Heading Off Disaster: Preparing for a Coordinated Care Organization Closure

Learn how taking a disaster relief approach helped CareOregon prepare for a 40% increase in membership. In one day.

Contributed by Point B

Rarely does the collapse of a Coordinated Care Organization and subsequent movement of thousands of patients from one CCO to another – all within a matter of days – go off without a hitch. But that was the case in the recent closure of FamilyCare Health, a Portland OR-based CCO.

What could have been a catastrophe – moving thousands of patients from one CCO to another literally overnight while ensuring life-critical medicines and procedures were delivered – turned out to be a non-event, thanks to the thoughtful work and dedicated teams across CareOregon, the primary risk-accepting entity of Medicaid managed care for Health Share of Oregon, the largest CCO in the state, and Point B, a management consulting firm focused on not missing a beat during the transition.

CareOregon’s structure and purpose gave it the ability to handle the transfer, ensuring the most vulnerable are cared for during turbulent times. In late 2017, FamilyCare was one of 16 Oregon CCos when it announced in December that it would cease operations, discontinuing its Medicaid managed care plan effective February 1, 2018.

No CCO in Oregon had ever gone out of business, making the move of approximately 120,000 Medicaid patients in a single day to Health Share of Oregon unprecedented. For CareOregon, as the risk-accepting entity, this meant significant safety, operational and financial risks that needed to be addressed in advance of the switch.

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Washington DC Watch

Future of MSSP/Pathways Engenders Hot Debate

“If the Medicare Shared Savings Program had started out the way the Centers for Medicare & Medicaid Services wants it to look in the future, 60% of Accountable Care Organizations in it now probably would not be. While there are many positive changes in the proposed Pathways to Success, there are a number of concerning provisions as well.”

The full-court press continues. Trade groups in the nation’s capital – led by the National Association of ACOs – are turning up the volume on their demands that federal payment policy embrace and invest in product innovation and market development, instead of focusing solely on spending less on improving the population’s health. Here’s a look at recent developments.

NAACOS Comments Include ‘Notable Findings from Recent ACO Poll’

The MSSP boasts 561 ACOs collectively caring for 10.5 million Medicare patients, “and CMS has proposed a number of changes that would make major modifications,” the organization says in a statement.

- The proposal represents “efforts to modernize the program and improve it through providing increased program stability and predictability and allowing more program flexibility and opportunities to engage beneficiaries,” the association says in a 39-page comment letter submitted to CMS.

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- A critical part of any transition is access to data to get an understanding of exactly how many people would be impacted, which patients had critical needs and so forth.
- However, sharing of data in advance of the transition was not an option, meaning project teams needed to create plans based on some guesswork – and fill in the blanks once they had access to data.
- In the absence of critical data and an incomplete picture of the transition population, one of the keys was to accept that CareOregon had to over-prepare as much as possible, so that by go-live, the teams would have thought of everything.

In partnership with Point B and HealthShare of Oregon, CareOregon seamlessly transitioned the FamilyCare members, while creating the necessary visibility to ensure success. “Mobilizing while maintaining existing business and taking care of existing patients while safely transitioning those patients was paramount,” says Mindy Stadtlander, CareOregon’s Executive Director of Medicaid and Network Services.

Operationally, the teams began planning even before they received official word of the transition. With partnership from HealthShare of Oregon, which maintained constant communications to ensure the transition happened effectively, the teams took a disaster management approach wrapped in Agile principles:

They designed proactive strategies and scenarios around what might happen to each area touched by the member transition – from the obvious needs of those members through information technology, pharmacy, the Centers for Medicare & Medicaid Services and beyond.

Accounting for the complexity of internal health plan operations in the face of a significant increase in member volume is challenging. Layering on CCO requirements – its accountability to its provider network, consumers and the state health authority – took a maximum level of coordination. Structurally, the team created a steering group that met every morning to provide updates and stay aligned. Each day the team coordinated clinical/operational teams and executive leaders to plan for the transition and develop project governance, success criteria, metrics and more. The team:

- conducted a readiness assessment to uncover enterprise gaps and strengths
- led teams to develop use case scenarios and surge plans/resource requests
- organized and led cross-functional “tiger teams” leveraging Agile principles
- developed an information systems and business intelligence intake process

Through an explicit “say something” policy that put member outcomes at the forefront, CareOregon team members were directed to say something early if they anticipated any issues, whether or not there was a risk.

Also critical was having a tool in which to capture all FamilyCare membership information for constant communication between CareOregon teams. Clinically, from pharmacy operations to front-line clinical operations, the team identified all the potential major risks that could occur during the 30-day preparation period leading up to the transition; for example, they developed triage plans to ensure the pharmacy stayed intact so patients could get medications, prioritizing life-critical medications such as insulin over acne medication.

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During and after the transition, there were no sentinel member safety events or other compliance issues, with minimal disruption to clinical/operational teams and minimal impact on appeal/grievance and quality scores.

The leadership team created a sense of mission and a spirit of willing engagement, readiness and confidence among front line staff, who were empowered to contribute their insights and needs to the process.

“By taking a disaster relief-type approach combined with project management, we were able to head off what could have been a disaster,” says Amit Shah, CareOregon’s Chief Medical Officer. “We truly feel that had we not been there, who knows what could have happened.”

CareOregon is a non-profit organization providing Medicaid managed healthcare plans to low-income Oregonians. FamilyCare ramped down operations for its Medicaid members and continued its Medicare program, per CMS guidelines.

FamilyCare publicly expressed its concern with its ability to remain sustainability both before and after a state-sponsored actuarial assessment was done to determine its Medicaid reimbursement rates. Whether this is a warning sign for CCOs generally remains to be seen.

CareOregon has a Management Services Agreement in place as the Managed Care Organization health plan for HealthShare members. Point B provided consulting services to help organize and focus CareOregon teams to effectively manage to the complexity of such a large-scale member transition. For more information, contact Lisa Brandli-Johnson at lbrandlijohnson@pointb.com.

Oregon OKs Continued Value-Based Care in Medicaid

Oregon will “continue the transformation of its Medicaid program with a focus on behavioral health, value and social determinants of health in Coordinated Care Organizations,” the American Journal of Managed Care website reports: the state says CCOs have “improved access to primary care, reduced emergency department visits by 50% and saved Oregon $2.2 billion in avoided healthcare costs over five years.”

CCOs have a global budget for behavioral, physical and dental health, with “flexibility to support new models of care,” the website notes. CCOs must meet performance or improvement targets for more than a dozen quality measures using these strategies:

- pay for outcome and value
- shift focus upstream
- improve health equity
- increase access
- enhance care coordination
- engage stakeholders and community partners
- measure progress

Policy changes for CCO contracts starting in 2020 focus on four key areas:

- improving the behavioral health system
- increasing value and pay-for-performance
- focusing SDOH and health equity
- maintaining sustainable cost growth

The new approach “makes CCOs responsible for making 70% of payments to providers under value-based contracts by 2024,” the report adds. Visit ajmc.com/newsroom/.

Washington DC Watch

Future of MSSP/Pathways Engenders Hot Debate ... continued from page 1

- It’s “ready to work with CMS to update the program in a way that works better for the long-term financial future of Medicare without inadvertently forcing ACOs and providers to remove themselves from the bipartisan goal of lower-cost, higher-quality care,” adds Clif Gaus ScD, CEO and President.

- But the NAACOS also emphasizes that it “believes that the speed of CMS’s proposed path to risk and its proposal to significantly cut financial incentives will make participation in this voluntary program untenable for new ACOs.”

So the NAACOS urged CMS to:

- reverse its proposal to reduce the shared savings rate from 50% to 25% for ACOs in shared savings-only or low-risk models and instead to set shared savings rates at 50% for Basic Levels A and B, 55% for Basic Levels C and D and 60% for Basic Level E.

- allow ACOs entering the program to remain in a shared savings-only model for four years, with an additional fifth year available for those that demonstrate superior performance. NAACOS data “shows that of the 142 ACOs that earned shared savings payments in 2017, 36% had losses in one of their first two years of the program, illustrating the need to allow ACOs adequate time to prepare for risk.”

- not finalize the distinction of high- and low-revenue ACOs. “The proposed 25% threshold of ACO participant revenue of total ACO spending for the assigned population appears arbitrary and creates division where none should exist,” the letter adds. “All ACOs should be on the same path to assuming risk.”

- finalize the proposal to enact five-year agreement periods. “Many ACOs want more program stability and predictability,” the NAACOS says, “and shifting to longer agreement periods will enable that.” (continued on page 4)
Comments Support NAACOS Positions

The healthcaredivide.com website took a look at comments posted on the CMS website about the Pathways to Success proposal – which the blog author calls "a controversial plan that would force Accountable Care Organizations to take on more financial risk sooner than originally scheduled." Noting that "the agency now faces the question of how hard and how far to push providers into taking on risk" – and noting as well that "some major industry groups have implied the agency is cracking down on the program in an attempt to kill it, despite the fact ACOs are widely regarded as harbingers of value-based care" – the post, called "Industry on Medicare ACO Plan: Too Much Risk Too Fast," includes these excerpts:

- One commenter wrote: "25% shared savings is too low to support ROI for population health -- change to 40% to 60% range for Basic track" and "lowering the MSR for physician-led ACOs is a great way to get more of them in and moving to risk."
- The American Hospital Association warned CMS that “the proposal would likely result in a significant decrease in MSSP participation,” urging CMS to instead allow ACOs to stay in an upside-only model for three years, a suggestion echoed by the American Medical Group Association in its comments.
- “Even the Health Care Transformation Task Force, a mixed group of industry players that originally applauded the proposed rule, submitted a comment calling on CMS to dial back on forcing ACOs out of upside-risk prematurely,” the blogger wrote. “And the HCTTF encouragement of CMS to adopt a more ‘formal’ program evaluation, writing in its comment that the CMS method ‘underestimates true savings to the Medicare program.’”
- The American College of Physicians commented that it “firmly opposes strict limits” on how long ACOs can remain in a shared savings model; cuts to shared savings rates, the group added, would trigger a “mass exodus.”
- One commenter wrote: “tell @CMSGov ACOs need ROI to survive. Cut shared savings rates in half and you can expect participation rates to drop! ACOs are saving Medicare money. Why mess with a good thing?”

Visit healthcaredivide.com.

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They cited these data in the letter:

- 2017 statistics from the Department of Health and Human Services showing that 472 MSSP ACOs caring for 9 million beneficiaries generated gross savings of $1.1 billion and netted $314 million to the Medicare Trust Fund.
- An actuarial study that found that ACOs saved $1.8 billion from 2013 through 2015 and reduced Medicare spending by $542 million.
- CMS comments that estimate the overall impact of ACOs, including “spillover effects” on Medicare spending outside the ACO program, lowered spending by $1.8 billion to $4.2 billion in 2016 alone.
- Peer-reviewed studies by Harvard University researchers that found that the MSSP saved more than $200 million in 2013 and 2014 and $144.6 million in 2015 after accounting for shared savings bonuses earned by ACOs.

The healthcare-informatics.com website noted in a recent blog post: “It remains to be seen how CMS will respond to the pushback from NAACOS and others of late, though up to this point CMS has taken a firm stance that upside risk-only ACOs have not been effective.”

APG Launches Task Force to ‘Develop Future A-APMs’

America’s Physician Groups reports forming a Risk Evolution Task Force, which it calls “a learning collaborative dedicated to accelerating the volume-to-value movement and supporting the development of the next iteration of Advanced Alternative Payment Models.” APG and Task Force members “are committed to the proliferation of accountable care,” a statement notes, adding: “Data tells an important story: integrated, risk-bearing delivery systems outperform fragmented, fee-for-service systems in cost and quality.”

The Task Force will focus on “the dual purpose of educating and sharing of best practices among its members and advocacy activities focusing on key members of Congress and officials at the Department of Health and Human Services and the Centers for Medicare & Medicaid Services.” It will be led by two APG member Co-Chairs, Melanie Matthews, CEO at Physicians of Southwest Washington, and Niyum Gandhi, Executive Vice President and Chief Population Health Officer at the Mount Sinai Health System.

It will also rely on two national subject matter experts assisting with data analytics and care transition planning, Aneesh Chopra MPP, President at CareJourney and former US Chief Technology Officer, and Eric Coleman MD MPH, Founder of The Care Transitions Program and Professor of Medicine and Head of the Division of Healthcare Policy and Research at the University of Colorado Anschutz Medical Campus.

- Chopra and his team at CareJourney “will provide ACO-level benchmarks defined by the Task Force and derived from its Innovator access to CMS’ national dataset,” the statement notes. CareJourney provides clinically relevant analytics supporting the transition to value “and will provide insights to the Task Force via its Network Advantage market intelligence and benchmarking product.”
- Coleman will be the SME for improving care transitions to reduce hospital and emergency department admissions and re-admissions; he brings 20 years’ experience partnering with care delivery organizations.

The Task Force’s advocacy efforts will be led by Valinda Rutledge, APG’s Vice President of Federal Affairs. APG says it’s “the nation’s leading professional association for accountable physician groups.”

Contact Gaus at 202-640-1898 or at cgaus@naacos.com. Visit healthcare-informatics.com and apg.org.

Becker’s Details a Gross of ACOs

Becker’s Hospital Review names this year’s ‘ACOs to Know’ in effort to ‘highlight ACOs across the country and examine the opportunities for improving quality care and care coordination.”

Here are 649 Accountable Care Organizations across the US, according to the National Association of ACOs, including Medicare ACO program participants and independent ACOs, and Becker’s Hospital Review – a monthly offering business and legal news and analysis for hospitals and health systems – picked 144 to profile. The editorial team there accepted nominations for the list and “conducted independent research;” the complete list includes a profile of each ACO.

Becker’s notes that the list is not an endorsement.

Here’s a breakdown by state, ranked by most ACOs on the list.

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Texas: Baylor Scott & White Quality Alliance, Methodist Alliance for Patients and Physicians, Southwestern Health Resources and Tenet Healthcare, Dallas; Rio Grande Valley ACO Health Providers, Donna; Accountable Care Coalition of Texas, Memorial Hermann ACO and Mid-Atlantic Collaborative Care, Houston; Christus Health Quality Care Alliance, Irving; UMC Accountable Care, Lubbock; Rio Grande Valley Health Alliance, McAllen

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## Becker’s Details a Gross of ACOs … continued from page 5

### Ohio
- NewHealth Collaborative, Akron; Adena Healthcare Collaborative, Chillicothe; Healthcare Solutions Network and Mercy Health Select, Cincinnati; Cleveland Clinic Medicare ACO and University Hospitals, Cleveland; OhioHealth Venture and Partners for Kids, Columbus; University Hospitals Coordinated Care Organization, Shaker Heights; ProMedica Health Network, Toledo.

### Florida
- Accountable Care Options and Bethesda Health Quality Alliance, Boynton Beach; Millennium ACO, Fort Myers; Broward Guardian, Hollywood; Baptist Physician Partners ACO, Jacksonville; Adventist Health System ACO, Maitland; Collaborative Care of Florida, Orlando; Palm Beach ACO, Palm Springs; West Florida ACO, Trinity

### Illinois
- Amita Health Accountable Care Organization, Arlington Heights; Rush Health, Chicago; DMH Health Network, Decatur; Advocate Physician Partners Accountable Care, Downers Grove; Ingalls Care Network, Harvey; Northwestern Medicine Physician Network, Oak Brook; OSF HealthCare System, Peoria; Mercy Health Corp. ACO, Rockford; HSHS ACO, Springfield

### New York
- Montefiore ACO, Bronx; CareMount ACO, Chappaqua; ProHEALTH Accountable Care Medical Group, Lake Success; Northwell Health ACO, Manhasset; NYC Health + Hospitals, Mount Sinai Care and New York Quality Care, New York City; Rochester Regional ACO; Healthy Communities ACO, Suffern

### New Jersey
- AllCare Health Alliance, Camden; Hackensack Meridian Health, Edison; Princeton HealthCare Partners, Lawrenceville; Atlantic Accountable Care Organization, Morristown; Robert Wood Johnson Partners, New Brunswick; ColigoCare, Paramus; Optimus Healthcare Partners, Summit; Capital Health Accountable Care Organization, Trenton.

### Massachusetts
- Lahey Clinical Performance ACO, Beverly; Boston Accountable Care Organization; Partners HealthCare, Needham; Southcoast Accountable Care Organization, New Bedford; Atrius Health, Newton; Pioneer Valley Accountable Care, Springfield; Beth Israel Deaconess Care Organization, Westwood

### Wisconsin
- ThedaCare ACO, Appleton; Bellin Health Partners, Green Bay; UW Health ACO, Madison; Accountable Care Coalition of Southeast Wisconsin, Accountable Care Organization of Aurora and Aurora Accountable Care Organization, Milwaukee; ProHealth Solutions, Waukesha

### Maryland
- LifeBridge Health ACO and MedStar Accountable Care, Baltimore; Aledade, Bethesda; BetterCARE Partners, Hagerstown; Frederick Integrated Healthcare Network; Johns Hopkins Medicine Alliance for Patients, Glen Burnie

### North Carolina
- Carolinas HealthCare System ACO, Charlotte; Triad HealthCare Network, Greensboro; Coastal Plains Network, Greenville; CHESS, High Point; UNC Senior Alliance, Morrisville; WakeMed Key Community Care, Raleigh

### Pennsylvania
- St. Luke’s Medicare ACO, Bethlehem; Genesis HealthCare ACO, Kennett Square; Children’s Hospital of Philadelphia and Einstein Care Partners, Philadelphia; Physician Partners of Western PA, Pittsburgh; Delaware Valley ACO, Villanova

### California
- National ACO, Beverly Hills; Adventist Health Accountable Care, Glendale; Heritage California ACO, Northridge; Torrance Memorial Integrated Physicians; John Muir Health, Walnut Creek

### Michigan
- Physician Organization of Michigan ACO, Ann Arbor; DMC ACO and Henry Ford ACO, Detroit; Trinity Health ACO, Livonia; Beaumont Accountable Care Organization, Southfield

### Tennessee
- Maury Regional Health Network, Columbia; AnewCare, Johnson City; Qualauable Medical Professionals, Kingsport; University Health ACO, Knoxville; Ascension Care Management, Nashville

### Virginia
- Signature Partners, Falls Church; Central Virginia Accountable Care Collaborative, Lynchburg; Riverside Health Source, Newport News; Richmond Good Help ACO; Hampton Roads Good Help ACO, Suffolk

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Becker’s Details a Gross of ACOs … continued from page 6

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<th>State</th>
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LAN Progress Update: ‘Adoption of APMs Continues to Increase’

The Health Care Payment Learning & Action Network report “also details the need for additional progress in moving to payments with risk.”

A new report shows that 34% of US healthcare payments in 2017 were tied to Alternative Payment Models – shared savings, shared risk, bundled payments and population-based payments – “increasing at a steady pace from 23% over a two-year span.” The report, from the Health Care Payment Learning & Action Network, also shows this breakdown of healthcare dollars into the four categories of its Refreshed APM Framework:

- 41% in Category 1 (fee-for-service, no link to quality & value)
- 25% in Category 2 (FFS, link to quality & value)
- 34% in Categories 3 (APMs built on FFS architecture) and 4 (population-based payment)

The LAN is a public-private partnership, launched in March 2015 by the US Department of Health and Human Services, with a mission to “accelerate the healthcare system’s transition to APMs that pay providers for improved health and lower costs.”

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LAN Progress Update: ‘Adoption of APMs Continues to Increase’ ... continued from page 7

This is the first time the Measurement Effort included findings at the payment or subcategory level; "notably," the report says, "most of the spending tied to Category 3 and 4 APMs falls in the Framework’s 3A category, which focuses on shared savings."

Only 12.5% of payments were made in Categories, 3B, 4A, 4B and 4C combined. "Therefore, there are additional opportunities to increase payments through episode- and population-based payments that have additional risk," the report adds.

Overall, it says, "there is sustained, positive momentum in the effort to shift payments from traditional fee-for-service into value-based payments."

This report also is the first with payment data by line of business — commercial, Medicaid, Medicare Advantage and FFS Medicare – rather than across lines of business only. The Effort includes FFS Medicare data and data from 61 health plans and three FFS Medicaid states, representing 77% of US covered lives.

“When comparing APM adoption across different market segments,” the report points out, "it is clear which markets are driving the overall adoption of value-based payments."

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CMS Original Payment Model

Category 4
Population-Based Payment

Category 3
APMs Built on Fee-for-Service Architecture

Category 2
Fee for Service – Link to Quality & Value

Category 1
Fee for Service – No Link to Quality & Value

Payments are based on volume of services and not linked to quality or efficiency.

At least a portion of payments vary based on the quality or efficiency of health care delivery.

Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.

Payment is not directly triggered by service delivery so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 year).

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LAN Progress Update: ‘Adoption of APMs Continues to Increase’ … continued from page 8

- Medicare Advantage had 49.5% of healthcare dollars in Categories 3 and 4.
- FFS Medicare had 38.3% in those categories.
- The commercial line of business had 28.3%
- Medicaid had 25%.

The Updated APM Framework

Visit hcp-lan.org.

Payment Reform Goals

Visit hcp-lan.org.
Thought Leaders’ Corner

Each month, Accountable Care News asks a panel of industry experts to discuss a topic suggested by a subscriber. Here’s this month’s question, and here are our experts’ answers.

Q Recent RAND research found that ‘many physician practices still lack the skills and experience with data management and analysis needed to perform well in Alternative Payment Models.’ What one thing – if cost were not an issue – could payers do that would provide the most help to doctors in gaining those skills and experience?

"I’ve spoken with a lot of physician groups (some that are succeeding in Alternative Payment Models and some that aren’t) and have gained significant insights into the skills set that leads to winning in this market. In my experience, the physician groups that are not successful do not lack data management and analysis skills – physicians are inherently very good data scientists and value statistical analysis because of their extensive scientific training. The reasons these groups are struggling fall into two categories:

1. Inability to operate in a mixed business model that is in transition. The transition from fee-for-service to pay-for-performance and other APMs is not easy to manage. In addition, most physician groups are balancing multiple types of contracts. Clinicians struggle to operate in ambiguity with conflicting performance measures, unlike major corporations in the business world.

2. Lengthy time horizons. Most investments in data management and analysis require process re-engineering and assessment that stretches up to 3 years. This is the amount of time that is necessary to measure the impact of any data-driven intervention programs, which is so contrary to what physicians are inherently trained for. They like immediate results. So they don’t invest in analytics or give up on data management initiatives too quickly.

If the independent physician groups cannot acquire these new skills sets and learn to operate in a more ambiguous environment, then they should join an Integrated Delivery Network or a payer-driven provider network. These sorts of networks provide clarity to physicians’ incentive systems based on APM contract performance and a unified vision for all the physicians involved. It makes the transition easier to stomach."

Jay Reddy  
CEO  
Vitreos Health  
Plano TX

"With data everywhere, it’s very discouraging for physicians to have to practice at a disadvantage because no one has sat down to show them how to use this data to qualify as an Advanced-Alternative Payment Model and get out of the Merit-Based Incentive Payment System. Conceptually, physicians must accept the goals for Medicare and other payers to move providers to taking risk. This has been talked about since 1974, and Medicare is a main market mover because of its tremendous influence over the individual physicians and the delivery networks that they must form to leverage this data to their advantage.

Payers make this more complicated than it has to be. Simply stated, each payer has its own set of data points it wants reported by individual physician offices. In some cases, this data is either irrelevant to that practice or the way the insurance company comes at it is very complicated. If payers standardized reporting, they would get more data and better cooperation. Practices may have seven Medicare Advantage contracts and an Accountable Care Organization, but reporting of each population segment is different. This does not benefit anyone and adds to the physicians’ burden of work and their opinion that managed care is the enemy.

The other way we have worked with physicians to fix the data problem is having them form a Management Services Organization. The MSO centralizes all data reporting and billing, which is a real advantage to the managed care organization. The MCO could offer to invest in the MSO startup, so the physicians could buy a good data platform and a staff person to run it. The managed care company does not need to own it. It’s simply a loan that the doctors pay back as part of the fees they charge the MCO for renting the network and offering the physicians an increased reimbursement for joining. Once paid off, the MCO continues to be a source of revenue to the MSO, but the MSO becomes property of the physicians.

Also, remember that as an A-APM, the physician receives a 5% increase in Medicare payments, so this can be a worthwhile proposition long term. For an insurance company to set up and launch an Independent Practice Association-like network of physicians would cost the insurer at least $550,000. But to ask physicians to do this themselves in exchange for a $75,000 grant and a $250,000 loan can make sense because a 20-member physician network bound through central contracting and preparing standardized reports for the payer and/or payers will save a lot of money versus trying to do this office-by-office.

This has been tried in several markets where physicians see the value of the data to improve their own offices by getting reports from their own MSO versus the insurer spending time critiquing the provider performance. There are incentives built into this kind of a solution that lets the physician peer pressure and innovation get better results for the MCO than they can do by themselves."

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CEO & President, DeMarco and Associates Inc.  
Rockford IL & St. Paul MN

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UnitedHealth Developing EHR-Esque Solution With ‘Baked-In Analytics’

William J. DeMarco MA CMC refers to a recent post on the fiercehealthcare.com website to enhance his comments. Here are excerpts:

- “Its plans are still shrouded in ambiguity, but UnitedHealth is poised to launch its own version of an electronic medical record – what CEO David Wichmann called a “fully integrated and fully portable individual health record that delivers personalized next best health actions to people and their caregivers.”
- UnitedHealth comments also indicate the solution will “have some kind of baked-in analytics.”
- The post quotes “industry insiders” as saying that “it’s unlikely UnitedHealth is going after the traditional EHR market,” adding that “more likely, the company is focused on an ‘Apple-type strategy,’ doing this for the consumer play and the consumer issues.”
- The company is “using Rally as its jumping-off point,” a platform it bought in 2017; and “several other acquisitions over the last decade could play a role in the new offering” – including Humedica, CentriHealth, Axolotl and Picis.
- Experts have doubts about “issues around usability and interoperability.”

Access the article, “EHR, PHR or something in between? UnitedHealth’s tech venture prompts skepticism and intrigue,” at www.fiercehealthcare.com.

Industry News

MassHealth Opts for MAeHC to Provide Technical Assistance to ACOs

The Massachusetts eHealth Collaborative, which “works alongside providers to support the meaningful adoption of health information technology,” reports being selected to provide technical assistance to MassHealth Accountable Care Organizations and Community Partners. MAeHC won a master contract from the MassHealth Delivery System Reform Incentive Payment technical assistance program, a new initiative to support ACOs and Community Partners in improving health outcomes and experience for Medicaid patients. MAeHC was chosen to provide support across all nine domains of the program:

- strategies for value-based payments
- care coordination/integration
- community-based care and social determinants of health
- consumer engagement
- flexible services
- HIT/Health Information Exchanges
- performance improvement
- population health management
- workforce development/training

MAeHC will “draw from its successful track record of integrating with ACOs and years of experience in ACO clinical quality reporting,” a statement says. It will partner with Cognizant on the financial aspects of the TA program “to offer ACOs an end-to-end technology solution.”

“As part of the MassHealth DSRIP TA program, an online marketplace has been created “to help MassHealth ACOs and CPs easily search for, request and secure technical assistance,” the statement adds; the MA DSRIP Technical Assistance Marketplace was co-created by the Commonwealth of Massachusetts’ Medicaid and Children’s Health Insurance Program and contractor Abt Associates Inc. MAeHC is a non-profit services firm that delivers strategic guidance, project management, data warehousing and analytics services and hands-on implementation support. Visit maehc.org.

Catching Up With Mara McDermott JD MPH …continued from page 12

Coalition Aims to Boost NGACOs

The Next-Generation ACO Coalition, “a strong and experienced group,” says it will “identify opportunities for members to shape the Next Generation ACO program to ensure it meets the needs of a delivery system transitioning to higher levels of accountability for both financial and health outcomes.” Specifically, the Coalition plans to “focus on developing elements of future payment policy, network design and beneficiary engagement.” Members will also continue their individual dialogues with the Centers for Medicare & Medicaid Services and the Center for Medicare & Medicaid Innovation “to address issues related to the program’s stability and transparency.” The Next-Gen ACO program is “a performance-based risk model in which groups of doctors, hospitals and other providers come together to provide care to traditional Medicare populations; in it, ACOs take downside risk in exchange for regulatory flexibility.”
Catching Up With ….

Mara McDermott JD MPH
Executive Director
Next-Generation ACO Coalition
Washington DC

McDermott’s Coalition was formed to advocate for the preservation and expansion of the Next-Generation ACO program, “which has benefited individuals, communities and federal payers since its establishment by the Center for Medicare and Medicaid Innovation in 2016.”

Accountable Care News talked to McDermott about passion projects and making the NGACO program permanent.

Accountable Care News: Tell us about your professional journey, from university through your current situation. Is it anything like the journey you imagined when it started?

Mara McDermott JD MPH: I grew up on the East Coast, but I went to UC Davis to pursue competitive gymnastics. After college, I moved back home to the DC area and did a combined Master’s in Public Health and law degree at the George Washington University. From there, I went to a law firm, where I practiced in the healthcare regulatory group, working with health industry clients. While I was at the firm, I started work in the delivery system reform space, beginning with the provisions of the Affordable Care Act. I left the firm to open the Washington DC office of a professional association representing physician organizations practicing capitated, coordinated care. My work continued to focus on the delivery system – the intersection of the payment models and the delivery of care, and specifically what that means for physicians and their patients. After five years with the association, I moved to my current position at McDermott+Consulting, where I work with health industry clients on policy and strategy, particularly in the Medicare space. The Next-Gen ACO Coalition is a passion project, allowing me to continue to work on behalf of the providers who are truly transforming the delivery of care in their local communities.

ACN: What made this the right time for an advocacy organization specific to Next-Gen ACOs? What needs to be said that isn’t being said now? What’s the first big accomplishment you’re aiming for?

MM: The Next-Gen ACOs are the leading cohort of Accountable Care Organizations in terms of taking on financial risk and redesigning care in their communities. It is the most advanced of the population health models in the traditional Medicare portfolio. However, due to its relatively small size – 51 participants – the program has not received the attention we feel it deserves. The participants in this program are transforming their local care delivery systems and building the infrastructure for the future. We are excited to share their experiences and use the Coalition to help them continue their leadership in the value movement.

ACN: How will NGACOs evolve in the near and long terms? Do you see entirely new entities emerging? Will they stay largely the same? Where are performance-based payment models headed?

MM: A lot of this depends on the work of the CMS Innovation Center and the NGACOs themselves. As new models come out, NGACOs are likely to have additional options for participating in performance-based risk. For example, we anticipate a model in the near future that involves direct provider contracting. That type of model may be attractive for some NGACOs and unattractive for others. That type of progression would be very organization-specific. At the same time, we are hopeful that the successes of the NGACO program would make it a candidate to become a permanent part of the Medicare program, allowing organizations to continue their participation in that model and allowing new entrants to move up the risk ladder from MSSP into Next-Gen over time.

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