Transitioning Into a Successful Risk-Based ACO

Part 2: How to prepare for risk

June 19, 2018

1pm EST

RELIANCE CONSULTING GROUP

RISK STRATEGIES

Validate HEALTH

PRESENTERS

John Schmitt, Ph.D., FASHCRM
Managing Director
Reliance Consulting Group

Chuck Newton
Sr. Vice President
Risk Strategies

Andrew Webster, M.S., ASA, MAAA
ACO Actuary
Validate Health

AGENDA

I. SPEAKER PRESENTATIONS

- The standoff between ACOs and CMS
- 10 reasons ACOs can fail
- ACO risk management: 5 operational steps
- Key actuarial considerations for success
- Risk protection tools and examples

II. DISCUSSION QUESTIONS AND ANSWERS

III. CLOSE

Heading to the Exit

"(In May 2018) the National Association of ACOs released a survey of 82 ACOs that began in 2012 or 2013, and 71% said they are likely to leave the MSSP if forced to take on more risk."

(Source: "Rather than face risk, many ACOs could leave", Modern Healthcare, May 14, 2018)

The Whitehouse Standoff

Accountable Care Organizations are failing to meet their promise to save Medicare money, and regulations governing the model need to change, according to senior White House officials.

"There are a lot of broken promises and failed estimates in the Affordable Care Act, and the hope and promise of this complicated value design is one of them," Joseph Grogan, associate director of health programs at the White House's Office of Management and Budget, said Wednesday at the National ACO, Bundled Payment and MACRA Summit….

Policy changes are coming to Medicare Shared Savings Programs ACOs via a proposed rule posted on OMB's website. The rule will aim to facilitate ACOs' transition to downside risk, according to a HHS summary of the rule.

(Source: "White House officials call for ACO rule changes", Modern Healthcare, June 7, 2018)

Why ACOs Might Leave

RISK OBJECTIONS

40% The amount of **risk** is too great	40% Concerns about **unpredictable changes** in CMS rules
40% Desire for more **reliable financial projections**	36% Concerns about **past performance**

Source: National Associate of ACOs

Top 10 Reasons ACOs Fail

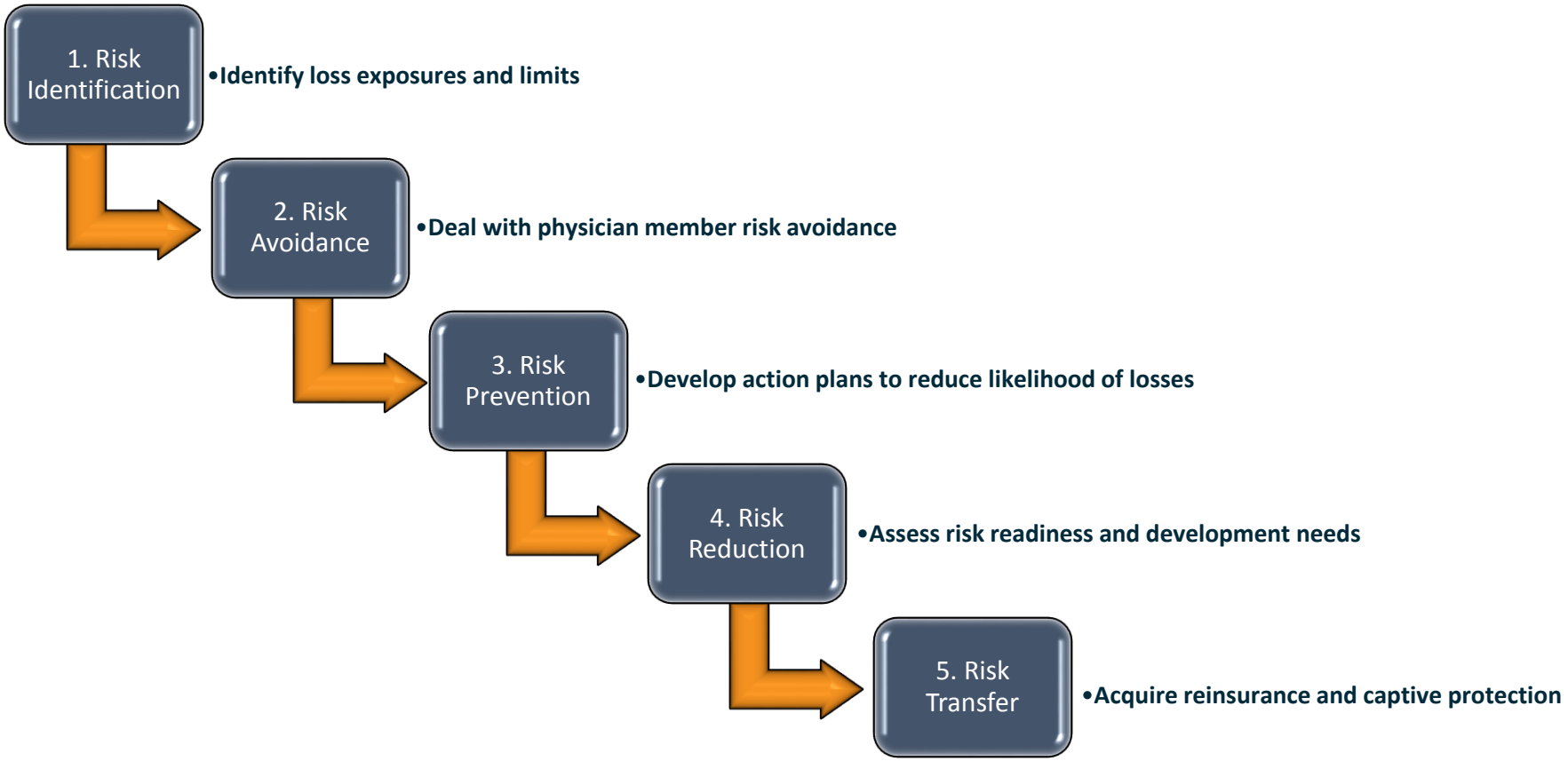
ANY GIVEN ACO CAN FAIL BECAUSE:

1. ACO does not have enough lives to take on risk
2. Lack of training and process improvement
3. ACO lacks accountability and transparency
4. Behavioral and mental health needs not addressed
5. HCC coding is poor and inconsistent
6. ACO patients are not managed better than FFS average
7. Member practices don't have staff to support population health
8. Clinicians can't get data at the point of care
9. Physician members are not on board/engaged
10. ACO cannot execute on quality improvement and reporting

BECKER'S HOSPITAL REVIEW

(Source: Becker's Hospital Review, May 8, 2018)

5 Essential Steps of ACO Risk Management



Step 1: Medicare ACO Loss Exposures and Limits

ACO Type	Shared Loss Rate	Loss Sharing Limit	Shared Savings Rate	Performance Payment Limit
MSSP Track 1	N/A	N/A	50%	10%
MSSP Track 1+	30% of benchmark	Lessor of: 4% of benchmark, 8% of revenue	50%	10%
MSSP Track 2	40%-60%	5% PY1, 7.5% in PY2, 10% in PY3 and later	Up to 60%	15%
MSSP Track 3	40%-75%	15%	Up to 75%	20%
NextGen	80% or 100%; symmetric with shared savings rate	5% to 15%; symmetric with performance payment limit	80% or 100%; symmetric with shared loss rate	5% to 15%; symmetric with loss sharing limit

Step 2: Physician Member Risk Culture Change

PHYSICIAN CULTURE CHANGE (ENGAGEMENT & COMMITMENT)

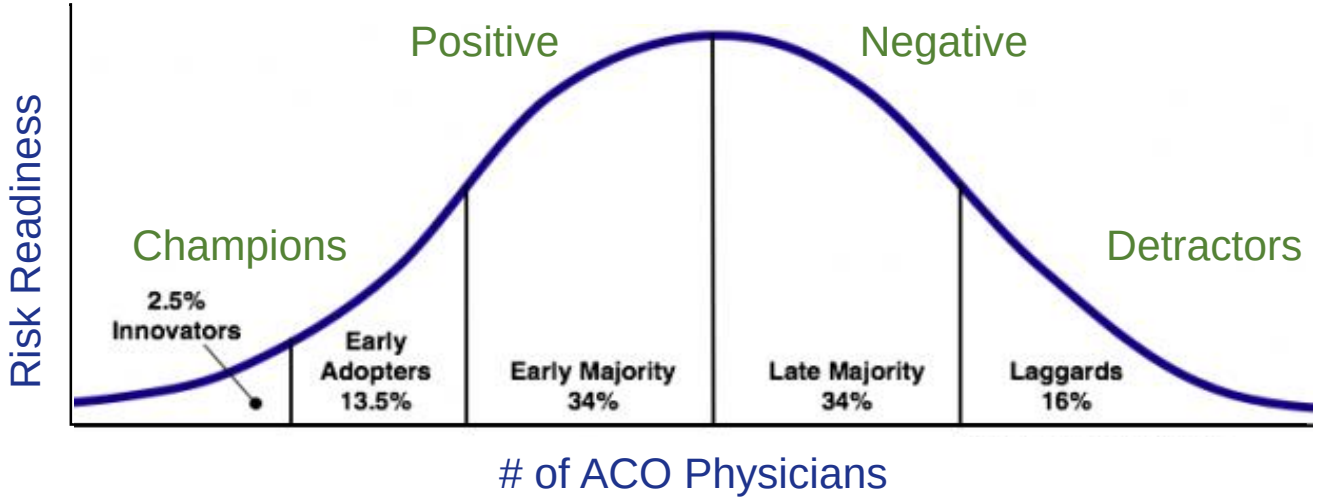
Representation: Governance / Board of directors

Membership: Medical committees

Appointments: CMOs, regional MD directors, MD department chairs

Participation: Operational meetings & conference calls

Commitment: Culture change (risk readiness & incentive compensation)



Step 3: Example Action Plans to Prevent Likelihood of Losses

CENTRALIZED TRANSFER CENTER

Concept	Population	Key Elements	Potential Risks/Barriers
• Centralized Patient Transfer center with one call acceptance of patients based on specialty/ hospitalist pre-defined criteria. • Improved transfer capture will replace bed day capacity created by integrated inpatient management. • Preliminary Financial Impact: $5.6 million based on an average revenue estimate of $3,000 per admission.	• Regional opportunity is preliminarily estimated at over 1,000 transfers annually. • Based on limited data, 1,800 estimate is supported.	• Regional number with one-call acceptance. • Pre-defined criteria for acceptance that hospitalists/specialists will support. • Coordinate/dispatch transportation. • Offer to all regional hospitals including coordination of transfers to other hospitals. • Significant marketing effort required. • All regional transfers managed through Centralized Transfer.	• Inability to secure hospitalist/specialist agreement on acceptance policies. • Objections by other hospitals. • Have to “get it right” or no second chances with hospitals. • Unwillingness of regional (unaffiliated) hospitals to use ACO center because of existing relationships.

Step 4: Risk Reduction By Readiness Assessment

ACO RISK READINESS ASSESSMENT CRITERIA

- Governance/Leadership
- Organizational Culture - Communication
- Relationships with Providers
- Claims Access
- IT System
- Clinical Med Management System
- Financial Risk Management
- Ability to Risk-Share with Providers

Step 4: Risk Reduction By Readiness Assessment

ACO RISK READINESS ASSESSMENT EXAMPLE

CRITIERIA	Development Required	Limited Capabilities	In-Place: Performance Evident
Financial Risk Management			
Medical service expense (MSE) management capabilities			
Processes to assess financial risk			
Cost accounting capabilities across episodes			
Provider-health plan partnerships			

Top Factors Determining ACO Risk Appetite

- Does your past data indicate savings under future rules?
- Do you have hospital participants?
- Are there any planned ACO changes?
- Do you prefer prospective or retrospective attribution?
- Have you explored regional arbitrage opportunities?

Financially Optimize

STRATEGIES BEFORE ENTERING DOWNSIDE RISK

Regional Arbitrage

Assess savings variation by beneficiary county

Participant Selection & Compensation Strategies

Isolate physician variation and negotiate participant contracts

Optimal Track and Contract Parameter Selection

Choose appropriate level of risk in the track, prospective vs. retrospective assignment and minimum savings/loss rate

Benchmark Maintenance

Accurately capture risk score prior to entering downside risk

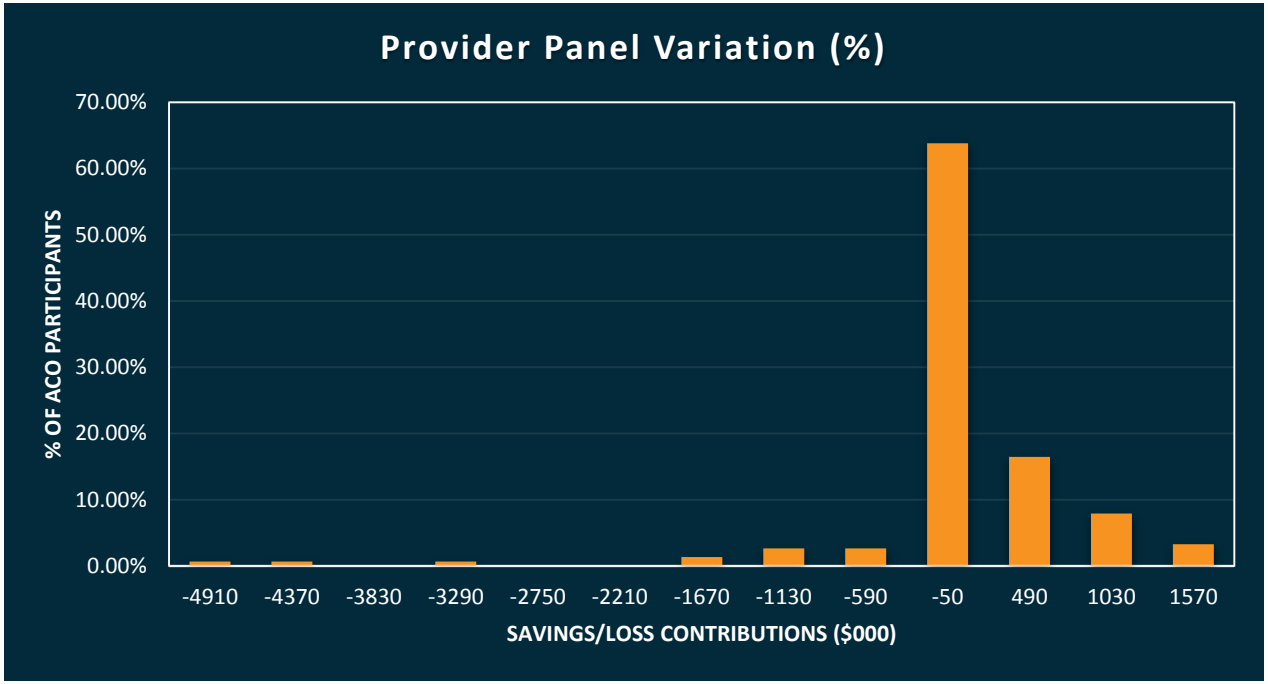
Regional Arbitrage

- Significant regional variation on raw and risk-adjusted bases
- Measure advantages/disadvantages prior to selecting which counties to participate
- Concentrate the ACO in regions with low efficiency/high risk- adjusted cost to reinforce the goals of MSSP

2016 Aged Non-Dual			
State Name	County Name	Per Capita Expenditures	Risk Adjusted Per Capita Expenditures
Illinois	Cook	$10,303	$10,095
Illinois	DeKalb	$9,335	$9,793
Illinois	DuPage	$9,915	$10,225
Illinois	Kankakee	$10,553	$9,665
Illinois	Kendall	$9,696	$10,411
Illinois	Lake	$9,979	$10,220
Maximum Variation		113%	108%

Participant Selection & Compensation Strategies

- Significant variation in participant savings/loss contribution
- Select serious and compliant participants for downside risk
- Consider a bifurcation approach with one upside-only and two-sided ACO



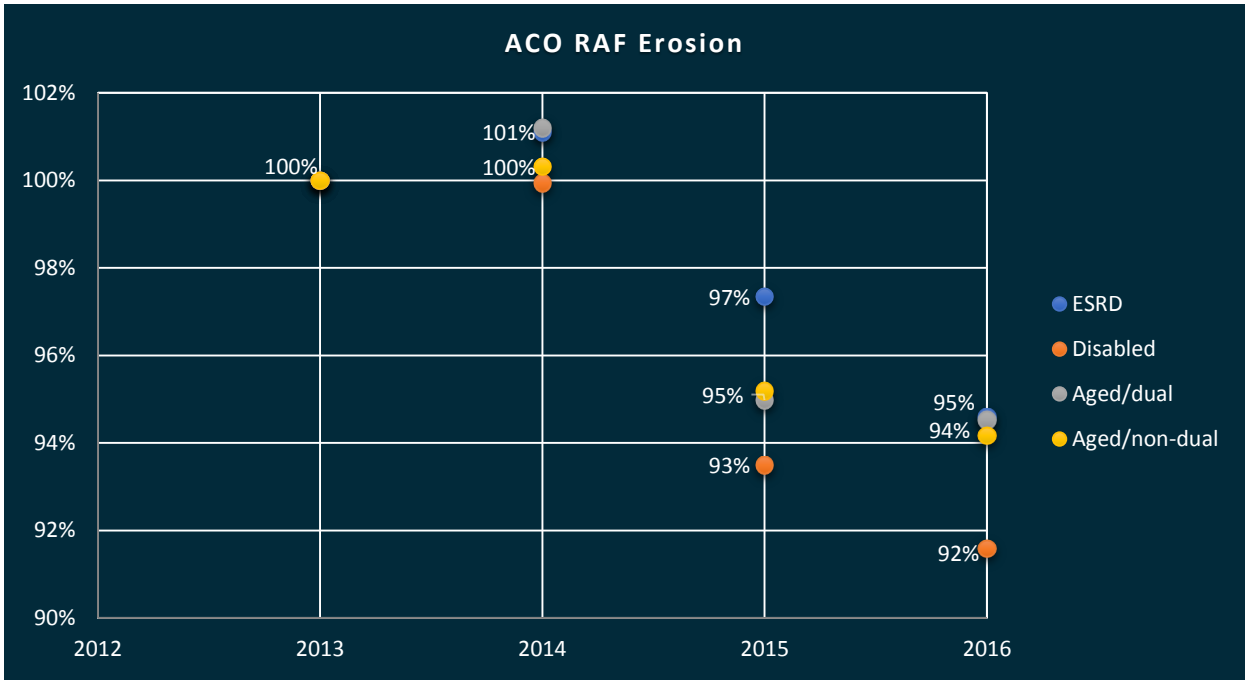
Optimal Track and Contract Parameter Selection

- Physician-led ACOs should consider T1+ due to differential loss limit treatment while qualifying for 5% AAPM bonus under MACRA
- Weigh differences between prospective and retrospective assignment carefully
- Model savings sensitivity to all contract parameters

Probabilities of Risk Corridor Range										
Risk Corridor	Percent of Benchmark			Benchmark $			Probability			Likelihood Ratio
Width	Lower	Middle	Upper	Lower	Middle	Upper	Lower	Middle	Upper	
0.0%	0.0%	0.0%	0.0%	–	–	–	0.68%	0.68%	99.32%	0
0.5%	-0.5%	0.0%	0.5%	($51.55)	–	$51.55	0.49%	0.68%	0.94%	1.3
1.0%	-1.0%	0.0%	1.0%	($103.10)	–	$103.10	0.34%	0.68%	1.29%	1.8
1.5%	-1.5%	0.0%	1.5%	($154.65)	–	$154.65	0.24%	0.68%	1.74%	2.4
2.0%	-2.0%	0.0%	2.0%	($206.20)	–	$206.20	0.16%	0.68%	2.31%	3.1

Benchmark Maintenance

- Savings is highly sensitive to accurate risk score capture
- At least a 2 – 5 year lag before ROI is realized
- Ongoing interdisciplinary effort



Unintended Consequences of Unwinding the ACO

- Loss of program waivers
- Loss of engagement with physician community and favorable treatment under MACRA
- Contracting implications for other payer arrangements (commercial, MA, Medicaid)
- Loss of paid claims data and other information

Insurance Solutions

- Aggregate Stop-Loss
- Specific Stop-Loss
- Surety Bonds
- Bundled Payments Stop-Loss
- Managed Care Errors & Omissions
- Directors And Officers Liability
- Cyber Liability

Aggregate Stop-Loss

- ✓ Provides protection against abnormal frequency of claims in total.
- ✓ Appropriate for MSSP Tracks 1+, 2, and 3 and Next Generation ACOs
- ✓ Also possible for commercial and Medicaid ACOs with 2-sided risk.
- ✓ Cross population aggregates are an option for ACOs with multiple risk based contracts.

Aggregate Stop-Loss

Example - How an aggregate stop loss policy can provide financial protection to an ACO	
ACO Type	MSSP Track 1+
Assigned Beneficiaries	10,000
Performance Year Benchmark - PMPY	$10,500
Performance Year Benchmark - Annualized	$105,000,000
Loss Sharing Limit as a Percentage of Benchmark	8%
Loss Sharing Limit in Dollars	$8,400,000
Aggregate Stop Loss Attachment Point as a Percentage of Benchmark	103.0%
Aggregate Stop Loss Attachment Point in Dollars	$108,150,000
Actual Expenditure - PMPY	$11,214
Actual Expenditure - Annualized	$112,140,000
Actual Expenditure as a percentage of Benchmark	106.8%
ACO Loss Share Rate	30.0%
ACO's Liability to CMS	$2,142,000
Amount Insured through Aggregate Stop Loss	$1,197,000
ACO's Liability Net of Stop Loss Recovery	$945,000

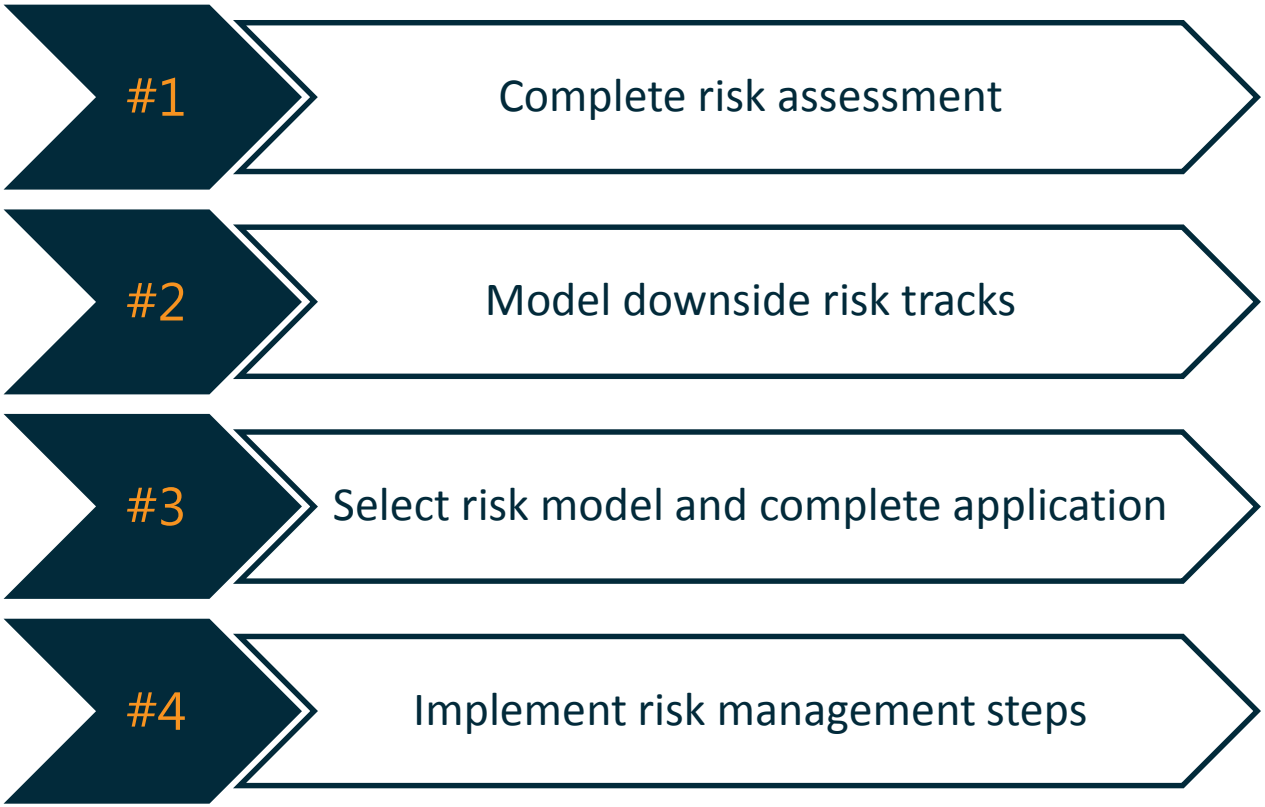
Funding Reserves: Options

Shared loss rates (maximum):

- Joint ventures
- Shared savings retention
- Private equity investment
- Line of credit
- Surety bond
- ACO Malpractice offering
- Other

ACO Risk Readiness: Next Steps

FOUR CRITICAL STEPS



Contact Us

John Schmitt, Ph.D., FASHCRM -- *Managing Director*
Reliance Consulting Group
jschmitt@reliancecg.com
423-304-4343

Chuck Newton -- *Sr. Vice President*
Risk Strategies
cnewton@re-solutions.net
804-647-8360

Andrew Webster, M.S., ASA, MAAA -- *ACO Actuary*
Validate Health
andrew.webster@validatehealth.com
888-507-3870

Q&A

Recording will be available in the library at: www.ACOExhibitHall.com

RELIANCE CONSULTING GROUP

RISK STRATEGIES

Validate HEALTH