Listening Session 1: *Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models*

Presenters:

Subject Matter Experts

- **Clif Gaus, ScD, MHA** – Past President and Chief Executive Officer, National Association of ACOs
- **David Johnson, MD, MPH** – Assistant Professor of Urology, University of North Carolina, and Clinical Operating Partner, Rubicon Founders
- **Angelo Sinopoli, MD** – Executive Vice President of Value-Based Care, Cone Health
- **Dan Liljenquist, JD** – Chief Strategy Officer, Intermountain Health

Listening Session 1: ***Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models***

Clif Gaus, ScD, MHA

Past President and Chief Executive Officer,
National Association of ACOs

Approaches for Determining and Improving Predictability of Benchmarks

Clif Gaus, ScD

Past President and CEO, NAACOS

About NAACOS

500+
ACO MEMBERS

9.5M
BENEFICIARY LIVES IN MEMBER ACOS

76%
OF ACOS ARE NAACOS MEMBERS

160+
PARTNER ORGANIZATIONS

THOUGHT LEADERSHIP

NAACOS works to advance and promote coordinated, patient-centered, value-based care through research, publications, and other forms of thought leadership.

EDUCATION

NAACOS offers a variety of educational webinars, conferences, and other events to help value-based care entities stay up-to-date on the latest developments in the field and learn from experts and peers.

ADVOCACY

NAACOS advocates through various means, such as engaging with policymakers, participating in rulemaking, collaborating with other organizations, and communicating with the public.

Founded in 2012, the National Association of ACOs (NAACOS) is a member-led and member-owned nonprofit helping ACOs succeed in efforts to coordinate and improve the quality of care for their patient populations.

Over a Decade of Success

Over **13 million** traditional Medicare beneficiaries in value models

More than **700,000 clinicians** participating in APMs, with more than **75%** now participating in two-side risk models

Payer-provider negotiated APM arrangements are growing in Medicare, Medicare Advantage, Medicaid, and Commercial

Since 2012, ACOs have saved Medicare **$28.3 billion** in gross savings and **$11.1 billion** in net savings (**85%** saved Medicare money in 2023)

Cost growth has slowed, actual Medicare/Medicaid spending in 2022 was **9% lower** than projections due to better management and technology

100% of ACOs met quality standards with most having high performance on measures focused on keeping patients healthy-- diabetes control, cancers screening, falls risk, statin therapy for cardiovascular conditions, depression screening and follow-up

Provider Adoption Challenges

- Misaligned incentives– remaining in FFS can be the stronger financial option
- Investment required to transition to value
- Burden associated with quality reporting
- Inadequate budgets (benchmark) to manage patient population

Benchmark Challenges Stall Participation

Goals

- Set a budget for treating the patient population– historical spending or rate books based on average FFS spending in region
- Account for individual patient factors- HCC capture clinical risk; emerging approaches to account for other patient factors like income and health related social needs
- Offer an opportunity for the accountable entity to reduce costs and share in the cost reduction
    - The reduction in costs can be reinvested in provider payment, technology and other infrastructure, expanding care teams, etc.
- Account for changes in spending patterns from when benchmarks are set

Challenges

- Varying approaches across ACOs and MA require providers to manage to programs rather than patient
- ACOs held to stricter financial performance expectations without approaches like narrow networks or utilization management
- Reducing opportunity to generate shared savings impacts reinvestment in care, provider payment, technology adoption

Setting Benchmarks

	MSSP	ACO REACH	MA
Benchmarks	• 3 years of historic spending • Adjusts for regional expenditures • 1/3 is prospective trend • Prior savings adjustment • Health Equity Adjustment • Accountable Care Prospective Trend (ACPT) – prospective trend factor for new contracts in 2024	• Prospective blend of historical spending and adjusted MA Rate Book • Health equity benchmark adjustment • Retrospective trend adjustment	• County-level FFS spending • Plans bid to provide coverage of services • When bids are below benchmark, plans receive a rebate • Increased for Star Rating 4+ • Prospective Trend Adjustment
Risk Adjustment	• Prospective HCC risk score • Positive adjustments subject to a 3% cap per agreement period • Demographic risk scores changes applied before 3% cap	• Risk adjusts historical baseline, regional expenditures, and capitated payments • Concurrent model used for High Needs track • Coding Intensity Factor	• Multiple opportunities to updating coding contributing to risk score
Shared Savings Approach	• ACOs earn a percent of savings if spending is below benchmark • Savings rates range from 40% to 75%, increasing with risk	• Professional: 50% savings rate • Global: 100% savings rate after discount	N/A

Benchmark Challenges

Setting the Benchmark

- Use of historical spending leads to a “ratchet effect” where the accountable entity is penalized for successful performance
- MSSP has implemented adjustments (regional spending, prior savings adjustment, trend factors) to counter but they remain insufficient
- Use of Rate Books will be difficult as FFS population continues to decrease
- Potential solutions: improving current adjustments, administratively set benchmarks

Accounting for Changes in Spending with Trend Factors

- Prospective trends create certainty but can be inaccurate (e.g., MSSP ACPT is significantly lower than changes in national spending)
- Retrospective trends create uncertainty (e.g., ACO REACH was modified to create guardrails to provide more certainty for RTA)

Risk Adjustment to Account for Patient Population Factors

- HCC scores are used across programs but applied differently (caps on the accountable entity, program caps, additional opportunities to capture risk scores)
- There is need to consider other patient factors, but current approaches are limited and need additional development

In Conclusion

- Make benchmarks more predictable and stable
- Allow for adjustments when predictions fail
- Provide ACOs a more level playing field with MA by adopting an improved risk adjustment model and rewarding, not penalizing for quality
- Improve the ACO business case to grow the beneficiaries and preserve the traditional Medicare option for beneficiaries
- Increase the inclusion of past savings in new benchmarks to avoid ratcheting down until administrative benchmarks are fully implemented

Challenges

	Challenges	Solutions
Historic Benchmarks	• Basing benchmarks on historic spending creates a "ratchet effect" over time • MSSP implemented a prior savings adjustment to bolster benchmarks, it is insufficient to counter ratchet • Regional adjustment that includes ACO patients creates "rural glitch"	• Remove historic spending altogether and rely solely on a rate book-style approach; challenges remain with dwindling FFS population • Improve prior savings adjustment by increasing and allowing combination of regional adjustment and prior savings adjustment • Remove ACO-assigned beneficiaries from the regional comparison groups

Trend Adjustment	• Prospective trends can be inaccurate
	  • ACPT is 3.6% yet national expenditures are 9%
	• Retrospective adjustments in ACO REACH create uncertainty
	  • Negative RTA led to need for caps
	  • In 2024 caps are negatively impacting providers
		• Reconsider need for prospective trends within MSSP
		  • Remove ACPT for 2024
		  • Consider regional administrative trends
		  • Guardrails for when trends are inaccurate
		• More transparency on RTA and revisit guardrails

Challenges

	Challenges	Solutions

Risk Adjustment	• Limited opportunity to adjust for changing clinical risk of population
	• Burden of collecting codes for risk adjustment is onerous and impacts certain providers who have not historically risk coded (e.g., FQHCs, RHCs)
		• Address current risk track issues
		  • Raise the 3% cap on risk scores in MSSP; consider replacing cap with audits
		  • CIF for REACH?
		  • Consider a concurrent risk adjustment model for all REACH tracks and MSSP
		• Explore other risk adjustment approaches and align across programs

Other Patient Risk Factors	• Current approaches rely on duals, LIS, ADI are limited • Limited opportunity to receive • MSSP ACOs receive the higher of the heath equity adjustment, prior savings adjustment or regional adjustment	• Inclusion of HSRN in risk adjustment approaches • Avoid limitations on benefitting from accounting for other patient risk factors

Listening Session 1: ***Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models***

David Johnson, MD, MPH

Assistant Professor of Urology, University of North Carolina, and
Clinical Operating Partner, Rubicon Founders

Role of Conveners in Increasing Participation in PB-TCOC Models

David Johnson, MD, MPH
Clinical Operating Partner, Rubicon Founders
Associate Professor of Urology, UNC Chapel Hill
Former Medical Director of Value Transformation, Blue Cross Blue Shield of North Carolina

View are my own and do not necessarily represent the views of any current or past employers

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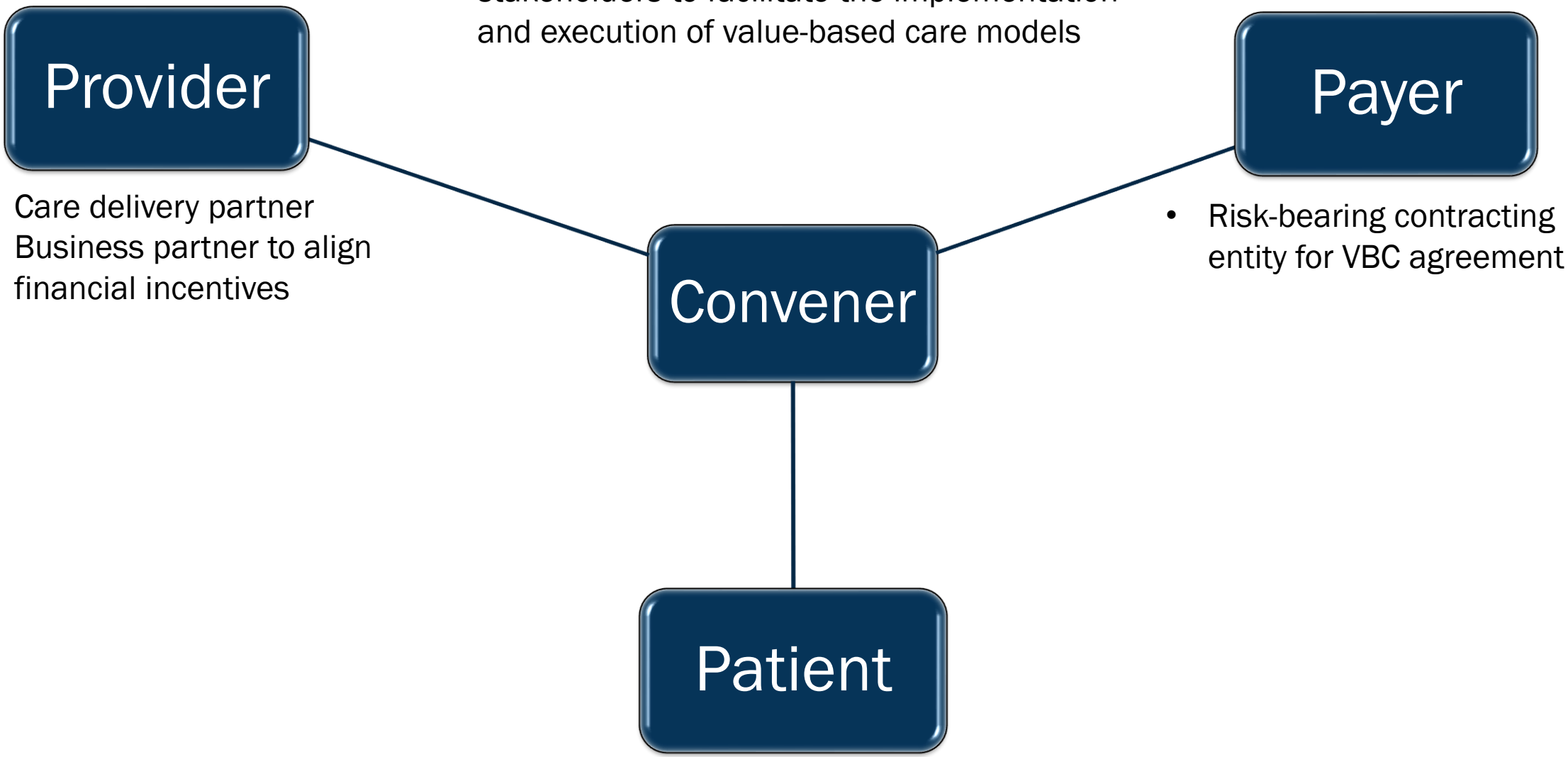
Definition of a Convener

Organization or entity that engages multiple stakeholders to facilitate the implementation and execution of value-based care models



- Care delivery partner
- Business partner to align financial incentives

- Risk-bearing contracting entity for VBC agreement

- Variable engagement depending on the type of provider partnership, services provided, and contract terms

Requirements to Manage Total Cost of Care for a Population

Shift in Clinical Focus

Full Visibility

Capital

Cash Reserves

Actuarial Expertise

Stable Population

Stable Population

Aggregate patients to increase actuarial stability

- Spread risk across multiple practices, geographies, lines of business, and/or payers
- Allows smaller practices to participate
- Facilitates taking risk on a more narrowly defined population

Actuarial Expertise

Provide consultative actuarial science expertise

- Identify cost variation and savings opportunities within the population of interest
- Predict future expenditures
  - Analyze practice and market claims and trends
  - Apply population-specific secular trends to historical spend

Cash Reserves

Maintain adequate financial reserves

- Shield the provider partner from downside risk
- Satisfy statutory requirement for two-sided risk contracts
- Ensures financial solvency in “down” years and/or if actuarial projections are inaccurate
- Provides financial wherewithal to sustain care transformation investments during savings ramp

Capital

Invest in practice:

- Infrastructure: i.e., ASCs, after hours urgent care, nurse triage line
- Staff: i.e., non-revenue generating supportive care
- Technology: i.e., EMR, population health management platform, ePROs, performance dashboards

Full Visibility

Help providers understand what is happening to patients outside of their clinic walls

- Real-time aggregation of complete clinical data
  - EMR connectivity, ADT feeds, HIE feeds, lab and imaging data
- Social drivers of health
  - Sociodemographic data, distress screens

Shift in Clinical Focus

Incorporate new and/or different clinical capabilities that focus on value, not volume

- Screening, early detection, prevention, shared decision-making, goal-directed care, conservative management

All Conveners are Not Created Equal

Providers must understand:

- Services/functions offered by convener
- Convener's business model
- Integration into core clinical operations
  - Provider experience
  - Patient experience
- Alignment with convener's care delivery vision
- Incentive alignment

Payers must consider:

- Why a convener is better suited to provide the services or functions than the practice
- Degree of practice integration and provider buy-in required for success
- Attractiveness of convener's model to network practices
- Appetite for outcomes-based reimbursement (downside risk)
- Alignment of convener's business model with payer goals

Listening Session 1: ***Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models***

Angelo Sinopoli, MD

Executive Vice President of Value-Based Care,
Cone Health

Incentives for Clinical Integration: Driving Health Centered Care

Aligning Financial, Operational, and Quality Incentives to Achieve Care Coordination

Angelo Sinopoli, MD

EVP Value-Based Care, Cone Health, Value-Based Care Institute

VALUE-BASED CARE INSTITUTE

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What is Clinical Integration?

- **Definition: Structured collaboration** among physicians, hospitals, and care teams to **improve quality, efficiency, outcomes,** and **affordability.**

- **Key elements** include, but are not limited to:
    - Physician leadership,
    - Coordinated care delivery,
    - Shared data and technology platforms, and
    - Aligned financial incentives.

Cone Health's Ecosystem: Working as Individual Units

Horizontal Health Care Delivery

Acuity


Home


Virtual Care


Mobile Care


Community Resources


Provider Clinics

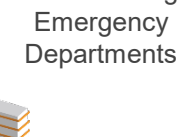

Retail Pharmacy


Medical Centers


Behavior Health Services


Diagnostic Imaging Center


Urgent Care


Freestanding Emergency Departments


Ambulatory Procedure Center


Hospital


Skilled Nursing Facility


Inpatient Rehab


Outpatient Rehab


Home

VALUE-BASED CARE INSTITUTE

Data & Technology Systems

sg2 health care intelligence

Our Network: Working As A Single Organism

Together, we are shaping a healthcare system that prioritizes patient outcomes and centers on health and clinician well-being.

Financial Incentives Driving Clinical Integration, the Great Divide

- The need for an All-Payer Model
- Most physician practices today function in a hybrid financial environment; this creates operational tension because:
    - **Practices struggle to fully adopt** team-based, preventive, and coordinated care if FFS is still dominant.
    - Unless at least **40-50%** of the practice's patient panel is under an APM, the **practice is still structurally forced to operate like an FFS business**.
    - **The cost of start-up 1.8 million dollars**

Equitable Care for All of Our Communities

- Medicare REACH
- Medicare Advantage
- Medicaid
- Commercial Payers
- Provider – Owned Health Plan
- Direct to Employer Contracting
- Uninsured

What Enables Clinical Integration?

- Critical mass of APM Patients
- Governance and physician engagement
- Financial incentives and Payment Models
- Technology and data-sharing enhancements
- Care coordination and patient navigation
- Patient engagement and digital health tools
- Contractual and legal mechanisms

Increased Flexibility to offer Financial and In-Kind Support

- **Cost-sharing for Technology and Infrastructure**
  - Health systems can now subsidize EHRs, and other technology platforms and cybersecurity tools, provided the arrangement meets an applicable exception/safe harbor.
- **Under new value-based exceptions and safe harbors, health systems can, depending on the level of risk undertaken by the value-based enterprise:**
  - Provide direct financial incentives to participating physicians.
  - Offer gainsharing programs that reward cost reduction and quality improvements.
  - Use performance-based payments linked to total cost of care or quality metrics.
- **In-kind Support for Care Coordination & Staffing**
  - Telemedicine and remote monitoring tools
- **Practice Transformation Support**

Reduced Restrictions on Physician-Hospital Alignment within Value-Based Arrangements

- **Directed Referral Requirements and In-kind Support**
  - Under value-based care exceptions, hospitals have increased flexibility to provide resources to physicians within the value-based enterprise (VBE) to achieve permissible value-based purposes for a target patient population.
  - Directed referral requirements within the VBE for a target patient population are also permissible, provided certain administrative safeguards are followed.
- **Flexible Shared Savings and Risk Agreements**
  - Potential for more innovative revenue-sharing arrangements between hospitals and independent physician practices.
  - Capitated or global budget models structured to comply with value-based rules.

Stronger Incentives for Specialists to Participate in Value-Based Care

- Traditionally, specialists have been slow to join value-based models due to **misaligned incentives.**
- **The value-based rules may allow for:**
  - Innovative gainsharing opportunities for specialists within ACOs and CINs in furtherance of value-based purposes under certain risk arrangements.
  - More flexibility for bundled payments and capitation models in specialties like cardiology, oncology, and orthopedics.
  - Increased funding for care coordination programs within specialty groups.

Small ACOs

- Limited Risk Pool & Statistical Variability
- Stay focused on high-impact interventions
- Leverage partnerships and shared resources
- Optimize care management with AI & technology
- Target niche populations with unique needs

Modernizing Incentives and Physician Alignment

- Direct Payment to Providers participating in full-risk arrangements
- Expand Non-financial support
- Staffing & Embedded Care Coordination Support
- Preferred Provider Networks within the value-based enterprise
- Understand Key Regulations Supporting Clinical Integration
- Best Practices
    - Tie incentives to quality & cost outcomes, not volume
    - Ensure financial and in-kind support meets an applicable value-based care exception and safe harbor
- Increase Lives at Risk through all payer contracts

Thank You

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Dan Liljenquist, JD

Chief Strategy Officer,
Intermountain Health

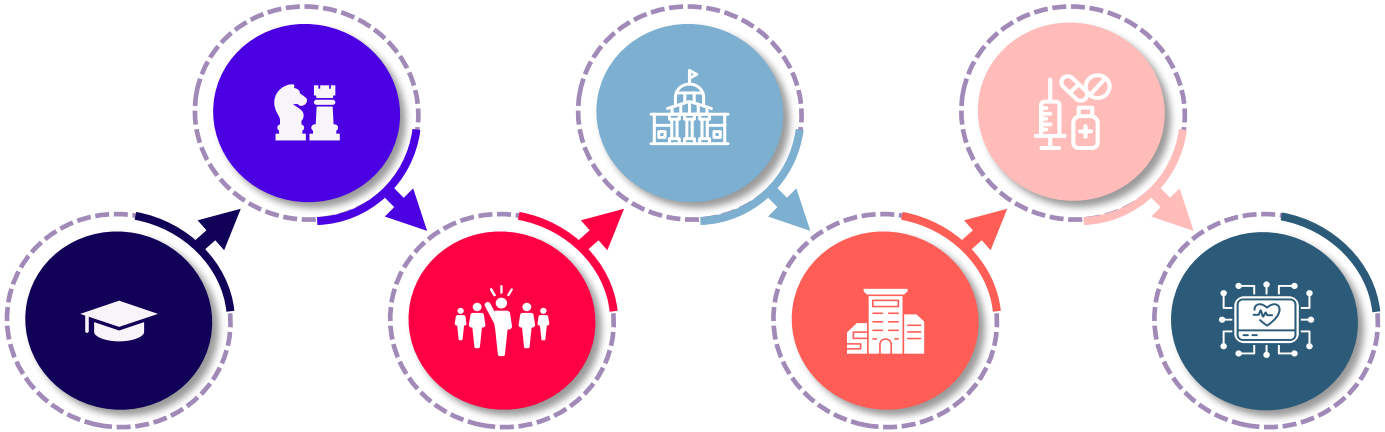
Intermountain Health

Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models

PTAC Public Meeting
Monday, March 3, 2025

Dan Liljenquist
Chief Strategy Officer
Intermountain Health

About me



Education

Undergraduate: Economics
Graduate: Juris Doctorate

Strategy

Consultant at
Bain & Co.

President & COO

Focus
Services

Senator

Member of
Utah State Senate

Intermountain Health

Chief Strategy Officer
Enterprise Initiative Office
Population Health

Civica Rx

Founder &
Board Chair

Graphite Health

Board Chair

Our Mission

Helping People Live the Healthiest Lives Possible®

Our Vision

Be a Model Health System

Intermountain Health

Strategy at Intermountain Health

Taking full clinical and financial accountability for the health of more people

Partnering to keep people well

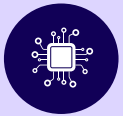
Coordinating and providing the best possible care

System Initiatives

Simplifying for caregivers, patients, and members

Expanding proactive care

Focused Investments



Adopting cutting-edge technology

Enriching consumer experience

Reimagining our work

Growing at-risk payments

Moving upstream to keep people well

Creating and expanding proactive care models

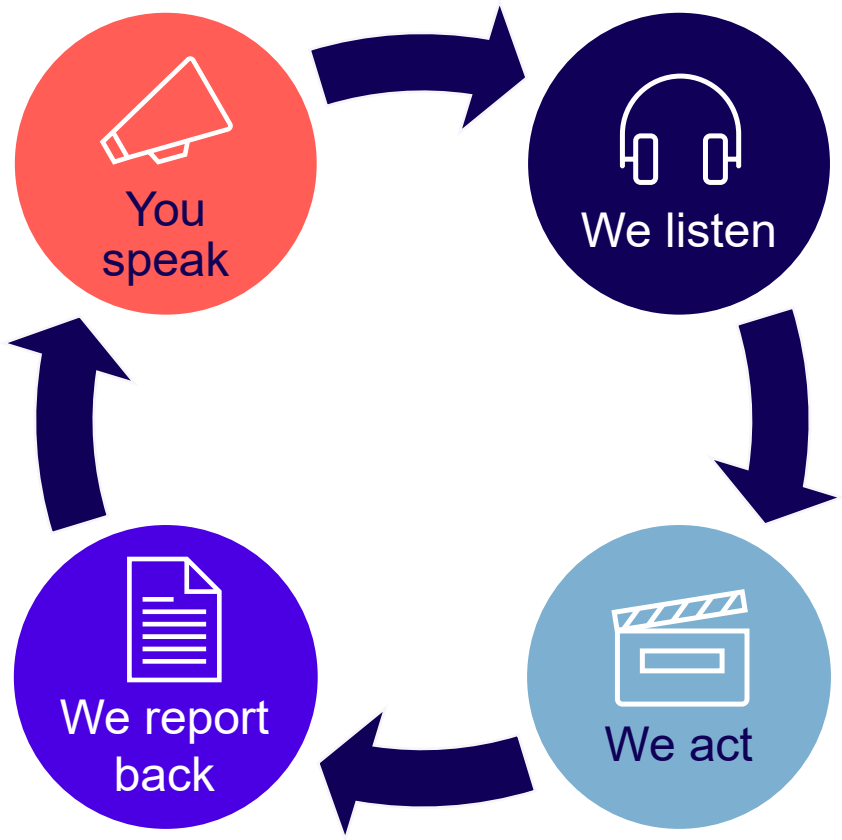
Building trust

How Intermountain Health instills confidence in PB-TCOC models

Intermountain Health

Feedback loop

Building trust through communication and action



Thank you