

# Payers and ACOs Improving Care for People with Serious Illness

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## Background

Health plans and accountable care organizations (ACOs) have the opportunity to implement specific strategies to ensure high-quality and cost-effective care for people living with serious illness. To accelerate adoption of these strategies, the Center to Advance Palliative Care (CAPC), with support from the West Health Institute, the Commonwealth Fund, the John A. Hartford Foundation, and the Peterson Center on Healthcare, launched the **Medicare Advantage (MA) and ACO Learning Communities**, providing education and peer support to expedite needed changes and expand access to palliative care among high-need populations.

Forty-four organizations participated, covering over 3 million Medicare beneficiaries across 32 states. Among the MA organizations, 20 have traditional plans, with 12 also having special needs plans (SNPs), primarily dual SNPs with 1 institutional SNP and 1 chronic SNP. Among the ACO organizations, 17 are in the Medicare shared savings program, with 2 NextGen participants, 12 in private MA ACO arrangements, and 1 in a Medicaid ACO.

The Learning Community participants attended an in-person kick-off meeting where their challenges and suggestions were collected, followed by 4 virtual convenings to explore each recommended strategy in-depth. CAPC resources were shared with all the participants, and individual coaching calls helped each organization with their own implementation efforts.

## Methods

Organization efforts were gathered via the individual coaching calls, held November 2019 thru February 2020. 42 of the 44 organizations participated.

## CAPC Recommended Strategies

Based on previous work to collect and synthesize best practices for payers (see *Serious Illness Strategies, 2017*), CAPC organized the MA and ACO Learning Community around four key recommended strategies:

1. **Proactively identify** the population living with serious illness
2. **Enhance Care Manager capabilities** to enable comprehensive assessment and effective communications with those living with serious illness
3. **Support home-based care** for a sub-set of those living with serious illness
4. **Educate and incentivize the network** to build and maintain core capabilities (including communication skills and specialty palliative care access)

## Strategies Being Pursued

All but three of the Learning Community participating payers and ACOs had been pursuing at least one of the four recommended strategies at the time of the individual coaching calls. Then, through the Learning Community participation, most organizations began considering additional strategies. Strategies being pursued and considered as of February 2020 are shown in the table below:

	Currently Pursuing*	New Interest in Pursuing*
Proactive Identification	18	11
Enhanced CM Role	6	18
Home-based Care	18	10
Network Education/Incentives	6	7
Other: Advance Care Planning	10	
Other: Embedded Expertise	6	3

## Discussion

At the start of the Learning Communities, both the MA plans and ACOs had the strongest interest in providing home-based care for their members/patients living with serious illness, and concurrently identifying the “right” individuals for that service. Learning Community discussions have led to heightened interest in the role of existing Care Managers, particularly as the best source for identifying appropriate patients for home-based care and for driving engagement in those services. Debate continues on what is the most effective duration for home-based care, given that such care is expensive and resources are limited (see considerations below).

Beyond home-based care, another common area of interest, particularly among the ACO participants, was in incentivizing and supporting clinician training. Most participants expressed disappointment in current efforts, and Learning Community conversations discussed whether the focus should shift from advance care planning to broader “serious illness conversation skills”.

All conversations resulted in a collection of both good advice and potential challenges, which are being compiled for dissemination across these audiences.

## Home-based Care Frequency and Duration Remains Unknown

### Short-Term Care

- IDT visits for 2 to 3 months
  - May coincide with home health episode
- Emphasis on shared decision-making/advance care planning and symptom management
- Transition to primary care or hospice
  - Program may provide ongoing light telephonic support

### Ongoing Care

- IDT responsible for palliative and primary needs
- Disease management as well as symptom management and communications
- Transition to hospice when appropriate