FEATURE

The Medicare Shared Savings Program: A TRANSFO STRATEGY

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With all the positive developments for the Health Center Program that have stemmed from the Affordable Care Act (ACA) – New Access Points, Base Grant Adjustments and money for capital – there have also come a slew of consultants and thought leaders who are telling Community Health Centers that the healthcare delivery system has been forever altered and they need to "get with the program." The sheer number of new consultants and vendors now interested in health centers has increased exponentially and all have a different opinion on the future direction of the program.

While it is true that the ACA has permanently, and positively, impacted the Health Center Program, the biggest impact to health centers arguably is yet to come – driven by last year's enactment of the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA. In a major effort to move the U.S. healthcare system from a volume-based to a value-based system of payments for healthcare, the most well publicized part of MACRA replaces Medicare's Sustainable Growth Rate (SGR) payment policy with a Merit-Based Incentive Payment System incorporating provider incentives for joining Alternative Payment Models.

While this new policy change has no impact on Federally Qualified Health Centers' Medicare Prospective Payment System, health centers will see downstream changes as MACRA will force ALL payers to move toward value-based payments for care.

How do we know this? First, we know the Centers for Medicare and Medicaid Services (CMS) has set the goal of moving 30 percent of Medicare Payments into value-based and alternative payment models by 2016 and 50 percent by 2018. Secondly, we know as Medicare goes, so goes the rest of the nation's health delivery system. In fact, some commercial plans are well ahead of CMS' pace for implementation.

Finally, we may have already seen how this will play out for health centers on a small scale. The Menendez Amendment under the ACA with respect to Marketplace Exchanges

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provides some flexibility for insurance companies to choose which providers they offer contracts. As MACRA is fully implemented, we believe there will be a continued narrowing of provider networks in health plans offered in the marketplace, which will be effectively sanctioned by CMS's focus on quality and value- (outcomes) based reimbursement.

So how does the average health center, Health Center Controlled Network or Primary Care Association react to this? The simple answer is to improve quality. But health centers still must acquire new skills (think predictive analytics, risk stratification, population health metrics, etc.) before signing agreements and to avoid downside risk for as long as possible.

NACHC has studied many accountable care models over the last couple of years and has found that Medicare, specifically the Medicare Shared Savings Program (MSSP), might be the right answer for many health centers.

We know what you're thinking… Medicare? Yes – Medicare!

Of the countless numbers of accountable care platforms studied, most have proven to be unsatisfactory for health centers for several reasons. It boils down to the simple fact that in these agreements, not enough emphasis is placed on the value of primary care providers. More often than not, another entity, typically an insurer or hospital, stood to reap the benefits of the agreement, leaving the health center to shoulder much of the upfront costs but not enough return on investment.

As a result, NACHC began looking for an accountable care platform with the following attributes:

- A focus on the value provided by primary care
- A strong health center governance presence
- A horizontal, not vertical care network – the ability to aggregate patients from multiple health centers in a clinically integrated environment
- A potential for upfront investment
- An ability to focus on the skills necessary for future financial success with low/no downside risk for a reasonable amount of time
- No nonsense on data analytics

As we continued to follow health centers joining MSSPs across the country, we noticed the program not only met the above qualifications, but CMS itself had already lauded primary care-led Accountable Care Organizations (ACOs). In September, 2015, CMS reported that 44% of health center or Rural Health Clinic-led ACOs, without a hospital as part of its network, achieved shared savings – far superior than all other ACOs examined.

Still not convinced MSSP is worth taking a look at? Consider this –

- There is no downside risk for a minimum of 3 years.
- MSSP requires 5,000 patients which promotes the creation of health center led clinically integrated networks – a critical com-

ponent of business success for all health centers moving forward.

- Recent changes to the MSSP program and Medicare in general have made the program extremely attractive:

— Recently increased Medicare PPS rates, enhanced 1st visit payments and care coordination payments (per member/per month).

— Patient attribution issues have been addressed to include mid-level provider visits.

- Medicare numbers are transparent – there is a high level of data clarity to improve your health center's chances for shared savings.
- The Medicare population for health centers overall is small allowing you to alter your care delivery team for a small payer/population and become proficient without risking larger revenue streams.
- Once proficient, skills can be applied to any payer or population.
- MSSP's AIM — Accountable Care Organization Investment Model

— Focused on MSSP ACOs forming in rural and underserved areas

— Upfront and ongoing payments based on the number of beneficiaries

— Funding is paid back based upon shared savings

As a result, it can be concluded that the MSSP program makes strategic sense for health centers. It is the safest — and comes with minimal upfront costs.

At some point, and sooner rather than later, health centers must partner with other providers in ways that were unimaginable just a short time ago. Why not partner with other health centers that are like-minded and share the same mission?

Make no mistake, while MSSP seems to be a great model for health centers, the preparation and eventual success will require very hard work. Most health centers still have very low margins and the idea of taking on another "project" will be difficult. Further, health centers must solve their coding and billing issues to be successful in this new value-based world. But there's an additional advantage no one can overlook: 10,000 new Medicare patients enter the system every day. This is a patient base health centers must begin to embrace! ◆

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NOTE: NACHC hosted three Accountable Care Academies last year and plans are underway to hold another in late April or early May focusing on the Medicare Shared Savings Program. More information about this training is coming soon.

Regardless of the value-based care conversation you are having, NACHC continues to support field work on all accountable care opportunities and is available to help you. It will also be releasing best practice documents exploring outstanding relationships with managed care plans, as well as how Primary Care Associations, Health Center Controlled Networks and groups of health centers have worked together to form clinically integrated networks. Six of these documents are scheduled to be released by June 2016.