


Medicare Accountable Care Organizations: What it's about

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Medicare Accountable Care Under the Medicare Shared Savings Program

- Accountable Care Act - 2010
 - Goals
 - Improve quality of care
 - Reform health care delivery system
 - Appropriate price services and modernize financing systems
 - Fight waste, fraud and abuse

Key cost Containment Strategies in ACA

Cost Containment Strategies	Key Provisions	10/11 Cost Savings	10 yr Cost Savings
Improve the quality of care	Reduce hosp admits Reduce hosp acquired conditions Bundled payment ESRD Improve phys quality reporting – value modifier	- - -	\$8.2 Billion \$3.2 Billion \$1.7 Billion \$1.9 Billion
Reform delivery system	ACO Indep Payment Advisory Board	-	\$4.9 Billion \$23.7 Billion
Approp price services, Modernize financing systems	Decrease MA payments Modify payments for advanced imaging (overutilization) Competitive bidding for DME	\$5.3 Billion \$0.1 Billion \$0.5 Billion	\$1.45 billion \$2.0 Billion \$17 Billion

Key cost Containment Strategies in ACA

Fight waste, fraud and abuse	Expand RAC's Require face encounters with phys prior to receiving certain services (phy must be enrolled in MC for HH and DME, require face to face) Increased profiling Enrollment screening – legitimate providers, re-validation,	\$0.4 Billion	\$4.9 Billion
Total of selected provisions		\$7.7 Billion	\$417.5 Billion

Medicare Shared Savings Program

- Effective January 2012
 - Encourage providers of services and suppliers (physicians and hospitals, others involved in patient care) to create a new type of health care entity = ACO
 - Improve health and experience of care for individuals
 - Coordinate patient care
 - Improve communication within providers
 - Right care at the right time, right provider
 - Prevent medical errors
 - Avoid duplication of care
 - Avoid unnecessary care
 - Improve the health of the population
 - Reduce the rate of growth in health care spending

Medicare Accountable Care Organizations

- Who can be an ACO participant
 - ACO professional = physician, hospitals
 - Networks of individual practices of ACO professionals such as independent practice associations
 - Partnership or joint ventures between hospitals and ACO professionals
 - Hospitals employing ACO professionals
 - Primary care practices structured as a patient centered medical home
 - Medicare enrolled provider
 - SNF and LTCHs MAY NOT be ACO participants

Medicare Accountable Care Organizations

- What is required of an ACO entity?
 - Separate tax ID number
 - 3 year contract with CMS, approval process
 - Medicare enrolled provider
 - Mechanism for shared governance
 - 75% of the BOD must be an ACO participant
 - Can have health plan participation, but the health plan CANNOT run the ACO
 - ACO participants must have appropriate proportionate control over the decision making process
 - Consumer participation in governance
 - (advisory committee okay)
 - Authorized under State law to:
 - receive and distribute savings
 - Repay shared losses
 - Implications for Stark, anti-kick back

Medicare Accountable Care Organizations

- ACO Operating Requirements
 - Staffing: Executive, Medical Director and Compliance Official
 - Committees: Quality Assurance, Process Improvement Committee, Member Advisory Committee
 - Patient-centered processes, including:
 - Administering a beneficiary care experience of care survey: CAHPS survey and functional status survey module Identifying high risk individuals and developing individualized care plans for targeted patient populations
 - Health risk assessment
 - Using technology to facilitate coordinated care, transitions of care
 - Communicating clinical information to beneficiaries and engaging them in shared decision making
 - Measuring clinical and service performance by physician and across practices
 - Using information to drive improvements

Medicare Accountable Care Organizations

- ACO Operating Requirements:
 - Reporting: 65 quality measures
 - Regulatory: compliance, audits, marketing
 - Information technology infrastructure
 - Electronic exchange with patients
 - Electronic exchange amongst providers
 - Point of care updates
 - Medicare fee for service billing
 - Bear financial risk
 - Sufficient # of PCP's
 - >5,000 beneficiaries/year
 - ACO's may contract directly with payer, employer to provider care

Medicare Accountable Care Organizations

- What is hospital/provider relationship in controlling the ACO?
 - Controlling entity: captures largest share of savings, greatest financial risk
 - Physician controls ACO
 - Contract with hospital based on value, cost, outcomes
 - Transparency of cost, services, value
 - Physician organization controls funds flow
 - Hospital controls ACO
 - Physician employment model or hospital-provider model
 - Implications on income, autonomy, work environment
 - Hospitals control high \$ items

Medicare Accountable Care Organizations

- Isn't this just “managed care in drag” – SORT OF!
 - Key differences
 - No “single gate keeper” defined, but implied with medical home PCP's
 - “Narrow network” – group of ACO providers based on commitment to cost, quality, communications, transitions, but this is not a managed care network defined by an external entity
 - Patients role:
 - Patients are FFS
 - Not obligated to seek care from an ACO provider and ACO provider cannot prevent care from a non-ACO provider
 - 1/3 outpt E&M services, 1/3 hospital admissions outside “normal” patient network
 - Currently no financial incentive to stay within the ACO network
 - Under discussion – lower co-payments, lower premiums, default assignment

Medicare Accountable Care Organizations

- ACO Member Assignment
 - Retroactive assignment at the end of every year
 - Pioneer ACO model
 - Prospective assignment
 - Only for established high functioning ACO programs
 - Practice must post notice of participation in an ACO
 - Patients must consent to share beneficiary identifiable data with an ACO, may opt out
 - Attribution based on plurality of allowed charges to ACO PCP's, defined as Internal Medicine, Family Practice, GP, Geriatrics
 - 99201-99215 (office outpatient)
 - 99304-99340 (nursing facility, domiciliary or rest home visits)
 - 99341 – 99350 (home visits)
 - G0402 (WTM)
 - G0438, G0439 (annual wellness visits)

Reporting Requirements

Domain	Category	Table 1 Measures (total)
Patient/caregiver experience		1-7 (7 measures)
Care Coordination		8-23 (16 measures)
Patient safety		24-25 (2 measures)
Preventive Health		26-34 (9 measures)
At-risk population/frail elderly health	Diabetes, Heart failure, CAD, Hypertension, COPD, Frail Elderly	35-65 (31 measures)

Shared Risk Methodology

- CMS will set annual cost benchmarks based on prior 3 years of expenditures
 - CMS HCC model will be employed
 - Importance of coding IN ADVANCE in ACO
 - Benchmark set on prior HCC scores, same risk score applied x3 years
 - Experience with MA increase HCC score due to coding initiatives
 - Truncate total annual per capita expenditures at the 99th % (approx \$100K – 2008) to minimize variation due to catastrophic claims
- Includes Part A and B FFS expenditures for beneficiaries who would have been assigned to the ACO
- Must make adjustments to avoid penalizing certain providers/hospitals
 - DSH hospitals
 - Teaching hospitals, GME, IME dollars
 - Geographic variation – high cost, low cost
- Must exclude PQRS, HIT, ERX dollars

Shared Risk Methodology

- 2 ways for ACO's to contract
 - Shared Risk Option 1 – One Sided Risk Model
 - Receive up to 50% of any savings achieved above the MSR
 - Shared savings ONLY for yrs 1&2
 - Gain-sharing is capped at 7.5% of benchmark level
 - Shared savings AND losses in yr 3
 - Up to 5% of any loss must be repaid to CMS
 - No minimum loss rate
 - 25% withhold rate on earned performance to ensure repayment of shared loss
 - Entry point for organizations with less experience
 - Establish a minimum savings rate (MSR) to account for normal variations in HC spending
 - % of benchmark that savings must exceed for an ACO to qualify for \$\$
 - 2% - 3.9% based on # of beneficiaries assigned
 - Waiver can be obtained for small practices, rural practices, FQHC
 - Share in savings based on quality scoring

Shared Risk Methodology

- Shared Risk Option 2 – Two Sided Risk Model
 - Receive up to 65% of any savings achieved above the MSR
 - Shared savings for years 1-3
 - Gain-sharing is capped at 10% of benchmark level
 - Shared losses years 1-3
 - Not responsible for to repay CMS for losses within the minimum loss rate
 - Up to 5% of loss repaid to CMS in yr 1
 - Up to 7.5% of loss repaid to CMS in yr 2
 - Up to 10% of loss repaid to CMS in yr 3
 - 25% withhold rate on earned performance to ensure repayment of shared loss
 - Entry point for organizations with more experience
 - Establish a minimum savings rate (MSR) to account for normal variations in HC spending
 - % of benchmark that savings must exceed for an ACO to qualify for \$\$
 - MSR = flat 2\$
 - Share in savings based on quality scoring

Reporting Requirements

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ACO Performance Standards

- See attached handout for specific performance criteria
- If participate in yr 1 (2012) ACO's may receive entire shared savings payment if they report on 100% of measures, not based on quality score. In subsequent yrs amount of shared savings payment depends on overall quality score
- Must report on all measures in all domains
- 5 domains weighted equally
- Quality measure benchmarks based on MFF/MA performance data
- Must obtain > minimum attainment level determined by CMS on all measures
 - Max 2 points per measure for performance >90th percentile
 - 0 points for performance <30th percentile
 - If > minimum attainment level but < benchmark may receive sliding scale points
 - Some scores are all or none
- ACO's must submit measures for PQRS
- At least 50% of PCP's in an ACO must be meaningful EHR users by yr 2

Medicare ACO Potential Outcome Scenarios Option 1

Best Case	# bene/ % saved	5,000	7,500	10,000	Worst Case	# bene/ % saved	5,000	7,500	10,000
3 yr \$\$		\$2.7 million	\$4.7 million	\$6.7 million	3 yr \$\$		-\$125k	-\$190K	-\$250k

Medicare ACO Potential Outcome Scenarios Option 2

Best Case	# bene/ % saved	5,000	7,500	10,000	Worst Case	# bene/ % saved	5,000	7,500	10,000
3 yr \$\$		\$5.0 million	\$7.5 million	\$10 million	3 yr \$\$		-\$570k	-\$850K	-\$1.2 million

Additional Notes

- CMS will monitor ACO's to identify avoidance of at-risk-beneficiaries
- Physician self-referral law (Stark) – to ensure that physicians have no financial incentive to refer patients for unnecessary services or to particular providers
 - CMS proposes to waive limitation on such referrals – basis of ACO
- Federal Anti-Kickback statute
 - CMS proposes to waive limitation on such referrals – basis of ACO
- Civil Monetary Penalties – limits hospital payments to physicians to reduce services to MC/MK patients even if unnecessary
 - CMS proposes to waive if the payments are not knowingly made to induce physician to reduce services, and the hospital and physician are ACO participants, or ACO providers

Are You On the ACO Path?

- Requires an assessment of:
 - Willingness to endure a Medicare “experience”
 - Medicare value, priority
 - Total revenue
 - Medicare ACO as the basis to change all other payers
 - Establish key partnerships: external practices (PCP, specialty), hospital(s), administrative entity (UPI), CM vendors,
 - Key infrastructure (IT platform, reporting)
 - Willingness to create shared clinical governance, clinical operations
 - Willingness to act toward a common goal
 - Willingness to practice to specified standards
 - Willingness to use data to change practice that doesn't meet specified standards, may imply penalties to those that don't perform

Are You On the ACO Path?

- Requires an assessment of:
 - Willingness to invest in infrastructure
 - Ancillary provider types
 - Care management/coordination resources
 - Patient education
 - End of life care
 - Willingness to tolerate loss \$\$\$, although model 1 not great



The Alternative Platform?



- Self insurance trust
- Medicaid RCCO
- Large clinical trials
- “Self created” demonstration project
- Commercial payer based project
- Must do something



Questions/Comments



When do I retire?

Sources

- Accountable Care Organizations: Summaries of the Proposed Regulation and Related Documents:, Health Policy Alternatives, Inc., April 6, 2011
- www.cms.gov/sharedsavingsprogram
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- Patients' role in ACOs, NEJM, December 30, 2010
- Physicians vs Hospitals as leaders of ACO's, NEJM December 30, 2010