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Accountable Care NEWS

Stretched to the Limit by COVID-19, Will Providers Get Relief from Medicare Value-Based Programs?

by Theresa Hush, Co-Founder & CEO, Roji Health Intelligence, Chicago

COVID-19 continues its inexorable, exponential spread here in the US. Hospitals in New York City, now accounting for more than 7% of confirmed cases worldwide, have less than a quarter of the critical equipment and supplies needed to serve an overwhelming surge of patients. Our healthcare providers are facing impossible choices, even considering universal Do Not Resuscitate orders for patients with COVID-19.

Less than one month ago, CMS was closing applications from providers willing to be part of a major movement to adopt financial risk as a new type of payment model. Under Direct Contracting, providers would face per-patient spending limits under a capitated payment scheme. Now that movement could be in question, along with other provider risk programs, as total and per-case spending soar under COVID-19.

With the public health crisis upending life everywhere and provider capacity already stretched to the limit, will Medicare continue its full court press for providers to adopt financial risk? Conversely, how will CMS loosen efforts to control healthcare costs when its own expenses for the highest-risk group of coronavirus patients will overrun the federal budget?

- *Already, those costs are estimated to increase exponentially.*
- *The National Association of Accountable Care Organizations estimates that Medicare could be hit by COVID-19 claim costs of between $38.5 billion and $115.4 billion in the next year, depending on pandemic expansion and hospitalization rates.*
- *In addition, the $2 trillion stimulus plan – not likely to be the last – will expand the already mushrooming federal deficit.*

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In This Issue

Washington DC Watch

ACOs, Others Seek, Get Relief from Risk, Reporting Requirements

Accountable Care Organizations and other Alternative Payment Models got part of what they asked for. Two letters from organizations representing doctors, hospitals, colleges and ACOs outlined to Washington DC how they want the feds to help them weather the financial blows of COVID-19. It's a long-term challenge, and the Centers for Medicare & Medicaid Services has responded with, so far, sort-term fixes.

Doctor Group Seeks Reduced Reporting, Longer Deadlines

America's Physician Groups and Premier Inc. sent a letter to the Department of Health & Human Services and CMS asking for "guidance on financial and quality mitigation policies for all quality programs and value-based arrangements." Noting their "strong support" for such programs, they state that "the unprecedented surge in demand and shortfall of products we are expecting requires a major shift in focus." Providers "are also concerned," they add, "that they will face serious financial consequences as a result of factors not under their direct control."

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Stretched to the Limit by COVID-19, Will Providers Get Relief from Medicare Value-Based Programs? *…continued from page 1*

One thing is certain: No matter what the trajectory of the coronavirus outbreak ultimately is, it will result in future budget cutbacks on spending. The only question is when those will begin. Let's look at some of the possible scenarios ahead for providers, consumers and Medicare.

Scenario 1

Medicare will implement risk payment models for providers, including Direct Contracting and ACOs, as planned.

Depending on economic pressure, CMS could stay on the current risk track with its value-based healthcare programs. Next-Gen ACOs could be allowed to expire, and Direct Contracting could proceed toward a performance year and its capitated payment mechanisms. Shared Savings ACOs could remain on the "glide path" scripted by current regulations, and be under risk.

The problem is this effort could induce some ACOs to leave the program, if there are no concessions on COVID-19. Depending on which provider ACOs exit, their departure may be important enough for CMS to be more lenient. It's too early to tell how CMS will view its options, especially as it has been less forgiving with ACOs than with direct providers, especially physicians, or with Medicare Advantage plans.

Scenario 2

Risk payment models will continue, but adjust risk to carve out COVID-19 costs.

Medicare could continue to roll out payment models that drive providers to adopt risk, but create carve-outs for costs associated with COVID-19, especially for hospitalized patients. While this scenario addresses vulnerability for providers, it does not recognize the rising healthcare costs borne by consumers through premiums, copayments and other provisions. Millions of Americans have struggled to meet high deductibles and copays under the best of circumstances, and with months of lowered or no income during this period, many will hardly be able to afford higher insurance costs going forward.

Nor, if the emergency magnifies into a long-term recession, will many companies be able or willing to pick up a bigger share of coverage costs. Medicare has ensured first dollar testing coverage, but consumers will still face a much different "risk" environment for their own budgets because of higher medical costs, the problem of "out-of-network" coverage when COVID-19 care cannot be provided in all settings and the threat of frequent viral re-emergence.

If there is a longer-term recession, it may not be possible for CMS to address provider cost concerns without also dealing with the impact on consumers. That makes this a much more costly scenario – and more unlikely.

Scenario 3

Providers will stay in Implementation Year stages, with CMS delaying Performance Year payment models.

Some hospitals – even some regional health systems – could collapse under the surge of severe COVID-19 cases. The spending ability of hospitals and local health systems is not infinite, nor is their expansion capability. Despite the overwhelming numbers right now, we are at an early stage in the surge. Whether there will even be enough hospital beds to handle the volume of patients – an urgent question now in New York City – is a question that is likely to be repeated throughout many areas of the country. The fact is that we don't know whether we can prevent local hospitals and health systems from collapsing.

CMS will, no doubt, have to reckon with the prospect of adding financial risk to an already-overextended health system. Delay in the actual instruments of risk, like capitated payments or paybacks of over-expenditures, could be allowed. But because of its own budgetary pressures, CMS may not want to dismantle reforms too easily.

There could also be negotiated solutions, such as longer-term payback or more reinsurance of risk, to assuage providers, while CMS keeps mostly on track with payment models.

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Of course, given that the COVID-19 outbreak is still surging upward, it may be that Scenarios 2 and 3 could be consolidated into a complex carve-out/temporary push-back solution.

Scenario 4

CMS will expand and encourage Medicare Advantage while scaling back regulations for provider risk programs.

It is also conceivable that CMS will look to further privatize Medicare through Medicare Advantage plans and create a buffer for the direct costs that will hit the traditional Medicare budget. This scenario would be in keeping with CMS's favorable view of Medicare Advantage as well as the commitment to working through the private sector in other federal programs – like current efforts to increase the supply of personal protective equipment via private manufacturers.

Surviving the Pandemic Will Be a Long-Term Effort that Extends to Post-Pandemic Surveillance

COVID-19 will be with us well beyond the next few months. Until there is an effective vaccine and proven treatments to lessen the virus's severity, vulnerable individuals will remain vulnerable. As routine care is severely reduced to free up resources for the sickest among us, those with chronic conditions who do not receive regular check-ups will get sicker as well. There is already evidence of virus after-effects on liver function and cardiovascular disease in some patients. In other words, the pandemic will not end entirely, but create a new set of challenges that healthcare providers must be ready to address.

How the healthcare system will weather the existing crisis and prepare for the future under scarcer resources will be an issue that both government and providers must address in the months ahead. Only one scenario is clear right now: The flush days of healthcare – and the time for playing cat and mouse with healthcare funding – are over. Now may actually be the time we figure out how important healthcare is to people, and how we're going to pay for it.

Hush is a strategist and change expert with experience across the healthcare spectrum. Contact her at hush@rojihealthintel.com.

Roji Reports Launching Population Health Solution for Patients at Risk of Severe COVID-19

To assist providers' efforts to combat COVID-19, Roji Health Intelligence reports launching a new Population Health Registry for Patients at High Risk for Severe COVID-19. The registry, which the firm says is up and running, "helps providers track patients by multiple risk factors that lead to severe disease," a statement explains.

- *Roji has "committed to help providers proactively manage the high risk to patients who either acquire COVID-19 or who must defer care during the pandemic," it says.*
- *The company is "offering the technology to its current clients at no additional cost."*

Says Roji Health Intelligence co-founder and CEO Theresa Hush: "Our goal is to help providers track, monitor and communicate with patients whose underlying health conditions make them more vulnerable to COVID-19, so their physicians can keep them informed and monitor their health." She adds: "Patients are being asked to put off routine care, and this High-Risk Registry will enable providers to quickly identify those who need close monitoring and outreach for telemedicine appointments."

Roji's consultants and healthcare professionals "will customize the Registry and tailor processes to help providers proactively manage chronically ill patients," the statement adds. Says Thomas Dent MD, Roji's co-founder and Medical Director: "The need to monitor them will intensify as social distancing extends for, possibly, months."

- Some may "disappear" from regular schedules "due to the onslaught of urgent COVID-19 patients," the statement points out, or as providers become overwhelmed and cannot handle even routine telemedicine appointments.
- Providers "must be prepared for long-term management of vulnerable patients," it adds, "whose conditions may worsen without routine visits and ongoing health maintenance."
- The Roji Registry helps them" more easily meet demand under these extreme conditions without additional internal resources."

The Population Health Registry for Patients at High Risk for Severe COVID-19 filters providers' data for millions of patients and determines who will need urgent contact. A "distinguishing feature," Roji says, is the use of actual clinical data and relevant CDC risk factors – including prescription information and identified patient data – to calculate risk. The Registry facilitates:

- *Performing outreach to patients to educate, connect with resources and schedule ongoing care*
- *Informing patients how to access providers if COVID-19 is suspected, including testing instructions*
- *Monitoring patients with early or light stages of COVID-19*
- *Scheduling telemedicine appointments*
- *Tracking separate classes of risks by age and other factors*
- *Creating continued surveillance for patients with COVID-19*
- *Managing patients' individual conditions that pose risk for disease*

Chicago-based Roji aims to help systems, providers and patients "achieve better health outcomes and affordability through data-driven tools," the statement notes. Hush has worked in the public, non-profit and private sectors to create access to affordable care, especially for disadvantaged populations. Dent practiced in clinical settings and then applied his knowledge to train and organize physicians to deliver quality care. Visit rojihealthintel.com.

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Some quality and value-based programs "have 'extreme & uncontrollable circumstance' policies in place," the letter concedes, adding: "But they are not consistent and don't adequately address the impact of coronavirus." Most "were put in in place in response to natural disasters in 2016 and 2017 impacting a few regions," it argues; several Innovation Center models lack them altogether. But the healthcare system "will need to ramp up capabilities for longer acute lengths of stay, more intense utilization, higher skilled nursing facility utilization, increased discharges to long-term care hospitals and increases in ED admissions and readmits."

Here are CMS' additional "extreme and uncontrollable circumstances" policy exceptions and extensions:

Provider Programs

Quality Payment Program, Merit-Based Incentive Payment System, Medicare Shared Savings Program Accountable Care Organizations

2019 Data Submission

- Deadline extended from March 31, 2020, to April 30, 2020.
- MIPS-eligible clinicians who have not submitted any data by April 30, 2020, will qualify for the automatic "extreme and uncontrollable circumstances" policy and will receive a neutral payment adjustment for the 2021 MIPS payment year.

2020 Data Submission

- CMS is "evaluating options" for providing relief around participation and data submission for 2020.

Hospital Programs

Ambulatory Surgical Center Quality Reporting Program, CrownWeb National ESRD Patient Registry & Quality Measure Reporting System, End-Stage Renal Disease Quality Incentive Program, Hospital-Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting Program, Hospital Outpatient Quality Reporting Program, Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Promoting Interoperability Program for Eligible Hospitals & Critical Access Hospitals

2019 Data Submission

- Deadlines for October 1, 2019, through December 31, 2019, data submission optional.
- If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate).
- If data for Q4 is unable to be submitted, the 2019 performance will be calculated based on data from January 1, 2019, through September 30, 2019, and available data.

2020 Data Submission

- CMS will not count data from January 1, 2020, through June 30, 2020, for performance or payment programs.
- Data does not need to be submitted to CMS for this time period.
- For the HACRP and the HVBPP, if data from January 1, 2020, through March 31, 2020, is submitted, it will be used for scoring in the program (where appropriate).

Post-Acute Care Programs

Home Health Quality Reporting Program, Hospice Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, Skilled Nursing Facility Quality Reporting Program, Skilled Nursing Facility Value-Based Purchasing Program

2019 Data Submission

- Deadlines for October 1, 2019, through December 31, 2019, data submission optional.
- If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate).

2020 Data Submission

- Data from January 1, 2020, through June 30, 2020, does not need to be submitted to CMS for purposes of complying with quality reporting program requirements.
- Home Health & Hospice Consumer Assessment of Healthcare Providers & Systems survey data from January 1, 2020, through September 30, 2020, does not need to be submitted to CMS.
- For the SNFVBPP, qualifying claims will be excluded from the claims-based SNF 30-Day All-Cause Readmission Measure calculation for Q1-Q2.

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So the pair penned this list of requests:

[1] CMS should "temporarily convert all downside risk arrangements to a no-risk model for the 2020 performance year."

- Many policies "mitigate the potential for shared losses or repayments in performance periods affected by extreme and uncontrollable circumstances" or "remove episodes" altogether, it adds.
- The "cost impacts and the disruption in care beyond the time period of the public health emergency declaration are unknown," and "current policy fails to recognize the impacts of shifts in care."

[2] CMS should "suspend MIPS, ACO and other APM quality reporting requirements for PY 2020 – recognizing that all quality metrics will be impacted – and delay them for 2019."

- Many ACOs "have expressed concerns about quality resources being diverted to other areas of the business," the letter says, so they "should have at least a three-month extension."
- The letter also asks CMS to "delay application deadlines for MSSP and Direct Contracting, and to implement one-year extensions for all MSSP and Next-Generation ACOs" with agreements expiring this performance period.

[3] CMS should "ensure that an ACO that loses population through claims attribution has sufficient time to rebuild its population before the next contract cycle."

- CMS should also "establish a low volume exception for bundled payment programs and primary care models that may have a reduction in clinical episodes or attributed beneficiaries as a result of coronavirus."

[4] CMS should "readjust rates this year to supplement the impact of decreased risk adjustment capture in the 2021 payment year as well as potentially increased costs."

- CMS should also "allow telehealth visits for risk adjustment assessments in the 2021 PY for risk score accuracy."
- Even if COVID-19 is contained, the letter says, "it is likely there will be fewer senior assessment visits through June, affecting PY 2021 payments, impacting operations significantly and decreasing the stability of the Medicare Advantage program."

Visit apg.org.

ACOs, Hospitals, Medical Groups, Colleges Seek Similar Relief, 'Urge Congress, CMS to Hold ACOs Harmless in 2020'

In letters to House and Senate leaders, 10 provider organizations asked for guarantees that "clinicians focused on value-based care are not inappropriately penalized for the extreme costs of handling the COVID-19 pandemic." Specifically, they want politicians to "shield participants in ACOs and other value-based payment models from financial penalties because of costs incurred." ACOs, they add, "could spend well more than their pre-determined targets because of spikes in hospitalizations and prolonged ICU stays."

The signers

- American Academy of Family Physicians
- American College of Physicians
- American Hospital Association
- American Medical Group Association
- America's Essential Hospitals
- Association of American Medical Colleges
- Federation of American Hospitals
- Health Care Transformation Task Force
- Medical Group Management Association
- National Association of ACOs

Their demands

- Hold clinicians harmless from performance-related penalties for 2020, particularly those in two-sided risk Alternative Payment Models.
- Make appropriate adjustments to spending targets, performance scores, patient attribution and risk adjustment.
- Consider additional options to support APM participants, including financial support and reinsurance.

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Washington DC Watch

agilon, MD Practices Team Up for DC Program Participation

agilon health and nine independent physician practices report applying to participate in the Centers for Medicare & Medicaid Innovation's Direct Contracting model. The model, a statement says, is "aimed at reducing expenditures and enhancing quality for seniors in fee-for-service Medicare:" the applications, it adds, "represent potential participation by over 500 primary care doctors and 78,000 patients in five states."

- The DC model is a voluntary demonstration project that "changes the way that practices are paid," the statement adds, "to a capitated model that rewards better outcomes."
- It "seeks to align payment models across traditional Medicare and Medicare Advantage," it says, "creating efficiencies for physician practices."
- The ability to offer enhanced benefits, it continues, "gives DC model participants additional tools to improve patient care."
- The model also will help "alleviate the burden for primary care physicians."

agilon was founded in Long Beach CA in 2016. Visit agilonhealth.com.

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- Hold clinicians harmless from quality assessments and reporting obligations for 2020.
- Delay upcoming APM program application and quality reporting deadlines.

"Clinicians in value-based arrangements face even higher levels of financial risk as a direct result of COVID-19," a letter states. "Any resources spent mitigating COVID-19 will cost them twice, once at the onset and again when spending is evaluated at year-end in the context of their value-based performance."

The timing creates challenges, the groups add, as "organizations are in the middle of reporting quality for 2019 and application deadlines for Direct Contracting and the Medicare Shared Savings Program. Allowances should be made for both."

- Citing "years investing in the infrastructure and cultural changes needed to succeed in value-based care models" and "serious, positive results," the groups say the pandemic "could wipe out years' worth of shared savings and threaten our movement to accountable care models."
- And they caution policymakers to "see the big picture and assure ACOs during a once-in-a-lifetime pandemic."
- APM participants "will be faced with difficult decisions about whether they can continue to afford to provide advanced preventative care, care coordination and behavioral services, hallmarks of those models," a letter threatens.

"Clinicians should not fear having it count against them later," it concludes. "They need assurance that this will not be the case." Visit naacos.com.

NAACOS Follows Up in Email: 'Relief Necessary to Prevent a Mass Exodus'

The National Association of ACOs also sent an email from CEO Clif Gaus to senior CMS officials; the organization is also "working channels on Capitol Hill," it says, "on the next relief package." ACOs' "ability to coordinate care across providers is invaluable in caring for patients affected by COVID-19," the email adds, noting that "lack of workforce and high volume of patients will surely put a strain on the clinical system as well as ACO finances."

The final tab is "unknown and unprecedented in our generation," the email continues. "While ACOs are focused on treating patients, we are reaching out to you on their behalf to ensure COVID-19 does not derail the ACO and value movement." That could happen, NAACOS warns, "if steps aren't taken by CMS to ensure ACOs aren't held accountable for the costs associated with the pandemic."

- Modify the MSSP "extreme and uncontrollable circumstances" policy to exclude expenditures for patients with COVID-19 from PY 2020 reconciliations.
- Hold harmless ACOs in MSSP and Next-Gen Models for PY 2020.
- Extend the March 31 quality reporting deadline and the PY 2021 MSSP and DC application deadlines.
- Commit to a DC application cycle for PY 2022.

That's necessary to "prevent a mass exodus of ACOs from the program," the email warns. The MSSP holds ACOs in the program June 30 accountable for losses, it notes, adding that "many ACOs are considering dropping out in advance of that deadline given the unknown trajectory." And, the email says ominously, "we hope you and your staff are aware of potential consequences to ACOs and what that would mean to the overall move to value."

Visit naacos.com.

CMS Touts 'Unprecedented Relief' for Providers in Quality Reporting Programs

The Centers for Medicare & Medicaid Services – specifically boasting about helping "the 1.2 million clinicians in the Quality Payment Program and on the front lines of America's fight against COVID-19" – will "grant exceptions from reporting requirements and extensions with respect to upcoming measure reporting and data submission for those programs."

- Data submission deadlines in April and May 2020 "will be optional," a statement says, "based on the facility's choice to report."
- As well, "no data reflecting services provided January 1, 2020, through June 30, 2020, will be used in calculations for the Medicare quality reporting and value-based purchasing programs."

CMS says it "recognizes that data collection and reporting during this time period may not be reflective of true levels of performance on cost, readmissions and patient experience measures" and that it "seeks to hold organizations harmless for not submitting data during this period." Visit cms.gov.

Thought Leaders' Corner

Each month, *Accountable Care News* asks a panel of industry thought leaders to comment on a question submitted by a reader. To send a question, contact us at info@accountablecarenews.com. Here are this month's results.

"How has accountable care and the transition from volume to value affected healthcare organizations' internal audit function? Do integrated networks, enhanced data interoperability and more focus on finances complicate the auditor's job? Or smooth things out and make it easier?"

In the largely fee-for-service world, health plans and providers had very structured and transactional audit processes for certain functions – like billing. However, as the industry has invested more in value-based payment arrangements, there has been a corresponding increase in quality measures, electronic data exchange rules and complex contracts. As a result, we have seen an increase in new repeatable, data-driven processes that can more quickly identify areas that need to be further examined for quality and variability issues. Investments in machine learning and artificial intelligence to improve risk adjustment has also been a big help to payers in identifying potential under- and overstatement of payments. While data quality was initially a hurdle, the entire healthcare industry has addressed these issues. We now have more robust internal audit and risk assessment programs – and these programs are less adversarial, thanks to shared investments in transparent data collection and analytic reporting capabilities.

Swati Abbott
CEO
Blue Health Intelligence
Chicago

The question of volume-based care versus value-based care is an interesting one. It signifies a fundamental shift in the way healthcare is billed. I don't think it'll have any substantial underlying effects for internal auditors. I do believe that it will bring up some additional opportunities to add value to your organization. Allow me to explain.

- Internal auditors, by nature of the job, evaluate processes to determine if those processes are operating in a manner that effectively achieves the goals and objectives.
- The next layer is to determine if those processes are efficient as they effectively achieve the goals and objectives.
- So over time, methodologies and processes and people will come and go.
- But auditors will always be required to evaluate those processes that people are performing.
- So this shift will be nothing new to the core function of internal auditing.

However, where I see the true opportunity for auditors is helping organizations analyze patient performance using data. In theory, value-based care will add value because built into the model are things like cost savings and cost sharing. But successful implementation of value-based care will cause clinicians and administrators to form a new kind of working relationship.

I've seen the two groups at odds when it comes to the healthcare cycle; each may accuse the other of things that, in my experience, tend to not be true. For example, there can be a stigma surrounding conversations of profit and patients, because some clinicians believe that profit should not be considered when delivering patient care and may thus view administrators as cold for focusing on the finances. Administrators may have the false perception that clinicians are reckless in developing treatment plans without considering the cost.

Neither of these is true. The real issue is that each speaks a different language. Total patient care requires balance between the services provided to patients and the associated cost. And value-based care attempts to bring that balance. Every organization needs revenue to survive. Healthcare is no different. And the four types of value-based care add more financial measures to the healthcare equation than ever before.

- *First, the shared-risk model involves keeping spending at or below the budget.*
- *Second, the per-member-per-month VBC model requires that long-term and short-term patients share healthcare costs amongst themselves.*
- *Third, the bundled services offering involves cutting certain services that are usually provided in the bundle presented to patients. It allows patients to personalize their care, and it allows the healthcare provider to save money.*
- *And fourth, shared savings is where departments in the organization share the load. Money saved in one branch can cover the costs of others.*

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This is nothing new to business professionals. It is simply the way businesses have operated for years. Take a service-oriented company that provides an all-you-can-consume monthly plan. Some customers will be significantly below the usage limit, some will meet it and others will exceed it. But on average, if the organization manages usage, it can still remain profitable while delivering quality services to all. It's the same concept.

The huge opportunity for internal auditors is to use the data to help facilitate constructive conversations between clinicians and administrators while helping organizations maximize revenue. As the audit profession shifts, more auditors are comfortable with data. Transforming that data into business intelligence is the way forward for auditors in healthcare.

Robert Berry CPA CIA CISA
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NEWS @ DEADLINE

NAACOS Says COVID Could Cost Medicare $115B in 2020

COVID-19 could cost Medicare between $38.5 billion and $115.4 billion over the next year, says a new analysis from the National Association of ACOs. "The final number will depend on severity of disease and hospitalization rates," a statement adds, noting as well that the analysis is "one of the first to be developed on the subject."

- The pandemic "will place a hardship on healthcare organizations that participate in payment models, like ACOs, that hold providers accountable for healthcare spending," it says.
- More ACOs today are in at-risk models than ever before, it adds, "meaning they face penalties if spending rises above pre-set spending."
- A similar burden, it warns, "will be placed on Medicare Advantage plans."
- 20% of Medicare beneficiaries are assigned to ACOs, it notes, "so potential new COVID-related costs for Medicare ACO beneficiaries could range from $7.7 billion to $23.1 billion."
- Total spending for ACO beneficiaries was $125 billion in 2018, it adds, so "ACOs could see an increase in spending between 6% and 18% because of COVID-19."

Says Clif Gaus ScD, CEO & President at NAACOS: "We are just on the tip the iceberg of a global public health pandemic that is out of ACOs' control. We could see generated savings wiped out, massive penalties and, worst of all, ACOs dropping out of the program to avoid losses." And he repeats his common cautionary comment: "COVID-19 threatens to derail adoption of APMs and the movement to value-based care. We need policymakers to assure ACOs they'll take appropriate steps to provide needed protection."

- *NAACOS' COVID spending estimates are based on the number of Medicare beneficiaries and infection rates of 20%, 40% and 60%; inpatient admission rates "are derived from experience in China," the statement says.*
- *The average cost of a 90-day pneumonia hospitalization was used as a proxy for new Medicare spending.*
- *Included: "clinically relevant services provided post-discharge."*
- *Not included: "COVID-related costs for patients who are not hospitalized or costs faced for infection-control protocols and equipment."*

10 organizations, including NAACOS, recently wrote to the Centers for Medicare & Medicaid Services asking for "relief so that providers are not inappropriately penalized for the extreme costs of handling the COVID-19 pandemic." The parties want clinicians to be held harmless from performance-related penalties for 2020, appropriate adjustments to be made to spending targets, performance scores, patient attribution and risk adjustment and financial support & reinsurance to be provided.

Visit naacos.com.

Industry News

ApolloMed 'Closed Out 2019 On a High Note'

Apollo Medical Holdings Inc. (NASDAQ: AMEH), an integrated population health management company, says it "closed out 2019 on a high note" and executives are "very pleased with fourth quarter financial performance, which demonstrated meaningful improvements in revenue, net income and adjusted EBITDA." 2019 was marked by "significant accomplishments," a statement says, including acquiring Alpha Care Medical Group and Accountable Health Care IPA, closing the books on Allied Physicians of California IPA and managing 1 million lives.

IVQ19

- Total revenue of $178.8 million, an increase of 68% from $106.6 million for the quarter ended December 31, 2018.
- That's "primarily due to the acquisitions of Alpha Care Medical Group and Accountable Health Care IPA on May 31 and August 30, respectively."
- Capitation revenue, net, of $148.6 million, representing 83% of total revenue, an increase of 92% from IVQ18's $77.5 million.
- Risk pool settlements and incentives revenue of $18.5-million, an increase of 62% from IIIQ19's $11.4 million, "primarily due to the timing of incentives revenue paid and recognized."
- Net income attributable to Apollo Medical Holdings Inc. of $6.7 million, compared to net loss of $3.1 million for the quarter ended December 31, 2018.
- The increase was "primarily due to preferred dividends received from Allied Physicians of California IPA as a result of our completion of a series of transactions with APC on September 11, 2019," the statement says.

FY19

- Total revenue of $560.6 million, an increase of 8% compared to $519.9 million FY18.
- Capitation revenue, net, of $454.2 million, representing 81% of total revenue, an increase of 32% from $344.3-million in 2018.
- Net income attributable to Apollo Medical Holdings Inc. of $14.1 million, representing an increase of 31% from FY18's $10.8 million.
- Net income of $17.7 million, a decrease of 71%, compared to $60.3 million for 2018.
- Adjusted EBITDA of $74.5 million, an increase of 11% from FY18's $67.2 million.

2020 Guidelines

- Total revenue between $665 million and $675 million.
- Net income between $20 million and $30 million.
- EBITDA between $55 million and $67 million.
- Adjusted EBITDA between $75 million and $90 million.

This year, ApolloMed "updated Brandon Sim's title to Chief Technology Officer & VP of Engineering," the statement adds, and entered into an agreement with a 145,000-member IPA." Says Kenneth Sim MD, Executive Chair and Co-Chief Executive Officer at ApolloMed:

"In 2019, we worked to build an organization that is both scalable and profitable. We are well-positioned to deliver sustainable growth as we continue to support the shift to value-based care."

ApolloMed is a physician-centric integrated PHM company with subsidiaries including a Next-Generation Accountable Care Organization and affiliated IPAs and MSOs. It "leverages its integrated health management and healthcare delivery platform that includes NMM, an MSO; Apollo Medical Management Inc., an MSO; ApolloMed Hospitalists, a Medical Corp.; APA ACO Inc., an NGACO; APC IPA; Alpha Care; AHC IPA and Apollo Care Connect Inc., its digital PHM platform). Visit apollomed.net.

ValueH Targets Network at Small, Mid-Size Companies

FLAACOs parent ValueH Association LLC reports the official launch of its ValueH High-Performing Network, aimed at "delivering the superior transformation of healthcare across the state" for small to medium-sized self-insured employers. The Network will collaborate with Accountable Care Organizations and "other like-minded networks," a statement adds, "utilizing the relationships FLAACOs has built since 2013." ValueH says it's "well-positioned to leverage the best practices developed through the shared savings program," it adds, and is "poised to deliver significant value and patient engagement to employers and employees."

- Comments FLAACOs Chair & CEO Nicole Bradberry: "Florida ACOs are leading plans in other states in adopting best practices and sharing ideas to achieve outstanding results."
- Florida has "the highest concentration of independent Medicare Shared Savings ACOs in the country," she adds, attributing their success to "the idea that competing entities are able to share best practices through the formation of FLAACOs."
- Says FLAACOs officer Balford Francis: "One of the primary barriers to bending the cost curve for small to medium-sized employers is the lack of a state-wide high performing network aligned around the same principles as the ACOs."

ValueH delivers on all the critical elements of high-performing networks, Francis adds:

- Using them "can help reduce premiums – by 5% to 20% compared to those for broad network plans – and promote more affordable coverage options," according to the statement.
- High-value networks "are developed through a deliberative evolution process considering more than just fee levels," it adds.
- "Active cooperation and collaboration and participation by providers is a hallmark of successful plans."
- Quality measures are key among the criteria used for provider selection.
- And "the integration of the value network into plan designs" can improve care management and quality.

Visit flaacos.com and valueh.com.

Industry News

BHI, Decode Combine Data, ML Model to Predict Autoimmune Risk

Blue Health Intelligence and Decode Health, an analytics company, report "showing how a machine learning engine can be applied to large data sets to more accurately forecast which patients will get chronic diseases." Decode's analysis used a representative subset of BHI's National Data Repository, a statement explains, noting that it's "the largest and most longitudinally rich dataset in the nation." The aim: "show how healthcare claims data can be segmented to focus on specific sub-populations."

- Decode "developed an ML engine that uncovers specific patterns of chronic disease risk," the companies add.
- Decode was initially focused on inflammatory autoimmune diseases and "wanted to test the theory that its machine learning platform could be used to construct predictive models for multiple chronic diseases."
- To accomplish that, Decode "needed a comprehensive, multi-year, longitudinal data source that captured a wide range of patient populations across different geographies."
- So it turned to BHI.

The pair developed a custom claims dataset that included three years of continuous information from 2 million people "located in a region where autoimmune conditions, such as multiple sclerosis and Crohn's disease, are most prevalent."

Decode trained and tested "a series of disease-prediction models" to identify patients who had not received a conventional autoimmune diagnosis, "but who were predicted to be diagnosed in the future."

- It also used BHI data to see if clinicians properly documented the diagnoses, the statement adds, and to set up cost profiles "based on the actual date of diagnosis versus the predicted date."
- Using Crohn's as an example, "the cost profile for patients who received a diagnosis two years after Decode's predictions," the statement says, "were twice as high on average as for those diagnosed within one year of the predicted date."
- Says Chase Spurlock PhD, CEO at Decode: "By mining BHI's data, we identified specific patterns for MS and Crohn's that were indicators of future clinical events and periods of higher or lower future healthcare utilization."
- That, he adds, is "a significant breakthrough."

Decode also "proved its ML's ability to identify and monitor patients with an undiagnosed disease by using BHI's data to perform detailed studies of them," the pair continue. Decode's model "correctly identified a subset of 200 patients whose treatment costs made up 90% of the total cost profile." The approach, the statement adds, "resulted in additional cost-savings opportunities."

BHI "leverages the power of medical and pharmacy claims data from 200 million Americans," the statement points out. Its data analysts, clinicians, IT experts and epidemiologists provide analytics, Software-as-a-Service and consulting to payers, providers, employers and medical device companies. Visit bluehealthintelligence.com.

Catching Up With Robert Berry… *continued from page 12*

The next job I had reminded me so much of my old neighborhood. My coworkers were not only smart, but they were also caring. We had a lot of constructive conversations where they helped me identify strengths and opportunities for improvement. They helped me understand some of those unwritten business rules that many in my position would only learn after making a fatal error. And so I had a lot of unofficial mentors.

That's when I began learning a lot about Internal auditors. We were in the business of building relationships. And we partnered with a lot of clients to do good for organizations. So only a few years out of college, I was doing what I wanted to do: helping organizations. But I quickly discovered that my career choice was not like other careers. There are three things that make the internal auditing profession quite unique.

- *First, you have exposure to executive management in an organization quicker than you do in most fields. When you perform audits, there's usually a team that goes out together, and you're looking at the work product of people who report to a Vice President or higher in an organization. So you normally have some face time with that VP. I thought this was normal, but it wasn't. I had friends in other organizations who'd never met the VPs they reported to.*
- *Second, you get to see a lot of different things in the organization. Your span of authority, so to speak, is vast.*
- *And the third thing I learned was that auditors are not introverts. If you want to succeed, you have to be somewhat social. At that point, I leaned more towards the introvert side. Working with clients and helping them brought me out of my shell. Today, I lean more on the extrovert side than I do the introvert side.*

Now, these experiences not only got me out of the neighborhood that I grew up in, but they've also helped me to see the world. I've worked for some very large organizations. I've done speaking engagements across the country and even in other countries. I've been published in magazines, and I've written a few books – with a few more to come. I've met people who have become lifelong friends.

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Catching Up With Robert Berry… *continued from page 10*

I've come to believe that people are good and wonderful – and I can say that my experiences post-college have opened my eyes as an individual and restored my faith in people. It's also given me exposure and experiences that I never would have dreamed possible – all of this because as a kid I said, "When I grow up, I just want to help companies."

ACN: *What's a typical business day like? How do you spend your M-F/9-5 time? Is starting your own consulting firm going the way you anticipated?*

RB: A typical day for me is anything but typical. I think as humans, we all like to have consistency and structure in our lives. But there are always those unstructured elements that interrupt us. Therefore, I try to split my days so that part of the day is reserved for structured activities.

You see, a part of my business is passive income. I create and sell online training courses to auditors and business professionals. It takes time to create those courses. I publish and sell books. It takes time to write those books. But those are structured processes. So part of my day is spent creating and producing content.

In the other part of my businesses, I serve clients. I help with audits, or business processes or almost anything that fits my background. Part of that involves soliciting clients, writing proposals or answering requests or questions that clients might have. That's the unstructured part of the day. And you never know how good or bad it's going to be. So I try to make sure there's some consistency and normalcy in certain parts of the day, and other parts are just wide open to whatever the day may bring.

Like my post-college experience, having my own business is nothing like I expected. And I don't mean that in a bad way, either. It's fun and challenging, and a learning experience each day. It combines several of my passions, so it keeps a smile on my face.

ACN: *In your kingdom, how would healthcare be structured to make auditing it as simple and effective as possible? Is it the data going in that creates challenges? Or does the problem lie in stakeholders' expectations for what internal audit should be able to do with the data?*

RB: Auditing in healthcare is an experience unlike any other. The industry itself is so diverse and complex, you have to tackle it in small chunks. But internal auditors adjust to industries, not vice versa. One thing I've observed over time is that healthcare clinicians are extremely compassionate people, whereas back-office business folks tend to be structured and focused on processes and numbers.

It is important that these two differing work philosophies work well together. Otherwise, they're just like cars taking different routes to get to the same destination without talking to one another.

A lot of auditors tend to focus on the business side of healthcare. This makes sense, because most auditors come from some sort of business background. Numbers and data make sense, and there's a lot of information available. But what I also see is a lot of bureaucracy forcing clinicians to do things that they may or may not understand or may or may not have time for – or that may or may not be practical from an operational standpoint.

A clinician's first duty is to his or her patient. And so I think opportunities exist for auditors in bridging the gap between your back-office administration functions and your truly hands-on patient-centered operations. For example, I remember one audit of a specific clinic they were doing an excellent job of serving the local community with the services and care they provided. However, they were not making money. As a matter of fact, they were losing quite a bit of money.

The business office would send them reports showing their negative income and asking for action plans on how they could improve. In turn, they would respond to the business office acknowledging negative revenue and asking what they could do to improve. This goes back to that analogy of the two cars trying to get to the same destination using different routes – where they neither see nor hear one another.

The auditors obtained a ton of data from the operation, sliced and diced it 100 different ways and realized that, yep, indeed, the unit was losing money. We then went to the unit and began discussing the overall processes and profit points. That's when we realized that the unit was not billing for all of the services it provided following a fundamental shift in the way services were billed. Things that had not previously been allowable were currently allowable, and all the clinic needed to do was account for all the services it had been performing.

We helped the clinic determine the appropriate bill codes for the newly allowable services, which ended up boosting income. But because back-office professionals speak a different language from front-office clinicians, there's a communication gap. And that gap is where I believe there's an opportunity for internal auditors.

Data always tells a compelling story. So another opportunity for auditors is identifying the right data, obtaining it and doing proper analyses on it – which can help identify strengths and deficiencies in the operation. Again, I've found that the healthcare industry has some of the most caring professionals – but that oftentimes communication differences result in a lot of messed up back-end businesses, which increases risk exposure.

The bottom line: Making healthcare auditing as simple as possible will involve (1) using the data to tell a story, (2) connecting with clinicians, (3) understanding the back-end business processes and (4) facilitating a productive exchange between back-end business processes owners and front-facing clinicians.

Contact Berry at thatauditguy@gmail.com.

Catching Up With ….

Robert Berry, CPA, CIA, CISA

Principal
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Mobile AL

Berry is an independent risk, audit and compliance consultant who believes that people are the most important part of every organization. "When organizations focus on improving people," he says, "they will improve business processes, which leads to improved profits. Whether it's internal auditing, business consulting or data analysis, my focus is finding the tools to help people prosper."

Says Berry: "I am That Audit Guy. At some point, ask me how that name came about."

- *I have worked as an auditor and an accountant in small and multi-billion-dollar organizations.*
- *You will find the standard alphabet soup behind my name, but improving people, processes and profits is what matters most.*

That Audit Guy started as a passion project combining several personal interests: writing, technology and auditing. In 2011, I built a website and began blogging; now, over a million page hits later, I have trained auditors across the globe both live and online, authored numerous magazine articles, published a book and – best of all – helped organizations improve people.

- *We help organizations identify and implement better business practices through training, process evaluations and internal audits.*
- *Every organization exists to make some sort of profit: behind every profit is a series of business processes that must be in sync, but behind every process is a person.*
- *People are the heartbeat of every organization and need to be developed and supported.*

My training courses are practical and actionable, and the compelling content typically contains good visuals to stimulate recall along with clear and concise language. As a service provider, my approach is honest yet empathetic. We can work together to evaluate processes in your organization to bring out the best in everyone.

***Accountable Care News**: What has your professional journey been like since you finished college? Is it anything like you imagined it would be when you started?*

Robert Berry CPA, CIA, CISA: My Since graduating college, many moons ago, my professional journey has been nothing like I expected. And I mean that in a good way. So I think a little context is due. We grew up with, and learned to live on, very little. It wasn't until I was an adult that I realized that we would probably be classified today as poor. But it simply did not feel that way growing up.

For many of us, a common life goal was to live past 21. We did not travel a lot or live a lavish lifestyle. But what I did see were a bunch of people with a solid work ethic. From the time we were young, it was instilled in us that if we worked hard, it would all pay off one day.

Thinking back on preparing for college, I never knew what I wanted to be, but I knew what I wanted to do. I wanted to help businesses be better. I always had this knack for taking things apart and putting them back together, for seeing the flaws in the system and trying to make corrections to it. I don't know where that came from, but it initially led me to engineering. I initially thought that was my calling.

I joined a few engineering clubs in high school, and did not like them. I was very good at math, so I began to explore opportunities there, and then then all of a sudden I chose accounting as a major. The thought process was if I could understand the numbers – the flow of funds – in an organization, I could understand how it operates. If I understood how it operated, I could actually lend a hand to help it operate better.

While in college, I worked several jobs and managed to maintain a decent GPA. After graduating, I was thrust into the workforce, where I learned firsthand that being smart was not enough. My first job was with a *Fortune* 500 company, where many of the folks liked to enjoy the Florida sun with a round of golf. I didn't know how to play golf. I didn't even like golf. So no matter how smart I was, I was kind of the odd man out. I began to see the social aspect of the workforce.

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