

## CMS Proposes Revamp of Federal ACO Program

On August 9, 2018, the *Centers for Medicare & Medicaid Services* (CMS) announced their plan to overhaul the *Medicare Shared Savings Program* (MSSP) by removing the Track 1 and Track 2 financial models for *accountable care organizations* (ACOs), effectively eliminating the program’s zero and low-risk tracks.<sup>1</sup> The *Patient Protection and Affordable Care Act* (ACA) established the MSSP to encourage groups of doctors, hospitals, and other healthcare providers to join together as an ACO to promote coordination of care under Medicare Parts A and B, ultimately in efforts to lower healthcare expenditures and improve the quality and efficiency of healthcare delivery.<sup>2</sup> The MSSP began in 2012, and as of January 2018, was comprised of 561 participating ACOs serving over 10.5 million Medicare *fee-for-service* (FFS) beneficiaries.<sup>3</sup> All ACOs that participate in MSSP agree “*to be held accountable for the quality, cost, and experience of care of an assigned Medicare FFS beneficiary population,*” and all ACOs that successfully meet the quality and savings requirements are eligible to share a percentage of Medicare’s achieved savings.<sup>4</sup>

Currently, the MSSP includes three financial models (Tracks 1, 2 and 3), plus one additional option implemented in January 2018 (Track 1+); ACOs are allowed to select the arrangement that best suits their organization.<sup>5</sup> There is relatively high participation in Track 1, the one-sided, shared savings-only model; also called the “*upside-only*” track, 82% of MSSP ACOs participating in this model as of 2018, cumulatively assigned to 8,147,234 beneficiaries.<sup>6</sup> In this track, eligible ACOs receive a share of any savings under the benchmark, but are not required to share losses when spending goes over the benchmark.<sup>7</sup> Track 2 is the program’s two-sided, shared savings and losses model, wherein eligible ACOs share in a larger portion of any savings, but are also required to share losses, and, thus, endure more financial (downside) risk.<sup>8</sup> Participation in Track 2 has decreased over the years (only 8 ACOs currently participate),<sup>9</sup> especially after the 2016 introduction of Track 3, “*the program’s highest-risk track*”<sup>10</sup> (which also has the highest level of potential reward), with 38 ACOs currently participating.<sup>11</sup> Lastly, Track 1+ was introduced in January 2018 to accelerate the progress of Track 1 ACOs undertaking performance-based risk. Track 1+ is a two-sided model, but with lower downside risk, and as of January 2018, 55 ACOs were participating.<sup>12</sup>

The MPPS proposed rule states CMS’s plan to launch a “*BASIC*” track in replacement of Track 1 and 2, which BASIC track has the same maximum level of risk as the Track 1+ model.<sup>13</sup> CMS plans to keep the high-risk Track 3 option, to be renamed the “*ENHANCED*” track.<sup>14</sup> Prior to this proposed rule, ACOs were allowed to participate in Track 1, without assuming any responsibility for potential losses, for up to 6 years before having to transition to a two-sided model; the proposed rule changes the low-risk participation limit to 2 years for first-time ACOs,<sup>15</sup> and 1 year for returning ACOs.<sup>16</sup> Additional proposed policies to strengthen the MSSP include; (1) terminating ACOs with repeated poor financial performance; (2) ensuring ACOs are meeting local growth rates and spending levels; (3) providing ACO spending targets for accountability purposes; and, (4) requiring risk-based ACOs to offer financial incentives to patients to encourage healthy behavior.<sup>17</sup> CMS believes that the BASIC track will be a successful intervention, because their data indicates that two-sided models perform better over time and are more capable of lowering growth in expenditures and improving quality, when compared to one-sided model ACOs.<sup>18</sup>

ACOs were among the fundamental initiatives of the ACA, designed to address Medicare’s exponential costs; the non-partisan *Congressional Budget Office* (CBO) estimated that ACOs would save the government nearly \$5 billion in Medicare spending by 2019.<sup>19</sup> But as of the date of publication, the program is far from that estimate; the *Department of Health and Human Services* (HHS) *Office of Inspector General* (OIG) 2017 Report found that MSSP ACOs reduced Medicare spending by approximately \$1 billion from 2013 to 2016, but Track 1 ACOs cost CMS \$384 million over that same 3 year period.<sup>20</sup> In a statement released by CMS Administrator Seema Verma, the Administration believes that “*Medicare cannot afford to support programs with weak incentives that do not deliver value. ACOs can be an important component of a system that increases the quality of care while decreasing costs; however, most Medicare ACOs do not currently face any financial consequences when costs go up, and this has to change*” [emphasis added].<sup>21</sup> Further, CMS worries that the “*upside-only*” track (Track 1) models are encouraging marketplace consolidation, reducing competition, and consequently, reducing choice for Medicare FFS beneficiaries.<sup>22</sup>

CMS estimates that these proposed changes will save Medicare \$2.2 billion over the course of the next decade,<sup>23</sup> while simultaneously improving interoperability and coordination of care.<sup>24</sup> However, nearly 300 of the participating ACOs have already been using the Track 1 model for a period of over 2 years, so next year, after a 6-month grace period, these ACOs will need to decide if they are switching models or dropping out of the MSSP entirely.<sup>25</sup> A spring 2018 survey conducted by the National Association of ACOs found that 71% of the surveyed ACOs would likely drop out of the MSSP if forced to take on more financial risk.<sup>26</sup> Additionally, CMS has predicted that, within a decade, 109 fewer ACOs will participate in MSSP (resulting in 452 participating ACOs).<sup>27</sup> Industry experts have predicted even greater implications than CMS, i.e., that fewer than 100 ACOs will continue participating in the MSSP because of the required financial risk.<sup>28</sup>

Andy Slavitt, who previously headed CMS under the Obama Administration, stated, “[a]t first look, they [the contents of the proposed rule] look positive to me;”<sup>29</sup> however, his opinion is in the minority. Clif Gaus, CEO of the National Association of ACOs, believes the “*likely outcome will be that many ACOs quit the program, divest their care coordination resources and return to payment*

*models that emphasize volume over value.*”<sup>30</sup> Critics at large have asserted that this proposal is undermining the task of building a successful ACO, and that it is naïve to assume that ACOs are ready to take on large financial risk before they have voluntarily chosen to do so.<sup>31</sup>

MSSP ACOs are an important payment innovation designed to assist in the move away from volume-based reimbursement, and toward paying for value and outcomes.<sup>32</sup> While taking this into account, the Administration believes that requiring ACOs to accept the negative side of the risk model is necessary in keeping these organizations *accountable*.<sup>33</sup> But the Administration’s eagerness to require ACOs to abruptly take on financial risk cannot outweigh the economic realities faced by ACOs; the requirement of potentially having to pay back millions to Medicare, if costs exceed projections, is not feasible for many organizations.<sup>34</sup> Moreover, because MSSP ACOs (all but Track 1) are classified as Advanced *Alternative Payment Models* (APM) under the *Medicare Access and CHIP Reauthorization Act* (MACRA),<sup>35</sup> the potential unintended effects that may trickle down to MACRA will remain to be seen. Stakeholder comments on the proposed rule are due to CMS by October 16, 2018.<sup>36</sup>

1 “CMS plans to ‘retire’ some ACOs” By Virgil Dickson, Modern Healthcare, August 9, 2018, <http://www.modernhealthcare.com/article/20180809/NEWS/180809898> (Accessed 8/10/18).

2 “Statutes/Regulations/Guidance: Statutory Basis for the Shared Savings Program” CMS, [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes\\_Regulations\\_Guidance.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes_Regulations_Guidance.html) (Accessed 8/20/18); “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success” Federal Register, Vol. 83, No. 160 (August 17, 2018), p. 41786.

3 Federal Register, August 17, 2018, p. 41786.

4 *Ibid.*

5 *Ibid.*, p. 41787.

6 Federal Register, August 17, 2018, p. 41787; “CMS Issues Proposed ACO Rule; Would Extensively Restructure the Program” Federal Issue Brief, Missouri Hospital Association, August 13, 2018, [https://www.mhanet.com/mhaimages/Issue%20Briefs/Issue%20Brief\\_Proposed%20ACO.pdf](https://www.mhanet.com/mhaimages/Issue%20Briefs/Issue%20Brief_Proposed%20ACO.pdf) (Accessed 8/14/18), p. 2.

7 *Ibid.*

8 Federal Register, August 17, 2018, p. 41787.

9 Dickson, August 9, 2018.

10 Federal Register, August 17, 2018, p. 41787.

11 Federal Issue Brief, August 13, 2018, p. 1; Dickson, August 9, 2018.

12 Federal Register, August 17, 2018, p. 41787.

13 *Ibid.*, p. 41788.

14 Dickson, August 9, 2018.

15 “Trump administration proposed further dismantling of Affordable Care Act through Medicare” By Amy Goldstein, The Washington Post, August 9, 2018, [https://www.washingtonpost.com/national/health-science/trump-administration-proposes-further-dismantling-of-affordable-care-act-through-medicare/2018/08/09/cdf919f6-9c1a-11e8-843b-](https://www.washingtonpost.com/national/health-science/trump-administration-proposes-further-dismantling-of-affordable-care-act-through-medicare/2018/08/09/cdf919f6-9c1a-11e8-843b-36e177f3081c_story.html?utm_term=.06dfd095c754)

[36e177f3081c\\_story.html?utm\\_term=.06dfd095c754](https://www.washingtonpost.com/national/health-science/trump-administration-proposes-further-dismantling-of-affordable-care-act-through-medicare/2018/08/09/cdf919f6-9c1a-11e8-843b-36e177f3081c_story.html?utm_term=.06dfd095c754) (Accessed 8/10/18).

16 Dickson, August 9, 2018.

17 Dickson, August 9, 2018.

18 Federal Issue Brief, August 13, 2018, p. 1.

19 Galewitz, August 9, 2018.

20 “Dickson, August 9, 2018.

21 Moore, August 9, 2018.

22 Federal Register, August 17, 2018, p. 41787.

23 Galewitz, August 9, 2018.

24 Dickson, August 9, 2018.

25 Goldstein, August 9, 2018.

26 Dickson, August 9, 2018.

27 Galewitz, August 9, 2018. Estimated total ACOs participating found by subtracting 561 from 109.

28 Federal Issue Brief, August 13, 2018, p. 4.

29 Galewitz, August 9, 2018.

30 Galewitz, August 9, 2018.

31 Galewitz, August 9, 2018; Dickson, August 9, 2018.

32 Federal Register, August 17, 2018, p. 41786.

33 Galewitz, August 9, 2018; Dickson, August 9, 2018.

34 “ACOs at a Crossroads: Cost, Risk and MACRA White Paper” By Allison Brennan & Clif Gaus, National Association of ACOs, 2016, <https://www.naacos.com/assets/docs/news/acosatacrossroads-naacoswhitepaperfinal.pdf> (Accessed 8/10/18), p. 6-7.

35 APMs, one of two tracks under MACRA’s Quality Payment Program utilized for determining Medicare Part B payment adjustments going forward, is a “*payment approach that rewards providers for delivering high-quality and cost-efficient care.*” “Advanced APMs” Practice Fusion, <https://www.practicefusion.com/quality-payment-program/what-are-apms/> (Accessed 8/20/18); “APMs Overview” CMS, Quality Payment Program, <https://qpp.cms.gov/apms/overview> (Accessed 8/20/18).

36 Dickson, August 9, 2018.



**(800)FYI - VALU**

*Providing Solutions  
in the Era of  
Healthcare Reform*

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- [HCC Home](#)
- [Firm Profile](#)
- [HCC Services](#)
- [HCC Experts](#)
- [Clients & Projects](#)
- [HCC News](#)
- [Upcoming Events](#)
- [Contact Us](#)
- [Email Us](#)

## HCC Services

- [Valuation Consulting](#)
- [Commercial Reasonableness Opinions](#)
- [Commercial Payer Reimbursement Benchmarking](#)
- [Litigation Support & Expert Witness](#)
- [Financial Feasibility Analysis & Modeling](#)
- [Intermediary Services](#)
- [Certificate of Need](#)
- [ACO Value Metrics & Capital Formation](#)
- [Strategic Consulting](#)
- [Industry Research Services](#)



**[Todd A. Zigrang](#)**, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "[The Adviser's Guide to Healthcare – 2nd Edition](#)" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).



**[John R. Chwarzinski](#)**, MSF, MAE, is Senior Vice President of **HEALTH CAPITAL CONSULTANTS (HCC)**. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, as well as, economic and financial analysis. Mr. Chwarzinski is the co-author of peer-reviewed and industry articles published in *Business Valuation Review* and *NACVA QuickRead*, and he has spoken before the Virginia Medical Group Management Association (VMGMA) and the Midwest Accountable Care Organization Expo. Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. He is a member of the St. Louis Chapter of the American Society of Appraisers, as well as a candidate for the Accredited Senior Appraiser designation from the American Society of Appraisers.



**[Jessica L. Bailey-Wheaton](#)**, Esq., is Vice President and General Counsel of **HEALTH CAPITAL CONSULTANTS (HCC)**, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey-Wheaton is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the *Journal of Health Law & Policy*.



**[Daniel J. Chen](#)**, MSF, is a Senior Financial Analyst at **HEALTH CAPITAL CONSULTANTS (HCC)**, where he develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition, Mr. Chen prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services, and applies utilization demand and reimbursement trends to project professional medical revenue streams, as well as ancillary services and technical component (ASTC) revenue streams. Mr. Chen has a Master of Science in Finance from Washington University St. Louis.