Medicare Accountable Care Organizations – What & Why?

Third National Accountable Care Organization Congress

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The “Three-Part Aim”

- Better Health for the Population
- Better Care for Individuals
- Lower Cost Through Improvement
**CMS Levers**

- **Incentive Programs**
  - Quality Reporting Programs
  - EHR Incentives

- **Payment Policy**
  - Accountable Care Organizations
  - Center for Innovation

- **Quality Programs**
  - Partnerships for Patients
  - Quality Improvement Organizations
CMS’s ACO Strategy: Creating Multiple Pathways with Constant Learning and Improving

MSSP: Track 1 & Track 2

Pioneers

Advance Payment
Medicare Shared Savings Program (Shared Savings Program) Background

- Mandated by Section 3022 of the Affordable Care Act
- Establishes a Shared Savings Program using Accountable Care Organizations (ACOs)
- Must be established by January 1, 2012
- Notice of proposed rulemaking issued March 31, 2011
- CMS sought and received over 1,300 comments on the proposal.
- Issued Final Rule in October 2011.
ACOs grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality.

MedPAC featured the concept in its June 2009 Report to Congress.

During the development of this health care reform provision, Congress drew from these expert sources as well as from the Physician Group Practice (PGP) Demonstration project at CMS.
• Years 1-5:  
• All groups demonstrated quality improvement in measure modules including prevention, hypertension, congestive heart failure, diabetes, and coronary artery disease
• 7 of 10 groups shared $107M in savings
• In performance year 5, all ten physician groups achieved benchmark performance on at least 30 of the 32 measures
• All 10 PGPs are currently participating in the PGP Transition Demonstration
Medicare Shared Savings Program Goals

- The Shared Savings Program is a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures by:
  - Promoting accountability for the care of Medicare fee-for-service beneficiaries
  - Improving coordination of care for services provided under Medicare Parts A and B
  - Encouraging investment in infrastructure and redesigned care processes
ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health and lower growth in expenditures by:

– Putting the beneficiary and family at the center
– Remembering patients over time and place
– Attending carefully to care transitions
– Managing resources carefully and respectfully
– Proactively managing the beneficiary’s care
– Evaluating data to improve care and patient outcomes
– Using innovation focused on the three-part aim
– Investing in care teams and their workforce
What entities could form an ACO?

• Existing or newly formed organizations may form an ACO:
  – ACO professionals in group practice arrangements
  – Networks of individual practices of ACO professionals
  – Joint ventures/partnerships of hospitals and ACO professionals
  – Hospitals employing ACO professionals
  – Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
  – Critical Access Hospitals (CAHs) that bill under method II

• Secretarial discretion for other providers and suppliers of services
  – Other Medicare-enrolled entities may join the groups above as ACO participants.
Shared Savings Program ACO Structure

- **ACO**
  - Legal Entity

- **TIN’s**
  - **ACO Participants** Ex: Acute Care Hospitals, Group Practice, Individual Practice, FQHC, RHC, CAH, Pharmacy, LTCH, SNF, etc

- **Provider**
  - **ACO provider/suppliers** that bill through ACO participants (e.g. physicians, NPs, PAs, CNSs, pharmacists, chiropractors, etc)
Statutory Eligibility Requirements

1) Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it
2) Agree to participate in the program for at least a 3-year period
3) Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
4) Have a formal legal structure to receive and distribute payments
5) Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
6) The ACO shall provide information regarding the ACO professionals as the Secretary determines necessary
7) Define processes to (a) promote evidenced-based medicine (b) promote patient engagement, (c) report quality and cost measures and (d) coordinate care
8) Demonstrate it meets patient-centeredness criteria
Eligibility Requirement: Assignment

- Have a sufficient number of primary care professionals to care for the number of assigned beneficiaries assigned to the ACO. At a minimum, the ACO must have at least 5,000 assigned beneficiaries.
- Assignment is based on primary care services rendered by physicians.
  - This means some of the ACO participants must have primary care physicians that provide primary care physician services (e.g. hospitals employing physicians, group practices, etc).
Eligibility Requirement: Formal Legal Structure

- Have a formal legal structure to receive and distribute payments
  - If the ACO is an existing entity and is not joining with any other ACO participants, the ACO may use its existing legal entity
  - ACO Participants that are otherwise separate and join together to form an ACO, must establish a separate legal entity recognized and authorized under State, Federal or Tribal law
Eligibility Requirement:
Governance & Leadership

• Shared governance through a governing body with representation by ACO participants and beneficiaries
  – ACO participants hold 75% control of governing body
  – Beneficiary on the governing body
  – Flexibility for organizations to demonstrate how they will provide for meaningful representation of ACO participants and beneficiaries on the governing body

• Demonstrate an organizational commitment, leadership and resources necessary to achieve the three-part aim and demonstrate clinical integration
  – Experienced leadership team
  – Medical Director
  – Qualified health professional to lead the quality assurance/improvement process
Eligibility Requirement: Patient Centeredness

1. **Beneficiary experience of care survey** in place and results used to improve care over time
2. **Patient involvement** in ACO governance
3. A process for evaluating the health needs of the population, including consideration of **diversity** and a plan to address them
4. **Individualized care plans** used to promote improved outcomes for high risk and multiple chronic condition patients and any other target patient populations
5. Mechanisms in place for **coordinating care** throughout an episode of care and during its transitions.
6. Communicate clinical knowledge/evidence based medicine to beneficiaries in a way that is understandable to them.

7. Written standards for beneficiary access and communication and a process in place for beneficiaries to access their medical record.

8. An infrastructure for internally reporting on cost and quality that enables the ACO to monitor, provide feedback and evaluate, and improve care/service over time.
ACOs may choose to participate in one of two tracks:
- First agreement period of one-sided shared savings OR
- First agreement period of two-sided shared savings/losses

Track 1 Provides on-ramp for organizations to gain population management experience before transitioning to risk arrangements

All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided model.
• ACO accepts responsibility for an “assigned” patient population
• Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
• Assignment will not affect beneficiaries’ guaranteed benefits or choice of doctor or any other provider
• A preliminary prospective assignment methodology with a retrospective reconciliation
Patient Population

- Identify all beneficiaries who have had at least one primary care service rendered by a physician in the ACO.
- Followed by a two step assignment process
  - First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
  - Second, for beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any ACO professional
Other Aspects of Program Participation

- Participation in other initiatives
- Data Sharing
- Beneficiary communication
- Quality
- Benchmarking
Participation in Other Shared Savings Initiatives

• ACOs cannot participate in multiple Medicare initiatives involving shared savings, including:
  – Independence at Home Medical Practice Demonstration (ACA Sec. 3024)
  – Medicare Healthcare Quality Demonstration (MMA Sec. 646)*
  – Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)*
  – Physician Group Practice Transition Demonstration
  – Pioneer ACO Model Demonstration
  – Other ongoing Medicare demonstrations involving shared savings.
• Additional programs, demonstrations, or models with a shared savings component that may be introduced in the Medicare program in the future.

* Only contracts with shared savings arrangements
Data Sharing

- Aggregate data reports provided at the start of the agreement period, quarterly aggregate data reports thereafter and in conjunction with year end performance reports.
- Aggregate data reports will contain a list of the beneficiaries used to generate the report.
- Beneficiary identifiable claims data provided for beneficiaries on the preliminary prospective assignment list or who have received primary care services from an ACO provider/supplier.
- Beneficiaries must be notified and given the opportunity to decline to have data shared.
Beneficiary Communication

• Beneficiaries will be notified that their provider is participating in the program (ACO) via letter from the provider, or during an office visit.
• Beneficiaries will receive general notification about the program and what it means for their care.
• To prevent beneficiary steering, inappropriate advertising and to ensure information about ACOs is consistent and accurate, CMS has established requirements regarding marketing materials and activities.
• ACOs must give beneficiaries an opportunity to decline to have their data shared.
Other Beneficiary Protections

• Monitoring, by a variety of methods, assures general program compliance and focuses on avoidance of at risk beneficiaries and poor quality performance. Methods include, but are not limited to:
  – Analysis of specific financial and quality data as well as annual and quarterly reports.
  – Site visits.
  – Collection, assessment and follow up of beneficiary and provider complaints.
  – Audits (including, for example, analysis of claims, chart review, beneficiary surveys, coding audits).
Quality Measurement & Performance

- Quality measures are separated into the following four key domains that will serve as the basis for assessing, benchmarking, rewarding and improving ACO quality performance:
  - Better Care
    1. Patient/Caregiver Experience
    2. Care Coordination/Patient Safety
  - Better Health
    3. Preventative Health
    4. At-Risk Population
ACO Quality Performance Standard made up of 33 measures intended to do the following:

- Improve individual health and the health of populations
- Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement and care coordination
- Support the Shared Savings Program goals of better care, better health and lower growth in expenditures
- Align with other incentive programs like PQRS and EHR
- Exhibit sensitivity to administrative burden
Quality Data Reporting

• Quality data collected three ways:
  – Claims and other internal data
  – ACO-GPRO tool
  – Survey
• Complete and accurate reporting in the first year qualifies the ACO to share in the maximum available quality sharing rate
• Pay for reporting is phased in for the remaining performance years
• Shared savings payments are linked to quality performance based on a sliding scale that rewards attainment
  – High performing ACOs receive a higher sharing rate
Estimating Benchmarks

• Calculated at the start of each agreement period
• Based on parts A and B expenditures for Medicare beneficiaries who would have historically been assigned to the ACO in any of the past 3 years
  – Expenditures will be broken out into categories: ESRD, Disabled, Dual Eligible Aged, Non-Dual Eligible Aged.
  – Expenditures are adjusted for IME/DSH.
  – Expenditures are risk adjusted using CMS-HCC scores.
• Updated annually by the projected absolute amount of growth in national per capita expenditures for parts A and B services
Financial Performance

- Performance year expenditures are calculated and risk adjusted.
  - Account for health status and demographic changes during each performance year
  - Use an ACO’s HCC prospective risk score to take into account changes in severity and case mix for beneficiaries who are newly assigned
  - Use patient demographic factors only to account for changes in the beneficiaries continuously assigned to the ACO’s population, but if the HCC prospective risk score is lower in the performance year for this population, adjust for changes in severity and case mix using the lower HCC prospective risk score.
Financial Performance

• ACOs demonstrate savings if actual assigned patient population expenditures are below the established benchmark AND the performance year expenditures meet or exceed the minimum savings rate (MSR).
• The MSR takes into account normal variations in expenditures.
• Under the one-sided model, the MSR varies based on the size of the ACO’s population.
• Under the two-sided model, the MSR is 2% of the benchmark for all ACOs.
One-Sided and Two-Sided Risk Models

- One-sided risk model has a maximum share of savings of 50% for quality performance with a cap on shared savings
  - Cap on shared savings (10% of benchmark)
- Two-sided risk model has a maximum share of savings of 60% for quality performance with a cap on shared savings
  - Higher cap on shared savings (15% of benchmark)
  - Shared loss calculation is 1 minus final sharing rate as a function of quality performance (not to exceed 60%)
- All ACOs share in first dollar saved once they meet or exceed MSR
Interagency Coordination

Three notices have been issued with the Final Rule:

**Antitrust Agencies (FTC/DOJ):** Antitrust Policy Statement
[www.ftc.gov/opp/aco/](http://www.ftc.gov/opp/aco/)


**OIG/CMS:** Interim Final with Comment
Antitrust Policy Statement

- Antitrust Policy Statement outlines enforcement policies related to ACOs that are eligible to and intend, or are approved to participate in the Medicare Shared Savings Program.

- Antitrust policy statement applies to all collaborations between otherwise independent providers and provider groups.

- A key component to the Antitrust Policy Statement is the Primary Service Area (PSA) calculation for percent share for common services that are provided by two or more ACO participants.

- Newly formed ACOs may request a voluntary expedited review from the antitrust agencies.
Innovation Center Initiatives

• Pioneer ACO Model
• Advance Payment ACOs
The Pioneer ACO Model

• Designed for organizations that are:
  – Well on their way to changing care delivery and business model
  – Interested in being on the leading edge

• Allows ACOs to move more rapidly from shared savings payment model to population-based payment model
Advance Payment Model

• Designed primarily for physician-led and rural ACOs needing additional capital for care coordination capabilities

• Developed based on feedback from providers
  – Comments on Advance Payment Initiative
  – Comments on Shared Savings Program
Advance Payment Model

• Open only to ACOs participating in the Medicare Shared Savings Program meeting designated criteria

• ACOs meeting criteria will gain access to part of their shared savings up front

• Payments recouped through an ACO’s earned shared savings
Providers can choose from a range of care delivery transformations and escalating amounts of risk, while benefitting from supports and resources designed to spread best practices and improve care.

Tools to Empower Learning and Redesign:
Data Sharing, Learning Networks, RECs, PCORI, Aligned Quality Standards
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