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Senior Writer
Jane Anderson

Editor
Angela Maas

Executive Editor
Jill Brown

CMS Docked MSSP ACOs for Quality Lapses in Program's Second-Year Results

Only slightly more than one-quarter of Medicare Shared Savings Program accountable care organizations (ACOs) earned shared-savings payments totaling more than $341 million for the second performance year of the MSSP program, according to CMS data released Aug. 25. A similar percentage of MSSP ACOs received shared savings last year for their first performance year. But many ACOs lost a portion of earned shared savings because of their scores on quality measures, leading one observer to warn that CMS is "letting the perfect be the enemy of the good."

The payments earned this year will be much smaller on average than those won by successful ACOs in the program last year. And another quarter of the MSSP ACOs saved money for Medicare but will not share in any savings because they failed to beat their CMS-set benchmarks.

In total, the MSSP ACOs held spending $806 million below their benchmarks in 2014, and total net savings to Medicare was $465 million. There were no Track 2 ACOs, which accept two-sided risk, that owed CMS shared losses.

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Iora Health Expands Primary Care Deal With Humana, Enters Agreement With Tufts

A relatively new primary care company has expanded its agreement with one health plan and begun working with another. Building on a partnership that started last year, Iora Health and Humana Inc. are expanding their efforts, adding seven new practices to the four launched last year. And Tufts Health Plan recently unveiled a deal that will welcome two primary care practices this fall.

Iora doesn't accept fee-for-service payment *(VBC 7/15, p. 8)*. It partners with companies to create primary care practices aimed at serving specific communities. Moreover, it takes a care management approach that goes beyond traditional primary care and instead builds relationships with patients with an eye on helping them to change behaviors in order to improve their health. The company has health coaches who assist members with daily tasks to help them create a healthy lifestyle, focusing on overall wellness and population health management rather than simply therapy adherence.

Last year Iora opened two primary care practices in Phoenix and two in Seattle for Humana Medicare Advantage (MA) members. Then in July — the same month that Aetna Inc. said it would acquire Humana for $37 billion in a deal expected to close by the end of this year — Humana said it was working with Iora to open seven more practices for its MA members: three in Denver, one in Phoenix, one in Seattle and two in Tucson, Ariz. The plan selected these locations based on where its MA members were concentrated, explains Mark El-Tawil, West Division leader for Humana's Senior Products. "Additionally, we look at areas that are underserved or lack adequate access to primary care physicians. The goal is to provide our members with access to state-of-the-art health care with top physicians in an area close to their home."

continued

Iora's model appealed to Humana because the insurer "is dedicated to providing the best possible care to its members — in particular care that is truly coordinated and focused on managing chronic disease and illness, and promoting health and wellness," says El-Tawil. "What Iora does really well is focus on caring for a population of people. They are focused on getting close with the patient and helping patients navigate the health care system."

Humana was the first MA provider to partner with Iora on primary care practices, says El-Tawil. "Seniors are often managing chronic conditions and a number of medications and providers. It is easy to get lost, and Iora helps these seniors navigate care. Expanding the partnership to open additional primary care practices means we can offer even more seniors access to affordable, well-managed primary care that will result in better health outcomes."

Through its arrangement with Iora, the insurer "provides physicians with resources and technology to proactively improve health outcomes, patient engagement and care affordability," explains El-Tawil. "We provide a real-time health care analytic platform to help them manage their Humana Medicare Advantage patient population."

Humana, he says, "does not share in the operational costs to build out and/or operate these facilities." However, the insurer "does provide population health tools and provider development resources to support new primary care clinic development." In addition to assisting Iora in expanding its population health capabilities, Humana has helped with "deploying data, analytics and tools for" its MA members treated at Iora primary care facilities. Asked if the deals were for a certain period of time, El-Tawil says that Humana's "goal is a lasting partnership to engage both Iora Health and Humana to collaborate and improve the members' health."

A spokesperson for Iora Health said the company was not able to respond to *VBC* questions on the deals, including what its partners bring to the relationships.

El-Tawil says that "it's still too early in the relationship for measurable data [from the initial four locations]; however, we have already seen promising results on an individual member basis. Every day we hear success stories of patients whose lives are changing and benefiting from the care they are receiving at Iora."

In April Humana unveiled its goal to improve the health of members in the communities it serves 20% by 2020 "by making it easy for people to achieve their best health," says El-Tawil. "Partnerships like the one with Iora Health will help Humana be successful in achieving this goal." He tells *VBC* that the insurer has more than 900 accountable care relationships involving 45,500 providers and about 1.5 million MA and 200,000 commercial members. The plan has 56% of its MA members in some kind of value-based relationship, with a goal to increase that to 75% by 2017.

Tufts Deal Also Focuses on Seniors

In July, Tufts Health Plan became the second insurer to announce a deal with Iora focused on seniors. Iora is opening two primary care practices this fall in Boston that will serve Tufts' Medicare Preferred HMO and Senior Care Options members. "We hope to enroll 2,000 members at each practice location," says Sonya Hagopian, a spokesperson for the health plan. Tufts worked with Iora to select the locations, which were chosen "based on easy accessibility for the patients and the need for primary care physicians in these neighborhoods."

"Iora's model is very similar to ours and what we have been doing for the more than 20 years we have been serving Medicare members: working closely with providers in an integrated care management model which benefits the health of our members," explains Hagopian. Iora, she says, "share[s] our vision of meaningful payer/provider relationships and coordinating care on behalf of members."

According to Hagopian, "The Iora model is a great complement to our own and is particularly good for older adults, who often need to manage chronic condi-

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

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tions. Very often, older adults have multiple needs" including "complex issues that span medical, social and behavioral" care. "We feel it's a good match," she tells *VBC* of the partnership. She adds that "more than 90% of our contracts in our Medicare network are value-based arrangements."

Tufts has "made an investment to help open these [Iora primary care] practices," says Hagopian, although she does not offer details. In addition, "We will be sharing data we typically do with providers who care for our members." The plan does not provide specific terms of the deal, "but we've entered into a contract with Iora just as we would with other providers," she explains.

Contact El-Tawil through Marina Renneke at mrenneke@humana.com and Hagopian at Sonya_ Hagopian@tufts-health.com. ✧

NJ ACO Demo in Partial Limbo As Groups Await MCO Contracts

New Jersey has certified three Medicaid accountable care organizations charged with better managing care for beneficiaries in three cities. But two of the three new ACOs do not have a significant funding source for their population health management activities, casting doubt on how much they'll be able to actually accomplish.

The three-year ACO demonstration project, finalized in late June and launched on July 1, ultimately could provide shared savings payments from the state for the ACOs, which are:

- ***Camden Coalition of Healthcare Providers***
- ***Healthy Greater Newark ACO***
- ***Trenton Health Team***

The state has not specified any funding source for the care management initiatives expected to come from the nonprofit ACOs. Instead, it anticipates that the ACOs will negotiate that funding in the form of per-member per-month (PMPM) fees and other support with the for-profit Medicaid managed care organizations (MCOs) operating in their areas.

However, the Medicaid MCOs in New Jersey haven't immediately jumped on the ACO bandwagon, which leaves the ACOs with a dilemma: How can they impact care enough to earn shared savings without any mechanism to fund care interventions?

The two ACOs without MCO contracts remain optimistic that they'll ultimately negotiate deals. The payers "are all definitely coming to the table," Colleen Woods, interim executive director of the Healthy Greater Newark ACO, tells *VBC*. "We expect to contract with the ACOs."

However, ACOs stakeholders acknowledge that the MCOs, most of which are for-profit, can benefit from Medicaid ACO activities without paying those ACOs or agreeing to share savings with them.

The New Jersey Department of Human Services, which administers the Medicaid program, is encouraging — but not requiring — the MCOs, which cover 90% of Medicaid beneficiaries in the state, to contract with the ACOs. Meanwhile, the state itself will not pay the ACOs anything for their activities, says New Jersey Department of Human Services spokesperson Nicole Brossoie.

But only one ACO — the Camden Coalition — currently has such contracts, both of which actually predate the ACO program. The other ACOs have not yet been successful in persuading the MCOs to work with them. That leaves the entire program in limbo, even as the ACOs are supposed to be ramping up to manage care, the ACOs tell *VBC*.

The ACO applicants were required to be nonprofit organizations serving a minimum of 5,000 Medicaid beneficiaries within their designated regions. In addition, they must contract with 100% of the hospitals, 75% of the primary care providers and at least four mental health providers within their service regions.

The ACOs — all of which are run by existing nonprofit community public health organizations — generally are using a combination of providers from federally qualified health clinics (FQHCs) and hospitals with which the parent nonprofits have worked before, so organizing and motivating the providers isn't an issue, the ACOs say.

In addition, all three ACOs have some seed funding from grants, including from the Nicholson Foundation, a Newark, N.J.-based organization dedicated to improving health in vulnerable communities in New Jersey and elsewhere. That funding is allowing the ACOs to do some provider training and data mining.

Grant Money Is Not Enough

However, grant money won't be enough for the ACOs to scale their care management operations to the point where they can have a major impact, says Gregory Paulson, executive director for Trenton Health Team. Therefore, the funding issue may stymie two out of three of the ACOs before they even get started.

"We are advocating to the state that there needs to be some sort of funding for this," Paulson tells *VBC*. "The state is very receptive, but the challenge is the state can't do something just because it's the right thing." The state itself will not fund PMPM fees, he says.

"This funding issue is significant enough that if the state can't resolve it, I don't see how the project can continue to move forward," Paulson adds. "It's very difficult to make an impact without resources."

continued

The legislation authorizing the New Jersey Medicaid ACO pilot, approved in 2011, did not specify a funding source. Partnerships between the ACOs and the MCOs that would pay the ACOs PMPM fees are purely voluntary on the part of the MCOs, and the state is taking a "hands-off" approach — it's not attending meetings between the ACOs and the MCOs, for example.

Paulson notes that the MCOs themselves are managing care, and any partnership between an MCO and an ACO would need to align programs and priorities. In Trenton, for example, Horizon NJ Health is the main Medicaid MCO, and "we have been working to get in a contract with Horizon for nearly a year," Paulson says, adding wryly, "the meetings have been relatively infrequent."

Horizon has contracted with the Camden Coalition for Medicaid care management.

Horizon declined to comment.

Other Medicaid MCOs in New Jersey include UnitedHealthcare, which also has contracted with the Camden Coalition; Anthem Inc., which acquired Amerigroup Corp. in 2012 and which hasn't yet contracted with an ACO; and WellCare Health Plans, Inc, which also hasn't yet contracted with an ACO.

ACOs WIll Look to Community Resources

The ACOs are responsible for all Medicaid beneficiaries in their service areas, including those dually eligible for Medicaid and Medicare, disabled beneficiaries and those residing in nursing homes, says Brossoie. "That was by intent and design," adds Paulson. "It forces a population-level approach."

Beyond the possibility of PMPM fees, all the nonprofit organizations behind the ACOs are actively seeking to leverage community resources in order to impact community health. For example, Trenton Health Team is working to engage the faith community in an initiative that helps to encourage healthy eating and may improve care transitions, Paulson says.

"If we're going to be a success, we need to leverage community resources," he says. "We're doing things that will help the community at large get healthier, and all those things are good for the ACO population." Still, "if we're working with a church to improve diabetes, we're not going to see a cost impact for a long time."

The grant funding from the Nicholson Foundation allowed the Trenton Health Team to initiate a program to reduce unnecessary emergency room utilization and to prevent re-hospitalizations. But "whether or not the ACO can provide those services will depend on funding," Paulson says.

The Camden Coalition actually had signed its two contracts with MCOs that call for PMPM care management fees long before the start of the ACO demonstration project, says Mark Humowiecki, general counsel.

The contracts — with UnitedHealthcare and Horizon — call for an upfront PMPM management fee plus shared savings if the ACO meets cost and quality targets, Humowiecki tells *VBC*. Many components of the agreements, including the quality metrics, are the same for both MCOs, he says.

The United program was launched in late 2013 and currently includes about 8,000 Medicaid beneficiaries, while the Horizon program was launched this year and includes about 25,000 Medicaid beneficiaries, Humowiecki says. It's too soon to know whether the ACO will earn shared savings for the first year of the United contract, he adds.

The PMPM amounts paid to the Camden ACO by United and Horizon do not cover all the services the ACO is providing, Humowiecki says. To cover the shortfall, the group has strung together a series of grants and other funding sources, he says.

Group Will Provide Housing Vouchers

The Camden Coalition is working on some innovative initiatives to impact Medicaid beneficiaries, Humowiecki says. For example, the organization is working with other community groups and local governmental entities to build supportive housing for high-cost beneficiaries. "A lot of the highest users are homeless," he says. "We've become very enamored of the 'housing first' model." A total of 50 affordable housing vouchers will become available this month for homeless beneficiaries, he says.

Assuming the Newark ACO obtains funding from the local MCOs, it will start with Medicaid's high utilizers and focus hard on behavioral health issues, says Woods. "One hundred percent of our Medicaid high utilizer population have behavioral health issues," she says. Grant money from the Nicholson Foundation and the HealthCare Foundation of NJ will help the ACO begin training its providers for this initiative while the organization negotiates with the Medicaid MCOs for the funding to continue, she says.

Getting good data should not be a problem, the ACOs say. New Jersey Medicaid will provide claims data for eligible beneficiaries in the service regions, and there are active health information exchanges in the service areas that can provide real-time clinical data, the ACOs say.

In an unusual twist, each ACO is free to propose its own methodology for determining savings under the plan. However, New Jersey Medicaid worked with the Rutgers Center for State Health Policy to develop a model for what the state is calling the "gainsharing arrangement," and ACOs potentially can use that methodology.

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.

New Jersey state Medicaid Director Valerie Harr holds out the possibility of additional ACOs joining the program. "The level of interest and partnership in this effort is staggering," she says. "We see tremendous potential in the ability of these communities to coordinate care in a way that makes sense for their Medicaid residents and provider community."

The ACOs also see tremendous potential for making an impact on care, but they realize they need funding first. "We have 10 years of building partnerships in Trenton, working with all the providers who are touching this population," says Paulson. "All the stars are aligned to be very successful in this population. All we need are the resources to do it."

Woods says the ACOs will work in some capacity, regardless of whether they're able to negotiate enough funding from the MCOs. "We know we'll be persistent whether our approach stays the same or whether we modify it as we go," she says, adding that she has reason for optimism: "Medicaid is paying attention."

Contact Paulson at gpaulson@trentonhealthteam.org, Brossoie at nicole.brossoie@dhs.state.nj.us, Woods at colleen@cmhexecconsulting.com and Humowiecki at markh@camdenhealth.org. ✧

Universal American Says It Plans To Add More MSSP ACOs for 2016

Universal American Corp. intends to expand its stable of Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) next year following news from CMS of stronger 2014 program year results (see story, p. 1).

A total of nine of the company's two dozen ACOs have qualified for shared savings for 2014, compared to just three for 2013, the company said Aug. 7 as part of its 2015 second-quarter earnings statement.

The Universal American ACOs earned $26.9 million in shared savings for 2014. Individual providers will take $6 million of that, leaving $20.9 million for the company, which also reported $9.3 million in operating expenses for its ACOs in the second quarter.

"We think we are going to add at least a couple [of MSSP ACOs] for 2016," Richard Barasch, chairman and CEO, said during an earnings conference call. "One of the things I think we got really good at is understanding what it takes for an ACO to work." The MSSP program doesn't work for everyone, Barasch said, and successful ACOs need motivated physicians.

"It's really a question for us of sort of pruning away the [ACOs] that won't work, and we have done that. We will continue to do that," Barasch said. "But we also really want to start, and we will be aggressive towards adding to our portfolio on the ACO side."

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Universal American had 34 MSSP ACOs in 2014, but the company said mid-year that it would stop supporting those ACOs that underperformed *(VBC 9/14, p. 6)*. It ultimately dropped nine MSSP ACOs and merged two. Three Universal American ACOs qualified for a total of $13.4 million in shared savings in MSSP's 2012-2013 reporting period, and the company said at the time that another 11 had showed savings but didn't beat the CMS benchmark.

Overall for the second quarter of 2015, Universal American posted net income of $1.6 million, or 2 cents per share, on total revenues of $416 million. ACO-related income helped to buoy financial results in other parts of the company in the second quarter. However, when both the first and the second quarters of 2015 are taken into account, Universal American's ACO business lost $400,000.

Universal American's stock took a beating in August after the company missed the consensus earnings estimate of 6 cents a share for the second quarter, and revenue was down nearly 10% compared with the same quarter in 2014.

Contact Universal American President and CFO Robert Waegelein at (914) 934-8820. ✧

CareFirst Says Its PCMH Program Showed Savings Over Four Years

Since launching its patient-centered medical home (PCMH) program in 2011, CareFirst BlueCross BlueShield has continued to expand the program. And with that expansion have come savings: The insurer said recently that it had spent $609 million less than expected on medical costs in the program's four years.

When the PCMH started in 2011, CareFirst was seeing an average 7.5% annual increase overall in medical spending. But by 2014, that rate had slowed down to 3.5%. And when taking into account only the CareFirst members in the PCMH, the rate was just 2%, according to the company's *2014 PCMH Program Performance Report*, released at the end of July.

"The medical cost trends we are seeing are remarkable and energizing," said CareFirst President and CEO Chet Burrell. "Even with slowing national medical cost trends in the last few years, to see sustained overall increases as low as we are now seeing is dramatic. While we would not attribute such trends solely to the PCMH program, the 2 percent rate of increase for the members covered by the PCMH program is difficult to ignore. Just as importantly, quality performance has remained strong even as the savings against the expected cost of care has grown. This data, bolstered by increasing evidence of physician engagement and uptake in the program, makes us confident the program is taking root and yielding just the type of results we hoped for."

CareFirst also reported the following results per 1,000 members:

◆ ***Over all four years, the program has had 19% less hospital admissions.*** In 2014, there were 5% less admissions.

◆ ***There have been 15% less days in the hospital for PCMH members overall,*** with 11% less last year.

◆ ***Since the program began in 2011, the PCMH has had 20% less hospital readmissions,*** with 8.5% less in 2014.

◆ ***There have been 5% less outpatient facility visits over the four years of the program.*** Last year there were 12.5% less outpatient visits.

Over the years, the savings for CareFirst based on projected medical costs have ticked up. From $39 million saved in the first year, the second year saw $98 million in savings, and then $127 million in 2013, with last year's savings more than doubling from the previous year's to $345 million. Tom Merrill, a senior analyst who leads accountable care organization (ACO) research at Leavitt Partners, tells *VBC* that "these savings seem to be really impressive, but it all depends on what percentage of the total spend $345 million actually represents." If CareFirst's "methodology is really generous, then the savings might not be as impressive" — which is something he says that Leavitt is hearing "on the ACO front from organizations involved with commercial plans."

About 80% of CareFirst primary care providers — which include both physicians and nurse practitioners — participate in the PCMH program, says the insurer. Providers are organized into panels of five to 15 mem-

Selected Recent Health Plan ACO Arrangements, Collaborative Agreements

Health Plan Affiliates	Provider Affiliates	Service Area	Launch Date
Aetna, Inc.	North Shore-LIJ Health System	NY	Announced in July 2015
Blue Cross and Blue Shield of Illinois	DuPage Medical Group	IL	Announced in August 2015
Empire BlueCross BlueShield	North Shore-LIJ Health System	NY	Announced in August 2015
Humana, Inc.	Premier Health	OH	Announced in July 2015
	Unity Healthcare	IN	Effective July 1, 2015

SOURCE: Compiled by AIS from health plan press releases in July and August 2015.

bers who will coordinate members' care. Last year 84% of the panels achieved savings, according to CareFirst.

"That seems really high," says Merrill. "However, they don't share a lot of specifics as to the distribution of savings. It could be that although 84% created 'some savings,' not all created the kind of savings that are worth writing about. All we know is the average, which doesn't tell us how lopsided the distribution of doctors who save may have been."

According to William DeMarco, president at Pendulum HealthCare Development Corp., "part of the manner in which payment and bonuses are shared may also slow down innovation as the CareFirst payment schedule goes to small groups of physicians, not individual physicians. So to wring out more savings means there needs to be more tools given to the PCMH to enforce change within their group. I have seen PCMH groups have a real leader in their midst and make incredible changes despite some infighting among the partners as to whether making clinical improvements were for the patients or for the insurance company," which, he says, is "always a challenging argument."

With a lot of value-based initiatives, the "programs take time to get up and running, and providers have to acclimate," says Merrill.

Will More Savings Be Hard to Come by?

"I think the savings are laudable overall, but always remember the savings start against a benchmark," DeMarco tells *VBC*. "In some areas for Maryland and Virginia the savings have already been taken out, so the maximum additional savings may be very hard to come by. This means that while CareFirst sees the additional possibility of savings, this assumes you have that local PCMH leader in-house that also sees the issues and the opportunity and is willing to put his or her reputation on the line to lead that change and get their partners to participate heavily in the change. Value-based means more downstream risk to practitioners and/or groups of practitioners, and that's the fact of life for commercial reimbursement as well as Medicare reimbursement."

CareFirst's "keys to success" with the program, says DeMarco, were to have high-end analytics in place, increase access for more primary care participation, train physician leadership at the community level and reimburse both fees and bonuses tied to value not just production."

"What I found interesting was that the state was so impressed with the results and the general condition of the commercial insurer's program that they plan to transition their pilot members into what CareFirst and Cigna are doing," says Merrill, citing a *Baltimore Sun* article on CareFirst's results. According to that article, "Ben Steffen, executive director of the Maryland Health Care Commission, said the state found its pilot medical home program promising and plans to migrate the 53 participating practices to CareFirst's program and another existing program run by Cigna. The state also is encouraging other insurers to launch programs."

View CareFirst's 2014 performance report at http://tinyurl.com/qec6kv4. Contact DeMarco at bill.demarco@pendulumhealth.com and Merrill through Jordana Choucair at jordana.choucair@leavittpartners.com. ✧

Oncology Practice Applies PCMH Standards With Impressive Results

Recognition by the National Committee for Quality Assurance (NCQA) as a patient-centered medical home (PCMH) is a popular approach that primary care practices can take to transform themselves into medical homes. While NCQA has a subspecialty certification model, that isn't really oncology-specific. However, Consultants in Medical Oncology & Hematology (CMOH), a community-based medical oncology practice in Pennsylvania, has been able to apply the principles of the PCMH model to improve the way it provides care, in the process becoming the first oncology practice that NCQA has recognized as a level III PCMH — and, it says, reaping tremendous benefits in terms of patient care and costs.

John Sprandio, M.D., co-founder and chief physician at CMOH, spoke at the July 30 AIS virtual conference *Oncology Management 2015: Innovative Strategies for Health Plans and Providers* about how oncology practices can incorporate PCMH standards. In primary care, characteristics of the PCMH include "a personal physician to coordinate care," enhanced access to care, comprehensive care and "whole-person orientation….The concept of following patients through the acute, chronic, preventive and end-of-life phases of care certainly speaks to oncology," he noted.

To answer "where the specialists fit in" the primary care PCMH model, he pointed to a 2010 policy paper from the American College of Physicians' Council of Subspecialty Societies. It was published, he said, at a time when the PCMH model seemed "to be taking off in primary care," prompting the question of "where does that leave us as specialists, especially and in particular the specialists who are involved in chronic care management of complex patients like [in the areas of] oncology, cardiology, nephrology, rheumatology and so on?" The group addressed the relationship between the PCMH model and specialty practices, coming up with the concept of a "PCMH neighbor," as well as developing a framework categorizing interactions between the PCMH and PCMH

neighbor, and principles to guide the creation of care coordination agreements between them.

In determining value in cancer care, "quality and cost are completely intertwined," he said, citing Institute of Medicine definitions. Quality is "the degree to which services increase the likelihood of desired outcomes and are consistent with the current professional knowledge. It broadens the potential scope of what quality is…beyond, for example, pathway guidelines or multidisciplinary care guidelines."

Cost is "the utilization resource" related to the delivery of care, and value is best described, he maintained, as the definition of quality "with the caveat that it is delivered with the proper allocation of resources." He noted that "You can devise and execute the most eloquent guideline-adherent, multidisciplinary-care adherent plan of care, and if your patients are using unnecessary resources because they're lined up in the ER, because they didn't have access to daytime visits and weren't engaged to become good reporters, you're delivering poor quality of care even though you're adherent to things that we think of as the quality standards in oncology," such as guidelines from the National Comprehensive Cancer Network, American Society of Clinical Oncology and

VALUE-BASED CARE PROFILE

BCBSIL Teams With Independent Physicians in Value-Based Agreement

Health Care Service Corp. (HCSC) subsidiary Blue Cross and Blue Shield of Illinois is partnering with the state's largest independent physician practice, DuPage Medical Group, to continue bringing solo practitioners into the fold of accountable care. The deal is the second major partnership of its kind for HCSC, which launched a similar initiative earlier this year.

The two sides hammered out the agreement, dubbed BCBSIL Practice Advance, in little more than six months, according to DuPage CEO Michael Kasper. HCSC had been searching for another physician group to partner with following the February launch of TMA PracticeEdge in Texas, a collaboration between Blue Cross and Blue Shield of Texas and the Texas Medical Association (TMA).

The Illinois deal took effect Aug. 1, and while both BCBSIL and DuPage declined to share specific clinical targets, Kasper mentioned orthopedics and cardiology as two potential areas of focus. DuPage differs from TMA in that the 425-physician group already has established IT and electronic health record (EHR) systems in place, having used Epic Systems Corp. products since the early '90s. The absence of IT infrastructure is a major hurdle in incorporating independent doctors into accountable care organizations (ACOs), and one reason why insurers typically partner with health systems instead.

"Other than them being transparent with some of their data at a high level and doing some of that analytical work to support the relationship, they're not making any investments in IT for us," Kasper says. "We're basically in place to query our data and produce the medical-record view of the patient while they'll help us with the claims-based view."

Combining DuPage's medical data with BCBSIL's claims data will give both organizations a more complete picture of population health. Kasper says the value-based care teams are beginning to take shape, and will include analysts, operations experts and physicians from both sides. The team will meet twice monthly to examine data and discuss where and how outcomes could be improved.

"What's going to happen is we're going to start to really cull the data, get information about where the best places to provide certain services are," Kasper tells *VBC*. "One of the things that we're trying to make clear about how the relationship is going to work is that historically, if people say, what's the lowest unit-cost pricing for something, and wherever the lowest cost pricing is, that must be the most cost-effective place to receive services. The reality is that's not always the case because you have to factor in quality data and look at readmissions and the overall cost of care."

The value teams also will focus on which services could be moved from an inpatient to an outpatient setting, and determine the most cost-efficient locations to refer their patients for services such as MRIs. Collaborating with BCBSIL also will help DuPage doctors to streamline their processes for claims, reimbursements and other back-end operations. Kasper dismisses the notion that being an independent physician group presents challenges that hospitals are more equipped to handle.

"I actually think we have advantages versus challenges," he says. "The advantage that we have is that

Commission on Cancer. "It's the way the services are delivered that really has a lot of sway and influence on the quality of care that's actually being experienced by the patient," he said.

"We realized years ago that in order for us as physician providers to become more accountable for quality and the consistency of the care as well as the cost, we faced several barriers on our way to really delivering consistent care that was executed in a standardized way from one doctor to the next in our practice of 10 physicians." The practice realized this about 10 years ago after it took a look at itself and realized "there was great variability in the roles and responsibilities" of the different members of the care team, from administrative assistants to chemotherapy nurses and nurse practitioners.

So CMOH "went on a mission…to streamline our processes of care, take out valueless variation, [and] standardize the roles and responsibilities." That included such tasks as turning receptionists into "lay patient navigators" responsible for tasks such as scheduling tests and appointments and helping patients find various resources. By their taking "away clinically irrelevant activities from our physicians," this gave the providers "the time to make complex medical decisions,…maintain personal relationships with patients and their families,… [and] fix accountability within the care team at the locus of control."

The practice followed these principles and "developed data systems tracking performance and developed technology support to enable the care team to execute at this level." By adhering to treatment guidelines and providing the appropriate therapy, CMOH was able to give "rational and informed care." It increased patients' access to care and "improved patient navigation, coordination and communication, and we reduced patients' avoidable complications and unnecessary utilization of services," including emergency room trips and hospital admissions.

All of these actions "had a significant impact on costs, as well as the consistency of our execution of care."

CMOH looked to NCQA for many of the standards and features — which had been "tested and verified"

VALUE-BASED CARE PROFILE (continued)

health systems' hospital-centric views of these kinds of relationships always have to contemplate the trade-off between the volume at the hospital level to support the fixed infrastructure of health systems. Because we're an outpatient-dominant organization, we don't have responsibilities, necessarily, of trying to figure out what the census of a hospital is. That's a tough balance for folks as they go down the value-based path, which is what trade-offs are they making within their business structure in order to really get efficient, and I think that becomes a conflict for folks on the system side."

BCBSIL offers several models on the "spectrum" of value-based care, says Opella Ernest, M.D., chief medical officer and divisional senior president for health care delivery, and is always looking for ways to include physicians regardless of where they register on the scale.

"What we're trying to do now is say, 'look, I'm an independent doctor,'" Ernest tells *VBC*. "'I may not be ready for an ACO. I may have a smaller practice, but I still want to be a part of this change from fee-for-service to value.' So by partnering with these independent physicians, we're going to allow them to be a part of this transition from fee-for-service to value so that they can do population health in a way they hadn't been able to do previously."

More than 30% of HCSC members nationwide currently are incorporated into accountable care arrangements. BCBSIL already has nine existing accountable care agreements with health systems throughout the state, encompassing 450,000 lives and including what it claims is the largest commercial ACO in the country — a deal with Advocate Health Care.

That collaboration resulted in significantly lower health care costs in 2011 and 2012 — a 10.6% reduction in emergency room visits, a 12.1% drop in hospital admissions per 1,000 and a 13.8% decline in inpatient days per 1,000.

Ernest says the success of this partnership hopefully will drive similar arrangements with doctor groups down the road, but Kasper says DuPage is currently just concentrating on achieving better outcomes with BCBSIL.

"Sometimes I think folks get really ambitious and get out there in a lot of different ways and end up finding themselves underwater," he says, "and I think for the foreseeable future we're going to stay focused in this relationship."

Contact Ernest via Mary Ann Schultz at mary-ann_schultz@bcbsil.com and Kasper via Maria McGowan at maria.mcgowan@dupagemd.com.

— that it used to drive quality and value. "Process standardization was really key to this," Sprandio maintained. By having a standardized evidence base that helped drive a consistent set of services provided by all members of the team in delivering care, the practice was able to "make the right thing to do the easy thing to do." CMOH also was able to measure outcomes by looking at claims data and patient satisfaction.

"A medical oncology practice can really serve as the hub of coordination and accountability, meeting all cancer care needs," he asserted. "It integrates well with primary care PCMH practices, as well as surgical, radiation oncology and so on." The model, said Sprandio, reduces costs by "addressing symptoms in a timely fashion, intervening and continuing to have a focus on process improvement."

In 2010, NCQA awarded CMOH level III PCMH recognition. That same year, the American Society of Clinical Oncology recognized the practice as one of 140 certified Quality Oncology Practice Initiative (QOPI) practices nationwide.

Model Produces Various Efficiences

The practice continues to produce impressive results, said Sprandio. In 2014, CMOH clinical nurses took almost 5,000 symptom-related phone calls. Eighty-three percent of patients were able to self-manage their symptoms at home, 7.5% were seen within 24 hours, and only 2% were instructed to go to the emergency room — a percentage that previously was closer to 12%, he said.

A Milliman analysis of commercially insured patients found an average of two annual emergency room visits per chemotherapy patient among members with cancer. At CMOH, the average visit among all of its patients was 2.6 in 2004, a number that has steadily dropped, coming in at 0.5 last year. The same Milliman analysis showed there was about one hospital admission per chemotherapy patient per year. CMOH in 2007 had an average of 1.1 admissions for its total patient population, which had dropped to 0.5 in 2014. Sprandio said there were many reasons for the decreases, but two important ones were allowing timely unscheduled visits and continuous care for and interaction with patients.

He also shared some preliminary risk-adjusted data from one of its local payers on hospitalizations within 60 days of a chemotherapy treatment. For commercial members, "our rate was 33% below the rest of the market," and it was 61% below the rest of the market for Medicare Advantage members. Emergency room utilization "was also significantly lower on the commercial side." In the first seven months of the contract with the payer, Medicare Advantage members treated by CMOH had no hospitalizations within the last 30 days of life, compared with the plan benchmark of 0.447. Similarly, none of these CMOH patients received chemotherapy within the last 30 days of life, compared with a benchmark of 0.458. And CMOH-treated patients had an average of 15.25 hospice days during the last 60 days of life, compared with 13.84 days. "Quite frankly, that's probably not enough — I know it's not enough — but we beat the rest of the market" by more than 10% on that, Sprandio said.

"When you change the way that you deliver care, and you're purely in a fee-for-service environment, watch out because it affects revenue," he said. "But we were able to take a positive slant on the effect it had on revenue, and we became more efficient." For example, he said, in 2007, the practice had 8.3 full-time equivalents per physician, but since 2011, that number has been at 5.6 or 5.7. "That's all from standardizing roles and responsibilities, and leveraging technology to the fullest without giving up on oversight from the physician perspective," he explained. "We've been able to negotiate different contracts" and "improve physician efficiency."

"Overall it was a bumpy ride, but ultimately it was a positive experience on the practice."

Contact Sprandio at jsprandio@cmoh.org. ✧

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Medicare ACO Results Disappoint

continued from p. 1

Meanwhile, Medicare Pioneer ACOs generated total savings for CMS of $120 million, and 11 earned shared-savings payments (see box, p. 11).

The financial results — which National Association of ACOs (NAACOS) CEO Clif Gaus characterizes as disappointing — cast some doubt on the long-term future of the program, although Gaus says CMS seems to have about the same number of new MSSP applicants for 2016 as it has had in previous years.

"Our view is that if only about a quarter of the ACOs can earn savings, it will diminish the new applicants in the long run," Gaus tells *VBC*. He says many MSSP ACOs are investing more than $1 million per year in the program.

"Any venture where the organization is investing more than a million dollars a year has to have a return for sustainability. Large hospitals can more easily sustain the losses and will have more staying power, but the small medical groups do not have the capital for three or four years of losing investments," he maintains.

NAACOS estimates that about one-quarter of the first 220 MSSP ACOs will not renew their contracts with CMS in 2016. However, more than 100 new ACOs are

likely to join the program next year, so the net gain will be around 50 to 60 ACOs, Gaus says.

Out of the 333 total MSSP ACOs participating in 2014, 92 earned performance payments of more than $341 million, for an average shared-savings payment of $3.7 million. Another 89 ACOs saved money, but not enough to beat benchmarks and earn shared savings.

Those average payments are far below last year's results: For the first performance year, 58 MSSP ACOs split $315 million, for an average shared-savings payment of $5.4 million per ACO.

Also, the yet-to-be-released individual results will show that some ACOs earned far larger payments than others. For example, the Memorial Hermann Accountable Care Organization in Houston, which earned the largest payout — $28.34 million — for the first performance year *(VBC 10/14, p. 9)*, will repeat as the highest-gaining ACO in the second performance year, CEO Christopher Lloyd tells *VBC*.

NAACOS points out that 241 ACOs will receive no return on their investment in the form of shared savings. The organization is urging policymakers to change the

In Pioneer, 11 Share Savings While Three Will Pay CMS

Eleven out of the 20 Medicare Pioneer accountable care organizations earned shared savings during the third performance year of the program, CMS said Aug. 25. Meanwhile, three ACOs generated losses outside their CMS-set benchmarks and owe CMS a total of $9 million in shared losses.

Financial results continued to improve for the third year of the program: The Pioneer ACOs cumulatively generated $120 million in savings, an increase of 24% from the $96 million generated in the program's second year. The ACOs generated $88 million in savings in the program's first year.

Meanwhile, total average savings per ACO in the program increased to $6 million in year three, an increase from $4.2 million per ACO in year two and $2.7 million per ACO in year one.

Of course, 12 of the original 32 Pioneers dropped out of the program over the last two years, with many citing concerns about having to pay back losses to CMS if they remained in Pioneer *(VBC 10/14, p. 8)*. These dropouts may have skewed the program towards the more successful ACOs and improved the overall average financial results of those that remain.

Fifteen out of the 20 ACOs remaining in the program for 2014 saved money for CMS, although only 11 exceeded their benchmarks and will receive shared-savings checks, CMS said. Five ACOs generated losses, but only three of those owe CMS money.

Quality continued to improve in the program: The mean quality score among Pioneer ACOs increased to 87.2% in performance year three, compared to 85.2% in performance year two and 71.8% in performance year one, CMS said. The organizations showed improvements in 28 of the 33 required quality measures, and experienced average improvements of 3.6% across all quality measures in year three compared to year two.

CMS did not report results for individual ACOs. However, two ACOs that were successful in earning shared savings announced their results publicly.

Bronx, N.Y.-based Montifiore Health System tells *VBC* that it saved $13 million overall and earned $8.4 million in shared savings for year three of the Pioneer program. The ACO, which has shared in savings for each program year and in fact has been one of the highest-performing ACOs in Pioneer, credits its success to proactive care management of its highest-risk beneficiaries, many of whom are dual eligibles *(VBC 10/14, p. 10)*.

"Montefiore's success is due largely to the comprehensive wrap-around services it provides and collaborations with private practice physicians in the community," the organization says, noting that overall quality scores in the program's third year increased more than 10% from the previous year. One-quarter of Montefiore's patient population is over age 85.

Meanwhile, Phoenix-based Banner Health Network reported delivering its best-ever results in its third year of Pioneer, saving more than $29 million for the Medicare program and improving its quality score by nearly 10% over the previous year.

Lisa Stevens Anderson, Banner Health's CEO, attributes the organization's success to highly engaged providers and strong health IT, along with a new telehealth program, the development of an affiliated post-acute care network, and "a continued focus on care management and care coordination."

Contact CMS public affairs at (202) 690-6145, Banner media relations at media@bannerhealth.com and Montefiore spokesperson Arielle Sklar at (718) 920-4011.

way Medicare beneficiaries are attributed to ACOs, improve the risk adjustment and benchmarking formulas, and eliminate the "penalty-only" quality scoring.

However, since CMS just finalized the rules for the next three years of the MSSP *(VBC 7/15, p. 1)*, and since applications appear strong for ACOs seeking to enter the program in 2016, it's not clear how much the federal agency would be willing to change.

Leavitt Partners LLC Director of Research David Muhlestein says quality results began counting toward shared savings for ACOs in their second performance year, which will lessen shared savings for many.

"People are not getting all the quality," Muhlestein tells *VBC*. "We're looking at the scores for quality, and they're kind of across the board — most are in the 70th percentile, and nobody's at 100%."

ACOs that are eligible for shared savings must also meet quality benchmarks in order to receive any money, and missing even a few can ratchet down the total, Muhlestein says. "It really quickly can take 20% of your savings. The quality component has some teeth now."

Second-year MSSP ACOs collectively improved on 27 of 33 quality measures. Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctors, screening for tobacco use and cessation, screening for high blood pressure and electronic health record use.

Gaus calls the quality penalty "unfair," and blames it for the fact that shared savings per ACO decreased. It's "so stringent that unless an ACO scores perfectly on every quality measure, their [shared] savings will be reduced. We expect ACOs to deliver better care for Medicare beneficiaries but the quality benchmark that CMS prescribes is the government example of letting the perfect be the enemy of the good."

A total of 72% of the MSSP ACOs did not make the 90th percentile benchmark set by CMS, and those that earned shared savings had their payments reduced as a result, Gaus says, adding that NAACOS advocates a quality benchmark set at the 50th percentile level.

Muhlestein says he doesn't think the results will discourage new ACOs from joining the program. "The reason is, enough people are doing well — there are more than 100 ACOs, if you include Pioneers, that are seeing shared savings." Those numbers will be enough to encourage new ACOs to join, he says, especially if the new ACOs believe they can produce above-average results.

"The shared savings program's not a resounding success, but it's far from a failure," Muhlestein says.

Contact Gaus at (202) 640-1898, Lloyd at christopher.lloyd@memorialhermann.org, Muhlestein via Leavitt Partners spokesperson Jordana Choucair at jordana.choucair@leavittpartners.com, and CMS public affairs at (202) 690-6145. ✧

NEWS BRIEFS

◆ **Anthem Blue Cross and Blue Shield in Colorado said on Aug. 19 it had shared nearly $4 million in cost savings with primary care doctors through its accountable care agreements since 2013.** The Enhanced Personal Health Care program realized 7.8% fewer acute inpatient admissions, 5.1% savings in outpatient surgery costs and a 3.5% drop in emergency room costs. Anthem's Colorado value-based care initiative includes 1,800 physicians and 200,000 members. Visit http://tinyurl.com/orzkwf9.

◆ **A Blue Cross & Blue Shield of Rhode Island pilot program that placed pharmacists inside six patient-centered medical homes (PCMHs) saved the insurer more than $1 million,** the plan said on Aug. 10. Of those savings, $800,000 came from MA patients. The program also achieved a 60% engagement rate, conducting 400 comprehensive medication reviews and more than 750 targeted medication reviews. Visit http://tinyurl.com/qjv3tgl.

◆ **Primary care providers have mixed views on medical homes and accountable care organizations,** according to the Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers. The survey asked primary care physicians, nurse practitioners and physician assistants about recent changes in health care delivery and payment. Although providers had positive views on health IT and its impact on quality of care, they were negative about the use of quality metrics to assessment performance. Visit http://tinyurl.com/pqp3ma2.

◆ **Cigna Corp. reported second-year quality and financial results from a collaborative care program with Franciscan St. Francis Health.** The program, launched in 2013, showed a 4.3% lower medical cost trend compared with the market. It also reported a 21.3% reduction in emergency department utilization for non-emergency care and a 4.3% drop in inpatient readmissions. Visit http://tinyurl.com/psafojo.

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