Volume 9, Issue 4 April 2018

Accountable Care NEWS

Balancing Risk and Rewards: Advanced Alternative Payment Model Participation in 2018 and Beyond

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As we approach the third anniversary of the signing of the Medicare Access and CHIP Reauthorization Act of 2015, providers and health systems continue to evaluate the best ways to align and take advantage of positive payment adjustments and incentives available under the Act. Physicians have voiced concern that MACRA's value-based payment options put too much financial risk and administrative burden on their practices. As physician payment programs created by MACRA continue to be reformed and refined, health industry leaders should continue to weigh the challenges and opportunities presented by MACRA, and particularly the benefits of participating in one sided- or two sided-risk Alternative Payment Models.

As providers evaluate their options, APM participation presents itself as an attractive option to achieve scale and enhance care coordination along the continuum of patient care. Participating in APMs with downside risk – known as Advanced APMs – also prepares providers for additional risk sharing in the future.

MACRA Background

MACRA is bipartisan legislation that fundamentally transforms the way Medicare pays physicians and hospitals for professional services. While Medicare traditionally paid physicians on a fee-for-service basis, MACRA marks a shift to paying physicians for successful treatment outcomes and rewarding value over volume.

(continued on page 3)

In This Issue

Journal Scan

ACOs, Other Models Struggle With Getting, Using Data

The Commonwealth Fund, discussing a study in *Health Affairs*, notes that "Accountable Care Organizations and other newer care delivery models use some health information technology to drive innovation, but most report difficulty accessing, sharing and applying data for performance improvement;" as well, the organization reports, the article, "Data-Driven Diffusion of Innovations: Successes and Challenges in 3 Large-Scale Innovative Delivery Models," argues that "to drive innovation in patient care, ACOs and other new care delivery models need help from external experts to help them exploit the data they collect." Indeed, the Fund says, "electronic health information has had only a limited impact on how healthcare is delivered, despite experts' hopes that such data would improve quality of care and reduce costs," adding: "Public policy efforts, the authors say, should focus on helping providers use data more effectively to improve information-sharing and patient care."

Even though "many stakeholders expected that the substantial national investment in health IT and electronic data would be paying off in the successful adoption of data-driven innovation models in healthcare delivery," the Fund reports, "evidence from three large-scale and diverse innovations suggests that this is not yet the case."

- *ACOs.* The researchers "found that 97% of ACOs have an EHR system in place," The Fund reports, "making it the most widely adopted data tool; ACOs also use measurement data on providers' performance, often reporting feedback directly to physicians." But, the *Health Affairs* article notes, "ACOs find it difficult to obtain complete health data for patients who receive care outside the ACO."

(continued on page 6)

Accountable Care News
April 2018 – Volume 9 Issue 4

ISSN 2166-2770 (Electronic)
ISSN 2166-2738 (Print)

Publisher
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Accountable Care News is published monthly by Health Policy Publishing LLC. Newsletter publication administration is provided by MCOL.

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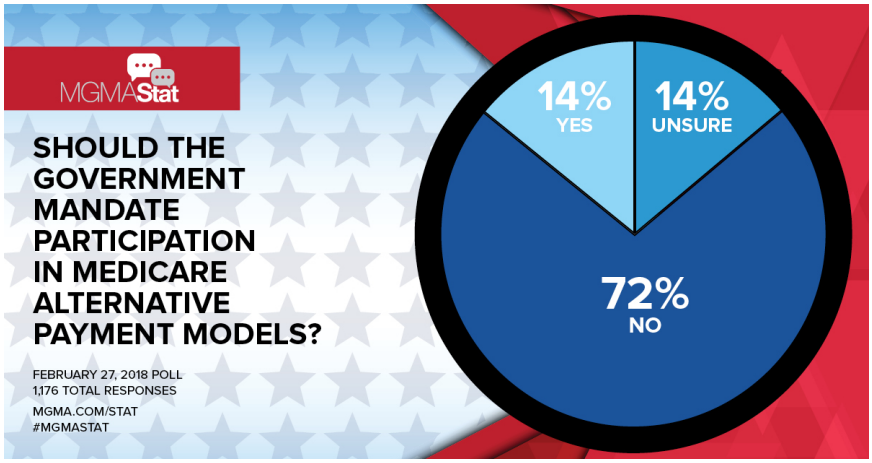
Washington DC Watch

MGMA Finds Members Oppose Mandatory APMs

Saying that medical group practices "overwhelmingly prefer flexibility and financial incentives to move to Medicare Alternative Payment Models," the Medical Group Management Association says in a Stat poll that "despite support for APMs, a large majority of physician practices oppose government-mandated participation, citing lack of evidence, diversity among medical practices and the negative impact on practice innovation." MGMA says it "has long championed voluntary APM opportunities for physician group practices of different types, sizes and specialties and continues to urge CMS to eliminate barriers to physician participation in payment models that support high-quality, cost-effective patient care." Visit www.mgma.com.



Reps Form Value-Based Payment Caucus

A group of representatives has created the Health Care Innovation Caucus, which it says is "supported by a diverse group of healthcare organizations from throughout the nation" and which will "advance a legislative agenda that encourages innovative policy ideas to improve the quality of care and lower costs for consumers."

- "An organization of leading companies from all sectors of healthcare applauds the Caucus, focused on encouraging new concepts in payment and delivery that emphasize improved value and superior health outcomes." The Healthcare Leadership Council, in fact, adds that it's "an important step in maintaining momentum in the ongoing transition from fee-for-service healthcare to value-focused systems."
- The Health Care Transformation Task Force says it also "welcomes the launch," noting that its members "recognize all too well the need for a sweeping revolution of the healthcare system."
- The National Coalition on Health Care adds that "there's little more important to long-term healthcare affordability than moving beyond today's costly volume-centered paradigm" and argues that "expansion of Advanced Alternative Payment Models opportunities should be the top priority for the Centers for Medicare and Medicaid Innovation."
- Premier Inc. says it's been "a stalwart supporter for more than 15 years of the national move away from perverse incentives in today's FFS system in favor of new, value-based, alternative payment models" – which it credits with "generating significant returns in cost and quality." The company also calls for "meaningful, transparent measures of provider performance; access to timely, accurate and complete claims data to better facilitate care management; creation of additional payment models that support high-value services at a reduced cost; deregulation of the fee-for-service legal and regulatory requirements that increase costs and impede collaboration and innovation; and alignment between private and public sector programs."

(continued on page 3)

Washington DC Watch

The Caucus founders, noting that the healthcare industry is "rapidly transforming from a volume-driven system to one that rewards value and outcomes," add that "it's vital that we encourage a marketplace of multiple payment models using lessons learned to improve care for consumers. The main focus of the Caucus will be to explore and advance successful, innovative payment models as well as the technologies needed to support these models."

7 ACOs Call It Quits After Next-Gen Program Risk Rules Change

The news on the websites is pretty blunt when it comes:

- "Effective March 19, 2018, MemorialCare [Regional ACO] will no longer participate in the Centers for Medicare & Medicaid Services Next-Generation Accountable Care Organization model."
- "Effective Feb. 28, 2018, Sharp HealthCare, Sharp Community Medical Group and Sharp Rees-Stealy Medical Group will no longer participate in the Centers for Medicare & Medicaid Services Next-Generation Accountable Care Organization model. This enhanced care coordination initiative began on January 1, 2017."

Elsewhere on its website, and later in two seminars, Sharp explains to members how to access coverage and move to a Medicare Advantage plan – and when their ACO programs and services will end if they don't. In all, seven ACOs have left the Next-Generation model, the *American Journal of Managed Care* website reports, leaving 51 in the program – and "disappointing" the National Association of Accountable Care Organizations, which added in a statement to the site that the ACOs that bolted "felt the program was no longer a good fit. Some are leaving because of the challenges they faced earning savings and in response to concerns about Innovation Center policy and methodology changes, such as recent changes to risk adjustment."

- Sharp may sue, saying CMS made "a unilateral change to the participation agreements" after it had already "invested $2 million in care management programs."
- Fairview Health Services said "the model design penalizes ACOs that already deliver high-quality, low-cost care," the website reports, saying the Next-Gen model's structure "focuses on improved performance rather than sustained low cost level, and does not take into account our already-excellent performance as compared with the rest of the country" – so it would "impose a significant penalty on our network."

The NAACOS statement to the *AJMC* website also said the departures "illustrate the broader challenges of assuming and managing risk, which continue to be a significant hurdle for ACOs," and called for "fair methodologies and program structure that allows ACO performance to reflect their true efforts;" specifically, the group asks CMMI not to "implement unpredictable unilateral changes during the agreement period" that "lessen the ability of ACOs to reap benefits from more accurate coding."

Balancing Risk and Rewards: Advanced Alternative Payment Model Participation … *continued from page 1*

MACRA ended the Sustainable Growth Rate formula and required the Centers for Medicare and Medicaid Services to implement the Quality Payment Program. The QPP provides two pathways for physician payment:

- *The Merit-Based Incentive Payment System program*. Payments to physicians who elect the MIPS option are adjusted (positively or negatively) based on how the physicians score on a number of performance metrics relative to their peers. MIPS streamlines multiple legacy CMS quality and incentive programs, such as PQRS and the Meaningful Use incentive program.
- *Advanced APMs*. Physicians who elect to participate in an Advanced APM instead of MIPS can be exempt from MIPS's reporting requirements and may be eligible to receive a 5% annual payment bonus, if a sufficient portion of their revenue comes through Advanced APMs. Starting in 2026, they are also eligible for higher annual Medicare Physician Fee Schedule adjustments.

When MACRA was enacted, 2017 and 2018 were slated to be the only transition years before providers' payments were affected in 2019. Recent changes to the MIPS program have altered the MIPS implementation timeline and the amount of positive payment adjustments that may be earned by providers participating in that model. When deciding whether to participate in MIPS or an Advanced APM, providers should evaluate each model to determine the best fit based on its care strategy, incentives and risk structure.

Considerations for Participating in MIPS, Advanced APMs or MIPS APMs

"The MIPS program has been controversial since its implementation due to its complexity and onerous reporting requirements."

[1] MIPS

MIPS requires providers to report to CMS across four separate categories: quality, cost, clinical practice improvement activities and electronic health record meaningful use (known now as "advancing care information"). Providers may receive sliding scale bonuses or cuts to their Medicare payments based on their reporting and performance in the categories. Providers have the ability to choose which metrics to be measured against and report on, depending on the size of their practice and its strengths. Providers can be exempt from MIPS reporting if they meet Advanced APM participation criteria, if they are new to Medicare or if they care for a low volume of Medicare patients.

(continued on page 4)

Balancing Risk and Rewards: Advanced Alternative Payment Model Participation … *continued from page 3*

The MIPS program has been controversial since its implementation due to its complexity and onerous reporting requirements. Congress recently approved the Bipartisan Budget Act of 2018, which makes key reforms to the MIPS program.

- Rather than require adjustments to providers' Medicare reimbursement starting in 2019, the BBA gives CMS three additional years (through performance period 2021) to start lowering payments to physicians in connection with their performance. This decreases the number of physician practices that face potential Medicare payment reductions under MIPS in the near term.
- The BBA further limits MIPS payment adjustments by prohibiting CMS from applying any adjustments to separately billed items like drugs and biologics. This is a significant carve-out from the program and has a large impact on oncologists and other physicians whose charges for separately billed drugs represent a significant portion of their in-office services.
- Finally, the "low-volume threshold" exemption now excludes the cost of such drugs and services from the amount of Medicare charges needed to be able to participate in MIPS, excluding even more physicians from MIPS.

Taken together, the recent changes to MIPS in the BBA signal a slow-down by CMS in implementation of the MIPS program. Assuming CMS continues to set relatively low performance thresholds during this extended transition period, physicians will continue to enjoy only moderate upward adjustments and fewer physicians will receive downward adjustments.

This is a stark departure from the originally proposed 9% adjustment in payments under the original MIPS program. Importantly, the BBA also reduces the general MPFS annual update for 2019 from 0.5% to 0.25%. This will reduce total Medicare payments to physicians by more than $100 million next year. In light of these changes and the overall reduction in Medicare reimbursement, providers should consider participating in Advanced APMs to take advantage of potential upward payment adjustments and incentives that are available.

[2] Advanced APMs

An APM is a payment model that differs from the traditional fee-for-service model; physicians are reimbursed through it with a fee set according to the MPFS. Healthcare providers in an APM seek to align themselves with the goal of taking better care of a certain population of patients, usually within a targeted geographic area. If an organization adopts one of CMS' APMs, all participants agree to be paid according to the payment model's rules.

A common example of an APM is the Medicare Shared Savings Program. In that program, an Accountable Care Organization applies to participate in the MSSP APM option. Under the MSSP, if the ACO can realize savings by providing high-quality and low-cost care to the Medicare beneficiaries who are assigned to the ACO, Medicare will share the savings with the ACO. Physicians in the ACO may be eligible to share in the ACO's savings. Only the APMs that CMS deems Advanced allow participating physicians to achieve qualifying participant status and thus be eligible for the annual 5% payment bonus.

Advanced APMs must meet the following three requirements:

- Providers in the APM must accept financial risk which is "more than nominal" (e.g., either withhold payments, reduce rates or require the APM entity to pay CMS back if the APM entity's actual expenditures exceed expected expenditures).
- Payments must be tied to MIPS or comparable quality measures. No minimum number of measures is required, but at least one must be an outcomes-based measure.
- At least 50% of the Advanced APM participants must use certified EHR technology in the first performance year. This requirement increases to 75% in the second performance year.

Physicians who participate in Advanced APMs and meet the patient or revenue threshold requirements to be recognized as QPs are exempt from the complex MIPS scoring system, and they receive 5% bonuses between 2019 and 2024, and a 0.75% increase in the MPFS in 2026 and beyond. The Advanced APM bonuses and incentives are in addition to any APM-specific benefits that participating providers may receive through their participation in an APM (e.g., shared savings from an ACO).

"Physicians who participate in Advanced APMs and meet the patient or revenue threshold requirements to be recognized as QPs are exempt from the complex MIPS scoring system, and they receive 5% bonuses between 2019 and 2024, and a 0.75% increase in the MPFS in 2026 and beyond."

Whether or not a provider will be recognized as a QP is a determination made at the APM entity level for all providers participating in the Advanced APM. CMS calculates the total Advanced APM Medicare Part B payments made to the Advanced APM entity providers, and also determines the number of Advanced APM entity-attributed lives. CMS then compares the total Advanced APM entity Medicare Part B payments and the total number of Advanced APM entity-attributed lives to thresholds. If either threshold is met, all providers in the Advanced APM entity are deemed QPs for that performance year, and receive the 5% payment bonus.

A provider can choose to participate in several different APMs, however, CMS may make adjustments in certain of its calculations to prevent providers from "double dipping" in program incentives that otherwise cover the same set of Medicare beneficiaries. For example, CMS requires providers who participate in both an MSSP ACO and a Comprehensive Primary Care Plus program primary care practice to forfeit the quality incentive bonus otherwise payable under the CPC+ program. Providers should therefore weigh the likely amount of any anticipated shared savings they might earn from participating in the MSSP against the amount of the quality incentive payment they would be forfeiting under the CPC+ program were they to participate in both programs.

(continued on page 5)

Balancing Risk and Rewards: Advanced Alternative Payment Model Participation ... *continued from page 4*

For the 2019 performance year, clinicians may earn a 5% annual incentive payment on their total Medicare reimbursements through sufficient participation in any of the following Advanced APMs:

- CPC+
- MSSP Tracks 1+, 2 and 3
- Comprehensive ESRD Care Model (Large Dialysis Organization [LDO] arrangement and non-LDO two-sided risk arrangement)
- Next-Generation ACO Model
- Oncology Care Model (two-sided risk arrangement
- Comprehensive Care for Joint Replacement Payment Model CEHRT track
- Bundled Payments for Care Improvement-Advanced Model

That list is anticipated to grow as CMS introduces more value-based payment models and programs.

[3] MIPS APMs

Even if providers in an Advanced APM do not qualify as QPs, or if providers participate in an APM that is not an Advanced APM but meets certain criteria to be a MIPS APM, favorable MIPS scoring and APM-specific rewards are still available to participating physicians. Non-Advanced APMs that meet the following criteria are deemed by CMS to be MIPS APMs:

- The APM entity has an agreement with CMS (e.g., MSSP-CMS Participation Agreement)
- The APM entity has at least one MIPS-eligible clinician on its roster who is on a CMS participation list (e.g., MSSP ACO participant)
- Payment incentives under the AMP (either at the AMP entity level or the provider level) are based on cost/utilization and quality measures (e.g., MSSP benchmarks and quality metrics)

As an example, participation in an ACO in Track 1 of the MSSP offers physicians the opportunity to earn a portion of the ACO's shared savings payment from CMS without any downside risk, and prepares the physician for the shift to value-based care.

- In a MIPS APM, physicians are scored under the same four performance categories as regular MIPS, except cost (referred to as "resource use" by CMS). Providers in ACOs are not scored on cost factors because CMS is already evaluating this metric as part of their participation in the MSSP.
- In addition, providers in ACOs that qualify as MIPS APMs receive credit in other performance categories required in MIPS because they are already making efforts in value-based payment models – such as population health and care coordination.
- Another advantage of participating in a MIPS APM like the MSSP is that the ACO does the quality reporting on the provider's behalf.

"Providers in ACOs are not scored on cost factors because CMS is already evaluating this metric as part of their participation in the MSSP."

Physicians may ultimately find participation in an ACO attractive because the ACO handles the majority of the MIPS reporting requirements. Furthermore, once a provider has gained experience through participation in a Track 1 ACO, the provider might find participation in a newer Advanced APM model, such as MSSP Track 1+, attractive as a next step in the evolution toward risk and value-based payment. The MSSP Track 1+ is an Advanced APM and a two-sided risk model with less downside risk than Tracks 2 and 3.

Choosing a Path Forward

CMS is not alone in rolling out innovative risk-based payment models. Many commercial payers are following suit, finding that the quality of care can greatly increase while simultaneously decreasing costs when providers are invested in outcomes.

So, how do you know whether your organization and providers are ready to participate in an Advanced APM? Implementing an APM strategy that will ultimately generate savings can be a years-long endeavor that should be approached in a stepwise fashion. At the outset, providers that desire to leverage MACRA's payment incentives need to complete an assessment of their readiness and willingness to potentially take on risk – and their likelihood of success. Key APM strategy considerations include the following:

[1] Understand the timing and deadlines for applying for APM programs and models. For example, the deadline for 2019 Medicare Shared Savings Program participation is May 2018, whereas the deadline for submitting 2017 MIPS performance data was March 31.

[2] Review the organization's historical PQRS, Hospital Value-Based Purchasing Program and Meaningful Use performance to help forecast potential APM bonuses and MIPS payment adjustments.

[3] Perform an APM versus MIPS participation cost/benefit analysis.

[4] Assess organizational readiness to accept risk-based reimbursement under Advanced APMs.

[5] Evaluate APM and commercial contracting strategies to project risk-based revenue sufficient to qualify providers in the organization as QPs who are thus eligible for the 5% Advanced APM bonuses and the long-term 0.75% increase in the MPFS starting in 2026. Assess which commercial payer agreements will need to be renegotiated to contain clear metrics and goals, and ensure that data can be shared across involved parties.

(continued on page 6)

Balancing Risk and Rewards: Advanced Alternative Payment Model Participation ... *continued from page 5*

[6] If considering participation in multiple APMs, consider the potential financial tradeoffs. For example, providers who participate in both MSSP and CPC+ must forgo the CPC+ quality incentive payment and instead are only entitled to share in any MSSP ACO savings.

[7] Assess data management capabilities to support integration and sharing of clinical and claims data.

[8] Develop plans for clinical integration across providers and ways to appropriately share information to track care for patients that is accessed out-of-network, i.e., outside the ACO.

[9] Plan to include specialists and ancillary providers such as behavioral health, rehabilitative services, post-acute and hospice care.

Conducting a readiness assessment and adopting a stepwise approach to Advanced APM participation can help providers ease their way into value- and risk-based payment models under MACRA, while simultaneously helping them develop and implement care redesign strategies that will help them succeed in the ever-expanding value-based reimbursement environment.

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ACOs, Other Models Struggle With Getting, Using Data ... *continued from page 1*

- *Comprehensive primary care*. CPC practices "have adopted a wide range of new health IT systems," the Fund says, for "care management referrals, care planning and communication with patients and care teams;" by 2016, 81% were also "using health data for quality improvement and risk stratification."
- *EvidenceNOW*. More than half of practices "reported participating in the Centers for Medicare and Medicaid Services' meaningful-use EHR incentive program," The Fund says *Health Affairs* said, "and more than half indicated they could use their EHR systems to produce reports on quality of care."

Additional findings: Nearly all ACOs use EHRs, but only 65% draw from disease registries and 53% from personal health records; just 39% "take advantage of secure messaging technology." As well, 62% of ACOs report that "exchanging health information between inpatient and outpatient settings was 'very challenging'" and "while external experts can help physicians and practices learn how to compare their own data against performance benchmarks, such technical assistance can consume a large amount of staff time and resources."

DA Dorr, DJ Cohen and J Adler-Milstein, "Data-Driven Diffusion of Innovations: Successes and Challenges in 3 Large-Scale Innovative Delivery Models," *Health Affairs*, Feb. 2018 37(2):257–65

MSSP ACOs that saved enough to share savings, "holding all else equal, spent 0.36% less on inpatient, 0.31% less on skilled nursing facilities and 0.16% less on home health expenditures" than ACOs that didn't save.

'Medicare Accountable Care Spending Patterns: Shifting Expenditures Associated With Savings'

Researchers conducted a sensitivity analysis that showed that, on average, Medicare Shared Savings Program Accountable Care Organizations that saved enough to share savings, "holding all else equal, spent 0.36% less on inpatient, 0.31% less on skilled nursing facilities and 0.16% less on home health expenditures" than ACOs that didn't save. "MSSP ACOs were shifting their expenditures and care utilization patterns," the paper says. "Between 2013 and 2016, they made modest but nonetheless meaningful changes to where money was spent, [with] a greater proportion on services in the physician office setting and on hospice." Researchers also found that "although all MSSP ACOs shift expenditures, the ACOs that improved their savings rate most rapidly were those that had shifted SNF and inpatient expenditures more dramatically, indicating that the degree to which ACOs shift their expenditures matters and that significant additional savings can be gained by shifting inpatient and SNF spending toward physician services."

That's "consistent with the argument that some services may provide more value, leading to reductions in the cost of delivering healthcare," the paper authors note. "Increasing care in the physician office setting may reduce hospitalizations and the increased costs associated with inpatient stays, while focusing on well-structured care transitions between the hospital and the PAC setting may reduce unnecessary costs." But seeing that ACOs are changing how they spend, and seeing that those changes are associated with "modest savings," still doesn't show "how or why ACOs are making these changes," they add. "Our companion study found that, on average, MSSP ACOs have improved most quality measures. Importantly, this suggests that there is no association between shifting expenditures away from the hospital setting and a reduction in quality outcomes."

The paper adds that "sustainable changes to our healthcare system require more than just paying differently for care; they involve delivering care in a different way, including prioritizing lower-acuity, lower-cost settings," noting as well that "new payment models, such as the Alternative Payment Models encouraged under the Medicare Access and CHIP Reauthorization Act, represent an important avenue to incent such changes." Specifically, they say, "our research adds to the literature that suggests reducing spending on SNFs presents an opportunity for ACOs to lower costs," so "policy makers should continue to develop programs that incentivize care coordination, well-planned care transitions and strategic partnerships between hospitals and PAC settings that have been shown to lower spending." Indeed, they point out, "our finding that shifting more money to the physician office setting and away from SNF and inpatient spending is correlated with greater overall savings suggests that this tactic may be pursued by other ACOs to achieve greater reductions in overall spending without compromising quality."

The American Journal of Accountable Care. 2018;6(1):11-19 *(continued on page 7)*

ACOs, Other Models Struggle With Getting, Using Data... *continued from page 6*

'Variations in ACOs and Narrow Networks Challenge Efforts to Track Their Impact'

Noting that "narrow networks are groups of contracted providers that are smaller than a health plans' broadest network offering and provide care, sometimes better care, at a more affordable price," the *American Journal of Managed Care* author adds that "while there are features common to both models, Catalyst for Payment Reform has learned that what constitutes Accountable Care Organizations and narrow networks is inconsistent across health plans." CPR set out to "determine how to measure the prevalence of ACOs and narrow networks," because "presence of ACOs could indicate that providers are changing the way they deliver care, working toward a more coordinated and continuous experience for the patient, and the presence of narrow networks may be a good indicator that payers are signaling to providers that they will reward more affordable care with more patients."

But "we learned that it is virtually impossible to track the prevalence of these models or their impact on the healthcare system without standard definitions." ACOs can have a variety of features, the author adds, noting that "providers could be held accountable for spending over the target budget or not bear any financial risk at all" and that ACOs "can be structured around a group of providers or a hospital or health system." But, the article says, "less is known about the variation in how health plans define and design narrow networks."

- CPR "conducted interviews with health plans in hopes of converging on a single definition."
- Researchers "postulated that we would be able to conclude that a narrow network is one in which health plans exclude providers whose prices are one standard deviation above the mean or who don't meet minimum quality thresholds."
- As well, they wanted to learn "how health plans determine who among certain provider types (primary care providers, specialists and hospitals) is eligible to participate."

But CPR "found no consistent formula across health plans," the research paper says; plans "primarily consider which hospital or provider group will agree to a certain price, based on a premium analysis; whether excluding others is feasible given each provider's market power or 'must have' status; and whether excluding the hospital or physician group creates access issues." CPR adds, importantly: "It is notable that among the health plans we spoke to, none used provider quality as the primary selection criterion."

The paper adds: "CPR thought it would be valuable to understand the percentage of a health plan's total contracted providers in shared-risk contracts. However, plans warned us that counting the number of providers would be an arduous and imprecise task. Some health plans count the number of individuals under a single contractual umbrella, whereas others count the number of contracts, not the number of physicians covered. Instead, plans advised us to measure the number of shared-risk contracts, regardless of whom they are with or how many providers are covered under the contracts, to track prevalence and growth."

Access the article at http://www.ajmc.com/contributor/suzanne-delbanco/2018/01/variations-in-acos-and-narrow-networks-challenge-efforts-to-track-their-impact.

"Currently, specialists are advantaged through fee-for-service, and financial incentives for ACO participation are weak, at best."

'How to Engage Specialists in Accountable Care Organizations'

The ACO model "centers on transferring financial risk for the cost and quality of care from the payer to an ACO," the paper says, "theoretically incentivizing the delivery of high-value healthcare services and minimizing waste;" it adds that "a large segment of America's healthcare is driven by specialties" and "clinicians in these fields need to prepare for the day when they will be required to participate in payment models arising as alternatives to traditional fee-for-service reimbursement." ACOs have focused on primary care, the article notes, pointing out that "no better evidence is there than the way the Medicare Shared Savings Program determines which of its beneficiaries are attributed to an ACO" – to wit: "If a patient's primary care physician is enrolled in an ACO, then the patient frequently belongs, even though he or she may not know it; however, these same ACOs are accountable for the overall per-beneficiary annual costs, including specialty care."

The *New England Journal of Medicine* authors – citing research showing that 66.7% of specialist office visits were provided outside of assigned ACOs – offer "a business-based framework for making strategic decisions about whether and how to include specialists in ACOs, and for working toward a common goal of delivering high-quality, low-cost care." Now, they add, "considerable variation in surgeon participation in early ACOs is largely driven by a practice's contractual role in an ACO, not the specialist's strategic value to the organization;" but, they argue, they "believe that assessing both the strategic value of potential partnerships and predicted cost savings provides the platform for informed decision making." It will become increasingly important to provide financial incentives to make ACO participation advantageous for physicians, the article adds, stating that "currently, specialists are advantaged through fee-for-service, and financial incentives for ACO participation are weak, at best."

Indeed, there are "significant unanswered questions," the paper concedes, "about the degree to which contemporary ACO programs can control specialists' behavior, specifically with respect to use of high-cost diagnostic testing and procedures;" and no one knows yet if "the extensive addition of specialists would dilute the shared savings and financially affect primary caregivers." The bottom line, according to the authors: "There is no optimal one-size-fits-all approach to aligning incentives. Organizations will have to continually evaluate the strategic value of specialist integration, as well as the financial benefit of partnerships." That's why, they say, "applying a conceptual framework for these partnerships may crystallize the benefit and risk balance."

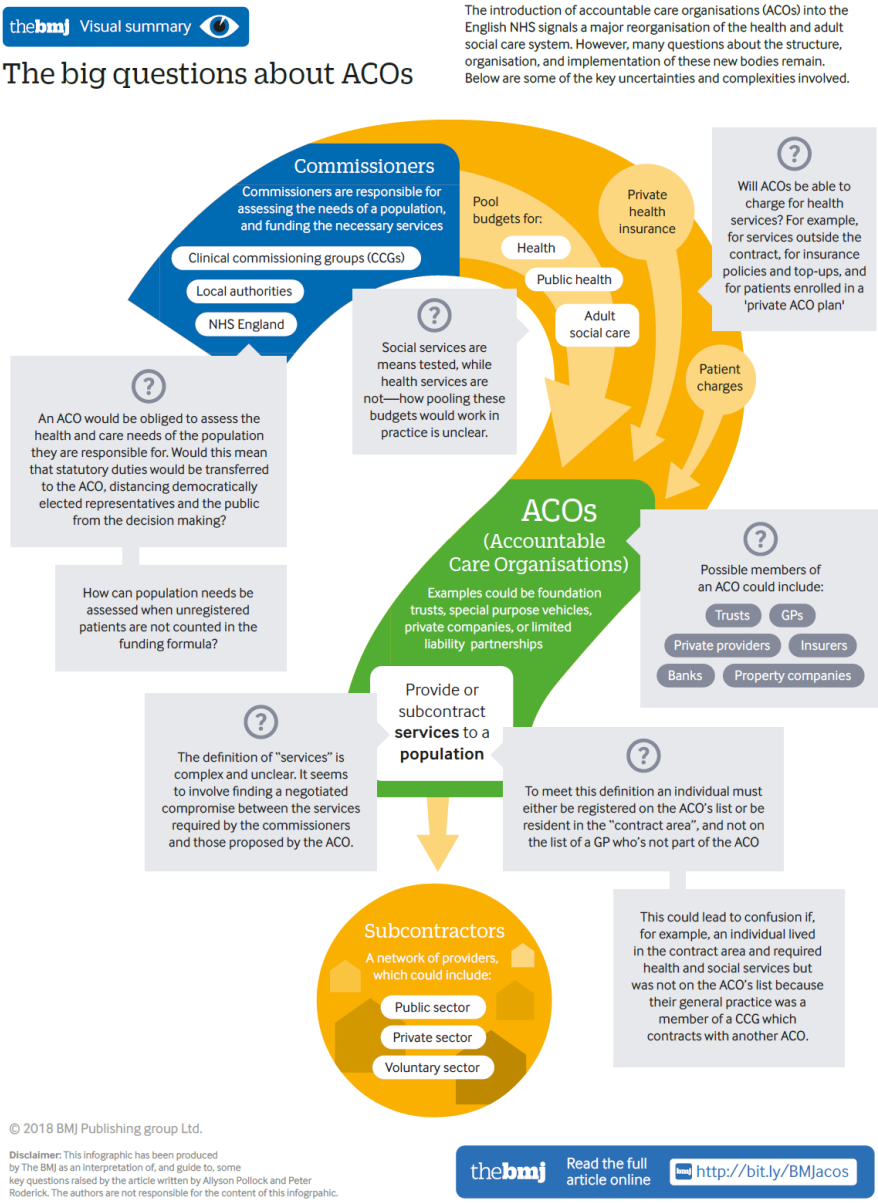
Access the article at https://catalyst.nejm.org/engage-specialty-care-accountable-care-organizations/. *(continued on page 8)*

ACOs, Other Models Struggle With Getting, Using Data… *continued from page 7*

'Why we should be concerned about accountable care organisations in England's NHS'

They're a bit skittish about Accountable Care Organizations across the pond. A recent article and accompanying infographic in the *British Medical Journal* argues that "the government and the National Health Services' plans for a major reorganization of the health and adult social care system must come under greater scrutiny," adding that "consultation and legislation are necessary safeguards to ensure that the plans are consistent with the fundamental principles of the NHS of a universal and comprehensive service that is publicly funded, accountable and free at the point of delivery."

- ACOs, the paper points out, "were designed to improve patient experience and control federal expenditure within the US healthcare system, which is dominated by private health and insurance companies. So far the evidence of the effect of ACOs on quality is contested, and at best mixed."
- Specifically, it says, "the projected savings to federal budgets translated into a net loss in 2015, and spending may have actually increased," and "the US insurance-based system does not seek to provide universal care, giving rise to several questions and uncertainties about how the ACO model will apply in the NHS."
- The draft ACO contract [in the UK] "is intended to facilitate the use of two new models of care – fully or partially integrated 'multispecialty community providers' and 'primary and acute care systems'," the article notes. "In the fully integrated model, the ACO has 'full responsibility for provision and integration of care' for up to 15 years."
- The government's intention, the paper continues, "is to move to a capitation system with a linked outcomes and incentives payment scheme," but it adds that "the complexity in deriving risk-adjusted capitation is enormous and well-known. Personal health budgets [could] further undermine risk pooling, social solidarity and equity, which are required for universality."
- And, it notes, "social services are means tested and charged for, while health services are not; how pooling these budgets would work in practice is unclear."



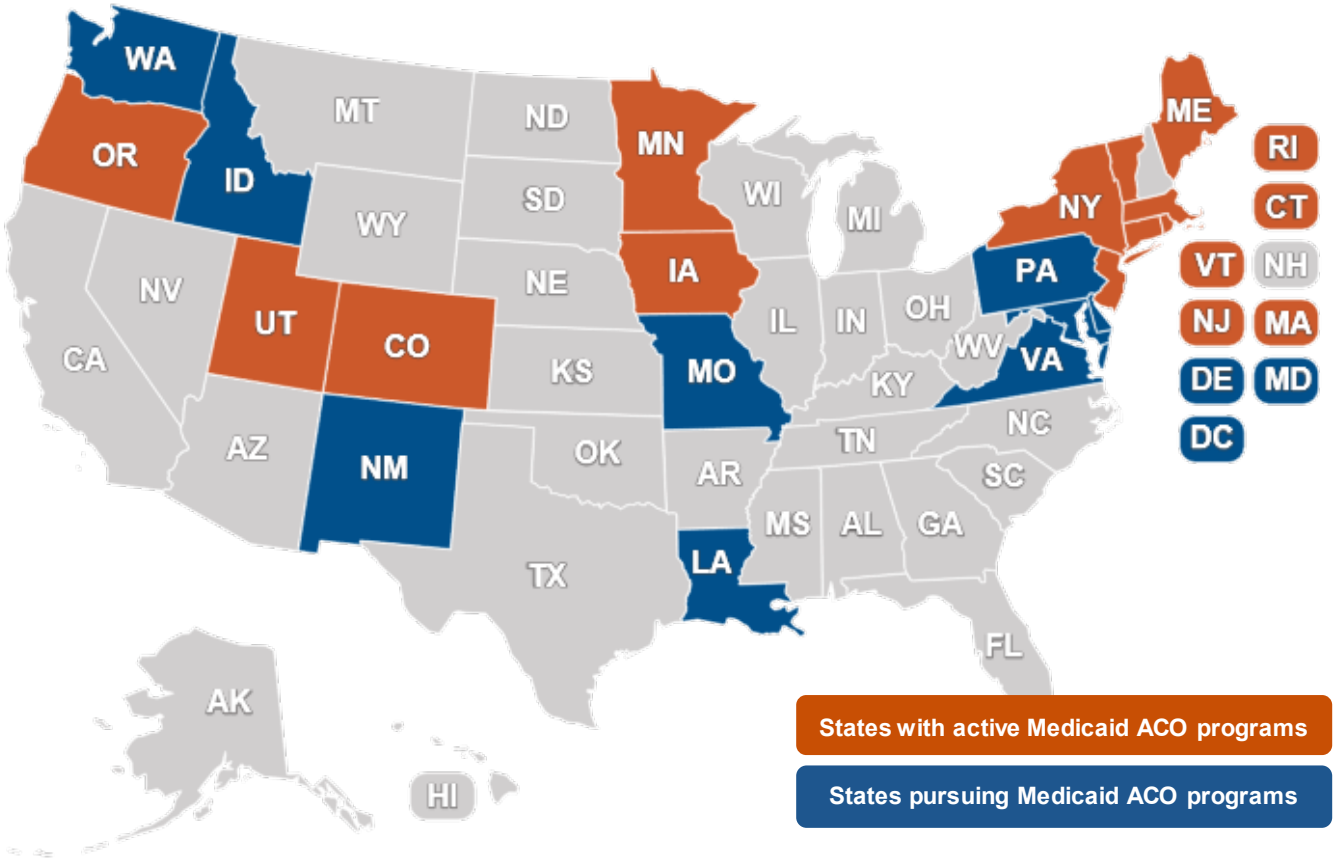
Another concern: "Transferring billions of pounds to non-statutory providers raises important accountability issues," the paper authors argue, "and there are several ways public involvement in and accountability for ACO decisions on services would be degraded, compared with the current position." ACOs would not have statutory obligations; their terms "are enforceable by parties to the contract, not by members of the public." And, the paper says, "we do not know whether individual ACOs could be subject to judicial review, or to a human rights or freedom of information challenge." Interestingly, the article adds, the head of the NHS said publicly that ACOs "will effectively end the purchaser-provider split, bringing about integrated funding and delivery" – but the paper added that "the purchaser-provider split is established in primary legislation, so it is unclear how ACOs will end it."

BMJ 2018;360:k343; http://www.bmj.com/content/360/bmj.k343

(continued on page 9)

ACOs, Other Models Struggle With Getting, Using Data... *continued from page 8*

More States Addressing Medicaid ACOs



State-based Medicaid ACOs "are becoming increasingly prevalent across the country," according to The Commonwealth Fund, with more and more states "pursuing ACOs as a way to improve health outcomes and control costs through greater provider accountability." *https://www.chcs.org/resource/medicaid-aco-state-update/*

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Thought Leaders' Corner

Each month, *Accountable Care News* asks a panel of industry experts to discuss a topic suggested by a subscriber.

Q. Which type of ACO activity will have more impact on stakeholders in the long term: Medicare, Medicaid or commercial?

I think Medicare ACO activity will have the most impact in the long term based on where incentives are maximized.

- Fully capitated plans such as Medicare Advantage and managed Medicaid plans will have the highest incentive to reduce costs and maintain high quality scores. This is where ACO activity will produce the best outcomes. The per member per month costs are high to make it attractive for providers to participate in these performance-based contracts.
- However, compared to Medicare ACOs, Medicaid has higher churn rates. This makes it challenging for the providers to manage these members with a long-term perspective. If the churn rates are high, chronic care management activities will not have enough time to impact patient behavior and outcome.

So the Medicare ACO plans that are fully capitated and have minimal member churn will have the highest impact.

Kirit Pandit
Co-Founder & Chief Technology Officer
Vitreos Health
Plano TX

Right now, it's synergistic. Medicare is by far the nation's largest payer, but joining an ACO is voluntary. However, Medicare's clout and standardization are critical. On the other hand, Medicaid and private payers can both push their programs on providers (a state or large employers can choose only ACOs) and be much more innovative. Statutorily, CMS could switch all Medicare to ACOs without additional congressional authorization. If that ever happens – with implicit Congressional approval and definitely in the long term – this question will have answered itself.

Michael Millenson
President
Health Quality Advisors LLC
Highland Park IL

We think after all the dust settles, Medicare will offer the biggest impact on stakeholders. This considers total dollars and the fact that 10,000 Baby Boomers turn 65 every day and total cost of care will continue to rise ahead of inflation – so it will always be a big number. Medicaid will continue to be in a constant state of change on a state-by-state basis, but will slowly follow the ACO transition that may very well lead to more Special Needs and Dual-Eligible strategies being promoted by states and offered by insurers, as well as provider-led health plans that see the advantage of receiving a large capitated sum from Medicare and Medicaid for eligible patients. I say this based upon the number of Section 1115 waivers being sought to permit states to offer above and beyond Medicaid benefits through ACOs and CCOs. Commercial will always be in transition, as self-funded and fully insured are finding big deductibles do not work and the fiduciary accountability starts to weigh heavily on many of the purchasers of care. What employers are interested in are ACOs that can manage the active workers and retirees at a predictable cost. Health plans and insurers are seeing their profitability is linked with these ACOs that can take partial or full risk for the medical portion of the premium, and this allows the health plan to improve administrative cost savings – plus predict total cost of care.

William DeMarco
Founder and President, Pendulum HealthCare Development Corporation
CEO & President, DeMarco and Associates Inc.
Rockford IL & St. Paul MN

Industry News

Evolent Health Supports 10 Next-Gen ACOs

Evolent Health (NYSE: EVH), which provides an integrated value-based care platform to leading health systems and physician organizations, reports that 10 of its partners have been formally accepted to the Centers for Medicare and Medicaid Services' Next-Generation Accountable Care Organization program for the 2018 performance year, including four provider partners that are new to Evolent's network. Evolent will support nearly one-fifth of all organizations accepted to the program nationwide, a statement points out. New partners include CoxHealth, in Missouri, Franciscan Missionaries of Our Lady Health System Health Leaders Network, in Louisiana, South Shore Health System, in Massachusetts, and St. Joseph's Health, in New Jersey.

Across its Next-Gen ACO cohort, the company reports, it's "deploying physician-led, evidence-based patient programs and market-leading technology to improve quality, reduce cost and enhance the care experience for its partners' Medicare beneficiaries." Its partnership model "enables providers to take on upside and downside risk by providing core capabilities for maximizing savings and improving quality," it adds, "including care and quality performance management; coding and documentation education for physicians; analytics and reporting to drive collaboration across the provider network; and population health technology with Evolent's Identifi platform."

Noting that CMS has "made clear its intention to make Medicare Advantage an increasingly attractive option in the future," Evolent says "many providers want to take advantage of this window of opportunity to build their skills in managing clinical and financial risk for all Medicare beneficiaries in their community." Some technical capabilities are needed in both programs – such as predictive modeling for identifying high-risk patients and effective network performance management – so the company predicts partners will "take advantage of the experience of their peers in our ACO cohort,…

Evolent Health Supports 10 Next-Gen *…continued*

…calling one another and sharing lessons learned to help accelerate success in different regions of the country." Visit evolenthealth.com.

MassHealth Move to ACOs Begins

The major restructuring at MassHealth – affecting care delivery for 1.2 million people insured by Medicaid and intended to improve overall health while containing costs – has begun, the State House News Service reports, adding that 17 Accountable Care Organizations will cover 800,000 to 850,000 Masshealth members, "with the ACOs responsible for the total cost and quality of care for patients." The Executive Office of Health and Human Services there says HHS will judge the ACOs on member satisfaction, the SHNS adds; they're on the hook for "preventive care, managing chronic diseases, integrating behavioral and physical care and ensuring appropriate follow-up care after a hospitalization." The ACOs will work with 27 community partners statewide to "provide specialty services and care coordination for members with complex behavioral and long-term needs," the Service reports; those partners will launch later this year.

MassHealth members are automatically enrolled in an ACO based on their primary care provider; they can change plans for any reason for 90 days. Members who opt out of ACOs can choose one of two managed care organizations, that will cover about 200,000 members, or MassHealth's primary care clinician plan, expected to cover about the same-size member population. Primary care physicians can participate in just one ACO, but specialists can sign up with multiple networks, so patients' pairs of providers may no longer be in the same plan. The state is spending close to $2 billion over five years on the program; half comes from the federal government. Visit www.masshealth.gov.

Catching Up With Matt Amodeo and Jeanna Palmer Gunville *…continued from page 12*

JPG: Many of my projects involve providers that are altering their care delivery models to better address clinical and non-clinical patient needs, often as a step towards taking on risk in value-based or bundled payment models. My clients are evaluating their competencies and engaging partners to help with initiatives involving telehealth, patient engagement and care management. The lack of one clear path to follow can be the biggest hurdle to navigate, but we are finding flexibility within the available ACO guidance to support arrangements with both traditional and non-traditional partners.

ACN: *You get to rewrite the laws around ACOs. What would you change first?*

MA: I would relax the antitrust laws so that providers in ACOs could collaborate and manage patient care more effectively without having to worry about coming under scrutiny for price fixing or engaging in anti-competitive behavior.

JPG: I would like more certainty regarding the timeline for shifting to value-based care, but I appreciate how the value-based payment environment is continuing to evolve. Changes to the ACO laws and regulations are slowly rolling out and providing more regulatory and operational flexibility. The clients that engage in novel care models or alternate revenue streams to counter declining revenue and control costs now will be better situated for whatever regulatory change happens next.

Contact Amodeo at matthew.amodeo@dbr.com and Palmer Gunville at jeanna.gunville@dbr.com.

Catching Up With ….

Matt Amodeo, Partner, Albany
Jeanna Palmer Gunville, Associate, Chicago
Drinker Biddle & Reath LLP

- BA, College of the Holy Cross, 1987
- JD, New England School of Law, 1991
- Amodeo focuses his practice on hospital-physician affiliation transactions, accountable care arrangements, managed care contracting and related federal and state regulatory issues.
- Clients include health systems, post-acute providers, Accountable Care Organizations, clinically integrated networks, provider-sponsored health plans and population health management companies.
- Also advises clients on federal and state Exchange-related matters, the Medicare Shared Savings Program, Next-Generation ACOs, the Comprehensive Care for Joint Replacement model, the Medicare Access and CHIP Reauthorization Act and other Medicare payment reform initiatives under the Affordable Care Act.
- For the past several years, he's been a contributing author to the American Health Lawyers Association's *Health Plans Contracting Handbook*; his most recent contribution includes a chapter on the "Implications of HealthCare Reform on Payer-Provider Contracting and Relationships."
- Amodeo represents a large community hospital in creating an integrated delivery system and implementing a managed care contracting strategy and advised a multi-hospital health system on establishing a shared-risk arrangement and co-branded insurance product with a large national payer.
- He also advised a regional health network on establishing a shared-risk arrangement with a state-funded employee benefit plan and assisted a large integrated delivery system in creating a regional ACO with community-based providers for MSSP participation.

- BA, cum laude, University of Notre Dame, 2003
- JD, Loyola University Chicago School of Law, 2007; *Annals of Health Law*
- Palmer Gunville focuses on corporate healthcare transactional work and regulatory matters.
- Experience includes representing hospitals, health systems, academic medical centers, dialysis facilities, multi- and single-specialty medical practices and ambulatory surgery centers in sales and acquisitions, joint ventures, general corporate matters, contracting and regulatory matters.
- She negotiates and drafts transaction documents and counsels clients with regard to the legal aspects of day-to-day operations, including general corporate matters, anti-kickback and Stark issues, self-referral, corporate practice of medicine and fee-splitting prohibitions, the Health Insurance Portability and Accountability Act, governance and non-profit issues and Certificate of Need and licensure requirements.
- Also advises hospital and health system clients regarding procurement and outsourcing arrangements, including materials management and hotel services, and provides counsel on a range of financing transactions for nonprofit, healthcare and healthcare-related organizations.

Accountable Care News talked to Amodeo and Palmer Gunville about navigating ACO law and regulation and what each one would fix first.

***Accountable Care News**: Tell us a little about your professional journey since college. Has it been what you expected?*

Matt Amodeo: I made a few pit stops before I settled on the law – first in retail, then in education (I thought I wanted to be a teacher). But once I went to law school, I knew that I had found my calling. I started working in healthcare law 28 years ago as a second year law student and never looked back. I absolutely love it.

Jeanna Palmer Gunville: When first entering law school, I knew I wanted to assist providers with healthcare delivery, but I lacked appreciation for how changes in the regulatory landscape would inspire my long-term enthusiasm for the practice of law. My practice has necessarily become more diverse as I have developed expertise to support strategic client initiatives in response to these regulatory changes. No day is the same.

***ACN:** What are you working on most these days? Are particular areas of ACO regulation generally more vexing than others?*

MA: Many of my ACO clients are venturing into the world of direct-to-employer health plans. These arrangements can offer employers a customized, patient-centric benefit plan option for their employees. The problem is these arrangements can be very complicated and often involve not only ACO rules, but also the Employee Retirement Income Security Act and state insurance laws as well.

(continued on page 11)