



Innovations in Medicare Advantage To Improve Care for Seriously Ill Patients

Andrew Olson, Matthew Harker, Robert Saunders, Donald H. Taylor, Jr.

KEY THEMES

- Medicare Advantage's financing structure and increased flexibility following recent statutory and regulatory changes make it a fertile environment for testing new payment and care delivery innovations for patients with serious and advanced illness.
- Several new models have been developed by third party firms to improve care quality and reduce emergency department visits and hospitalizations for patients with serious and advanced illness. These models accomplish this by providing high-touch care management and non-medical services that are poorly reimbursed by fee-for-service billing.
- Innovations in care for seriously ill patients have spread rapidly within Medicare Advantage, but face challenges to broader expansion throughout the health system. Policymakers and health system stakeholders can facilitate greater diffusion of these innovations by encouraging their expansion in traditional Medicare, expanding the supply of rigorous evidence for their impact, and supporting workforce development initiatives.

Introduction

The financing structure of Medicare Advantage makes it a fertile testing ground for new payment and care delivery approaches, including value-based payment models. For 2016, Medicare Advantage plans reported that more than 4 in 10 of their care dollars were paid through alternative payment models, the most of any market sector, and previous studies have found that Medicare Advantage plans are implementing a range of payment and benefit reforms, from bundles to accountable care organizations to value-based insurance design.^{1,2}

Medicare Advantage plans receive per member per month payments that are adjusted for each enrollee's age, location, and health status. If the cost of care for enrollees is less than their capitated payments, the plan is able to keep the savings. Plans are also eligible for bonus payments if they demonstrate that they are delivering high quality care, as measured by the Centers for Medicare & Medicaid Services (CMS) through the Star Ratings program. It is this underlying incentive structure that makes Medicare Advantage plans such prime drivers for testing payment and care delivery innovations that align the interests of private payers, patients, and CMS.

Enrollees that offer the greatest potential return on investment (in terms of shared savings and improved quality of care) for plans are complex patients with serious or advanced illness that have the greatest needs and incur the highest

costs. As a result, Medicare Advantage plans are piloting new care models designed for these members.^{3,4} A common approach is to deliver care management and the kind of high-touch, non-medicalized services that are poorly reimbursed (if at all) through the fragmented fee-for-service payment model in traditional Medicare, but that may reduce total cost of care by reducing high-cost acute care encounters like emergency department visits and hospital admissions.

However, there is very limited publicly available evidence about value initiatives launched by Medicare Advantage plans, including broader payment, delivery, and benefit reforms.⁵ Greater information sharing could mean that effective innovations can be diffused more quickly to other market segments, especially traditional Medicare, where they can improve quality of care for a greater number of patients with serious or advanced illness and expand the scale of cost savings across the health system.

The goal of this brief is to begin filling the information void by examining three models that have been developed by third-party firms that contract with Medicare Advantage plans: Aspire Health, Landmark Health, and Turn-Key Health. While theirs are not the only models in practice, and some Medicare Advantage plans have developed their own serious illness programs in-house, these three examples demonstrate the kinds of services and approaches that have flourished in this swiftly evolving market. These three firms have expanded rapidly in recent years, implementing their solutions with multiple Medicare Advantage plans and across the country, and their experience provides valuable insights. We report on what we have learned about their model designs and approaches to managing care for patients with serious and advanced illness, noting the mechanisms that drive their impact on cost and quality of care, as well as opportunities and challenges to scaling and replicating the models in different markets and geographic areas. We then identify recommendations to facilitate the accelerated diffusion of serious illness models across the health system.

What serious or advanced illness patients are targeted by these models?

Although there is no single, precise, and common definition for serious or advanced illness, the terms are typically applied to patients who are characterized by the following.^{6,7,8,9}

- one or more serious chronic illnesses;
- complex care needs, likely including high utilization and associated costs;
- functional limitation or disabilities; and
- for patients with advanced illness, health is unlikely to improve but face variable rates of continued decline.

Each of the three models that we examine operationalizes a definition by establishing specific eligibility criteria for individual enrollment, but the patients they engage can all be described as having serious illness and most are very advanced.

We note one important serious illness population that largely falls outside of our scope: patients who are at the end of life and eligible for hospice services (defined by a prognosis of six months or less to live). The reason is due to the structure of the Medicare Advantage program. Hospice services are carved out of the Medicare Advantage benefit, and to elect hospice requires disenrollment from Medicare Advantage and back into Medicare Part A. Necessarily, all three of the models that we examine aim to identify and engage patients upstream of hospice and end of life.

What are the models, and how do they function?

All three of the models that we examined share common features. First, all three analyze the claims data they receive from plans in order to identify patients that meet the eligibility requirements for their services. This process is often more sophisticated than simply applying certain diagnosis and utilization criteria to patients based on their current health status, but instead entails predictive analytics that can identify patients who will incur increasing utilization and costs in the near-term as their illness progresses. As one of the leaders we spoke with pointed out, a key challenge is ensuring that they do not capture patients who have experienced an emergency event or acute exacerbation but are likely to stabilize on their own, because without rising risk of high-cost care encounters there is little potential savings to be gained from the intervention.

Another common feature shared by the models is that members of the care team conduct their own health and functional assessments of patients when they enter their cohort and update them regularly while patients are in their care. These assessments enable the teams to gain a more comprehensive understanding of patients' health and risks by evaluating and recording factors such as safety concerns in patient homes and any issues related to social determinants of health. The information recorded in these assessments may then be used to inform risk stratification within patient cohorts, to prioritize resource needs for patients, and to tailor care plans.

The assessment data is aggregated along with claims into software platforms where it can be analyzed to monitor the health status and risk of patients in their cohorts. These systems generate dashboards and regular reporting on measures related to patient engagement, quality of care, utilization, and outcomes that are utilized by their care teams to flag when they

should proactively intervene to prevent high-cost encounters like emergency department visits and hospital admissions.

Although the composition of care team roles varies by model, all of them deliver care to patients in their home or residence in facility settings. In addition, all of them provide round-the-clock accessibility to patients, which is critical for quickly addressing patient concerns and needs in order to prevent or divert emergency visits and hospital admissions.

Providers from all three models conduct advance care planning discussions with patients and their families and caregivers in order to help them consider and plan for decisions that will need to be made as the patients approach the end of life. Care teams from each of the models will also work to refer patients to hospice when it becomes appropriate for their disease progression and when it aligns with patient and family goals of care and preferences.

Table 1. Model profiles along various dimensions of their approaches to care for serious and advanced illness.

	Aspire	Landmark	Turn-Key
Eligibility and Patient Identification	Identify patients two ways: by predictive analytics, primarily of claims but also other clinical data sources, and by receiving direct referrals from providers, such as primary care physicians and care managers. Enroll patients that are likely entering last year of life, have multiple chronic co-morbidities, and are at risk for high utilization and cost of care.	Utilizes a claims-based algorithm that identifies patients with at least five or six chronic co-morbidities like COPD, cancer, ESRD, and heart disease. Patients identified by this algorithm will have high medical cost and care needs without close management of their chronic conditions and typically have a 10 to 15 percent expected annual mortality rate.	Historical and temporal claims encounter and clinical data are utilized for predictive modeling to identify patients who are at risk of a poor quality, over-medicalized last six to twelve months of life, leading up to a very short length of stay in hospice. Patients are also directly identified through case managers and clinicians within risk-bearing entities.
Relation to Existing Providers	Co-management model, in which Aspire team is an extension of primary or specialist care that visits patients in their homes. Clinical care team may diagnose, prescribe, and deliver care as needed, but communicates and coordinates care with existing providers.	Model complements primary care. Instead of replacing the primary care physician, the Landmark team coordinates care and communication with the existing provider network. Patients and PCPs can request Landmark to perform evaluation and treatment in the home 24/7, with interventional capabilities such as lab draw, IV insertion, IV hydration, IV medication administration, catheter insertion, wound care, and minor procedures.	Turn-Key serves as an extension of medical practices, enabling a palliative medical home model. Turn-Key's palliative teams provide supportive home-based assessments and interventions, communicating relevant information back to the primary treating physician/medical home to foster better communication and to ensure care delivery is consistent with patient goals.
Care Team Composition	Physicians, nurse practitioners, social workers, and chaplains. Nurse practitioners serve as "quarterbacks" for care for patients.	Physicians, nurse practitioners, physician assistants, behavioral health specialists, nurse care managers, social workers, pharmacists, nutritionists, and care ambassadors.	Turn-Key convenes, trains, and manages networks of palliative care specialists. Comprised mainly of palliative care trained nurses and social workers, the teams are also augmented by nurse practitioners and physicians, where medical intervention is needed.
Technology Platform and Data Analytics	Receives claims and structured data from plans that are used for analytics. Has built clinical platform like an EHR that is used internally and shared with plan and providers to track quality and outcome measures.	Uses a proprietary EMR to document key assessments, care plans, and outcome measures and report to health plan partners. Data analytics employed to measure risk of future adverse medical events, quality of care gaps, and to stratify patients by risk to inform care plans.	Turn-Key leverages analytics and technology in three ways. First, proprietary analytics are utilized to identify and stratify a patient's likelihood of being over-medicalized related to a serious or advanced illness. Second, a custom palliative population health platform manages patient populations, reports interventions, and standardizes care. Last, Turn-Key developed a Palliative Activation Scale (PAS sm), which is the measure of a patient's propensity to adopt a palliative care approach, to improve quality of life and outcomes.
Payer Types	Majority of work is with Medicare Advantage plans, but also contract with commercial plans, ACOs, Medicaid Managed Care, and oncology clinics.	Medicare Advantage plans; Medicaid, including dual eligibles; and commercial.	Medicare Advantage, Provider Risk-bearing Entities, Medicaid/Duals/MLTSS, Commercial, Self-Funded/ASO.

Lastly, each organization explained that specific payment and performance metrics often varied across their contracts with different plans, emphasizing the degree of flexibility in contracting and payment structure that the organizations have while still making their models work for all parties.

What prevents serious or advanced illness models from spreading more rapidly across the health system?

All three firms started by contracting with Medicare Advantage plans, but have since spread into other market segments as well, such as commercial plans and Medicaid Managed Care. As they have grown within Medicare Advantage and into new markets and geographic areas, these firms have grappled with a number of challenges. Their experience scaling their models offers insights for policymakers interested in facilitating the diffusion of care innovations for patients with serious or advanced illness.

First, the leaders we spoke with noted that rural areas pose distinct challenges to successful implementation. Each of the models is predicated on delivering care to patients in their homes, but in rural areas where patients are few and widely dispersed, time and travel costs are real barriers to the financial viability of the models. Advancements in telehealth may help expand the reach of the models, but their current payment structure makes them best-suited for implementation where there is an adequate density of patients served.

Another set of challenges relate to identifying and cultivating the workforce needed to make their models run. One of the leaders we spoke with cited a challenge of finding strong candidates to fill clinical leadership roles. Care management teams like those established by these models are led by individuals that must have clinical knowledge but also take on management responsibilities that they may not have prepared for through their training or prior work experience. Another leader noted that, in the early stages of their model development, they had difficulty finding providers who were willing to work in a risk-bearing model. Although alternative payment models with downside risk are spreading, they are still new to many providers who are accustomed to the prevailing fee-for-service system and do not yet have experience orienting their practices to perform to the specific quality and cost targets defined in value-based payment models.

Finally, one leader noted that a significant expansion, especially into traditional Medicare, would require a shift in management approach by payers. The models all got their start being implemented by Medicare Advantage plans as pilot programs that only impact a small number of plans' total covered lives and so were closely managed by plans with substantial and frequent communication. For traditional Medicare or any large

payer to scale these models widely and efficiently, they would likely have to trade off the approach of close supervision and regular communication for more formal and standardized rules. However, those rules would necessarily limit the flexibility of the models to meet the needs of patients in their cohorts and to continually innovate, which has been a key to their success.

Policy Support for Serious or Advanced Illness Model Development and Diffusion

Because these models are being developed by private firms contracting primarily with private plans and provider-led entities, they are not being evaluated like Center for Medicare & Medicaid Innovation (CMMI) demonstrations, or any similar external, independent evaluation. Such an evaluation is a critical test for estimating the true impact of any new model, and yet in the absence of such evidence, these models have all passed a less empirical, but similarly rigorous, market test. For example, in less than five years (often the time it takes for CMMI to demonstrate a model and complete a full impact evaluation), Aspire has grown from 2 employees to 700, operating in 25 states and the District of Columbia, and an agreement has just been announced for the company to be bought by Anthem.¹⁰ This kind of rapid expansion indicates both the demand for new approaches to serious or advanced illness and the value that purchasers place on these models. It also demonstrates the difference in evidence standards between what is sufficient for a private firm to decide to implement a new model compared to what is required to change Medicare policy.

Despite the growth of these models to date, there is still plenty of opportunity for greater scaling and diffusion, especially into traditional Medicare. Continued development and refinement of models, informed by rigorous and transparent evaluation, can help hasten the spread of innovative approaches to serious illness care, and the federal government has recently announced two changes to Medicare Advantage that may help advance this evolution.

First, recent statutory and regulatory changes have the potential to give models like these even greater flexibility to innovate and better address the health needs of their patients with serious or advanced illness.¹¹ Earlier this year, Congress passed the CHRONIC Care Act, which calls for expanding the non-medical supplemental benefits that Medicare Advantage Plans may offer their chronically ill members, starting in 2020.¹² In addition, the Centers for Medicare & Medicaid Services (CMS) recently announced reinterpretations to Medicare Advantage requirements that will enable plans to expand the supplemental benefits they can offer to subsets of their members, such as those with serious illness, starting in the 2019 contract year.^{2,11,13,14} CMS has detailed its interpretation of the types of

services that would be covered under these new supplemental benefits. These benefits include, but are not limited to, home-based palliative care for terminally ill members, in-home support services that can assist individuals with functional limitations, caregiver support or respite care, and home and bathroom safety devices or modifications.¹³ The new flexibility will allow plans to implement new approaches to help their serious illness population,^{14,15,16} which may be implemented directly by the plan or through a third-party (such as those described in this brief).

Second, in April of this year the CMS announced that it will make Medicare Advantage encounter data available to researchers for the first time.^{17,18} Having independent researchers analyzing this data may yield insights into how well Medicare Advantage plans are performing on cost and quality measures for their patients with serious and advanced illness, producing evidence for what is working and pointing to directions for improved approaches.

In addition to these developments, these models' experience could inform additional policy changes that can be implemented to help overcome existing barriers and accelerate the diffusion of innovations in serious and advanced illness care:

Recommendation 1: Provide incentives, through payment and delivery models, to encourage innovation in serious or advanced illness care for the traditional fee-for-service Medicare population.

There are several opportunities to expand incentives for improved serious illness care in traditional Medicare. For example, CMS could broaden the Independence at Home demonstration¹⁹ to allow participation by models like those profiled here with interdisciplinary care teams and that are focused more narrowly on patients with serious or advanced illness. There are also two proposals for alternative payment models related to serious or advanced illness care that were submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which has recommended them to the Department of Health and Human Services for limited-scale testing.²⁰ The first is the *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*, submitted by the Coalition to Transform Advanced Care, and the second is the *Patient and Caregiver Support for Serious Illness* model, submitted by the American Academy of Hospice and Palliative Medicine (AAHPM).^{21,22} CMS' implementation of one of these, or a similar payment model, could encourage serious or advanced illness models to spread within traditional Medicare.

Recommendation 2: Rigorously study these new serious or advanced illness programs to expand the evidence on utilization, quality, and cost effects.

A critical first step was sharing Medicare Advantage encounter data, and more evidence could be created through external evaluations of new demonstration models (like those two recommended by PTAC²⁰). However, in order to generate evidence that meets the standard required to potentially influence broader Medicare policy, researchers will still need to apply rigorous quasi-experimental study designs to this data, with carefully constructed control groups and appropriate risk adjustment. This is an especially complicated challenge for a serious or advanced illness population. There is no single definition for serious or advanced illness; care costs trend upward as disease progresses; and there is great variability based on age, gender, diagnoses, co-morbidities, disability, and a number of other factors. However, actuaries, academic researchers, and CMS and its independent evaluators all are crafting practical solutions to this challenge. If experts can coalesce around a common evaluation framework for serious and advanced illness programs, it would facilitate evidence generation that better estimates the impact of individual models and aids comparison across models.

Recommendation 3: Support workforce development initiatives that train clinicians for roles in alternative payment model care teams.

As explained by the leaders we spoke with, these new models require clinical providers to have the ability to manage complex patient care and implement organizational changes that support new care approaches. However, most clinicians, including physicians and the nurse practitioners that quarterback care teams, do not have training in these areas. To ensure future providers have the skills to practice in an environment with more value-based payment and care delivery models, clinical training curriculums should be expanded so that students learn and practice the care management roles and responsibilities that they will likely be called on to fulfill. For existing providers, new learning and training opportunities may be provided, building on existing professional development efforts by groups such as the Center to Advance Palliative Care (CAPC) and its Palliative Care Leadership Centers (PCLC).²³

Conclusion

The three models examined in this brief illuminate just some of the innovative approaches to payment and care delivery that have been developed within the Medicare Advantage market for patients with serious or advanced illness. These models have spread rapidly across Medicare Advantage plans, and their experience can inform steps that can be taken by policymakers and other health system stakeholders. To accelerate progress, there is a need to better estimate the cost and quality impact of such models and share that evidence broadly so those benefits can be shared with a greater number of payers, providers, and patients.

References

1. Health Care Payment Learning and Action Network (HCP-LAN). APM Measurement Effort: Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs. McLean, VA: The Mitre Corporation; 2016. <http://hcp-lan.org/workproducts/apm-measurement-final.pdf>. Accessed April 9, 2018.
2. Japinga M, Bleser W, Olson A, Saunders R. Gauging Payment Reform Progress in Medicare Advantage: Current State and Opportunities for Improvement. The Robert Wood Johnson Foundation and Duke Margolis Center for Health Policy; May 2018. https://healthpolicy.duke.edu/sites/default/files/atoms/files/duke_ma_combined_050118_final.pdf. Accessed May 25, 2018.
3. Center to Advance Palliative Care. Serious Illness Strategies for Health Plans and Accountable Care Organizations. New York, NY: Center to Advance Palliative Care; https://media.capc.org/filer_public/2c/69/2c69a0f0-c90f-43ac-893e-e90cd0438482/serious_illness_strategies_web.pdf. Accessed May 31, 2018.
4. McCarthy D, Ryan J, Klein S. Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis. The Commonwealth Fund. Published October 2015. https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2015_oct_1843_mccarthy_models_care_high_need_high_cost_patients_ib.pdf. Accessed July 7, 2018.
5. Japinga M, Bleser W, Olson A, Saunders R. Gauging Payment Reform Progress in Medicare Advantage: Current State and Opportunities for Improvement. The Robert Wood Johnson Foundation and Duke Margolis Center for Health Policy; May 2018. https://healthpolicy.duke.edu/sites/default/files/atoms/files/duke_ma_combined_050118_final.pdf. Accessed May 25, 2018.
6. Hayes SL, et al. The Commonwealth Fund Issue Brief: High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? August 2016. https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2016_aug_1897_hayes_who_are_high_need_high_cost_patients_v2.pdf. Accessed July 7, 2018.
7. Nguyen K, Schmidt T, Whitney R, Bacher G, Bell J, Ozcelik S. Toward a Serious Illness Program Design & Implementation Framework. Coalition to Transform Advanced Care. 2017. <https://www.thectac.org/wp-content/uploads/2017/08/CTAC-SIP-Framework-2017.pdf>. Accessed July 7, 2018.
8. Kelley AS, Covinsky KE, Gorges RJ, et al. Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care. *Health Serv Res.* 2017;52(1):113-131.
9. Kelley AS, Bollens-Lund E. Identifying the Population with Serious Illness: The “Denominator” Challenge. *J Palliat Med.* 2018;21(S2):S7-S16.
10. Livingston S. Anthem to Buy Nashville Palliative-Care Company Aspire Health. *Modern Healthcare.* May 23, 2018. <http://www.modernhealthcare.com/article/20180523/NEWS/180529971>. Accessed July 7, 2018.
11. Silvers A, Fields T, Kytönen A, Meier DE. Medicare Advantage Flexibility: Improving Care for Seriously Ill Beneficiaries. *Health Aff Blog.* July 6, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20180702.641853/full/>. Accessed July 9, 2018.
12. Tumlinson A, Burke M, Alkema G. The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs. Long Beach, CA: The Scan Foundation; March 2018. <http://www.thescanfoundation.org/chronic-care-act-2018-advancing-care-adults-complex-needs>. Accessed July 9, 2018.
13. Centers for Medicare & Medicaid Services. Reinterpretation of “Primarily Health Related” for Supplemental Benefits. Baltimore, MD: Centers for Medicare & Medicaid Services; April 27, 2018. <https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf>. Accessed May 29, 2018.
14. Centers for Medicare & Medicaid Services. Reinterpretation of the Uniformity Requirement. Baltimore, MD: Centers for Medicare & Medicaid Services; April 27, 2018. <https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Uniformity-Requirements-4-27-18.pdf>. Accessed May 29, 2018.
15. Montgomery R, Valuck T, Webber A. Increasing Access to Serious Illness Care Through Innovation in Health Benefits. *Health Aff Blog.* June 4, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20180601.361099/full/>. Accessed June 15, 2018.
16. Willink A, DuGoff EH. Integrating Medical and Nonmedical Services—The Promise and Pitfalls of the CHRONIC Care Act. *N Engl J Med.* 2018 Jun 7;378(23):2153-5.
17. Centers for Medicare & Medicaid Services. CMS Administrator Verma Unveils New Strategy to Fuel Data-driven Patient Care, Transparency. April 2018. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-26.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>. Accessed May 24, 2018.
18. Dickson V. CMS Releases Medicare Advantage Data for First Time. *Modern Healthcare.* April 26, 2018. <http://www.modernhealthcare.com/article/20180426/NEWS/180429915>. Accessed July 8, 2018.
19. Independence at Home Demonstration. Centers for Medicare & Medicaid Services Web site. <https://innovation.cms.gov/initiatives/independence-at-home/>. Updated May 2, 2018. Accessed May 29, 2018.

20. Physician-Focused Payment model Technical Advisory Committee. Report to the Secretary of Health and Human Services. Comments and Recommendations on Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model & Patient and Caregiver Support for Serious Illness (PACSSI). May 7, 2018. <https://aspe.hhs.gov/system/files/pdf/255906/PTACCommentsRecommendationAAHPMCTAC.pdf>. Accessed July 8, 2018.
21. Coalition to Transform Advanced Care. Proposal to the Physician-Focused Payment Model Technical Advisory Committee: Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model. October 4, 2017. <https://aspe.hhs.gov/system/files/pdf/253406/ACM.pdf>. Accessed July 8, 2018.
22. American Academy of Hospice and Palliative Medicine. Proposal to the Physician-Focused Payment Model Technical Advisory Committee: Patient and Caregiver Support for Serious Illness (PACSSI). August 15, 2017. <https://aspe.hhs.gov/system/files/pdf/255906/ProposalAAHPM.pdf>. Accessed July 8, 2018.
23. Cassel JB, Bowman B, Rogers M, Spragens LH, Meier DE, Palliative Care Leadership Centers. Palliative Care Leadership Centers Are Key To The Diffusion Of Palliative Care Innovation. *Health Aff Proj Hope*. 2018 Feb 1;37(2):231-9.

Acknowledgements

We would like to thank the following individuals and organizations for interviewing with us during our information gathering stage for this issue brief. They provided crucial insight as well as answered key questions we had, and we greatly appreciate their time and contributions to this work. The viewpoints expressed in this brief do not necessarily reflect the viewpoints of the individuals below nor their organizations.

Brad Smith, Co-Founder and Chief Executive Officer, Aspire Health

Carol Devol, Co-Founder and Chief Operating Officer, Landmark Health

Michael Le, Co-Founder and Chief Medical Officer, Landmark Health

Duncan MacRae, Vice President of Health Care Economics, Landmark Health

Terri Maxwell, Chief Clinical Officer, Turn-Key Health

We would like to thank members of our broader research team at Duke University's Robert J. Margolis Center for Health Policy for strategic guidance and input, including Mark B. McClellan, MD, PhD, Aaron McKethan, PhD, David Anderson, MS, and Ellen de Graffenreid, MA, MBA. Thanks also to Center staff who made this project possible, including Mark Japinga, MPA, and Will Bleser, PhD, MSPH.

Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. We would like to acknowledge specific support and interest from Katherine Hempstead, PhD.

About the Robert Wood Johnson Foundation

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

About Duke Margolis Center for Health Policy

The Robert J. Margolis, MD, Center for Health Policy at Duke University is directed by Mark McClellan, MD, PhD, and brings together expertise from the Washington, DC, policy community, Duke University and Duke Health to address the most pressing issues in health policy.

The Center's mission is to improve health and the value of health care by developing and implementing evidence-based policy solutions locally, nationally, and globally. For more information, visit healthpolicy.duke.edu.

For more information about this brief, please contact: Andrew Olson, MPP, at Andrew.Olson@duke.edu.