

Medicare and Health System Transformation



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During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Accountable Care Organizations (ACOs)

Principles Underlying Our ACO Strategy

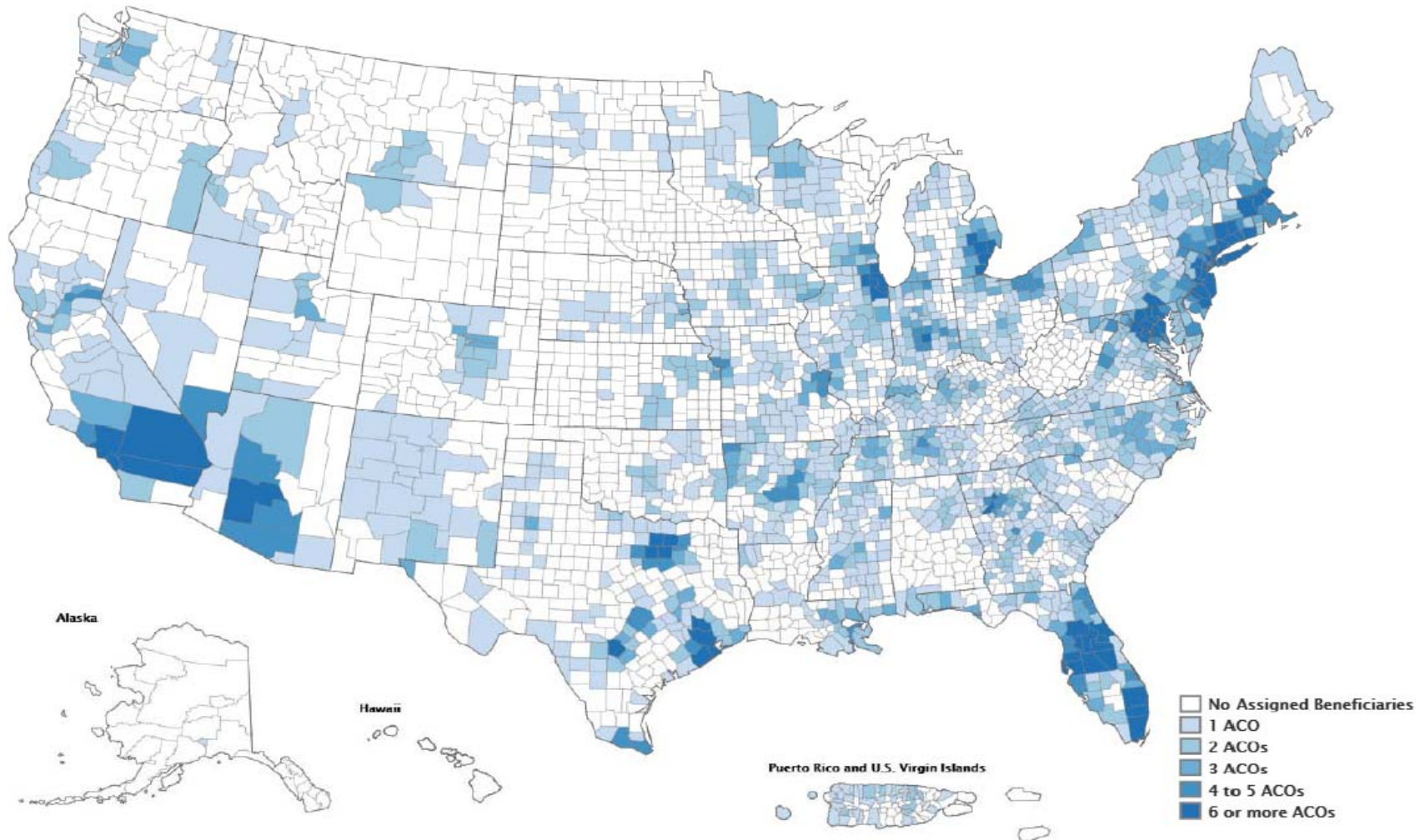
- Maintain a test bed of models thru CMMI
- Expand models based on testing experience
- Tailor ACO opportunities to different segments of the market
- Improve coordinated care in both traditional Medicare and Medicare Advantage
- Aim for overall improvement in quality and costs
- Balance rewarding improvement and attainment in spending performance

CMS ACO Initiatives

- Medicare Shared Savings Program – 3 Tracks
- Pioneer ACO Model
- ESRD ACO Initiative
- Advance Payment Model
- ACO Investment Model
- Next Generation ACO Model

ACO Participation

ACO-Assigned Beneficiaries by County



Promising Results

- Pioneer
 - Total model savings of **\$120 million** - an increase over the first two performance years
 - Improvements in **28 of 33** quality measures
 - Average improvements of **3.6%** across all quality measures
- Medicare Shared Savings Program
 - Total net savings **\$383 million**
 - Improvements in **27 of 33** quality measures for ACOs that reported in 2013 and 2014
 - Achieved higher performance than other FFS providers on **18 of the 22** Group Practice Reporting Option Web Interface measures

Summary of Final Rule Program Improvements

- Addressing **participation agreement renewals** including allowing eligible ACOs to continue participation under the one-sided model (Track 1) for a second agreement period;
- **Increasing the emphasis on primary care services** in the beneficiary assignment methodology;
- **Streamlining data sharing** to provide improved access to data necessary for ACO health care operations such as quality improvement and care coordination, while maintaining beneficiary protections;

Summary of Final Rule Program Improvements

- **Adding a new performance-based risk option (Track 3)** that includes prospective beneficiary assignment and a higher sharing rate;
- **Providing ACOs choice of symmetric threshold for savings and losses** under performance-based risk tracks;
- Establishing a **waiver of the 3-day stay SNF rule** for beneficiaries who are prospectively assigned to ACOs under Track 3 (on or after January 1, 2015);

Summary of Final Rule Program Improvements

- **Refining the methodology for resetting benchmarks** to help ensure that the program continues to provide strong incentives for ACOs to improve the efficiency and quality of patient care, and generate savings for the Medicare Trust Funds;
- **Conducting further development and testing of other selected waivers through CMMI**, including a waiver of the billing and payment requirements for telehealth services;

Opportunities for Future Rulemaking

- We intend to address other modifications to program rules in future rulemaking in the near term to improve ACO willingness to take on performance-based risk including:
 - **Modifying the assignment methodology** to hold ACOs accountable for beneficiaries that have designated ACO practitioners as being responsible for their care;
 - waiving the geographic requirement for **use of telehealth services**

Opportunities for Future Rulemaking

- **Additional notice and comment rulemaking in 2015 for a methodology that would reset ACO benchmarks** in part based on trends in regional fee-for-service costs rather than solely ACOs' own recent spending

Next Generation ACO Model

Next Generation ACO Model Principles

- **Prospective attribution**
- **Protect Medicare FFS beneficiaries' freedom of choice;**
- **Create a financial model with long-term sustainability;**
- **Rewards quality;**
- **Offer benefit enhancements that directly improve the patient experience and support coordinated care;**
- **Allow beneficiaries a choice in their alignment with the ACO**
- **Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms.**

Overview of benchmark

The benchmark will be **prospectively set prior to the performance year** using the following four steps¹:

Baseline

Determine ACO's baseline using one-year of historical baseline expenditures (2014)

Trend

Trend the baseline forward using a regional projected trend, defined as combination of national projected trend with application of regional price adjustments.

Risk Adjustment

The full HCC risk score will be used. Average risk score of ACO beneficiaries allowed to grow by 3% between the baseline and the given performance year. Decrease also capped at 3%.

Quality and Efficiency Adjustment

Apply adjustment derived from quality adjustment and efficiency adjustment.

¹ Benchmark will be prospectively set with retrospective adjustments based on final risk adjustment and quality score information

Risk Arrangements

| Arrangement A: Increased Shared Risk | Arrangement B: Full Performance Risk |
|---|---|
| Parts A and B Shared Risk <ul style="list-style-type: none">•80% sharing rate (PY1-3, 2016-2018)•85% sharing rate (PY4-5, 2019-2020)•15% savings/losses cap | 100% Risk for Parts A and B <ul style="list-style-type: none">•15% savings/losses cap |

- Benchmarks calculated the same way for both arrangements.
- Different sharing rates affect ACO risk.

Payment Mechanisms

| Payment Mechanism 1: Normal FFS | Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payment | Payment Mechanism 3: Population-Based Payments (PBP) | Payment Mechanism 4: Capitation (2017) |
|---|---|---|---|
| Medicare payment through usual FFS process. | Medicare payment through usual FFS process plus additional PBPM payment to ACO. | Medicare payment redistributed through reduced FFS and PBPM payment to ACO. | Medicare payment through capitation; ACO responsible for paying ACO Provider/Supplier and Capitation Affiliate claims |

- Goals of payment mechanisms:
 - Offer ACOs the opportunity for stable and predictable cash flow; and
 - Facilitate investment in infrastructure and care coordination.
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures.

Benefit Enhancements

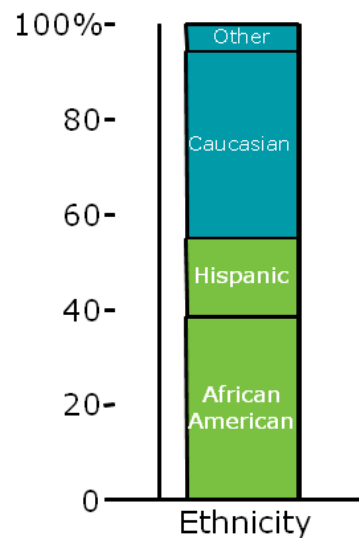
- Medicare payment rule waivers designed to improve care coordination and cost saving capabilities:
 - Telehealth expansion
 - Post-discharge home visits
 - 3-Day SNF Rule waiver
- ACO may decide which, if any, to implement.
- For each, ACOs must submit an implementation plan describing how the ACO will utilize, monitor, and report on the benefit enhancement.

Comprehensive ESRD Care Initiative

Why target the End-Stage Renal Disease (ESRD) patient population?

- Beneficiaries with ESRD are among the most medically fragile populations served by the Medicare program.
- Many experience multiple underlying co-morbidities, leading to high rates of hospital admission and readmissions, and a much higher mortality rate than the general Medicare population.
- ESRD patient population suffers from:
 - Minimal coordination
 - Fragmentation
 - Limited access
- The challenge and opportunity is to reorient providers toward a care model that better serves the fragile ESRD population.

A Population That Needs Accountable Care



- Over 50% minority
- 40% dual-eligible
- 3+ co-morbidities, ~ 50% diabetic
- ~8 medications
- 20% mortality

- 8% of Medicare spending
- \$70K per patient per year
- 55% IP admits are avoidable
- 30% re-admission rate

Source: USRDS, Healthy People 2010, HRSA: Health Disparity Prevention, DVA Data

Model Goals

Improved care coordination

- Certain co-location and/or rounding services allowing central coordination of services across settings.
- Coordination of a full range of clinical and supportive services
- Data-driven, population care management for targeting broad care improvement efforts

Enhancing communication between providers

- Key clinical and support service electronic health record information exchange among providers
- Whole-patient care management
- Processes that address areas such as functional, cognitive and psychosocial status, goals and preferences, effective care transitions, and medication management

Increasing access to care

- Facilities with extended business hours, utilizing a nurse call-in line after hours
- Enhanced convenience through certain arrangements for on-site “rounding” by non-dialysis providers at dialysis facilities or home visits
- Provision of certain items that facilitate access to care such as transportation to care sites, nutritional supplements, etc.
- Self-management promotion and patient/caregiver education about home dialysis options, renal transplantation, palliative care, etc.

LDOs and Non-LDOs

- LDOs are companies with 200 or more dialysis facilities and non-LDOs have fewer than 200
 - Currently, DaVita, Fresenius, and DCI are the LDOs participating in the model
- Separate financial models for each
- LDOs face two-sided risk with upside and downside and higher sharing rates and caps
- Non-LDOs are in an upside-only arrangement

Medicare/Medicaid Integrated ACO Concept

Model Description

- Hypothesis: comprehensive medical management of, and better care coordination for, ESRD beneficiaries will result in improved outcomes and expenditure savings
 - Comprehensive and Coordinated Care Delivery
 - Enhanced Patient-Centered Care and Improved Communication
 - Improved Access to Services

Integrated ACO Aim

- An Integrated ACO should empower providers to improve the quality, cost, and coordination of care for dual eligible beneficiaries.
- An Integrated ACO would test the viability of a **provider-led, fee-for-service (FFS) ACO** in parallel to the existing CMS programs, models, and demonstrations.

Roles

- ACO:
 - Indicate interest and support for partnership on Integrated ACO
 - Take responsibility for coordinating care of aligned population
 - Report quality measures
- States:
 - Collaborate in model design with both CMS and providers
 - Share Medicaid data with both CMS and providers
- CMS:
 - Collaborate in model design with both providers and State
 - Operationalize model and provide technical assistance and analytics
 - Support a platform for states and ACOs to share best practices, improve care coordination, improve quality and reduce cost
 - Share Medicare data with States and ACOs