Eric: Race to Value listeners, we have such a great episode for you today. If you are an ACO trying to figure out, "Do I do MSSP enhanced? Do I go into the new Direct Contracting model? How do I make this decision?," this is the episode for you. Today, we have Mr. Rick Goddard, a market strategy leader for Lumeris. Lumeris is a company that supports healthcare organizations like yours, that are in this journey to manage value-based care risk. They have a comprehensive value-based toolkit, the experienced human capital and the technology to really provide end-to-end support and partnership for their client organizations.

Rick Goddard is the absolute expert on Direct Contracting and all of the new payment models coming out of CMMI and, of course, the MSSP. We had such a great episode, Daniel, I thought, in really trying to dive into, what does this all mean and how do you make a decision? So excited to get this out there and really support our ACLC members and other healthcare organizations that are trying to figure out what decision to make at this important time in value.

Daniel: You know, Eric, I think you're right that our listeners are really gonna value this conversation. I'm excited about this episode because it's an analysis of these two contracts and it's this conversation that we have with Rick that highlights a brief that we wrote together with Lumeris--a deep dive analysis of the options between the two MSSP advanced risk options, as well as the Global and Professional options in DC.

And this is one that I'll just say up front, you're gonna want to listen to this more than once. You're gonna want to reference the bookmarks that we have on the website. Uh, there's a lot of technical information, but it's really good, solid analysis, and I'm excited for our listeners to hear it.

So, with that, let's turn it over to Rick for our next episode of Race to Value.

Eric: Rick, welcome to Race to Value! You're joining us today for a very important episode.

Rick: Thanks for having me.

Eric: ACOs are at this pivotal point in deciding how best to proceed in performance-based risk in the Medicare program. This is also going to be our first podcast episode where we've analyzed a specific payment model with a guest. Here today, we're talking about the Direct Contracting model and how it compares to the Medicare shared savings program. And recognizing that there's going to be sections of our conversations that are going to get into the details of the models, I wanted to first get into just getting to know you as a person, and I thought a great way to start our conversation would be to ask about your personal why. As I understand, you're a triathlete, health is really important to you. How did you get involved in healthcare? Is there a personal connection? And also, what is it about value-based care that is most exciting to you?

Rick: First of all, Eric, Daniel, thanks for having me on. A pleasure, and honestly, know there's a lot of great people that you've interviewed thus far and I'm excited to be a part of this great alumnus base here.

So for me as a personal connection with healthcare, I think mental health is a key personal connection. Family and friends, provider colleagues, and even some of our close fellow healthcare administrator colleagues who we lost the past couple years due to mental illness, it's been an increasingly focus of mine to support and destigmatize throughout the healthcare industry.

And so, with COVID-19 proliferating, there has just been a compounding issue amongst the pandemic via joblessness, social isolation, political turmoil, social and racial injustice, family member stress with the illness, death and dying. Very close to me right now is childcare needs, and all the family dynamics to make sure you keep people safe. And then those with jobs, you know, job stress and doing more with less.

So, all that compounding in a very unique time, and I hope this is the one period in our lives that we'll have to deal with this. But we look at our colleagues that are struggling with this and may not be at eye-to-eye view, but they need the support. So, I found it important to work with mental health friends and colleagues to drive forward with the de-stigmatization of getting help when access is more important than ever. Even for me.

I chose to channel my stress in triathlon training for the last 10 years, and as the standard oblivious male, I just assumed working out can solve all my stressors. And that's not true. And basic balance is needed across all aspects of life. So even when I was training for the Ironman World Championship in Kona in 2019, I thought I had it all right. Great job, great work life balance, great family life. My wife and I just had our first newborn the previous year. And I felt good spiritually, too. But if you focus much of your energy in a couple aspects of your life, the others suffer, thinking about how sometimes we can learn from that imbalance. And it gives you a good place to level set on how you can calibrate in the future.

Therefore, I think about helping others think through stressors and options for help to destigmatize mental support--because everyone deals with it--but don't know where to start. So, the National Alliance on Mental Health Illness is a great place to help those in need if folks are looking for immediate guidance.

So as for value-based care, we all see it as a large problem, like mental health. And some look at it as a task you can't surmount to address systematically. Some freeze, do nothing, and think it will pass with the next administration, while others will put a toe in the water and test it at 2% of their operating budget. So, I guess what excites me is there is starting to get enough momentum in the environment that thaws some providers as it forces them into the game. To

improve quality and lower cost as an entire healthcare continuum, but it also is allowing the providers and consumers to thrive after several decades of testing value-based methods while in part or in whole--right, if you're taking partial risk or taking fully delegated risk--combined with market attention, growing competition. The massive amount of private and public money now flowing through the space, and the general frustration with the status quo. I think we're humming. And I think you guys have highlighted that much in your podcast with previous guests.

But much of which I was excited about to join Lumeris three years ago, is they've been around for a decade operating, and ready for the critical mass point that I think we're at with market. So, I'm excited to be in this phase of my career where I can both lead and operate to execute on value-based care opportunity across the many unique markets that Lumeris operates and will operate. So, with unique patient profiles needed to change the quality of care that's delivered.

Daniel: Rick, thanks for sharing that. I know our listeners appreciate the personal connection and you and I have had this conversation before. The mental health challenge hits close to home for me as well, and so I appreciate you highlighting that and sharing your why.

Let's dive into this conversation, this analysis today, by looking at the Advanced MSSP models and the new DC models by discussing the context around APM's accomplishments to date and what they include. So, the MSSP program began in 2012, when there were only 220 ACOs. Today there are over 500 ACOs providing care to 11 million plus beneficiaries across the United States. Thousands of hospitals and health centers have participated in the MSSP and almost half a million clinicians. That's a lot of reach and a lot of impact. And counting the recently released 2019 results, CMS has realized nearly 2 billion dollars of net gain with the MSSP program over the course of its history and, importantly, more than half of that occurred in 2019 alone.

The MSSP programs have continued to grow and evolve over the years and experiences with MSSP have really informed the development of CMS's latest model offering, Direct Contracting. And you recently wrote about the new model saying, "DC improves upon MSSP by offering more operating levers to help providers successfully manage their population, such as: beneficiary engagement incentives, benefit enhancements, and pass through of benefits to preferred providers to create a virtual network." Can you help our listeners understand at a high level the importance of creating a model that offers these additional levers and what changes in these models result from lessons learned by CMS in previous iterations?

Rick: Yeah, absolutely. So, by background, I was a consultant for several years in a company called the Camden Group, which was bought by GE, I think, in 2015. And so, we supported several engagements of BPCI when it came out in 2012 and ACO implementations across the

US. And many markets had several different experiences, but when I was offered the opportunity to lead Advocate Health Care / Advocate Physician Partners ACO programs across the commercial and Medicare populations, I got really deep into one single market and the nuances associated.

So really, if you've seen one market, you've seen one market. I know, as many of us have lived through many of the early Medicare demonstrations and those that came along post the Affordable Care Act, we became students of the business opportunity, the program methodologies, the downstream impacts, the patients, the total organizational impact to the bottom line, provider behaviors, and all the administrative burden to launch ACOs in their early days. Fun times.

MSSP had Pioneer in 2011 and 2012. I mean, this is fairly simple. CMS managed all the reconciliation and the program design. ACOs just had to make sure that they were setting up the internal care model, setting up a compliant entity in associated governance with the rules, the extended care network to manage the total cost of care to the best of your abilities, even though leakage was inevitable in an open-access environment. And understood that their TIN, since MSSP was a TIN-based attribution program in how you sign them up, not how NextGen or Direct Contracting is at the [TIN/]NPI combination level, was in respect to their own performance in the base years. So, beating yourself, right?

And so, given a majority of the early years included ACOs that only performed in track one, which was upside only, and those that are more recent to MSSP, this is pathways to success evolution to Basic A and B. You have to understand the history of it all, right? So, it was a strange time, the first 6 years of MSSP. We watched as our hospital-driven ACOs were fighting tooth and nail with other leadership to justify to CFOs on the business proposition and whether it was cannibalizing our Medicare revenue and managing the utilization more effectively. The upside-only opportunity didn't just have the teeth, or the program offered effective levers for us to succeed in managing the total cost of care.

So, what it came down to was managing to compliance. Beneficiary complaints towards the data opt-out. Delayed CCLF data's incongruent with the trend reports. I remember we were getting data 6 months late and so anybody that's managed HMOs or managed care contracts with claims connected to them, it's like when you're getting it a few days later, they're trying to make interventions, versus 6 months later and seeing someone fully develop a chronic issue since that time. It's a big deal, it's different. And you can't make those interventions associated.

And then in program requirements then, getting a black box financial reconciliation and how we earn shared savings, or not. Then back then, those that took downside risk at that time. God

bless them, but for me personally, I didn't see the juice worth the squeeze with the care delivery controls at that time.

Also, with the ruling on not being able to go back in risk with your entity if you went to a higher risk track, it didn't allow for much strategic thinking on how much your risk organization is willing to take with a relatively uncontrolled population. And I thought many times, we're fighting against moving up in the track because we're still doing quite well on track 1 up. And so just with extensions you saw that there was opportunity to progress but there just wasn't enough levers yet. There weren't enough managed care-like designs to assist MSSPs to progress in risk.

And so that's in all I've learned about it, in hundreds and thousands of comment letters to CMS and our own ACO learnings and operating one myself. And proving them led to more ways to operate a managed care model under a traditional Medicare chassis.

With all this said, kudos to CMMI and CMS for listening, and keeping focused on all the work across administrations. That's a big lift. So, I think this is a good opportunity to share that you're doing good stuff.

So as ACOs progress up the ladder in risk and offer more carrots, more benefits, like rewards, CMS offered to entice ACO leadership and providers to accept more risk and drive the total cost of care down. So, these inclusions, in prior years, referenced a SNF 3-day rule, Telehealth waivers, an availability to work with a prospective attribution model. And you saw final rule making in new contract periods and tweaks also committed to the improved design.

However, up until the Next Generation ACO [since Pioneer concluded], there were not options to participate at the [TIN/]NPI level of network inclusion. And so, availability for capitated payments to participating providers and beneficiary engagement incentives up to a certain dollar amount to drive consumer engagement and align physicians--that was a good test. And so, given there are no sticks--you know, we talk about the carrot and stick--there's no sticks or denials or punishments in traditional Medicare because there's no behavioral disincentive to go out of network or stay coordinated within your ACO care-network. ACOs continuously had to innovate to drive in-network value and provide loyalty/stickiness, to drive care coordination across their network in managing this for the next population.

With us reaching Direct Contracting at this point in time, as its latest innovation in the Medicare ACO, they've modeled Medicare Advantage-like levers--and it's not a coincidence, there's a lot of learning that went into this--that have proven to influence quality and cost-effective behaviors and to implement across the network to what you described as the virtual network, to arrange those managed care controls that are desperately needed in a PPO-like environment.

So, managing that and actually having the ability to pass it along to your preferred providers who are not required that they take 100% reduction in their fee-for-service schedule, really starts to do something interesting with your whole continuum.

Eric: So, Rick, we're in this ACO landscape right now, and you have these groups moving into two-sided risk options already like the MSSP Basic E and Enhanced models, and then to your point, CMMI is looking at okay, how do we leverage MA and think about creating a risk progression path that's gonna be congruent with what provider groups are doing in that space? And the Direct Contracting model really seems to be it. With both professional and global options, it really provides the new opportunity with flexibilities that aren't in other CMMI models or available currently in the MSSP.

Prospective participants really need to start thinking now. We're at this moment, like today, you need to make a decision. How are you going to proceed in the 2022 performance year with both the MSSP and Direct Contracting application cycles quickly approaching? And after a COVID-caused moratorium on new entrants, CMS will soon reopen the MSSP application cycle for the 2022 performance year, and though the specific application window hasn't yet been announced, we're expecting that here shortly. Similarly, the application period for the Direct Contracting model in the 2nd and final cohort, that hasn't been finalized, but we're anticipating it's going to open around March to May of this year, according to the last timeline that CMMI was discussing. So now is that time. ACOs in the industry and provider organizations out there looking to progress in risk, they have to evaluate their options and make those critical decisions.

So, to aid in that analysis and decision-making, we partnered together--the ACLC and Lumeris. We came up with this incredible intelligence brief, I'm so excited today to be able to discuss this brief with you on today's podcast, and there's seven key areas that we outlined in our intelligence and our research together. Let me just read through a couple of those: participant eligibility, beneficiary attribution, financial benchmarking, quality performance, payment models, financial settlement, and then additional benefits. Rick, can you provide our listeners today maybe with just a brief explanation of all the major changes that are happening in these areas? What are the key elements from the brief that you would like to highlight for those evaluating their options currently?

Rick: Yeah definitely, and Eric, thanks for the opportunity. I think, you know… You're gonna have to help me in case I miss a few of these in terms of the list here, but… I think if you think about participant eligibility, this is--for MSSP--relatively straightforward to provider health system for ACOs who are eligible in ACO in those Medicare ACOs.

With DC, you're allowed the entrance of new entrants and payer-based conveners, partnered with private equity-backed physician aggregators, the inclusion of high-needs organizations that

manage, let's just say SNP patients. Medicare Advantage or Medicaid managed care like organizations. And so even if I reference Geo rather briefly, it's important, I think, we don't avoid that there's a whole other model that's going on right now in the Geographic model that was released in December.

They added a requirement of a covered entity requirement. So, this is HIPAA-designated payer-providers. So, providers that plan to join will have to put forth a minimum financial assurance--the surety bond line of credit or escrow based on the model they choose--to cover downside losses if they occur. And I think there's a fairly significant lift between those compared to MSSP.

Another thing is just there's early term withholds against the benchmark to ensure providers proceed past the first performance year in Direct Contracting. I think this was in observance to the come and go in NextGens. [in reference to NGACO behavior] After noticing their ACO was trending in the wrong direction, they pulled out early. Realistically, performance won't be seen after the first year anyway. So, folks should know by the time that they sign the agreement, if they were to join Direct Contracting, whether they're ready to take the risk.

And I think I heard, you mentioned beneficiary attribution, Eric. I mean, claims-based attribution still exists as the core driver for attribution in populations. However, more prominent is the use of voluntary alignment in Direct Contracting. And its influence over the prior years with an increased competition in the market.

Retrospective and prospective were also offered in MSSP, whereas DCs can choose between prospective--which is kind of an annual understanding of what your beneficiary list is--and prospective plus alignment--which is a quarterly inclusion period for newly voluntary aligned patients. Just a nuance. Only participating providers continue to be the marker for eligibility for claims-based attribution, so that's really consistent with MSSP.

The one that we've been highly anticipating since the beginning of the announced release in April 2019 is just, how is this all gonna work financially? The highly anticipated release of the financial benchmarking breakdown came out in I think it was September 2020. And so, they outlined a few key things that's important for us to understand as we make some decisions on if this is the right model for us.

So just to be very brief, right? Three-year baselines exist for DC and MSSP as part of their claims-based component of the benchmark. However, Direct Contracting focuses heavily on 2017 through 2019, throughout the whole contract as the baseline period. So, it's important to understand in performance those baseline years to determine how much lift you would have if a majority of your population is being carried over from previous claims-based attribution ACOs.

The second is regional benchmark. In MSSP, it's retrospective based on fee-for-service expenditures and assigned by the county. Whereas DC is prospectively determined for each PY from a Direct Contracting rate book, which is modeled off the MA rate book, which I think provides a more predictable prospective spending target that capitalizes on the DC rate calculations.

So I think, if you've read some of the other summaries… There has been some interesting commentary that this does favor the new entrants, because all of their benchmark is based off of regional because they're all net-new voluntary aligned patients.

Another component is risk adjustment. Modest risk score capped at plus 3% over a 5-year period in MSSP, versus in Direct Contracting, you have CMS HCC prospective scoring, which is similar to how MA is evaluated --which is based on a diagnosis from the prior year and expenditures from the current year. But the key point to notice, while there's still a cap on risk adjustment expenditures annually, it's going to be evaluated on an annual rolling basis with its coding intensity factor. Which, if you compare to MSSP across the entire agreement, that's a substantial improvement. And, perhaps, initiative to introduce a risk adjustment program.

And up last, and probably most controversial, is the inclusion of this discount. So, there's no discount in MSSP or professional Direct Contracting, but for the global model, it's an escalating 2-5% over the contract period. And so that's really taking up to that discounted amount is where you start your first dollar in managing the risk of that global population.

I know that I'm going fairly in-depth, and I know this is technical, but I'll do my best to talk through things as the biggest implications for you as you're making that decision, podcast listener. I think quality performance is a huge thing to be paying attention to. We know in MSSP there's several measures we have to pay attention to, in inclusion of self-reported measures. But that comes as a trade-off with Direct Contracting because quality performance is tied to a 5% [quality] withhold compared to the benchmark to earn back that first dollar. And while albeit, the quality burden is a lot lower compared— since there's no self-reported measures—I think that's a positive thing for reporting version wise, but less measures means each individual measure is that much more important. So just an important consideration to make sure you have your quality in line and ready to manage a claims-based profile.

The key thing that MSSP did not have payment mechanisms. It was simple, your providers and downstream systems would bill Medicare as usual and you would get a reconciliation at the end of the year. Now you have the opportunity to produce downstream capitated payments to your providers, and CMS has left it fairly flexible for how you would pay those downstream providers. And so, developing that design for what you're intending your provider makeup to be is a key portion that we think about when we help our clients, and then the operational

distribution of it, given TPAs and standard payers don't necessarily have this use case where they're managing post-adjudicated claims from CMS and then administering the payment downstream. Depending how complex you get it, that's a pretty advanced operation to put forth. But we've been thinking about that for our own clients as we start to proceed.

The other thing just to cover so I can kind of hand this off is just, I think the additional benefits [beneficiary engagement incentives] is huge. Cost sharing is the biggest callout for beneficiary engagement incentives. The ability that you can essentially provide coinsurance coverage to increase access in your beneficiary population to encourage people to come to the doctor more, I think it's incredibly effective against the cost given these beneficiary incentives will be charged against your-- you have to manage to your own benchmark under budget.

But getting the access into PCPs, the investment return, way surmounts the cost. And so, I think about the type of things that can give access and also keep people healthy in these beneficiary engagement incentives, and they mimic--and it's not a coincidence--much of what's going on in Medicare Advantage. And these benefits are gonna be market specific in what appeals to the beneficiary in their region, but I strongly encourage because these things are gonna be, you can also market to it in voluntary alignment. So, this is, I think, a game changer especially when selling over an MSSP to a beneficiary.

So, I think that covers some of the high-level grids, gentlemen.

Daniel: Great, thanks. Yeah, that's great. Super helpful to hear that and yeah, there's a couple of those that are really interesting to me and I want to stay on this topic and go a little deeper into some of those--specifically, this increased emphasis on voluntary alignment is pretty significant. It's a big deal. And then you called out the regional versus claims-based benchmarking, I think that's worth diving into. And then I think organizations are gonna also want to learn a little more about the risk adjustment differences and the increased capital requirements. So, if you wouldn't mind just taking a couple minutes and tell us a little more in-depth what those changes mean in those areas, I think our listeners would appreciate hearing that.

Rick: Yeah, so let's start with voluntary alignment. So, it's been around for several years under former Medicare ACO models, and it has been a loyalty option to encourage members that have had a standoff on plurality of services to where between two ACOs, such as provider-led ACOs, would be effective. But however, there's very little uptake, and folks had other stuff to do.

So now through Direct Contracting voluntary alignment, and really now for all Medicare programs in a given market, given this is available for DC, voluntary alignment is crucial. First, in

Direct Contracting, from an alignment perspective, it takes precedence over claims-based alignment.

So, think about that. You have been seeing a patient for years and this set of doctors come into town and begin talking to that patient, and then voluntary alignment occurs and that patient gets the supplemental benefits associated with it. And so, you certainly could see your attribution dwindle right before your eyes.

So second, Direct Contracting members can market their patient engagement incentives that their specific DCE offers. Let's just say-- I'll take that example a little bit deeper. So, let's say that beneficiary has a relatively loose relationship with their normal primary care physician. Maybe a 1 to 2 time a year visit. That beneficiary begins to see marketing in the community that can acquire benefits to participate with another doctor network near home and they can get transportation to office visits, their coinsurance waived for all PCP visits, and receive a 75-dollar gift card for completing their weight management program.

So, their current doctor, who is participating in MSSP--and albeit a loose relationship--can offer no additional rewards to maintain that patient other than the provider patient loyalty to rely on. So, if that patient is cost sensitive but also sick of paying premiums on their supplemental Part B insurance, they also may see the local DCE benefits to surpass the values of that cost of that self-insurance. So, I expect that new entrants in progressive health system-based DCEs will be looking to grow membership, and market share. This is a great opportunity to do this, but also look at it as an opportunity to defend their membership. So just because you have that claims-aligned patient today, it behooves you to still voluntary align them. So, there's not the opportunity where others can trump your voluntary aligned beneficiary.

So voluntary alignment also has implications on the benchmark. If they're a new patient, they get the regional alignment, which is mostly beneficial to the benchmark rather than using claims-based benchmark. So, there's some organic growth plus benchmark advantages, which is a win win strategy to acquire new patients in voluntary alignment.

And I wanna reference Geo again. Lastly, in Geo markets, voluntary alignment is at the top of the attribution precedence list. Those Geo DCEs that market well and align with strong preferred providers will have consumer engagement plus aligned incentives to drive comprehensive care throughout the DCEs continuum.

So, talking about risk adjustment is one of the other things I think you called out, right? MSSP uses the CMS HCC risk adjustment model and will allow for modest risk score growth, so it's, as I mentioned, capped at a 3% increase over a 5-year agreement period.

So, DC does a couple things that are a little different. So, they use, in CMS HCC, prospective models. So, this is applicable for both standard and new entrant DCEs as models, and risk models based on diagnoses from prior year and expenditures from the current year, and it's designed for MA and has been applied to numerous CMMI APMs. But there's this new entrance of this CMMI HCC concurrent model which is kind of being a pilot for maybe future rollout, but it's used solely for the high-needs population Direct Contracting entities. Risk model is based on diagnoses and expenditures from the current year, and it's designed for a Direct Contracting model and intended to improve payment accuracy for small populations of these high-risk beneficiaries.

I think it needs to take note that risk adjustment is subject to that 3% cap, but it's on an annual rolling basis and inclusive of normalization and coding intensity factor. But it really, the juice is worth the squeeze to begin early if you don't already have a program in place to ensure patients are accurately documented and reflected what their current diagnoses are annually, and so making sure you have that, it's really important.

And under Geo, there's no cap in coding intensity. However, there is a, via budget neutral normalization back to a 1.0 risk score, so much like we've seen commercial exchanges operate, and these organizations that put the better risk adjustment programs in place with providers will have the advantage in the market.

So, the third and I think final I think I'd want to cover, Daniel and Eric, is just the capital requirements, and this is just in observance, right? So, in MSSP, financial insurance for DC Basic and Enhanced is 1% of the benchmark, and I think there's a 2% if it's the lesser, which if you're an ACO that's based on revenue. But in Professional Direct Contracting, this is 2.5% of that benchmark, and global, so they split it because they want to make sure that there's more assurance for those that are gonna be paying back total care capitation versus primary care capitation, so in global that's 3% of benchmark and PCC, and 4% in TCC.

So, the cap requirements for Geo deployment, if you caught that, is 10% of benchmark. So, these are much heftier numbers to get issuance of a surety bond, letter of credit, or put funds in that escrow, and each of those have different balance sheet impacts and bank fees associated with issuing those instruments. But ensuring that you have enough capital reserved for repayment mechanism, financial assurance is important.

Just to put it in a scale of numbers, so for 25,000 live Professional DCE, and let's just pick a market. Looking at Denver, right? Your total annual benchmark is gonna be roughly 230 million, just crunching some math that I pre-prepared-- Just so you don't think that I actually have a calculator in my head. At a 2.5% benchmark, you'll need roughly about $5.75 million in issuance. Now, on the other end of the spectrum, you have Geos. At a 10% benchmark--let's

just say you're 1 in 4 Geos and there weren't any other professionals in the market. No MSSPs. So, you can even split the eligibles at say, 50,000 lives. Your premium would be roughly at 460 million, and need an assurance of 46 million to procure for CMS's requirements.

So, this is not insignificant--which is a major hint by CMS is that they're looking for large players with a lot of access points. So, one could say this is a fit for national payers, but I know CMS is looking for a combination of providers and payers, as a threshold to ensure folks are serious about the risk at hand. That's my coverage on that one.

Eric: Well Rick, you mention the importance of getting these large players in the Direct Contracting model with different access points, having clinical integration, large systems managing hundreds of thousands of lives, potentially. And I think about how health systems are gonna progress in this new risk model and position themselves competitively in their market, and I'm just thinking about all the conversations we have with health systems in the ACLC. I mean, we're hearing it right now. They're feeling some pain right now. Because of this pandemic.

Over the last 10 months, providers on the health system side are having to expand capacity and redesign their staffing model, their workflows, adopt new virtual solutions, they're dealing with PPE shortages. Of course, the drops in revenue are just significant. And then they have a patient population that's plagued with all this misinformation about the virus and having to think about the vaccine rollout. I mean, these health systems right now don't have a lot of attention span right now to really focus on how they progress in risk and thinking about Direct Contracting, but there's definitely some health systems out there that would succeed in this model. And I think about how they can navigate this decision point at this critical, historical moment we have in time.

So, it seems like the business models and the strategies for these health systems that are gonna retain or increase market share, they've never been more important. So, I wanted to ask you, Rick, how do the MSSP and the Direct Contracting options impact the likelihood of losing or gaining market share for these health systems? How can they create or limit competition in the Medicare market and how can these organizations respond and recover from the financial implications of the pandemic? And how should they be thinking about this movement towards longer term, creating more of an asset-light business model and thinking about the shift to ambulatory care and leveraging innovation and technology in the right way. How does that fit into this important decision as they evaluate the Direct Contracting model? What are maybe some of the entrepreneurial things that they should be thinking about as they progress in risk within this new CMMI model?

Rick: That's a great question, Eric. I mean, if you had asked me that question 5 years ago, I feel like I would've had a bit more indifference to the impact MSSP was having on the Medicare market share and how providers reacted to it in the markets. You have to remember in 2015, we're still amidst of BPCI, the Oncology Care model launching, ESRD thing starting, and getting to the next renewal cycle of Tracks 1 through 3 in MSSP. Plus, we were still figuring it out, and it was a good retention strategy for CMS, the "what have you done for me lately" bonuses in a clinically integrated network. Even in very competitive markets, it wasn't a big deal.

The folks who probably felt the squeeze the most were the post-acute organizations that were oversaturated to begin with and focused on maximizing revenue on a day's basis, and not used to being positioned against a post-acute network and see volume and share going to go if they weren't high performers and to STAR programs. Not to mention that BPCI impact of diverting post-surgery episodes from SNF to home. That was the stuff that we got to see at that time.

So, enter the MACRA legislation in 2015, which formed the quality payment program where we see, I'm sure everybody is familiar with MIPS and Advance APM at this time. I know we're wrought with acronyms in healthcare, so the merit-based incentive program and advanced alternative payment models. I know there are mixed feelings across my provider friends and fellow admins, but there was some purpose to it, and it added a layer of complexity to the strategy for how some of us make decisions on proceeding down the path to risk as an ACO. Some pretty good macro behavioral economics came into play when they said to docs directly, "hey, try your luck at MIPS against your quality performance on a bell curve, or join an APM (which were bundles or ACO in that time) and get group coverage on reporting (which was the MIPS APM) or even do an advanced APM and we'll give you 5%."

So that was an interesting time for strategy in the progressive organizations. One I was a part of with… Advocate Physician Partners retained our 5,000-doc network under our MIPS APM in our track 1 ACO. And then we charged toward Advanced APM status for the part B 5% bonus. In some markets, docs would jump ACO to ACO to join a practice due to the reporting burden that MIPS was incurring, and this shifted Medicare strategy and created a view into how competition could move in on attribution and impact market share.

Now the quality payment program combined with Direct Contracting and voluntary alignment in play, the thresholds for Advanced APM have increased and we are getting past the point of non-participating providers just going along for the ride, right? DCE rewards high performers by placing them in these high performing Direct Contracting networks. And through a strong voluntary alignment strategy, inclusive of these national payer MA conveners and new entrants, can impact the Medicare dollar even further within a given network. This should not be a wake up one day and wonder where my Medicare referral downstream went for these incumbent providers. The writing is on the wall, and it's seemingly very intentional.

So, I'm not sure how MSSPs can help recover from financial implications during COVID, unless they're already part of an ACO that had forthcoming shared savings. However, I heard you talk to Dr. Gordon Chen and Dr. Kevin Spencer in previous episodes about how the capitated payment cash flow is available in Direct Contracting Entity participants, and preferred providers if they're interested and if DCE has enrolled it, provides the revenue flow they need when the volume contracts.

Direct Contracting payment mechanisms will be a major value add for practices looking for budget protection consistency, but also adds the benefit of why folks take cap in the first place. Get off the hamster wheel of 20 visits a day and spend more time with patients to manage their conditions and coordinate them effectively throughout your care network to keep them healthy.

And I heard you ask about; how do we impact the ability to move to an asset-light business model and leverage different models? I hear that question and I think wow, that's something I hope everybody's thinking about. We can't all do this ourselves. We need to be thinking about what we can leverage as not maybe a poor asset or poor skillset and then perhaps grow them or just totally decide hey, this is not something I'm going to do but I'm going to find the right partner.

So as any practice or health system leader is thinking about their own operating cost per unit of service and executing the day-to-day operations of the enterprise, thinking about the value-based care investments in ongoing review of an intervention ROI is a prudent thing to do, and it's not old school. That should continue as a good business principle for years to come. But thinking about the right assets to lower your cost per unit of service and making the right informed decisions on intervention investments is paramount.

What I usually say is, in value-based care on mind: start with access. In a VBC business model this usually begins and ends with: did you give your network enough access and engagement to ensure they got the resources when they needed it and understood why they needed it at that point? As we saw in mid 2020, the pandemic has become a catalyst for telehealth access growth. It will take time culturally to adapt to that fully and embrace the extra access points that brings a risk bearing organization towards that.

The great thing from an asset-light perspective: there's not a ton of baggage in the value-based care space because it's only been tested and partially implemented in systems to where there would be a skill transfer than any job loss. So, an example would be skillsets that would need to be integrating APIs into the core system of new intervention-based programs and technology.

Shoutouts to my friends at Cerner and our co-product Maestro. Without an integration of EMR agnostic inputs since Cerner's HealtheIntent, which is Cerner's, of course, data ingestion and

output engine. I just find that there's gonna be plenty of things for people to do and because this is only 10 years to 15 to 20 years in, depending on some organizations, there's plenty of work to do to go around.

So, another one of my hats off with Advocate [Aurora Health] is their innovation incorporation with the VBC business model. The key thing ACOs and risk bearing organizations should focus on is starting with the really low hanging fruit, with multiple comorbidity patient management--and there's applicability to the business model across MA, etcetera. But there are hundreds of apps out there to help with diabetics by focusing on one area really well, such as screening patients for diabetic retinopathy and then preparing a care plan ahead of time--that's a major intervention. And so, finding other ways to do asset-like activities where you can get people into the office on a periodic basis while monitoring their vitals ongoing will be advancing rapidly. We'll probably be talking about this two years from now as like, man that was cool. Integrating those assets in a meaningful direction along with our provider colleagues and assuring not making solutions that continue to provide alert fatigue to our provider colleagues is essential.

Daniel: So, Rick, the major opportunity provided by the MSSP in comparison to DC is a greater sense of security. Not only is the degree of shared risk literally lower as you've talked about, but the MSSP in another way is a safer bet because it's been tested for many years and by many previous participants. So, some of the risks associated with selecting the MSSP over new DC options include, as you mentioned: leaving generated savings on the table, which result in business model and investment constraints caused by the fee-for-service based chassis. Conversely, DC offers more incentives to both providers and beneficiaries to support care coordination and alignment with managed care-like benefit designed to drive down unnecessary medical costs. Similarly, there are general opportunities and risks associated with DC's innovative model policies. For example, DC has this added layer of financial risk linked with quality scores that would-be applicants should keep in mind, but it's also got this added bonus through the high performers pool, the HPP. And then as you mentioned, there's this fact that it has the potential for full capitation, which is a significant benefit that you just outlined.

So, I'd like you to talk a little bit more about the risks and opportunities available in DC compared to MSSP and how can the DC models be leveraged to really advance care and how do they align for organizations considering Medicare Advantage? And finally, what are you hearing from providers who are not moving to DC? What's the dealbreaker for them? Is it something that you're hearing universal, similar answers or are they individual reasons for each of them?

Rick: Great question, Daniel. I'll try to tackle; I think there are 4 questions in that. You look at Direct Contracting from an opportunity standpoint. I'll hit a few of the majors and then a few of the risks.

So, the ones that come to mind first is cash flow mechanisms and as we've seen throughout the COVID situation it smooths revenues for practices, but it also has the opportunity to behavioral incentivize creatively downstream in partnership with our provider partners. So, I think increase capitalization, invest in non-revenue generating services and improvements. So, you're getting that cash flow as a lump sum that you are free to really work through and invest in different components of your ACO now with DCE.

A Direct Contracting Entity fosters creativity and customization. We can think about a lot of different things that we want to do with our beneficiary engagement incentives. We're looking at additional tools that we're being offered to work with the DCE, as far as waivers.

I think I like allowing providers to attract and compete for loyalty in beneficiaries. This is an opportunity to really show why you're the best at what you do and you have great connection points. But that is going to halo effect across your populations. If it wasn't a reason to really promote some marketing and get this going, this is a great opportunity to do this with financial levers behind it.

This incentivizes long term investment. This won't be the first time a model like this occurs and we'll begin to see the phasing out of the old models because of the lack of benefit to the Medicare bottom line. And so, investing in new models--and ones that could be successful that potentially scale nationally--is pretty important.

I think from Lumeris's standpoint, we think about this as a tune up for a network for Medicare Advantage. Really, this is an opportunity for you to tune up your skillsets, to take on partial or fully delegated risks, or perhaps, if you're interested, to move into the provider-sponsored healthcare plan space. So, a lot to think about there.

On the risk basis--any new model, there's a lot of unknowns. And I think CMS has done a pretty good job at--we think about the delays in rollouts, and it's unfortunate due to COVID--of the specific detail needed in order to proceed. There's still stuff that's missing but they're doing a good job communicating to us on when things will be available.

I think the discount methodology within global makes it more difficult to achieve savings. Mentioned that before. The quality withhold is a bit of a difference and with the lesser measures to work really hard at, but you have to make sure you can really execute at it. The withdrawal penalty--so if you're not serious about this, you're really going to have to focus hard on: I'm going to make this at least a 3-year commitment and make sure I invest appropriately so I win.

Other than that, I really believe that the competition issue is going to be something that folks really focus on and find that they will oversee the risks associated by making the right investments accordingly.

And so, you asked how DC models can leverage to advanced care, as I wrote it down. Medicare programs--especially this one in Direct Contracting--can be parlayed into multiple population types. So, a lot of the investments you make in the infrastructure now can produce a halo effect that can be very powerful across your other populations.

You talk about Medicare Advantage and I'll just come back to that. There's a couple things that I see as very well aligned, like the supplemental benefit alignment. You start tuning up these Direct Contracting Entity benefits where they allow you to do this under these waivers and provisions, you make it very much aligned with what you're planning to do in your MA strategy, right? Or with your preferred partner or your operating partner to deliver MA downstream. But you could start to educate patients fairly easily and bring the cost of acquisition down of an MA patient if you're already starting very early in the age-ins. So, it's a particularly interesting alignment strategy.

Another one would be tuning up skill sets and what we call "mind share" at Lumeris, of the providers on the participant network to have the critical skill to say: "I'm going to change the way I run my practice to a value-based care model, as opposed to using this revenue model and fee-for-service is giving less rewards to continue doing it this way." So, you're achieving that skill by more patients that are than your current patient base that are focused on value.

And then I just say you're starting to build comfort with risk, right? Comfort with capitation and downstream payment mechanisms and risk adjustment programs and functioning under a STAR quality program. A lot of that is just great tune ups and this is not unintentional. I think the DC designers thought a lot about how this could look at the successes of MA and how do we align programs to give the beneficiary the best quality opportunity and be good stewards of the Medicare dollar?

So, I think the last question you asked is, what are you hearing from providers who are not moving to DC? What is the dealbreaker for them, right? It's really market specific in a self-evaluation of their readiness. So, we help clients think through that as a self-evaluation is a reality--well, given where the market is, and they have their own assets to deploy. Certainly, we do not encourage those with limited downside risk planning to jump in headfirst, but we try to work with our operating partners in the long-term play to winning on their Medicare strategy.

So, this includes bringing along folks without the organization, who are risk-averse to begin with. So, we also help, depending on the risk averse situation, on de-risking it due to our own customized governance approach.

Also, model specific, it is sometimes misinformation on how MSSP and DC benchmarks interact and can put them on the same axis and plane. If you put them on the same axis with the same benchmark rules, folks may defer to MSSP comfortably. But the benchmarks are very different to make a quick judgement on whether or not it's right for me as an organization and this warrants investigation--especially if competitors are encroaching on your turf.

Eric: So, Rick, you mention the importance of having some prior success and fully delegated Medicare Advantage risk models and I'm thinking about that and some of the organizations that we've profiled on our podcast. You referenced ChenMed and Dr. Spencer from Agilon Health. These are organizations that have specific competencies and infrastructure investments that are gonna allow them and their clients to succeed in Direct Contracting and you think about on the care delivery side, you have to have a wide array of different population health management capabilities. You also have to have a really good track record in risk adjustment and managing care gaps and you really have a high touch model, thinking about boundary spanning interventions that are really targeted with specific patient segments. And then I think about all of the administrative services that you would have in a fully delegated risk model--credentialing and claims and capitation payments and UM and care management and having a good PR team and think about all the network management that goes into that and the sub-contracting.

I'm just thinking about, if I'm an organization and I'm considering Direct Contracting, I need to know exactly what types of investments I need to make in my current infrastructure to be successful. Can you talk a little bit about the process an organization needs to have when deciding on the strategy moving forward in this new model? What kind of data and analytics maybe would kind of help them frame up this decision point and guide them in the evaluation?

And then, also, how should they be looking at strategic partnerships? There's obviously a buy or build decision point. Do they partner up with an organization that can provide them with economies at scale that already has kind of a turnkey, plug and play infrastructure or do they need to maybe be thinking about what they can do in-house?

And then also the other big thing is, what do they do with their workforce? They've gotta be able to pivot their organization. As I mentioned earlier on the care delivery side, really deliver care in a way that's gonna be more accountable to outcome. We're here, at the ACLC, really big on workforce development. I would also love to get your thoughts beyond the infrastructure. How do you approach, as a provider organization, reskilling and upskilling at this point to be successful in Direct Contracting?

Rick: Yeah, Eric, I'm glad you asked that because workforce development and retention of any organization is just core to leadership, right? We think about how do we grow them and we

think through what are the ways to get more folks interested in moving to this business model that I think you guys have spearheaded tremendously and scaled it across many different voice overs in your podcast. Allow me to address the strategy in DC and what are the things that they're gonna absolutely need, but I do want to get to that important workforce component because we really are gonna see 5 years from now relative to the investment here, it's the investment in human capital, and making sure that we're investing even in grad school, medical school, and thinking through how do we make this work?

So, just in terms of the Direct Contracting program--if you're really interested and you're thinking about the strategy, you're gonna have to be thinking about a few of these things. So, like, ability to manage higher levels of risk--which is including up to 100%. You're gonna have to have accurate performance forecasting, no doubt. Like, you're gonna have to work with some data that's not currently available to you that's distributed about your network two months before you start, right? You're gonna have to start looking at 100% claims data, looking at your history, your base years, looking where your regional benchmark can land, and begin preparing your board for these discussions. This is significant risk, and the deadline timing is not on our side here.

So, ability to engage beneficiaries. So certainly, you're gonna have to build compliant marketing activities and figure out how you're going to increase outreach and interaction. Direct Contracting offers so many opportunities to actively engage beneficiaries. So, if you're thinking about developing a consumer engagement program and you haven't invested in it, there's an opportunity to do dually. It's the great thing about when you get these regulatory changes and what you talked about earlier with telehealth. Gives you a really good catalyst to start doing the stuff that you always intended to do.

So, I also think about experience with working with, you know, if you have an existing provider network and developing that high-performing network. So again, I mentioned DC is a [TIN/]NPI-based program, so you're going to be having to walk away from a TIN-based program in MSSP if you choose to do it, and you could start segmenting out your TIN and thinking about new strategies of getting those NPIs into a high performing network. And graduation strategy for those that… We talk about folks that maybe haven't contributed to the benchmark improvement or the quality effort. This is gonna really give the high-performers an opportunity to shine while also pushing the network along.

You're gonna need to understand and effectively manage leakage. Guys, this continues to be an open access population and it's no joke. There will still be plenty of snowbirds exiting your market, so you have to understand where the geographic and social movement of patients are across the network and understanding ahead of time how much is gonna be the expected leakage and where are they going and what could they be doing as to running up the cost? So,

thinking about what are the appropriate ways to engage and include people in this virtual network I talked about.

You're gonna have to continue to expand and grow your payer contracting team. You're gonna have to be focused on some of the negotiations. They're gonna make you leverage your existing team, but you could also outsource to do that deployment of downstream negotiations with your participant providers for how you're intending to pay them in this capitated environment.

I can't overstate the amount of work, at least putting in place, the technology associated with that if you don't have a structure today. And if you're a single employer TIN and you have your own downstream payment, that may be fairly easy. But if you're looking to deploy this across multiple independent TINs and NPIs that don't have the same revenue cycle and payment arrangements in place and you want to pay them, let's just say, a percentage of a cap agreement of a 3-year lookback, you're gonna have to think through what are the systems to pay them downstream?

So I think that really covers it outside of leveraging your existing payer assets. They can develop select functions such as network management, compliance and audit, risk adjustment programs, etcetera. That's incredibly important. But I want to just point out, if you're a health system going into this, you have the stronger name recognition in the community that can help you with voluntary alignments. Don't let that go to waste.

And if you are a risk-averse organization, instituting reinsurance or stop loss with an informed perspective on cost and benefit is important. You don't even have to be risk-averse, it's a good due diligence effort to do this. And while CMS offers a premium opportunity against the benchmark to do reinsurance, there's other options out there commercially, too.

So, I want to just quickly cut to what's the importance of competency development, and how do you build a workforce through this? There's plenty of things I think from a competency perspective. Folks really have to dig into this. I talked about behavioral economics and I told you I wasn't good at micro and macroeconomics in school. My professors at University of Illinois would probably agree. But understanding what humans are motivated by with, be it intrinsic value, resources, recognition, and positioning those incentives to mutually drive towards a goal--this is stuff that is core to value-based care.

And I also think a mutual appreciation of provider and payer-based strengths and skillsets. The worlds are blending and considering yourself a payer or provider person is an old way of thinking. Learning about clinical situations, provider issues by a payer is just as important of a provider to learn about actuarial risk, understanding what a commercial employer is interested in, and MCR/MLR in financial improvement. It will serve you better in negotiations, creating JVs, appreciating others' point of view, and leveraging innovations in both policies and settings.

And please have an appreciation of policy. Being able to follow where Medicare and Medicaid is going, as a majority of the provider payer mix, will inform where the commercial and the private market will move. It's shown itself time and again. So, appreciate how that's moving.

It's just from an organization standpoint, just build the functions for risk. We should appreciate approaching build versus buy, assess your own strengths. There's plenty of organizations that can help you from an operating standpoint but the organization I joined, Lumeris, really focuses on managing the soup to nuts of executing on that.

And then, I just think it's important from an organizational, cultural standpoint… Many of the existing jobs in the world should continue from the VBC model. The new additions are likely helpful to produce scale, such as automation, or resulted in positive results from the community interventions or support for vulnerable populations. You should continue investing in things that work and try to make them better by educating your workforce and engaging everyone in the strategy, whether they are only a small part of the operation. If they know where the organization is driving, they will influence others to go the extra mile influencing outcomes. So, educate a physician, or they'll educate you. Reach out to coordinate an at-risk patient visit to the doctor's office. Those extra efforts have big impact.

So, I think about continuing this business model of an enterprise entity and many cases, the health system-- reform your operating OKRs and goals to measure what matters and align value into the culture. A good example is to stop thinking about revenue targets for hospital presidents as being the primary and only goal. Look to have leadership to drive access or reduce unnecessary utilization.

So as a percentage of risk contracts surpass fee-for-service based contracts, I think these left pocket, right pocket, when we just talk about CINs coordinating through downstream provider systems, those discussions will begin to lessen.

And I appreciate all the work you guys are doing so thanks for allowing me to talk through that.

Daniel: Rick, thank you so much for joining us today on the Race to Value. I know our listeners are going to appreciate your description and explanation and deep analysis of the comparison between the two models. For the final question as we go out today, Rick, how can our listeners find out more about Lumeris and the work you're doing to advance value?

Rick: Well, they can certainly reach out to me, rgoddard@lumeris.com, but our whole company has a wealth of resources on its website at www.lumeris.com and we're also available to chat if you have any questions.