Aetna-Humana and Cigna-Anthem Deals May Accelerate Value-Based Transition

Aetna Inc.’s acquisition of Humana Inc. and Anthem Inc.’s purchase of Cigna Corp. signal what industry analysts believe may be an accelerated move toward value-based purchasing. The deals, announced within three weeks of each other last month, also could spur fence-sitting providers to begin their own transitions from fee-for-service to accountable care and value-based reimbursement.

The four insurers involved in these acquisitions all have significant footholds in the value-based reimbursement space (see table, p. 11).

Aetna CEO Mark Bertolini said earlier this year that 30% of the insurer’s contracts were value-based, and it intended to increase that figure to 75% before the end of the decade. Humana says providers in its accountable care arrangements have helped drive up Medicare Advantage star ratings (VBC 1/15, p. 6).

Meanwhile, Anthem has more than 115 ACO or patient-centered medical home provider contracts, with more than $38 billion in payments tied to value, and Cigna has more than 100 value-based contracts — including some with specialists and small physician groups — with more than 1.3 million lives.

“I think both deals are about both (a) fixed cost synergies and (b) synergies from more leverage with hospitals and physician groups,” Leerink Partners LLC analyst Ana Gupta, Ph.D., tells VBC. “The latter can enable and accelerate the move to value-based contracting.”

continued on p. 11

CMS’s Hip/Knee Bundled Payment Model Signals Significant Shift for Providers

It’s no surprise that HHS wants to transition reimbursement for Medicare beneficiaries from a fee-for-service model to one that is value-based. But the program outlined by CMS in a recently unveiled proposed rule demonstrates that CMS is taking a huge step toward this goal.

CMS on July 9 proposed a new bundled payment model (80 Fed. Reg. 41197, July 14, 2015) that will put hospitals at financial risk if they do not make quality and care improvements for patients transitioning from surgery to recovery for knee and hip replacements. The five-year Comprehensive Care for Joint Replacement (CCJR) payment model would be mandatory for providers in 75 markets, and following a comment period that ends on Sept. 8, would take effect on Jan. 1, 2016. The payment changes would affect around 800 hospitals and some 100,000 patients per year, equating to 25% of all such procedures covered by Medicare. Providers would continue to receive fee-for-service payment for hip and knee replacements for a period from the time of surgery through 90 days after for an entire “episode” of care. But depending on the “hospital’s quality and cost performance,” it “may receive an additional payment or be required to repay Medicare for a portion of the episode costs,” CMS said.

continued
Some commercial payers already are offering bundled payment programs for knee and hip replacement, many of them “a little more innovative” than CMS’s program, including some prospective payment models, says Ellen Lukens, a senior vice president and head of the Providers Practice at Avalere Health LLC. Still, CMS has laid out “a very clear framework” that commercial plans can use to help structure a contract. “They could end up piggybacking on that framework,” she says.

“The key difference” between this newest program and all of the CMS ones before it is the hip and knee replacement initiative “will have the participation of all the hospitals in a market,” explains Lukens. In voluntary programs, there may be situations where only certain types of hospitals join or where hospitals include only those patients who would be most beneficial to their performance, but these circumstances won’t be issues now.

“This is a significant shift,” Lukens contends. “To date, all CMMI [i.e., CMS Center for Medicare and Medicaid Innovation] programs have been voluntary. This one is the first to be mandatory. This signals a big shift at CMS.”

Also of note is the “large-scale” approach, she says. CMS could have gone with a smaller program, perhaps one with 10 metropolitan statistical areas (MSAs), she explains. But the 75 MSAs in the initiative “represent 25% of all the hospitals in the country….This underscores the extent to which CMS has confidence in bundled payments as a model.” Lukens points to the January announcement by HHS Sec. Sylvia Burwell that the agency has a goal of tying 50% of fee-for-service Medicare payments to quality- or value-based models by 2018. “This is clearly a part of” that effort, says Lukens.

CMS will pay for all services on a fee-for-service basis, and then it will make a reconciliation payment — assuming the hospital’s actual episode payment is less than the established CCJR target price — on a retrospective basis. If the episode payment is higher than the target price, then the hospital would repay that difference to Medicare.

**Targets Will Be Hospital-Specific Initially**

The CCJR target price will be “initially based on a hospital’s historical experience,” Lukens says. The experience will be in two-year increments, which “will move the baseline over time,” she adds. Then these hospital-specific amounts will be blended together with “regional historical CCJR episode payments, transitioning from primarily provider-specific to completely regional pricing over the course of the 5 performance years, to incentivize both historically efficient and less efficient hospitals to furnish high quality, efficient care in all years of the model,” explains CMS. “Regions would be defined as each of the nine U.S. Census divisions.” The implication, says Lukens, is that CMS “is really trying to move away from” using data solely based on hospitals’ historical performance.

She points out that by “basing the target price on [a hospital’s] historical performance, high performers are at a considerable disadvantage.” For example, if a hospital has been relatively efficient, perhaps with a post-acute care bundle of $8,000, compared with another hospital that’s been around $10,000, the more efficient hospital will be at a disadvantage because it has to hit a lower target price, Lukens explains.

Some within the industry question whether the proposal is a true bundle. “Add to that the fact that they are basically mandating that hospitals take responsibility for something that they don’t actually get any control over,” Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform, tells VBC's sister publication *Health Plan Week*. CMS proposed that the acute care hospital that is the site of surgery would be held accountable for spending during the episode of care. That hospital would have to work with physicians, home health agencies and nursing facilities to coordinate care. “If you have a true bundle and you say, ‘OK, group of providers, get together, manage this bundle and kind of figure out how you want to deliver care differently, and
then divide up the money however you want to,’ people
commit to it however they want to and structure it in a
fair way. But if you say to one entity you are going to be
financially responsible for what all the other entities do
but you won’t actually have any control over them, what
are you going to do?”

**CMS Is Familiar With Joint Replacement**

The condition CMS selected is important, says
Lukens, who notes that CMS had “some experience with
joints” in its Medicare Acute Care Episode (ACE) dem-
onstration. Hip and knee replacements are high-volume
procedures, with more than 400,000 inpatient procedures
performed on Medicare beneficiaries in 2013, which cost
the program more than $7 billion in hospitalizations
alone.

While reconciliation payments will be made in
the first year of the program, hospital repayments will
not start until the second year. “In year one, there is no
downside risk; it’s upside only,” she explains. So while
it may seem like the program is starting rather quickly,
CMS is taking “the whole first year for hospitals to gain
experience.”

Lukens says that Avalere assumes the data and
educational resources that CMS will provide participat-
ing hospitals are “similar data consistent with that in
the Bundled Payments for Care Improvement (BPCI)
initiative,” which includes “data feeds monthly” on par-
ticipating hospitals and their markets. This is “closer to
real-time data,” she says.

That program, which was unveiled in 2011 (VBC
9/11, p. 10), takes four broad approaches to bundled
payments:

◆ “Model 1: Retrospective Acute Care Hospital Stay
Only”
◆ “Model 2: Retrospective Acute Care Hospital Stay
 plus Post-Acute Care”
◆ “Model 3: Retrospective Post-Acute Care Only”
◆ “Model 4: Acute Care Hospital Stay Only”

Lukens says she thinks the CCJR program doesn’t
preclude CMS from opening the BPCI program to other
conditions. She says there were 6,000 participants in
Models 2 and 3, “but we don’t know how many moved
forward” to the next phase of the program. Participants
had to make that decision, though, by July, so it should
be public knowledge soon, she adds. And CMS has start-
ed other different types of bundled models, such as the
five-year experimental Oncology Care Model, unveiled
earlier this year (VBC 3/15, p. 1).

According to Lukens, to add a clinical condition to
the BPCI initiative would require CMS to go through the
rulemaking process, the same route it is taking with the
CCJR model. “This is one of many programs that CMS is
probably contemplating,” she says. So with that in mind,
what seems to be a priority for CMS as far as next steps
with these models? “A prospective payment program,”
says Lukens, noting that “there is one model that does
this” — Model 4 of the BPCI initiative — “but it is small.”

“CMS is really demonstrating its confidence that
bundled payments are effective” and can “lower
Medicare spending” while at the same time resulting in
“better patient outcomes,” says Lukens. The CCJR
model “really accelerates CMS’s efforts to transition…all
providers” to alternate payment models. And although
other CMS efforts have developed more slowly, “with
this program, in one fell swoop,” the agency’s push to
value- and quality-based payment models “picked up
momentum,” she maintains.

“Once 25% of the hospitals in the country are in the
program, it’s hard to dial it back.”

View the proposed rule at http://tinyurl.com/o47w3qy. Contact Lukens at (202) 459-6263. 

**HealthSpring Enters North Texas Market With Premier Arrangement**

Accountable care organization (ACO) Premier Pa-
tient Health Care and Cigna Corp.’s Cigna-HealthSpring
unit will partner on a deal that they predict will benefit
HealthSpring’s Medicare Advantage customers in north
Texas. The agreement, which goes into effect Sept. 1, will
incentivize Premier physicians to provide high-quality
care and supply them with additional support from
HealthSpring resources. And even though HealthSpring
has been working with providers for about 15 years, this
deal is slightly different from other partnerships it has.

Premier, which has more than 350 north Texas phy-
sicians in its network, has served the Dallas/Ft. Worth
area since 2013. The group is effective because it has
physicians managing other physicians, maintains Peter
Gardner, chief operating officer in the Texas division of
HealthSpring, which also offers Medicare Part D pre-
scription drug plans and Medicaid plans.

A physician’s job is to practice medicine, he says, but
when one is seeing 40 patients per day, it can be hard to
devote time and resources to administrative-type duties
beyond that, says Gardner. So HealthSpring will perform
tasks such as paying claims and producing reports on
data including utilization, claims and provider perform-
ance, offering a “sophisticated and physician-friendly
means to provide data to physicians.”

Although HealthSpring is a Cigna company — the
insurer purchased it in January 2012 — Gardner says he
thinks of his company more as “a management company

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than a health plan....Our DNA has always been the engagement of physicians.” HealthSpring wants to provide Premier physicians with “the tools to manage their own network, ... work collaboratively with other doctors.” The health plan also wants doctors “to perform good preventive care, and we’ll reward them for that.”

“It’s been really an interesting relationship between our two organizations,” Gardner tells VBC. “They’re very good with the doctors they have relationships with.... We’re very like-minded with what we’ve been” doing. The deal also made sense because HealthSpring was trying to get into the north Texas market, while Premier was “looking for a partner in the Medicare Advantage space,” he says.

According to Gardner, Premier has “had tremendous growth over the past year.” If you “rewind to two years ago, they weren’t on anyone’s radar.... To their credit, they’ve done a fantastic job with organizing their physicians and becoming the No. 1 independent physician group in the north Texas market.” Premier, he says, is “very open-minded, very nimble, quick to respond and easy to work with.”

Before the deal, both companies “did a lot of thinking outside the box together.... When we first started talking to them, within 60 days of our first meeting, we were able to execute the agreement we just announced,” says Gardner. And “this was not a simple one-page” deal — it has “some complexity” to it. The companies, he says, were in sync with “how we work with physicians and how we incentivize them.” This shared approach was “what attracted us to each other,” which in turn allowed the deal to “come about in really short order.”

HealthSpring “is very selective in who we partner with,” maintains Gardner, eschewing the “mile-wide, inch-deep” approach. The company wanted to “establish a strong beachhead in north Texas,” where it “felt confident we could achieve a minimum of four stars.” The company was “looking for a group of physicians interested in growing their Medicare Advantage membership.” But it wasn’t looking for just any group of independent physicians. HealthSpring sought one that “was very well-organized and very well-managed,” he says. Premier has a “good approach to physicians and how to manage them.... They talk to their physicians frequently and meet frequently.” Ultimately, Gardner says, “if we have that beachhead, the quality is better,” and there is “a lot more likelihood of achieving four stars” than there would be in markets where his company is not as involved.

HealthSpring, which is based in Nashville and serves 16 states and Washington, D.C., has had a strong presence in other Texas areas such as Houston and the Rio Grande Valley for many years, Gardner says. “We actively entered” the north Texas market in 2010, he says.

In Houston, HealthSpring works with Renaissance Physician Organization, an independent physician association (IPA) owned and operated by more than 1,400 primary care physicians and specialists. And the Rio Grande Valley has a “large, engaged IPA group there” that’s “very focused on quality of care.”

North Texas is a bit different market, though, says Gardner. Because many of the practices are hospital-owned, it’s “a little harder to find a group of independent physicians to rally together. That makes it more unique than” the situation with Renaissance in Houston, for example. “North Texas has been challenging because it’s a little more fragmented.” But Premier was able to pull together the independent physicians.

But although the Premier deal was only recently unveiled, Cigna-HealthSpring is no newcomer to the approach. “We’ve really been in that value-based engagement of physicians dating back to 2000,” he explains.

According to Gardner, the deal is both similar to and different from other value-based care arrangements HealthSpring has. It’s similar in that “we have traditionally had the engagement in Texas and elsewhere” in which “we serve as the management company.” And “while the incentives we’re putting into place with Premier are similar [to those in other arrangements], what is unique is we’re providing services we’re strong with”

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<thead>
<tr>
<th>Health Plan Affiliates</th>
<th>Provider Affiliates</th>
<th>Service Area</th>
<th>Launch Date</th>
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<tbody>
<tr>
<td>Aetna Inc.</td>
<td>University of Chicago Medicine</td>
<td>TX</td>
<td>Effective July 1, 2015</td>
</tr>
<tr>
<td>Anthem, Inc.</td>
<td>University Hospitals (UH)</td>
<td>OH</td>
<td>Announced in July 2015</td>
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<tr>
<td>Cigna Corp.</td>
<td>PrimeHealth Physicians, LLC</td>
<td>FL</td>
<td>Effective July 1, 2015</td>
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<td></td>
<td>Providence-Swedish Health Alliance ACO</td>
<td>WA</td>
<td>Announced in July 2015</td>
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<td></td>
<td>Premier Patient Health Care</td>
<td>TX</td>
<td>Effective Sept. 1, 2015</td>
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<tr>
<td>Humana Inc.</td>
<td>Oak Street Health</td>
<td>IL</td>
<td>Effective June 1, 2015</td>
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<td>Iora Health</td>
<td>AZ, CO, WA</td>
<td>Effective Aug. 1, 2015</td>
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<td>UnitedHealthcare, Inc.</td>
<td>Presbyterian Healthcare Services</td>
<td>NM</td>
<td>Announced in June 2015</td>
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SOURCE: Compiled by AIS from health plan press releases in June and July 2015.
such as reporting on trends, utilization and claims, and Premier is providing more services on the care side. “They were already doing a good job” at this, so HealthSpring took the attitude of “you guys do that — you’re good at it — and we’ll do this.”

This approach, though, required HealthSpring to “look ourselves in the mirror” and ask, “Are we willing to do that?” Gardner says the company wouldn’t enter into such a partnership with just anybody, but Premier’s approach “made us more comfortable...[and] gave us a lot of confidence” in the arrangement.

ACA Was ‘Headwind-Tailwind Situation’

HealthSpring’s efforts predate the Affordable Care Act (ACA), which has been a more recent impetus for a shift to value-based care. The ACA, says Gardner, presented a bit of a “headwind-tailwind situation.” It was a tailwind in terms of the ACA being “an affirmation of the networks of physicians we’d been working with; it kind of reaffirmed that model, if you will,” he says. “A lot of those changes that came into the Medicare Advantage world, such as star ratings and coding acuity, the doctors were kind of prepared for,” with HealthSpring networks “typically hav[ing] four- and five-star performing physician practices.”

The ACA presented a headwind with respect to shifts in reimbursement: “There was less reimbursement to work with,” says Gardner, something the “physicians were prepared for” as well. “Star ratings had been around a while, but they really had no bearing” on physicians. “When they started affecting the quality bonuses we share with physicians,...[the doctors] performed very well even in a tighter reimbursement environment.”

Gardner says HealthSpring has learned a few lessons from the various deals it’s done over the years. First, in working with provider groups that may not be familiar with such a model, “you have to quickly get to this kind of arrangement” in today’s market, as opposed to taking four or five years to ramp up to it as some groups have done. “There’s now the pressure of stars and coding acuity,” he notes, so “we have to get to that quicker...We had to shorten the window from when we entered the market to when the IPA was fully engaged.”

“We’re a lot quicker to get there than we used to be — and, quite frankly, so are the physicians,” he says. And this has happened during a time where they’ve seen “the whole reimbursement methodology change to more value-based....There is a trust factor of, ‘We can learn with you guys.’” Because providers realize how much of their practice is impacted — “not just 10%...but 80%” — “a lot have taken this to heart and worked with us.” Those partnerships have “aligned incentives” between the groups. “Where they’re doing well, we’re doing well,” he contends.

HealthSpring, says Gardner, is “very excited” about the arrangement with Premier. “We’ve always been looking for this opportunity in north Texas.” But “the heavy lifting now has to occur....We’ve got to grow in that market...[and] deliver to physicians what they’ve been promised.”

Contact Gardner through Katie Sulkowski at katie.sulkowski@healthspring.com.

Downside Risk Pacts Are Eyed As Health Insurers Consolidate

With massive consolidation on the horizon for large health insurers (see story, p. 1), both provider groups and payers are anticipating an even stronger push toward value-based payments in commercial contracts.

And as those value-based contracts evolve, they’re more likely to move away from the upside-only shared savings agreements that are commonplace today, and toward new arrangements that push more risk — including downside risk — onto providers, industry stakeholders told attendees on June 16 at the Accountable Care Organization Summit in Washington, D.C., sponsored by Global Health Care, LLC.

“A lot of payers are experimenting,” said David Muhlestein, senior director of research and development at Leavitt Partners LLC. “On the commercial side, provider arrangements are more flexible. They might start with creating a patient-centered medical home and providing care management fees, or start paying for [providers to collect] quality measures. Over time, they move up the risk spectrum.”

According to Leavitt’s data, private payers have about 14 million people enrolled in accountable care, while Medicare has 7.8 million and Medicaid has 1.7 million lives in accountable care.

ACO growth “initially was really being driven by the commercial space — before MSSP [the Medicare Shared Savings Program],” Muhlestein said.

Now, Leavitt Partners counts about 528 commercial contracts and 523 government ACO contracts, he said. “It’s about the same number of contracts, but commercial ACOs tend to be much larger,” so there are many more members enrolled in commercial ACOs than in Medicare and Medicaid ACOs.

There are 136 different payers — both government and commercial — who have ACO contracts. Of these, three have 51 or more contracts (one of these is CMS), and three more have between 21 and 50 contracts.

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Muhlestein said. Most — 81 payers — have just one contract, and 19 have just two contracts in force.

About 30% of Aetna’s contracts are in value-based pacts currently, Charles Saunders, M.D., CEO of Healthagen, an Aetna Inc. subsidiary, told conference attendees.

Saunders, who spoke before the proposed Aetna-Memorial Hermann Inc. merger was unveiled, predicted the number of contracts in value-based payments would grow substantially and rapidly for Aetna. “At five years [from now], 15% of our network will be capitated, and 70% will be in some sort of value-based reimbursement. A small percentage of the marketplace will be in care bundles, and a very small percentage will be in percentage of premiums, participating in underwriting margin as provider-owned health plans or joint ventures.”

With Aetna and other large health insurers moving this fast into value, close relationships between provider groups and commercial payers are important, said D. Keith Fernandez, M.D., president and physician-in-chief for Memorial Hermann Physician Network and chief medical officer for Memorial Hermann ACO in Houston.

**ACO Attributes Success to Aetna**

Memorial Hermann ACO saved nearly $60 million for CMS during the first reporting period for the MSSP, earning a shared savings payout of about $30 million. But Fernandez told conference attendees that much of the ACO’s success as an ACO is “directly related to our relationship with Aetna,” which was the first commercial payer to approach Memorial Hermann about value-based payments. The Aetna-Memorial Hermann ACO took about a year of planning and opened its doors in January 2013.

“With Aetna, we have this great partner. Every week, we’re talking to Aetna. When we look at how we interact with them, it just looks like one group of people trying to solve problems,” he said.

The ACO ultimately took what it learned from its pact with Aetna and used it to become successful in MSSP, which it actually joined in July 2012, before the Aetna deal formally launched, Fernandez said.

He added that he anticipates similar stellar financial results from the second MSSP reporting period later this year.

H. Scott Sarran, M.D., divisional senior vice president and chief medical officer, government programs, for Health Care Service Corp., said commercial payers such as HCSC need to deploy increasingly innovative products that are attractive and affordable enough to win customers.

Provider partners, he said, can help moderate price increases, create predictable pricing and facilitate price stability over time, all of which are critical in an environ-
Cleveland Clinic Reinvents Itself on Quality, Cost, Access

Cleveland Clinic had a problem: Although it was almost universally regarded as one of the top medical centers in the U.S. and in the world, especially for treatment of cardiovascular conditions, it wasn’t well set up to compete in the new world of value-based reimbursement. Costs were high, and some of its quality and patient satisfaction measures were falling short.

“We believe that ultimately as we head to value, we have to have quality, affordability and accessibility,” Toby Cosgrove, M.D., Cleveland Clinic’s president and CEO, told attendees June 19 at the Accountable Care Organization Summit in Washington, D.C., sponsored by Global Health Care, LLC.

Cleveland Clinic’s integrated care model for population health encompasses the entire care system, from the emergency room and hospitals to retail venues and home-based care, Cosgrove said. The provider opened its first patient-centered medical home in 2010 with 230 primary care physicians and about 300,000 patients, receiving National Committee for Quality Assurance Level 3 PCMH accreditation in 2010 and Joint Commission PCMH certification in 2013.

Clinic Adopts Care Paths

The organization also increasingly relies on what it calls care paths, which are versions of practice guidelines that guide clinicians and their patients through specific diagnoses. Currently, Cleveland Clinic has 106 guides in place, 14 of which are enabled through specific diagnoses. Currently, Cleveland Clinic has 106 guides in place, 14 of which are enabled through specific diagnoses.

So far, Cleveland Clinic has done well on some of the MSSP quality measures, especially those measuring timeliness of care, doctor communication, doctor rating and access to specialists — but is well below the 90th percentile of ACOs on influenza vaccination, body mass index screening and follow-up, and blood pressure control, he said.

As its transition to population health management began, the organization began brainstorming ways to improve access to care, Cosgrove said. “Access is actually getting to see the care provider. We’ve put a lot of effort on this over the last couple of years. [Patients] should be able to see a physician anytime, anywhere.”

These “anytime, anywhere” visits can include virtual visits as well as visits to more traditional care settings, such as hospitals, physician offices, urgent care clinics and emergency rooms, he said.

‘A Lot of Work’ Improved Ranking

Quality of care also required some attention, Cosgrove said. In 2010, Cleveland Clinic ranked in 80th place in the quality and safety rankings developed by the University HealthSystem Consortium, a national organization of most academic medical centers. In 2014, following “a lot of work on the part of the institution,” Cleveland Clinic came in at No. 10 on the list.

Patient safety indicators continue to improve: For example, hospital-acquired infections have fallen by about one-third, he said. The organization implemented an aggressive hand hygiene protocol that included electronic reminders on doors and saw its level of appropriate hand washing rise from 66% in 2013 to 72% this year. But, Cosgrove noted, “I can’t believe we can’t get everyone to wash their hands every time.”

Meanwhile, the 30-day all-cause readmission rate has dropped slightly, from 14% to 13%. “This is very stubborn,” Cosgrove said. “Cleveland Clinic has the highest acuity level in the U.S.” Readmissions are common in cardiac and heart failure patients, he said, although he added, “we are making some progress.”

Cleveland Clinic’s scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, used to measure patient experience and satisfaction, range from the 88th percentile in provision of discharge information to the 23rd percentile in quiet (referring to the noise level for patients in the hospital). Doctor communication sits at the 50th percentile, and Cosgrove said that one has been a challenge: “It’s a major complaint across the organization.”

The clinic has implemented communication courses for its physicians, he said.

“As HCAHPS scores go up, we’ve seen the number of complaints and grievances go down,” Cosgrove
CMS’s Investment Model Changes Open Door to MSSP for Rural ACOs

Two changes to the CMS ACO Investment Model have opened the door to the Medicare Shared Savings Program (MSSP) for rural accountable care organizations that wouldn’t otherwise have been able to join the program, says the head of the CMS division helping rural groups make the transition to value-based payments.

The changes in the nine-month-old program, announced by CMS Deputy Administrator for Innovation and Quality and Chief Medical Officer Patrick Conway, M.D., should mean more rural groups will gain access to some of the $114 million offered in upfront investment money by CMS to ACOs, Conway said.

The investment model modifications mean:

◆ **ACOs that entered the MSSP in 2015 will be able to apply for investment model funding in the upcoming application round this fall.**

◆ **MSSP ACOs will be eligible for funds regardless of how many beneficiaries they have attributed to them.**

Previously, only MSSP ACOs that had 10,000 or fewer beneficiaries were deemed eligible for investment model funds.

“These two changes reflect [CMS’s] commitment to listening to suggestions and ensuring that demonstrations are widespread, including rural providers and smaller physician groups,” Conway said.

The changes do indicate that CMS is committed to helping rural ACOs gain a foothold in the market, says Lynn Barr, chief transformation officer for the National Rural ACO, which helps rural provider groups join together to form ACOs.

“We were thrilled by their announcement to change the rules to accommodate rural providers,” Barr tells VBC. “I think there is an important psychological impact. For years, the prevailing sentiment in rural America has been that CMS was not on our side. Clearly, by the actions taken by CMMI [the Center for Medicare & Medicaid Innovation] and CMS, it is obvious they are bending over backwards to help us.”

VALUE-BASED CARE PROFILE (continued)

said, from 2.5 per 1,000 patients in 2009 to 1 per 1,000 in 2014.

Meanwhile, to improve patient satisfaction scores, Cleveland Clinic has been focusing on wait times for patients to see physicians, Cosgrove said, and has reduced them from more than half an hour in 2010 to 13.6 minutes so far in 2015.

Same day visits — appointments completed on the same day they were requested — have increased from 687,000 in 2008 to more than 1.1 million in 2014, he said.

“We ask people if they want to be seen today, and 90% of those who ask for [a same-day appointment] get one,” he said.

Shared medical appointments — much longer appointments that include 10 to 15 patients and can serve as support groups — also are on the rise: Cleveland Clinic had just 678 of those in 2009, but reported 6,124 in 2014, Cosgrove said.

The organization has implemented shared medical appointments for 15 conditions and areas of focus, ranging from asthma and addiction to general men’s and women’s health.

Finally, for the third leg of the value-based care stool, Cleveland Clinic is taking aim at affordability.

“From 2014 to 2015, we’ve taken 9% out of clinic costs and about 15% out of administrative costs,” Cosgrove said. These efficiencies have saved about $513 million in that time frame, he said.

The organization asked all its caregivers to submit ideas to save money, and those 932 ideas — which ranged from turning off the escalators at night to reducing the size of soap containers — have led to about $3.2 million in savings, he said. Energy usage also has fallen, and the percentage of recycled waste has risen.

Care pathways also have helped to save money.

For example, “we took almost $1,000 per day out of the cost by putting together a care pathway for stroke,” Cosgrove said. Stroke costs declined from $3,402 per day to $2,553 when that care pathway was implemented. A care pathway for multiple myeloma decreased drug costs from $150,000 to $61,000, a 59% reduction, he said. Finally, the care pathway implemented for thyroid surgery called for the site of surgery to be moved from the main campus — a high-tech facility — to a community hospital. This reduced the cost per case from $3,100 to $2,600, a 16% reduction, he said.

“Physicians respond to data,” Cosgrove said.

“We’re a very data-driven group. It takes about six months to convince them the data is good, then six months more to change behavior.”

Contact Cleveland Clinic spokesperson Heather Phillips at (216) 445-4517.

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Under the ACO Investment Model, announced last fall (VBC 11/14, p. 2), CMS will lend $114 million to as many as 75 MSSP ACOs to help them make necessary investments in health information technology infrastructure and care management capabilities so that they can better manage care. The agency will give preference to those ACOs that sign MSSP contracts with two-sided risk, but will not limit its payments to those ACOs that accept downside risk.

To participate in the investment model, ACOs:

- **Cannot include a hospital unless it is a critical access hospital or inpatient prospective payment hospital with 100 or fewer beds;**
- **Cannot be owned or operated by a health plan; and**
- **Can’t have participated in the Advance Payment Model,** the previous ACO loan program run by CMS.

Existing MSSP ACOs must have successfully reported quality measures in the most recent performance year, and ACOs chosen for the program must commit to moving to two-sided risk, either immediately for organizations starting on Jan. 1, 2016, or in their second three-year agreement with CMS for ACOs already in the program.

The investment model program was specifically targeted at ACOs operating in rural areas. But Barr says its initial restrictions — specifically, the rule capping attribution at 10,000 Medicare beneficiaries — made it difficult for nascent ACOs to meet the criteria.

“The main problem with the cap is that attribution is very hard to predict, and CMMI made a rule that said once you applied for the ACO Investment Model funding, you couldn’t add or subtract anyone from your ACO,” Barr says.

However, final attribution numbers varied widely when compared with the numbers of Medicare patients seen by these providers in the past year, she says: “We had anywhere from 6% to 88% of those [patients seen by providers] attributed to their ACOs. We estimated that we would guess wrong for about half of our applicants, and they would be disqualified” from receiving funding unless the 10,000 beneficiary cap was removed.

CMMI had intended the cap to eliminate applicants that really didn’t need the money, but Barr says it actually was eliminating worthy applicants. “We explained to Dr. Conway and his staff that in our model, we are aggregating small health systems to work together to win an ACO. We could have 20,000 lives made up of 20 rural health systems — that doesn’t make them wealthy. In fact, we want to make our ACOs as large as possible to lower the risk corridor.”

Had the rule remained in effect, “we would have had to cut up the applicants in ways that didn’t make sense in order to try to avoid the cap and get the funding. Make no mistake, most rural providers can’t move forward if they don’t get ACO Investment Model funding. We want to combine everyone within state lines whenever possible.”

The National Rural ACO is submitting applications for ACO Investment Model funding for 179 rural health systems, Barr says, adding that the funding has certainly encouraged rural providers to establish accountable care in areas that are not currently participating in the MSSP.

The groups applying for funding include independent physician groups, critical access and small hospitals, rural health clinics and federally qualified health centers, Barr says.

Under the investment model, existing ACOs will receive $36 upfront per prospectively aligned beneficiary and an additional $6 per beneficiary per month on an ongoing basis. ACOs joining the MSSP program as of Jan. 1, 2016, will need to commit to two-sided risk immediately and will receive $250,000 plus $36 per beneficiary upfront, along with $8 per beneficiary per month.

The ACOs will reimburse CMS through shared savings for the investment. Existing ACOs that don’t earn enough shared savings to pay back the CMS investment may see CMS come after them for the money if they quit the program after their three-year agreement expires, but CMS won’t seek to recoup its money in that fashion unless they leave the program in the middle of their three-year agreement.

Contact CMS public affairs at (202) 690-6145 and Barr at lbarr@nationalruralaco.com.

**Aetna and UChicago Medicine Launch Oncology Medical Home**

Aetna Inc.’s latest value-based care arrangement is an oncology medical home with the University of Chicago Medicine that started July 1. As the insurer continues its transition from a fee-for-service approach, the groups hope to impact increasing health care costs, inefficient care and redundant services.

The model will automatically be in effect for Aetna members treated at UChicago Medicine, with an initial focus on three cancers: breast, lung and colon. However, Michael Kolodziej, M.D., Aetna’s national medical director for oncology solutions, notes that “the analytics have been built to accommodate all cancer types. The challenge is that for rare tumors it is tough to analyze the data. But we will be expanding the cancers we look at in the program.”

The major support that Aetna provides UChicago Medicine is data, says Kolodziej. “We have built an analytic tool that allows us to provide a snapshot of cancer...
care as viewed by the payer...We can focus on a specific cancer type, specific areas of resource utilization, and then, in collaboration with the team at the University of Chicago, look at the specific opportunities for improving care.”

According to Walter Stadler, M.D., professor of surgery and medicine and chief of the section of hematology/oncology at UChicago Medicine, “We’ll be working with Aetna as we analyze our treatment trends and try to learn where we can improve. For example, we already have very good data regarding hospitalizations and ER visits at the University of Chicago. But we often don’t know when our patients show up at outside institutions. Now, with data from Aetna, we will have complete information on these patients.”

Clinical Pathways Are Used

“Our physicians and nurses who have expertise in these cancers devote their practice and academic pursuits to these diseases,” explains Stadler. In creating clinical pathways, “they provided their assessment of the current highest standard of care, including the incorporation of clinical trials.”

“We believe compliance with evidence-based pathways is a critical component of success,” maintains Kolodziej. “In our relationships with community oncologists, we require use of a pathways tool, though we do not dictate a specific tool.”

But in Aetna’s arrangements with academic centers, “where there is clinical expertise, we will accept the pathways developed by the institution,” he says. “However, these must meet two important characteristics: (1) There must be a process for evidence evaluation, and presentation of this evidence to doctors at point of care, and (2) there must be measurement and reporting. Accordingly, we strongly encourage all partners (academic or otherwise) to take a close look at the pathways programs that are out there.”

Kolodziej acknowledges that “building and maintaining pathways is a lot of work. Since most of our practices have not used pathways in a rigorous fashion, we anticipate there will be a learning curve. Our agreements do not set an absolute performance threshold; rather, they require improvement over time with a goal of 80% compliance.”

Although Aetna does not have a specific return on investment expected with this program, Kolodziej tells VBC that the insurer does have multiple goals: “First, we want to reduce unnecessary ER and inpatient stays. Second, we want to improve end-of-life care. Third, we want to identify and broadcast best practices. Fourth, and perhaps most importantly, we want to build a collaborative relationship with some of the best academic medical centers in the country around defining the value they bring to the health care system and to Aetna members. We have a devoted team including contracting and analytical support. Aetna is transforming the health care system by moving away from ineffective models to one that supports value and places the patient at the center of care. Our efforts have been enthusiastically supported by Aetna leadership.”

Out of the approximately 23.7 million medical members that Aetna serves, about 5.8 million “receive care from doctors committed to the value-based approach, with approximately 30 percent of Aetna claims payments going to doctors and providers who practice value-based care,” says the insurer. “Aetna has committed to increasing that number to 50 percent by 2018 and 75 percent by 2020.”

Aetna Has Similar Arrangements

The partnership is not the first oncology medical home arrangement into which Aetna has entered. For instance, since 2013 it has worked with Pennsylvania’s Consultants in Medical Oncology and Hematology, PC, which was the first oncology practice that the National Committee for Quality Assurance (NCQA) recognized as a level III patient-centered medical home. And in April Aetna said it had launched an oncology medical home in February with Moffitt Cancer Center in Florida.

According to Kolodziej, Aetna “has been working on an advanced care delivery model, the oncology medical home, for the last three years. Most of the work has been with community oncology practices. Last year, Moffitt Cancer Center in Florida approached us. They had started some work with another payer and were looking for a multipayer model, and we were able to adapt the oncology medical home model so that we could take advantage of their capabilities as a comprehensive cancer center. We have continued to refine this cancer center adapted model and have been looking for other interested partners. The University of Chicago was identified by the local Aetna market as a good potential partner. After some early discussions, we found our views on oncology care...
Deals May Hasten Value-Based Shift
continued from p. 1

Both deals are likely to accelerate a move to value-based care, Gupte says. In a combined Aetna/Humana, “we can expect to see the shared savings contracting models in Medicare and the risk sharing and capitated contracting in Medicare Advantage begin to spill over into the commercial market.”

Meanwhile, in a merged Anthem/Cigna, “we could also see the deal catalyze a further move to value-based care. Cigna has a Medicare Advantage book with [subsidiary] HealthSpring that has been a leader in value-based contracting, and these approaches are likely to penetrate the rest of the book, across Cigna and Anthem, with the local market concentration of Anthem offering more leverage with providers during contracting,” Gupte says.

Aetna agreed July 3 to purchase Humana for $37 billion in cash and stock in a deal that analysts viewed as synergistic: Aetna is primarily a commercial insurer, while Humana is a leader in Medicare Advantage.

For Aetna and Humana, “I view it as two different service lines coming together,” says David Muhlestein, senior director of research and development at Leavitt Partners LLC. “Aetna has not been in the Medicare Advantage space, and Humana has not been in the commercial space.”

Meanwhile, Anthem’s July 24 deal to buy Cigna for $54.2 billion would create the largest health insurance entity nationally, surpassing UnitedHealthcare. The new entity also would gain a presence on the health insurance exchange markets, where Anthem and Cigna now compete in five states.

Anthem and Cigna don’t seem to have much overlap in value-based contracts, Muhlestein tells VBC. “Broadly, it will further the movement toward value — it’s part of the business strategy to move to value-based contracts.”

The deal would broaden Anthem’s footprint in Medicare and large-group accounts, and also provide

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<th>Reported Covered Lives Under Value-Based Contracts (in thousands)</th>
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SOURCE: Chart compiled by VBC from data provided by companies and Leavitt Partners LLC.
more pharmacy benefit management options given Cigna’s significant membership base, says Oppenheimer & Co Inc. analyst Matt Nirenberg.

“Both managed care organizations serve a diverse population of individuals and groups,” adds Stifel analyst Thomas Carroll. “Anthem’s Medicaid book and Cigna’s unique Medicare Advantage book would make clear complements, while synergies would almost certainly be sourced from both firms’ expansive commercial books.”

Muhlestein says he believes consolidation in the health insurance industry will both strengthen the payers’ push to value-based care and help providers by giving them more patients to manage under population health models. “From the ACO side, I think there will be more overlap as to how to approach the different populations,” he says. “This will be helpful to the ACOs. It also gives them scale. In markets where they both have plans, there’s the opportunity to move a lot of lives.”

Commercial payers generally work very closely with their ACO provider organizations, and each one of these contracts looks a little different, Muhlestein says. Therefore, increasing the number of lives covered by an individual value-based contract can help both the insurer and the provider group, he says.

“For the ACOs, I think overall it’s a good thing,” he says. “It allows people to start putting all the patients in the same contract.” However, none of this may happen quickly, he adds. “The reality is, it’s going to take a long time to figure out how to merge the ACO operations. It’s not a year one priority.” The insurers will need to work through the individual states to see what operations they can merge and what they can’t merge, Muhlestein notes.

Ultimately, payers could offer providers one value-based contract that covers multiple lines of business, including Medicare and commercial lives, Muhlestein says. However, the insurers would need to determine how that would work between the separate service lines of commercial and Medicare Advantage, and such contracts could run afoul of insurance regulations.

These two mergers — which would increase the market shares of insurers that have been strong proponents of the move toward value-based reimbursement — also could encourage providers who have been on the fence about value-based transformation, he says.

Still, there are plenty of questions remaining, he says. “Does the ACO become the standard model for population-based payment? Do we continue to work under the shared savings model, or do payers start to move more aggressively toward capitation? There’s an increasingly broad consensus on moving toward value, but it’s not clear what exactly that looks like.”

Of course, Nirenberg points out that the more immediate question is “whether or not regulators will be comfortable with the move from five to three large diversified [insurance] players.”

Contact Muhlestein via Leavitt spokesperson Jordan Choucair at jordana.choucair@leavittpartners.com, Gupta at ana.gupte@leerink.com, Nirenberg at (212) 667-6143, and Carroll at (443) 224-1310. 

### NEWS BRIEFS

**UnitedHealthcare on July 20 said it made more than $54 million in bonus payments to more than 4,000 care providers serving Medicare Advantage beneficiaries.** The physicians were named winners of the insurer’s PATH Excellence in Patient Service Awards by reaching “the highest adherence levels for key quality measures” for UnitedHealthcare Medicare Advantage members. The PATH program includes 17 Healthcare Effectiveness Data and Information Set (HEDIS) measures, including cancer screenings and medication adherence. Through the program, UnitedHealthcare said it provides support and incentives for both providers and members to improve engagement. There are four components: patient support and communication, actionable patient data and reporting, financial compensation for doctors, and practice-based support. The insurer said that in the last three years, it has tripled total payments to providers that are tied to value-based arrangements, to $38 billion. Visit http://tinyurl.com/nbhd1fc.

**Three New Jersey Medicaid accountable care organizations will participate in a three-year demonstration project in the state that will test ACOs as an alternative or even as an adjunct to managed care organizations.** The demonstration involves upside risk only and will pay the participating ACOs — Camden Coalition of Healthcare Providers, Healthy Greater Newark ACO and Trenton Health Team — any shared savings. Gainsharing plans are due from each ACO by June 30, 2016, and, once approved, payments will be distributed by the state Medicaid program according to those plans. Contact New Jersey Department of Human Services spokesperson Nicole Brossoie at nicole.brossoie@dhs.state.nj.us.
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