AMERICA'S PHYSICIAN GROUPS

Medicare ACOs: Problems and Solutions

Sean Cavanaugh, Chief Administrative Officer

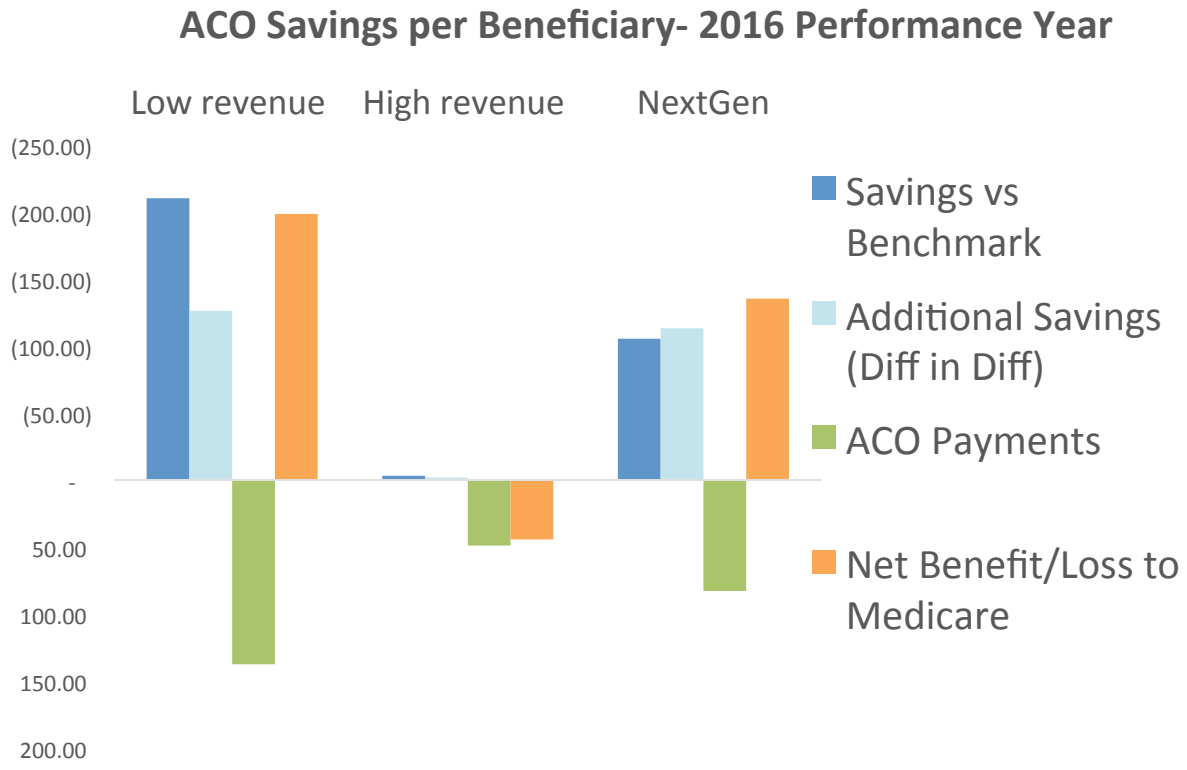
Aledade

The MSSP Proposed Rule is Good for Physician-Led, "Low Revenue," ACOs

The Key Takeaways

- Strengthens the program by recognizing the unique value of physician-led ACOs
- Illustrates CMS' commitment to helping more independent physicians move to value based care
- Boosts likelihood of shared savings earlier for physician-led ACOs and motivates ACOs by introducing shared losses earlier in the program

“Low Revenue” Physician Led ACOs Outperform All Other ACOs



- Using CMS’ data and methodology, Low Revenue Track 1 ACOs performed as well as Next Gen ACOs
- Policies that incentivize physicians to participate in low revenue ACOs will save money and lives
- Low revenue ACOs serve 5x more beneficiaries than NextGen and are easier to launch and scale
- Payments made to low revenue ACOs reflect gains, not losses, to Medicare

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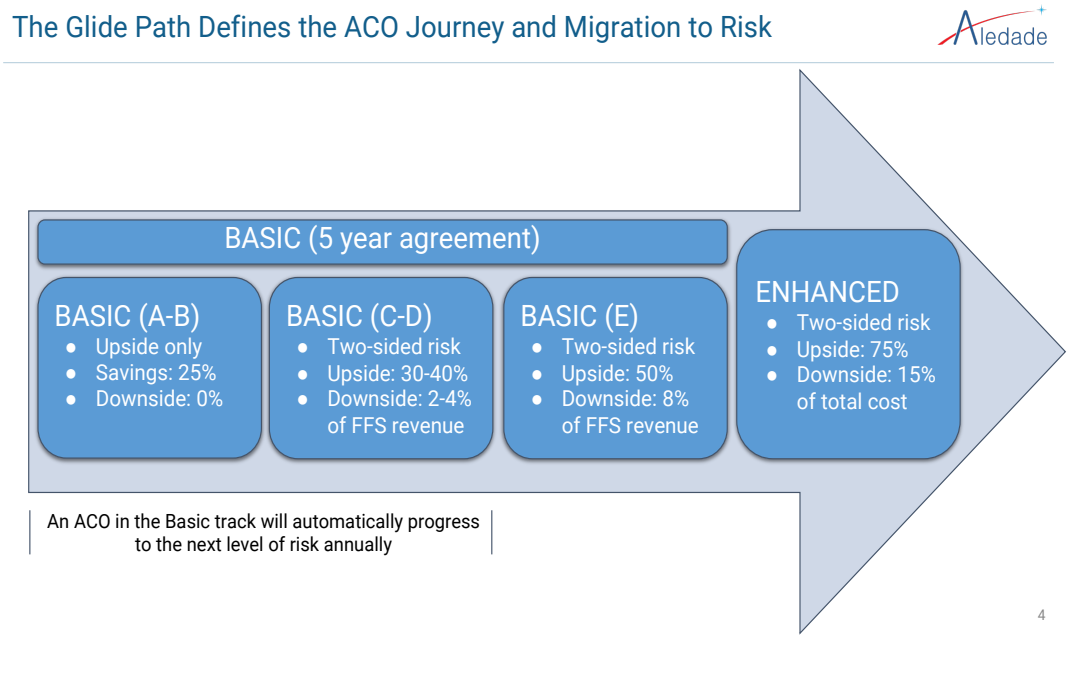
Source: CMS ACO 2018 Rule, Table 15, and NextGen Fact Sheet

There are Three Main Categories of Policy Changes

1. Glide Path to Risk
2. Enhanced Flexibility
3. Refined Benchmarking Methodology

1. Glide Path - Perspectives



What we like:

- Brings revenue-based risk to MSSP
- Downside risk weeds out ACO squatting

What worries us:

- Low gainshare in first 2 years insufficient to entice new participants, support investments
- Gaming by hospitals to qualify for "low revenue" definition

What we propose (with logical outgrowth):

- Increase gainshare and lower MSR for low revenue ACOs
- Scrutiny of participant ownership

2. Enhanced Flexibility Gives ACOs More Control and Mobility

All ACOs can:

- Choose their beneficiary attribution methodology (retrospective or prospective)
- Accelerate their path to risk as desired

ACOs in a two-sided model can:

- Choose their Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)
  - 0%
  - Symmetrical; 0.5% increment between 0.5-2.0%
  - Symmetrical; based on the number of assigned beneficiaries
- Establish a beneficiary incentive program
- Apply for Skilled Nursing Facility (SNF) 3-day waivers

What we like:

- Shifts decision-making from CMS to ACOs

What worries us:

- Any progression to opt-in requirement creates massive paperwork and administrative burden

What we propose:

- Allow ACOs to choose to go to ENHANCED at any time
- Opt-in required only when beneficiaries lose a benefit- eg narrow network design

3. Refined Benchmarking Methodology (“more similar to MA”)

- Improved benchmarking methodology incorporates regional trend and efficiency starting in the first agreement to more accurately reflect changes in cost and quality for patients attributed to ACOs (see table)
- Updated cap to risk score adjustment of +/- 3% more accurately reflects the changing profile of beneficiaries attributed to ACOs within a contract

	1st Agreement (1 - 5 years)	2nd Agreement (Soon as Yr 2 Late as Yr 6)	3rd Agreement
Regionally Efficient ACO	35% Regional Costs 65% ACO’s Historical Costs	50% Regional Costs 50% ACO’s Historical Costs	50% Regional Costs 50% ACO’s Historical Costs
Regionally Inefficient ACO	25% Regional Costs 75% ACO’s Historical Costs	35% Regional Costs 65% ACO’s Historical Costs	50% Regional Costs 50% ACO’s Historical Costs

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What we like:

- Greater predictability through risk adjustment, regional trend, and regional efficiency

What worries us:

- Caps on risk adjustment inadequately controls for rising risk, and introduces gaming potential on falling risk
- Cap on regional efficiency blunts further improvement (“100% tax bracket”)

What we propose: (“more like MA”):

- Renormalization, not a risk adjustment cap
- Raise regional efficiency cap

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Rural ACOs are still Disadvantaged with the Proposed Rule

Market Share	Savings Lost
0%	0%
5%	5%
10%	10%
20%	20%
40%	40%

Including an ACO's population in their regional benchmark reduces their savings opportunity in direct proportion to their market share.

What we like:

- Taking seriously the predicament of rural ACOs

What we are worried about:

- Proposed solution does not address this systematic problem- hurts as many as it helps

What we propose:

- Do not include the ACO's population in the regional benchmark
- Expand geographic area to deal with low population situations- as done by MA

Summary Policy Recommendations to Further Improve the Rule

It does come down to the Benchmark

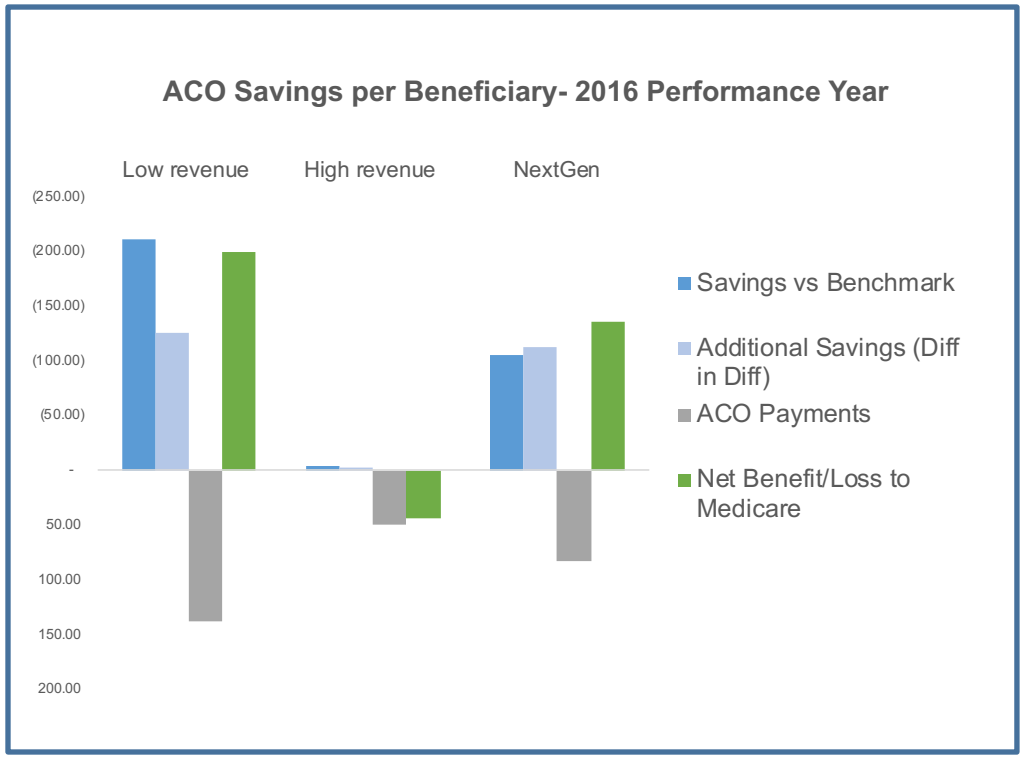
Benchmark- Further increase predictability and fairness

- Increase regional efficiency to maintain motivation, and recognize the multiple years of work that go into hitting those caps
- Replace risk coding caps with renormalization
- Improve benchmarking calculation methodology for rural ACOs

Glidepath- Create incentives for physicians to continue to move towards robust risk-taking ACOs

- Increase gainshare and lower MSR for low revenue ACOs in first 2 years
- Ensure integrity of “low revenue” designation through scrutiny of participant ownership
- Allow ACOs to choose to go to ENHANCED at any time

Issue to Consider: Finding the Optimal Balance Between Protecting Trust Fund from Saving Payments versus Healthcare Cost Growth?



- Current impact assessment emphasizes reducing ACO net earnings versus increasing shared savings:
  169 fewer ACOs through 2024
  - -$330 million in "net federal impact"
  - $390 million in reduced ACO earnings
  - $60 million in INCREASED claims costs (and lost benefit to beneficiaries)
- Creating greater incentives for ACO participation and motivation will spur private sector investment and progress towards value-based care, quality gains.
- Payments made to low revenue ACOs reflect gains, not losses, to Medicare
- Does *not* include positive spillover effects to community costs, and Medicare Advantage premiums

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Providence St. Joseph Health

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Providence St. Joseph Health Employed & Foundations Provider Network

PROVIDENCE Medical Group

- Alaska
- Northwest Washington
- Southwest Washington
- Spokane
- Southeast Washington
- Oregon
- Montana
- California- Los Angeles

PROVIDENCE Medical Institute

SWEDISH MEDICAL GROUP

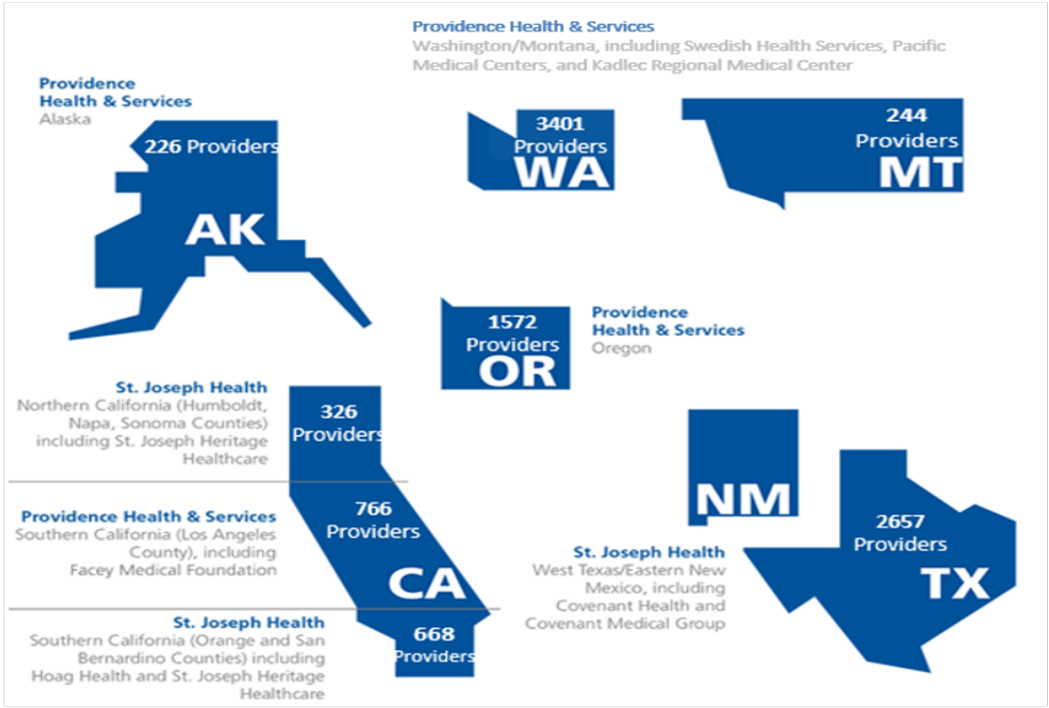
FACEY MEDICAL GROUP

pacific medical centers

KADLEC CLINIC

St.JosephHealth St. Joseph Heritage Healthcare

CovenantHealth Medical Group



850 Clinics

8.5M Visits

7,400Providers

14 Medical Groups

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Health Connect Partners Overview

Track and Start Date

- 1st agreement period 2014-2016 Track 1
- 2nd agreement period 2017-2019 Track 1

States: Alaska, Washington, Montana, California

Number of Practitioners: 6,221 (2017)

Number of Assigned Beneficiaries: 112, 692 (2017 Final Attribution)

Number of EMR instances across participant states: 6

Participated in MSSP to alleviate MIPS reporting burden and to encourage cooperation among providers to improve quality of care; Focused on Quality through 2017; no additional Cost/Utilization Initiatives specifically for the MSSP population.

Key Highlights / Experience

Quality Efforts

- Main Focus of Program has been Quality, and we have had great results
  - 2014: 100% (Pay for Reporting)
  - 2015: 97%
  - 2016: 98%
  - 2017: 92%*
    - Added a large TIN of over 40,000 beneficiaries with no insight into data until the end of the year.
- Engagement of Providers in Primary Care Realm
  - Operations Committee with regional and system department representation
  - Quality Performance Improvement plans and meetings with Regional Quality Leaders on monthly basis

Shared Savings for 2017 : $10.7 M

Lessons Learned

- Need for Analytics around Beneficiary Attribution and Demographics to identify shared savings drivers (e.g. HCC Coding and Regional Benchmark Composition)

- Cost and Utilization Initiatives are needed going into two-sided risk models in 2020. Quality Focus is not enough.

- Data Transparency and Timely Report-Outs are necessary for all participating regions in order to get a full picture of program success (some regions *just* started providing data in 2018).

- Provider/Regional Engagement is Key when you have a large system infrastructure with no direct control over regional initiatives or resources.

Next Steps

- Evaluation of 2020 Participation Options (Pathways To Success)
  - Level of Entry for 2020
    - Do we go for 1 more year of upside-only (Level B in GLIDE Path) or do we jump to Level E and participate as an Advanced APM?
  - ACO/TIN Composition
    - Analysis on current ACO participants and which TINs are ready for down-side risk
  - Beneficiary Attribution Method- Prospective v Retrospective
  - Financial Impact of Benchmark changes, Risk Coding Caps, Waivers and Beneficiary Incentive Program Options
- Cost/Utilization Initiatives for 2019 across Medicare Programs
  - Post-Acute Strategy Workgroup
  - HCC Education Strategy/Workgroup
- Optimize Quality and Closing Gaps in Care- Continue Great Work in Quality Realm
- Engage Specialty and Inpatient Providers; Case Management

Melanie Matthews, CEO

Physicians of Southwest Washington, LLC

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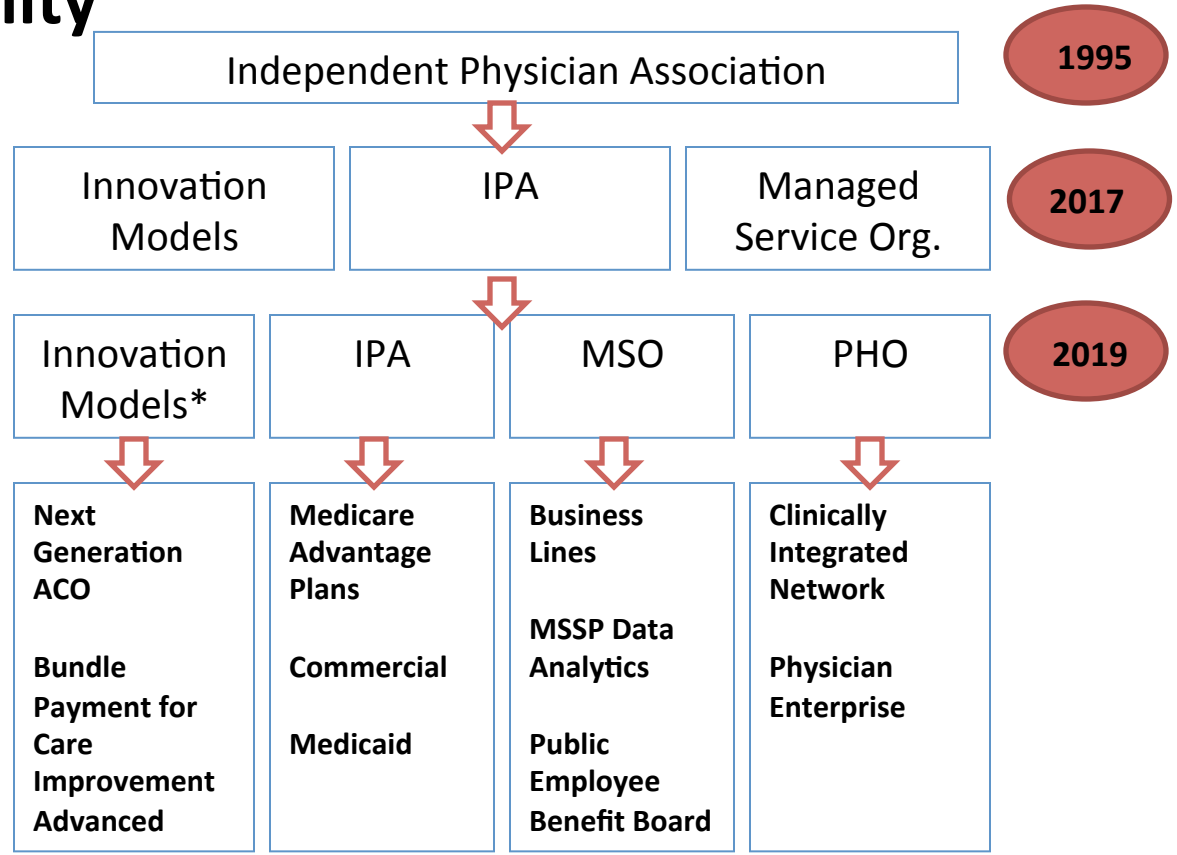
Building Sustainability

PSW VALUE
Core Competencies
Intellectual Worth
Diversified Business Models
Risk / Population Health company

DECISION DRIVERS
Align with partners
Commitment to Innovation
Flexibility
Legal structures

STRATEGIES
Expand
Evolve
Diversify
Partner



* NW Momentum Health Partner ACO, LLC legal structure and governance partner with Capital Medical Center

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ACO Features

Next Generation ACO

- In program since 2017
- Approx $9k lives
- Shared Savings Success in year 1
- Built upon Medicare Advantage delegated risk model for infrastructure
- Administrative revenue solely on Infrastructure payment loan to fund operations
- Partner with local hospital in biz model including to fund ESCROW
- Program focus is high touch physician engagement and addressing social determinants of health

Our Mission

Northwest Momentum Health Partners ACO, LLC is a community of health care providers committed to transforming clinical practice with the goal of improving quality, reducing expenditures and enhancing both the patient and provider experience.

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Challenges and Opportunities

Challenges

- Program size requirements
- Quality Reporting
- Resources to implement the waivers
- Model changes
- Equity to scale
- Other MSSP models TIN exclusive limits
- “Marathon not a sprint”

Opportunities

- Collaborative environment with CMMI for learning
- Data to share with providers on market outcomes for total cost and quality
- Creating a network with new partnership opportunities
- Waiver expansion
- Engagement of beneficiaries

Strategy:
Continue to participate in CMMI Innovation Models

- Encouraged by ACO model outcome report that supports the value to the system
- Thumbs up on proposed rule to continue directional movement from FFS to value based and pressure for 2 sided risk model
- Be Advanced Alternative Payment Model for network to exempt MIPS and show financial value
- Expand ACO for physician groups and partners through high touch provider engagement and provide base infrastructure
- Continue to work with stakeholders on shaping the longevity and direction of "What's next for Next Gen" building upon lessons learned for model opportunities and successes