Volume 9, Issue 5 May 2018

Accountable Care NEWS

Top 5 Strategies to Mitigate ACO Culture Clashes

Those clashes create some of the biggest challenges to forming an ACO, but these tips can help organizations overcome them.

by Sarah Bliss Matousek PhD MPH

An astounding 83% of mergers and acquisitions fail to boost shareholder returns. The same technological, organizational and cultural issues that plagued corporate mergers like HP and Dell, AOL and Time Warner, Daimler and Chrysler and Sprint and Nextel are increasingly being observed in the healthcare industry, where providers are merging or affiliating with hopes that their new capabilities will make them successful under risk contracts. Many of these relationships looked great on paper but ultimately failed due to difficulties stemming from the complex personalities of the people and cultures of the participating organizations. Accountable Care Organizations are no different, they often consist of independent entities whose marriages are rocky from the start. Here are some of their most common difficulties.

5 Cultural Challenges and Mitigation Strategies

[1] *Leading a new "blended" organization.* Establishing the leadership of an ACO is a very difficult task, both in designing the structure and carrying out the responsibilities. Any collaboration between organizations requires a balance of autonomy and authority, and ACOs are no different. Too much autonomy and decision making can become a muddled and confusing process that lacks cohesive, aligned strategy. Too much authority and participants feel marginalized.

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How Origami is Like Managing an ACO

New surveys find that population health is not growing at the rate many expected it to – and some respondents say only 10% of revenues comes through risk-based agreements. ACOs across the country are facing the challenge, but many hesitate to take on more risk because they don't feel ready.

by Pranam Ben

Recently, I was helping my daughter learn origami, the ancient Japanese art of paper folding. As we were folding little bits of paper, I became frustrated that my designs were falling apart, or just didn't look right. Not knowing why I was struggling, I did some Google searches about origami and learned about Robert J. Lang PhD, an American physicist who is also considered the finest origami artist in the United States. A quote from Dr. Lang stuck with me: "Almost all innovation happens by making connections between fields that other people don't realize."

Lang consults with carmakers, manufacturers and other companies about design, but his theories could also teach a lot to Accountable Care Organizations. After all, helping patient populations achieve better outcomes is about using data to find connections that are not obvious. By finding those connections, making predictions and acting on them, we can help ACOs achieve the Triple Aim of improving experience and care quality, improving outcomes and reducing costs; in other words, the goals of value-based care.

Finding unseen connections, unsurprisingly, is not simple. ACOs need to establish operational strategies that leverage automation and create insight-driven clinician workflows that enable efficient responses when trends are identified. Making these connections easily actionable is just as important as discovering them.

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Accountable Care News
May 2018 – Volume 9 Issue 5

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

Publisher
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Editor
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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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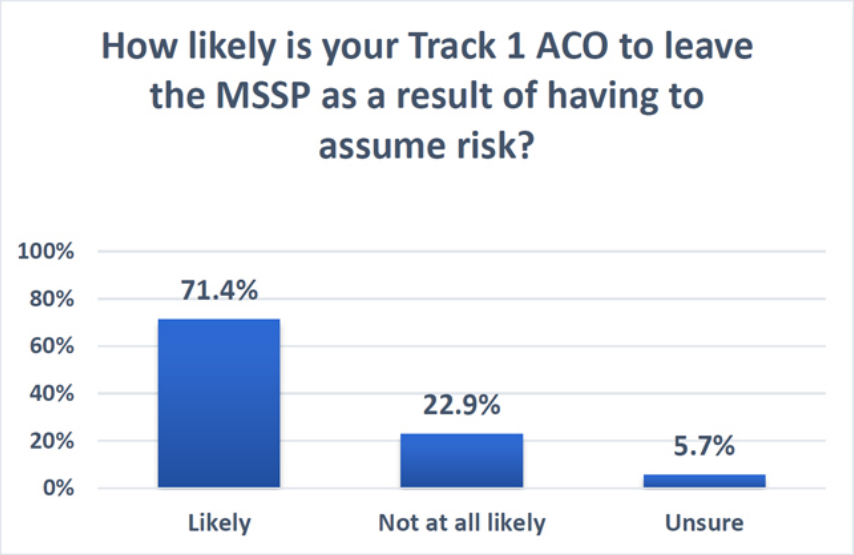
NAACOS Reports Dissatisfaction with MSSP, Asks Congress Not to Delay Some MIPS Standards

Responses to a key question in a recent survey about assuming risk and future participation plans for Medicare Shared Savings Program Track 1 ACOs show that 71% are likely to leave the program "as a result of having to assume risk."

The National Association of ACOs wanted to "better understand what ACOs are planning and how they feel about risk," a statement says; the group is "pleased that 43% responded to the survey," but adds it's "troubled by the results, which illustrate NAACOS's long-standing concerns about forcing ACOs into risk-based contracts." The association says it "encourages ACOs to prepare to move to risk and strongly supports ACOs that are ready to do so" – but does not support "forcing ACOs to assume risk if they are not ready. Says Clif Gaus ScD, CEO and President at NAACOS: "It's naïve to think ACOs that aren't ready will be forced into risk in what is ultimately a voluntary program. The more likely outcome will be that many ACOs quit the program, divest their care coordination resources and return to payment models that emphasize volume over value."



The web-based survey was conducted in April; survey links were sent to Track 1 ACOs entering their third agreement periods in 2019. While it "focuses on a select group of ACOs," the NAACOS statement notes, "forcing ACOs into risk will become an annual issue, as more ACOs move through their second agreement periods. It would be devastating to see ACOs quit the program, especially considering the progress we are starting to see."

- MSSP ACOs that earned shared savings in 2016 had "a significant decline in inpatient hospital expenditures and utilization," the statement says, "as well as decreased home health, skilled nursing facility and imaging expenditures."
- MSSP ACOs subject to pay-for-performance quality measures earned an average quality score of 95% in 2016.
- Additionally, ACOs participating over a longer period "show greater improvement in financial performance;" for example, 42% of MSSP ACOs that started the program in 2012 earned savings in Performance Year 2016 versus 18% of those that began in 2016.
- Finally, "research shows that ACOs are reducing costs relative to their peers in strictly fee-for-service payment," the statement adds.

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NAACOS Reports Dissatisfaction with MSSP, Asks Congress Not to Delay Standards … *continued from page 2*

"It's important to note that ACOs have a number of valid reasons for not being ready to assume risk," the association asserts.

- the amount of risk is too great, according to 39.4 %
- concerns about unpredictable changes to the ACO model and Centers for Medicare & Medicaid Services rules, cited by 39.4%
- desire for more reliable financial projections, chosen by 39.4%

More than 80% of Medicare ACOs remain in MSSP Track 1, the statement adds, "which is largely a result of the challenges listed above." Another top challenge, selected by 36%, was "concerns about past performance." Says Gaus: "We also need to see more realistic levels of risk, provide greater predictability of rules and allow more reliable financial projections, ideally through greater use of prospective benchmarks that provide an upfront spending target for ACOs." The survey also asked ACOs if they'd stay in Track 1 if they could; 76% said they would be "completely likely" or "very likely."

Table 1: 2018 Medicare ACO Model and Track Participation

MSSP Track 1	MSSP Track 1+	MSSP Track 2	MSSP Track 3	Next Generation Model	CEC	All Medicare ACOs	
460	55	8	38	51	37	649	
First Year of the Model and Track							
2012	2018	2012	2016	2016	2016		

Figure 1: 2018 Medicare ACO Model and Track Participation/**https://www.naacos.com/overview-of-2018-medicare-aco**

Graph A: Medicare ACO program participation by year (2012 – 2018)

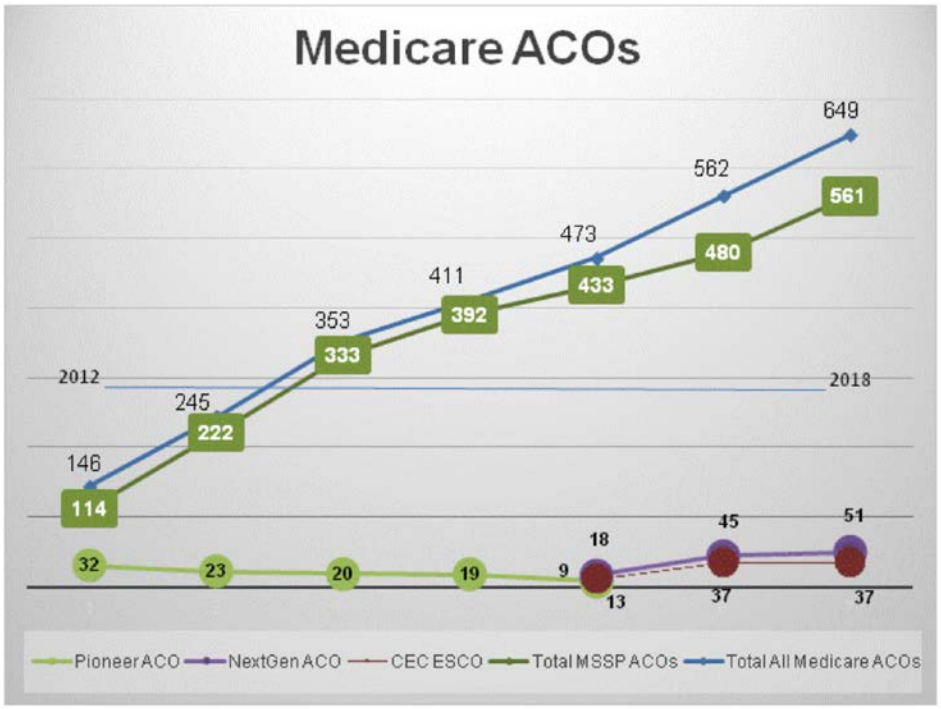

Figure 2: Medicare ACO program participation by year/**https://www.naacos.com/overview-of-2018-medicare-aco** *(continued on page 4)*

NAACOS Reports Dissatisfaction with MSSP, Asks Congress Not to Delay Standards … *continued from page 3*

NAACOS to Reps: 'Fix MACRA'

The association recently spoke out about the Medicare Access and CHIP Reauthorization Act – in testimony before the US House of Representatives Committee on Ways & Means Subcommittee on Health hearing "Implementation of MACRA's Physician Payment Policies" – stating that "it is critical that Congress ensure an effective implementation of MACRA" and expressing support for "the notion that Alternative Payment Models are a key piece of the transition to a value-based payment system" – adding: "We are therefore disappointed to see Congress and CMS further delay implementation of MACRA's intended performance thresholds and cost accountability measures." Here are additional excerpts from the testimony:

- NAACOS is concerned that Congress and CMS "continue to dilute accountability for quality and cost performance," noting that "exempting nearly half of providers will discourage clinicians who have already invested time and resources towards making the shift to value-based care.
- Instead, they should "reward high-performing clinicians who have invested heavily in performance improvement," supporting "a phased-in approach to value-based payments for Medicare," but stressing that clinicians in those legacy programs "have had ample time to prepare."
- As well, NAACOS continues to worry about "CMS' lack of strategic direction regarding how to handle the overlap of multiple Advanced APMs," arguing that CMS "has attempted to deal with overlap on a per-program basis rather than taking a coordinated approach."
- NAACOS "continues to believe that CMS must include MSSP Track 1 as an Advanced APM" – noting that ACOs "have significantly invested in their development and early success" and "excluding them undermines this important transition."
- The organization notes that "the A-APM bonus is based on payments for covered professional services under the Medicare Physician Fee Schedule" and "strongly recommends" instead focusing "solely on revenue" because "not doing so creates an asymmetry between the risk level and A-APM payments and could create an unintended consequence of ACOs dropping hospitals as ACO participants."
- The association argues as well that "the disproportionate emphasis on reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers, which benefits patients and the Medicare program generally." Track 1 ACOs "have generated savings to the government while improving patient care," it adds, "which studies show has a positive downstream impact on spending but may take years to fully materialize."
- CMS, the organization argues, "has struggled to effectively communicate how MIPS policies apply to ACOs specifically," which has "created an enormous amount of confusion." But "CMS staff continues to provide unclear guidance" and community supports "are often not educated about the nuances for ACOs," so ACOs end up "constantly educating providers, resulting in a considerable amount of wasted staff time."
- NAACOS also opposes "the unfair policy" of CMS counting MIPS payment adjustments as ACO expenditures, which "will punish ACOs for their high performance in MIPS. This is an unfair and untenable policy."

Table 2: Medicare ACO Annual Counts:

ACO Model	2012	2013	2014	2015	2016	2017	2018
Track 1	110	217	330	389	411	438	460
Track 1+							55
Track 2	4	5	3	3	6	6	8
Track 3					16	36	38
Pioneer	32	23	20	19	9		
NGACO					18	45	51
CEC					13	37	37
All Medicare ACOs	146	245	353	411	473	562	649

Figure 3: Medicare ACO Annual Counts/https://www.naacos.com/overview-of-2018-medicare-aco

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NAACOS Reports Dissatisfaction with MSSP, Asks Congress Not to Delay Standards … *continued from page 4*

Graph B: MSSP ACO participation by track

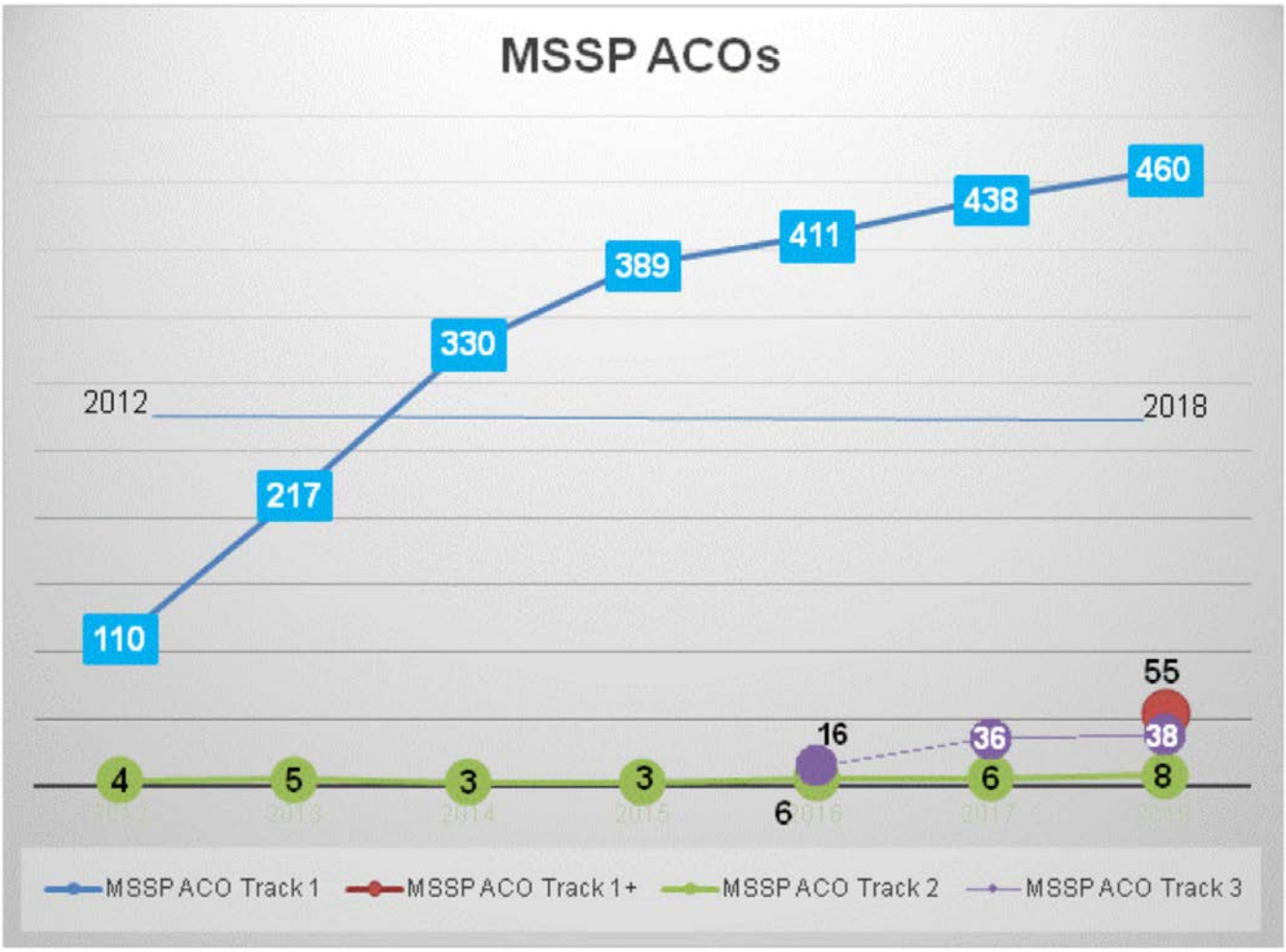

Figure 4: MSSP ACO participation by track/**https://www.naacos.com/overview-of-2018-medicare-aco**

NAACOS Applauds CMS' DPC Model RFI

CMS released a Request for Information on a new initiative that sees the agency contracting directly with providers through a new payment model, direct provider contracting, that the ACO association says is "similar to an ACO model in terms of an accountability for certain costs and quality of a specific patient population and emphasizing primary care" – but notes that "it also differs in many ways." In general, says Gaus, NAACOS is "pleased to see CMS considering more options for provider accountable care models," but wants to "help shape it into a meaningful program that complements existing Medicare ACO options."

- The RFI "explains a number of notable differences between existing ACO options and the DPC model," the organization explains; for example, "beneficiaries would have to select a primary care practice and actively enroll with participating organizations, and there would be per-beneficiary-per-month payments."
- CMS is "soliciting feedback on a number of key program elements," the group adds, "such as potential levels of risk, if organizations would participate independently or through a convening organization like an ACO and what support CMS would need to provide to participants."
- Adds Gaus: "NAACOS has been advocating for increased beneficiary engagement tools, flexibility from onerous regulations and administrative burdens, and new opportunities for payment mechanisms other than fee-for-service, so there are a number of valuable concepts incorporated into the outline of the DPC model."
- He emphasizes, too: "It will be imperative that CMS calibrate model details like risk and accountability appropriately for this to be a success."

The RFI solicits feedback on how DPC would "interact with, enhance and/or refine current ACO initiatives," the association says. "Given the progress we have seen with ACO development and care transformation," Gaus adds, "it's essential that a DPC model work alongside ACOs. It's essential that we also fix and improve existing models." Visit www.naacos.com.

Top 5 Strategies to Mitigate ACO Culture Clashes … *continued from page 1*

Strategy

- In healthcare partnerships among different entities, buy-in from both clinical and administrative leadership is critical. Elevating a clinical champion to set the vision and assigning an administrative partner to get things done is a strategy that has worked for many organizations.
- A solid governance structure to support these leaders will ensure that all participants are involved in the decision making process. For example, besides the ACO board, an Executive Council and supporting workgroups for various capability areas – clinical, data, communications, etc. – will help organize work, clarify roles and create a clear escalation process.
- Employing the "loose-tight approach" can help right-size oversight to different governance processes. The ACO should map the flow of information and decisions through the organization to prioritize and design clear decision making processes for each of them. Some will require tight control by leadership and some will be less stringent, and each process should be tailored and right-sized to its importance and circumstances.

"Employing the 'loose-tight approach' can help right-size oversight to different governance processes."

[2] Ambiguous accountability. Who is responsible, and for what? How will we measure performance and ensure the work gets done? The way organizations define roles and handle accountability is one of the most obvious expressions of their cultural identity. Some groups have formal job descriptions and clear accountability processes, while others might use informal job descriptions and *ad hoc* performance evaluation. Both types may feel strongly that the way they handle these things is core to their values.

Strategy

- Depending on the level of integration, there may be a need to consistently redefine – or define for the first time – roles and accountability throughout the participating organizations.
- Expect frustration from all parties if the process changes the status quo, and expect real push back if the changes threaten their organizational values. At the very least, leaders should clarify the work that needs to be done at the new merged organization and who is responsible for doing it as early as possible.
- Leaders will need to repeat the exercise, as roles often shift while the dust settles. However, the risk in waiting is that is won't get done at all. If possible, we recommend building criteria for role definition, performance evaluation and an audit mechanism into the contract negotiations, at least where shared resources are concerned.
- At the very least, discussing how these things are handled at each participating entity will give some idea of how difficult it will be to standardize. If a major culture clash is a risk, leaders will do well to anticipate the challenges early on. The goal should be to come to agreement on how to ensure that roles are clear and the system is fair without sacrificing critical components of the participants' cultural identity.

[3] Creating true clinical integration. Clinical integration initiatives typically involve physician-led clinical teams, patient-centered coordinated care and population health management – preventive care, chronic disease management, etc. Accomplishing successful integration is easier when clinical groups have similar structures, governance, EHR systems and cultures. However, most ACOs consist of providers whose differences extend even beyond culture and structure into completely different operating models, including:

- Solo practices
- Physician-hospital organizations or independent practice associations
- Medical services organizations
- Hospital-employed medical groups
- Networks of independent affiliated practices

Each model has merits, but all differ in several aspects, including the level of autonomy clinicians have in the way they control their practices. Getting functionally and culturally different clinical groups to swim in the same direction for coordinated clinical integration in an ACO model is extremely difficult.

"Ensuring that each group has appropriate representation on decision making bodies, and that a fair process is set up to make those decisions, is critical to avoiding conflict and developing clinical integration over time."

Strategy

- To begin the process, there must be, at baseline, some level of consensus about how the group will function as a unit, both clinically and administratively.
- Clearly, willingness to accommodate change for the benefit of the entire ACO should be assessed before groups are invited to join. More important expectations, like a glide path to EHR interoperability, should be written into the contract language.
- Ensuring that each group has appropriate representation on decision making bodies, and that a fair process is set up to make those decisions, is critical to avoiding conflict and developing clinical integration over time.

[4] Managing different patient populations. ACOs often pull together provider groups in neighboring geographic regions, merging patient populations with different needs and sociodemographic characteristics as a result. Attributing more shared resources to and designing programs for populations with greater needs may benefit the entire ACO; however, clinicians in areas with healthier patients may not appreciate this in the short term.

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Top 5 Strategies to Mitigate ACO Culture Clashes … *continued from page 6*

For example, one ACO found it difficult to agree on patient scenarios to use for patient journey maps because the stories differed so greatly between two regions within the ACO. Conflict arose between two clinicians over choosing between a college student struggling with depression and an eating disorder and a middle aged homeless patient with an opioid addiction. Different perceptions, expertise and experiences will all play into disagreement among providers, making organization-wide alignment complex and difficult.

Strategy

The Dartmouth Institute provides a framework of policies to ensure full inclusion of patients in accountable care. Key best practices include:

- *Financial*: Robust risk adjustment ensures that spending targets accurately reflect the mix of clinically vulnerable patients; systems should not unfairly reward providers who care for healthier patients (absolute targets) or sicker patients (improvement targets).
- *Performance measurement and monitoring*: Effective performance measurement, like patient-reported outcomes, ensures consistent standards of care and identifies and stratifies patients; systems should carefully monitor patient populations on both enrollment, to identify patient dumping patterns, and quality, to track changes on practice and clinician levels; implementation and performance should be evaluated periodically.
- *Promoting ACO formation and performance*: Fund or provide incentives to providers to develop new programs or implement existing programs tailored to their patient populations.

In addition to these recommended policies, educational campaigns can help entities across the ACO better understand populations with which they are less familiar. Publicly available data from resources like Community Commons can shed light on health and social factors prevalent in other entities' geographic footprints. The Cleveland Clinic Diversity Toolkit can serve as a quick reference guide to patients from different ethnic, racial, religious and national backgrounds. Knowledge-sharing sessions allow clinicians to share experiences and cases from their patients and enhance understanding across the ACO.

"Communication processes are the foundation of a well-integrated organization and should be established first."

[5] Administrative burden. Difference in administrative procedures is often a source of confusion and contention among ACO participants. Workflows and habits must be reshaped to fit the new organization. Smaller entities joining larger ones frequently experience policies and layers of bureaucracy to which they are not accustomed, as larger organizations often delegate administrative functions to higher levels in the organization to leverage economies of scale. Decisions can take longer to make and require input from more stakeholders. Layers of administrative burden are already perceived by many physicians as a distraction from the provision of care, and adding even more complexity increases the risk of burnout.

Strategy

- A strong and clear governance structure with workgroups tasked with implementing the ACO should be responsible for the creation of administrative workflows and processes. Making them streamlined and efficient is as important as designing them to be foolproof – many detailed and well-thought-out processes fail because they are unclear or burdensome and nobody follows them.
- Processes should be standardized across participating organizations where possible. Communication processes are the foundation of a well-integrated organization and should be established first.

The disappointing results of the Managed Services Organizations that proliferated during the 1990s cannot be pinned to a singular cause. Technological constraints were certainly to blame in part, but perhaps more important was a widespread lack of integrated organizational planning due to difficulties stemming from cultural clashes. For example, disease management and population health programs were developed in parallel to provider workflows and failed to truly sync operationally and culturally. The full importance of cultural integration was not fully recognized at the time, but healthcare providers now have an opportunity to learn from these failures and build integrated systems that seek to enhance the best cultural aspects of participating organizations and, hopefully, create a new culture of true collaboration.

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How Origami is Like Managing an ACO … *continued from page 1*

Becoming a Clinically Intelligent Network

ACOs belong to a class of healthcare organizations that includes large health systems, academic medical centers, multi-disciplinary physician groups and other large institutions: clinically integrated networks. Some of these organizations were early advocates for the free flow of data across their enterprises, knowing it was essential for safe, effective care and for identifying population health trends – even before the Medicare Shared Savings Program existed. Now that nearly every hospital has an electronic health record system, the vast majority of CINs are pursuing similar population health management goals. While they may be integrated, many CINs are still not able to accurately identify trends, determine the causes, make predictions and take action.

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How Origami is Like Managing an ACO... *continued from page 7*

The CINs that are now forming connections and making insight-driven interventions are what I like to call "clinically intelligent networks." They are using analytics and automated workflows to more efficiently and effectively manage patient populations. Transitioning to a clinically intelligent network involves answering four key questions for every patient and population:

[1] What happened? All CINs are continually capturing data from around the enterprise. They are most interested, however, in the data concerning patients with multiple chronic conditions, any of which could land them in the emergency room or admitted to the hospital. Capturing and sharing this historical data amongst providers is the first step in becoming an intelligent network, but discovering the underlying causes needs to follow.

[2] Why did that happen? In origami terms, historical clinical data is the paper, and advanced analytics technology available today is how we start to make the connections that are unseen by the naked eye. Clinical data, however, is just the foundation. We also need demographic, environmental, lifestyle and many other data points to accurately determine why patient population health trends are deteriorating or improving.

[3] What will happen? What it is even more challenging, even for higher-performing ACOs and clinically integrated networks, is making predictions about patients' health and behaviors. These are the most difficult connections to see, but, again, advanced technology powered by machine learning capabilities is helping. At a rapid pace, artificial intelligence programming within population health management platforms is helping ACOs make more accurate predictions about the likelihood of an ER visit or admission, care plan adherence and usage of preferred network providers.

[4] What should I do? Just as quickly as predictions are formed, AI alerts physicians, care managers and other providers about opportunities to intervene – even for patients who perhaps are not even considered high risk or at risk. These AI-generated notifications can also prompt automated outreach activities, such as text messages, to help patients stay on track with their care plans. Automated outreach can also help patients overcome social determinant of health-related obstacles, such as transportation or in-home caregiver support gaps. Frontline clinician workflows can be aligned with the AI functionality, so they can concentrate on the most challenging patients and help them achieve better outcomes.

"ACOs and other CINs are able to predict emergency department utilization per 1,000 patients on a quarterly and yearly basis with a variance of only 3%."

Visualizing results

Clinically intelligent network transitions are happening now all around the country. By utilizing advanced population health management technology, organizations are finally visualizing these unseen connections. ACOs and other CINs are able to predict emergency department utilization per 1,000 patients on a quarterly and yearly basis with a variance of only 3%. Likewise, ACOs are predicting patient admissions on a weekly, monthly and quarterly basis with similar accuracy and are forming monthly, quarterly and yearly spending forecasts with only a 0.25% variance.

AI and similar analytics technology is helping ACOs adjust patient behaviors, too. Managing referral networks and enhancing automated communications with patients is helping ACOs reduce utilization of non-preferred providers by 3% and save 15% on referral care costs. This improved oversight directly impacts their MSSP incentive or value-based payment. They are receiving real-time insight and notifications into outstanding and unusual diagnoses and medications, which helps care managers discover care gaps and reduce wasted care.

Seeing populations in new ways

Just as Dr. Lang encourages us to approach a simple piece of paper with a new mindset, I encourage ACOs to approach care with an equally new perspective. It is easy to become bogged down in daily patient care needs, of which there are many. But it is equally important to anticipate care needs that are not yet obvious. Technology can help, but it is this new mindset of looking toward the future and taking action now that will help all organizations transition from mere integration to true intelligence.

Ben is founder of and Chief Executive Officer at The Garage.

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Avalere: Medicare ACOs 'Increased Federal Spending, Contrary to Projections'

Incentive payments in upside-only ACOs "have increased federal costs," researchers say, "but data suggest that ACO experience and adoption of two-sided risk could constrain future Medicare costs."

Avalere's Josh Seidman, John Feore and Neil Rosacker report that "new analysis finds that the Medicare Shared Savings Program has performed considerably below the financial estimates from the Congressional Budget Office, made when the MSSP was enacted." That, they add, "has raised questions about the long-term financial success of Medicare's largest Alternative Payment Model," noting that the MSSP "has grown from 27 ACO participants in 2012 to 561 in 2018" and that "most ACOs continue to select the upside-only Track 1, which does not require participants to repay the Centers for Medicare & Medicaid Services for spending above their target."

- Avalere's research shows that "actual ACO net savings have fallen short of initial CBO projections by more than $2-billion," in fact, the consultants point out. "In 2010, the CBO projected that the MSSP would produce $1.7 billion in net savings to the federal government from 2013 to 2016. However, it increased federal spending by $384 million over that same period."
- Why? "Because most ACOs have chosen the bonus-only model," notes Seidman, senior vice president at Avalere.
- But while the MSSP overall "was a net cost to CMS in 2016," Avalere emphasizes that "there is evidence that individual ACO performance may improve as they gain years of experience with the program." The firm found that MSSP ACOs in their fourth performance year "produce net savings to the federal budget, totaling $152 million, suggesting that CBO's initial projections may not have taken into account the time it takes for ACOs to gain experience with the program and to start to produce consistent savings."

Figure 1: MSSP Performance Year Results vs CBO Projections (Millions), PY 2013 – PY 2019

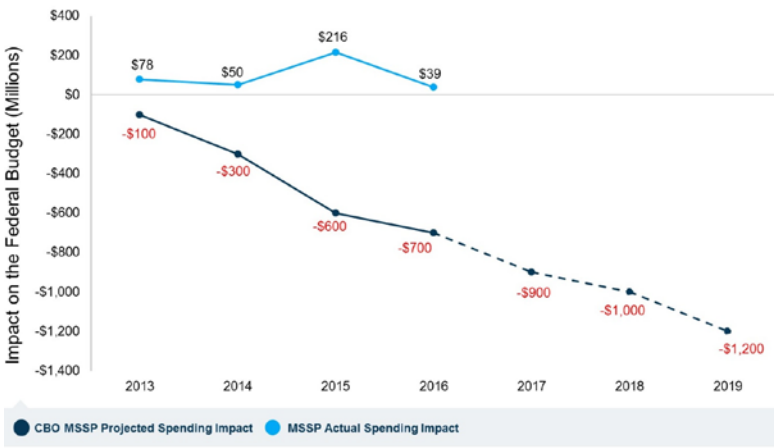

Figure 5: MSSP Performance Year Results /captured from http://avalere.com/expertise/managed-care/insights/medicare-accountable-care-organizations-have-increased-federal-spending-con

Avalere's analysis also shows that "the downside-risk models in the MSSP, Tracks 2 and 3, have experienced more positive financial results overall, indicating the potential for greater savings to CMS over time as the number of downside-risk ACOs increase."

- The upside-only model "increased federal spending by $444 million compared to the downside-risk ACOs," the consultants say, which "reduced federal spending by $60 million over five years."
- ACOs that accept two-sided risk "may help the program turn the corner in the future," but "the long-term sustainability of savings in the MSSP is unclear," comments Feore, director at Avalere Health. "ACOs continue to be measured against their past performance, which makes it harder for successful ACOs to continue to achieve savings over time."
- Avalere's research also finds that MSSP ACOs "have produced $1.6-billion in program savings compared to benchmark projections over the life of the program, increasing the savings each year." Visit http://avalere.com.

Figure 2: MSSP ACO Performance Results by ACO's Year in Program, Net Savings to CMS (Millions), PY 2013 – PY 2016

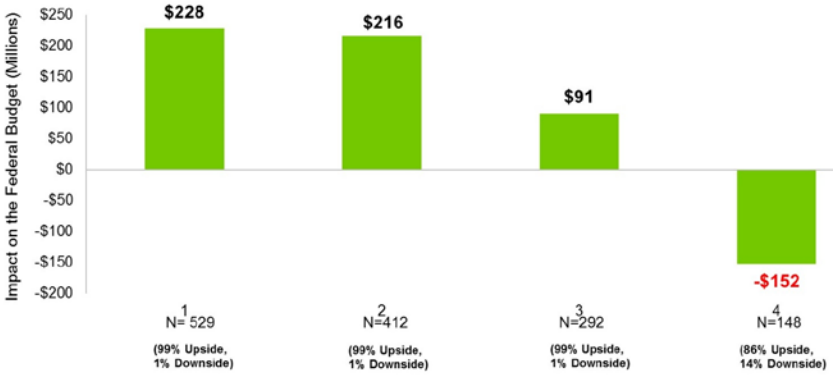

Figure 6: MSSP ACO Performance Results/captured from http://avalere.com/expertise/managed-care/insights/medicare-accountable-care-organizations-have-increased-federal-spending-con

Thought Leaders' Corner

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

Q. Will ACO federal policy and regulations have more impact on payers and providers in the long term than ACO state-level policy and regulations? Or vice versa?

The ACO federal rules will have a long-lasting effect on the greater segment of the marketplace called Medicare. Most of the employers are following this same attribution formula and similar shared savings payment formula for the first three to five years, then going to capitation/full risk, meaning the ACO will need a state license. At the state level, there is a lot of activity in Medicaid ACOs or Coordinated Care Plans; some of the savings are being shared, but each state is very different in how it handles the ACO designation for Medicaid.

- In North Carolina, they use of mix of prepaid health plans now bidding for the business along with local ACOs.
- Colorado has divided the state into quadrants, having providers in each quadrant compete for savings with one another.
- In Minnesota, the state had authorized 10 Medicaid ACOs, mostly in rural counties, and will share savings using similar metrics.

So we see the actual influence of ACO structure and payment change toward value-based compensation reach far beyond the framework of any one ACO — but rather having a strong influence for the entire population being served by the sponsoring physician practices. (*Editor's note: Visit www.healthaffairs.org.*)

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

I'd expect that federal policy and regulations overall will be far more influential:

[1] *Significance of payments.* While there's variation by specialty and geography, Medicare reimbursement makes up an average of about 40%+ of provider reimbursement — far more than state Medicaid.
[2] *Uniformity & standards.* Payers — especially national payers — will pay more attention to one set of federal requirements than to idiosyncratic issues across 50 states.
[3] *Exceptions.* Some bellwether states will grab attention due to innovative experiments, relatively large size and other TBD factors.

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Accountable Care Organization federal policy and regulations will have more impact on payers and providers in the long term than Accountable Care Organization state-level policy and regulations.

[1] There are over 270 Accountable Care Organizations in the United States, but only 13 states as of 2017 had ACOs in place, according to Kaiser Family Foundation data.
[2] The federal policies and regulations addressing anti-kickback and Stark law issues that are waived for ACOs have a huge impact on ACOs, where some states do not really have laws that address these areas specifically as they pertain to ACOs.
[3] Payers — whether Medicare, Medicaid or private — look to the federal law as it pertains to ACOs when making their determinations on things like reimbursement for items and services.
[4] Also, preemption would trump any federal or state law difference, sliding the deciding factor toward the federal law.

As well, the power of the ACO when it comes to complying with other federal laws like MACRA also means federal policy and regulations will have a greater effect than those at the state level. (*Editor's note: Visit www.kff.org.*)

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Industry News

Cape Fear Valley Health, UnitedHealthcare Launch ACO

Cape Fear Valley Health and UnitedHealthcare report launching an Accountable Care Organization for UnitedHealthcare Medicare Advantage plan members that will "encourage better health and better care," according to a statement, "and put greater focus on the total cost of care."

The relationship "provides the industry expertise, data and support that will enable Cape Fear to treat patients using an innovative value-based model focused on helping keep people healthy," it adds; UnitedHealthcare shares data with Cape Fear about patients' underlying medical conditions, past treatments, missed care opportunities, medications prescribed and future care needs – "taking the burden of connecting information from each doctor visit off patients, reducing duplicative tests and improving care coordination across specialties and care settings."

Through the ACO, Cape Fear and UnitedHealthcare "can identify clear, actionable information specific to individual patients' health needs," the statement adds, also improving "the ability to identify patients at high risk and help them reduce emergency room visits and readmissions to the hospital, manage their chronic health conditions and take their needed medications."

More than 15 million people in UnitedHealthcare plans have access to accountable care programs, the company says, "delivered in part through more than 1,000 accountable care arrangements nationwide," as it "engages in deeper, more collaborative relationships with physicians and hospitals." And, the insurer adds, "providers are showing strong interest in a shift to value-based care," noting that "total payments to physicians and hospitals that are tied to value-based arrangements have tripled in the last three years to $65 billion." By the end of 2020, that figure should be $75 billion. Cape Fear Valley ACO/Valley Connected Care was established in 2015; since then, membership has doubled.

Visit www.uhc.com.

PeraHealth Receives FDA Clearance for Clinical Surveillance Technology

PeraHealth reports that its "predictive, real-time clinical surveillance technology," PeraTrend – "trusted by" Yale New Haven Health System, Houston Methodist Health and Mission Health – is the first solution of its kind to receive 510(k) clearance from the Food and Drug Administration. PeraHealth solutions are powered by the Rothman Index, "a comprehensive measure of the patient condition for healthcare providers," a statement says, "leveraging data within a hospital's existing electronic health record to quantify and visualize patient deterioration, risk and improvement in real time." Other solutions "depend on vital signs alone," it adds, but "the peer-reviewed RI model uses a range of physiological measures – including labs, vital signs and nursing assessments – to produce a continuous measure of patient condition across diseases, conditions and levels of care, trended over time." Says Michael Rothman PhD, PeraHealth's Chief Science Officer and co-founder: "PeraHealth will continue to research, innovate and share strategies for enhancing patient-centered value-based care, including mortality reduction and earlier identification of sepsis." Clinical results, the statement adds, include "reducing all-cause mortality rates, length of stay and readmissions." Visit perahealth.com.

Fallon Health Names Weinreb Medicaid, ACO Medical Director

Fallon Health, a community-based not-for-profit healthcare services organization, reports the appointment of Linda Weinreb MD as Medical Director of its Medicaid programs and Medicaid ACOs. A family physician with 25 years' experience directing clinical programs for, and conducting research with, vulnerable populations, Weinreb is "a nationally recognized expert on the health and support needs of homeless families and the integration of behavioral health and primary care services for vulnerable populations," a statement says, adding that she has "extensive expertise with the impact of social determinants on health." Visit www.fchp.org.

Catching Up With Sarah Bliss Matousek PhD MPH *…continued from page 12*

***ACN:** If you could implement five universal changes to ACOs to make them perfect – expense isn't an issue, neither are logistics – what would they be?*

SBM: [1] Universal EHR system that is fully interoperable with every community organization, payer and provider (I can dream, right?). [2] Robust data and analytics team that can perform qualitative and quantitative analysis and report at a cadence that makes the data easy to manage to (i.e., it isn't three years old and irrelevant by the time people see it). [3] True value-based payment methodology. Most ACOs use a traditional fee-for-service payment approach with a shared savings bonus on the back end. Truly moving to value-based payment means that providers shouldn't be paid FFS. We need to better align incentives for appropriate, high-quality care. [4] Care management program that provides whole person care (addressing physical, mental and social health needs) with appropriate case loads. [5] Strong operations management team focused on quality improvement, operational efficiency and change management across entities.

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Catching Up With ….

Sarah Bliss Matousek PhD MPH

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She brings more than 12 years' healthcare and research experience to her client work – her expertise includes data and analytics, quantitative and qualitative research, operations, program development, change management and strategic planning/implementation – and she's currently immersed in payment reform.

- PhD, neurobiology & anatomy, University of Rochester
- MPH, health policy & management, Boston University
- Joined Day Health Strategies in 2014, where she has led multiple engagements related to population health, coordinated care delivery and clinical design.
- Examples of client work include ACO planning and implementation, payer and provider leadership development, analytic program design, dashboarding and primary care/behavioral health integration efforts.
- Holds adjunct faculty position at Boston University's Metropolitan College.
- Also an Affiliate Member of Ariadne Labs at the Harvard TH Chan School of Public Health.
- Also co-leads ongoing global health research with a Boston-based team working remotely on a surgical navigation and outcomes program in rural Haiti.

Accountable Care News talked to Bliss Matousek about overburdening providers and auditing ACOs.

***Accountable Care News**: What has your career path been, starting right out of college? Has it been anything like what you anticipated?*

Sarah Bliss Matousek PhD MPH: I entered a doctoral program in neuroscience immediately after graduating from college, so my career started with basic science research. After grad school, I spent about three years as a post-doctoral research fellow at Harvard before leaving to study public health at Boston University. While there, I taught a few courses, launched a surgical navigation program in Haiti and ran big data analysis for a long-term services and support organization. After I finished that Master's degree, I began a new career in healthcare management consulting with my current company, and have loved every minute of it. This path is not something I anticipated, but every step of the way I collected skills and knowledge that I use every day with the companies I serve, so I wouldn't have it any other way.

***ACN:** What's a "typical" day like? What kinds of tasks and functions occupy you from 9 to 5?*

SBM: My "typical day" starts very early and ends very late, but I'll stick to the official working hours. In my profession, the schedule varies widely from day to day, so I'll pick a typical Tuesday. I start with a series of 1:1 meetings with my staff and project management updates. I then work on client follow-ups and have client meetings in the afternoon. We have a staff meeting toward late afternoon and I finish my workday by making phone calls on my commute back to Boston from our office in Somerville.

***ACN:** You discussed making sure an audit mechanism is built into contract negotiations when ACOs form and merge. Has a body of specialized audit knowledge developed around ACOs yet? Have they been around long enough? Are there internal and external audit issues unique to ACOs?*

SBM: Because no two ACOs are exactly alike, internal audit functions are going to look different, but there is definitely a body of specialized knowledge that has developed over the last eight years since the Medicare ACOs launched as a part of the Affordable Care Act. We recommend building the internal audit mechanism into the contract terms, particularly when there are several disparate entities coming together that haven't ever worked together before. Internal auditors may have to step outside their comfort zones to take on new issues like care management and other aspects of patient care.

***ACN:** You discussed ensuring that each of an ACO's member provider groups has representation on decision making bodies, and you talked about minimizing administrative density and hassles. How much day-to-day administration and policy-setting should be handled by doctors/providers? Should ACOs have professional management?*

SBM: Great question. While we need to ensure provider buy-in and input, we have to be careful with their time. I do think ACOs should have professional management, and a part of the task would be to ensure that balance is tended to. In my opinion, very little day-to-day administration should be handled by providers, but they should be at least consulted on policy-setting. Strong administrators will know how best to use physician time such that the ACO leverages their expertise without overburdening them with work that someone else can do.

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