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How to Better Support Small Physician-led Accountable Care Organizations: Recent Program Updates, Challenges, and Policy Implications

Jonathan Gonzalez-Smith, Hannah Crook, Elizabeth Singletary, William Bleser, Robert Saunders

KEY THEMES

- **Small physician-led Accountable Care Organizations (ACOs) have been a critical part of ACO programs and have shown historical success in reducing costs with improved quality.**
- **Small physician-led ACOs face practical challenges in taking on risk, from the structure of their ACO contracts (including the cost benchmark they are expected to improve on), their limited capital reserves, and their need for advance investment and technical assistance.**
- **These types of ACOs will need additional support to more quickly transition to downside risk, as required under the new risk requirements for the Medicare Shared Savings Program, or in new ACO-type programs, like the Direct Contracting program or complementary programs, like the Primary Care First program.**
- **To access additional support, many small physician-led ACOs are partnering with third party firms. These "ACO Enablers" provide upfront capital and a shared service infrastructure for ACOs to augment their existing capabilities to better operate in risk-bearing models.**

Introduction

Over the last eight years, the Centers for Medicare and Medicaid Services (CMS) has expanded its Accountable Care Organization (ACO) offerings to provide clinicians with alternative payment model options that focus on value and outcomes. These programs have shown quality improvement and savings, although achieving savings has taken time. Moreover, there has been significant variation among different types of ACOs, such as by size or by organizational structure. Small physician-led ACOs in particular have shown positive results in their shared savings and quality scores, however there are concerns about their ability to join or remain in these ACO programs.

This brief identifies trends and strategies that small physician-led ACOs have taken to achieve success in ACO programs, drawn from public performance data and phone interviews with ACO leaders. The brief then considers what opportunities and challenges these types of ACOs anticipate from recent policy and program changes, and implications for new and revised ACO programs. While the brief focuses on small physician-led ACOs, several challenges also apply to other types of ACOs.

Why Should Policymakers Care about the Sustainability of Small Physician-led ACOs?

Physician-led ACOs constitute a large part of the overall ACO landscape, and have shown positive results to date. As of July 2019, there were approximately 246 physician-led ACOs, representing 45% of the ACOs participating in the Medicare Shared Savings Program (MSSP), the largest Medicare ACO program.[1] In analyses of ACO results, physician-led and small ACOs have shown positive results, being more likely to generate shared savings, driving much of the program savings to date, and at the same time achieving high-quality care.[1–6] (It is important to note that performance has varied significantly across small physician-led ACOs, indicating that many factors determine success.) Recent tracking has also found that physician-led ACOs are as likely to take on downside risk as other categories of ACOs for Medicare and commercial payers.[7] However, physician-led ACOs have exited the MSSP at higher rates, with some recent departures due to concerns about transitioning to greater financial risk.[8,9]

Small Physician-led ACO Characteristics

- Small size: less than 10,000 beneficiaries
- Physician governed
- Mainly provide outpatient services

The structure of physician-led ACOs may allow them to more easily engage physicians. Engaging clinicians can be critical to success,[10] and we found that successful physician-led ACOs made a deliberate effort to engage physicians in a meaningful way. For instance, these ACOs typically included physicians in leadership positions, incorporated their perspective into the decision-making process, or embedded physicians in change management projects. Importantly, successful ACOs created a culture designed around a shared vision, with some ACOs carefully recruiting physicians committed to the ACO goals. The interviewed physician-led ACOs suggested that their organizational structure facilitated their ability to incorporate physicians in these leadership positions.

> **"I would bet there is no ACO that is successful that doesn't have significant physician leadership."**

Smaller, physician-led ACOs often have a more nimble organizational structure. Smaller, physician-led ACOs tend to have a more decentralized organizational structure with smaller administrative hierarchies. A decentralized or small hierarchy allowed the ACOs to be flexible and experiment with new initiatives quickly.[6] Size also may be conducive for fostering relationships across participating physicians, patients, and staff, leading to easier communications and trust that results in better patient engagement, care management, and better outcomes for patients.

Providing options for smaller clinics to remain independent can reduce the trend toward provider consolidation. Nationwide, there has been substantial push towards consolidation, with many smaller practices being acquired by larger systems. This consolidation trend has been associated with increases in total health care spending, especially for commercial payers. It is therefore important to understand how smaller clinics can remain independent but join together virtually to participate in value-based payment programs, such as ACOs.

How Will Program Changes Affect Small Physician-led ACOs?

Recent policy changes could affect whether physician-led ACOs, especially smaller ones, remain in existing programs or join new ones. For example, CMS recently overhauled its longest running ACO program, the MSSP, through the *Pathways to Success* rule to transition ACOs to downside risk more quickly. CMS also launched the *Direct Contracting Model*, which would provide an ACO-like contract for organizations willing to take on greater risk for populations while receiving greater flexibility and predictability. (The MSSP and *Direct Contracting* changes are summarized in the appendices.) Another new option is

the *Primary Care First* program, which provides more support for primary care practices. While not an accountable care program, *Primary Care First* engages a critical component of ACOs in its ability to manage populations of patients, and ACOs can participate in both the MSSP and *Primary Care First* simultaneously.

Below we summarize how physician-led ACOs that we interviewed regard these changes and what opportunities and challenges they anticipate. Reflecting on these interviews, we offer recommendations in each section to better account for the unique circumstances that smaller, physician-led ACOs face.

Access to Capital

Smaller ACOs may struggle to acquire the capital needed to move to downside risk more quickly. An organization requires significant investment to participate in an ACO program, both to develop the infrastructure and competencies for success and build sufficient capital reserves in case of shared losses. This is harder for smaller ACOs who are more capital constrained to begin with, and physician-led ACOs may struggle given that many use cash accounting and do not have large (or any) capital reserves for their practices. This problem is more acute when an organization joins an ACO program, as successful ACOs will gain sufficient capital over time by reinvesting a portion of their shared savings.

Smaller or physician-led ACOs have partnered with third party firms, such as Aledade, Caravan, Evolent, and others, to access needed upfront capital. These "ACO Enablers" also provide technical assistance like care management support, access to IT infrastructure, and data analytic support. Several interviewed ACOs cited the importance of the *ACO Investment Model*, a CMS program that provided advanced shared savings for the supply of capital. The *ACO Investment Model* program has been shown to significantly reduce spending in rural and underserved ACOs,[11] and the discontinuation of the program may limit the ability of smaller or physician-led ACOs to access the capital they need to enter an ACO contract. However, some physician-led ACOs may receive additional capital through the *Primary Care First* program to build up their primary care capabilities.

To help physician-led and similar ACOs remain in the program, CMS enacted several changes intended to support them and provides a glide path to risk. In the MSSP overhaul, CMS required that all ACOs transition to risk quickly. However, CMS also recognized that physician-led ACOs will need a longer transition period given their capital challenges and limited infrastructure. Physician-led ACOs are difficult to identify directly using existing data, so CMS used "revenue status" as a proxy, with "low-revenue" ACOs, or those ACOs who are responsible for a smaller portion of their attributed beneficiaries' spending, receiving a longer transition period (3 years if new to performance-based risk Medicare ACO initiatives, 1-2 years if prior experience in these initiatives). However, ACOs have indicated some concern about whether "low-revenue" status is an accurate proxy for physician-led ACOs.[8]

One notable MSSP policy change that could help physician-led ACOs is the new methodology for calculating the limits for shared losses in the Basic Track. In the past, the maximum amount of losses that an ACO could incur was based on a percentage of its total benchmark. However, as recognized in the revenue status change, physician-led ACOs tend to only receive a portion of a beneficiary's total expenditures (which are used to calculate the benchmark), so a loss that is a percentage of their benchmark would be a very large amount of their total revenues. ACOs noted that a benchmark-based loss could be a ruinous amount for a physician-led ACO and cause them to close their practice. By capping losses based on their total revenue in the Basic Track, a physician-led ACO is more likely to be able to manage a loss if it occurs.

Direct Contracting also includes a number of mechanisms that could help a smaller physician-led ACO participate – like prospective payments so that ACOs do not have to front capital and wait for revenues, advanced payments for certain services, and an optional provisional financial reconciliation immediately following the end of the performance year for a timelier distribution of shared savings – which should provide more stable and upfront revenue streams.

***Pathways to Success* also allows smaller ACOs the ability to participate with less capital reserves.** CMS requires ACOs participating in two-sided risk to demonstrate that they can repay CMS if they incur shared losses. Under prior rules, CMS set this amount to at least one percent of an ACO's benchmark expenditure, which was a significant challenge for smaller ACOs. (As noted above, physician-led ACOs often are responsible for a smaller percentage of their beneficiaries' expenditures, which is how the benchmark had been calculated, so a benchmark-based number can be a very large amount of the ACO's revenue.) As a remedy, the *Pathways to Success* rule reduces the required amount by calculating repayment as a portion of revenue (instead of benchmark) and allows ACOs to establish repayment mechanisms for a shorter duration. These changes lower the barrier for resource-strapped ACOs to join *Pathways to Success*.

However, these efforts to mitigate increased risk exposure may not offer enough security for physician-led, and otherwise resource-constrained, ACOs to participate. Compared to the earlier MSSP models, shared savings under the *Pathways to Success* overhaul are lower in most tracks. Some ACOs we spoke with also indicated that the marginal increases in shared savings are not enough to outweigh the steep increase in risk when moving from Basic E to Enhanced tracks. High risk levels in *Direct Contracting* (50%-100% total risk in the first risk corridor) may also be unpalatable to resource-constrained ACOs.

POLICY IMPLICATIONS

Offer upfront investment. Smaller, physician-led ACOs have limited resources to redesign clinical practices, which requires significant investments in data analytics and other activities. Many ACOs suggested continuing the *ACO Investment Model* program, which provided upfront payments for ACOs in rural or low ACO penetration areas. This program encouraged ACO participation and was associated with reduced spending.[11] Though CMS discontinued the program, smaller organizations would stand to benefit from a similar program that advanced payments in turn for participating in risk-sharing models.

Upfront capital would also help small physician-led ACOs with establishing care coordination and the staff required to manage their beneficiaries' care. As some interviewed ACOs noted, the ACOs have often initially invested in care coordinators or staff who could assist physicians in managing care. This had two advantages. First, by alleviating a physician's workload the ACO could prevent physician burnout, which is a national problem. Second, prior research has found that ACOs with more care coordination services were associated with a reduced risk of exiting the MSSP.[16] Coordinating care is, as one ACO described, the "spinal cord of the entire model."

Key Takeaway

ACOs need significant capital to develop the appropriate infrastructure and competencies to move into value-based payment arrangements. Smaller ACOs reported difficulty accessing and building up this capital and could benefit from programs that provide additional upfront investment.

Pace to Risk

The accelerated transition to risk is the most acute issue concerning small physician-led ACOs.[12] Both the MSSP and *Direct Contracting* programs encourage participating organizations to adopt higher levels of downside financial risk on faster or immediate timelines**.** Under the *Pathways to Success* rule**,** all ACOs will be required to take on risk at a quicker pace compared to earlier versions of the MSSP, though an ACO's exact risk requirements depends on an ACO's revenue status and previous experience with risk-based contracting. For instance, an ACO that is "low-revenue" and had not participated in the MSSP would move to downside risk within three years versus six years in the earlier version of the MSSP. In *Direct Contracting*, all organizations will participate in downside-risk immediately.

Small physician-led ACOs believe they may not be able to transition to downside risk in the time required. Most ACOs take several years to develop savings and may need more time to build up sufficient capital. It can take several years for ACOs to acquire and build the right processes, people, technologies, and organizational competencies to succeed in value-based payment models. Some evidence suggests that at least three years—the maximum amount of time *Pathways to Success* currently allows in upside-only risk (only for new, low-revenue ACOs inexperienced in risk)—may be the minimum time necessary to generate savings and for long-term commitment to the program.[13,14] To date, the majority of small physician-led ACOs in the MSSP have only participated in one-sided risk models (0.8-3.3% of small physician-led ACOs participated in downside risk in the first four years of participating in the MSSP, then up to 8.0% in the fifth year).[7] Without additional time or support, ACO leaders we interviewed indicated that physicians are less willing to join ACO programs.

As a result, some physician-led ACOs are exiting; merging with larger multi-specialty provider groups; or working with "ACO Enablers" that can provide more resources, technical assistance, and capital. Some of the ACOs that we interviewed are confident in their ability to adopt higher risk levels but suspect newer physician-led ACOs will struggle to develop the capabilities needed to succeed in downside risk under a truncated timeframe. Indeed, in prior analysis we found that physician-led ACOs had modestly higher dropout rates immediately following the MSSP overhaul compared to hospital-led ACOs,[8] potentially from the accelerated timeline under the *Pathways to Success* rule.

POLICY IMPLICATIONS

Adjust the transition to downside risk to accommodate for smaller, physician-led ACOs. In prior research, we found that the rate at which ACOs exited the MSSP was associated with the timing of moving into downside risk, but starts to decrease after the first three years.[16] Accordingly, CMS can achieve its stated goal of moving all ACOs to downside risk, but can do so in a way that does not increase exit rates for smaller or physician-led ACOs. One remedy is to allow ACOs more time in upside-only risk to build reserve requirements, organizational competencies, and other necessary infrastructure.

In addition to providing a longer "on-ramp" in the Basic MSSP track, CMS can provide a softer transition between the MSSP Basic and Enhanced tracks. CMS uses different methodologies between the two tracks to calculate shared losses (losses in the Enhanced track are based on the ACOs' benchmark rather than revenues and the loss limits are much higher) so ACOs are exposed to a significant difference in potential losses when moving to the Enhanced track. In comments on the proposed rule, many commentators suggested options to bridge the tracks, from introducing an intermediate track to phasing the loss sharing limits incrementally.[15] CMS did not ultimately adopt these recommendations,[15] but our interviews indicate that ACOs continue to welcome proposals that assist smaller ACOs in moving to the Enhanced track.

Key Takeaway

While downside risk can improve the overall ACO program, the fast transition may prove difficult for small or physician-led ACOs to acquire and build the right processes, people, and technologies in order to succeed. Though many ACOs indicated they would remain in the MSSP, some are exiting or merging with larger ACOs that have more resources to support additional risk.

Benchmarking and Forecasting Costs

Many smaller, physician-led ACOs have difficulty accurately forecasting costs. Understanding benchmarking methodologies and forecasting costs will remain challenging for many smaller or physician-led ACOs. For example, prior to joining the MSSP, ACOs will need to calculate the historical costs of their potentially attributed beneficiaries (currently they only see a portion of their spending) as well as compare their predicted costs to regional costs (as benchmarks increasingly incorporate regional spending trends). Doing so requires a range of capabilities—having the right health IT infrastructure, cleaning data, managing and processing claims data, forecasting how clinical changes will affect benchmarks—that smaller ACOs may initially lack. To address this, some ACOs have hired actuarial firms to help forecast costs, though this can be expensive, or work with a third-party firm, like Aledade, Caravan, Evolent, or others. Other ACOs developed the capabilities internally. This requires the ability to collect regional Medicare costs; understand how a benchmark is constructed (which requires the ability to match CMS reports to an ACO's data system and recreate the benchmark on their own); and discern how care coordination, care interventions, and other delivery changes will affect utilization and benchmark rates. Successful ACOs underscored the importance of following coding trends and coding correctly to ensure benchmark accuracy.

Regionally-based benchmarks may help high-performing ACOs. For instance, incorporating regionalization during an ACO's first agreement period may better reflect their performance relative to peers. Previous rules weighed historical performance more heavily, effectively penalizing high-performing ACOs by grading them against their own continually decreasing benchmark and making it more difficult to achieve savings further into the program. By introducing the regional component sooner into the methodology, the *Pathways to Success* rule partially mitigates this issue. However, in a voluntary program, regionalization can discourage ACOs with expenditures higher than their region from participating.[16] Though many ACOs have advocated for a higher blend of regional benchmarking,[17] further research is needed on crafting a benchmark that encourages continued improvement across ACO types.

Other benchmark changes will bring about more predictability. For instance, agreement periods in *Pathways to Success* are longer (five years instead of three), which means benchmarks will change less frequently. *Direct Contracting* will calculate regional benchmarks based on the methods used by Medicare Advantage, which is a mature system and could be

easier for ACOs to understand.[18] These changes, while beneficial to all ACOs, may be particularly helpful for smaller ACOs that are more sensitive to fluctuating benchmarks and unpredictability.

Key Takeaway

Under the MSSP and Direct Contracting programs, ACOs will need to accurately forecast costs, which requires sophisticated data analytic capabilities that new, small ACOs often lack. CMS can provide targeted support, like nationwide peer-learning networks, to help ACOs develop these tools.

Administrative and Regulatory Burden

The reduction in quality measures may reduce administrative burden, but may not solve the broader measurement burden challenge. For instance, both the MSSP and *Direct Contracting* programs reduce the number of measures to report.[19] The *Pathways to Success* rule narrows the previous 31 quality measures in the MSSP by 8 (to 23 total), and *Direct Contracting* will contain 14 total measures.[20,21] Many ACOs welcomed the intent behind these changes but felt that it would not meaningfully diminish measurement fatigue. Most ACOs work with a plurality of payers, each with distinct reporting requirements. ACOs typically report on more than 100 measures across these payers—so a reduction of 23 measures is helpful but does not solve the broader measurement burden challenge. Additionally, ACOs indicated that they would still have to report to other payers on the same measures CMS removed. These measures are also standard components of clinical care that ACOs evaluate regardless of reporting requirements. CMS should continue to build off current efforts, like the Meaningful Measures initiative,[22] to achieve more standardized outcome-based measures.

Physician-led ACOs welcomed the expanded use of waivers. More ACOs will be eligible for the three-day skilled nursing facility (SNF) waiver, which allows beneficiaries to go directly to a SNF without staying in a hospital for three days. In addition, *Pathways to Success* broadens the use of telehealth services, allowing ACOs in prospective alignment to provide telehealth services in the beneficiary's home. To encourage patient engagement, some ACOs in downside risk can provide up to $20 to attributed beneficiaries for certain primary care services. *Direct Contracting* will also give providers greater flexibility to provide enhanced benefits, such as asynchronous telehealth services, cost sharing support for Medicare Part B services, and care management services.[21] While the exact details of some of these waivers are not yet available, ACOs will likely appreciate and benefit from any additional flexibilities.

POLICY IMPLICATIONS

Introduce more support for organizations to develop technical capabilities. Smaller ACOs face unique challenges developing the competencies necessary to succeed in value-based care. Learning collaboratives and other firms that support small ACOs can provide targeted support to help these ACOs develop the strategies, tools, and knowledge necessary for clinical transformation. For example, CMS can identify and share successful strategies used by ACOs to improve the cost and quality of health care. A nationwide peer-learning network, similar to the Transforming Clinical Practices Initiative,[23] is another approach to help clinicians exchange best practices in developing core competencies. Further, CMS can provide timelier data and financial feedback reports to better equip ACOs with the information needed to optimize clinical transformation. CMS is taking some steps to promote collaborative learning in new payment models. In *Direct Contracting,* CMS will support providers through a "learning system" for Direct Contracting Entities. Providers will be required to participate in the learning system, which will use group-learning approaches to help DCEs share experiences and track progress.[21]

Reduce regulatory barriers. ACO leaders we interviewed felt that regulations like the Stark Law and Anti-Kickback Statutes limited their ability to coordinate and manage care effectively. These rules are intended to reduce fraud and abuse by prohibiting referrals that financially benefit physicians but may be clinically inappropriate. ACOs often seek additional advisory opinions to not violate these statutes, which can be costly. Smaller ACOs also reported limiting or not pursuing relationships that could help redesign care out of fear that they might run afoul of these rules. In response, CMS recently proposed changes to both rules to provide greater flexibility for organizations in value-based payment arrangements.[24] The proposed rules would provide new exceptions and safe harbors for providers that bear risk or are in risk-bearing arrangements. While the types of exemptions vary by the level of financial risk assumed, the modifications could provide greater latitude for ACOs to manage and coordinate patient care to achieve better outcomes.

Simplify program rules. ACO leaders expressed difficulty keeping up with changing policies and priorities, where small changes can have an outsized impact on resource-constrained ACOs. ACOs we interviewed highlighted the difficulty of following policy trends on top of their daily clinical demands. Some ACOs

dedicated time to understand the program, communicated these policies to clinicians, and translated policies into action. By doing so, they were also able to make informed decisions about participating in different risk tracks and could better prepare for program changes. However, this is time-consuming and detracts from investing in care improvement activities. Smaller organizations are unlikely to participate in new tracks or programs when significant features of the value-based model remain uncertain or too complex to understand.

CMS can help by communicating the rationale behind rules more clearly and provide greater predictability by, for instance, codifying changes like safe harbor exemptions. As small organizations evaluate whether to participate in *Direct Contracting*, they will look for CMS to establish additional details around fundamental program components such as risk-adjusted payment rates, administrative and reporting requirements, and benchmark calculations.

Key Takeaway

Both the MSSP and Direct Contracting programs introduce modifications intended to reduce administrative burden and provide greater flexibility for ACOs to deliver care. However, some features of the programs, particularly quality measurement and frequent changes to regulatory policies, can challenge ACOs and impede their sustainability.

Conclusion

CMS is unmistakably moving away from fee-for-service. As CMS encourages providers to adopt downside risk (as a means of encouraging broader improvements in care), it should take additional steps to support smaller physician-led ACOs. These types of ACOs have been key assets to CMS' accountable care programs but have exited at high rates in recent years. As our interviews have made clear, ACOs, especially smaller ones and those in more resource-deprived settings,[25] need additional support in building the organizational competencies (such as clinical care redesign and forecasting costs) to take on increased risk.

Given these challenges, many small physician-led ACOs are partnering with third-party "ACO Enablers" that provide upfront capital and additional services to help ACOs better participate in risk-bearing models. CMS can help smaller, physician-led ACOs succeed by continuing to reduce regulatory and measure burdens, reduce program uncertainty, expand data availability and feedback, and refine benchmarks to account for a small physician-led ACO's revenue and provide greater stability. These changes can help CMS support the transition to risk while better supporting small, physician-led ACOs in achieving better outcomes while reducing costs.

Appendices

Appendix 1. Summary of the Pathways to Success Program

***Pathways to Success* replaces the initial MSSP structure with two tracks.** The first track ("Basic") includes five levels of risk (labeled A-E). Most new ACOs will begin in the upside-only risk levels (A-B) for 2-3 years, and then phase into progressively higher levels of risk every year (levels C-E, named the "glide path"). The second track ("Enhanced"), similar to the MSSP Track 3, is the highest risk sharing arrangement and provides additional tools and flexibilities. The Basic track levels C, D, and E, and the Enhanced track also qualify as Advanced Alternative Payment Models (APMs) under CMS' Quality Payment Program, exempting those providers from participating in the Merit-based Incentive Payment System (MIPS) and offering them a bonus on their fee schedule. Figure 1 demonstrates how the *Pathways to Success* model will organize tracks and levels.

Figure 1. Summary of Pathways to Success

<table>
<tr><th colspan="2">Program Tracks</th><th>Shared Savings Rate</th><th>Shared Losses Rate</th></tr>
<tr><td rowspan="4">Pathways to Success - Basic</td><td>Level A & B
(Upside only)</td><td>Up to 40%, not to exceed 10% of updated benchmark</td><td>NA</td></tr>
<tr><td>Level C
(2-sided)</td><td rowspan="3">Up to 50%, not to exceed 10% of updated benchmark</td><td>Up to 30%
Capped at lesser of 2% of Part A and B revenue OR 1% of updated benchmark</td></tr>
<tr><td>Level D
(2-sided)</td><td>Up to 30%
Capped at lesser of 4% of Part A and B revenue OR 2% of updated benchmark</td></tr>
<tr><td>Level E
(2-sided)</td><td>Up to 30%,
Capped at lesser of percentage of revenue specified by Quality Payment Program OR 1% higher than benchmark nominal risk amount</td></tr>
<tr><td colspan="2">Pathways to Success - Enhanced (2-sided)</td><td>Up to 75%, not to exceed 20% of updated benchmark</td><td>Up to 40-75%
Capped at 15% percent of benchmark expenditure</td></tr>
</table>

Two factors determine which track an ACO will enter and how fast they progress along the glide path. These include revenue status (the percentage of Part A and B FFS revenue compared to benchmark expenditures) and previous experience with risk-based contracting (Figure 2). CMS believes these two components are good indicators for risk tolerance: the more control an ACO has over its beneficiaries' expenditures and the more experience their providers have in risk-based models, the more risk the ACO is prepared to bear. While inexperienced, low-revenue ACOs can remain in a one-sided risk model for up to three years under a one-sided model, high-revenue, experienced ACOs are placed immediately in two-sided risk. The vast majority of ACOs will have only 1-2 years of upside risk before being required to take on downside risk.

Figure 2: How ACO Revenue and Risk-bearing Experience Influence Where They Enter the MSSP		
	Low-Revenue	High-Revenue
Experienced	Basic E or Enhanced	Enhanced
Inexperienced	Basic B	Basic B

In exchange for faster transitions to higher level of risk, *Pathways to Success* offers higher savings rewards and gives ACOs some new flexibilities. Examples include extending agreement periods to five years instead of three, reimbursing telehealth services and offering incentive payments for certain health promoting behaviors, and allowing ACOs to choose their beneficiaries prospectively.

Appendix 2. Summary of the Direct Contracting Program

Direct Contracting is part of CMS' "Primary Cares Initiative," an effort to support advanced primary care using population-based payment models. CMS released the request for applications for two of the tracks recently and is still developing the geographic track.[21] As noted in Figure 3 below, core features include three voluntary population-based (PBP) models that aim to reduce administrative burden while providing increased accountability for population outcomes.

- **Professional PBP** is the lowest risk-sharing arrangement. Participants will be financially accountable for the total cost of care (starting at 50% of shared savings/losses under Medicare Parts A and B) for attributed beneficiaries. Participants receive an additional per-member, per-month (PMPM) capitated payment for enhanced primary services (which can include "infrastructure, technology, tools, and resources to support increased access to primary care, provision of care, and care coordination").[21] The amount will equal seven percent of estimated total cost of care for the aligned population.

- **Global PBP** will hold participants financially accountable for the total cost of care (starting at 100% shared savings/losses under Medicare Parts A and B) for attributed beneficiaries. Participants chose between the primary care capitation in the Professional PBP model or a PMPM risk-adjusted payment for estimated total cost of care.

- **Geographic PBP** participants would assume total cost of care risk for all Medicare FFS beneficiaries in a defined geographic region (with at least 75,000 beneficiaries). Participants can choose between prospective capitation or FFS claims payments reconciled (retrospectively) against a benchmark. *This track remains under development and may be released later.*

Figure 3 – Summary of Direct Contracting

Program Tracks		Shared Savings Rate	Shared Losses Rate
Direct Contracting	**Professional PBP** (2-sided)	Tier 1 - **50%** for all savings **5%** under benchmark Tier 2 - **35%** for all savings between **5-10%** under benchmark Tier 3 - **15%** for all savings between **10-15%** under benchmark Tier 4 - **5%** for all savings greater than **15%** under benchmark	Tier 1 - **50%** of all expenditures up to **5%** over the benchmark Tier 2 - **35%** of all expenditures between **5-10%** over benchmark Tier 3 - **15%** of all expenditures between **10-15%** over benchmark Tier 4 - **5%** of all expenditures greater than **15%** over benchmark
	Global PBP (2-sided)	Tier 1 - **100%** for all savings **25%** under benchmark Tier 2 - **50%** for all savings between **25-35%** under benchmark Tier 3 - **25%** for all savings between **35-50%** under benchmark Tier 4 - **10%** for all savings greater than **50%** under benchmark	Tier 1 - **100%** of all expenditures up to **25%** over the benchmark Tier 2 - **50%** of all expenditures between **25-35%** over benchmark Tier 3 - **25%** of all expenditures between **35-50%** over benchmark Tier 4 - **10%** of all expenditures greater than **50%** over benchmark
	Geographic PBP (2-sided) *The details for this program are still under development*	Up to **100%**	Up to **100%**

A series of risk corridors will determine the exact amount of shared savings or losses in the Global or Professional tracks. The risk corridors are comprised of four tiers (described in Figure 1), with gross savings/losses decreasing across tiers. As an example, an ACO in the Professional Track with a $100 million benchmark ($10,000 per member, with 10,000 members) and $105 million expenditures would be in Tier 1 and owe $2.5 million (50% of $5 million). If expenditures were $110 million, they would owe $4.25 million, since they are responsible for both the amount in Tier 1 ($2.5 million) plus the amount in Tier 2 (35% of $5 million, or $1.75 million).

Other notable features of the program include voluntary alignment (allowing beneficiaries to pick their health care provider); a high-needs population track for organizations interested in focusing on that subset of patients; provisional reconciliation (reconciling expenditures for the first six months of the Performance Year for a timelier distribution of shared savings/losses); prospective payments to provide predictable revenue streams; and reduced quality measures. Additionally, *Direct Contracting* participants will qualify as advanced APMs and would therefore be eligible for a five percent incentive payment and exempt from Medicare Quality Payment Program's Merit-based Incentive Payment System requirements. CMS designed the program to attract a variety of organizations that demonstrate the capability to manage risk-based contracting, including Medicaid managed care organizations (MCOs), ACOs, physician-led organizations in Medicare Advantage (MA), Next Generation ACOs, and other organizations like health plans and health care technology companies that partner with providers and suppliers and assume risk. An initial "implementation period" for the Professional and Global models will start in May 2020 with a formal 5-year agreement period beginning in January 2021. While estimates of expected participation vary widely, over 1,000 organizations submitted a Letter of Intent to CMS.[26]

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For more information about this brief, please contact: Robert Saunders at robert.saunders@duke.edu