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Medicare Risk Strategy

Navigating ACO programs, Medicare Advantage, and the future of risk-based payment

RESEARCH REPORT

Look inside for:

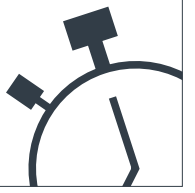
- Decision guide on how to choose the right ACO model
- The must-have contract terms for Medicare Advantage risk arrangements
- Tactics for sustaining contract economics post-negotiation

TOPIC

Accountable care

READING TIME

1.5 hr.



BEST FOR

Strategy and finance leaders

WHAT YOU'LL LEARN

- How MACRA should—and shouldn't—impact your Medicare risk strategy
- The most important distinctions between the different Medicare ACO models
- What to prioritize in MA risk contract negotiations
- Tactics to accelerate entry into the MA market
- How to ensure your Medicare risk strategy is sustainable across the long term

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RESEARCH REPORT

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Flip to the appendix to access the following tools and decision guides:

- Medicare risk acronym glossary
- Illustrative financial model: How ACO participation impacts MIPS performance
- Detailed overview of ACO benchmarking methodologies
- Decision tree for evaluating downside ACO models
- Evaluation guide for potential MA plan partners
- Pick-list of short-term savings opportunities

Medicare Risk Strategy

10 Takeaways for Hospital and Health System Executives

The details contained in this research brief are current as of its publishing in May 2017. As has been the case since the start of CMS's payment reform efforts, the agency will continue to adjust and evolve the details of programs, particularly as it transitions to new leadership under the Trump administration. However, the principles for effectively evaluating risk-based payment models and designing a successful Medicare risk contracting strategy outlined in this publication are unlikely to change over time. Below are 10 takeaways for hospital and health system executives striving to establish an intentional Medicare risk strategy.

1. **Payment reform is a bipartisan concept, and the federal government continues to establish new incentives for providers to embrace risk.** The origins of Medicare ACOs can be traced to the Physician Group Practice Demonstration launched during President George W. Bush's administration. And while the ACA's coverage reforms generated significant debate, the law's delivery system reforms have garnered bipartisan support.
2. **The advent of MACRA creates new urgency to reevaluate Medicare risk.** Many drivers of Medicare risk have been in place for some years now. The advent of MACRA both establishes the first focused incentives for physicians to embrace risk and shifts the economics of existing models, making some—including MSSP Track 1—more attractive than ever before.
3. **MACRA means that ACOs are no longer simply a stepping stone to Medicare Advantage risk—providers should pursue both types of risk.** Due to early challenges with ACO models and favorable payment offered by MA, many have come to view MA risk as an ideal end-state. However, APM qualification is contingent on taking risk in Traditional Medicare, meaning most providers will need to balance both types of Medicare risk indefinitely.
4. **Speed-to-market is crucial for securing the best partners and maximizing lives under management.** First-mover ACOs can solidify relationships with preferred physician partners, ensuring sufficient scale under utilization-based attribution models. In MA, early movers will capitalize on attractive reimbursement, and those interested in joint product offerings with plans will have the best opportunity to secure preferred plan partners.
5. **Regardless of experience, there is value in beginning new contracts in upside-only arrangements.** With MACRA's 5% APM bonus looming, it may seem tempting to jump straight to downside risk. However, initial experience in MSSP Track 1 is invaluable in building the capabilities and expertise necessary to successfully manage downside risk. And in MA, even experienced population health managers often negotiate an initial upside-only term to test the strength of a new partner or contract.
6. **Don't get stuck in upside—establish a clear glide path to downside risk.** While an initial upside-only term may be a helpful starting place, experienced organizations ensure that they don't linger for too long. Providers should have clear, predetermined criteria for deciding when to transition a contract from upside-only to downside-risk arrangements.
7. **Selecting contracts with favorable benchmarks—and maintaining those benchmarks over time—is key to managing downside risk.** Early ACO participants underestimated the importance of the benchmark, with many learning the hard way that they had selected a contract that offered little chance for success. With an ever-growing number of downside risk options, organizations must conduct a robust financial analysis to select the right model. MA offers even more flexibility for providers to negotiate a favorable benchmark. And across both types of contracts, thorough coding and documentation is crucial to maintaining an accurate benchmark over time.
8. **A comprehensive risk contracting strategy extends beyond the negotiating table.** Improving accuracy of coding and documentation is just one example of a performance lever that strengthens contract economics after negotiations are complete. Ensuring positive results early on is also critical; without initial wins, it can be difficult to maintain stakeholder buy-in and to sustain the momentum necessary for longer-term transformation.
9. **Experienced organizations will play an active role in plan enrollment.** As organizations gain a better understanding of which contracts are most favorable, they should actively encourage beneficiaries to sign up for the insurance products that align with those contracts. In the MA market, providers must remain within the bounds of relevant regulations.
10. **Loyalty is critical to successfully managing Medicare risk in the long-term.** No matter how attractive the contract terms, providers will struggle to succeed if patients frequently leave the provider network. Successfully executing on a Medicare risk strategy will require providers to develop durable loyalty both at the point-of-care and the point-of-coverage.

Reevaluating the Medicare Landscape

Unpacking the Drivers of Medicare Risk

While the government has tested various models for shifting risk to providers for decades, three major forces are currently intensifying the pressure providers face to enter into Medicare risk-based contracts.

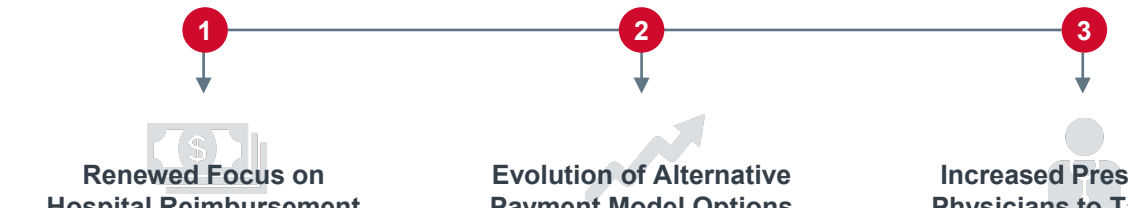
First, CMS continues to erode pricing growth. Many providers faced payment cuts as a result of the ACA, and subsequent regulations targeted hospital reimbursement specifically. While these changes do not wholly eliminate viability under fee-for-service payments, long-term success under fee-for-service economics will likely require unprecedented improvements in efficiency.

Second, CMS is evolving the range of alternative payment models. New ACO models continue to proliferate, and CMS has also revised existing options to address providers' concerns.

Both of these trends—the decline of fee-for-service and the expansion of new payment models—have been underway for some time now. However, the third force pushing providers toward risk emerged more recently. After the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physicians now have incentives to take on risk for the first time.

Critical Reasons to Revisit the Issue Now

Medicare Risk Circa 2017: A Far Different Story



	Renewed Focus on Hospital Reimbursement	Evolution of Alternative Payment Model Options	Increased Pressure on Physicians to Take Risk
Past	• ACA Productivity Adjustments • Process-focused Pay-for-Performance	• Physician Group Practice (PGP) Transition Demonstration • Acute Care Episode (ACE) Demonstration • Pioneer ACO Model	• Physician Quality Reporting System (PQRS) • Meaningful Use • Value-Based Payment Modifier
Present	• Outcomes-focused Pay-for-Performance • 2017 Outpatient Prospective Payment System (OPPS) Proposed Rule Site-Neutral Payments Provision	• Medicare Shared Savings Program (MSSP) • Next Generation ACO (NGACO) Model • Comprehensive Primary Care Plus (CPC+) • Bundled Payments for Care Improvement (BPCI) Initiative • Comprehensive Care for Joint Replacement (CJR) Model • Episode Payment Models (EPM)	• Medicare Access and CHIP Reauthorization Act (MACRA)

Source: Health Care Advisory Board interviews and analysis.

Election Raising Questions About Future of Risk

Momentum behind payment transformation built up across the Obama administration, but the GOP's sweep of the White House and Congress in the 2016 elections created newfound uncertainty for the future of the Center for Medicare and Medicaid Innovation (CMMI), MSSP, and MACRA.

While some lingering uncertainty may remain as Republicans debate the future of health care policy, payment reform appears to be one of the least vulnerable parts of the ACA.

Payment reform generally enjoys bipartisan support, and MACRA passed Congress with strong support from both Democrats and Republicans. Across the Trump administration's first 100 days in office, the GOP's repeal and replace legislation, the American Health Care Act (AHCA) focused on repealing the ACA's taxes, reforming the individual market, and restricting Medicaid financing. Payment reform was excluded from the proposed legislation.

While Congress and the new administration may modify individual programs, no evidence suggests a full return to pure fee-for-service economics.

Despite Uncertainty, Payment Reform Likely to Remain in Some Form

Key Payment Reform Questions Looming with Change in Leadership

- ? Will the new administration migrate away from payment transformation?
- ? What is the future of CMMI and programs such as NGACO?
- ? What is the long-term trajectory of programs such as MSSP?
- ? How will the new administration tweak MACRA implementation?

But Many Reasons to Bet on Future of Payment Reform

- ✔ Strong bipartisan support for concept of payment reform
- ✔ Tom Price acknowledged promise of CMMI in confirmation hearings
- ✔ Repeal of MSSP likely falls outside bounds of budget reconciliation
- ✔ Near-unanimous bipartisan support for MACRA legislation

> "...I'm a strong supporter of innovation at every level. CMMI I believe has great promise to do things that would allow us to change the payment model, and I strongly support that."
>
> *Representative Tom Price, Nominee for HHS Secretary, Senate HELP Committee Hearing*

Source: Price T, "Obamacare Agency Escapes Congressional Oversight," www.budget.house.gov; Health Care Advisory Board interviews and analysis.

Proceeding Amid Uncertainty

Given the bipartisan support for payment reform, hospital and health system leaders should continue to develop and implement Medicare risk strategies. Organizations can enjoy an early-mover advantage in adopting risk-based payment models, especially as physicians adapt to the new realities of MACRA. Many of the steps organizations would take for ACO preparation will also help physicians improve performance under MACRA.

Unless leaders lack the political capital necessary to motivate change, they should continue down the path to risk.

With 2017 Decision Points Looming, Better to Be Prepared

Inaction Not an Option for Most Providers

Reasons to move forward with ACO strategy

First-Mover Advantage in Partner Alignment

Key physician partnerships at stake; delay threatens alignment opportunities

Future Application Periods Uncertain

NGACO application period open for 2018; no future application periods indicated

Population Health No Longer Optional

High likelihood focus on population health remains; MIPS forces providers to be efficient managers; investments time intensive

Opportunity to Shape Program Evolution

Program participation allows more input on reform; CMMI particularly flexible to provider opinions

For Select Few, One Good Reason to Wait and See

Waste of Valuable Political Capital

Pushback from key stakeholders; risk of alienating physicians, executives, board should programs be eliminated

Source: Health Care Advisory Board interviews and analysis.

ACO Growth Continues

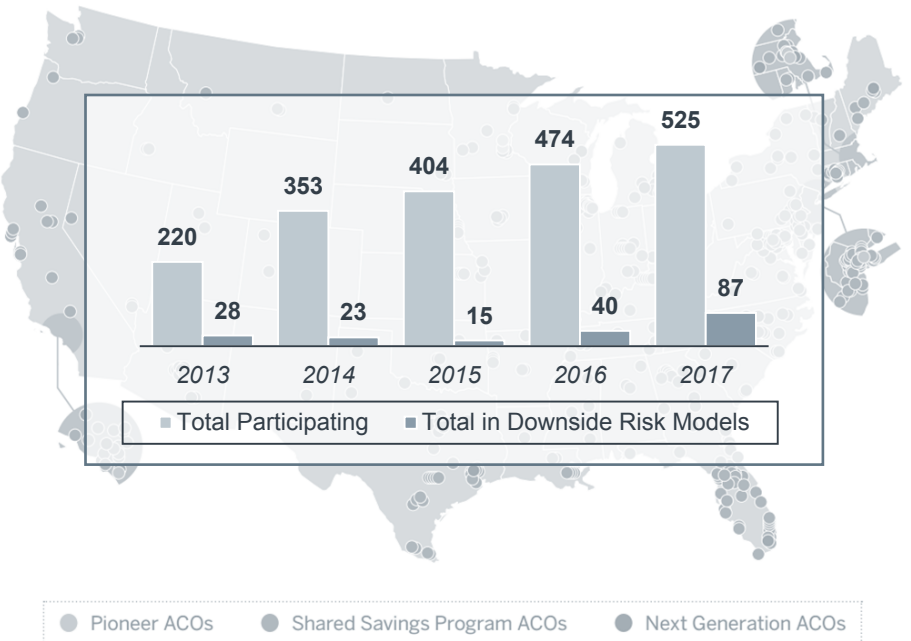
Progressive providers across the country are already demonstrating their commitment to Medicare risk. At the start of 2017, 99 new Medicare ACOs launched, and the number of organizations participating in downside risk models more than doubled compared to 2016.

Additionally, several high-profile population health managers—including both Sharp HealthCare and Dartmouth-Hitchcock—rejoined the ACO programs in 2017. These organizations previously left early ACO models due to challenges with program design. But after revisions to the ACO models, they are once again expressing optimism about the potential for risk in Medicare.

Despite Election Results, More ACOs Launched in 2017

Overall Participation Continues to Grow

Total ACO Participants, by Performance Year



Progressive Organizations Rejoining ACO Model

"There were certain features of the Pioneer ACO Model that proved challenging to Sharp HealthCare. However, the financial targets set under the Next Generation Model address these issues and Sharp is excited to participate."

Alison Fleury, CEO, Sharp HealthCare ACO-II

Source: CMS, available at: data.cms.gov, accessed October 3, 2016; Advisory Board, "Where the ACOs are", available at: advisory.com, accessed October 3, 2016; Health Care Advisory Board interviews and analysis.

Election Reinforces Strong Outlook for MA

In some respects, recent political developments have strengthened the case for Medicare risk. For example, Republican control in Washington bolsters the outlook for Medicare Advantage.

In addition to presenting an attractive financial opportunity for providers, Medicare Advantage is a growing segment in many markets. An increasing proportion of Medicare beneficiaries select Medicare Advantage plans over traditional Medicare. By 2025, the Congressional Budget Office estimates that 40% of all Medicare enrollees will select MA plans, accounting for 30 million total enrollees.

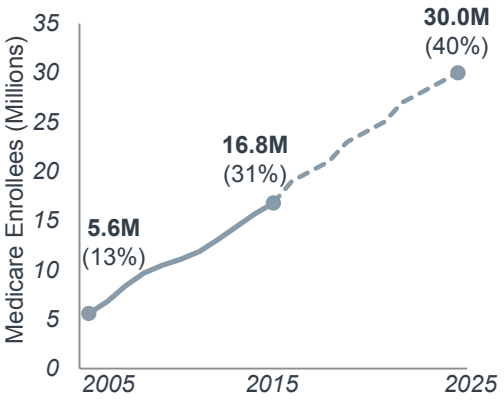
After making their initial selection, Medicare Advantage enrollees tend to remain within the program. In any given year, only 2% of MA enrollees voluntarily switch to traditional Medicare coverage. MA thus presents an emerging opportunity to build durable relationships with Medicare beneficiaries over the long term.

However, MACRA changes how MA should factor into providers' Medicare risk strategy.

More Seniors Are Choosing and Staying with Medicare Advantage

MA a Growing Opportunity…

Enrollment, Percentage of Total Medicare Population



….To Build Long-Term Member Relationships

48% Of new MA plan members are newly eligible for Medicare coverage

Of Medicare Advantage beneficiaries voluntarily switch to traditional Medicare each year

Source: CBO, "March 2015 Medicare Baseline," March 9, 2015, available at www.cbo.gov; Jacobson et al., "At Least Half of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006-2011", *Health Affairs*, January 2015 , available at www.healthafffairs.org; Jacobson et al., "Few People Switch Medicare Advantage Plans Each Year, Raising Questions About Whether Seniors Have the Tools and Information They Need to Compare Plans," *Kaiser Family Foundation*, September 2016, available at www.kff.org; Health Care Advisory Board interviews and analysis.

MACRA Solidifies Role of Traditional Medicare

Since Medicare ACO programs first launched in 2012, some providers have viewed ACOs as a means to eventually transition to MA risk. But MACRA reinforces the role of Medicare ACOs.

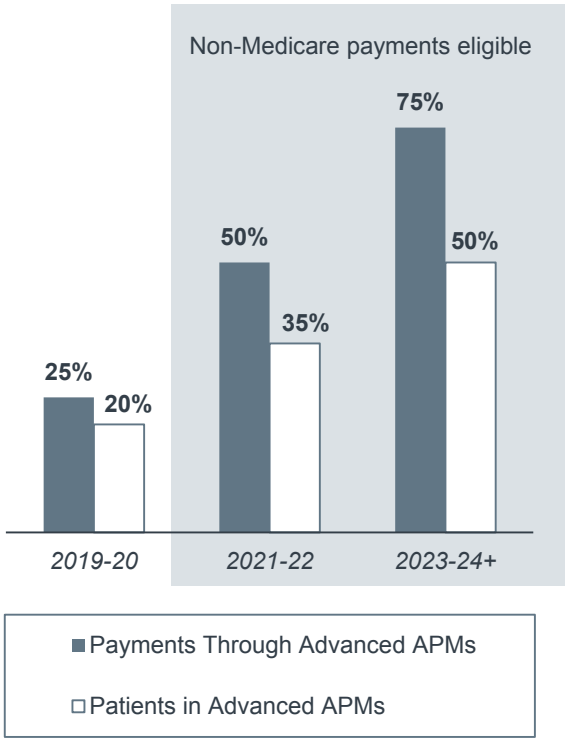
For the initial two years of MACRA's payment adjustments, providers can only qualify for the APM track by taking downside risk in Traditional Medicare. Beginning in 2021, the "All-Payer Combination Option" will allow other forms of risk—including MA risk—to count toward APM qualification. This is particularly appealing to providers with significant portfolios of commercial and MA risk arrangements.

A close reading of the final rule, however, reveals that providers must still meet a minimum threshold of Traditional Medicare risk before CMS will consider other types of risk contracts. As a result, the all-payer option does not provide an off-ramp to risk in Traditional Medicare.

Ultimately, establishing an effective Medicare risk strategy is not a decision between pursuing risk in Traditional Medicare or risk in the Medicare Advantage market. Moving forward, providers will need to balance a mix of risk-based contracts across their Medicare book of business.

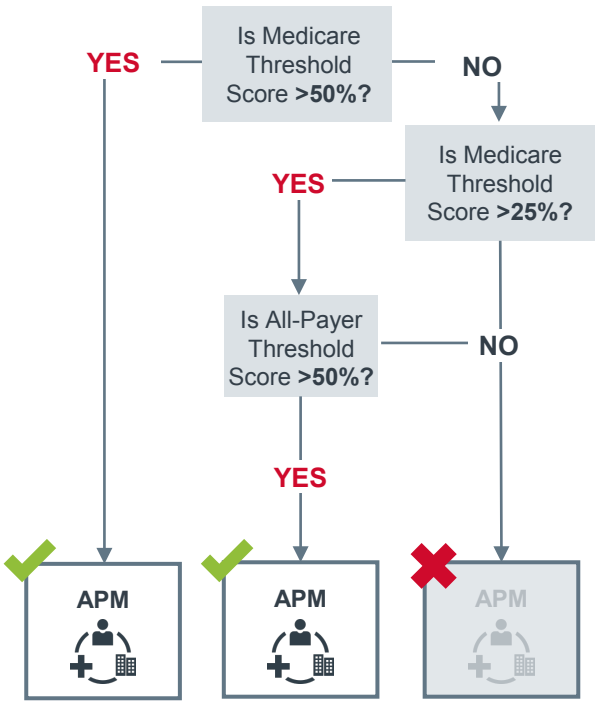
Medicare ACOs Not Just a Stepping Stone to MA Risk

MA Contributes to APM Thresholds Beginning in 2021…



…But Providers Must Still Meet Traditional Medicare Threshold

Two Ways to Qualify for APM Track in 2021



Source: CMS, "All-Payer Combination Option," available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-All-Payer-Overview.pdf, accessed October 3, 2016; Health Care Advisory Board interviews and analysis.

Defining an Intentional Medicare Risk Strategy

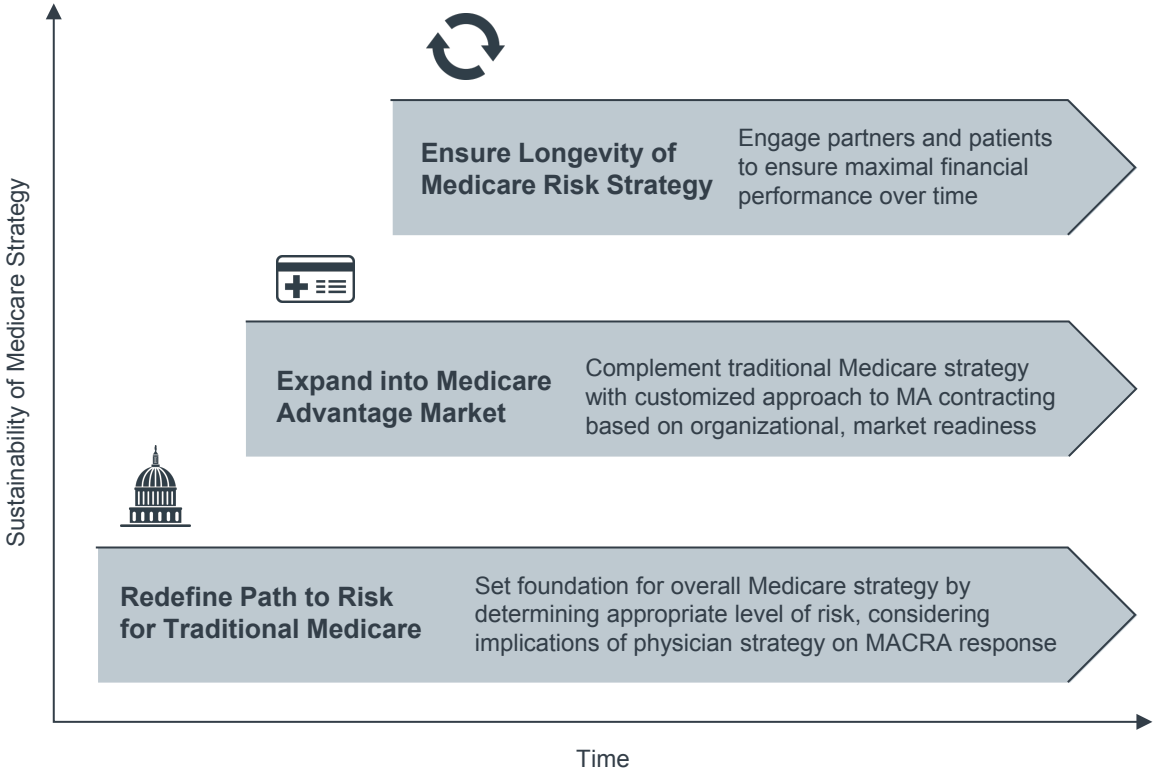
Given the industry's continued push toward risk, complacency is not an option. To be successful across the long-term, hospitals and health systems must develop an intentional strategy for entering into risk-based contracts for their Medicare business, which includes three key components.

First, the urgency around MACRA means that developing a risk strategy for Traditional Medicare is the clear starting place. Even if organizations have evaluated Medicare ACOs previously, new market forces warrant another review.

Second, providers cannot ignore the attractive opportunities to enter into risk contracts in the Medicare Advantage market. Providers must understand the options for expanding into Medicare Advantage risk—and the keys to success.

Finally, providers need to ensure the long-term viability of their risk contracts. After forming Medicare ACOs and accepting MA risk, providers must take several purposeful steps to ensure the longevity of their Medicare risk strategy.

Three Steps to Establishing a Sustainable Medicare Risk Strategy



Source: Health Care Advisory Board interviews and analysis.

Medicare Risk Strategy

11 Imperatives for an Intentional Medicare Risk Strategy

Secure Attractive Risk Contracts

Solidify Contract Sustainability

1 Redefine Path to Risk for Traditional Medicare

Laying the Foundation

1. Capitalize on newfound opportunity through Track 1

Evolving Past the Pilot Phase

2. Prioritize benchmark analysis to pace transition to downside
3. Match model selection to risk tolerance

2 Expand into Medicare Advantage Market

Fine-Tuning Contract Terms

4. Set parameters for must-have contract elements
5. Establish clear glide path to increased risk over time

Expanding Scope of Control

6. Clarify desired scope of delegated responsibilities
7. Secure first-mover advantage in provider-sponsored MA

3 Ensure Longevity of Medicare Risk Strategy

Engaging Partners

8. Improve coding, documentation to ensure a fair standard
9. Prioritize near-term savings to protect buy-in

Engaging Patients

10. Tip market toward most favorable contracts
11. Minimize churn to stabilize cost targets, enable ROI

Source: Health Care Advisory Board interviews and analysis.

1

Redefine Path to Risk for Traditional Medicare

Laying the Foundation

1. Capitalize on newfound opportunity through Track 1

Evolving Past the Pilot Phase

2. Prioritize benchmark analysis to pace transition to downside
3. Match model selection to risk tolerance

Revisiting a Familiar Decision Through a New Lens

With MACRA starting to affect provider strategy in 2017, organizations must revisit the options for risk in Traditional Medicare to ensure sufficient time for planning a MACRA response strategy. Organizations face a crucial decision surrounding whether or not to join one of Medicare's ACO programs. With the first ACO programs introduced in 2011, this is not the first time providers have faced this particular decision. However, the considerations driving the evaluation process have since evolved in several ways.

Providers now have more options to consider. They can choose among four tracks of MSSP and the NGACO model. Additionally, providers must account for a broader set of strategic considerations when determining ACO participation. It is no longer sufficient to examine feasibility and potential ROI; providers must now also assess how their decision impacts potential performance under MACRA.

To select the appropriate model and plot an intentional transition path, providers must answer two key questions. First, which model presents the best starting point for those new to risk? Second, how should organizations pace their transition to downside risk?

Assessing Medicare ACOs in Post-MACRA Reality

An Expanding Set of Medicare ACO Options to Evaluate

MSSP Track 1	MSSP Track 1+	MSSP Track 2	MSSP Track 3	NGACO[2]
Upside-only shared savings with maximum share rate of 50%	Two-sided shared savings with fixed loss rate of 30% and maximum share rate of 50%	Two-sided shared savings with maximum share/loss rate of 60%	Two-sided shared savings with maximum share/loss rate of 75%	Two-sided shared savings with choice of 80% or 100% share/loss rate
438 Participants[1]	Begins in 2018	6 Participants	36 Participants	45 Participants

Two Key Questions to Chart Transition to Risk

1 Which model is the **best place to start?**

2 How do we **pace the transition to downside risk?**

1) As of January 2017.
2) Next Generation ACO.

Source: NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; CMS, "Next Generation Accountable Care Organization Model (NGACO Model)," January 11, 2016, available at: www.cms.gov; CMS, "2016 Medicare Shared Savings Program Organizations," October 2016, available at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt; Health Care Advisory Board interviews and analysis.

For Most Newcomers, Track 1 Is Ideal Starting Point

For the majority of provider organizations who have limited experience with risk-based contracts, MSSP Track 1 provides the ideal vehicle to kick-start population health efforts without taking on undue levels of financial risk.

Track 1 is an upside-only model, so participants have no chance of owing money back to CMS. The shared savings model is also built on the fee-for-service system, thereby limiting disruption to providers' established revenue cycles.

Upside Only, FFS Reimbursement Attractive for First Movers

MSSP Track 1 in Brief

Agreement Length	Three-year agreement period[1]
Minimum Size	5,000 beneficiaries
Attribution	Retrospective
Reimbursement	**FFS** with reconciled shared savings
Sharing Rate	Up to 50%
First Dollar Savings	MSR[2] based on size, between 2.0% and 3.9%
Maximum Gain	10% of benchmark
Maximum Loss	0%, **upside only**

Benchmark Methodology for New Track 1 Participants

1. Past three years' Part A and Part B expenditures
2. National trend factors and risk ratios used to state BY[3]1 and BY2 expenditures in BY3 dollars
3. Benchmark set as weighted average of BY1 (10%), BY2 (30%), and BY3 (60%)
4. Benchmark rebased each performance year for changes in ACO participant list and adjusted for projected growth in national FFS expenditures

1) Allowed to renew for a second three-year period or to apply for an additional year in the first period to delay move to downside track.
2) Minimum Savings Rate.
3) Benchmark year.

Source: NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; Health Care Advisory Board interviews and analysis.

Supporting Success in MIPS in the Near Term

Track 1 participation also presents near-term financial advantages as Track 1 ACOs receive preferential scoring in MIPS and several practical benefits.

First, Track 1 ACOs are exempt from scoring in the cost category. Although this is true for all MIPS providers in year one, this advantage will continue indefinitely for Track 1 participants.

Second, Track 1 ACOs automatically receive full credit in the Improvement Activities (IA) category without having to report.

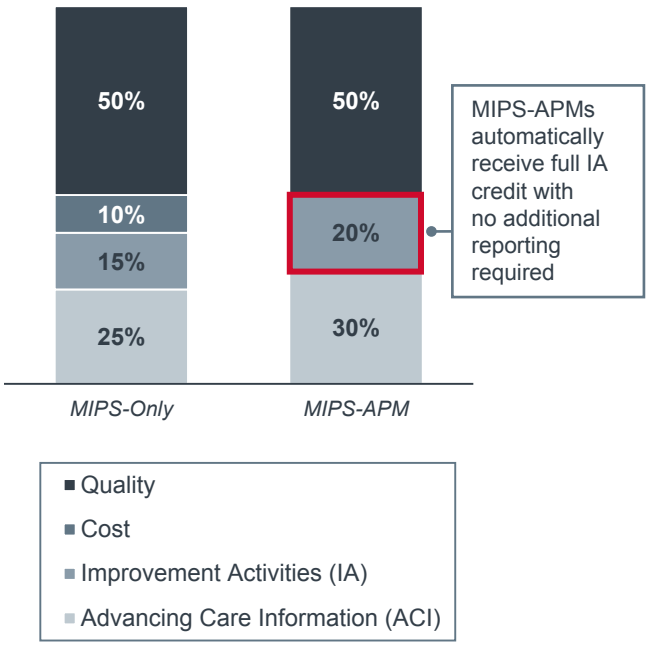
Finally, Track 1 ACOs are not required to submit additional quality data to CMS. Their MIPS score for the quality category is determined from the quality data that ACOs already submit for MSSP.

Taken together, these advantages make participation in MSSP Track 1 more attractive than ever before.

Preferential Scoring Makes Track 1 More Favorable Than Ever Before

Track 1 Participants Exempt from Cost Category,[1] Get Full Credit for Improvement Activities

MIPS-Only and MIPS-APM Scoring Standards, 2020[2]



Contingent on Reporting, Scoring Requirements

Reporting

- Quality measures must be submitted through CMS Web Interface by ACO on behalf of MIPS participants
- ACI data must be submitted per normal MIPS requirements

Scoring

- Performance evaluated collectively at the APM entity level
- Held to the MSSP quality benchmark criteria
- Scoring standard stays at 100% with readjusted weights for the remaining performance categories

$500M Extra pool of incentives for MIPS eligible clinicians whose performance is equal to a threshold final score of 70 or higher

1) MIPS Eligible Clinicians exempt from cost category in 2019, accountability begins in 2020.
2) Payment year.

Source: CMS, Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 FR 28161, https://federalregister.gov/a/2016-10032; Health Care Advisory Board interviews and analysis.

Not Quite a No-Regrets Decision

Despite its range of benefits, Track 1 participation is not without its risks.

For example, despite its scoring advantages, Track 1 participation does not guarantee exceptional MIPS performance. In fact, organizations using ACO participation to expand physician partnerships may experience some dilution in their MIPS performance. While growing the physician network may be necessary to manage population health, adding more physicians to the network can also impact performance under MIPS. For many systems, network expansion will require partnering with small physician practices that may be less prepared to report quality data or meet IT requirements. Preferential scoring will offer some protection but is unlikely to cover the difference entirely.

Additionally, while providers are not required to accept downside financial risk through Track 1, ACOs are not without their costs—both in direct startup investments and the political capital necessary to ensure buy-in and drive cultural changes. With few organizations earning savings in the initial years of participation, providers must view participation as a long-term investment.

Physician Network Growth May Dilute MIPS Score

Potential Drawbacks of Track 1 Participation

Dilution of MIPS Performance

Many ACOs include independent physicians in their network to ensure necessary scale and scope; performance of independents may dilute MIPS score[1]

Difficulty Achieving Early Savings

Few ACOs earn savings right out of the gate; early movers note that it takes time to analyze data to pinpoint opportunities, build out necessary infrastructure, and refine care delivery

Significant Start-Up Costs

Direct investment cost of applying for the program, building out necessary infrastructure, ensuring compliance with ACO reporting requirements, etc.

Substantial Political Capital Required

Successful participation in ACO program requires significant cultural shift and complete buy-in from a variety of key stakeholders across the organization

1) Please see appendix for illustrative financial model.

Source: Health Care Advisory Board interviews and analysis.

Providing On-Ramp to Downside in the Long Term

In fact, the strongest reasons to participate in MSSP Track 1 are strategic in nature. The biggest benefit is not the potential for a higher MIPS score or an immediate shared savings payment. Instead, providers should view Track 1 participation as preparation for a long-term transition to downside risk.

As a starting place, organizations should use Track 1 to establish and strengthen physician relationships. Moving early will give organizations an advantage over competitors and allow time for aligning new partners with the broader goals of the network.

Second, systems should use participation as motivation to begin building out population health infrastructure.

Finally, providers should take full advantage of the data CMS shares with Medicare ACOs. Claims data and financial results provide insight into CMS's benchmarking methodology and help identify opportunities to target avoidable spending and network leakage.

Providers who successfully execute on these goals should be ready to at least evaluate a move to downside risk by the end of the maximum six years of participation in Track 1.

Capitalize on Strategic Opportunities

Three Primary Strategic Aims in Track 1 Participation

Establish
Key Physician Relationships

First-mover advantage in securing physician partnerships in market before competitors; allows time for alignment of network with ACO's population health goals

Build
Population Health Infrastructure

Investments in care delivery transformation to transition to value-based care model; incentivize behavior change in new model with potential for shared savings

Analyze
Valuable Data

Transparency into areas of spending opportunity, leakage; potential to use Track 1 performance data to evaluate performance in future contracts

6 Years Maximum time allowed for participation in Track 1 before transition to two-sided risk

63% ACOs with downside risk that started in MSSP Track 1

Source: NAACOS, "NAACOS ACO Comparison Chart", October 2016, available at: https://naacos.com/pdf/RevisedSummaryACO-ComparisonChart021916v2.pdf; Health Care Advisory Board interviews and analysis.

Pacing Transition to Downside No Easy Feat

When organizations evaluate the transition to downside risk, they have more options available than ever before. As of the 2017 application period, providers can select among four different downside risk models in Traditional Medicare: MSSP Track 1+, MSSP Track 2, MSSP Track 3, and NGACO. However, identifying the most favorable option requires a complicated set of comparisons.

Financial and structural features of the models vary significantly, and providers must decide which features to prioritize in program selection. Early movers to downside risk cite miscalculations in this prioritization process as one of the biggest potential pitfalls in early risk-contracting efforts.

Leaders Evaluating Programs Across Multiple Dimensions

Comparing Four Downside Risk Options

	MSSP Track 1+	MSSP Track 2	MSSP Track 3	NGACO
Sharing Rate	Loss rate fixed at 30%; shared savings rate of up to 50%	Up to 60%	Up to 75%	Choice of 80% or 100%
Maximum Gain[1]	10%	15%	20%	15% + applied discount
Maximum Loss[1]	8% of FFS revenue or 4% of benchmark	5%, 7.5%, 10% in years 1, 2, 3 respectively	15%	15% + applied discount
First-Dollar Sharing?	Optional	Optional	Optional	Yes
Payments	FFS, reconciled shared savings/losses	FFS, reconciled shared savings/losses	FFS, reconciled shared savings/losses	Four options including FFS or population-based payments
Attribution	Prospective	Retrospective	Prospective	Prospective
Waivers	3-day SNF	None	3-day SNF	3-day SNF, telehealth, post-discharge home visit

1) Expressed as percentage of benchmark expenditure target.

Source: Centers for Medicare and Medicaid Services, "Accountable Care Organizations: A Final Rule," *The Federal Register,* June 9, 2015; Health Care Advisory Board Company interviews and analysis.

Don’t Be Blinded by the 5% Bonus

A crucial part of the decision-making process is understanding which items organizations should not prioritize in program evaluation.

With the advent of MACRA, for example, many providers have expressed interest in capturing the 5% bonus available through APM track qualification. However, Advisory Board analysis revealed that this incentive alone should not drive program selection.

The APM bonus is applied to providers’ Part B professional fees exclusively, while ACO performance is determined by the total cost of care—Part A and Part B spending—for attributed beneficiaries. Therefore, if an ACO loses money by prematurely taking on downside risk or selecting the wrong program, it is unlikely that the APM bonuses would offset the ACO’s losses.

In sum, while providers should certainly consider the 5% bonus as part of program evaluation, the bonus alone does not warrant a shift from upside to downside risk.

Desire to Qualify for APM Track Should Not Determine Move to Downside

APM Bonus Not Guaranteed to Offset Potential Losses in Two-Sided Models

($4.23M)	+	$2.71M	=	($1.52M)
Losses owed by average 2015 MSSP ACO with spending above attribution-based MLR,[1] assuming same performance in Track 3 in 2017		Value of 2019 APM bonus for average 2015 MSSP ACO with average amount of MACRA-eligible Part B payments		Net amount owed to CMS after accounting for APM bonus
ACO owes in **July 2018**		Physicians receive in **early 2019**		

APM Performance Modeling Assumptions

- The average 2015 MSSP ACO was constructed using publicly available performance results
- Average attribution size (n=18,547) was determined by taking the average size of all 2015 ACOs
- Average per beneficiary benchmark ($10,082 per-beneficiary per-year) was determined by dividing the total benchmark expenditures of all ACOs ($73,297,675,699) by the total attributed beneficiaries of all ACOs (n=7,270,233)
- The total loss used was -5.66% of the benchmark, which is the average percentage of spending above the benchmark for all ACOs that exceeded an assumed MLR based on attribution size
- The shared loss rate was set at 40%, assuming that the ACO was in Track 3 and had the overall average quality score of 91%
- The APM bonus was determined using the Medicare Part B National Average Expenditures as a percentage of overall spending (29%)

1) Minimum loss rate.

Source: CMS, “Medicare Quarterly Data”, 2015; CMS, “Medicare Shared Savings Program Accountable Care Organizations Performance Year 3 Results,” September 2016, available at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/x8va-z7cu; Health Care Advisory Board interviews and analysis.

Prioritize Model Economics in Program Selection

Ultimately, organizations should evaluate differences in ACO models' financial features to drive their downside risk participation decisions. Providers must consider two primary questions.

First, organizations should determine which model offers the most attractive performance target. The size of an ACO's benchmark has outsized influence on its ability to earn shared savings payments. Providers should identify the program that offers the highest benchmark and therefore the most room to drive savings.

Second, organizations must identify which program offers the optimal mix of risk and reward. Providers should look for the option that maximizes reward potential while minimizing downside risk.

Financial Features Have Greatest Impact on Potential Results

Two Key Questions to Evaluate Downside Risk Options

Which model offers us the most **attractive performance target?**

1 Prioritize benchmark analysis to pace transition to downside

Which model offers us the **optimal mix of risk and reward?**

2 Match model selection to risk tolerance

Source: Health Care Advisory Board interviews and analysis.

Maximizing Benchmark Central to Success

As a starting place, organizations need a clear understanding of the methodology used to set performance targets in each of the ACO models to accurately evaluate the downside risk ACO models.

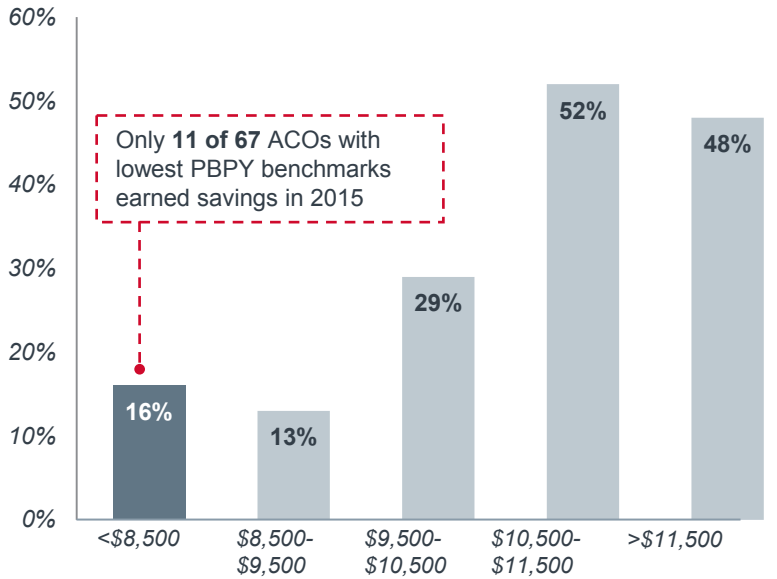
In fact, one of the biggest predictors of success among early ACO participants has been the size of an ACO's performance target. Data from past performance periods have demonstrated that organizations with higher benchmarks have been significantly more likely to earn shared savings payments than those with below-average benchmarks. In 2015, 48% of MSSP ACOs with per-beneficiary per-year (PBPY) benchmarks exceeding $11,500 earned savings, compared to just 16% of those with benchmarks below $8,500.

Since the benchmarking methodologies vary across the Medicare ACO models, organizations need to find the option that offers the most favorable benchmark.

Low-Cost Providers at a Disadvantage

Size of Benchmark Significantly Impacts Likelihood of Earning Savings

MSSP ACOs that Earned Savings in 2015, by PBPY[1] Benchmark



Average Spending Among "Savers" is Higher

$10,140

Average PBPY spend for ACOs that came in under benchmark

$9,909

Average PBPY spend for ACOs that came in over benchmark

1) Per-beneficiary, per-year.

Source: Jha. A. "ACO Winners and Losers: a quick take." September 2016, available at: https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/; Muhlstein, D., Saunders, R., McClellan, M. "Medicare Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues", *Health Affairs*, September 2016, available at: http://healthaffairs.org/; Health Care Advisory Board interviews and analysis.

Benchmark Calculation a Key Distinction

CMS uses different benchmark methodologies for three distinct groups: first-time MSSP participants, MSSP participants in subsequent performance terms, and NGACO participants. All three utilize the same basic formula, but differences in individual inputs produce final benchmarks that can vary widely.

Across all programs, CMS first establishes a baseline using the ACO's past expenditures. While MSSP ACOs are subject to a three-year historical average, NGACOs are compared to spending in 2014 exclusively.

Next, CMS trends this baseline forward using a growth rate. The trend factor applied in MSSP favors those in high-growth regions, while the methodology used in NGACO favors those in high-cost regions—for example, regions with a high wage index.

Finally, CMS risk-adjusts the trended baseline. While only newly attributed beneficiaries can adjust an MSSP ACO's target upward, NGACOs can see their benchmark increase by up to 3% annually due to changes in risk scoring across their entire population.

Providers must evaluate differences between all of these factors to determine which program is likely to result in the highest target.

Comparison of Benchmark Calculation by Program

Target Spend = (Expenditures) x (Growth Rate) x (Δ Risk Score)

MSSP First Contract Term	Past three years' expenditures	National projected FFS growth rate	Risk score for continuously assigned beneficiaries can only decrease benchmark; scores for new beneficiaries can increase or decrease benchmark
MSSP Subsequent Contract Terms[1]	Past three years' expenditures	Regional projected FFS growth rate	Risk score for continuously assigned beneficiaries can only decrease benchmark; scores for new beneficiaries can increase or decrease benchmark
NGACO	2014 expenditures	National growth rate with regional price adjustments based on area wage index and geographic practice cost index	Up to 3% increase or decrease in benchmark based on risk score change from 2014

For more details on benchmark methodology, please see appendix.

1) Takes effect for second and subsequent agreement periods beginning in or after 2017; ACOs already in second term will have to wait until 2019 for rule to take effect.

Source: CMS, "Next Generation ACO Model: Review of Alignment/Benchmarking Methodology," April 5, 2016, available at: https://innovation.cms.gov/resources/nextgenaco-2017financial.html; CMS, "Final Medicare Shared Savings Program Rule (CMS-1644-F)," June 6, 2016, available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-06.html; Health Care Advisory Board interviews and analysis.

Recognizing the Right Opportunity

Current Medicare ACOs have learned just how impactful differences in the benchmarking methodologies can be in finding the right downside ACO model.

Henry Ford Health System, based in Detroit, Michigan, applied for MSSP in 2015 but withdrew its application before the start of the performance year due to a low projected benchmark.

When the NGACO model became available for 2016, the system once again evaluated participation. The system's financial analysis revealed that the NGACO model's benchmarking methodology would produce a PBPY benchmark more than $1,000 higher than MSSP's methodology. As a result of the more favorable benchmark, Henry Ford decided to move forward with NGACO participation.

Benefits of NGACO Model Enticing Henry Ford to Participate for First Time

MSSP Methodology Not Favorable

Intended to participate in MSSP in 2015 but withdrew before performance year

Internal financial analysis projected little opportunity for success because of **low potential benchmark**

NGACO a More Attractive Alternative

Benchmark evolution with regional and national efficiency adjustments produced **more favorable target**

Ability to update benchmark across performance year through risk score improvement offered even more opportunity

$1,212 PBPY

Differential between estimated MSSP benchmark and actual NGACO benchmark

Case in Brief: Henry Ford Health System

- Five-hospital integrated health system based in Detroit, Michigan
- Withdrew MSSP application due to unfavorable benchmark projection
- Joined NGACO in 2016 because of potential for more favorable benchmark due to updated efficiency and risk adjustments

Source: Health Care Advisory Board interviews and analysis

Due Diligence Still Required

While Henry Ford found NGACO to be the more favorable program, the results of this type of analysis will vary across organizations.

As a top performer in the Pioneer ACO Model, leaders at Banner Health originally assumed that NGACO would be the natural next step in their Medicare risk strategy. However, when Banner brought in their financial team to confirm that assumption, the resulting analysis revealed that the benchmarking methodology of MSSP was significantly more favorable for Banner. In fact, the ACO would have had to attain an unrealistic level of performance to have any chance of earning savings in NGACO.

As a result of these findings, Banner applied to participate in MSSP and joined Track 3 in January 2017.

Experience, Past Success Should Not Dictate Program Selection

The Evolution of Banner's Strategy

As top performer in Pioneer ACO, originally assumed NGACO would be natural next step

Used Pioneer data to run actuarial analysis comparing performance likelihood in NGACO versus MSSP Track 3

Analysis revealed that despite past experience and success, chances of achieving savings in MSSP were greater than in NGACO

Applied for MSSP Track 3, began agreement period in 2017

> "The overall savings that we would have had to achieve in Next Gen would have been **greater than our best year in Pioneer**."
>
> *Lisa Stevens Anderson, VP and CEO*
> *Banner Health Network*

Case in Brief: Banner Health

- 23-hospital health system based in Phoenix, Arizona
- Pioneer ACO participant since 2012
- Financial modeling revealed that NGACO would not be as beneficial as originally thought; joined MSSP Track 3 in 2017

Source: Health Care Advisory Board interviews and analysis.

NGACO a Riskier Proposition

After evaluating potential benchmarks, organizations must also understand how CMS calculates savings and losses against those targets.

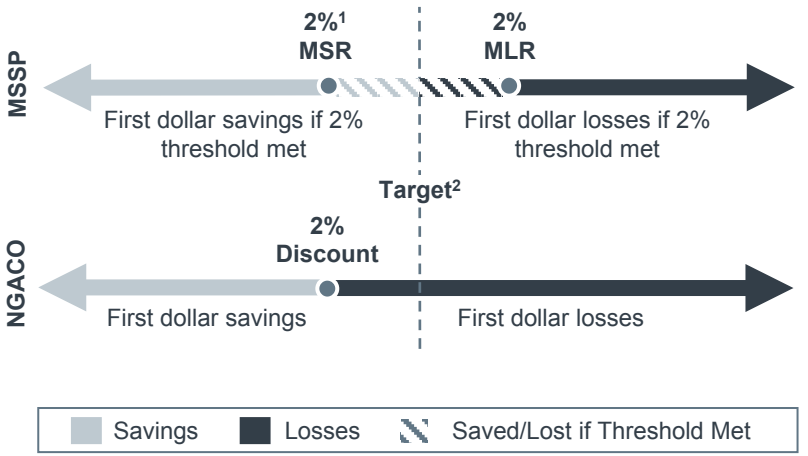
MSSP uses a Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR) to protect against random variation. An organization only earns savings or owes losses if its spending is below the MSR or above the MLR. If that occurs, bonuses and penalties then begin at the original target amount, know as "first dollar" savings or losses.

In contrast, NGACO uses a discount methodology. First dollar savings or losses are calculated from the performance target minus the discount amount. The size of the discount varies based on an organization's quality and efficiency, with most ACOs falling between one and three percent. The structure of this discount methodology means that providers face a higher performance threshold; it is possible to reduce spending relative to the target and still face a penalty.

Ultimately, a substantially higher benchmark in NGACO could mitigate the drawbacks of the discount methodology. However, if neither target is significantly more favorable, having the protection of the MLR makes MSSP the safer option.

Discount Methodology Removes MSSP's Safety Net

Illustrative Comparison of MSSP MSR/MLR to NGACO Discount



Influence of Factors on Size of NGACO Discount	
Quality	↓
Efficiency Compared to Region	↓ ↑
Efficiency Compared to Nation	↓ ↑

Decision Guidance

1. A substantially higher target in NGACO could justify selection despite disadvantages of discount methodology
2. If baseline targets are relatively similar, MSSP stands to be lower risk than NGACO within typical performance range

1) Assumes selection of 2% symmetrical MSR/MLR.
2) Assumes baseline target same for MSSP and NGACO before discount taken in NGACO.

Source: Source: CMS, "Next Generation ACO Model: Review of Alignment/Benchmarking Methodology," April 5, 2016, available at: https://innovation.cms.gov/resources/nextgenaco-2017financial.html; Health Care Advisory Board interviews and analysis.

Track 3 Almost Always a Safer Bet Than Track 2

Organizations that elect for MSSP over NGACO must also decide between MSSP's three downside risk models: Track 1+, Track 2, and Track 3. However, most organizations will ultimately find that this decision will end up a choice between Track 1+ and Track 3. Track 2 is rarely the right choice for any organization.

This unexpected outcome is the result of differences in how risk and reward are calculated in each track. In theory, Tracks 1+, 2, and 3 offer progressively higher levels of potential reward in exchange for a willingness to bear increasing levels of risk. However, the exact level of risk exposure depends on an organization's quality score. Due to differences in the relative impact of the quality score across the three models, any ACO that expects to exceed a quality score of 55% will actually face a lower loss rate in Track 3 than in Track 2. With almost all ACOs historically exceeding that threshold, organizations willing to bear the level of risk required in Track 2 would be better off opting for Track 3, which ultimately offers both lower risk and higher reward.

Higher Reward Doesn't Always Mean Higher Risk

Track 3 Offers Higher Reward..

Higher Sharing Rate

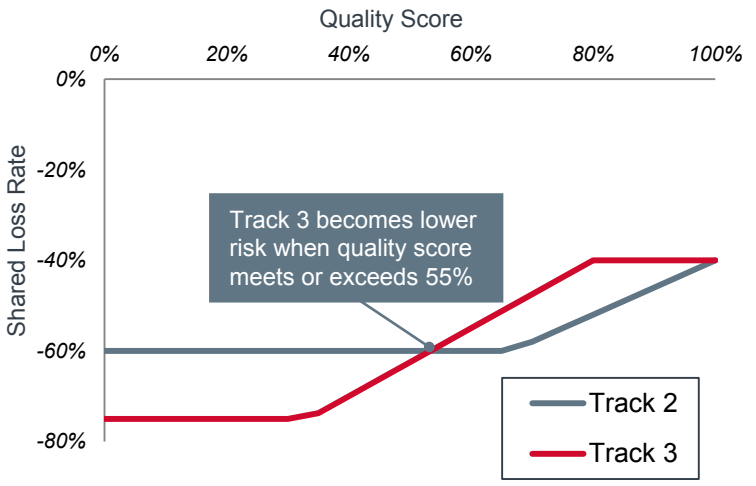
Track 3 has a maximum sharing rate of 75%; Track 2 has maximum sharing rate of 60%

Higher Maximum Savings Cap

Track 3 ACOs can earn up to 20% of benchmark compared to 15% in Track 2

…But Also Lower Risk for Most

Loss Rate by Quality Score, Track 2 versus Track 3



98% Of MSSP ACOs receiving a quality score above 55% in PY2015[1]

1) Excludes first-years participants that are pay-for-reporting.

Source: CMS, "Medicare Shared Savings Program Accountable Care Organizations Performance Year 3 Results," September 2015, available at: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt; Health Care Advisory Board interviews and analysis.

Track 3, Track 1+ Comparison Less Clear-Cut

As a result, balancing risk and reward in downside MSSP models comes down to a decision between Track 1+ and Track 3 for most organizations. The right choice for any organization will depend on two factors: the organization's risk tolerance and the organization's confidence in its ability to perform well.

On one hand, Track 1+ is the lower risk option. It allows providers to bear the minimum level of risk needed to qualify for MACRA's APM track. On the other hand, if an ACO stands to perform well, it would earn a significantly lower bonus in Track 1+ compared to its earning potential in Track 3. As a result, organizations opting for Track 1+ would be trading lower reward for lower risk.

Track 1+ will be particularly attractive to small ACOs and independent physician groups. In contrast, larger systems are better positioned to accept the additional risk of Track 3 to gain the higher upside potential.

Decision Dependent on Risk Tolerance

Track 3 Riskier, but More Rewarding if Successful

	Track 1+	Track 3
Potential Losses Owed Assuming Average Negative Performance	-$2.2M	-$4.2M
Potential Bonus Earned Assuming Average Positive Performance	$5.9M	$8.9M

Key Takeaways

- If performance is uncertain, MSSPTrack 1+ is a safer bet than Track 3
- ACOs that earn savings leave significant bonus potential on the table if opting for Track 1+ over Track 3

Important Considerations

1. Track 1+ is offered in supplement through CMMI; requires concurrent participation in Track 1
2. Participants currently in Track 1 have the option to finish out current agreement period in Track 1+
3. ACOs that already participated in downside Tracks 2 or 3 cannot participate in Track 1+

Source: Health Care Advisory Board interviews and analysis.

Key Takeaways

1	**MSSP Track 1 is best bet for newcomers, but only as an on-ramp to downside risk**	Track 1 is a good place to start for first movers because of the risk-free opportunity to build a provider network, invest in infrastructure, and analyze data; necessary to commit to improvement in order to offset any dilution in MIPS score and to prepare for eventual transition to downside risk.
2	**The most important factor to consider when transitioning to downside risk is how performance targets are set**	Variation in benchmark methodology is likely to result in significantly different targets for each model; ultimately, a higher benchmark increases chances of success.
3	**The right level of risk depends on expected performance, with NGACO requiring significant confidence**	Higher sharing rate in NGACO makes it higher reward for ACOs that expect to perform well against target, while MSSP is safer option if performance is uncertain; MSSP Track 1+ a good option for those with low risk tolerance, Track 3 a better bet than Track 2 for those ready for more risk.

Source: Health Care Advisory Board interviews and analysis.

2

Expand into Medicare Advantage Market

Fine-Tuning Contract Terms

4. Set parameters for must-have contract elements
5. Establish clear glide path to increased risk over time

Expanding Scope of Control

6. Clarify desired scope of delegated responsibilities
7. Secure first-mover advantage in provider-sponsored MA

Unpacking a Favorable Financial Opportunity

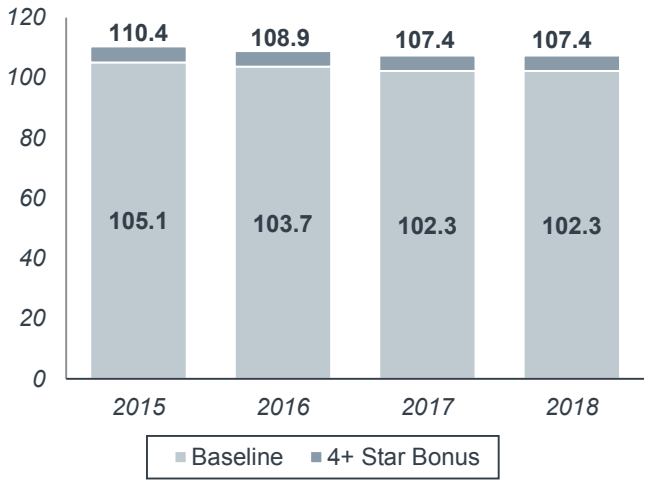
Although focusing on risk opportunities for Traditional Medicare risk will almost certainly be the top near-term priority for most organizations due to the higher volume of beneficiaries and immediate connection to MACRA, a comprehensive Medicare risk strategy should also include Medicare Advantage.

The Medicare Advantage market offers some clear financial opportunities. Despite reimbursement cuts in recent years, overall payment rates to MA plans remain high. This is especially true for plans that qualify for a reimbursement bonus by earning a rating of four stars or higher.

Additionally, two important program features create tangible opportunities for plans and providers to collaborate: star ratings and risk adjustment. Success in both arenas ultimately depends on provider engagement.
As a result, MA plans and providers can structure risk-based contracts to motivate and share mutual gain.

Despite Cuts, MA Reimbursement Expected to Remain High for Foreseeable Future

MA Reimbursement Relative to Expected FFS Costs



Two Opportunities for Plans and Providers to Partner to Increase Total Reimbursement Opportunity

★★★

Star Ratings

Providers can inflect key satisfaction, clinical quality metrics to improve star ratings; plans with 4+ star ratings receive reimbursement bonus

Risk Adjustment

Improved HCC[1] scoring as a result of more accurate coding, documentation, results in higher PMPM[2] payment from Medicare

1) Hierarchical Condition Category.
2) Per-member, per-month.

Source: Ladsariya et al., "Medicare Advantage: Dispelling market misconceptions," *McKinsey & Company,* January 2014; Health Care Advisory Board interviews and analysis.

More Systems Jumping Straight to Plan Ownership

As a result of Medicare Advantage's enrollment projections and favorable economics, more provider organizations are deciding to launch their own MA plans. In fact, 58% of newly-offered MA plans in 2016 were provider-sponsored plans.

However, successfully running a provider-sponsored MA plan is no guarantee. Several high-profile plans have faced significant setbacks In recent years as they attempted to launch their MA strategies.

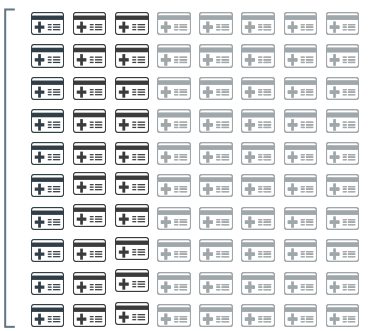
As providers explore risk-based contracting opportunities in the MA market, they must remember that plan ownership is only one option—there are many paths to MA risk.

But Health Plan Ownership Entails Distinct Challenges

Provider-Sponsored Medicare Advantage Organizations, 2016

Newly Offering MA in 2016:
11 of 19 MAOs[1] (58%)

Continuing to Offer MA in 2016:
59 of 159 MAOs (37%)



Far from a Slam-Dunk Investment

Modern Healthcare
"Health Systems With Insurance Operations Stumble in 2015"

CATHOLIC HEALTH INITIATIVES℠
"Catholic Health Initiatives to Divest Health Plan Operations"

Neighborhood Health Plan
"Neighborhood Health Plan Batters Partners HealthCare's Finances in 2014"

CrestPointHealth Your MEDICARE ADVANTAGE
"Mountain States Terminating CrestPoint Health Insurance Plans for Employees, Medicare Advantage"

1) Medicare Advantage Organization.

Source: Avalere, "Medicare Advantage: 2016 National Snapshot," May, 2016; Health Care Advisory Board interviews and analysis.

Multiple Avenues to Medicare Advantage Risk

The full spectrum of options for taking on Medicare Advantage risk includes two major categories.

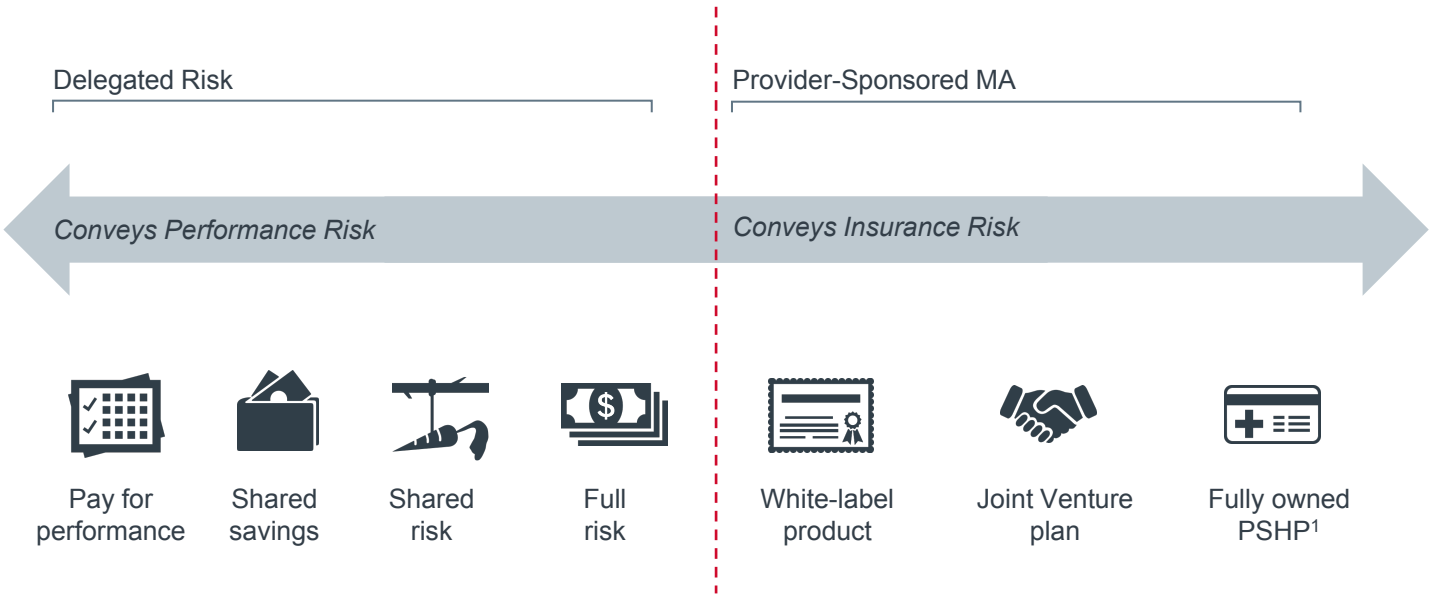
First, in delegated risk arrangements, providers establish a risk-based contract with an existing Medicare Advantage plan. Delegated risk options range from upside-only pay-for-performance models to full financial risk under capitated models. Each of these arrangements shifts performance risk onto the provider partner without requiring the adoption of true insurance risk.

Second, under provider-sponsored MA arrangements, provider organizations launch a new MA product, either independently or in partnership with a health plan. In addition to full plan ownership, these arrangements include white-label and joint venture offerings.

Provider organizations must determine which of these paths to Medicare Advantage risk will offer the greatest opportunity for success.

Plan Ownership Far from the Only Approach

Full Spectrum of Medicare Advantage Risk Models



1) Provider-sponsored health plan.

Source: Health Care Advisory Board interviews and analysis.

Designing a Medicare Advantage Risk Strategy

To determine their ideal positioning on the spectrum of Medicare Advantage risk options, providers should carefully assess three key questions.

First, providers must determine the parameters of an ideal Medicare Advantage risk contract for their organization. What financial terms, for example, are most likely to lead to success?

Second, providers must determine which traditionally plan-owned functions they are prepared to own. How much operational responsibility should they assume?

Third, providers must consider if they ever intend to pursue ownership of a product or plan, and if so, which ownership model is right for them. Ultimately, do they desire an ownership stake in the MA plan?

Three Questions for Establishing an Intentional MA Risk Strategy

Contract Terms

What should we prioritize in contract negotiations to support success?

4. Set parameters for must-have contract elements
5. Establish clear glide path to increased risk over time

Operational Responsibilities

Which plan functions are we realistically prepared to own?

6. Clarify desired scope of delegated responsibilities

Ownership Structure

At what point should we consider getting into the plan business, and what is the right model for doing so?

7. Secure first-mover advantage in provider-sponsored MA

Source: Health Care Advisory Board interviews and analysis.

Identifying Must-Have Contract Terms

In order to determine the elements of an ideal Medicare Advantage contract, providers should first outline the complete list of terms that are most likely to support success.

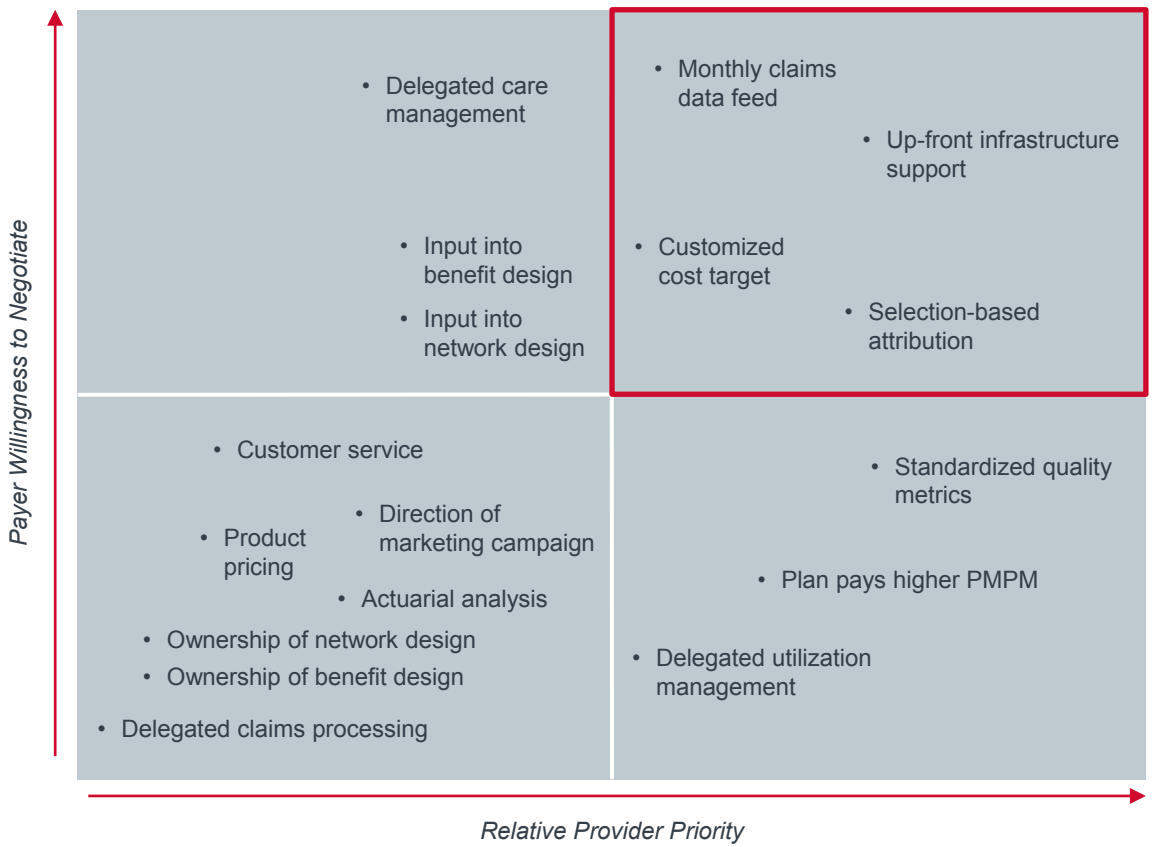
While engaging in this planning exercise is crucial to effective negotiations, providers are unlikely to secure the ideal contract. As a result, leaders must prioritize terms, trimming their wish list into a smaller set of must-have terms that would make or break contract negotiations.

This consolidation effort involves two key steps. First, organizations must determine how important each desired element is to their ultimate success. Second, providers must anticipate how likely a payer is to agree to each item. Any contract term that scores high on both criteria should be held as a top priority throughout the contracting process.

While exact contracting priorities may vary by organizations, four key elements stand out as must-haves for most providers.

Prioritize Core Drivers of Contract Economics and Performance

Balance Importance with Payer Willingness to Negotiate



Source: Health Care Advisory Board interviews and analysis.

Prioritize Active PCP Selection

The first contract element to prioritize is the patient attribution model.

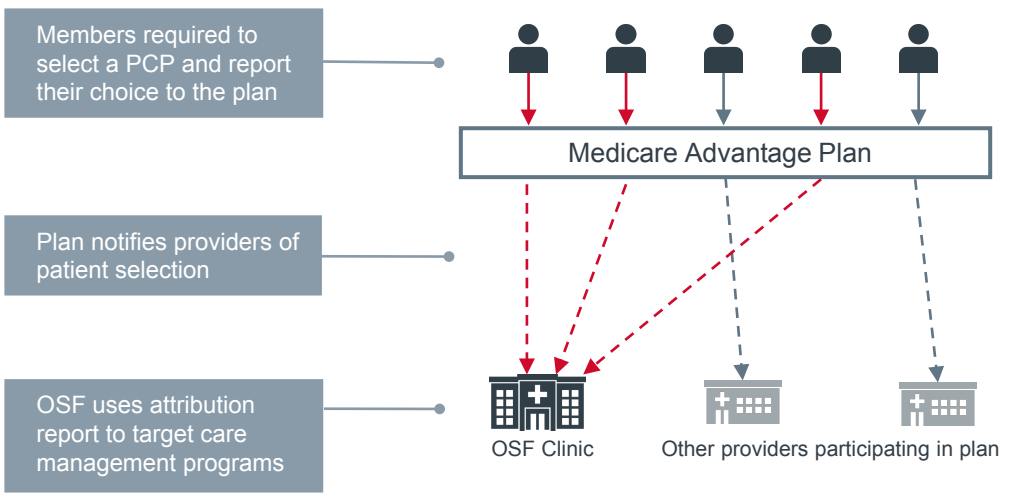
Medicare ACO models typically operate on utilization-based attribution models, under which patients are assigned to an ACO based on where they receive the majority of their care across a year. Whether prospective or retrospective, utilization-based attribution models create patient churn, complicating care management efforts.

In contrast, selection-based attribution models, common in HMO and narrow network products, require patients to select a primary care physician upfront. As a result, patients are more active participants in the attribution process.

OSF HealthCare, based in Peoria, IL, works with its MA plan partner to use this selection process as the basis for attribution. Any patient who selects an OSF-affiliated PCP becomes attributed to OSF. Whenever possible, providers should prioritize selection-based attribution models over utilization-based methods.

Selection-Based Attribution Ensures Clarity, Beneficiary Engagement

Plan Requires Members to Select, Report a PCP



Case in Brief: OSF HealthCare

- 11-hospital integrated health system based in Peoria, Illinois
- Completed performance period in Pioneer ACO Model; currently participating in Next Generation ACO program
- At full risk for Medicare Advantage product with national payer
- Plan-required PCP selection enables proactive care management

Source: Health Care Advisory Board interviews and analysis.

Contracting Around the Premium Dollar

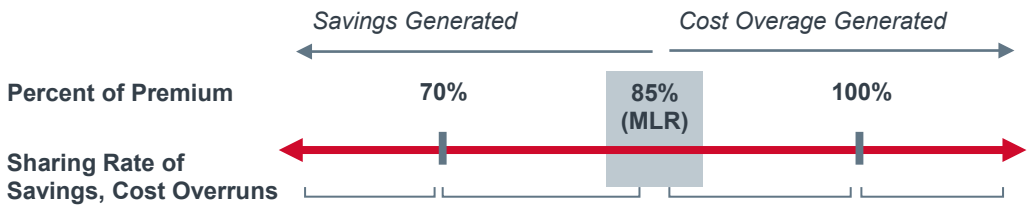
Second on the list of must-have contract terms is the performance target against which the providers are held accountable. Medicare Advantage risk contracts most frequently use a percent of premium target, often based around the Medical Loss Ratio (MLR).

Lawson Health System, a pseudonymed organization, worked with a local Medicare Advantage plan to develop a risk-based contract with spending targets set at the MLR, in this case 85% of the premium. If the system's actual expenditures in a performance year are below that target, it shares in a percentage of the savings. Under their tiered model, significantly lower expenditures result in the system earning a higher share of the savings. As their contract involves two-sided risk, Lawson would repay a percentage of any overage back to their plan partner if expenditures exceed the MLR target.

In addition to aligning incentives between the plan and providers, this methodology capitalizes on the actuarial expertise of the plan partner, a major advantage to providers starting to enter into risk contracts.

Percent of Premium Methodology Aligns Plan and Provider Economics

Sliding Scale of Opportunity, Risk



Health Plan	25%	50%	65%	75%
Lawson Health System	75%	50%	35%	25%

Case in Brief: Lawson Health System[1]

- Medium-sized health system based in the South
- Negotiating risk-based contract with local Medicare Advantage plan
- Expenditure target determined by medical loss ratio (MLR), which is set at 85% of the premium collected by the health plan
- Bonus, overage sharing rate depends on performance against MLR

What is the MLR?

- Created by the ACA, requires health plans to spend at least 80-85%[2] of premiums collected from beneficiaries on medical care
- Common expenditure target in MA contracts
- No need for provider to risk-adjust, as health plan takes risk into account when setting premium

1) Pseudonym.
2) 80% for individual, small group markets; 85% for large group markets.

Source: "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," The Center for Consumer Information & Insurance Oversight: Centers for Medicare and Medicaid Services, December 2, 2011, available at: http://www.cms.gov; Health Care Advisory Board interviews and analysis.

Ensure Cost Target Is Suited to Experience Level

While percent of premium contracts are most common in MA risk contracts today, they are not the only option. Different models for setting the spending target will benefit different providers based on their experience managing population health and market position. Whenever possible, providers should prioritize models that offer the greatest reward based on their relative efficiency and experience.

First, organizations in the early stages of population health in the Medicare Advantage market are likely to benefit from a cost target based on historical expenditures. This approach determines spending targets based on providers' past performance, giving opportunity to improve over time.

However, providers with significant experience should generally pursue contracts with cost targets based on a percent of premium. This model capitalizes on the actuarial expertise of health plans to set and monitor cost targets, while rewarding efficiency beyond initial gains.

Finally, especially high performing population health managers may benefit most by comparison to less-efficient peers. This would remove the pressure to continually out-perform previous years' targets.

Reassess Common Methodologies as Cost Efficiency Increases

Historically High-Cost Organizations → *Low-Cost Organizations*

1 Comparison against historical baseline

Plan calculates provider's historical spend for attributed population, applies trend to factor

Pro: Providers new to population management earn rewards for early improvements

Con: Diminishing returns as spending is brought under control

2 Comparison against percent of premium

Plan defines a percentage of premium dollars collected from attributed population as cost target

Pro: Capitalizes on actuarial expertise of health plan; shifts target away from historical performance

Con: Success is dependent on the plan's actuarial accuracy and pricing decisions

3 Comparison against local, network benchmark

Plan determines benchmark, cost growth target for provider's market or rest of health plan network

Pro: Highly efficient organizations rewarded for out-performing the market

Con: Difficult to define, agree on fair comparison group

Source: Health Care Advisory Board interviews and analysis.

Share Cost of Mutually Beneficial Investments

The third element to prioritize in contract negotiations also deals with the financial mechanisms of the contract. Whenever possible, providers should secure upfront support for investments in population health infrastructure.

This support most commonly comes in the form of a care coordination fee paid to the provider on a per-member, per-month (PMPM) basis. For example, Summa Health, based in Akron, OH, receives care coordination fees from each of its MA plan partners in order to fund care management initiatives.

Providers may also negotiate for direct resource support to help close a gap in their skill set. For example, pseudoynmed Alderson Health secured direct support from their MA plan partner to help educate and audit Alderson's providers on HCC coding.

Providers in longer-term relationships with their plan partners may simply be able to negotiate higher rates for specific projects. For example, New West Physicians, based in Denver, CO, successfully negotiated a higher PMPM payment to support expansion of its hospitalist program.

Care Coordination Fees Only One Category of Support

Cases in Brief:	Negotiated Support:
Summa Health • Five-hospital system based in Akron, Ohio • Fully-owned health plan includes MA product; ACO also engaged in shared savings arrangements with national MA plans	*Care Coordination Fees* Each of Summa's value-based MA contracts include care coordination fees that may be spent as ACO sees fit; payments are guaranteed in return for ongoing data transparency and care management initiatives, the plans' top priorities
Alderson Health[1] • Health system in the Northeast • Currently negotiating transition from upside-only to downside on MA product with local provider-sponsored health plan	*Embedded Resource Support* Alderson negotiated to have an HCC coding expert on-site to ensure that their providers rapidly achieve competency in that area; funding for the FTE is partly provided by the payer partner
New West Physicians • 100-provider primary care medical group based in Denver, Colorado • Ceased accepting traditional Medicare in 1999; currently at risk with a national payer for MA and a local payer on a Medicare Cost Plan	*Increased PMPM* New West negotiates a temporary raise in PMPM from their payer partner to fund specific projects such as the expansion of their hospitalist program into a broader service area

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Secure Timely Access to Claims Data

Finally, the fourth must-have element for newly negotiated Medicare Advantage risk contracts is timely access to appropriate data. At an absolute minimum, providers should secure monthly access to raw claims data.

However, best-in-class plan partners are willing to share more than the baseline. Boston-based Atrius Health reports that its MA payer partner also provides real-time authorization alerts and post-acute quality data. The additional data helps Atrius's providers improve their utilization management efforts and ensure referrals to high-quality post-acute providers.

Taken together, these four must-have contract elements will help ensure that a provider organization maximizes its likelihood of success in initial risk-based Medicare Advantage contracts. However, they only represent the first phase of successful MA contracting.

Monthly Data Feeds Crucial for Proactive Care Management

Claims Data Feed Meets Minimum Contract Requirement

- Contract stipulates monthly feeds of raw claims data from payer partner
- Provider partner integrates raw claims data into Atrius analytic system
- Internal analytics division generates timely, actionable insights on utilization

Engaged Payer Partners Provide More Depth in Their Data

- Network-wide data gives insight into Atrius performance against peers
- Real-time authorization alerts enable proactive care coordination
- Quality data helps Atrius select best-in-market partners, e.g., SNFs

Case in Brief: Atrius Health

- 750 independent physician practice based in Boston, Massachusetts
- Currently in fifth and final year of participation in Pioneer ACO program; engaged in risk-based MA contract with one local payer
- Payer partner submits monthly transmission of raw claims data reports, plus additional network-wide cost, utilization, and quality data

Source: Health Care Advisory Board interviews and analysis.

Hardwire Contract Evolution at Outset

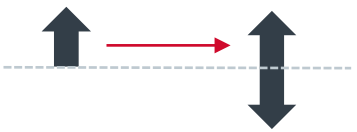
Negotiating a contract that favorably addresses all four high-priority contract terms creates a solid foundation for success. In general, these four elements remain static over the course of the contract.

A complete risk-based contract should also codify how the financial terms of the arrangement will evolve over time.

Providers should assess two key elements of contract evolution at the outset: the transition from upside-only to downside risk and how the level of risk-sharing between the plan and providers changes over time.

Ramp-Up of Risk Possible in Two Areas

Set Explicit Triggers to Transition Contract to Downside Risk



- First phase of contract is upside-only
- Contract includes specific criteria that must be met to change risk arrangement
- Transition to downside when criteria are met

Increase Provider Share of Risk Over Time

- Plan bears the majority of risk in early phases of contract relationship
- Share/loss rate changes to increase provider risk/reward as contract matures
- Provider may attain full risk over time

Source: Health Care Advisory Board interviews and analysis.

Establish Clear Triggers for Transitioning to Downside

To address the first element of contract evolution—the transition to downside risk—Summa Health establishes a set of triggers that, when met, prompt contracts to shift from upside-only to downside risk. Each risk-based contract the system signs is structured around a pre-negotiated set of triggers.

For example, one of the system's MA contracts includes a minimum population size threshold, a performance threshold, and a quality threshold. Summa must successfully meet each threshold for the contract to graduate to downside risk.

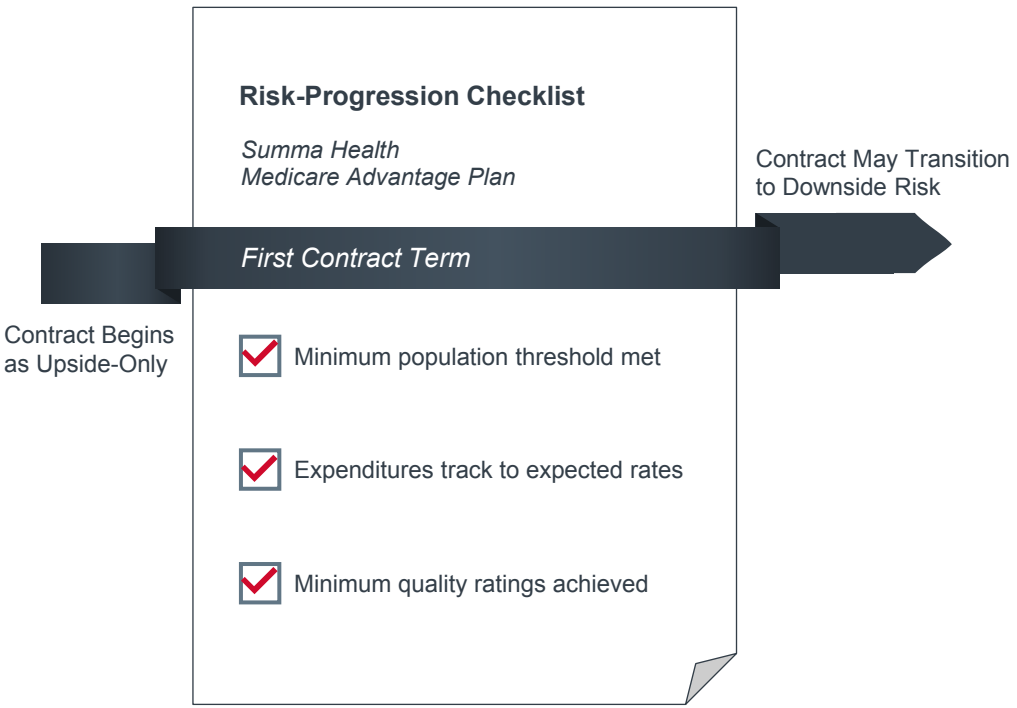
Establishing these triggers through mutual agreement allows both the providers and the plan to feel confident in moving towards greater risk over time. By starting with upside-only risk, both the providers and plan can validate the strength of the contract and partnership before transitioning to downside risk.

Ensure Safeguards in Transition To Risk

Case in Brief: Summa Health

- Five-hospital system based in Akron, Ohio
- Fully-owned health plan includes MA product
- ACO engaged in value-based arrangements with national MA payers
- MA contracts are all upside-only; include specific "triggers" that if met would allow re-negotiation to move to downside risk

Establish Concrete Indicators of Product Viability



Source: Health Care Advisory Board interviews and analysis.

Increase Share of Risk Over Time

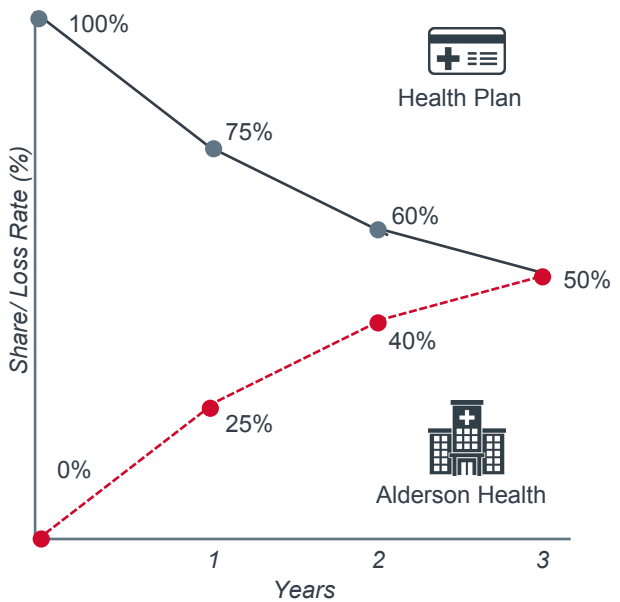
The second element of contract evolution to determine upfront is the level of risk assumed by the provider. In both upside-only and downside risk contracts, plans and providers typically negotiate a share rate. As providers gain population health experience, they should bear a greater share of the risk over time.

For example, Alderson Health, a pseudonymed organization, is currently negotiating with its Medicare Advantage plan partner to move an upside-only contract to downside risk. As part of these negotiations, Alderson is establishing a share rate that will increase annually, eventually reaching a 50/50 distribution by the third year of the contract.

By defining the progression of the share/loss rate at the outset, Alderson will ensure that it is able to take on more risk over time, and that the organization will have clear incentive to continue advancing its population health strategy.

Gradual Transition Maps Risk to Readiness

Plan and Provider Reach Loss Rate Parity After Three Years of Downside Model



Case in Brief: Alderson Health[1]

- Health system in the Northeast
- Currently in second participation period as a Track 1 MSSP ACO
- Participating in multiple value-based contracts; two contracts have downside risk
- Currently in negotiations with a local PSHP partner to transition from upside-only to downside on MA contract; contract includes increased share/loss rate over time

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Expanding Beyond Contract Economics

As providers bear more financial risk over time, they may also wish to take a more direct role in operational functions that plans have historically controlled. For example, providers managing risk may wish take ownership of care management or utilization management responsibilities, or to play a more direct role in network and benefit design. Establishing clarity around roles and responsibilities through contract negotiation both ensures that providers have the tools they need to perform well under risk and prevents the plan and provider partners from deploying duplicative or conflicting efforts.

Providers may take control of some plan functions through delegated risk arrangements, while others will likely require a more direct ownership stake in a plan.

Providers Increasingly Eyeing Traditional Health Plan Responsibilities

Traditionally Plan-Centered Functions

Plan Desire to Retain →

Achievable Through Delegation

Care Management

- Medication management
- Patient education
- Case management
- Disease management

Utilization Management

- Referral management
- Prior authorization
- Formulary design
- Data analytics

Likely Requires Financial Stake

Network Design

- Network composition
- Provider relations
- Clinician education

Product Development

- Benefit design
- Product pricing

Unlikely To Ever Be Delegated

Member Services

- Customer service
- Enrollment
- Billing
- Denials

Financial Management

- Actuarial analysis
- Claims processing

Source: Health Care Advisory Board interviews and analysis.

Plans Most Willing to Delegate Clinical Functions

When Atlanta-based Emory Healthcare first approached local Medicare Advantage plans to begin risk contracting, the system had a long list of responsibilities it hoped to take ownership of through delegation. However, Emory's contracting team quickly learned that plans were hesitant to cede so much control in initial arrangements. As a result, Emory worked with its population health partner, CareMore, to identify a shorter list of true must-haves. In the end, Emory determined that delegation of care management and disease management were the bare minimum for initial arrangements.

Similar to Emory, many providers have learned first-hand that plans are most willing to delegate clinical functions like care management, disease management, and case management upfront, as these functions build on providers' expertise. In some cases, these functions are even more effective when delegated to providers, as beneficiaries often respond more favorably to guidance from their provider team than from their insurance company.

Negotiation Process Involves Give and Take

1 Emory Proposes Ambitious List of Delegated Functions

List of functions requested:

- Case management
- Disease management
- Utilization management
- Pharmacy management
- Risk adjustment
- Claims management

2 Plans Hesitate to Grant Full Delegation

- Historically have performed all proposed functions for other providers, still do so in majority of contracts
- Unable to cede the premium dollar required for delegation of all proposed functions

3 Emory Refines List Around Must-Haves

- Plan must delegate case management and disease management
- Utilization management partially delegated
- Payers retain claims management delegation to be revisited over the next 3-5 years

Case in Brief: Emory Healthcare

- Academic Medical Center based in Atlanta, Georgia; includes 6 hospitals, the Emory Clinic, and Clinically Integrated Network of over 2,000 physicians
- Partnering with CareMore to customize and integrate population health model into the Emory Healthcare system through contracts with several existing MA plans
- Requests for extensive list of delegated functions unsuccessful; determined case management and disease management were true must-haves for initial years

Source: Health Care Advisory Board interviews and analysis.

Utilization Management Also on the Table

In addition to attaining control of clinical functions, providers with a longer history of risk-based contracting and population health management may be able to leverage their experience to take ownership of utilization management functions.

For example, Massachusetts-based Reliant Medical Group has been able to capitalize on their strong reputation and mature infrastructure to gain delegated responsibilities for utilization management from their MA plan partner.

The plan's willingness to delegate this function depended on Reliant's ability to demonstrate a high-quality referral network. The group has a comprehensive network that includes more than 30 specialties and an affiliated tertiary care hospital.

Reliant had also built the infrastructure necessary to effectively manage referrals. For example, the group has a referral hotline that manages authorizations and fields referral-related questions from patients.

Leverage Increasing Experience to Increase Delegated Responsibility

Reliant Has Tools and Expertise to Own Utilization Management

Call center referral hotline
Dedicated call line handles referral authorizations, patient questions

Comprehensive network
Physician membership covers more than 30 specialties, plus an affiliate tertiary hospital

Group-wide data compatibility
Referrals directed to high-quality member specialists who share common EMR

Customer support
Plan help line responds to beneficiary complaints, fully supports Reliant referrals

● Provided by Reliant ● Provided by Payer

Case in Brief: Reliant Medical Group

- 500-provider group practice headquartered in Worcester, Masachusetts
- Transitioned from Pioneer ACO program to MSSP Track 3 in 2016
- Holds exclusive Medicare Advantage contract with a large local payer
- Payer willing to delegate utilization management to Reliant due to their well-developed infrastructure and best-in-class referral system

Source: Health Care Advisory Board interviews and analysis.

In Search of Greater Control

While many providers will find that delegation of care management and utilization management functions can go a long way toward effectively managing risk, some providers seek additional tools to maximize success. Two traditional plan functions that are rarely delegated to providers—yet present significant opportunities to manage risk and grow the number of covered lives—are network design and benefit design.

Well-constructed networks and attractive benefits packages are key drivers of member retention and satisfaction as well as potential tools to steer patients toward high-value services. Provider-sponsored health plans are able to take advantage of these opportunities to shift utilization patterns. Beyond access to the full premium dollar, providers eyeing plan ownership are often seeking these strategic advantages.

Ownership Enables Influence Over Patient Habit, Spend

Owning Product Design Addresses Major Population Health Challenges

Network Design Mitigates Leakage
Patient choices determined by insurance plan, steering them to participating providers

Benefit Design Discourages Low-Value Utilization
Patients nudged toward high-value services within defined network

Provider-Sponsored Plans Capitalizing on Product Design Flexibility

PSHPs Offer High-Value Benefits

GEISINGER HEALTH PLAN®

selecthealth

UPMC *for Life*
UPMC Health Plan Medicare Program

SHARP®

115% Estimated revenue generated by a MA beneficiary compared to a traditional Medicare beneficiary within a narrow network PSHP

1 in 3 MA Value-Based Insurance Design Program participants are provider-sponsored

Source: Health Care Advisory Board interviews and analysis.

However, New Plan Ownership a Slow Journey

While attractive in theory, launching a health plan is an arduous and expensive process. Although providers face challenges in launching any type of insurance product, they must also confront additional challenges specific to Medicare Advantage. For example, MA plans operate in an individual market that requires door-to-door marketing capabilities. Furthermore, MA plans must meet a heavier compliance burden than other plans.

The CMS star rating system presents some unique challenges for providers thinking about starting an MA plan as well. Plans rated at 4 stars and above receive bonus payments in addition to their standard reimbursement rates. They also enjoy a distinct advantage in marketing efforts. New MA plans automatically receive a 3.5 star rating to start, creating financial and competitive setbacks.

Provider-Sponsored MA Plans Raise Host of Challenges

Any PSHP Requires Significant Investment; MA Brings Additional Challenges

Challenges for Any New PSHP

Capital Investments

- Technology infrastructure
- Specialized personnel
- Capital reserve, depending on state(s) of operation

Licensure and Credentialing

- Federal and state licenses
- Credentials as a risk-bearing entity, depending on state(s) of operation

Securing Enrollment

- Minimum number of lives for financial viability *(~5,000)*
- Sufficient scale to ensure consistent profitability *(~20,000+)*

Challenges Specific to Medicare Advantage Plans

Automatic Start at 3.5 Star Rating

- Not eligible for PMPM bump given to 4+ star plans
- Beneficiaries hesitant to enroll if a higher-star plan is available

Selling in an Individual Marketplace

- Enrollment usually depends on signing up one member at a time
- Requires further investment in retail sales infrastructure and marketers

Heavier Compliance Burden

- Must construct annual benchmark bid
- Benefit packages must meet strict compliance standards
- CMS performs frequent audits

3-5 Years Average time to viability for a new provider-sponsored MA plan

Source: Health Care Advisory Board interviews and analysis.

Partnership Accelerates Speed to Market

Given the substantial time, capital, and expertise required to launch a new provider-sponsored Medicare Advantage plan, many providers are considering partnership models over full plan ownership. A white-label arrangement—where an existing health plan offers a product in partnership with providers—can be especially effective at eliminating common start-up barriers.

Colby Health System, a pseudonymed organization, partnered with a large national payer to offer both commercial and Medicare Advantage products. For commercial products, the partners opted for a joint venture ownership model. However, due to the unique dynamics of MA—especially star ratings—the two parties opted to offer white-label products in the MA market.

Through this white-label arrangement, Colby entered the insurance market with their plan partner's existing 4-star MA product. They consequently received both higher reimbursement from CMS and greater consumer preference, while maintaining an elevated role in the product.

Desire to Retain Star Rating Advantage Prompts Unique MA Arrangement

- Plan retains ownership of MA products, eliminating need to re-apply for CMS contract
- Reinsurance arrangement still allows plan, provider to share financial stake in product offerings
- Maintains plan's 4-star rating rather than resetting at 3-stars, as required for new products[1]

Advantages of 4+ Star Rating

Enrollment

72% MA enrollees selecting a plan with 4 or more stars

Reimbursement

Additional reimbursement boosts profitability, used to improve product design

Case in Brief: Colby Health System[2]

- Mid-sized health system based in the Midwest
- Established joint venture with Gordon Health Plan[2] to provide commercial insurance products
- To maintain Gordon's 4-star rating, Gordon retains ownership of MA products; reinsurance arrangement still allows for shared stake in MA business line

1) As of 2016, new MA products now start at 3.5 stars.
2) Pseudonym.

Source: Avalere, *More than 70 Percent of Medicare Advantage Enrollees in Plans with Four or More Stars*, March 16, 2016; Health Care Advisory Board interviews and analysis.

Searching Near and Far for the Right Partner

For some providers, the opportunity to enter the Medicare Advantage market quickly and successfully may be stymied by a lack of willing health plan partners. St. Luke's Health System dealt with this challenge in its early attempts to shift to value-based arrangements. Local payers were simply unwilling to share risk.

As a result, St. Luke's decided to look for a potential partner outside of its immediate market. And given the challenges associated with early discussion with local payers, St. Luke's determined that a provider-sponsored plan would be an ideal partner. Ultimately, the system decided to partner with Intermountain Healthcare's insurance arm—SelectHealth—to bring commercial, exchange, and Medicare Advantage products to Idaho.

The partnership helped St. Luke's begin its journey toward risk with SelectHealth, but it also catalyzed a shift in the local market dynamics. St. Luke's now maintains several risk contracts with local payers, including two MA arrangements.

For a detailed assessment of potential health plan partners to accelerate speed into the MA market, please see the appendix.

Out-of-Market Partner Helps Tip Slow-Moving Market

Case in Brief: St. Luke's Health System

- Not-for-profit health system based in Boise, ID
- Currently in their second performance period as an MSSP Track 1 ACO
- Unable to convince local payers to begin negotiation for risk-based agreements
- Partnered with Intermountain's PSHP SelectHealth to bring commercial, exchange, and MA products to Idaho market
- Demonstration of success prompted local payers to make incremental moves toward risk

Demonstrate Value and Potential of Risk Arrangements by Partnering with an Out-of-Market PSHP

1) Currently 80k commercial, 33k Medicare Advantage lives in Idaho.

Source: Health Care Advisory Board interviews and analysis.

Key Takeaways

1	**Identify "must-have" elements for a risk-based MA contract; be flexible on the rest**	There is no such thing as a perfect contract, and compromises must always be made. Providers confident in care management capabilities may insist on delegation, but must be aware that both payers and providers will need time to evolve towards a truly equitable relationship.
2	**Don't get stuck in the pilot phase; structure contracts to evolve over time**	A system's infrastructure and capabilities evolve over time. Providers should prioritize contracts designed to progress to more risk, a higher share rate, and more delegated responsibility matched to their broadening experience.
3	**Launching a new MA plan is time-intensive; consider white-labelling to more quickly capture returns**	Launching a provider-sponsored health plan, and especially a Medicare Advantage product, is a complex process not to be taken on lightly. Many organizations will see more immediate returns through partnerships, particularly those that come with an established star rating, reputation, and enrollment.

Source: Health Care Advisory Board interviews and analysis.

3

Ensure Longevity of Medicare Risk Strategy

Engaging Partners

8. Improve coding, documentation to ensure a fair standard
9. Prioritize near-term savings to protect buy-in

Engaging Patients

10. Tip market toward most favorable contracts
11. Minimize churn to stabilize cost targets, enable ROI

Multiple Parties Central to Long-Term Viability

Selecting or negotiating a strong risk contract is only the first step in an intentional Medicare risk strategy. Once the initial contracts are signed, providers must also ensure that they will remain sustainable over time.

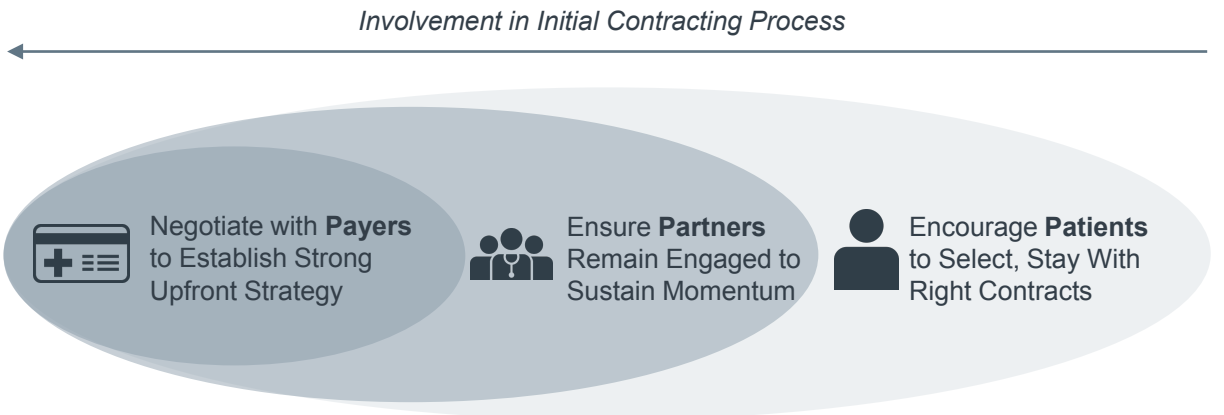
While contract negotiations require effective payer-provider relations, ensuring contract longevity necessitates engagement with two other groups of key stakeholders: partners and patients.

First, organizations must ensure engagement among key population health partners. Partners include a range of leaders whose ongoing commitment to population health is essential, including physicians, executive leadership, and finance teams. Even a strong Medicare strategy will falter without ongoing support from any one of these groups.

Second, providers need to effectively engage patients—and not just to improve health. For long-term risk contracting success, providers need to nudge patients toward favorable contacts and actively work to minimize patient churn over time.

Stakeholders Span the Care Continuum

Four Imperatives to Improve Contract Longevity



8 Improve coding, documentation to ensure a fair standard

9 Prioritize near-term savings to protect buy-in

10 Tip market toward most favorable contracts

11 Minimize churn to stabilize cost targets, enable ROI

Source: Health Care Advisory Board interviews and analysis.

Ensuring a Fair Baseline Over Time

To start, providers should focus on long-term engagement of key partners. Physicians are critical for a host of reasons, but they have a central role in ensuring that an organization is held to a fair standard over time through accurate risk adjustment.

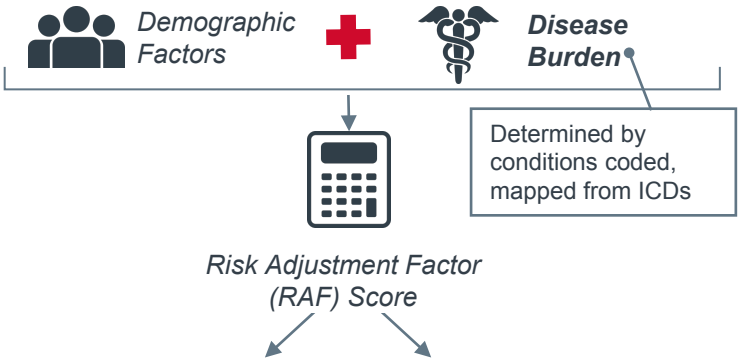
In Medicare, CMS uses a combination of demographic factors and measures of disease burden to calculate a Risk Adjustment Factor, or RAF, score. Historically, CMS has primarily used RAF scores to determine levels of health plan reimbursement in an effort to prevent adverse selection and stabilize insurance premiums. However, as payers have shifted risk onto providers, RAF scores have also started to impact provider reimbursement.

Risk Adjustment Helps Capture True Population Risk Profile

Risk Adjustment in Brief

- Risk adjustment models are used to predict health care costs based on the relative actuarial risk of patients
- Accurate risk-adjusted payment relies on comprehensive medical record documentation and diagnosis coding
- Applied to providers to ensure performance-based payments adequately reflect patient complexity and risk
- Applied to health plans to mitigate the impacts of adverse selection and to stabilize premiums

Crucial to Success Payment Under Medicare Risk



Impacts Payment Under Medicare Risk Contracts

Adjust PMPM payments to **MA plans** and target benchmark for savings under **MSSP, NGACO**

Supports Care Management Activities

Offers clearer and fuller picture of patient health to enable better targeting of care management efforts

Source: Health Care Advisory Board interviews and analysis.

Critical Under All Forms of Medicare Risk

The magnitude of this impact and how frequently the adjustment is applied varies by the type of program or contract.

In MA, for example, risk-adjustment impacts PMPM payments to the health plan. For providers who are sharing risk with the plan, this can mean a higher payment or bonus opportunity.

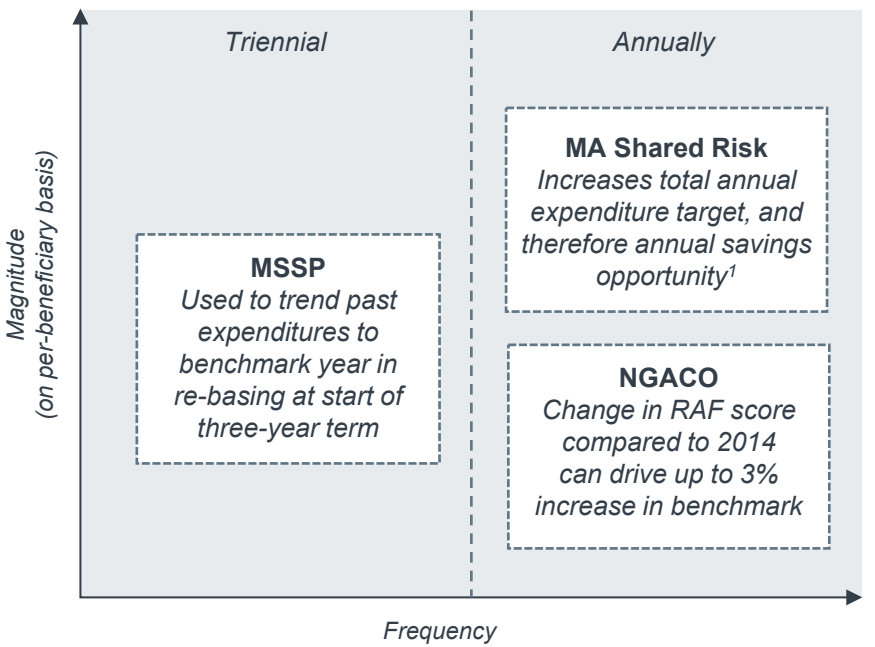
The effect of RAF scores in the Medicare Shared Savings Program is smaller but still significant. Across the course of a three-year agreement period, risk scores for newly assigned beneficiaries can increase or decrease the value of the ACO's benchmark. Continuously assigned beneficiaries can only decrease the benchmark value. However, changes in risk scoring across the entirety of the ACO population are taken into account when benchmarks are rebased at the start of a new three-year performance term.

In NGACO, the benchmark is adjusted upwards or downwards each year using the full risk score for all beneficiaries, with the adjustment capped at 3% in either direction.

Given limited focus on risk-adjustment in the past, providers stand to improve performance under risk contracts by improving accuracy of coding and documentation.

But Impact Depends on Type of Program, Reimbursement Model

Improvement Opportunity Varies by Magnitude, Frequency



1) Presumes contracts based on percent of premium cost target.

Source: Health Care Advisory Board interviews and analysis.

Engaging Physicians in Coding and Documentation

Since RAF scores depend largely on ICD coding, improvement efforts typically focus on physician collaboration. In particular, health systems need physicians to execute on two key tasks.

First, physicians must capture the full disease burden of their patients through accurate coding. Second, they must support that code over time with precise attention to documentation.

Health systems play a key role in helping physicians achieve these two objectives by securing buy-in, hardwiring coding and documentation processes, and—if needed—offering financial incentives to reward success.

System Strategy Must Support Physician Responsibilities

Two Key Tasks for Physicians

Use appropriate, **maximally specific ICD diagnostic coding** to capture full disease burden

Document comprehensively and precisely, both for individual visits and across time, to support diagnostic code

Three Key Tasks for the System

1. **Secure physician buy-in** through robust education, data transparency to identify improvement opportunities
2. **Hardwire coding, documentation processes** by offering on-the-ground staff and technology support
3. **Weigh necessity of financial incentives** to reward physicians for improvement efforts

Source: Health Care Advisory Board interviews and analysis.

Start with Broad-Based Education

Education is a critical first step in helping physicians improve coding and documentation.

Cornerstone Health Care, a multispecialty group based in North Carolina, has increased their focus on coding and documentation across the past few years. Their high-touch approach to education engages physicians in several ways.

For example, Cornerstone has staff dedicated to the effort, including a director of coding and documentation, who hosts regular education sessions. They also employ chart reviewers who identify missed coding and documentation opportunities.

Cornerstone also engages physicians with direct outreach. Updates on coding and documentation initiatives are included in the group's monthly newsletter. In addition, physicians receive personal notifications when patient scores are reset at the beginning of each year.

As a result of improved accuracy in coding and documentation, Cornerstone has seen an average increase of 0.04 in its RAF scores in each of the two years since the start of the initiative.

Transparency Fuels Educational Efforts

Taking a Multifaceted Approach to Education

- Director of coding and documentation hosts sessions for each service line
- Beginning-of-year reminders drive renewed focus after annual reset
- Monthly newsletters include updates on progress, challenges, and opportunities
- Internal, external coding staff review charts to identify untapped opportunities

Case in Brief: Cornerstone Health Care

- 275-physician multispecialty group based in High Point, North Carolina
- 12,000 lives in NGACO; 17,000 MA lives in risk-based arrangements
- Launched initiative to improve coding and documentation two years ago; have seen average annual RAF score increase of 0.04 per patient

Source: Health Care Advisory Board interviews and analysis.

Supplement with On-the-Ground Support

While education is an important starting place, coding and documentation efforts are just one item on a rapidly growing list of physician priorities. As a result, leading organizations supplement educational efforts with on-the-ground support. Making the process less burdensome for physicians helps to hardwire improvement efforts and sustain them over time.

Summit Medical Group, an independent primary care group in Tennessee, employs a team of 12 full-time certified coders to identify potential coding gaps and complete any steps physicians may have overlooked. Divided between a centralized team that works virtually and a rounding team that provides in-person support, these coders help with both pre-visit planning and post-visit coding.

Summit has seen an increase of 0.08 in its RAF score since deploying this specialized team.

Summit Medical Group Offers Wraparound Coding Assistance

Summit Strategic Solutions[1] Risk Adjustment Department

- Centralized team: ten certified coders and one department manager
- Rounding team: one Summit-employed certified coder and one MA plan-employed certified coder

Pre-Visit Planning

- ✓ Flag diagnoses from specialist reports that are not on PCP's problem list
- ✓ Identify prior year chronic conditions not documented year to date
- ✓ Close "false" quality gaps, identify true quality gaps
- ✓ Note embedded in EMR, PCP receives note just prior to scheduled appointment

Post-Visit Coding

- ✓ Review all documentation in the progress note immediately following a patient's visit
- ✓ Continually work to identify opportunities for more thorough documentation, higher-specificity ICD coding

0.08 Growth in Summit Medical Group's risk adjustment score

Case in Brief: Summit Medical Group

- 220+ physician, 165+ advanced practitioner independent primary care group based in Knoxville, Tennessee
- Works closely with Medicare Advantage health plan partner
- Provides wrap-around coding and documentation support for all scheduled appointments using teams of both centralized and rotating coders

1) Business partner of Summit Medical Group.

Source: Health Care Advisory Board interviews and analysis.

Hardwire System to Capture Full Risk Profile

Beyond adding staff support to improve coding and documentation, some systems are focusing on the role of technology to improve performance. Since coding and documentation efforts rely heavily on information captured in the electronic medical record (EMR), health systems can provide physicians with a more streamlined and accessible system to improve coding and documentation.

Mercy Health, a 23-hospital health system in Ohio, partnered with Advisory Board's Clinovations to hardwire its improvement efforts. In addition to assisting Mercy with staff and process redesign, Clinovations provided the technology solution that allowed Mercy to embed a decision support tool in its EMR. The tool walks physicians through the coding and documentation process at the point-of-care.

As a result of its efforts, Mercy estimated a $5.4 million dollar increase in incremental revenue in the first 10 weeks after launching this initiative.

Three-Pronged Approach Drives Improvement

Case in Brief: Mercy Health

- 23-hospital health system with locations across Ohio and Kentucky
- Transitioned from MSSP Track 1 to Track 3 in 2016; also taking on risk in MA
- Identified health risk assessment and adjustment as major opportunity, challenge
- Partnered with Advisory Board's Clinovations, who provided staff, processes, and technology to quickly scale improvement efforts

Step		Examples
1	**Engaged physicians and technologists directly**	• EMR-specific technical experts • Clinovations' physician informaticists
2	**Updated and aligned clinical, operational workflows**	• Audience-specific training sessions and demonstrations • Performance reporting
3	**Embedded point-of-care decision support tool in EMR**	• HCC auto-forms in EMR • Streamlined click paths to compliant documentation

58%
Total reduction the number of individuals with an HCC gap of <1

$5.4M
Incremental revenue from risk-adjustment factor (RAF) improvement in 10 weeks

Source: Health Care Advisory Board interviews and analysis.

Use Financial Incentives Sparingly

Given the key role that physicians play in driving coding and documentation improvement efforts, many organizations have considered incorporating financial rewards for these efforts. Top-performers, however, have found it best to use financial incentives sparingly for a few reasons.

First, attaching financial incentives to these efforts could inadvertently lead to upcoding.

Next, many organizations have made substantial progress without adjusting compensation, finding that education and resource support alone can drive significant improvements.

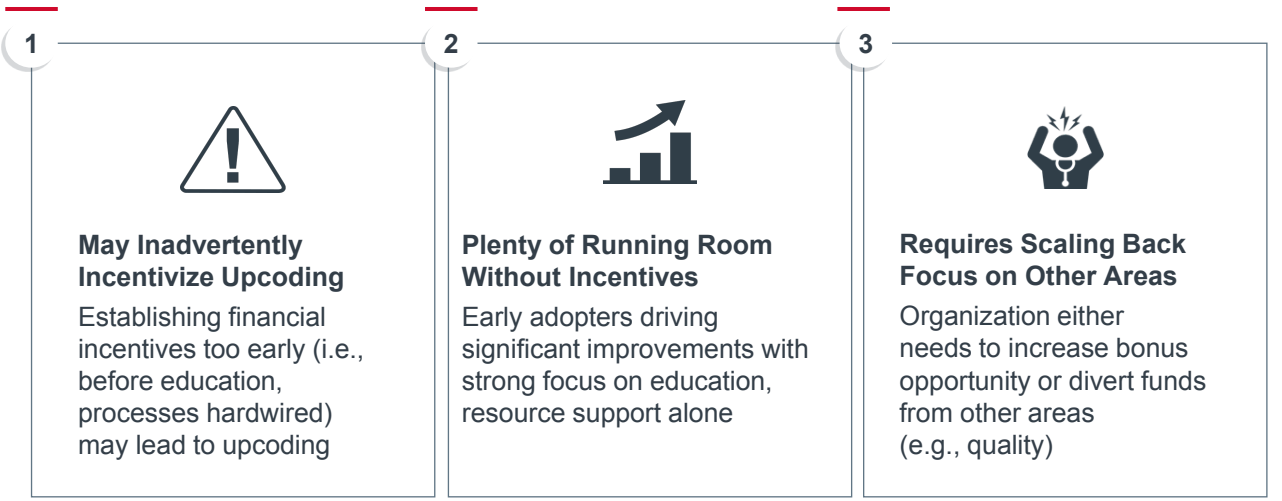
Finally, tying incentives to improvements in coding and documentation generally requires reducing valuable incentive dollars in another area.

Incentives may be useful in specific circumstances. For example, health systems might consider adding incentives if improvement efforts have plateaued or if they are just starting out and want to kick start efforts.

But many health systems are able to meaningfully improve coding and documentation without introducing financial incentives.

Careful Consideration Necessary Before Tying Coding to Compensation

Reasons Not to Rush to Financial Incentives Too Quickly



Source: Health Care Advisory Board interviews and analysis.

Maintaining Momentum Over Time

While engaging physicians in coding and documentation helps protect contract economics, hospitals and health systems must secure buy-in from a range of crucial stakeholders to sustain broader transformation efforts over time.

Building and sustaining this momentum often depends on an organization's ability to drive early returns from risk-based contracts. In the early years of the Medicare ACO programs, organizations that did not achieve initial savings were more likely to drop out of program participation.

It is particularly important to demonstrate returns to physicians, who often expect to share in savings because of their crucial role in improving quality and reducing spending.

Furthermore, payer partners and health system executives will also use early performance as a gauge for whether to continue risk contracting over time.

Demonstrating success to key partners—physicians, system executives, and payer partners—is critical to long-term sustainability.

Engage Partners to Ensure Long-Term Support

Hard to Sustain Momentum Without Savings

50% Of Pioneer ACOs that didn't earn savings in PY1 dropped out that year

3 of 21 NGACOs who have withdrawn from program citing no savings potential

Financial Return Key for Gaining Support from Three Primary Groups

Reward behavior change

Secure buy-in from key decision makers

Physicians

- Most added work due to care model change
- Expect increased work load to be reflected in compensation model

System Executives

- Have the ultimate decision making power
- Financial executives are most important in terms of seeing ROI

Payer Partners

- Financial stability necessary to secure delegation
- Key point of evaluation in enabling transition to downside risk

Source: Herman B, "Three ACOs bail on Medicare's Next Generation program," *Modern Healthcare*, July 15, 2016, available at www.modernhealthcare.com; Health Care Advisory Board interviews and analysis.

Care Management Necessary but Insufficient

Many early adopters of risk contracts have struggled to achieve savings despite significant effort and organizational transformation.

A Health Care Advisory Board survey of population health leaders found that initial efforts have focused heavily on care management. For example, providers have invested heavily in care management staff and primary care transformation.

While care management is crucial to any long-term population health strategy, early adopters have learned that such investments are typically insufficient and even ill-suited for driving near-term savings. Instead, these expensive investments often take many years to pay off.

Unlikely to Deliver Short-Term Savings

Care Management, Primary Care Transformation Topping the Population Health Investment Priority List

95% Respondents investing in care management staff, making it top on list of investments

80% Staff increases coming from investments in high-risk care managers

86% Respondents investing in patient centered medical homes

Care Management Alone Is Not Enough

Investments gradually change care delivery model; results manifest over **long-term**

Investments such as staffing additions and shared infrastructure for record sharing are **very expensive**

If **deployed too widely**, resources will drive little payoff (e.g. among healthy patients) at great expense

Efforts are **broad-based,** aim to decrease utilization across the board, rather than focusing on specific high-spend areas

Source: Health Care Advisory Board, "Prioritizing the Investment Plan for Population Health Management ", available at: advisory.com, June 2, 2014; Health Care Advisory Board interviews and analysis.

Target Near-Term Wins

To sustain momentum across the course of a contract, health systems must supplement their care management investments with more concentrated initiatives that can deliver near-term savings opportunities.

To identify these opportunities, providers must balance three criteria. First, they should identify high-magnitude opportunities to maximize potential impact. Second, they need to examine the variability of that spending, which signals avoidable spending and thus an achievable savings opportunity. Finally, leaders should evaluate their ability to and interest in inflecting that particular savings opportunity. Especially for hospital-led organizations, targeting acute care spending would threaten existing business models.

While reducing acute care spending should be a long-term goal for organizations committed to population health, near-term savings are likely to come from other areas, including post-acute care or drug spending.

Please see the study appendix for a full analysis of savings opportunities and related Advisory Board resources.

Identify Highly Variable, Actionable Opportunities

Three Criteria to Identify Near-Term Opportunities

1 **Magnitude**

Size of overall spend signals overall opportunity, impact

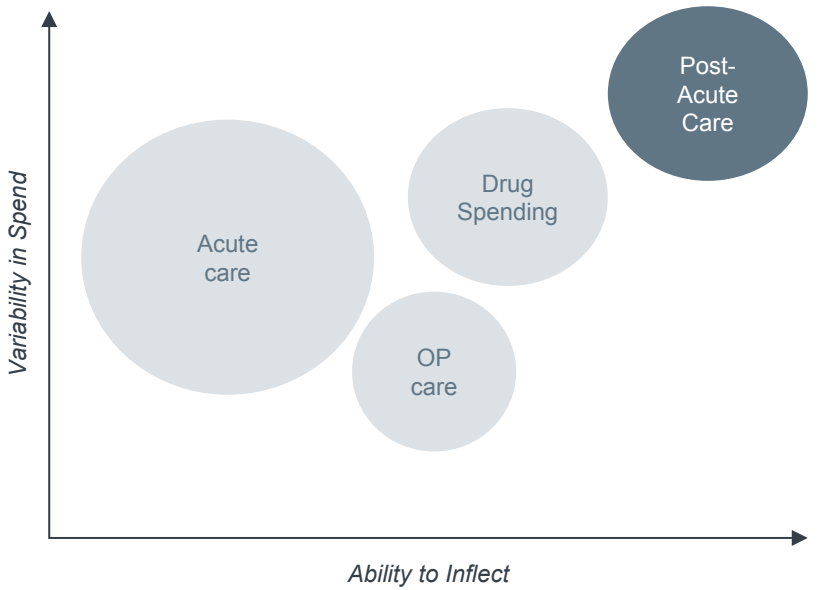
2 **Variability**

Good proxy for identifying areas of unnecessary spending

3 **Ability to Inflect**

Spending that does not directly reduce hospital revenue likely easier to inflect

Rank-Ordering Opportunities to Reduce Medicare Spending for Hospital-Led Organizations[1]



1) Size of bubble indicates magnitude of opportunity.

Source: Health Care Advisory Board interviews and analysis.

Doubling Down on Post-Acute Care Spend

Post-acute care spending, in particular, should be a top area of focus for any organization bearing Medicare risk due to high levels of avoidable spending. Furthermore, because hospital- and physician-led organizations typically have limited ownership stake in post-acute care assets, providers can drive savings without threatening the organization's revenue. And without direct ownership, or limited ownership, health systems can engage in network curation to strengthen relationships with top-performing post-acute care providers.

Banner Health, based in Phoenix, AZ, attributes much of its early success in the Pioneer ACO program to its efforts to build an affiliate network of high-quality post-acute care partners.

In its initial efforts, Banner focused primarily on Skilled Nursing Facilities (SNFs). Through an RFP process, the system selected 35 affiliate partners from a total pool of over 100 SNFs.

Selecting the right SNF partners was only the first step. Banner also updated patient-facing collateral and educated discharge staff to ensure patients use preferred facilities as often as possible.

Network Curation the Critical First Step

Banner's Process for Designing and Deploying Their Affiliated SNF[1] Network

Curating the Network

Collect Evaluation Data

Contracting team sent RFPs[2] to over 100 SNFs in market

Select the Right Partners

Followed strict review process to select 35 SNFs as affiliates

Revising Internal Operations

Update Choice Policy

Medicare-compliant choice policy encourages use of affiliate network

Educate Staff

Educated front line discharge staff on reasoning for new policy

Case in Brief: Banner Health

- 23-hospital health system, based in Phoenix, Arizona; Pioneer ACO participant since 2012
- Recognized significant opportunity to achieve savings in the post-acute care space
- Created an affiliated SNF network and used compensation models and care coordination support to achieve significant quality and cost improvements

1) Skilled nursing facility.
2) Requests for proposal.

Source: Health Care Advisory Board interviews and analysis.

Collaborate with Preferred Partners

While curating a network of preferred post-acute partners drives initial cost and quality improvements, a best-in-class approach extends beyond one-time improvements. Banner works closely with its affiliate SNF partners to drive continuous improvement over time. For example, Banner offers affiliate SNFs onsite nurse rounding support and 24/7 virtual consultations to prevent unnecessary readmissions.

Banner also designed a financial incentive program to reward affiliate SNFs who meet specific quality metrics. Using Pioneer's population-based payment option, SNFs agree to take a discount on their fee-for-service payments in return for the opportunity to earn a bonus.

Finally, Banner uses Pioneer's 3-day SNF waiver to discharge patients to affiliate SNFs more quickly and reduce unnecessary hospital admissions. Since 2015, the system has redirected nearly 1,000 patients from its hospitals to its affiliate SNF network.

Banner's ACO saw significant reductions in SNF length of stay and per-beneficiary costs after initiating this strategy. Due in large part to these improvements, Banner's overall shared savings payments across 2014 and 2015 exceeded $43M.

Banner Uses ACO Tools to Support Affiliate Partners in Variety of Ways

Offering Direct Operational and Clinical Support

- Deploys Banner nurses to round **at SNF facilities**
- **Contracts SNFists** to round at affiliate sites
- Offers **24/7 support** in ICU to provide virtual consultations to help avoid unnecessary ED admissions

Refining Incentives to Reward PAC Improvement

- Used Pioneer ACO's Population Based Payment arrangement to negotiate **discounted FFS payments** from ACO to SNFs
- Opportunity for even greater return through **rewards based on performance** against quality metrics such as LOS[1] and rehospitalization

Shifting Hospital Care to Affiliated PAC Sites

- Aggressive use of **SNF 3-day waiver** ensures appropriate utilization of affiliated network sites
- Waiver **shifts patients** from higher-cost hospital setting to lower-cost post-acute setting

961
Admissions to affiliate SNFs using 3-day waiver, January 2015-June 2016

24%
Length of stay reduction in Banner's affiliate SNF network in 2015

50%
Reduction in PBPM[2] costs in affiliate SNFs compared to ACO average in Q4 of 2015

$43.3M
Combined 2014-2015 shared savings in Pioneer, since focus began on post-acute spend

1) Length of stay.
2) Per beneficiary per month.

Source: Health Care Advisory Board interviews and analysis.

Engaging Beneficiaries the Last Piece of the Puzzle

Once an organization has secured the buy-in from partners necessary to sustain risk contracting across the long-term, it must ensure that patient behavior supports the organization's risk-contracting efforts.

Ultimately, the success of an organization's long-term Medicare risk strategy depends on two key patient decisions: which insurance products patients select and their loyalty to those products over time. To sustain a long-term risk contracting strategy, providers must play an active role in influencing each of these key patient decisions.

Providers Need to Play Active Role in Patient Plan Selection, Retention

Inflecting Patient Plan Choice Not a Role We're Used to Playing…

Typical health system approach is largely reactive; payer mix taken as a given and managed after the fact through marketing, services offered

…But Patient Choice Can Drastically Impact Sustainability

Over time, providers will gain more clarity around which contracts drive best financial and clinical outcomes—both for providers and for patients

Two Imperatives for Influencing Consumer Behavior

Influencing Initial Choice

10

Tip market toward most favorable contracts

Ensuring Continued Choice

11

Minimize churn to stabilize cost targets, enable ROI

Source: Health Care Advisory Board interviews and analysis.

Proactively Manage Mix of Risk Contracts

First, providers should encourage patients to select insurance products which support the organization's risk strategy. The preferred mix of contracts will vary by organization and will depend on which contracts perform well financially, satisfy cost and quality standards for patients, and include collaborative partnerships between the payers and the provider.

Ultimately, providers can shift their contractual mix in Medicare in two ways. First, by shifting the relative mix of Traditional Medicare lives versus Medicare Advantage lives. And second, by encouraging Medicare Advantage enrollees to select specific MA products.

While Optimal Portfolio Varies, Health Systems Have Active Role to Play

Determine Best-Fit Contracts

Key Questions for Consideration

- ☑ Which contract(s) are **performing best financially**?
- ☑ Which contract(s) drive the **highest patient satisfaction ratings**?
- ☑ Who are our most **collaborative plan partners**?
- ☑ Which contract(s) represent products that are **affordable for our patients**?
- ☑ Which contract(s) truly reward us for **cost, quality improvements**?

Tip Market Toward Preferred Contracts

Two Ways to Shift Contractual Mix

1 

Shift **Mix of Traditional Medicare, MA** Lives

Rightsize market penetration of Medicare Advantage relative to traditional Medicare

2 

Ensure Selection of **Best-in-Class MA Products**

Nudge beneficiaries toward highest-quality, lowest-cost MA plan partners, customized products

Source: Health Care Advisory Board interviews and analysis.

Rightsizing Mix of Traditional Medicare, MA Lives

Although Medicare Advantage enrollment continues to grow nationally, a majority of Medicare beneficiaries still remain in Traditional Medicare today. As a result, some providers who find MA more favorable are actively trying to increase MA penetration in their markets.

For example, pseudonymed Moss Health System has successfully operated an MA plan through its owned health plan—Wellick Health Plan—for many years. Although Moss also participates in the Medicare Shared Savings Program, it has struggled to achieve financial returns in the program.

As a result, Moss has launched a strategy to shift its attributed ACO beneficiaries toward Wellick's MA offerings. With some initial marketing efforts, Moss shifted one percent of its ACO population in 2016, which represented ten percent of the plan's growth that year. The system has since ramped up efforts, with the goal of converting five to ten percent of its ACO population in 2017.

Moss Health System[1] Actively Tipping Market Toward MA

Ramping Up Plan Marketing, Design Efforts to Increase MA Penetration

Initial Efforts Yield Modest, but Noticeable, Shift

- Letters to FFS Medicare patients
- Scripting provided to check-in staff
- Advertising on provider website
- Marketing materials placed in waiting area

1%

ACO beneficiaries shifted to Wellick Health Plan[1] MA in 2016, which accounted for 10% of plan's total sales

Scaling Up to Meet More Ambitious Goals

- Geofencing advertising
- Ancillary staff given scripting, "Ask Me About Medicare" pins
- Adding preventative dental, eyewear, and hearing aid coverage by Wellick
- Moss will offer value-added discounts and services, e.g., offset 50% of hearing aid copay required by Wellick and give additional 50% discount on eyewear

5-10%

ACO beneficiaries that Moss Health System is aiming to convert to Wellick Health Plan MA in 2017

Case in Brief: Moss Health System and Wellick Health Plan

- Moss Health System is a large independent medical group based in the Midwest
- Owns and operates Wellick Health Plan, which offers both commercial and Medicare Advantage products; Moss Health System also participates in MSSP
- Due to success in MA and mixed results in MSSP, has established clear goals to move beneficiaries from traditional Medicare to Wellick Health MA products

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Preempt Key Decision Point

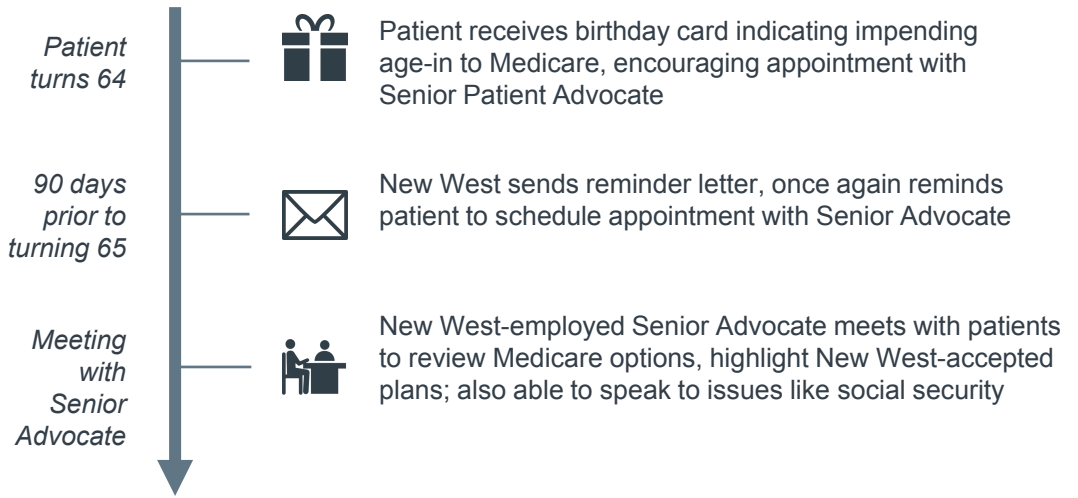
While it is possible to convert Traditional Medicare beneficiaries over to Medicare Advantage, other providers have found this strategy to be difficult and resource-intensive. Since few Medicare beneficiaries change their coverage selection between Traditional Medicare and Medicare Advantage in any given year, other organizations are shifting focus upstream with the goal of inflecting enrollees' initial decisions as they age into Medicare benefits.

As one of the few organizations that only accepts Medicare Advantage for Medicare-eligible patients, New West Physician is particularly proactive in engaging soon-to-be Medicare beneficiaries. New West has a thorough marketing and education effort that launches as soon as an existing patient turns 64. The goal is to educate patients on the benefits of MA and communicate which specific MA plans the organization accepts.

On average, 70% of New West's commercially insured patients choose one of these plans when they become eligible for Medicare.

Happy 64th Birthday!

Offer Support Services to Guide Beneficiaries Through Age-In to Medicare Process



Case in Brief: New West Physicians

- 100-provider physician-owned network based in Denver, Colorado
- Ceased accepting traditional Medicare in 1999, moved to MA-only model
- Has established extensive marketing, support services for age-in beneficiaries to maximize number of individuals who select one of New West's accepted MA plan options

Source: Health Care Advisory Board interviews and analysis.

Engaging Patients in MA Plan Selection

While New West works with multiple MA plans, some organizations are entering into exclusive relationships with a single MA partner.

After years of managing risk contracts with several MA plans, Reliant Medical Group in Massachusetts eventually decided to select a single, preferred partner. The decision to enter into an exclusive partnership was driven by several factors. First, the partner offered distinct marketing and enrollment advantages as the largest MA plan in the state. The plan also offered Reliant a higher percent of premium and greater levels of delegation than other MA plans. Finally, Reliant knew that exclusivity would eliminate the complexity of maintaining multiple risk contracts.

This decision affected nearly 16,000 of Reliant's patients, who would need to switch MA plans in order to remain with their Reliant provider. Reliant worked closely with its plan partner to launch a robust patient education effort. The strategy included traditional marketing as well as staff involvement. EMR triggers notified staff when they were about to interact with an eligible patient so that they could reinforce the upcoming change. Overall, Reliant's efforts successfully converted 90% of the affected patients.

Exclusive Plan Partnership Provides Platform for Change

Beneficiaries Willing to Switch Plans to Maintain Provider Relationships

Reliant Decides to Go Exclusive

- Superior marketing, enrollment advantages as largest MA plan in state
- Plan willing to offer higher percent of premium, ideal level of delegation
- Contracting with single partner reduces administrative burden

Deploys Year-Long Conversion Effort

- Used print ads, direct mail, and telephonic outreach to notify patients of conversion
- PCPs and office staff given talking points; EMR triggers flag impacted patients for staff
- Reliant staff host presentations at senior living, social service facilities to raise awareness

A Clear Success

90%

Affected Reliant patients who switched to exclusive plan partner to maintain Reliant provider

Case in Brief: Reliant Medical Group

- 500-provider medical group operating in Central and Metrowest Massachusetts
- In 2014, moved to an exclusive arrangement with a large Massachusetts health plan for MA; nearly 15,000 beneficiaries (out of 16,000) switched plans to maintain relationship with Reliant

Source: Health Care Advisory Board interviews and analysis.

Retaining Beneficiaries Beyond Initial Enrollment

Getting patients to choose the right plan at the outset is only the first step. Ultimately, providers and their plan partners need to ensure that patients remain loyal over time.

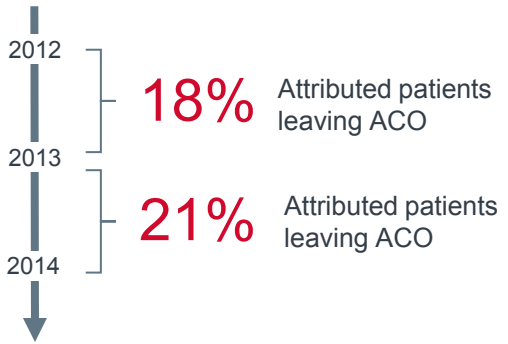
Changes in patient attribution year over year, or churn, is a major problem for many Medicare ACOs. Some ACOs are seeing attrition rates exceeding 20% annually.

Although patient churn is often lower in the MA market, it is not insignificant. In any given year, about 13% of MA enrollees voluntarily leave their existing plans. Most of these individuals stay within Medicare Advantage, deciding to switch to different plans.

Important to Address Churn in All Contracts

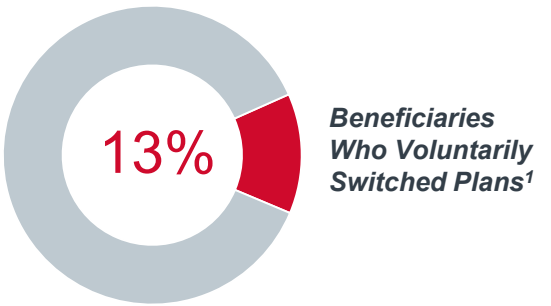
A Significant Problem for ACOs…

Attrition in Partners HealthCare Pioneer ACO



…But MA Not Entirely Immune Either

MA Enrollees, by Switching Status, 2013-2014



Study in Brief: "Patient Population Loss at a Large Pioneer ACO"

- March 2016 article in *Health Affairs*
- Examined rates of patient turnover in Partners HealthCare's Pioneer ACO

Study in Brief: "Medicare Advantage Plan Switching: Exception or Norm?"

- September 2016 brief published by Kaiser Family Foundation
- Analyzed claims to examine switching rates

1) Includes switching between MA plans, or from MA to TM.

Source: Hsu J et.al, "Patient Population Loss at a Large Pioneer Accountable Care Organization and Implications For Refining The Program," *Health Affairs*, March 2016, available at www.healthaffairs.org; Jacobson G et.al, "Medicare Advantage Plan Switching: Exception or Norm?" *Kaiser Family Foundation*, September 20, 2016, available at www.kff.org; Health Care Advisory Board interviews and analysis.

Difficult to Manage an Inconsistent Population

Churn threatens the longevity of a risk contract in several ways.

First, care management efforts take time to pay off. Providers will struggle to capture a return on these efforts and investments if patients leave for a different plan or network.

Churn can also directly impact the economics of a contract. For example, an organization could end up with a vastly different attributed patient population than the one used to establish the contract's cost target. Churn can also cause the contract's cost target to fluctuate over time and make it difficult to gauge performance.

While providers cannot eliminate churn entirely, they can strive to minimize it. Providers should deploy strategies to ensure an accurate representation of their population based on the attribution methodologies used in their contracts. For example, encouraging use of Annual Wellness Visits helps ensure attribution under utilization-based methodologies. Ultimately, providers should strive to build proactive loyalty to their networks.

Churn Threatens ROI, Destabilizes Contract Economics

Limits Pay-Off From Care Management Investments

Expensive investments in primary care, care coordination, and care management often take years to pay-off; churn results in inefficient resource use

Produces Inaccurate Comparison Group

For contracts where performance is based on historical spend, can result in dramatic difference in population demographics, risk relative to benchmark group

Causes Cost Target Fluctuation

Can cause cost targets to change year-to-year or between performance terms; difficult to track performance over time

Two Steps for Managing Churn

1

Maximize Use of Annual Wellness Visits

Increases chances of attribution through assignment-based attribution methodologies

2

Build Proactive Network Loyalty

Ensures proactive choice of provider network, regardless of contract type

Source: Health Care Advisory Board interviews and analysis.

One Strategy, Multiple Advantages

One underused strategy for addressing churn is the Annual Wellness Visit (AWV), a yearly preventive care visit for Medicare beneficiaries. AWVs include a specific set of preventive services, including a health risk assessment (HRA), a review of medical and family history, and a screening for cognitive issues.

AWVs benefit both patients and providers in a variety of ways. Visits are well-reimbursed for providers and are free of cost to patients. In addition, AWVs offer providers the opportunity to collect key clinical and psychosocial data, which can help advance coding and documentation efforts and refine care plans.

AWVs also help drive accurate patient attribution. Many ACOs currently experience high levels of churn among healthy segments of their populations since these patients might not incur a claim across the performance year. AWVs provide a clinically-appropriate interaction for helping ensure those patients remain attributed to the ACO. Some ACOs have reduced churn rates by 10-20% largely due to AWV initiatives.

Despite all of these benefits, fewer than one in five Medicare beneficiaries receive an AWV today.

Annual Wellness Visits Often a Missed Opportunity

What Is an Annual Wellness Visit (AWV)?

- A yearly preventive care visit offered at no cost to all Medicare Part B beneficiaries
- Visit must meet specific criteria for information-gathering, assessment, and counseling
- Can be conducted by any licensed health professional or a team of professionals, under the direct supervision of a physician

Advantages of Annual Wellness Visits

- Improves chances of attribution under assignment-based methodologies
- Generates upfront cash flow (typical reimbursement ranges from $111-$165)
- Opportunity to drive coding, documentation, both for risk-adjustment and MIPS
- Opportunity to collect valuable clinical, psychosocial, utilization data

17.7% Of Medicare beneficiaries currently receive an Annual Wellness Visit

Source: National Council on Aging, available at: ncoa.org, accessed October 3, 2016; Health Care Advisory Board interviews and analysis.

Proactively Managing Patient Attribution

Underutilization of these visits is due in large part to low levels of patient awareness. As a result, proactive provider outreach is crucial.

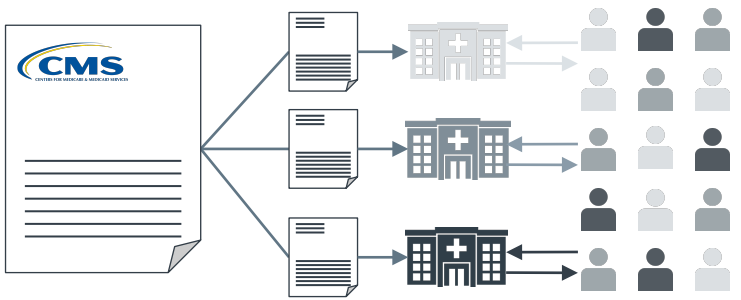
Eastern Maine Health System's ACO—Beacon Health—is addressing the issue of churn through a comprehensive strategy to increase use of AWVs.

Every year, Beacon uses the attribution lists it receives from CMS to conduct an internal analysis and assign each patient to a corresponding Beacon PCP. The ACO then distributes these patient rosters to its primary care practices. In turn, the practices use these lists to contact patients directly and schedule AWVs.

Some organizations are going even further to encourage utilization of AWVs. For example, Tucson Medical Center in Arizona is launching a home-based AWV program, with the goal of increasing use of the benefit among hard-to-reach populations, such as home-bound patients. The ACO plans to identify patients who have not scheduled an AWV and offer to send an Advanced Nurse Practitioner to their homes.

Use Annual Wellness Visit to Stabilize Attributed Population

Giving Primary Care Offices the Tools They Need to Prioritize Individuals For AWV Outreach, Scheduling



Beacon Health reconciles CMS data with internal data to assign each beneficiary to a primary care clinic

Primary care clinics given lists of attributed patients, responsible for outreach to schedule AWVs

> "One of our biggest learnings from Pioneer was that **we need to take direct responsibility for our attribution**. Any potentially-attributed beneficiary who is fairly healthy and does not see their PCP that year is a missed opportunity."
>
> *Mike Donahue, CEO, Beacon Health*

Case in Brief: Eastern Maine Health System

- Nine-hospital health system in Maine; owns and operates Beacon Health ACO
- Completed performance period in Pioneer ACO Model, currently operating both a Next Gen and a MSSP Track 1 ACO; has a risk-based MA contract
- Identified attribution as key challenge in Pioneer, now taking proactive approach to scheduling AWVs

Source: Health Care Advisory Board interviews and analysis.

Long-Term Loyalty the Ultimate Ambition

While ensuring attribution through an AWV strategy is a key starting place, especially for organizations subject to utilization-based attribution methodologies such as the Medicare ACO programs, providers should ultimately aim to build more proactive loyalty to their networks.

As a first step toward building loyalty, providers need a deeper understanding of the drivers of preference within the Medicare segment. This mandate is complicated by the fact that the Medicare population is currently in flux. As baby boomers age into Medicare, they are demonstrating a vastly different set of preferences than previous generations.

Advisory Board's Market Innovation Center conducted a set of consumer surveys to pinpoint the specific ways in which the Medicare population is shifting over time. The results of these surveys demonstrate that future Medicare beneficiaries value access and convenience far more than their predecessors, who deeply valued reputation and continuity.

Analyze Evolving Preferences of Medicare Population

Responding to Changing Beneficiary Preferences

		PREVIOUS GENERATION	BABY BOOMERS	CHANGE
Reputation	Clinic has partnership with best hospital in my area	#11 RANK	#18 RANK	↓
	Clinic has partnership with hospital that I have used	#16 RANK	#26 RANK	↓
	Doctor recommended the clinic to me	#18 RANK	#27 RANK	↓
Convenience	Clinic is located near my home	#14 RANK	#8 RANK	↑
	I have to travel 5 minutes to get to the clinic	#23 RANK	#19 RANK	↑

Market Innovation Center and Planning 20/20 members can download a full copy of *Meet Your New Medicare Patient,* available at advisory.com.

Key Takeaways

Reputation, physician relationships key for current Medicare beneficiaries

Access a bigger priority for boomers—new, future beneficiaries

Source: Market Innovation Center interviews and analysis; Health Care Advisory Board interviews and analysis.

Winning Through Service and Access

Given shifting preferences among Medicare beneficiaries, some health systems are already building a greater focus on access and convenience into their Medicare risk strategies to build long-term loyalty.

For example, UPMC Health Plan has a priority call line specifically for its MA members. Concierge staff on the line answer administrative questions, offer care advice, and schedule appointments. UPMC Health Plan sees impressive retention rates within their MA population, with over 97% of patients retaining their UPMC coverage each year. The plan attributes much of its success to offering personalized services and high levels of access.

Another provider-sponsored MA plan, Hometown Health, based in Reno, NV, focuses on convenience to drive loyalty to both the MA plan and network of providers. The PCPs affiliated with the health system—Renown Health—all offer 24-hour access guarantees. This encourages Hometown Health enrollees to select a Renown Health PCP and promotes plan renewals when patients are satisfied with the provider network.

Satisfy Patient Preferences to Improve Loyalty

Measurable Returns Generated Through Enhanced Access Programs

Nurse consultants staff priority call line for MA members to answer questions, give care advice, and schedule appointments

97.5% Retention rate among UPMC MA members

Beneficiaries selecting a Renown-employed PCP are guaranteed to see that provider within 24 hours for urgent concerns

60% Beneficiaries selecting Renown-employed PCPs

Case in Brief: UPMC Health Plan

- Fully-owned insurance arm of University of Pittsburgh Medical Center, serving more than 2.9 million members
- Maintains concierge call line to give MA beneficiaries priority access to nurse consultants

Case in Brief: Hometown Health

- Fully-owned insurance arm of Renown Health, a four-hospital system in Reno, Nevada
- Renown-employed PCPs offer same- or next-day appointment guarantees
- Access guarantee incents MA beneficiaries to select, stay with both plan and provider

Study in Brief: The Consumer Relationship Platform

Health Care Advisory Board study on how successful population health managers establish durable consumer loyalty to the health system; available on advisory.com.

Source: Health Care Advisory Board interviews and analysis.

Key Takeaways

1	**Risk-adjustment impacts contract economics long after program selection or contract negotiation**	Regardless of type of Medicare risk, risk-adjustment impacts the total reimbursement opportunity, making it a no-regrets strategy for the near-term; the best-in-class approach focuses heavily on education and on-the-ground support for physicians, with sparing use of formal financial incentives.
2	**Early returns not only protect the bottom line, but ensure continued support from key partners**	While many provider organizations have the means necessary to weather the cost of transformation, key stakeholders such as finance executives, plan partners, and physicians, will be keen to see early savings; providers will need to balance long-term care management investment with quick-win savings opportunities to ensure buy-in from these groups.
3	**Providers must take an active role in influencing patient plan selection and loyalty**	With a few exceptions, provider organizations have largely been passive bystanders to patient plan selection; however, as systems develop a clearer sense of which contracts are most beneficial, long-term viability will hinge on the ability to partner more closely with plans to inflect both initial plan selection and continued loyalty over time.

Source: Health Care Advisory Board interviews and analysis.

Appendix

Acronym Glossary

Acronym	Meaning	Definition
ACA	The Affordable Care Act	Federal statute enacted in 2010 to expand insurance coverage and payment reform
ACI	Advancing Care Information	MIPS reporting category that replaces Meaningful Use
ACO	Accountable Care Organization	Groups of doctors, hospitals, and other health care providers who come together voluntarily to coordinate high quality care for Medicare beneficiaries
APM	Advanced Alternative Payment Model	Payment path under MACRA that gives providers a 5% annual bonus on Medicare Part B payments, requires significant share of revenue in contracts with two-sided risk, quality measurement, and EHR requirements
ASC	Ambulatory Surgery Center	Outpatient facilities that provide same-day surgeries and procedures
AWV	Annual Wellness Visit	Annual primary care appointment covered for Medicare beneficiaries, visits must cover pre-determined set of preventive services, including a health risk assessment (HRA), a review of medical and family history, and a screening for cognitive issues
BPCI	Bundled Payments for Care Improvement	Four-model payment program developed by CMMI that links payments for services provided within an episode of care, first participants began in April 2013, participation in BPCI is voluntary
BY	Benchmark Year	Calendar year from which claims data is used to set target spend in ACO programs
CIN	Clinically Integrated Network	Collection of health care providers that come together to improve the quality and cost of care; allows health systems and independent providers to work together to meet the demands of population health while maintaining compliance with antitrust laws
CJR	Comprehensive Care for Joint Replacement	Episode-based payment initiative for lower extremity joint replacements, created by CMMI, participation began in April 2016 and is mandatory for selected geographic regions
CMMI	Center for Medicare and Medicaid Innovation	Division of CMS created by Congress through the ACA for the purpose of testing innovative payment and service delivery models to reduce program expenditures and enhance the quality of care for Medicare, Medicaid, and CHIP populations
CMS	Centers for Medicare and Medicaid Services	Agency within the U.S. Department of Health and Human Services, oversees many federal healthcare programs, including those that involve health information technology
CPC+	Comprehensive Primary Care Plus	Regionally-based, multi-payer primary care medical home model, two tracks available with incremental levels of delivery requirements and payment options

Source: cms.gov; Health Care Advisory Board interviews and analysis.

Acronym Glossary

Acronym	Meaning	Definition
ED	Emergency Department	Medical treatment facility specializing in emergency medicine
EMR/EHR	Electronic Medical/Health Record	Electronic version of a patient's medical history
EPM	Episode Payment Model	Episode-based payment initiative for heart attacks, bypass surgeries, and surgical hip/femur fractures, created by CMMI, participation begins in July 2017 and is mandatory in selected geographic regions
FFS	Fee for Service	Payment model where services are unbundled and paid for separately, used in traditional Medicare
FTE	Full-Time Equivalent	Number of hours worked by one employee on a full-time basis
HCC	Hierarchical Condition Category	Coding system by which Medicare providers and MA plans are reimbursed based on the specific health status of an enrollee
HHS	Department of Health and Human Services	Cabinet-level department of the government whose responsibility is to protect health and well-being by fostering advances in medicine, public health, and social services
HOPD	Hospital Out-Patient Department	The part of a hospital designed for the treatment of outpatients, people with health problems who visit the hospital for diagnosis or treatment, but do not require a bed to be admitted overnight
ICD	International Classification of Diseases	Standard diagnostic tool for classifying diseases, component of risk adjustment factor calculation
ICU	Intensive Care Unit	Department of hospital or health care facility that provides intensive medical treatment to seriously ill patients
IP	Inpatient	Refers to care that requires admission to a hospital
LOI	Letter of Intent	Used by providers/suppliers to declare intention of applying for Medicare payment programs
LOS	Length of Stay	Duration of an episode of care delivery in a facility, often used as a metric for measuring efficiency improvements in inpatient and outpatient facilities
MA	Medicare Advantage	Type of Medicare coverage offered by a private company that contracts with Medicare to provide Part A and Part B benefits

Source: cms.gov; Health Care Advisory Board interviews and analysis.

Acronym Glossary

Acronym	Meaning	Definition
MACRA	Medicare Access and CHIP Reauthorization Act	Enacted April 2015, repealed the Sustainable Growth Rate (SGR) and stipulated the development of two new Medicare payment tracks: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs); went into effect on January 1, 2017
MAO	Medicare Advantage Organization	Parent organization which has secured a contract with CMS to offer a Medicare Advantage plan
MIPS	Merit-Based Incentive Payment System	One of the new Medicare payment tracks created by MACRA, rolls existing quality programs into one budget-neutral pay-for-performance program, providers scored on quality, cost, improvement activities, and EHR use, assigned payment adjustment based on overall score
MIPS-APM	Advanced Payment Model within Merit-Based Incentive Payment System	A payment model that, while not sufficiently advanced to qualify for the APM track under MACRA, does qualify for a preferential scoring standard (e.g., MSSP Track 1)
MLR (premium)	Medical Loss Ratio	Percentage of premium revenue an insurer spends on claims and health care-specific expenses, Medicare Advantage plans must operate at a minimum 85% MLR under the terms of the Affordable Care Act
MLR (performance)	Minimum Loss Rate	Negative performance threshold that providers must exceed before overages are owed, in MSSP calculated as a percentage of benchmark that triggers first dollar loss once met or exceeded
MSR	Minimum Savings Rate	Positive performance threshold that providers must exceed before shared savings are earned, in MSSP calculated as a percentage of benchmark that triggers first dollar savings once met or exceeded
MSSP	Medicare Shared Savings Program	Program established by the ACA that rewards groups of providers that reduce their growth in health care expenditures for the Medicare population while meeting quality reporting and performance standards; participation is voluntary, and providers can currently choose from three different program tracks
NGACO	Next Generation ACO Model	CMMI ACO model, first cohort began January 2016, offers greater levels of risk and reward than current MSSP tracks and the Pioneer ACO model
NPR	Net Professional Revenue	Revenue generated per physician working at FTE
OP	Outpatient	Medical care delivered without requiring the patient to be admitted to a hospital
P4P	Pay-for-Performance	Payment models that include financial incentives for providers that achieve specific quality, efficiency, and/or value improvements and outcomes
PAC	Post-Acute Care	Rehabilitation or palliative services that beneficiaries receive after or in place of a stay in an acute care hospital; includes care received in settings such as Skilled Nursing Facilities and home health agencies

Source: cms.gov; Health Care Advisory Board interviews and analysis.

Acronym Glossary

Acronym	Meaning	Definition
PBPM	Per-Beneficiary, Per-Month	Expenses or reimbursement calculated on a monthly basis for individual beneficiaries, commonly used to determine reimbursement or performance targets in risk contracts
PBPY	Per-Beneficiary, Per-Year	Expenses or reimbursement calculated on an annual basis for individual beneficiaries, commonly used to determine reimbursement or performance targets in risk contracts
PCP	Primary Care Physician	Physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine
PMPM	Per-Member, Per-Month	Describes the amount and frequency of a payment from plan to provider, for example, commonly used to describe capitated payments in Medicare Advantage
PSHP	Provider-Sponsored Health Plan	Health insurance company fully owned by a health system, physician group, or hospital
PY	Performance Year	Year during which certain metrics are collected for providers to determine their performance for various payment reform programs
RAF	Risk-Adjustment Factor	Modifier applied to per-beneficiary cost, calculated from demographic factors and disease burden to ensure that providers and plans are reimbursed fairly based on risk-profile of population they care for or enroll
RFP	Request for Proposal	Type of solicitation where companies can place bids to participate in a program or project; for example, used by hospitals and health systems to solicit other provider partners to fulfill network building initiatives
ROI	Return on Investment	Gain or loss generated on an investment, relative to the amount of money initially invested
SNF	Skilled Nursing Facility	Health care institution that meets the federal criteria for Medicare and Medicaid reimbursement, including 24-hour availability of nursing care, physician supervision of each patient, and the full-time employment of at least one registered nurse

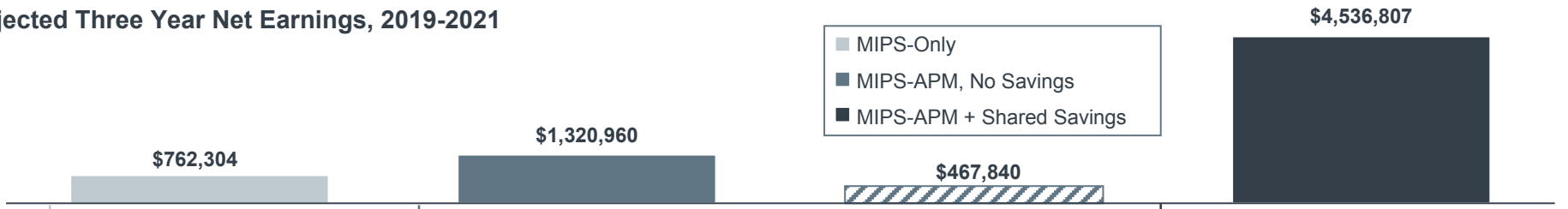
Source: cms.gov, Health Care Advisory Board interviews and analysis.

MIPS Impact of Adding Independent Physicians to ACO

Illustrative Financial Model

With the advent of MACRA, providers now face an additional set of considerations when evaluating ACO participation. While participants in Track 1 of the Medicare Shared Savings program cannot qualify for the APM track, they do receive preferential scoring in their MIPS evaluation which can provide a boost in MIPS bonuses. The modeling below demonstrates the potential advantage of this preferential scoring for an average five-hospital system with a 200-physician employed medical group. However, it is important to keep in mind that the majority of ACOs also include independent physicians as organizations strive to achieve the necessary scale and scope to manage a patient population. Introducing independent physicians into an organization's MIPS evaluation could lead to some dilution in MIPS performance, as demonstrated below. That said, organizations that can earn a savings in the program will more than offset that potential dilution.

Projected Three Year Net Earnings, 2019-2021



MIPS-Only

- 200 employer physicians
- No ACO participation
- MIPS scores: Quality (55th), Cost (33rd), IA (75th), ACI (65th)

MIPS-APM, No Savings

- Employed group alone *(left)* or with addition of 200 independents *(right)*
- In MSSP Track 1, no savings
- Independents in 33rd percentile for quality, 50th for ACI

MIPS-APM, Shared Savings

- Employed group plus 200 independents
- Average savings in Track 1 all three years
- MIPS performance held constant with previous scenario

Modeling Assumptions

- Five-hospital health system with 200-physician employed medical group; 33% are PCPs
- Assumes net professional revenue (NPR) per physician of $430,000; 40% of NPR is from Medicare, for an average Medicare NPR per physician of $172,000
- Model assumes employed physicians will perform well on Improvement Activities and Advancing Care Information categories due to resources and support available through system; performance on quality is assumed to be slightly above average; performance on cost below average due to focus on FFS, volume-based reimbursement
- Analysis projects physician network to double in size with Track 1 participation due to addition of independent physicians to round out network, increase in size of attributed population
- Independent clinicians assumed to fall in lower third quartile for quality due to lack of resources and infrastructure; performance in ACI assumed to be in 50th percentile due to less than average experience with CEHRT adoption; under MIPS-APM scenarios, all clinicians receive full points in IA, are not scored on cost, receive same composite MIPS score; earnings only include revenue adjustment for employed clinicians
- With addition of independent physicians, ACO assumed to have total of 132 PCPs, each with 100 attributed Medicare beneficiaries; total attributed population for Track 1 ACO is 13,200
- Savings in Track 1 calculated based on average benchmark size for MSSP ACOs in PY2015 ($10,082), with performance set at the average savings amount. MSSP ACOs that kept spending under target in PY2015 (4.79%) and share rate set at 45% based on average quality scores from MSSP ACOs in PY2015; model assumes same level of savings all 3 years
- Shared savings scenario assumes employed group sees only 50% of total savings earned (with other 50% shared among independent physicians)

Source: Health Care Advisory Board interviews and analysis.

Medicare Shared Savings Program

Detailed Benchmark Methodology, First Agreement Period

MSSP[1] Benchmark Calculation, New Participants (All Years)

		First Agreement Period, All Years
Step 1: Establish Benchmark		• Medicare Part A and Part B claims data used to calculate per capita expenditures for beneficiaries who would have been attributed to the ACO during the previous three years (benchmark years) • Per-beneficiary expenditures are truncated at the 99th percentile of national Medicare Part A and Part B spending • Member-month weighted average used to establish per capita baseline for each BY[2]; separate calculation for each of four Medicare entitlement categories (ESRD[3], disability, aged/dual-eligible, aged/non-dual eligible) • National growth rate for Medicare Part A and Part B assignable[4] FFS expenditures used to trend BY1 and BY2 to BY3 dollars • Full HCC[5] risk-score ratios used to trend BY1 and BY2 in terms of risk profile of BY3 • Three-year per capita baseline established as weighted average of BY1 (10%), BY2 (30%), and BY3 (60%)
Step 2: Update Benchmark Each Performance Year	Participant List	• Benchmark rebased each PY[6] based on updated ACO participant list to account for changes in the population that would have been attributed during benchmark years • Total benchmark calculated each year by taking the product of the three-year per capita baseline and the size of the PY attributed population
	Growth Rate	• For each PY, three-year per capita baseline adjusted by adding projected national per capita growth as an absolute dollar amount • Projected growth amount ***not*** reconciled based on actual observed growth in PY
	Risk Score	• Ratio of PY risk score and BY3 risk score used to rebase benchmark for each PY • Only newly assigned beneficiaries can increase the benchmark in the PY; patients defined as “newly assigned” were not attributed in previous year and did not receive care from ACO-participating primary care physician in previous year • Continuously assigned beneficiaries can decrease the risk score if HCC score decreases, but only measured for changes in demographic factors if score increases; patients defined as “continuously assigned’ were attributed in previous year or received care from ACO-participating primary care physician in previous year

1) Medicare Shared Savings Program.
2) Benchmark year.
3) End-stage renal disease.
4) Eligible for assignment to an ACO, including those already assigned to ACO.
5) Hierarchical condition category.
6) Performance year.

Source: CMS, “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations,” June 10, 2016, available at: www.federregister.gov; Health Care Advisory Board interviews and analysis.

Medicare Shared Savings Program

Detailed Benchmark Methodology, Subsequent Agreement Periods

MSSP[1] Benchmark Calculation, Contract Renewals (In or After 2017)

		Subsequent Agreement Periods, 2017 and Beyond
Step 1: Reset Benchmark		• Medicare Part A and Part B claims data used to calculate per capita expenditures for beneficiaries who would have been attributed to the ACO during the previous three years (benchmark years) • Per-beneficiary expenditures are truncated at the 99th percentile of national Medicare Part A and Part B spending • Member-month weighted average used to establish per capita baseline for each BY[2]; separate calculation for each of four Medicare entitlement categories (ESRD[3], disability, aged/dual-eligible, aged/non-dual eligible) • Regional growth rate for Medicare Part A and Part B assignable[4] FFS expenditures used to trend BY1 and BY2 in BY3 terms • Full HCC[5] risk-score ratios used to trend BY1 and BY2 in terms of risk profile of BY3 • Three-year per capita baseline established as average of BY1, BY2, and BY3 (equal weights)
Step 2: Update Benchmark Each Performance Year	Participant List	• Benchmark rebased each PY[6] based on updated ACO participant list to account for changes in the population that would have been attributed during benchmark years • Total benchmark calculated each year by taking the product of the three-year per capita baseline and the size of the PY attributed population
	Growth Rate	• Benchmark adjusted each PY using regional FFS adjustment which is calculated by taking the average per capita expenditures for assignable FFS beneficiaries in the regional service area and risk adjusting to account for the health status of the current ACO population; adjustment applied as a percentage of the difference between this number and ACO's rebased historical expenditures • Regional service area defined by the counties of residence of the ACO's assigned beneficiary population • In the first agreement period that this methodology applies, the percentage of difference in regional and historical spend used to adjust benchmark will be 35% for ACOs with lower spend than region and 25% for ACOs with higher spend than region • Benchmark also annually updated each PY using a growth rate that reflects growth in risk adjusted regional per beneficiary FFS spending for the ACO's regional service area
	Risk Score	• Ratio of PY risk score and BY3 risk score used to rebase benchmark for each PY • Only newly assigned beneficiaries can increase the benchmark in the PY; patients defined as "newly assigned" were not attributed in previous year and did not receive care from ACO-participating primary care physician in previous year • Continuously assigned beneficiaries can decrease the risk score if HCC score decreases, but only measured for changes in demographic factors if score increases; patients defined as "continuously assigned' were attributed in previous year or received care from ACO-participating primary care physician in previous year

1) Medicare Shared Savings Program.
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4) Eligible for assignment to an ACO, including those already assigned to ACO.
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Source: CMS, "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations," June 10, 2016, available at: www.federregister.gov; Health Care Advisory Board interviews and analysis.

Next Generation ACO

Detailed Benchmark Methodology, 2016-2018[1]

NGACO[2] Benchmark Calculation, 2016-2018

		2016-2018
Step 1: Establish Benchmark		• Medicare Part A and Part B claims data from 2014 used to establish the ACO's baseline expenditures for each of two alignment categories (Aged or Disability, ESRD[3]) • Claims used for beneficiaries who would have been assigned to the ACO in 2014 based on the current performance year attribution-eligible provider list
Step 2: Adjust Benchmark Each Performance Year	Growth Rate	• Baseline expenditures are trended forward each PY[4] using the national FFS expenditure percentage growth rate projected between 2014 and the PY • A regional geographic adjustment factor (GAF) trend is applied to the growth rate in order to adjust for regional pricing differentials; the trend adjustment accounts for the impact of performance-year factors on the baseline • GAFs include area wage index (AWI) and the geographic practice cost index (GPCI)
	Risk Score	• The trended baseline is risk-adjusted using the ratio of the full HCC[5] score in the current performance year to the full HCC score in 2014 • The ratio is capped at 1.03; providers only able to capture 3% increase in full HCC score compared to 2014 within entire NGACO agreement period
Step 3: Apply Discount Each Performance Year		• Base discount of 3% taken off growth rate and risk-trended baseline • Absolute value of discount decreased by up to 1% based on quality score • Absolute value of discount decreased or increased by up to 1% based on efficiency compared to region • Absolute value of discount decreased or increased by up to 0.5% based on efficiency compared to nation

1) CMMI has indicated that benchmark methodology may be updated for 2019-2020.
2) Next Generation ACO.
3) End-stage renal disease.
4) Performance year.
5) Hierarchical condition category.

Source: CMS, "Next Generation ACO Model: Review of Alignment/ Benchmarking Methodology," April 5, 2015, available at www.innovation.cms.gov; Health Care Advisory Board interviews and analysis.

Summarizing Financial Elements of Benchmark Methodologies

Methodology-Specific Adjustments Have Varying Effects on Value of Benchmark

Impact of ACOs' Market Structures on Dollar Value of Benchmark

	MSSP (First)	MSSP (Subsequent)	NGACO
Trend			
Low-Growth Region	↑	↓	↑
High-Growth Region	↓	↑	↓
Efficiency Relative to Region			
Lower Cost than Region	↔	↑	↑
Higher Cost than Region	↔	↓	↓
Efficiency Relative to Nation			
Lower Cost than Nation	↔	↔	↑
Higher Cost than Nation	↔	↔	↓
Regional Pricing			
Lower Wages and Practice Costs	↔	↔	↓
Higher Wages and Practice Costs	↔	↔	↑

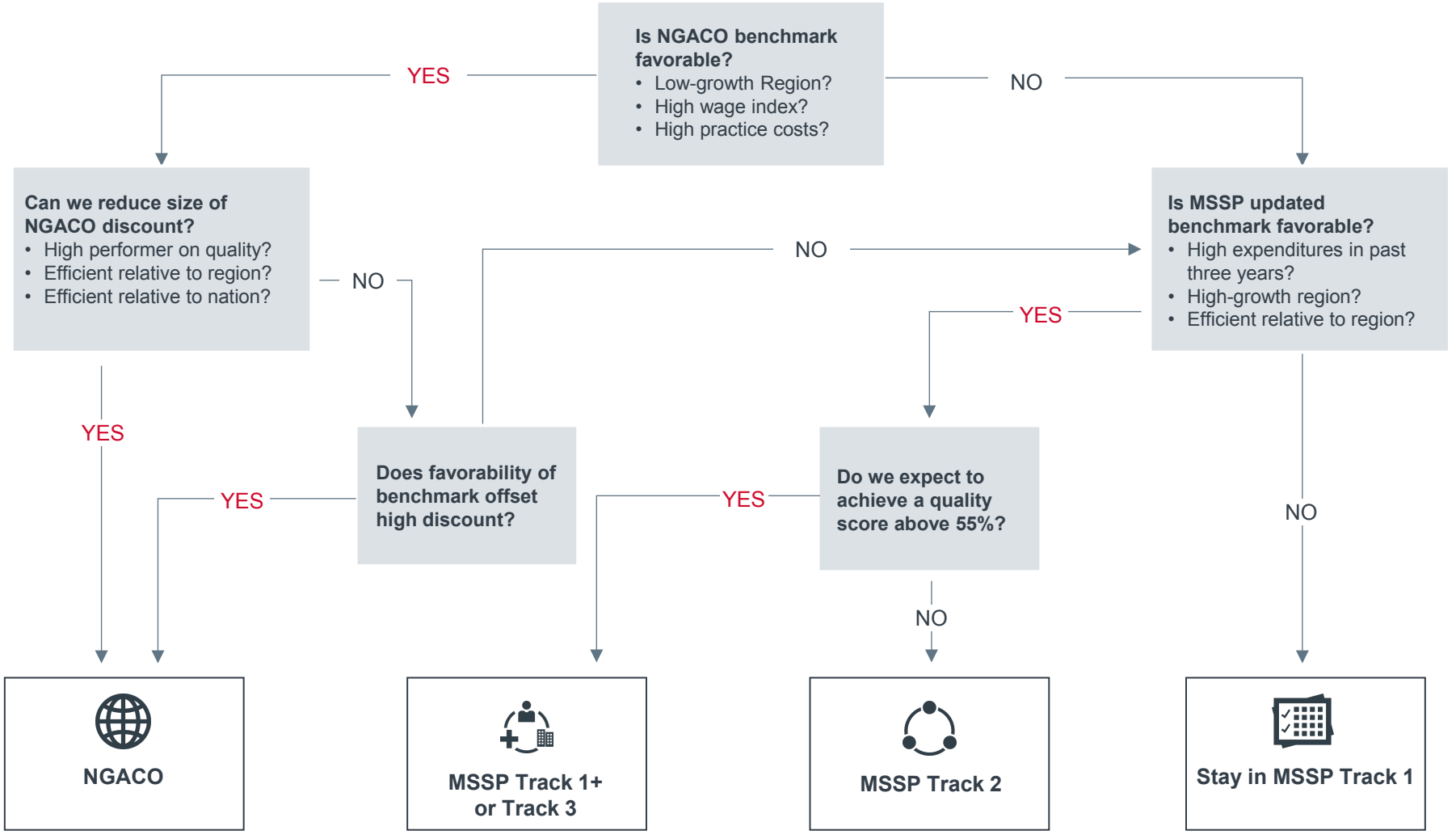
↑ Increases Benchmark

↓ Decreases Benchmark

↔ No Direct Effect on Benchmark

Source: CMS, "Next Generation ACO Model: Review of Alignment/Benchmarking Methodology," April 5, 2016, available at: https://innovation.cms.gov/resources/nextgenaco-2017financial.html; CMS, "Final Medicare Shared Savings Program Rule (CMS-1644-F)," June 6, 2016, available at: https://www.cms.gov; Health Care Advisory Board interviews and analysis.

Decision Guide for Evaluating Downside ACO Models



Source: Health Care Advisory Board interviews and analysis.

Evaluation Guide for Potential MA Plan Partners




	National Payer	Regional Payer	Regional PSHP	Out-of-Market PSHP
Pros	• Access to capital • Access to employer group contracts	• Depth of knowledge, experience with local market	• Shared culture • Established local reputation	• Willingness to partner for mutual market growth • Shared culture
Cons	• Can be inflexible in contract negotiations • National-scale priorities may decrease local focus	• Geographically limited, may limit future expansion	• May lack financial stability, durability if still in early years of operation	• May not provide any brand recognition locally
Examples	• Intercoastal Medical Group/ Aetna • New West Physicians/ UnitedHealthcare	• Steward Health Care System/ Tufts Health Plan • Essentia Health/ UCare	• Eastern Maine Health System/ Martin's Point Health Care • Deaconess Health System/ IU Health	• St. Luke's Health System/ SelectHealth • Optima Health/ OhioHealth

Source: Health Care Advisory Board interviews and analysis.

Picklist of Near-Term Savings Opportunities

Areas of Focus	Sample Opportunities	Advisory Board Resources
Post-Acute Care	• Curate SNF network • Curate home health network • Nurse, hospitalist rounding at partner sites • Implement SNFist program	• Assembling a High-Performing Post-Acute Care Partner Network • 10 Keys to an Efficient Post-Acute Episode • Blueprint for a Successful Post-Acute Network
Drug Spending	• Standardize physician use of Part B drugs (e.g., retinol injections, macular degeneration drugs) • Encourage use of Part D generics	• Health System Specialty Pharmacy • Integrated Pharmacy Models in Primary Care • 5 drug spending trends to pay attention to
Outpatient Spending	• Shift care from HOPD to ASCs • Curate specialty referral network to direct patients to highest-quality, lowest-cost PCPs and specialists	• How to Build ASC Referrals • The role ASCs should play in your value-based care strategy • How to Design the Cost-Effective Clinical Workforce
Hospital Spending	• Shift IP care to PAC setting (e.g., SNF) • Implement palliative care program • Reduce avoidable medical spend (e.g., septicemia) through care standardization • Shift one-day IP surgeries to OP space	• Primer on Avoidable Costs • Regional Cost Driver Tool • Setting the Standard for Patient Care • How to Reduce Avoidable Cost and Utilization

Source: Health Care Advisory Board interviews and analysis.

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