Overview

- CMS vision and goals
- Medicare Shared Savings Program operation highlights
- Next steps
ACO Vision

• An ACO promotes seamless coordinated care
  – Puts the beneficiary and family at the center
  – Remembers patients over time and place
  – Attends carefully to care transitions
  – Manages resources carefully and respectfully
  – Proactively manages the beneficiary’s care
  – Evaluates data to improve care and patient outcomes
  – Innovates around better health, better care and lower growth in costs through improvement
  – Invests in team-based care and workforce
CMS’s ACO Strategy: Creating Multiple Pathways with Constant Learning and Improving

MSSP: Track 1 & Track 2

Pioneers

Advance Payment
Medicare ACOs To Date

152 Accountable Care Organizations (ACOs) as of July 2012

- Pioneer ACOs: 32
- Medicare Shared Savings Program ACOs: 114
- Physician Group Practice Transition Demonstration: 6

Currently evaluating applications for the Jan 1, 2013 start date

Yearly start dates going forward
Geographic Distribution of ACO Assignees
(2.6 million total assignees in all programs)
Operating Principles

- Creating multiple pathways and on-ramps for organizations to participate
- Strong data partnership
- Beneficiary notification and engagement
- Maintain strong partnership with federal anti-trust agencies
- Robust quality measurement and performance monitoring
- Stronger business case to participate
- Excitement and momentum
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\textsuperscript{st} 2011
- CMS sought and received over 1,300 comments on the proposal.
- Issued Final Rule in October 2011.
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)
Eligible Organizations

- Physicians and professionals in group practice arrangements
- Networks of individual practices of physicians and other professionals
- Joint ventures/partnerships of hospitals and physicians and professionals
- Hospitals employing physicians and professionals
- Critical Access Hospitals (CAHs) that bill under Method II
- Other providers/suppliers may participate in an ACO but would not be used to directly assign patients
Two-Track Payment Approach

- ACOs may choose to participate in one of two tracks:
  1. Initial agreement of shared savings only
  2. An initial agreement of two-sided shared savings/losses

- All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided model

- Provides an “on-ramp” for organizations to gain population management experience and transition to risk arrangements
Assignment of Patient Population

- ACO accepts responsibility for an “assigned” Medicare 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

- Patients assigned to ACOs using a two-step method based on plurality of primary care services rendered by ACO physicians and other professionals

- Assignment will not affect beneficiaries’ Medicare benefits or choice of physician or any other provider

- Assignment of beneficiaries based on preliminary prospective assignment with retrospective reconciliation.
• Quality measures separated into four domains:
  1. Patient/Caregiver Experience
  2. Care Coordination/Patient Safety
  3. Preventive Health
  4. At-Risk Population/Frail Elderly Health
• ACOs that score higher will be eligible for greater savings
• Measures aligned with current CMS measurement efforts and incentive programs
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 and for beneficiaries who drop out of an ACO’s assigned population
  – Use patient demographic factors only to account for changes in the beneficiaries continuously assigned to the ACO’s population
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%)
    • ACOs which meet or exceed the minimum loss rate will share in losses on a first dollar basis
• All ACOs share in first dollar saved once they meet or exceed MSR
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 patients seen by ACO primary care providers who have been notified and not declined to have data shared.
Interagency Coordination

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


**OIG/CMS:** Interim Final with Comment
Next Steps
Questions?


Contact:  ACO@cms.hhs.gov