ACO Readiness to Take on Financial Risk in Light of CMS' Final Rule: Pathways to Success

Transforming healthcare and transitioning to value-based delivery are terms that may sound inviting and worthy but can be overwhelming. We've been on a significant journey over the last decade to become more patient-centered and to shift our approach from fee-for-service to value-based payment and delivery models. Many complexities come into play when working to impact outcomes for an empaneled population and perform to benchmarks or higher.

Never fear… no matter where you are on the journey there are many ways to jump in. The important thing is to start and keep forward momentum across your organization.

Evaluating Performance Improvement

A logical first step may be to evaluate current state and performance.

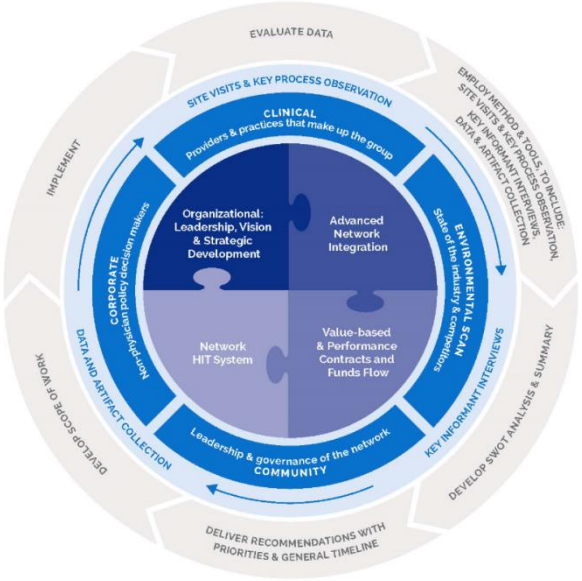
How are we performing overall?

Of all the drivers that impact our performance and ability to succeed in downside risk, where are we strong and where are there opportunities to become better?

What are our organizational challenges?

How do we move forward together from leadership to front-line care delivery?

What problems exist that we don't see?



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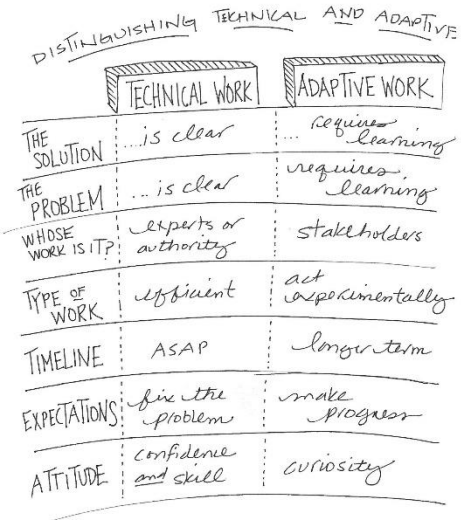
Solving a specific problem, challenge, or dilemma…



OMalley, & Cebula, 2015

No matter how far along you are on the journey to value, there are inevitably sticking points. Challenges that are adaptive in nature and persistent, problems we experience but can't quite diagnose, or problems clearly identified but not yet addressed.

While adaptive challenges require an integrated solution, there are iterative steps to root cause analysis and implementation that result in meaningful progress. In many cases, focusing on one point of pain or one key challenge promotes buy-in, re-energizes your workforce, and builds momentum for the journey.

Below is an example of a focused approach to current challenges in healthcare delivery and payment.

Evaluating Readiness to take on Financial Risk

CMS' recently released final rule Pathways to Success (CMS.gov, 2018) reflects a redesign of ACO options and includes a more rapid transition to performance-based risk. The ACO application timeline (CMS.gov, 2019) is open through the quickly approaching February 19, 2019 deadline for:

- Shared Savings Program (new Basic or Enhanced Tracks)
- Skilled Nursing Facility (SNF) 3-Day Rule Waiver (levels C, D, or E of the Basic or Enhanced Track)
- Beneficiary Incentive Program (BIP) (levels C, D, or E of the Basic or Enhanced Track)

Well-documented results of the Medicare Shared Savings Program (MSSP) revealed low revenue ACOs, including physician-led networks, outperformed high revenue ACOs such as hospital employed systems. However, CMS notes some "…lack a pathway to transition from a one-sided model *(upside risk)* to more modest levels of performance-based risk *(upside and downside risk)* that recognize they typically have less control over the Medicare FFS expenditures for their assigned beneficiaries" (CMS.gov, 2018). Integrated, proactive, coordinated care is essential to taking on accountability in value-based delivery and even more critical when sharing downside risk.

See below for more information on features and characteristics of CMS' new Basic and Enhanced Tracks, and the glide path within the Basic Track.

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	Basic Track (with 5-level glidepath)				Enhanced Track
	Levels A & B one-sided model	Level C *risk/reward*	Level D *risk/reward*	Level E *risk/reward*	Track 3 *risk/reward*
Shared Savings *(once MSR met or exceeded)*	First dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	First dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	First dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	First dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change. First dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses *(once MLR met or exceeded)*	Not applicable	First dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	First dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	First dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program capped at 1 percentage point higher than the benchmark nominal risk amount (e.g., 8% of ACO participant revenue in 2019 – 2020, capped at 4% of updated benchmark)	No change. First dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark
Annual choice of beneficiary assignment methodology?	YES	YES	YES	YES	YES

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Annual election to enter higher risk?	Yes, but new low revenue ACOs may elect an additional year under Level B if they commit to completing the remainder of their agreement under Level E.	Yes.	No; ACO will automatically transition to Level E at the start of the next performance year, except for July 1, 2019 starters that elect to enter at Level D.	No; maximum level of risk / reward under the BASIC track	No; highest level of risk/reward under Shared Savings Program
Advanced APM status under QPP?	No.	No.	No.	Yes.	Yes.
Beneficiary Incentive Program (BIP)	No.	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years
Expanded Telehealth Services	Not applicable.	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years
3-Day SNF Rule Waiver	Not applicable.	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years

Adapted from CMS.gov, 2018

If you are an existing ACO, considering becoming a new ACO, or exploring risk-based commercial contracting there is much to consider. In the context of a comprehensive performance evaluation or as a targeted look at readiness to take on risk-based contracting, the following components are essential.

- *Where do we want to be as an organization?*
- *How do we fit in the transition from volume to value?*
- *Do we have a business model, culture, and leadership skillset that can absorb, manage and succeed in downside risk as we improve outcomes and performance?*
- *Will we establish our own or join an existing Advanced Alternative Payment Model (AAPM)?*

Organizational Culture

Taking on downside risk is a big decision. An organization weighing such a decision should have a clear multi-year strategy that reflects directional consensus and clarity.

While it's important to understand the market around you, what's right for another organization may not be right for you. Ensure you have a clear picture of the current state. If you don't know your current performance and readiness, consider a realistic assessment as a first step. This may be more effective and unbiased if viewed through a third party's eyes. Know your payer mix, current contracting strategies, and performance in those contracting scenarios. One approach may be to evaluate the percent of contracts that fall into each category of the HCP LAN APM Framework Payment Categories (HCP LAN, 2018) as of today.

We assess the overall culture and level of burnout to understand where there may be challenges. Until these are addressed, changing delivery and payment models is likely to further stress the organization. Financial and business acumen and leadership and governance can further enhance or become roadblocks.

- *How do you describe your organization's tolerance for change?*
- *Do you have mechanisms to recognize and address change fatigue?*
- *What competing priorities may distract the organization from fully executing on the vision of the AAPM?*

When thinking of your current contracting, how are you performing? Are you leaving performance bonuses on the table, or are you maximizing coding and able to prove your ability to exceed benchmarks? Looking ahead to more advanced payment models, evaluate the associated financial risk and decide if it is acceptable for your situation and infrastructure. The ability to invest and sustain operations through changes in delivery models requires sufficient capital funding.

Leadership sets an important tone in executing the organization's mission. Influencers and decision-makers alike must be onboard and activated to engage stakeholders. Committee structure can be a cumbersome obstacle to agility but refining the types and accountability of committees will accelerate the work and provide a venue to engage unusual voices and factions.

Care Delivery

Of course, patient and family engagement has been central to improving healthcare performance in models like Patient-Centered Medical Home (PCMH), Advanced Primary Care (APC), and initiatives such as Comprehensive Primary Care (CPC and CPC+), Transforming Clinical Practices (TCPi), State Innovation Models (SIM), and the Hospital Improvement Innovation Network (HIIN). To be successful in accepting accountability for outcomes, a partnership with patients and families cannot be limited to satisfaction surveys, office visits, and customer service. An active partnership integrates patients and families in care redesign, quality and performance improvement, and governance. Designing processes and making decisions around patient's ability to opt-in or opt-out of your AAPM is an insufficient approach to engagement.

- *What is the financial model in which we can best thrive for the long term?*
- *What is our ROI?*
- *What is our financial tolerance to build capacity and infrastructure?*

Other components of care delivery essential when considering downside risk include the organization's effectiveness at change management. Improving competency in value-based delivery and adapting to change should be considered an ongoing initiative and not a one-time event.

Foundational to performance is sure footing in 'baked in' quality and performance improvement (QI/PI) methodologies. QI/PI is not effective in a top-down environment. Interdisciplinary and cross-organizational participation is needed, from front-line delivery staff to data analytics.

As care delivery improvements are made, they must be evidenced with accurate coding and risk adjustment illustrative of the acuity and severity of illness across your population and to secure optimal payment. This is not a one-time audit and adjustment, rather a sustainable programmatic expectation supported by clinical documentation improvement training and coding feedback.

Due Diligence

- *Do we need partners?*
- *What level of integrated services are necessary for successful performance?*

It does not matter if you are trying to get into an AAPM alone or if you want to join an existing AAPM, you still need to do your due diligence, either of your own organization or of your organization and that of the prospective partner.

Due diligence steps should include but may not be limited to gaining a clear market awareness, exploration of alignment between the AAPM and the organization's current transformation, growth, and delivery strategy, current payer mix and payer contract types, and competitor analysis to know what others in your region are doing as patients move across care settings.

While alignment is a common accelerant in many areas including performance improvement, be cautious to avoid shifting payment models without aligning measure strategies and compensation with AAPM goals.

Integrated Delivery Capabilities

- *What is the market / regional need?*
- *What is the competition doing?*
- *What are your population risks and how do they compare to your market's population risks?*
- *What's the market / regional need?*

Fragmentation (the opposite of integration) exponentially elevates the risk of penalty or financial loss in a downside risk arrangement. By nature, fragmentation reduces the visibility and awareness of care provided and needed. When held accountable for quality, safety, and cost of care – fragmentation is crippling. If it's true that you can't manage what you can't measure, it is also true that you can't impact what you can't see or, to some extent, control.

When working toward integrated care, delivery organizations should be thinking about market share. For example, how many primary care practices are needed to make participation in an AAPM a good decision? Which specialties are most important to the needs of our population? Where does it make sense to pursue affiliated relationships with providers and service lines? Reviewing HIE and utilization

data is an important step to validate assumptions or learn how many of your patients are receiving care within your organization and how often they are seeking care elsewhere.

Invest first in infrastructure that will add value even if there are changes in regulatory or market demands. There will be continued emphasis on cost and quality, so create an infrastructure that helps analyze and improve performance. A multi-criterion (ideally automated) risk-stratified algorithm should be applied to empaneled patients to make resource allocation decisions. Said simply, the needs of your population should drive team design. A population health-oriented infrastructure is likely to look a little different than a legacy fee-for-service staffing model. Readiness to take on and perform in an AAPM will require investment in infrastructure, workforce development, HIT and data analytics.

- *What will you do today, next month, next quarter, next year?*
- *How will you engage the team, stay on budget, prioritize and align initiatives to keep everyone moving in the same direction?*
- *How will you mitigate risk to implementation timelines or unexpected investments?*

Strategic Planning

Create a multi-year strategy that keeps you on the path to improving performance and viability. Consensus is communicated via the multi-year strategic plan as the 'how' to achieve your mission and vision under value-based payment models.

Once high-level multi-year and annual strategies are in place, they can be translated to operational and project plans with key milestones, timelines, and iterative implementation. Annual strategies and organizational goals are expressed in balanced performance scorecards, operational plans, working groups, and individual key performance indicators that drive the organization forward.

- *What HIT and analytic capabilities do we have?*
- *What are our gaps?*
- *How are we leveraging and optimizing HIT?*

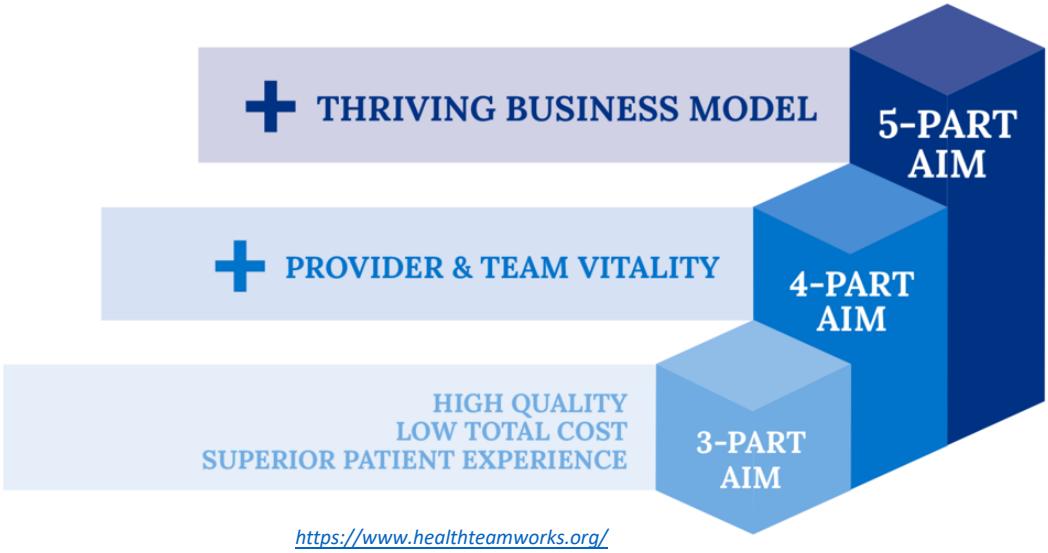
Your annual strategic and operational plan informs project plans implemented leveraging project management discipline. This process must be aligned across all levels of the organization (executive, operational, patient-facing). Chances of success increase greatly when all are swimming in the same direction and when driven by outcome trending rather than technical task lists.

- *How much time do we have to transition and what should be our pace of change?*
- *What are our strengths and gaps in arriving there? I.e. what capabilities do we have and what do we lack?*
- *What are our key stakeholders' goals (patients, providers, payers, employers, community)?*

Performance

While we have focused for some time now on the Triple Aim (better care for patients, improving the health of a population, and reducing the per capita cost of care) and in many cases add the quadruple

aim (provider and care team vitality), it's important, when considering transitioning from volume to value and options for shared risk, to ensure you are also measuring and managing to a fifth aim (thriving business model). You owe it to your teams, patients, and community to achieve good outcomes, provide excellent services, and to be sustainable.



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All of this works together to inform if you are ready for the journey – not just a transition from volume to value but to excel in shared financial accountability, including downside risk, for the care of your patients. CMS' final rule accelerates the need to honestly evaluate current performance and to plan objectively for the future of your organization and the patients you serve.

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