Larger Share of MSSP ACOs Earn Payouts For 2015 Program Year; Half Break Even

Almost one-third of Medicare Shared Savings Program accountable care organizations — 119 ACOs — earned shared savings payments for the third performance year of the MSSP program, according to CMS data released Aug. 25.

The results indicate improvements for ACO performance and payouts from the first two years of the program, when a smaller percentage of ACOs qualified for shared savings (VBC 9/15, p. 1).

However, numerous ACOs still fell short of earning shared savings: 38 ACOs reduced health care costs when compared to their benchmarks, yet didn’t meet the minimum savings threshold set by CMS and therefore didn’t earn shared savings. Another 189 ACOs — nearly half the total — broke even or lost money compared to their benchmarks.

“The National Association of ACOs was disappointed not to find stronger financial results that reflect the extensive financial and personal contributions invested by ACOs,” says NAACOS President and CEO Clif Gaus. “The results are not as strong as we, and many of our ACO members, had hoped for. But overall we are pleased to see the results show a positive trend for the program.”

Gaus points out that the MSSP program is in only its fourth performance year, and that ACOs have accomplished a lot in a short time to improve quality and reduce costs. ACOs with more experience in the program were more likely to earn shared savings in continued on p. 10

Support Is Strong, Stakes Are Modest for Value-Based Pay in Presidential Election

Although the Nov. 8 presidential election holds high stakes and a stark choice for the country, its results are unlikely to stop the momentum of value-based payment reforms, which have strong bipartisan support, analysts and stakeholders say.

But even if it wouldn’t derail value-based reforms spurred by the Affordable Care Act (ACA) and the 2016 Medicare Access and CHIP Reauthorization Act (MACRA), a victory by GOP presidential nominee Donald Trump could slow them down.

A win by Democratic presidential nominee Hillary Clinton, meanwhile, would mean a win for supporters of value-based payment, observers say. “Clinton has clearly indicated a commitment to value-based payment, but it’s hard to know what Trump would do,” says Clif Gaus, CEO of the National Association of ACOs (NAACOS).

“If Clinton wins, it will be ‘hold the course,’” adds Leavitt Partners LLC Director of Research David Muhlestein. “She’ll generally continue the Affordable Care Act, with value-based payment and ACOs and the like.”

Clinton’s biggest push on health care may come in the form of expanding Medicare as a buy-in option to those who are just short of retirement age — perhaps those 55 and older. “This could be more incentive [for providers] to participate in the Medicare Shared Savings Program, since more lives could go in there,” Muhlestein
says. Such a major Medicare expansion also could include a mandate for more value-based contracts, he says.

If Congress approves a Medicare buy-in program, NAACOS will push hard for an option for those who are not eligible to join Medicare Advantage plans to instead be able to select an ACO in their area, Gaus says. This would involve “financial incentives to reward in-network care but not a hard lock-in like Medicare Advantage,” he adds.

It’s also possible — but quite unlikely — that Clinton would be able to win approval for a public health insurance option for all ages, Muhlestein says. But, he adds, “a high risk pool is the most likely.”

Clinton “is a known commodity — we’ve obviously been hearing about her for years,” Muhlestein says. However, much of what she might be able to accomplish on health care (and on other issues) will depend on the composition of Congress, both beginning in 2017 and in 2019, after the mid-term election, he says. Even if the Democrats take back the U.S. Senate this year, they’re unlikely to hold it in 2018, when the electoral math favors the GOP.

Since Congress probably still will be divided following the election, it’s unlikely that lawmakers will pass any major reforms, Muhlestein says. Instead, any health care legislation passed will be tinkering on the margins, and could include elimination of the “Cadillac tax” on high-cost health insurance benefits and possibly some modifications of the health insurance exchanges, he says.

Blair Childs, senior vice president of public affairs at advocacy group Premier Inc., agrees that a split Congress will yield little in the way of significant health care legislation. “Health care changes will be through administrative authority, but there is little will to alter the policies around accountable, value-based care,” he says.

However, administrative action through CMS will continue going strong under a Clinton administration, regardless of which party holds Congress, he says. “Under a Democratic administration, aggressive Medicare payment reforms through administrative action and a continued shift in incentives to drive provider accountability for cost and quality of care will continue to move ahead quickly.”

**NAACOS Warns Against Layered Programs**

Regardless of whether it’s a Trump or Clinton administration, Gaus says NAACOS will push hard for the new White House “to more clearly commit to population-based, value-based payment models, and not layer on top of the current ACOs the myriad of other carve-out initiatives like bundled payment.”

“The overlap payment policies are undermining the continuity of care and damaging the business model by eliminating opportunities for savings,” Gaus says. “Imagine a world where all DRGs are in bundles and their finances are carved out of the ACO’s finances — ACOs are left with finding savings on preventive care and primary care. What kind of quality and cost outcomes will that produce?”

Even if the Republicans sweep Congress and the presidency, that won’t put the brakes on payment reforms already set into motion by the ACA and MACRA, Childs says, “due to financial pressure to reduce spending, bipartisan support for the reforms, and the fact that these ideas originated with the Republicans.”

Still, the health care policy priorities that might be found in a Trump administration are much less clearly defined. Trump has campaigned on a health care platform of repealing the Affordable Care Act, turning Medicaid into a block grant program, allowing insurers to market health policies across state lines and augmenting health savings accounts. But he hasn’t said anything about value-based care.

Muhlestein notes that Trump has shown little interest in health care policy. Although Trump repeatedly has vowed to ask Congress to repeal the ACA on day one of his administration, “he’s not campaigning on health care reform,” Muhlestein says.
Since “there’s going to be a limit on what Trump can do, as Congress isn’t going to repeal Obamacare,” Trump might then lose even more interest in health care, Muhlestein says.

Therefore, Trump might be inclined to provide significant latitude to his Health and Human Services secretary on health care policy issues, Muhlestein says, which makes the choice of that person critical to the value-based care programs that the Trump administration will inherit.

“The Trump campaign has been very clear about their desire to bring in as many outsiders as possible to the cabinet,” Childs adds. “But specific names have not been floated. It’s likely that [GOP vice presidential nominee and Indiana Gov.] Mike Pence will play a key role in advising on this selection, given that HHS in years past has traditionally been run by a governor.”

If the new HHS secretary “doesn’t understand health care and what’s happening, we could see an additional slowdown” in the pace of reform, Muhlestein says. “The goal of 50% payments in risk by 2018 — it would be really easy for the secretary not to focus on that.”

Childs agrees that a slowdown could occur under a Trump administration. “Under Trump, there will continue to be momentum, but at a slower pace as Republicans try to rally around a consensus policy for health care overall,” he says. “Under a divided government scenario, very little will be changed due to the political realities.”

Nonetheless, MACRA will continue to drive value-based payment adoption, even if the Trump administration doesn’t support the same types of reforms.

“There is bipartisan support to move away from fee-for-service and toward value-based care,” says Childs. “MACRA illustrates this reality, as well as the fact that Republicans started the changes that led to pay for performance, ACOs and bundled payment. There is no question that the vigor around change will be greater for Democrats to make the traditional Medicare program more competitive with Medicare Advantage plans, but both parties will work to implement these reforms, given the fiscal and health care quality needs.”

Still, “this is a different election than we’ve had in the past,” Muhlestein says. “It’s the epitome of the establishment against the anti-establishment. We know what the establishment’s going to do, but we don’t know what the anti-establishment is going to do. What do you do with an entire program you can’t repeal?”

There are some signs that CMS is well aware of the potential for an election-induced slowdown or pause in the rollout of programs, as it works to move as many initiatives as possible from the drawing board to the implementation stage by Inauguration Day on Jan. 20.

In the last three months alone, CMS has unveiled its new cardiac care and orthopedic bundled payment programs (VBC 8/16, p. 1), announced a new round of applications for its end-stage renal disease ACO program (VBC 7/16, p. 6), and launched its oncology value-based care program (VBC 8/16, p. 4).

In fact, when unveiling the cardiac care and orthopedic bundled payment programs at a briefing for reporters on July 25, CMS Deputy Administrator for Innovation

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- How can insurers offer “alliances for value” in their ecosystem?
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- Why are products without a primary care focus doomed to high costs?
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and Quality & Chief Medical Officer Patrick Conway, M.D., was asked whether the agency was moving quickly on various initiatives in order to make sure they are finalized before the November elections and January change of administration.

While Conway said the agency’s swift actions could be attributed to strong results in the programs that already are up and running, he acknowledged that he had taken time off from his July vacation to make this latest announcement.

“We think this is a huge opportunity for delivering system reform and improving care for patients,” he said. “We’ll move forward expeditiously.”

Contact Muhlestein via Leavitt spokesperson Jordana Choucair at jordana.choucair@leavittpartners.com, Childs via Premier spokesperson Amanda Forster at amanda_forster@premierinc.com or Gaus at (202) 640-1898.

CMS Chooses Regions, Payers for CPC+ Program Launching in 2017

CMS has chosen the 14 regions in which it will implement the public-private Comprehensive Primary Care Plus (CPC+) initiative and has provisionally selected 57 private insurers to participate as additional payers alongside CMS (see chart, p. 5).

Primary care practices in the chosen regions have until Sept. 15 to apply to participate in the program. The five-year program, in which CMS hopes to include up to 5,000 practices, will launch in January.

The CPC+ program was announced in April to build on its predecessor program, the Comprehensive Primary Care initiative (VBC 5/16, p. 1).

According to CMS, the CPC+ regions were selected based on payer alignment and market density to ensure that participating practices will have sufficient payer

PCMHs Meet Key Chronic Pain Management Goals More Often

Medical practices that are certified as patient-centered medical homes (PCMHs) may be better at managing chronic pain patients than other practices, a study finds.

The study, published in the Journal of the American Board of Family Medicine, found that key recommendations for chronic pain management were documented more often at PCMH practices, possibly indicating better overall management of chronic pain. Still, even PCMH practices show significant gaps in documentation of key aspects of care for chronic pain patients, the study found. These include “using structured instruments to assess pain, function, depression, and opioid risk.” The authors added, “multiple barriers still exist in the implementation of optimal pain management.”

The majority of patients with chronic pain receive care at primary care practices, the authors wrote. “However, the management of these patients is often considered onerous and burdensome for physicians and practice staff.”

Since PCMHs have resulted in improved adherence to care guidelines for common chronic conditions, it’s not unreasonable to think they might help in chronic care management, as well, the authors wrote. The PCMH chronic pain study included 485 charts from 65 clinicians at 12 practices. The practices were divided into non-PCMHs, PCMHs and those applying for PCMH recognition.

A total of 93% of the patients included in the study had musculoskeletal pain, including low back and joint pain, while 23% had neuropathy and 21% had chronic headaches (most in the study had two or more types of chronic pain).

The study tracked 10 recommendations for the management of chronic pain at the primary care level. “Without exception, those practices with PCMH recognition or applying for recognition documented these recommendations more often, most at a statistically significant level,” the study found. “For many assessments, including pain severity and functional disability, the practices that were in the process of applying for PCMH recognition performed the best.”

Some insurers, including Blue Shield of California, are hoping that better chronic pain management provided by accountable care organizations and patient-centered medical homes can help them curb the opioid epidemic.

In this study, 58% of patients had been prescribed chronic opioids, but there was no statistical difference in opioid use between the PCMH, non-PCMH and PCMH applicant practices, the study found. The cohort of practices now in the process of obtaining PCMH recognition achieved the best scores for every item.

View the study at http://www.jabfm.org/content/29/4/474.
Children’s National Shows PCMH Model Works in Academic Setting

Children’s National Health System realized it might encounter some roadblocks as it implemented medical homes — as an academic medical center, its systems had been set up in silos for the benefit of the faculty, residents, nurses and administration, not for patients and their families.

Despite these obstacles, Children’s National’s patient-centered medical homes (PCMHs) are increasing utilization of primary care while simultaneously cutting emergency department visits.

Overall, patient surveys and interviews indicate that more than 95% would recommend care at the Washington, D.C.-based health system. “This tells us we’re moving in the right direction, but we still have some work to do,” said Mark Weissman, M.D., chief of general pediatrics and community health at Children’s National.

“The medical home model can be implemented successfully in academic settings,” Weissman told attendees at the Medical Home Summit held recently in Washington, D.C., sponsored by Global Health Care, LLC.

Washington has a population of 650,000, including around 111,000 children. Some 27% of those children live in poverty, and 42% live in households that lack secure employment. Children’s National is the largest primary support to make fundamental changes in their delivery of primary care.

The initiative will involve two tracks for primary care practices:

♦ **In Track 1**, CMS will pay practices a monthly care management fee in addition to the fee-for-service payments the practice receives.

♦ **In Track 2**, practices also will receive a monthly care management fee. But instead of full Medicare fee-for-service payments, they will earn “hybrid” reimbursement of reduced Medicare fee-for-service payments and up-front comprehensive primary care payments for services, CMS says.

Payer partners include numerous regional Blues plans, smaller local insurers, state Medicaid programs and large national insurers. UnitedHealthcare, Amerigroup New Jersey, Arkansas Blue Cross and Blue Shield, Horizon Blue Cross Blue Shield of New Jersey, Anthem, Inc., Molina Healthcare, Inc., and the Tennessee and Oregon Medicaid programs all will participate, according to CMS.

The payer partners will provide their own financial support to the participating practices, separate from that provided by CMS.


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**CPC+ Participating Regions and Provisional Payer Partners**

[Map of participating regions with regions marked by different symbols indicating whether they span the entire state or a contiguous counties]

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AIS’s Value-Based Care News September 2016

The leading children’s specialty care center in the region.
“We take care of almost half of the kids in the District, and we’re growing,” Weissman said. “We are a medical home to D.C.’s most vulnerable kids.”

The system operates seven primary care health centers on its main campus and in underserved neighborhoods across D.C., along with a mobile health program. All are recognized as NCQA Level 3 PCMHs, and Children’s National has almost 40,000 attributed patients with 100,000 annual visits.

Children’s National built its primary care health centers in the regions of the city where emergency department visits were highest, which corresponded with where poverty was highest and in part with where primary care access was lowest, Weissman said.

Medicaid payments in D.C. don’t support care transformation activities, he added — there aren’t state or payer incentives for PCMH activities, nor are there any subsidies to help cover NCQA certification activities. Some 85% to 90% of the health center’s patients are Medicaid patients enrolled in Medicaid managed care organizations.

The challenge, Weissman said, was establishing continuity in a mixed staffing model with intermittently present faculty and residents. The answer was to focus on care teams, pods, and team-based care.

Smaller practice sites and teams can establish continuity more easily, while larger sites with rotating providers and residents have a greater challenge defining and documenting continuity, he said. This thought process resulted in “breaking our large, messy clinic into smaller, accountable pods,” he said.

Children’s National’s small practice teams have 5,000 to 6,000 attributed patients each, with three to four providers, he said. Residents also participate in care.

To address programs and services that go beyond medical care, “we have built dozens of wrap-around programs that go beyond our medical home,” Weissman said. These include legal assistance for health, housing and education; literacy programs; behavioral health; and specialty clinics for obesity, asthma and pediatric dentistry, he said.

Children’s National also has an abuse and neglect protection center, complex care coordination, parent navigators, an HIV services program, a youth pride program.

Wellmark Saved $35 Million With ACO Program in 2015

Wellmark Blue Cross Blue Shield’s accountable care organizations achieved savings of $35 million in 2015, or almost $200 per member, and improved its overall quality scores by more than 4%, the insurer says.

The ACOs achieved savings by reducing hospital readmissions by more than 22%, inpatient admissions by almost 8%, and emergency department visits by nearly 4%, according to Wellmark.

A total of 13 provider organizations have formed ACOs with Wellmark, and are accountable for more than 179,000 fully insured Wellmark members. Wellmark’s ACOs accept both upside and downside risk for cost and quality outcomes.

In addition to the ACO-related cost savings recorded for 2015, the ACOs also improved quality of care, increasing preventive care services for participating members, the insurer reports.

Among the results:
- 13,254 additional members visited a primary care physician in 2015, for a 4% increase;
- 995 more women received mammograms, for a 2% increase;
- 763 additional children had well child visits, for a 6% increase; and
- 243 additional members were screened for colon cancer, for a 2% increase.

In addition, many of the providers improved their continuity of care score. This score measures Wellmark members’ experience navigating the health care system, and includes elements such as: coordinating and scheduling multiple appointments with various health care providers; ensuring proper health information was shared; and following up with the member by answering questions and providing reminders.

The 13 health systems included in the 2015 ACO data include: Family Healthcare of Siouxland, Genesis Health Systems, Great River Health System, McFarland Clinic, Mercy Iowa City, Mercy Medical Center-Des Moines, Mercy Medical Center-Mason City, Nebraska Methodist Jennie Edmundson Hospital, Pella Regional Health Center, The Iowa Clinic, UnityPoint Health, Wheaton Franciscan Healthcare, and a collaboration between Mercy Medical Center-Cedar Rapids and University of Iowa Hospitals and Clinics.

The insurer says it will expand its ACO program to self-funded customers in 2017.
for the LGBTQ community, and a “healthy generations” program for teen parents and infants, he said. All these programs are supported primarily through grants and philanthropy, he said, adding that “the faculty are really good at writing grants.”

Parent navigators provide peer-to-peer guidance and support for families of medically complex children both in the organization’s primary care medical homes and in the Complex Care Program, Weissman said. These navigators, who are active members of the medical home practice redesign and management teams, are employees of the medical center and are partially supported by state grant money, he added.

The team also is supported by a wide variety of community health services, including social work, health education, care coordination, and other community services, he said. An “advanced health management center” provides appointment scheduling, triage/advice, refills, results, outreach and reminders, care coordination, patient education and disease management.

**PCMHs Focus on Integrating Behavioral Care**

Integrating mental health services into the primary care medical home is a particular concern, given that one in five children has a mental health issue in childhood, he said.

Therefore, Children’s National is co-locating psychiatry and psychology into all primary care settings, and is training and coaching all pediatric providers citywide on mental health screening, initial evaluation and referral, and management of common behavioral health concerns, he said. Since the start of the mental health initiative, screening rates for mental health concerns have jumped, he said.

To tackle emergency department overutilization, Children’s National first negotiated enhanced payments and incentives from contracting Medicaid managed care organizations so that it could extend its hours, Weissman said.

Then it implemented extended hours — evenings and Saturdays — at its primary care health centers, and offered scheduled appointments in extended hours for all visit types, including acute illness, well-child care, follow-up and chronic disease management, influenza vaccination and routine immunizations, he said.

The organization advertised these extended hours at bus stops throughout the parts of D.C. where patients are likely to live, Weissman said.

Finally, the medical center is reimagining patient engagement for a tech-savvy world, he said. It uses texts to confirm appointments, he said. In addition, “we mine records to find every kid who had an ED visit for asthma,” and texts specific health reminders to those patients in an attempt to avert a repeat ED visit, he said.

Quality improvement expertise and infrastructure are embedded in the academic faculty division, and Children’s National prioritizes quality improvement, with transparent benchmarking and dashboards for all centers and providers, he said.

“We established a robust survey process with exit interviews for families for ongoing family feedback,” Weissman said. Children’s National has collected more than 10,000 surveys within the past five years, and “we’ve used the results to help drive change.”

The results have shown definitively where there’s room for improvement, he said. For example, only 19% of families said that their access to timely appointments for injuries or sickness was “great,” and only 28% rated access “good.” In addition, only one-third said their ability to obtain medical advice when the office was closed was “great.” These results led the health system to add extended hours and centralized advice nurses, Weissman said.

In addition, patient complaints about long waits in the waiting room and exam room for routine care such as immunizations led to a redesign of the pod teams and the addition of medical assistants and registered nurses who could provide some of those services, he said.

One way to establish care continuity was to allow families themselves to decide who was their primary care physician, he said.

The medical home effort is seeing some early success. In its first two years of its drive to decrease emergency department utilization and increase medical home utilization, primary care visits increased by 10% and overall emergency department utilization for medical homes fell by 5%, Weissman said, even though “we still

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**Recent Health Plan ACO Arrangements, Collaborative Agreements**

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SOURCE: Compiled by AIS from health plan press releases in August 2016.
have way too many kids coming to the ED for low acuity concerns.”

In addition, he said, improved care delivery can translate to improvements in the bottom line for academic medical centers. “We’re generating more volume and more revenue in this model now,” he said.

For more information, contact Weissman at mweissma@childrensnational.org.

**Medical Neighborhoods Are Next Step for Successful ACOs**

Health systems that have invested extensively in patient-centered medical homes (PCMHs) and accountable care organizations now are focusing on creating medical neighborhoods that can support and enhance their value-based care initiatives.

By partnering with specialists, skilled nursing facilities, hospice, home health and other local organizations, systems such as Atrius Health and Delaware Valley Accountable Care Organization say they are able to improve their success rates in value-based care.

Emily Brower, vice president for population health for Atrius Health, credited Atrius’ medical neighborhood strategy for helping the health system’s Pioneer ACO be successful. “ACOs really start with a medical home foundation and a group practice-based system,” Brower told attendees at the recent Medical Home Summit in Washington, D.C., sponsored by Global Health Care, LLC.

Ultimately, Atrius Health saved $36 million in the Pioneer program compared to its market, and was noted as one of three Pioneers accounting for 70% of savings in 2013, she said. That certainly wasn’t because Atrius spent less on primary care, she said: “We brought patients to primary care more, we spent more on primary care. The savings was all on post-acute and acute care.”

Non-profit Atrius Health, which has about $1.8 billion in annual revenue, provides care for 675,000 adult and pediatric patients in eastern Massachusetts. The health system includes 750 physicians in more than 35 specialties across 32 clinical sites. It also includes the VNA Care Network Foundation, which provides home health, palliative care and hospice, and private-duty nursing.

As part of its strategy to move from medical homes to a medical neighborhood, Atrius has sought to integrate local elder services, known as Aging Services Access Points, or ASAPs, Brower said.

◆ **Phase 1** of this strategy involved direct communication between primary care practices and ASAPs via secure email.

◆ **Phase 2** involved enhanced care coordination and communication between the practice social worker and the ASAP to “close the loop” on services provided.

◆ **Phase 3** involved an ASAP-provided social worker embedded and integrated into the care team.

Early data from this strategy shows “directionally lower costs” and reduced utilization of unnecessary care, including hospital admissions, emergency department visits and skilled nursing facility days, she said. The care plans also indicate provider awareness of ASAP services.

Patient satisfaction surveys have shown this strategy also provides enhanced support for caregivers and families, plus enhanced access to ASAPs, Brower said. “There’s the potential for improved health outcomes through programs and services that assist patients in managing their health.”

Atrius also is collaborating with home health visiting nurse associations as part of this overall “medical neighborhood” strategy, Brower said. The percentage of patients referred to the preferred visiting nurse association has risen steadily, although far more patients in Atrius’ Medicare Advantage plan were referred to the preferred organization than were patients in its Pioneer ACO.

The same type of phenomenon occurs with skilled nursing facilities, where the average length of stay fell both for Medicare Advantage and Pioneer patients, but was still higher for Pioneer fee-for-service patients than in Medicare Advantage, she said.

Nonetheless, developing expectations and tools to manage skilled nursing facility utilization has led to overall decreases in the length of stay and the readmission rate for all patients, she said. These expectations focused both on facilities and on providers, and included a discharge workflow, electronic medical record documentation, and monitoring and reporting requirements, she said. “We tie it back to the medical neighborhood.”

**Atrius Targets Specialists**

“The specialists still think a visit is just a visit,” said Brower. “We’ve helped them to think of an episode of care” instead of viewing visits as discrete events.

To engage specialists, Atrius asked some of them to help the health system build clinical guidelines, such as those in place for chronic obstructive pulmonary disease, Brower said. “We’re looking within our walls to see who’s doing a really good job — using peer pressure to race to the top. We don’t have financial incentives.”

Atrius also developed a list of attributes for preferred specialists, which included standards for communications and turnaround time, and used these to determine which specialists were “preferred,” Brower said.
The health system has developed a sophisticated quality and performance measure system, and its quality scores were ranked No. 1 in New England and No. 3 nationwide for Medicare Pioneer ACOs in 2014.

“We have 80% of our revenue in global payment,” Brower said. “That does make it easier for us to do population health and to reap the return on care outside the medical home with the work we do inside the medical home.”

The system also features widespread population health management, including disease-based and risk-based rosters and population managers. And its corporate data warehouse integrates single platform electronic health record data with multi-payer claims data.

However, Brower said the real key to Atrius’ success is its patient-centered medical homes. All primary care practices are National Committee on Quality Assurance (NCQA) Level 3 PCMHs, and that’s “really the foundation of a lot of our work,” she said.

**Patients Are Divided Into Four Risk Groups**

Atrius uses a patient risk stratification tool that incorporates data from both claims and electronic health record databases and was built using off-the-shelf components, Brower said. This tool allows care managers to identify members at risk of hospitalization, poor health outcomes and high costs, she said.

According to Atrius’ patient risk stratification tool, about 2% of patients in the medical home need advanced illness management, while another 3% are high-risk poly-chronic and also require ongoing management. The next 15% are “rising risk” chronic care patients, while the remaining 80% require risk prevention and risk reduction, she said.

The top 20% of patients account for 60% of costs, Brower added.

Atrius addresses risk with high-risk roster review, advance care planning, post-acute episode management and integrated community support, Brower said. “We still have work to do,” she added, specifically in the areas of care transitions and palliative/hospice care, which are scheduled for redesigns this year.

Advance care planning initiatives have been important to Atrius’ care management strategy, Brower said, since “one of the things that risk stratification did was it highly predicted patients who were going to die.” Because of this, the health system:

- Developed new tools in the Epic electronic medical record system to track and document advance care planning across settings.

Atrius expects to use these tools to increase end-of-life conversations and collection of patients’ care wishes, advance directives and proxy information, Brower said. In addition, the tools should minimize use of aggressive curative care when it’s not aligned with a patient’s care wishes, she said.

Since these measures were put in place in the second quarter of 2013, the number of advanced care planning documents scanned in Epic has risen from less than 15,000 to well more than 50,000, Brower said.

**DVACO Builds ‘Super ACO’**

Delaware Valley Accountable Care Organization in Radnor, Pa., also is attempting to build a medical neighborhood, said Katherine Schneider, M.D., president and CEO of DVACO, which has 107,000 attributed MSSP beneficiaries and about 90,000 commercial ACO members.

Schneider characterized it as a “super ACO”: a joint venture of multiple health systems, including Main Line Health, Thomas Jefferson University Hospitals, Holy Redeemer Health System, Doylestown Health, and Magee Rehabilitation. “We’re not the typical hospital-sponsored ACO, and half of our primary care physicians are independent,” she said. Physicians in the ACO include “solo practitioners out in far-exurban areas to 700 physicians at area medical centers,” she added.

The ACO was formed three years ago as a small joint venture, but is “growing in leaps and bounds. This model is taking off, and we made money in our first year of MSSP,” Schneider said. The ACO saved $13.4 million overall in 2014, its first year in the program, and earned a shared savings payout of $6.57 million (VBC 10/15, p. 4).

The ACO’s “key opportunities” likely sound familiar to anyone in the industry, Schneider said. They include post-acute care, which has been “a giant black hole in our market.” DVACO’s spending on skilled nursing facilities has been 70% above average, and although some of that is due to risk, not all of it is risk-related, she said.

In an effort to partner with other local health care entities, the ACO has sought to be notified by other providers involved whenever an attributed patient visits the emergency department, is admitted to the hospital, or...
enters home health or a skilled nursing facility, she said, adding that this has helped considerably. “They’re not 100% onboard but it’s enough that we can really manage these,” she said. These event notifications, which are moving towards real-time notifications, are key to meeting 2016 goals, she added.

In addition, admissions to skilled nursing facilities need to be managed, she said. “Primary care doctors for the most part are completely out of the loop on skilled nursing.” Both utilization and length of stay at SNFs are very high, and there’s high variation between facilities, she added.

“When you talk about SNFs, it’s not just ‘which SNF?’ it’s ‘why SNF?’” she added.
nearly $37 million in shared savings for 2015. It earned more than $14 million for 2014 and more than $19 million for 2012-13.

Two newly formed ACOs — Cleveland Clinic Medicare ACO, LLC, and USMM Accountable Care Partners, LLC — earned spots on the 2015 top 25 list, as did two ACOs formed in 2014 — UT Southwestern Accountable Care Network in Texas and Orange Accountable Care of South Florida, LLC. But most of those ACOs earning top savings were formed in 2012 or 2013.

Quality scores continue to improve, CMS says. Overall, shared savings program ACOs that reported quality in both 2014 and 2015 improved on 84% of the quality measures that were reported in both years. The average quality performance improved by more than 15% between 2014 and 2015 for four measures:

<table>
<thead>
<tr>
<th>Medicare Shared Savings Program (MSSP) Accountable Care Organizations</th>
<th>States Where Beneficiaries Reside</th>
<th>Agreement Start Date</th>
<th>Track</th>
<th>Participate in Advance Payment/Investment Model?</th>
<th>Generated Savings in Performance Year 3</th>
<th>Earned Shared Savings in Performance Year 3</th>
<th>Generated Savings in Performance Year 2</th>
<th>Earned Shared Savings in Performance Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Hermann Accountable Care Organization</td>
<td>TX</td>
<td>7/1/2012</td>
<td>1</td>
<td>No</td>
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<td>Palm Beach Accountable Care Organization, LLC</td>
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<td>Advocate Physician Partners Accountable Care, Inc.</td>
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<td>$72,667,885</td>
<td>$33,537,591</td>
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<td>Millennium Accountable Care Organization, LLC</td>
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<td>Cleveland Clinic Medicare ACO, LLC</td>
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<td>UT Southwestern Accountable Care Network</td>
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<td>West Florida ACO, LLC</td>
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<td>Northern Maryland Collaborative Care LLC</td>
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<td>MyHealth First Network, LLC</td>
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<td>USMM Accountable Care Partners, LLC</td>
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<td>No</td>
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<td>$7,393,855</td>
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<td>Alicoare Options, LLC</td>
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<td>AnewCare Collaborative, LLC</td>
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<td>Physicians ACO</td>
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<td>Rio Grande Valley Health Alliance, LLC</td>
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</tbody>
</table>

NOTE: ACOs that started after 2013 did not generate results for Performance Year 2
SOURCE: Compiled by Atlantic Information Services, Inc., based on data supplied by CMS

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.
Screening for risk of future falls,
• Depression screening and follow-up,
• Blood pressure screening and follow-up, and
• Providing pneumonia vaccinations.

More than 91% of ACOs that were in their second or third performance year in 2015 increased their overall quality performance score.

CMS also reported on the fourth year of the Medicare Pioneer program, which dwindled to just 12 of the original 32 ACOs in the program. According to CMS, financial and quality results continue to be positive, with several Pioneer ACOs generating greater savings in the fourth performance year, and one ACO generating savings for the first time.

Overall, the 12 Pioneers generated total model savings of more than $37 million for performance year four of the program, according to CMS. Eight Pioneer ACOs generated savings, with six beating their benchmarks and sharing savings. Four ACOs, meanwhile, generated losses, and one ACO owed CMS shared losses. Year four of Pioneer marked the first use of re-based benchmarks and new benchmarking methodologies.

Quality scores for nine of the 12 Pioneer ACOs were above 90% in the fourth performance year, with scores ranging from 92.59% to 98.38%. All 12 Pioneers improved their quality scores from the first performance year to the fourth by more than 21 percentage points.


NEWS BRIEFS

Starting in 2018, Alabama, Michigan and Texas will join the Medicare Advantage Value-Based Insurance Design (VBID) pilot, CMS said on Aug. 10. Next year, the pilot will launch in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania and Tennessee. The agency will announce the health insurers taking part in the first year of the VBID model next month. VBID plans will offer supplemental benefits to cover chronic conditions like cardiac disease, diabetes and hypertension. As part of the 2018 expansion, the program will also give extra benefits for Medicare beneficiaries with rheumatoid arthritis and dementia. Visit http://tinyurl.com/hp2u2jk.

A bundled payment pilot conducted by the Pennsylvania Employees Benefit Trust Fund showed “cost savings, dramatic care process improvements and positive patient care evaluations,” PEBTF said Aug. 30. PEBTF provides benefits for 74,000 Pennsylvania public employees and 64,000 retirees. The study, conducted in 2015, reviewed total knee and total hip replacements for 73 patients. The Health Care Incentives Improvement Institute (HCII) assisted with the study and published a report on the findings. Outpatient costs for these patients fell by an average of $3,524. But although quality of inpatient care improved and length of hospital stays dropped, overall inpatient costs did not fall because the facility is reimbursed by the case, regardless of the length of stay. Visit http://tinyurl.com/zgthgk83.

Researchers developed a bundled payment model for breast cancer screening, publishing their findings on the Journal of the American College of Radiology website on Aug. 18. The bundle includes the mammography screen and related diagnostic breast imaging services for a year-long period. “Breast cancer screening may provide a mechanism to expand the use of bundled payments in radiology and could serve as a framework for other episodic specialty bundles,” the researchers explained. “Because screening bundles include costs for follow-up diagnostic imaging in addition to the initial screening mammographic examination, patient adherence to screening guidelines may improve, which may have profound effects on public health.” Visit http://tinyurl.com/zgthpvww.

Operating under the new Medicare cardiac bundled payment model, 85% of hospitals would see only a modest impact, finds a new analysis from Avalere Health LLC. But the remaining hospitals could see big gains or big losses. The program, which takes effect July 1, 2017, will reimburse providers a fixed amount for Medicare patients admitted for heart attacks and cardiac bypass surgery (VBC 7/16, p. 1). The payment covers all care from the initial hospital stay through 90 days post-discharge. Hospitals would be penalized if their spending exceeds the average in their region or rewarded if spending falls below the average. Avalere also found that for heart attack patients who are medically managed, only 35% of total spending is incurred during the inpatient stay, vs. 60% to 70% of spending for surgically managed patients. Almost 50% of spending on medical managed patients is linked to post-discharge care, Avalere said. Visit http://avalere.com.
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