Session 116, Success in Risk-bearing Arrangements

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BEYOND THE NUMBERS

Success In Risk-Bearing Arrangements

June 2019

PRESENTED BY

Aaron Jurgaitis, ASA, MAAA

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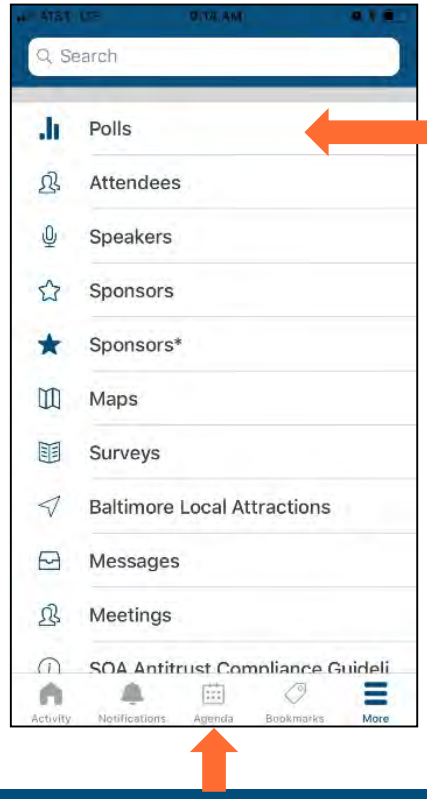

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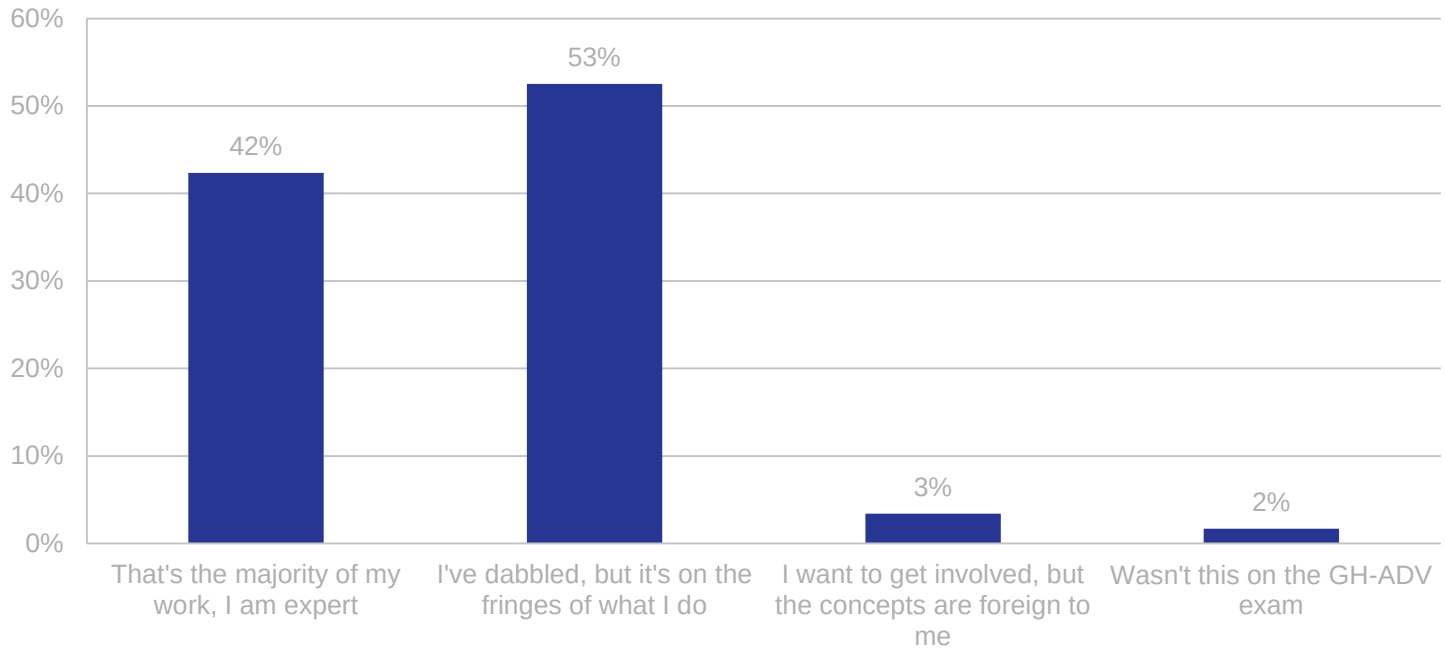
Success In Risk-Bearing Arrangements

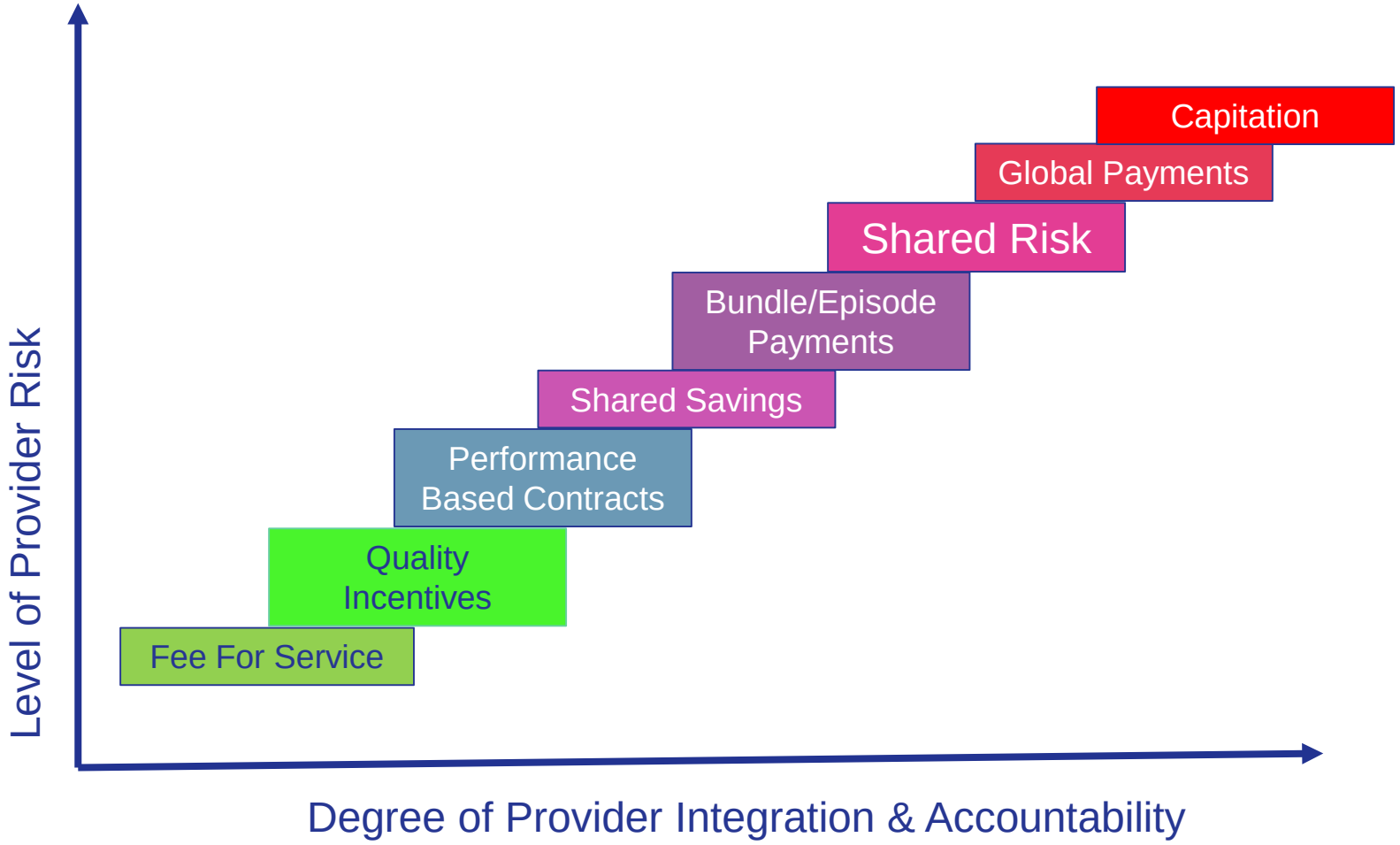
Session Objectives

- Review key elements necessary for providers to succeed in value-based payment models
- Review strategies for payers or provider groups to follow in moving from volume-based to value-based payment arrangements
- Explain how the provision of a shared savings model is likely to impact a payer or provider group

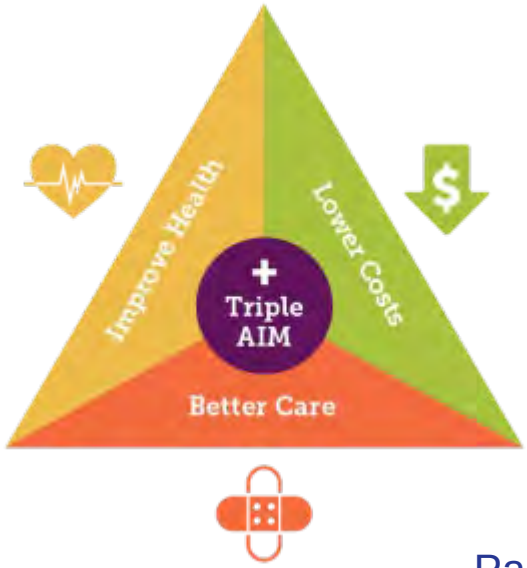
What is your current level of experience with risk-based arrangements?



Value-Based Models



- Value based program = care delivery reform + quality component + payment reform
- Value based care doesn't describe a model, but a spectrum of models



Value-Based Arrangements

What is a Value-Based Arrangement?

Payers and Providers are transitioning away from traditional Fee-For-Service model and shifting the focus to payment for value.

The overall level of risk involved doesn't change, who is responsible for the risk does.

Goals of the shift include:

- Improve patient experience
- Improve health outcomes
- Lowering costs
- Higher physician engagement

Value-based agreements can be delivered and measured in several different ways:

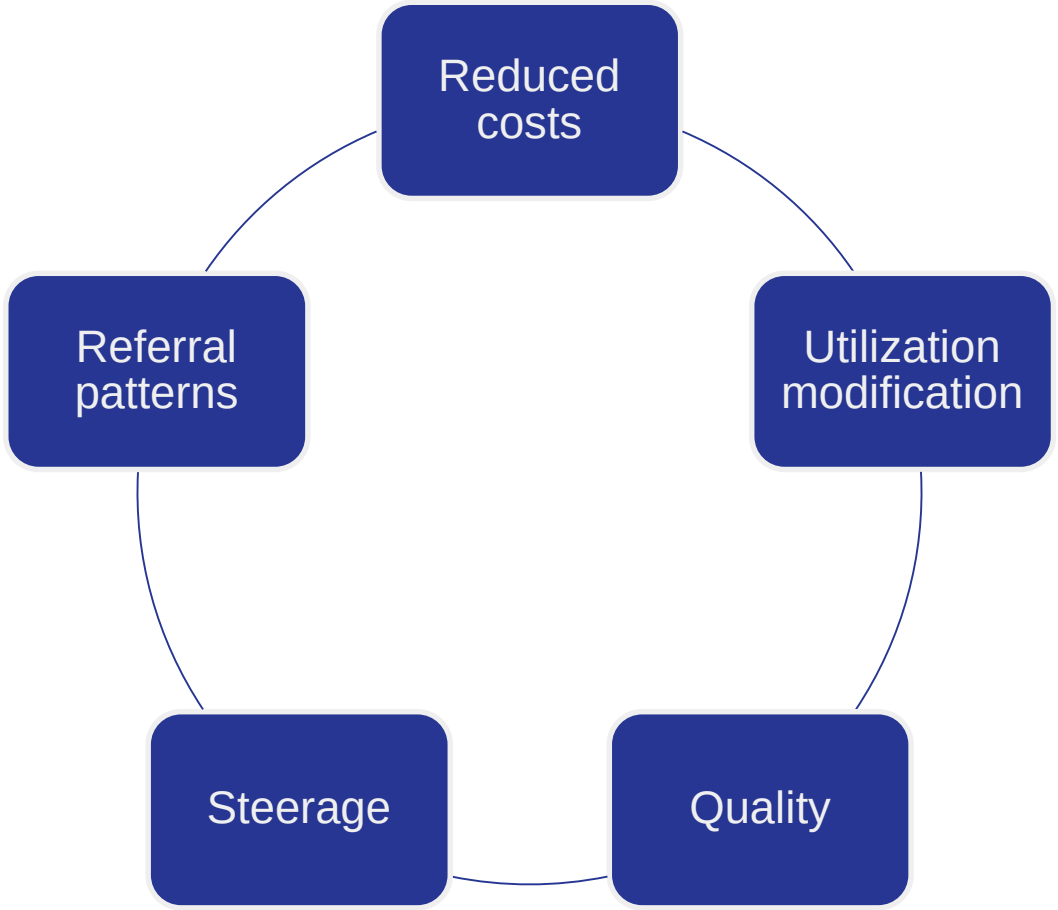
- Total cost of care
- MLR Targets
- Medical Cost Trend Targets
- And more…

Value-Based Arrangements

Key Elements

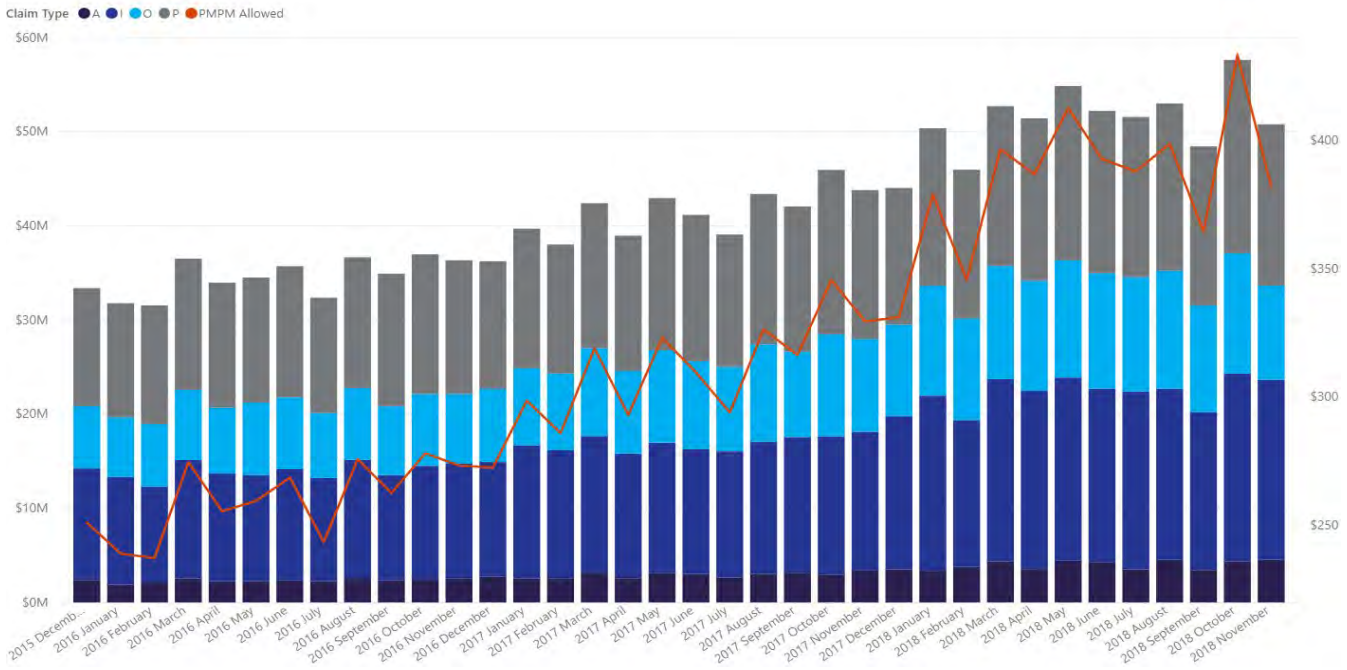
Goals of the Arrangement

- Clear identification of goals
- Aligned incentives
- Meaningful measurement of metrics
  - Quality and otherwise
- Measureable progress against Triple Aim
- Goals must be embedded into reconciliation methodology



How To Measure Success

- Contractual definition of success
  - What is the goal and what are the incentives
- Direction and magnitude of changes
- Cost savings
- Utilization
- Network retention
- PCP vs. specialist utilization
- Facility vs. provider utilization
- Change in quality



HCC Count Per Mbr	Avg Risk Score	PMPY Allowed	PMPY Allowed - Normalized	Util/1000_IPAcute_norm	Util/1000_SNF_norm	Util/1000_ED_norm	NYU ED Avoidable
2.45	2.20	$14,993	$6,808	141	18	235	38.47%
1.96	1.91	$12,753	$6,681	134	33	196	35.64%
1.94	1.88	$12,796	$6,796	154	29	252	34.68%
1.86	1.97	$12,496	$6,357	123	15	182	32.12%
1.85	1.87	$13,378	$7,161	159	22	210	36.77%
1.94	**1.93**	**$13,044**	**$6,764**	**141**	**25**	**205**	**35.41%**

Who Makes Up The Population

- Assignment and/or attribution
  - Terms generally used interchangeably, but they're not
  - Utilization based
    - Type and location of service
    - Type of provider
  - Member selection based
    - Selected PCP/practice
- Line of business specific arrangement
  - Differing utilization patterns, costs, presence of co-morbidities

Key Elements For Providers

- Consistency of contracts
  - Multiple arrangements, multiple payers, multiple populations
  - Model standardization across payers
  - Incentives and goals consistent across payers
  - Quality metrics are meaningful and are industry recognized standards
- Infrastructure to manage agreement
  - Financial
  - Clinical
  - Administrative
  - Actuarial
- DATA!

Key Elements For Payers

- Consistency of contracts
  - Across lines of business and regions
  - Administrative burden (both payer and provider)
- What problem are you trying to solve?
- Arrangement should be targeted to addressing the needs of the covered population
- DATA!
- Transparency
- Meaningful and timely reporting

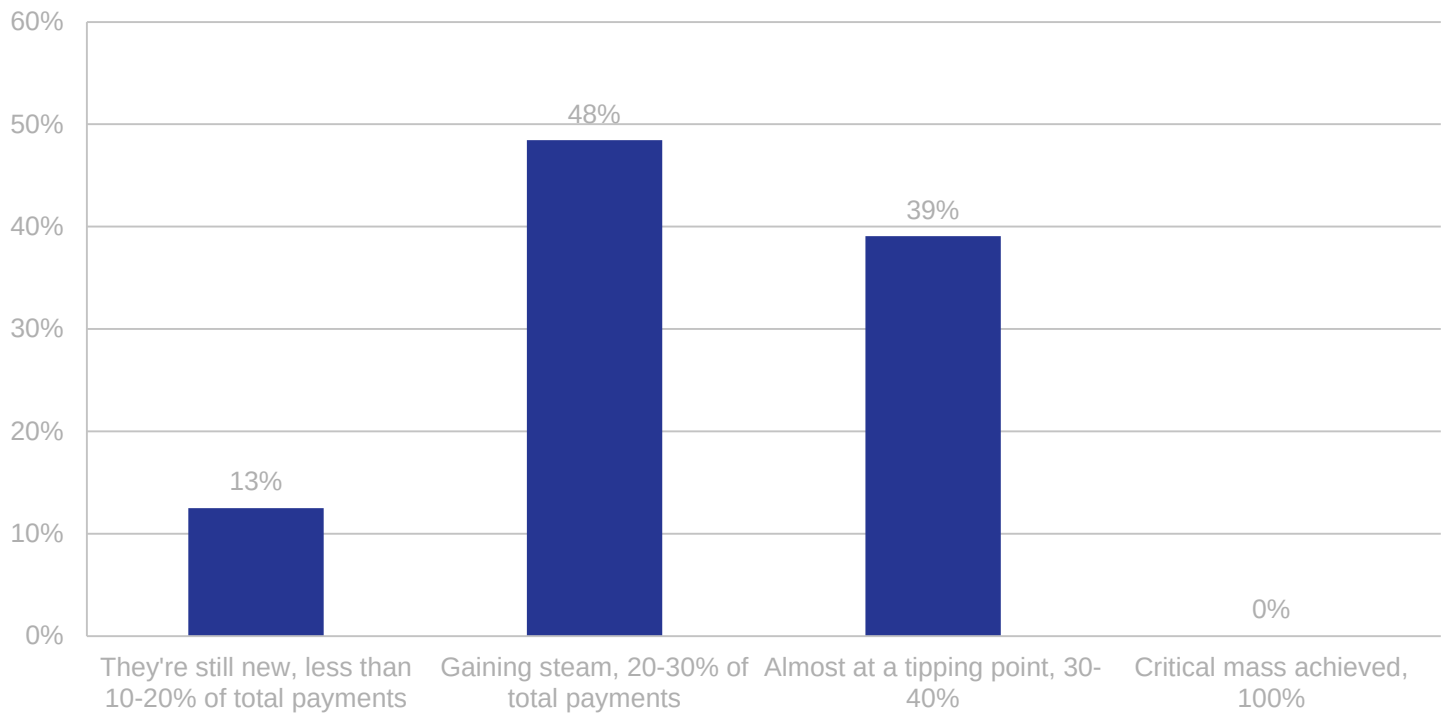
Additional Considerations in a Value-Based Arrangement

- Benchmarking methodology and frequency of resetting
- Closed vs. open group
- Glide path to risk in multi-year agreement
- Membership thresholds
- Risk corridors
- Stop loss insurance or reinsurance
- Claims run out – IBNR calculation
- Payment Terms
- Care coordination fees
- Definitions of key terms (MLR/MBR/MER, attribution, primary care provider)
- Payment bundles
- PCP caps

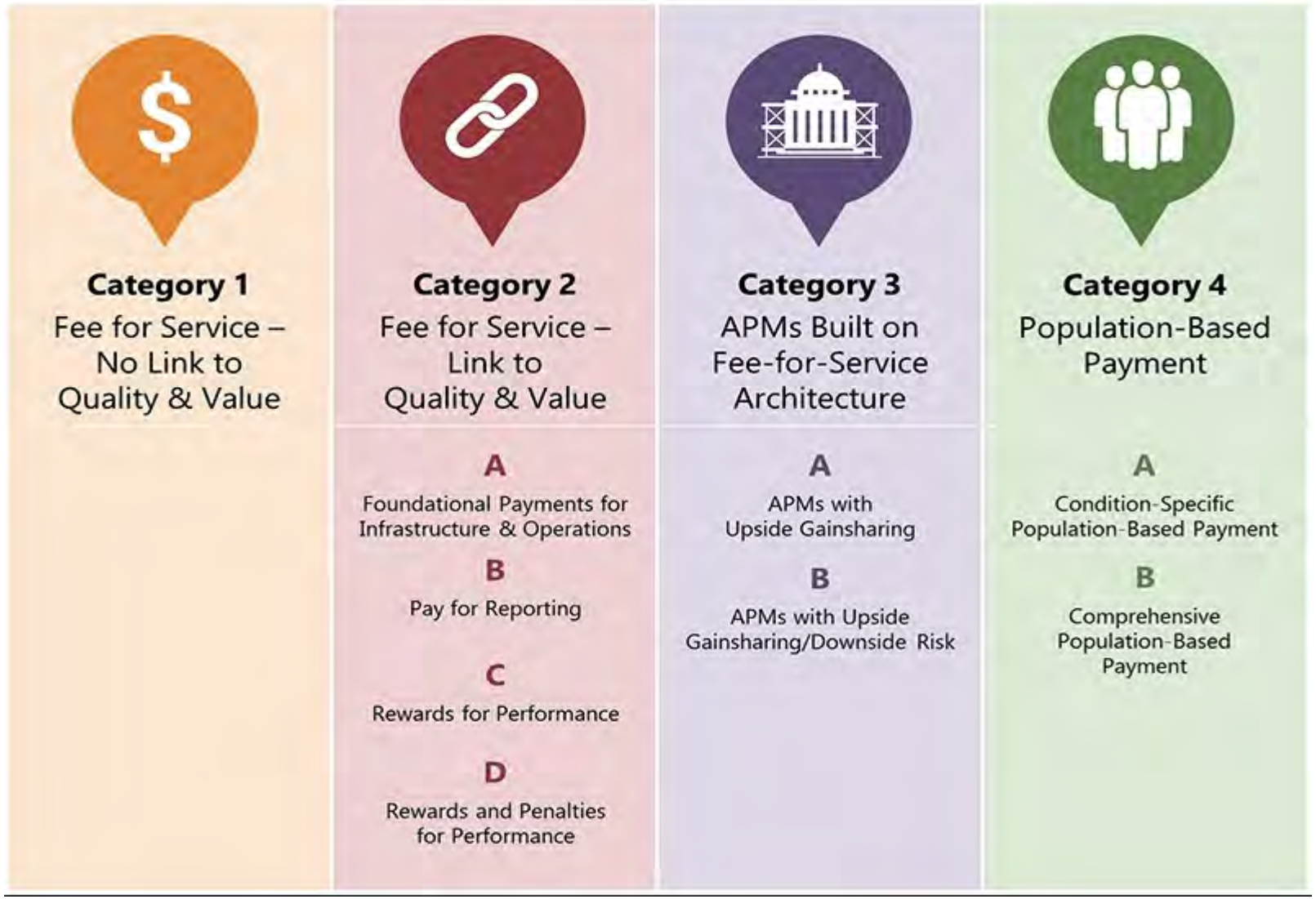
Value-Based Arrangements

Shift From Volume to Value

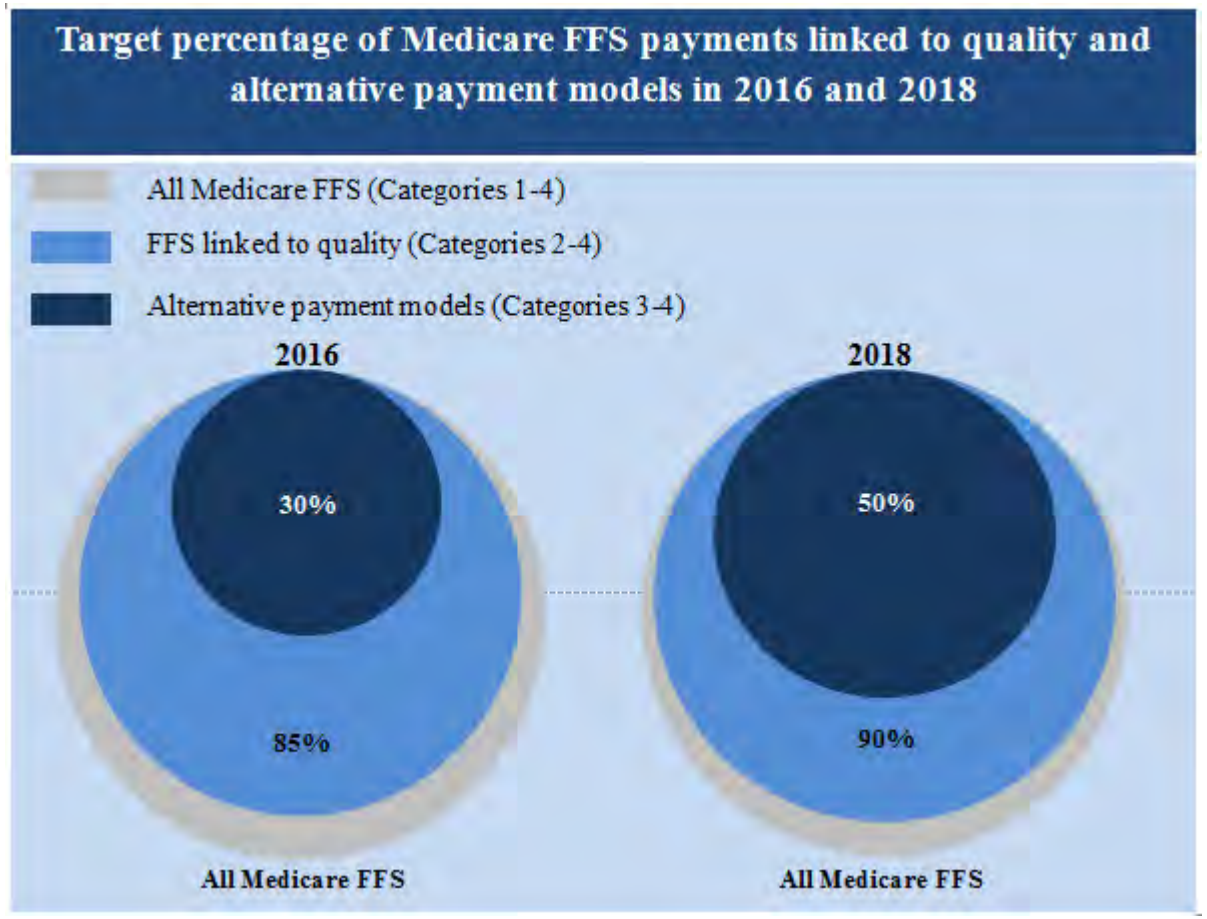
How prevalent do you think these arrangements are?



CMS's Categories for Different Alternative Payment Model Agreements



Transition from FFS to Fee For Value



- CMS is rewarding payments for value rather than volume
- CMS's goal is to move 50% of all Medicare payments and 90% of FFS payments to a value based model
- Reporting on progress in late 2018 states:
  - MA payments: 49.5% in category 3-4
  - Medicare FFS: 38.3% in category 3-4
  - Commercial: 28.3% in category 3-4
  - Medicaid: 25% in category 3-4

Strategies For Volume to Value Shift

Success takes time	Grade in downside risk	Respect the calendar
Know the population	Controllable vs. non-controllable (providers)	Robust population analytics
Leverage strengths, support weaknesses	Frequent opportunity analysis	Track progress

How to find the Sweet Spot

Measure the relationship of the organizations, and the provider's appetite for taking risk

Full transparency is key

- A true partnership will make both parties successful
- Short-term views will not make long-term success work
- **No data, no deal!**

Understand from data where both parties can make an impact

Agree on targets that are achievable and realistic to keep both parties interested

- Providers are effectively reducing revenue in hopes to gain shared savings and produce more unique volume to their group/system
- Fair targets will provide more motivation

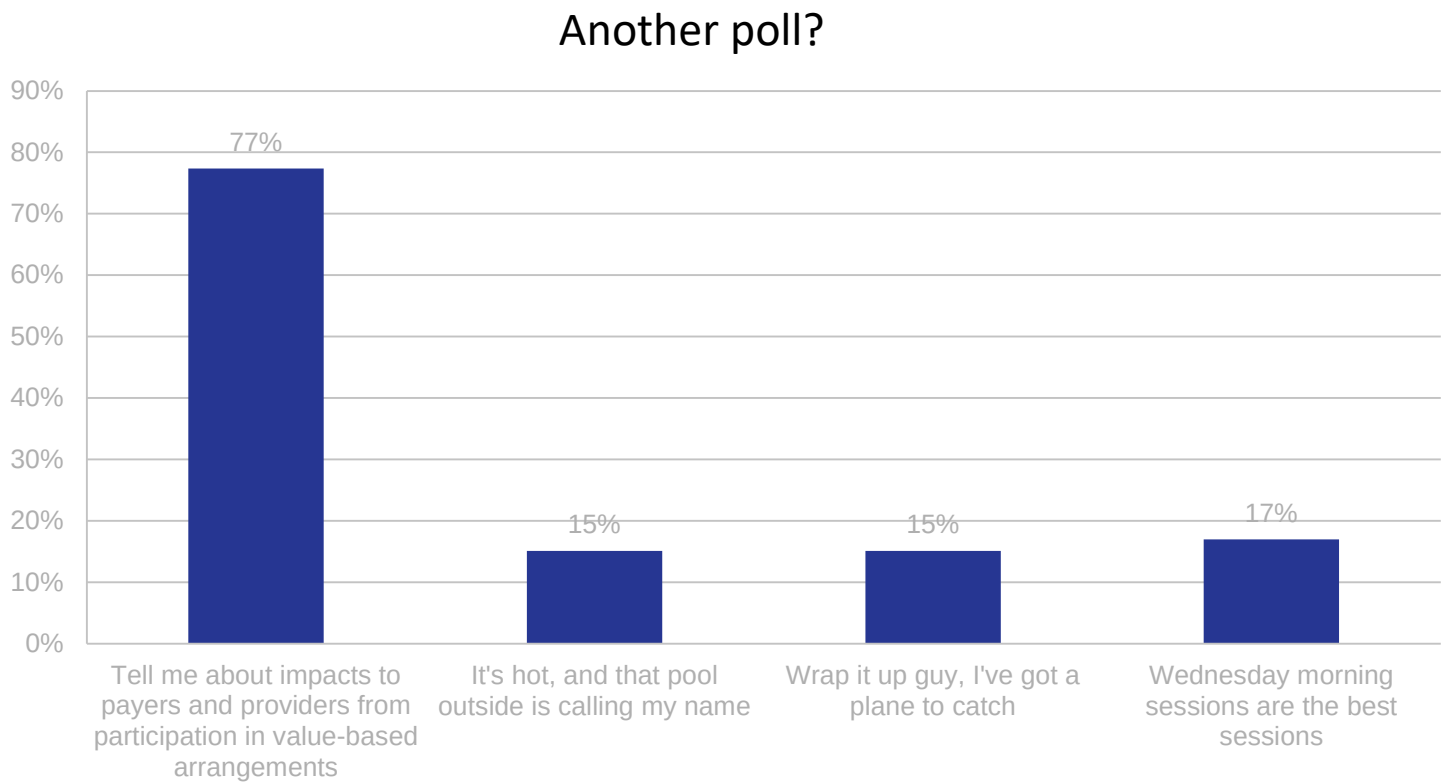
Are there opportunities for exclusivity or limited partnerships?

- Organizations only have so many resources, more focused can lead to higher achievements
- Grow in the market together

Shift sharing of risk over time

Value-Based Arrangements

Impacts to Payers and Providers


Another poll?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
77%
15%
15%
17%
Tell me about impacts to payers and providers from participation in value-based arrangements
It's hot, and that pool outside is calling my name
Wrap it up guy, I've got a plane to catch
Wednesday morning sessions are the best sessions

Impacts to Payers

Pros	Cons
• Deeper provider engagement • Development of exclusive partnerships • Achievement of goals (cost, utilization, steerage, etc.) • Shift of risk • Halo effect	• Administrative overhead • Transparency is hard • Sharing margins

Impacts to Providers

Pros

- Cutting edge, data focused, targeted medicine
- Funding for care delivery improvements
- Achievement of shared goals with payer

Cons

- Administrative overhead
- Standardization in portfolio of contracts is difficult
- New skillsets needed to develop/ /hire/contract out

Thank you

Success in Risk-Bearing Arrangements

Presented by: Richard N. Lieberman

2019 SOA Health Meeting

Phoenix, AZ

June 26, 2019

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HEALTHCARE ANALYTICS

Relevant Bio for Richard Lieberman

- Actively involved in the development of risk adjustment systems for 25 years
  - Johns Hopkins ACG Development Team, 1991-2005
  - Implemented the risk-adjusted payment system for Maryland Medicaid
  - Designed the clinical model for the first-to-market revenue management “suspecting” engine
- Developer of integrated decision-support platforms coalescing quality measurement, risk adjustment, and population health metrics
- Disseminator of risk adjustment and quality measurement technology and intellectual property to health plans, services vendors, and consultants
- Frequently engaged by Medicare-Advantage Organizations and ACOs and payers engaged in shared savings arrangements

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What Is Changing in the Healthcare Financing and Delivery System

- Value-Based Payments
- The increasing prevalence of multimorbidity
- CMS is pushing hard to implement interoperability requirements
- Medicare-Advantage risk adjustment is not the only game in town!
- MA risk adjustment gets even more complex
- EMRs are ubiquitous but remain challenging
- Both CMS and DOJ are ramping up their oversight of perceived risk adjustment overpayments
- The ongoing and likely to be perpetual, political tug-o-war around healthcare reform

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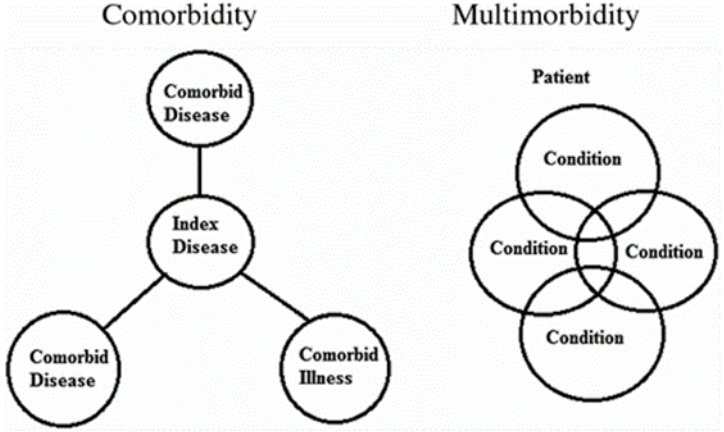
Increasing Prevalence of Multimorbidity

- Multimorbidity is defined by the presence of two or more long-term conditions (LTCs), which are those that cannot currently be cured but can be controlled through the use of medications or other treatments.[1]
- A considerable overlap exists between frailty and multimorbidity.
- Life expectancy continues to increase, concomitantly increasing the number of people managing multiple chronic conditions
- Patients with multimorbidity:
  - Cost more to manage
  - Will benefit from primary care practice transformation efforts
  - Are precisely the patients that a risk-adjusted provider group needs to be paid accurately for



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Why Accountable Care?

- To overcome the fragmentation of providers in the current health care delivery system and reward quality, encourage better outcomes, and lower health care costs, the ACA includes major delivery system and payment reforms that establish accountable care organizations within Medicare's fee-for-service program.
- In response to the ACA, the commercial market is following suit by implementing ACOs.

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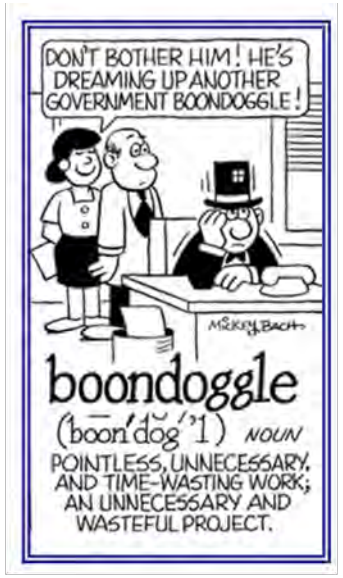
Let's Confront The Hype!

Are Accountable Care Organizations a "complete boondoggle" or the "best thing since sliced bread?"



- It's probably too soon to tell.
- Most of the published manuscripts of reasonable quality have only examined the first few years of ACO performance.

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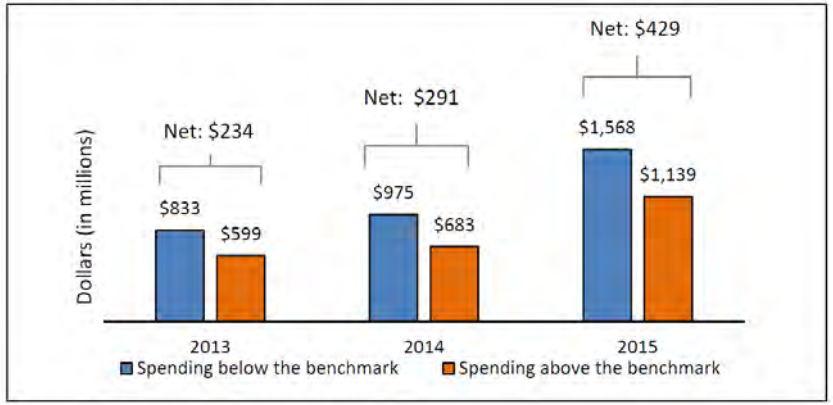
ACO Performance Through 2016

- With the Medicare Shared Savings Program (MSSP) providing the majority of ACOs to study, results to date are really a mixed-bag!
  - During the first 3 years of the program, two-thirds of all ACOs (282 of 428) reduced spending for at least one of the years they participated in the program. The remaining ACOs (146) had spending that exceeded their benchmarks for each of the years they were in the program. These ACOs were not able to reduce spending below their benchmarks.
  - The 428 ACOs reduced spending by $3.4 billion in the first 3 years of the program. There was significant variation in the reductions achieved by these ACOs. About half of the spending reductions—$1.7 billion—was generated by just 36 ACOs. Three ACOs in that group generated a quarter of that amount.

Exhibit 5: ACOs' Medicare Spending Above and Below Their Benchmarks, 2013 to 2015 (in millions)



Source: OIG analysis of ACO spending data, 2017.

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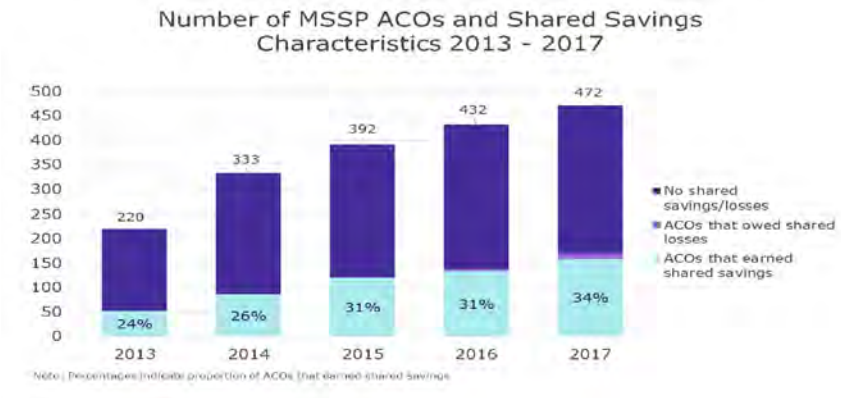
2017 Appears to be An Inflection Point for MSSP ACOs

- In 2017, 472 ACOs caring for 9 million beneficiaries participated in the MSSP, generating gross savings of $1.1 billion based on the CMS methodology for setting financial benchmarks.
  - Gross savings were generated by 60 percent of ACOs
  - $800 million in shared savings bonuses paid to ACOs
  - 34 percent of ACOs earned shared savings bonuses
  - $314 million in net savings to Medicare (after accounting for bonuses paid to ACOs)
  - A mean quality score of 90.5 percent for ACOs under pay-for-performance measurement



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But There's a Problem: Length of Time in MSSP Doesn't Matter Too Much!

- I used multiple linear regression to analyze the 2017 Shared Savings Program (SSP) Accountable Care Organization Public Use File (PUF)
- I looked at two dependent variables:
  - (Gross) Generated savings: Total savings (measured as Benchmark Minus Expenditures, from first to last dollar) for ACOs whose savings rate equaled or exceeded their MSR.
  - Total earned shared savings: The ACO's share of savings for ACOs whose savings rate equaled or exceeded their MSR, and who were eligible for a performance payment because they met the program's quality performance standard.
- N = 471 MSSP ACOs with reported data

Model: Generated_Total_Savings_Losses
Dependent Variable: gensaveloss_pmpy

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	4	5138512	1284628	4.91	0.0007
Error	467	122169549	261605		
Corrected Total	471	127308061			

Root MSE	511.47339	R-Square	0.0404
Dependent Mean	245.74530	Adj R-Sq	0.0321
Coeff Var	208.13151		

Parameter Estimates

Variable	Label	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	Intercept	1	398.17280	45.74757	8.70	<.0001
dummy_year1	1 Year in MSSP	1	-294.76582	69.41104	-4.25	<.0001
dummy_year2	2 Years in MSSP	1	-205.27728	69.41104	-2.96	0.0033
dummy_year3	3 Years in MSSP	1	-166.18346	74.39766	-2.23	0.0260
dummy_year4	4 Years in MSSP	1	-143.18609	73.51392	-1.95	0.0520

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Length and Size Together Matter More!

- Added three new dummy variables to an OLS mode with Generated Savings/Losses as the dependent variable:
  - Number of Attributed Beneficiaries in the Performance Year: Bottom 25th Percentile
  - Number of Attributed Beneficiaries in the Performance Year: 25-50th Percentile
  - Number of Attributed Beneficiaries in the Performance Year: 50-75th Percentile
  - Number of Attributed Beneficiaries in the Performance Year: 75th+ Percentile (reference category)

Model: Generated_Total_Savings_Losses
Dependent Variable: gensaveloss_pmpy

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	7	8575774	1225111	4.79	<.0001
Error	464	118732287	255889		
Corrected Total	471	127308061			

Root MSE	505.85428	R-Square	0.0674
Dependent Mean	245.74530	Adj R-Sq	0.0533
Coeff Var	205.84495		

Parameter Estimates

Variable	Label	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	Intercept	1	317.70766	58.55910	5.43	<.0001
dummy_year1	1 Year in MSSP	1	-326.77662	69.32868	-4.71	<.0001
dummy_year2	2 Years in MSSP	1	-232.33363	69.75002	-3.33	0.0009
dummy_year3	3 Years in MSSP	1	-169.72296	73.62071	-2.31	0.0216
dummy_year4	4 Years in MSSP	1	-156.14149	72.88126	-2.14	0.0327
dummy_size1	Bottom 25th Percentile, Attributed Benes	1	222.29115	66.45119	3.35	0.0009
dummy_size2	25-50th Percentile, Attributed Benes	1	124.49351	67.10573	1.86	0.0642
dummy_size3	50-75th Percentile, Attributed Benes	1	34.08375	66.30858	0.51	0.6075

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But It's What the ACOs Actually Do that Matters Most!

- Added two dummy variables to the OLS model with Generated Savings/Losses as the dependent variable:
  - Total number of primary care services per 1,000 person-years in the performance year.
  - Met the Quality Performance Standard: 0/1 flag; =1 if ACO met the quality performance standard; otherwise 0.
- By adding a process measure- number of primary care services per 1,000 person-years, the adjusted R^2 increases dramatically.
  - This utilization measures soaks up most of the variance reduction.

Model: Par_Total_Savings_Losses
Dependent Variable: gensaveloss_pmpy

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	8	18653154	2331644	7.10	<.0001
Error	153	50260647	328501		
Corrected Total	161	68913801			

Root MSE	573.15003	R-Square	0.2707
Dependent Mean	729.79660	Adj R-Sq	0.2325
Coeff Var	78.53559		

Parameter Estimates

Variable	Label	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	Intercept	1	-333.82119	464.56076	-0.72	0.4735
p_EM_Total	Primary care services	1	0.12378	0.02691	4.60	<.0001
Met_QPS	Met the Quality Performance Standard	1	-311.58427	342.09784	-0.91	0.3638
dummy_year1	1 Year in MSSP	1	-239.63847	149.62373	-1.60	0.1113
dummy_year2	2 Years in MSSP	1	-189.78414	137.03882	-1.38	0.1681
dummy_year3	3 Years in MSSP	1	-22.60345	146.35717	-0.15	0.8775
dummy_year4	4 Years in MSSP	1	-222.82651	125.44514	-1.78	0.0777
dummy_size1	Bottom 25th Percentile, Attributed Benes	1	415.05280	120.25169	3.45	0.0007
dummy_size2	25-50th Percentile, Attributed Benes	1	183.57374	113.15310	1.62	0.1068

MILE HIGH HEALTHCARE ANALYTICS

Model Improvement: Statistics to the Rescue!

Model: Par_Log_Total_Savings_Losses
Dependent Variable: gensaveloss_log

Number of Observations Read	473
Number of Observations Used	162
Number of Observations with Missing Values	311

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	10	27.39501	2.73950	10.96	<.0001
Error	151	37.74652	0.24998		
Corrected Total	161	65.14152			

Root MSE	0.49998	R-Square	0.4205
Dependent Mean	6.37943	Adj R-Sq	0.3822
Coeff Var	7.83733		

Parameter Estimates

Variable	Label	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	Intercept	1	4.36277	0.32182	13.56	<.0001
p_EM_Total	Primary care services	1	0.00010181	0.00002459	4.14	<.0001
dummy_year1	1 Year in MSSP	1	-0.23888	0.13190	-1.81	0.0721
dummy_year2	2 Years in MSSP	1	-0.22791	0.12213	-1.87	0.0640
dummy_year3	3 Years in MSSP	1	-0.11039	0.12945	-0.85	0.3952
dummy_year4	4 Years in MSSP	1	-0.26830	0.10958	-2.45	0.0155
dummy_size1	Bottom 25th Percentile, Attributed Benes	1	0.55167	0.10688	5.16	<.0001
dummy_size2	25-50th Percentile, Attributed Benes	1	0.35780	0.09969	3.59	0.0004
Current_Track_1	Track 1 in current agreement period	1	0.46226	0.13442	3.44	0.0008
Current_Track_2	Track 2 in current agreement period	1	-0.45859	0.32249	-1.42	0.1571
ADM_S_Trm	Short term acute care hospital discharges	1	0.00148	0.00070106	2.11	0.0362

- Because the distribution of the dependent variable is skewed to the right (skewness=5.58), a log-linear OLS regression model makes sense.
  - Not only does the log-linear model increase the R^2, it also makes most of the parameter estimates statistically significant at $p < .05$.
- Total number of primary care services per 1,000 person-years in the performance year drives the performance of MSSP ACOs in 2017.
  - Size matters a little bit, as does length of time in the Medicare Shared Savings Program.

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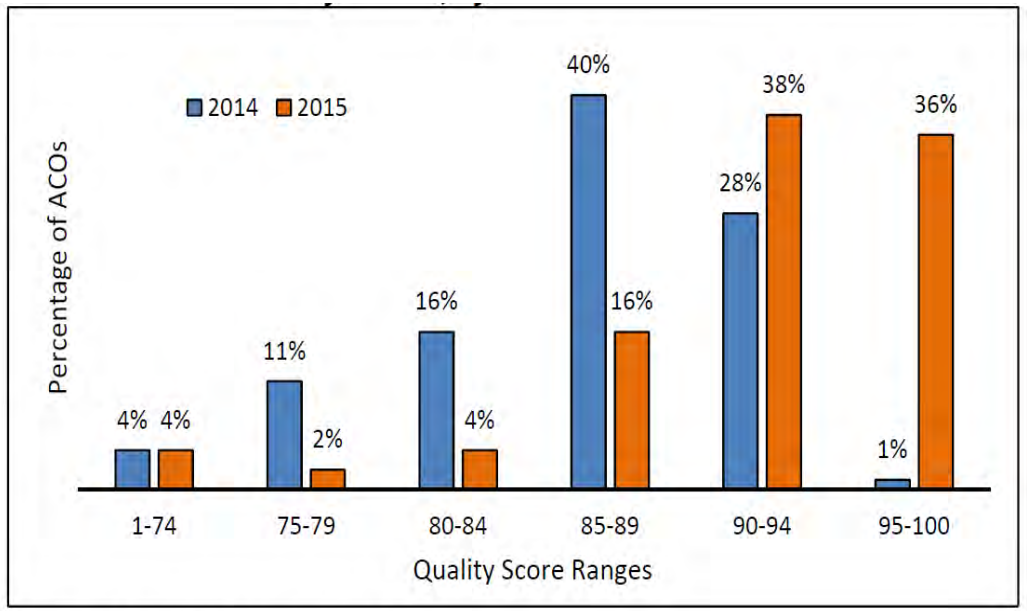
Overall, MSSP ACOs Improved Quality

- Each ACO receives an overall quality score based on its performance on the individual quality measures.
- ACOs' average overall quality score increased from the second to the third year of the program. In 2014, ACOs had an average overall quality score of 86, which increased to 91 in 2015. By 2017, the overall quality score was 92.4.
- The largest shifts in average scores were between 85 and 100. Notably, a much higher percentage of ACOs achieved a score of 90 or above—29 percent in 2014 compared to 75 percent in 2017.



Source: OIG analysis of ACO quality data, 2017.

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Are the MSSP ACOs Any Better than FFS?

- On average, ACOs outperformed fee-for-service providers on 81 percent (22 of 27) of the individual quality measures
- ACOs performed better than 90 percent of all fee-for-service providers in terms of low hospital readmissions
- ACOs also performed better than 80 percent of fee-for-service providers on three measures.

Quality Measures in Which ACOs Outperformed at Least 80 Percent of Fee-for-Service Providers

- Hospital Readmissions
- Screenings for Future Fall Risk
- Primary Care Physicians Qualifying for EHR Incentive Payment
- Depression Screenings and Followup Plan

Source: OIG analysis of ACO quality data, 2017.

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Quality Measurement Out There in Private ACOs

- We have seen private ACO arrangements require improvement in just a handful of quality measures
  - The allowed the ACO to declare, “we’re great at everything!”
- One private ACO arrangement focused on hospital quality using Medicare Hospital Compare data.
  - Hospital Compare data were not tied to the members attributed to commercial ACO
- One ACO told us, “we have doctor groups lined up at the door seeking ACO contracts. We have to be able to generate these deals at scale!”
- The situation will undoubtedly improve, but presently it’s a bit like the, “Drunkard’s Search”

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Quality Improvement Has a Long Way to Go

- It is about more than changing the things we measure
- It is about ensuring that the measures which are chosen are actionable and conform to the attributed members
- Outcome measures (the effect of care on the patient) are not necessarily the sole solution.
    - Outcomes are very tricky to measure. Risk adjustment is essential, but so is segmenting members by their propensity to access the delivery system and to implement their physician's recommendations.

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Risk Adjustment in Private ACO Initiatives

- Risk adjustment is far more opaque in private VBP initiatives
- Payers rarely know how to implement risk adjustment correctly
  - Inappropriate model selection and/or calibration to target population
  - Many payers struggle with basic “risk adjustment math”
    - Data preparation
    - What to do with missing values
    - How to interpret risk scores

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Which Risk Adjustment Model?

- There are plenty of risk adjustment models to choose from
  - The choice boils down to transparency vs. picking the optimal model
  - There is also the issue of licensing cost
- If you are going to use the risk weights that come embedded in a particular model, determine if those weights were derived from a population similar to one covered by the ACO program
  - Recalibration of the risk weights is usually a good idea
- ACOs that include attribution of Medicare-Advantage members should rely on the CMS-HCC model
  - It is likely that a good risk adjustment program for a private ACO initiative will rely on multiple risk adjustment models

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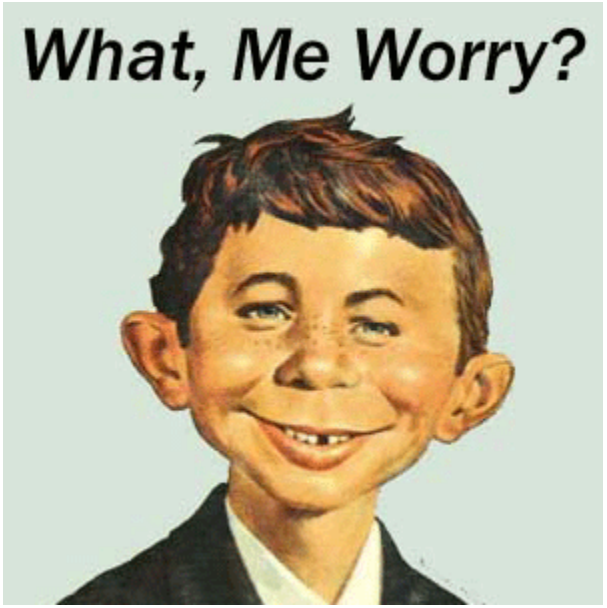
What Can Go Wrong: Risk Adjustment

- Not having complete historical data
  - Rx-based risk adjustment models can be a temporary fallback strategy when data has significant gaps
- Not filtering diagnosis codes correctly
- Choosing not to recalibrate the risk weights
- Not educating physicians about risk adjustment and/or educating them incorrectly.



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Shared Savings Models Are Extremely Sensitive to Risk Adjustment

	Actual Experience	2% Reduction	5% Reduction
Baseline Claims PMPM	$550.13	$542.63	$531.49
Pricing Trend	6.58%		
Risk Adjustment	1.015	0.994	0.964
Risk Adjusted Trend	6.68%	6.54%	7.01%
Risk Adjusted Claims PMPM	$586.86	$578.12	$531.49
Infrastructure/ Investment Funding	$11.33		
Other Expenses	$3.07		
Reinsurance	$17.80		
Total Indirect Expenses	$32.20		
Total Net Commercial Budget	$619.06	$610.32	$560.62
Total Gross Direct Expenses	$561.91		
Claims Above $150,000	($18.70)		
Total Net Direct Expenses	$543.21		
Total Indirect Expenses	$38.40		
Total Medical Expenses	$581.61		
Profit/(Loss)	$37.45	$28.71	$14.65
Risk Corridor Percentage	1.75%		
Net Commercial Budget	$619.06	$610.32	$596.26
Risk Corridor PMPM	$10.83	$10.68	$10.43
Is Risk Corridor Met?	Y	Y	Y
First Dollar	$37.45	$28.71	$14.65
Composite Quality Score	4.2		
Surplus Share %	50%		
Surplus Share	$18.73	$14.36	$7.32

- This is an excerpt from an actual shared savings settlement
- The only parameter that changes is the risk score
  - The table compares the actual data-driven risk score with risk scores arbitrarily reduced by 2 percent and 5 percent, respectively.
  - Trimming the risk score reduces shared savings by 21 – 64 percent.

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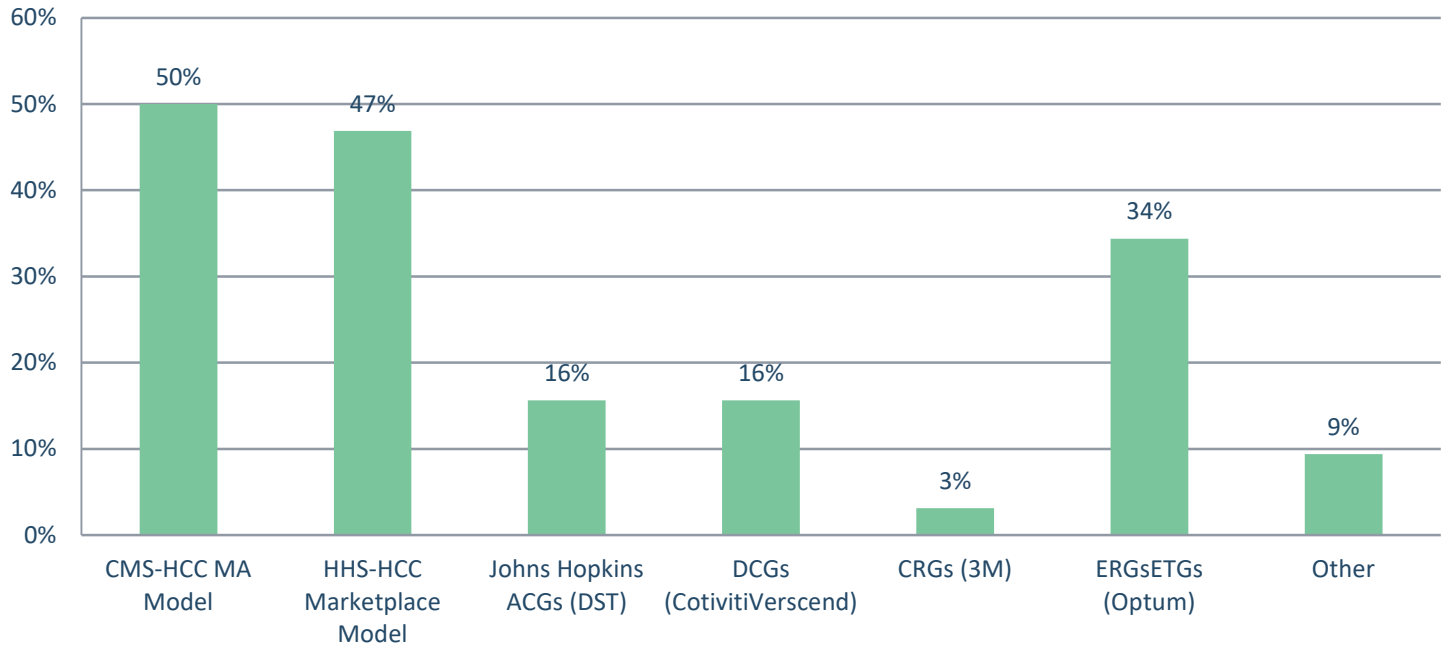
For Entities Involved in Private ACO Initiatives, Which Risk Adjustment Model Is In Use?



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Why Should Physicians Care About Risk Adjustment

- It provides a measurement framework
- It has a tremendous impact on the revenue flowing into the provider group
- MCOs with better documentation and coding will have more accurate risk scores and will be able to claim a more appropriate share of dollars
- Accurate risk scores mean:
  - More services for your high risk patients
  - Better rates for providers, especially if providers take capitation
  - If your patients are sicker, documentation and coding proves it

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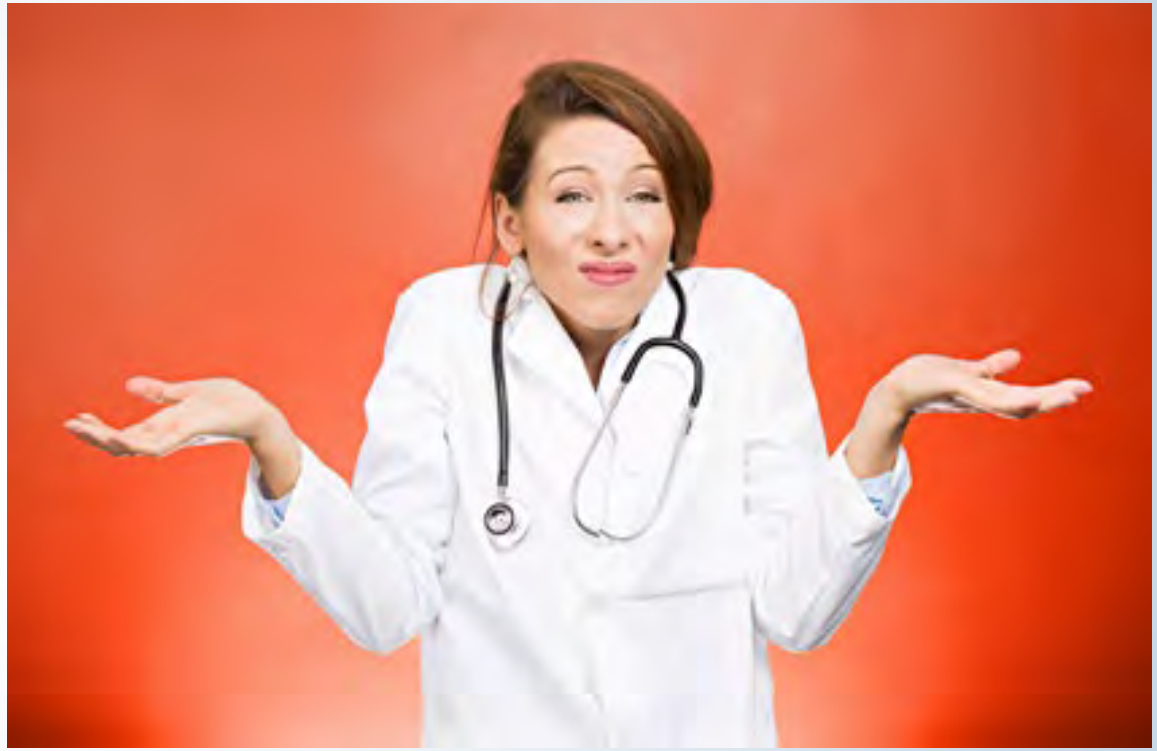
Improving the Interaction with Rank-and-File Physicians

- Physicians are increasingly hearing that they must “up their game” with regards to risk adjustment and coding.
- The problem is that they are often bombarded with exhortations to “code better,” “code to the highest degree of specificity,” etc.
    - “Code to the highest degree of specificity” is a “throw-away” line!
- Most of the ostensibly educational material provided to physicians is useless, factually incorrect, and/or purely MA-centric



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Why Document Better?

- With the increasing prevalence of multimorbidty, patients need accurate diagnostic profiles
- Interoperability means that patient's medical record data will be moving from provider to provider
  - Patient's will also have access to their data via government-mandated APIs
- Accurate risk scores can have a tremendous impact on the accuracy of shared savings.

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Data Sharing in Accountable Care

- The linchpin of making value-based care actually valuable, primary care practice transformation, will not happen without the sharing of accurate and comprehensive data
- Yet many payers engaging in private ACO initiatives display severe “allergies” to the idea of data sharing with at-risk provider groups
- You can’t monitor total cost of care if you can’t measure the total cost of care!

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Data Sharing in Accountable Care: What We Have Seen

- One payer couldn't supply risk scores for about 10 percent of the attributed members. Their response, "oh, well."
  - But they let the utilization dollars remain in the shared savings calculation!
- Another payer informed the ACO that they could not release allowed and paid amounts to the physicians because it exposed their previously negotiated fee schedules.
  - Payers can't have it both ways: either stay with an opaque FFS system where physicians "run up the tab" through utilization, or transition to true value-based care in which total cost of care can be acted upon by the physicians
- Another payer was actually completely transparent with their data. Except when it came to their Medicare EDPS data.

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In Summary….

- Rome wasn’t built in a day; And neither will accountable value-based care!
  - Anyone who thought that “physicians taking risk” would change everything doesn’t understand physicians
- Long-term, sustained success in accountable care requires aggressive practice transformation, particularly of primary care
  - Perhaps we are seeing the early stages of primary care practice transformation in the 2017 MSSP results?
- Risk adjustment is complicated and its processes must be respected!
- It’s been relatively easy for ACOs to “max out” quality measures. But making quality improvement “harder” is going to be a challenge

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