed the much-maligned Medicare Sustainable Growth Rate (SGR) formula and replaced it with two separate incentive payments. Physicians who participate in Alternative Payment Models (APMs) will be eligible for a 5% annual bonus from Medicare, while physicians not participating in APMs will instead need 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 MSSP’s 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.

Meanwhile, in April CMS will launch the Comprehensive Care for Joint Replacement (CJR) program (VBC 12/15, p. 1). This is the first mandatory value-based payment program for CMS, and will include bundled pay-
ments for hospitals in 67 metro areas for hip and knee replacements and other major leg procedures. Hospitals will be paid fee-for-service rates, but will receive additional payments if quality and spending performance are strong. They’re also at risk for having to repay Medicare if, conversely, quality and spending performance are weak. The charges will accrue from the time of surgery through 90 days after discharge.

“It’s hard not to have a sense that CMS is tired,” says Erik Johnson, vice president for network and population health consulting at Optum, Inc. “Medicare and CMS have tried really hard over the last five-and-a-half years to push the provider world and the payer world toward value-based models, and one could argue that they’ve pushed too hard, too fast. In the ACO world, the lack of overwhelming performance makes this really hard.”

Still, despite the fact that 2016 “ought to be a pause point” from the major changes CMS has implemented over the past several years, “CMS says no,” Johnson tells VBC.

Instead, 2016 will provide a tipping point for ACOs — especially hospital-based ACOs — to decide how steadfast they’re going to be in pursuit of the Medicare ACO model, Johnson says. “The NextGen model will help assuage some concerns of those in the existing MSSP, but overall for Medicare ACOs, we’re not going to see another tsunami of folks sign up — which I think is OK.”

Both Medicare ACOs and hospitals participating in BPCI have realized that taking risk “is really hard. Once they’re confronted with the reality of going at risk, they said they weren’t ready — and they really aren’t,” Johnson says.

That didn’t stop CMS from implementing CJR on the heels of the voluntary Bundled Payments for Care Improvement (BPCI) program, he notes. Could CMS decide to make ACOs mandatory? It’s possible at some point, Johnson says.

Andrew Croshaw, president of Leavitt Partners Consulting, tells VBC that he anticipates new cottage industries springing up around aspects of value-based care:

◆ New physician groups will specialize in providing services in post-acute care facilities. These physicians will work directly with skilled nursing facilities (SNFs) to improve quality and drive down costs.

◆ SNFs themselves will begin specializing in joint replacement as a way to capitalize on the Medicare CJR program and the BPCI program (VBC 11/15, p. 1). BPCI, in particular, has drawn broad participation from SNFs.

◆ Organizations will form that will manage post-acute care “almost like post-acute care ACOs,” Croshaw says.

“We’re seeing evidence of new businesses forming to help providers optimize the CJR requirements,” he says. “Hospitals have to be careful on how they advise patients. We’re also seeing more businesses providing educational content for patients, helping patients end up at the right rehabilitation facility.”

Johnson says there’s “a lot of innovation waiting to emerge in post-acute care in Medicare. If this is a window of opportunity for hospitals to engage with skilled nursing facilities and home health, we could see real progress made in Medicare.” But he notes that hospitals haven’t shown the initiative needed to set up these deals to date. “CMS has done as much as it can do. This needs to be a market reaction to CJR — part of that continuum. I’m still waiting for hospitals to get engaged.”

CMS’s goal “is to create a broad variety of programs incenting providers to move toward risk,” says Leavitt Partners LLC Director of Research David Muhlestein. “I would expect Medicare to continue to create these programs. They don’t have it in their power to force providers to move to risk, but they can encourage them.”

The agency will continue to develop different models for value-based payment, since there’s no one-size-fits-all model that will work for all provider organizations, he tells VBC.

However, it will be difficult for CMS to bring in many specialists beyond what the agency has done so far with renal care, oncology and joint replacement, Muhlestein says. “The specialty focus is tricky — in practice, it will be hard to move providers into these. For example, if you have a cardiovascular ACO and half of your patients also have cancer, how do you handle that?”

Johnson agrees. “There’s lots of talk — idle talk — about specialty ACOs around oncology. But no patient is going to want that to be the program they’re enrolled in. There are bundles that might work for some of that, but if you have lung cancer, and you have it for four years, how do you bundle that?”

continued

### Selected Recent Health Plan ACO Arrangements, Collaborative Agreements

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SOURCE: Compiled by AIS from health plan press releases in November and December 2015.

Web addresses cited in this issue are live links in the PDF version, which is accessible at VBC’s subscriber-only page at http://aishealth.com/newsletters/valuebasedcarenews.
The design features of any new programs need to “keep the top performers in, and encourage the low performers to get more efficient,” Bajner adds. This may mean more mandatory programs like CJR, he says.

It’s no secret that ACOs haven’t always been satisfied with CMS’s regulations implementing Medicare ACO programs, and so NAACOS is appealing to a higher authority in an effort to get some of the policy concessions it hasn’t received from CMS.

Gaus tells VBC that NAACOS is working with members of Congress in an effort to get legislation that would grant ACOs participating in MSSP Track 1 the ability to send patients to SNFs without a qualifying hospital stay; currently, only Track 3 MSSP ACOs can do that. The ACO industry group also wants the option of prospective alignment for Track 1. A bill that would accomplish these goals most likely will be introduced next winter, Gaus says.

Finally, the 2016 presidential election eventually may have an impact on the Medicare ACO program and other value-based initiatives, Gaus says. Of course, ACOs are a market-based solution, he points out, so CMS under a potential Republican administration might like them as much as CMS under the Obama administration or another Democratic president. Regardless, he says, “we’re watching carefully and trying to get a handle on what folks would do.”

Contact Laura Vinci for Bajner at lvinci@cooperkatz.com, Johnson at erik.johnson49@optum.com, Croshaw and Mulhestei via Leavitt spokesperson Jordana Chouc aig at jordana.choucair@leavittpartners.com, and Gaus at (202) 640-1898.

NEWS BRIEFS

- Humana Inc. and Delaware Valley ACO (DVACO) on Dec. 14 unveiled the results of their year-old Medicare Advantage (MA) accountable care organization program. The two reported that Humana members cared for under the value-based deal with DVACO had a 10% increase in medication adherence and a 4% increase in disease management program participation. Humana and DVACO also said they are expanding the arrangement to include another 22 medical groups. It now is available to 8,200 Humana MA members. Visit http://tinyurl.com/ztt89nh.

- One-third of family physicians are actively pursuing participation in value-based payment models, according to a study released Dec. 1 that was conducted by the American Academy of Family Physicians (AAFP) and sponsored by Humana. Another 19% reported that they are developing capabilities to participate in value-based payment models, but are waiting for more results before actively pursuing participation. The time commitment is a major issue, according to AAFP’s 2015 Value-based Payment Study. More than 90% of physicians reported that lack of staff time is a barrier to adopting value-based payment models. The survey was sent to 5,000 active members of the AAFP; a total of 779 surveys were completed, and 626 were evaluated after a screening process. Visit http://tinyurl.com/zzwmqls.

- Cigna Corp. and Seton Health Plan, Inc. on Dec. 10 unveiled a joint venture agreement detailing a new collaboration to offer employers in and around Austin and Waco, Texas, integrated health care products, the companies said. Seton Health Plan’s insured and self-insured offerings will be available in 2016 to employers with 51 or more workers within a 13-county area served by Austin-based Seton Healthcare Family and Waco-based Providence Healthcare Network, which along with Seton Health Plan are subsidiaries of Ascension, the nation’s largest nonprofit health system. “The health care products will guide customers of Seton, Providence and affiliates through a more clinically integrated and cost-effective system of care designed to improve quality and patient outcomes, reduce duplication of services and eliminate unnecessary costs. Seton Health Plan and Cigna expect to make products available to employers by the summer of 2016,” the companies added. Visit http://tinyurl.com/orwffxk.

- CMS posted results from one of its older value-based purchasing efforts, the Hospital-Acquired Condition (HAC) Reduction Program. The agency on Dec. 10 estimated that fiscal-year 2016 savings from the program will be $364 million. The HAC Reduction Program, created by the Affordable Care Act, cuts payments by 1% for the hospitals that rank in the worst-performing quartile of all hospitals on risk-adjusted HAC quality measures such as catheter-associated urinary tract infections and surgical site infections. The program took effect for discharges beginning on Oct. 1, 2014. CMS reported that the average performance across eligible hospitals improved on two of the three measures reported for both program years. Visit http://tinyurl.com/nbhmbls for the fact sheet.

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