The Medicare Shared Savings Program: Accountable Care Organizations

INTRODUCTION
Matthew P. Amodeo is a partner in the Health Law Practice Group. His practice is focused primarily on hospital-physician integration transactions, health care joint ventures and managed care contracting. He also advises several national providers and practice management companies on matters concerning New York regulatory compliance, including NY Medicaid billing issues.

Matt has served as the lead provider contracting lawyer for several HMOs and commercial insurers in the Northeast region. He also represents many hospitals and other providers in their managed care contract negotiations. In these capacities, Matt has drafted and negotiated many highly complex risk-sharing and other compensation arrangements. He has an in-depth knowledge of the competitive strategies of payors in the Northeast market and has been able to leverage this knowledge to advance the business interests of his health care provider clients.

René Y. Quashie is a government relations director/regulatory attorney in the firm’s Government Relations & Regulatory Affairs Practice Group. René focuses his practice on federal regulatory and administrative health care matters, including Medicare and Medicaid, privacy and security, general compliance, clinical research, FDA issues and product liability tort litigation.

René’s practice includes drafting comments on a variety of health care proposals and interim final regulations and policies, meeting with various CMS officials, and working with trade organizations, such as AdvaMed and FDLI on regulatory issues. In 2008, he was named by Nightingale’s Healthcare News as one of the 12 Outstanding Young Healthcare Attorneys.

Julie Scott Allen is a government relations director with the firm’s Government & Regulatory Affairs Practice Group.

For more than 15 years, Julie’s focus has been government relations, including advocating at the federal and state level and promoting legislative, regulatory and business agendas for nonprofit and for-profit clients and national organizations. Prior to joining the firm, Julie served as vice president and managing director at Thompson Advisory Group, where she represented clients before the executive and legislative branches in the areas of health care, education, document security, information technology, homeland security, law enforcement and the federal budget process.

Julie is skilled in assisting clients in developing and achieving legislative and regulatory goals and helping companies to grow business opportunities within the federal market. She has particular experience drafting legislative proposals, forming bipartisan alliances, developing coalitions and holding congressional briefings.

### Agenda

1. Introductory Remarks & Speaker Introductions – Julie Allen
2. Initial Impressions of Proposed Rules – Matthew Amodeo
4. ACO Goals Articulated by CMS
5. Entities Eligible to Enroll as ACOs
6. ACO Quality Measures – René Quashie
7. Beneficiary Assignment/Alignment – Matthew Amodeo
8. Risk Sharing Rules
   - Overview
   - Calculating Savings/Loss
   - Setting the Benchmark
   - Minimum Savings Rate (MSR)
   - Track 1 vs. Track 2 Comparison
   - Illustrations
   - Downsides Risk Issues
9. Applying to Become an ACO
Initial Impressions

- Primary care bias
- Heavily favors large, well-integrated, well-capitalized, established providers
- Favors developed markets
- High barriers of entry for mid-level providers—quality measures (65), IT investment (EHR), high-savings benchmarks, start-up/operating costs
- Large integrated system bias may lead to further market alignment/consolidation, upward commercial pricing pressure
- CMS expecting:
  - 75-100 ACO applications accepted
  - 1M-4M enrollees
  - Projected 3 year savings: $170M-$960M

Key/Unexpected ACO Proposed Rules

- Two-sided risk sharing (tracks 1 and 2)
- Retrospective assignment of beneficiaries
- PCP exclusivity
- Beneficiary representation on governing body
- Proportional representation of ACO providers on governing body
- 25% limit of non-ACO provider representation on governing body
- 5 quality domains/65 sliding scale quality measures
- Significant CMS monitoring/oversight with significant penalties for non-compliance
- No separate entity needed for Integrated Delivery System ACOs
- 50% PCP EHR “meaningful user” requirement
Goals

1. Triple aim (better care, better health, lower costs)
2. ACO should put the beneficiary and his/her family at the center of all activities; honor individual preferences, value, and culture; or engage in shared-decision making
3. Ensure coordination of care, regardless of time/place
4. Carefully attend to care transitions, especially from one part of a health care system to another
5. Manage resources carefully and respectfully
6. Continually reduce dependence on in-patient care (*hospitals take note)
7. Be proactive, reach out to patients with reminders.
8. Use data to measure processes and outcomes over time
9. Be innovative in achieving triple aim
10. Continually invest in ACO workforce/clinicians
Who Can Become An ACO

> Physician group practice
> Network of Independent Physicians (IPA)
> Joint Ventures Between Hospitals and Physicians (PHO)
> Hospital with Employed Physicians (IDS)
> Method II Critical Access Hospitals (CAH)
> Others approved by CMS
> No FQHCs or RHCs, but shared savings incentive available for including in network

ACO Minimum Requirements

1. Legal entity recognized under state law
2. TIN*
3. Capable of receiving/distributing savings
4. Can ensure provider compliance with ACO laws/rules, QI policies, etc.
5. Capable of performing all other ACO functions under ACO rules/regulations

* May or may not be an enrolled Medicare provider/supplier
Joint Venture (PHO)

ACO, LLC (PHO)
- Hospital
- Physicians (IPA)
- Ancillary Providers
- Community-Based (IPA) Providers

Integrated Delivery System

CMS
- FFS Reimbursement
- ACO 3-Year Agreement

Health System IDS ACO
- Hospital
- Physician Enterprise
- SNF
- HHA
Beneficiary Assignment

Overview

- Beneficiaries retain free choice of providers
- Retrospective assignment based on plurality of PCP services received during prior 3-year period
- Aligned with only one ACO at a time
- ACO providers required to notify/provide information to beneficiaries, re: ACO participation
  - Office signs
  - Written materials/hand-outs
- Beneficiaries may "opt-out" of CMS-ACO data sharing, but beneficiary data still counts towards risk share

Assignment Of Beneficiaries To ACO For Risk-Sharing Purposes

1. For each ACO, identify all primary care physicians (PCPs):
   - Internal medicine, family practice, geriatrics, general practice

2. At the end of performance year, determine all beneficiaries who received services from a PCP in the ACO

3. Determine total allowed charges for all "primary care services" received by beneficiaries in #2 above
   - "Primary care services": HCPCS 99201-99215, 99304-99340, 99341-99350, G0402, G0438 and G0439

4. For each beneficiary, add the total allowed charges for primary care services he/she received from a PCP in any ACO

5. Assign the beneficiary to the ACO if he/she received a plurality of his/her primary care services (based on allowed charges) from PCP in that ACO
CMS Beneficiary Data Sharing

> **Aggregate:**
  - CMS will share with ACO at start of 3-year agreement
  - Data will cover beneficiaries who **may** be assigned to the ACO based on having seen an ACO PCP within the prior 12 months
  - No member consent required

> **4 Data Points:**
  - Name, date of birth, gender, HICN of historically assigned patients
  - CMS will share automatically at beginning of ACO
  - No consent required

> **Beneficiary Identifiable:**
  - CMS will share on request:
    - Beginning of ACO agreement, or during term of 3-year agreement
    - Data limited to patients who saw a PCP in the ACO during prior 12 months
    - Member must not have opted out
    - CMS on "look out" for ACOs which submit repeated data requests

QUALITY PERFORMANCE MEASURES
Quality Performance Overview

> 65 quality measures

> CMS proposes to use 5 quality “domains”
  – Use same weight for all quality domains

> To meet quality performance standards
  – Report quality measures
  – Meet applicable performance criteria
  – Year 1 - ACOs required to only report on quality

> Phased-in approach to quality measurement
  – Higher standards and new measures over time

> Quality benchmarks based on Medicare fee-for-service, Medicare Advantage or ACO performance data

Quality Performance Overview

> All measures within a domain must have a score above the minimum attainment level for the domain to be eligible for shared savings
  – Sliding scale measure scoring approach proposed
  – More points for performance above the minimum

> Quality performance requirements for all domains must be met to share savings

> Certain eligible ACO participants also may earn PQRS incentives as group practices
## Quality Measure Table

<table>
<thead>
<tr>
<th>Domain</th>
<th>Category</th>
<th>Total Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td></td>
<td>7 measures</td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
<td>16 measures</td>
</tr>
<tr>
<td>Patient Safety</td>
<td></td>
<td>2 measures</td>
</tr>
<tr>
<td>Preventive Health</td>
<td></td>
<td>9 measures</td>
</tr>
<tr>
<td>At-Risk Population/Frail Elderly Health</td>
<td>Diabetes</td>
<td>31 measures</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frail Elderly</td>
<td></td>
</tr>
</tbody>
</table>

## Proposed Measures

> **Patient/Caregiver Experience**
  - Getting timely care, appointments, and information
  - How well patient’s doctor communicates
  - Patient’s rating of doctor

> **Care Coordination/Transitions**
  - Medication reconciliation
  - 30-day post discharge physician visit
  - Patient registry use
  - Percent of physicians meeting Stage 1 meaningful use criteria

> **Patient Safety**
  - Health care acquired conditions composite
Proposed Measures

- Preventive Health
  - Influenza immunization
  - Mammography screening
  - Colorectal cancer screening
  - Depression screening

- At-Risk Population
  - Diabetes mellitus – tobacco non-use
  - Heart failure – patient education
  - Hypertension – plan of care
  - Falls – screening for fall risk
  - Osteoporosis management in women who had a fracture

Calculating a Performance Score

- ACO will receive a performance score on each measure

- Benchmarks will be established for each measure
  - Medicare fee-for-service data, Medicare Advantage quality performance rates, percent performance rates that an ACO will be required to demonstrate (where applicable)
  - Will be made available to ACOs
  - In future years, ACO performance will be used to update the benchmarks

- Minimum attainment level will be established
  - 30 percent or the 30th percentile of Medicare FFS or the MA rate, depending on what performance data are available
  - Sliding scale up to 2 points (90 percent or 90th percentile of Medicare)
Measure Scoring

- Performance below the minimum attainment level would earn zero points for that measure (one-sided and two-sided risk models)

- Performance equal to or greater than the minimum attainment level but less than the performance benchmark:
  - Receive points on a sliding scale based on the level of performance
  - Two measures (diabetes and coronary artery disease composite measures) are all-or-nothing

Domain Scoring

- Quality standard for each domain at the reporting level (first year)
  - Subsequent years: percentage of points earned for each domain after determining points earned for each measure
  - Divide points earned across all measures in the domain by points available for that domain

- Each domain would be worth a pre-defined number of points based on the number of individual measures in the domain
### Points For Each Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>Table 1 Measures (Total)</th>
<th>One-Sided Model – Total Potential Points Per Domain</th>
<th>Two-Sided Risk Model – Total Potential Points Per Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient/Caregiver Experience</td>
<td>1-7 (7 measures)</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>2. Care Coordination</td>
<td>8-23 (16 measures)</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>3. Patient Safety</td>
<td>24-25 (2 measures)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>4. Preventive Health</td>
<td>26-34 (9 measures)</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>5. All-Risk Population/Frail Elderly Health</td>
<td>Diabetes 35-65 (31 measures)</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frail Elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Quality Points Available</td>
<td></td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Total Potential Shared Savings</td>
<td></td>
<td>50%</td>
<td>60%</td>
</tr>
</tbody>
</table>

#### Example Of Scoring

> Preventive health domain has 9 measures and would be worth a maximum of 18 points
  - 9 measures x 2 points = 18 quality points

> If an ACO earns 16.2 out of 18 points in the preventive health domain, the ACO earned 90 percent of the points for the preventive health domain

> Under two-sided model, if ACO earns 90 percent of the quality performance points across all five domains and generates shared savings:
  - ACO would receive 90 percent of the ACO's share of the savings or 54 percent of the total savings generated (90% of the 60%)
Failure To Meet Quality Standards

> If ACO fails to meet a performance standard
  – CMS will give a warning
  – Provide opportunity to resubmit
  – Re-evaluate ACO’s performance the following year

> If ACO’s continue to underperform
  – May be terminated from the program
ACO Risk-Sharing Rules

Overview

> Fee-for-service payments continue

> ACOs entitled to share in savings in excess of CMS determined cost target (benchmark)

> Two-track risk-sharing option:
  
  - Track 1:
    * No-downside risk until year 3
    * 50%-52.5% shared savings
    * Tiered minimum savings rate (MSR) based on population size
    * 2% net savings threshold before shared savings if MSR met

  - Track 2:
    * Day one downside risk
    * 60-65% shared savings
    * MSR fixed at 2%
    * First dollar shared savings if MSR met
    * Shared loss rate inverse to shared savings rate

ACO Risk-Sharing Rules

Overview (Con't)

> Cap on ACO savings
  
  - Track 1: 7.5% of benchmark
  - Track 2: 10% of benchmark

> Caps on ACO losses
  
  - Track 1: 5% of benchmark (year 3 only)
  - Track 2: yr. 1: 5%; yr. 2: 7.5%; yr. 3: 10%

> 25% withhold to cover losses

> Other “cost recoupment mechanisms” to cover up to 1% of annual FFS population expenditures
Process For Determining Potential Shared Savings/Loss

1. Establish the benchmark (including adjusters)
2. Compare benchmark vs. actual costs
3. Compare savings/loss to minimum savings rate (MSR)
4. If MSR met, determine the sharing rate (based on quality scores)
5. Apply sharing cap to savings/loss

Setting The 3-Year Benchmark

1. Determine patient population assigned to the ACO (based on plurality of PCP services received from a PCP in the ACO)
2. Determine part A & B expenditures over prior 3-year period for population that would have been assigned to ACO
3. CMS will share aggregate data with ACO on potential ACO assignees, and beneficiary identifying data on request
4. Make benchmark adjustments for beneficiary characters
   - Demographic factors
   - Diagnostic factors: MA program HCC model
5. Make technical adjustments to benchmark
   - DSH hospitals in ACO
   - Teaching hospitals (IME payments)
   - ACO in high cost vs. low cost area

6. Apply trend factors to benchmark
   - Benchmark calculation date to agreement start date
   - Annual adjustments for each performance period based on actual national per capita growth rate

---

**Minimum Savings Rate**

**Assumptions:**

> Greater variations and uncertainty in health status of smaller population ACOs = greater (easier) savings potential

> Larger population ACOs statistically have less deviation in health status across population = lower (harder) savings potential

> Savings can result from:
   - ACO activities (care coordination)
   - Normal variation in health status of population
Minimum Savings Rate (con’t)

- MSR calculated to minimize normal variations in population health status from savings calculation
- Track 1 ACOs: variable MSR with 2% net savings threshold before sharing in savings to reflect variations in small population ACOs
- Track 2 ACOs: fixed MSR w/first dollar shared savings (and losses), if MSR met

<table>
<thead>
<tr>
<th>MSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO TYPE</td>
</tr>
<tr>
<td>Track 2; Track 1 w/&gt; 60K Beneficiaries</td>
</tr>
<tr>
<td>Track 1 w/5,000-60,000 Beneficiaries</td>
</tr>
</tbody>
</table>

Risk Sharing Comparison

<table>
<thead>
<tr>
<th>Design Element</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Sharing Rate</td>
<td>50%-62.5%</td>
<td>60%-65%</td>
</tr>
<tr>
<td>Quality Scoring</td>
<td>Sharing rate up to 50% based on quality performance</td>
<td>Sharing rate up to 60% based on quality performance</td>
</tr>
<tr>
<td>FQHC/RHC Participation Incentives</td>
<td>Up to 2.5%</td>
<td>Up to 5%</td>
</tr>
<tr>
<td>Minimum Savings Rate</td>
<td>2%-3.9% (Varies by population)</td>
<td>Flat 2%</td>
</tr>
<tr>
<td>Minimum Loss Rate</td>
<td>None</td>
<td>Flat 2%</td>
</tr>
<tr>
<td>Maximum Sharing Cap</td>
<td>Payments capped at 7.5% of ACO’s benchmark</td>
<td>Payments capped at 10% of ACO’s benchmark</td>
</tr>
</tbody>
</table>
### Risk Sharing Comparison (con’t)

<table>
<thead>
<tr>
<th>Design Element</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared Savings</strong></td>
<td>- Savings shared if MSR is exceeded&lt;br&gt;- Unless exempted* share in savings net of a 2% threshold, up to 62.5% of net savings, up to cap</td>
<td>- Savings shared if MSR is exceeded&lt;br&gt;- First Dollar Savings shared up to 65% of gross savings, up to cap</td>
</tr>
</tbody>
</table>

*First dollar savings, if:
- Small ACO (<10K members); and:
- Group practice/IPA; or
- 75% ACO beneficiaries live outside MSA; or
- 50% ACO beneficiaries >1 encounter at FQHC/RHC; or
- 50% ACO beneficiaries assigned based on receiving method II CAH services

### Risk Sharing Comparison (con’t)

<table>
<thead>
<tr>
<th>Design Element</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared Losses</strong></td>
<td>- None&lt;br&gt;- Shared Loss Rate = Inverse of Shared Savings Rate (1-Shared Savings Rate)&lt;br&gt;- First dollar shared losses once the minimum loss rate is exceeded&lt;br&gt;- Cap on the amount of losses to be shared phased in over 3 years:&lt;br&gt;  - Year 1 = 5%&lt;br&gt;  - Year 2 = 7.5%&lt;br&gt;  - Year 3 = 10%&lt;br&gt;- Losses in excess of the annual cap would not be shared</td>
<td>- None&lt;br&gt;- First dollar shared losses once the minimum loss rate is exceeded&lt;br&gt;- Cap on the amount of losses to be shared phased in over 3 years:&lt;br&gt;  - Year 1 = 5%&lt;br&gt;  - Year 2 = 7.5%&lt;br&gt;  - Year 3 = 10%&lt;br&gt;- Losses in excess of the annual cap would not be shared</td>
</tr>
</tbody>
</table>
### Shared Savings Illustrations

#### TRACK 1 ILLUSTRATION: Joint Venture ACO which Includes FQHC

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO Enrollment</td>
<td>5,000 Members</td>
</tr>
<tr>
<td>Benchmark (incl. Adj.)</td>
<td>$8,000/Member</td>
</tr>
<tr>
<td>Aggregate Benchmark</td>
<td>$40,000,000</td>
</tr>
<tr>
<td>Actual FFS Expenditures</td>
<td>($30,000,000)</td>
</tr>
<tr>
<td>Total Savings</td>
<td>$10,000,000</td>
</tr>
<tr>
<td>MSR @ 5,000 Members (3.9%)</td>
<td>1,560,000</td>
</tr>
<tr>
<td>2% Shared Savings Threshold</td>
<td>($800,000)</td>
</tr>
<tr>
<td>Savings in Excess of Threshold</td>
<td>9,200,000</td>
</tr>
<tr>
<td>Sharing Rate (Assumes Highest Scores on All Quality Measures)</td>
<td>52.5%</td>
</tr>
<tr>
<td>ACO Share of Savings</td>
<td>$4,830,000</td>
</tr>
<tr>
<td>Apply Cap (7.5%)</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Deduct 25% Withhold</td>
<td>(750,000)</td>
</tr>
<tr>
<td>Net Distributable ACO Savings</td>
<td>$2,250,000</td>
</tr>
</tbody>
</table>

#### TRACK 2 ILLUSTRATION: IPA Model ACO, No FQHC or RHC

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO Enrollment</td>
<td>20,000 Members</td>
</tr>
<tr>
<td>Benchmark (incl. Adj.)</td>
<td>$10,000/Member</td>
</tr>
<tr>
<td>Aggregate Benchmark</td>
<td>$200,000,000</td>
</tr>
<tr>
<td>Actual FFS Expenditures</td>
<td>$150,000,000</td>
</tr>
<tr>
<td>Total Savings</td>
<td>$50,000,000</td>
</tr>
<tr>
<td>MSR Flat 2%</td>
<td>4,000,000</td>
</tr>
<tr>
<td>ACO Sharing Rate (Assumes Highest Scores on All Quality Measures)</td>
<td>60.0%</td>
</tr>
<tr>
<td>ACO Share of Savings</td>
<td>$30,000,000</td>
</tr>
<tr>
<td>Apply Cap (10%)</td>
<td>20,000,000</td>
</tr>
<tr>
<td>Deduct 25% Withhold</td>
<td>(5,000,000)</td>
</tr>
<tr>
<td>Net Distributable ACO Savings</td>
<td>$15,000,000</td>
</tr>
</tbody>
</table>
Downside Risk Issues

- First time downside risk introduced to FFS Medicare
- CMS concerned about incentives for providers to inappropriately withhold care in order to avoid losses, cost shifting
- Track 2 loss caps designed to protect ACOs from catastrophic losses, encourage ACO participation
- Savings caps discourage excessive restrictions on access to care
- CMS worried about means of recouping losses from ACOs (most ACOs will not be Medicare providers)

Loss Recovery/Recoupment Mechanisms

- 25% CMS withhold from ACO’s portion of shared savings
- CMS recoupment from FFS payments to ACO providers must be in all ACO provider agreements
- Self-executing recoupment options = 1% of annual ACO FFS expenditures
  - Acceptable security tools:
    - Letter of credit
    - Reinsurance
    - Surety bond
    - Escrow account
  - In place and documented in ACO application
  - Must also cover claims run out period
  - Track 1 ACOs must show ability to cover year 3 potential losses
Loss Recovery/Recoupment Mechanisms (con’t)

> Losses carried forward until fully recouped
> Losses must be repaid within 30 days
> Public reporting of losses
> Losses = termination from MSSP
Applying To Become An ACO

- No clear application process in the proposed rules
- Presumably final rules will establish deadline for 2012 ACO applications
- CMS will approve/deny applications in the same calendar year
- CMS considering 18-month term for first performance period (7/1/12-12/31/13) to allow more time for application submissions

Applying To Become An ACO

Organizational Documents:

- Certification that the ACO is a legal entity under state law and has a TIN
- Evidence that ACO governing body is a separate legal entity
- Evidence that ACO board is comprised of 75% ACO participants
- On request:
  - Charters
  - Bylaws
  - Incorporation documents
  - Financial statements
  - Remediation plans for non-compliant providers, including CAP and expulsion processes
- If applicable, “no challenge” letter from antitrust agency
Applying To Become An ACO
Application Requirements

Operational/Clinical Documentation:

- Documentation of scope/scale of QA and clinical integration programs, including performance standards and monitoring tools
- Materials that demonstrate:
  - Clinical and administrative systems consistent with MSSP and “triple aims”
- ACO plans for:
  - Promoting evidence-based medicine
  - Promoting beneficiary engagement
  - Coordinating care
  - Internal reporting of quality/cost metrics
- Individualized care program with sample individualized care plans for chronically ill and high risk patients

Organizational/Administrative Documentation:

- Initial data request - if ACO wishes to receive beneficiary identifiable clause data at the beginning of 3 year agreement
- Signed data usage agreement if ACO wishes to receive beneficiary identifiable data
- Copy of member data sharing opt-out form
- Copies of all marketing materials and activities; e.g. brochures, ads, letters, web pages
- Certification that ACO providers have agreed to be accountable for and report to CMS on quality, cost, and overall care of ACO beneficiaries
- Certification of accuracy, completeness and truthfulness of application information
- Evidence of partnerships with community stakeholders
Applying To Become An ACO
Applying To Become An ACO Application Requirements

Organizational/Administrative Documentation (Con’t)

> Documentation of an acceptable, self-executing repayment mechanism for recouping of ACO losses (1% of ACOs most recent year’s FFS expenditures)

> Documentation describing rights/obligations of ACO participants
  - Participating provider agreements
  - Shared savings distribution method which encourages adherence to QA and evidence-based medicine guidelines
  - Operating policies

> Organizational chart and management structure, including job descriptions of senior leaders

> Materials that demonstrate:
  - ACO management and leadership structure

Evidence of board certified physician as ACO medical director

> Compliance program

> Written standards for beneficiary access (to records) and communication

> Description of savings distribution policy:
  - Plans for intended use of savings payment and criteria for distribution to providers
  - How policy achieves MSSP goals
  - How policy will achieve triple aims

> Evidence of partnership with community stakeholders, e.g. employers, local agencies

> Once accepted, ACO must submit signed 3-year agreement
Medicare Payment Advisory Commission (MedPAC) Chairman, Glen Hackbarth, recently submitted comments in response to the Center for Medicare & Medicaid Services’ (CMS) Request for Information regarding the much-anticipated Patient Protection and Affordable Care Act (PPACA) Accountable Care Organization (ACO) regulations, to be published early next year. MedPAC’s comments were outlined in a letter dated November 22, 2010, from Mr. Hackbarth to CMS. MedPAC’s comments were focused on three primary areas that it believes will be crucial to the success of ACOs and the Shared Savings Program:

1. A two-sided (upside and downside) risk sharing model for ACOs;
2. Pre-notification to Medicare beneficiaries of assignment to an ACO; and

I. Two-Sided Risk Corridors.

MedPAC has expressed concerns over the shared-savings model under PPACA because, MedPAC contends, it places 100 percent of the risk for losses on Medicare. As currently contemplated under PPACA, if an ACO exceeds the spending target for the Medicare beneficiaries enrolled in the ACO, and/or the ACO fails to meet designated quality targets, ACO providers still receive 100 percent of the normal Medicare fee-for-service reimbursement. MedPAC refers to this as the “bonus-only” model and contends that the bonus-only model does not create sufficient incentives for cost reduction or quality improvement. In addition, the Commission argues that under the bonus-only model, some ACO providers would receive bonuses not based on quality of care or reduction of costs, but simply by virtue of random variations in the health status of beneficiaries enrolled in the ACO.

As such, MedPAC is recommending the inclusion of some type of minimum threshold of cost savings before the ACO would be eligible for any bonus distributions. The threshold would be higher for ACOs with smaller member enrollment (because of the greater variation in health status), and smaller for ACOs with higher enrollment. MedPAC points
out that in CMS’ group practice demonstrations, Medicare set a savings threshold of 2 percent before members of the group were eligible to receive a shared savings bonus. MedPAC advocates a larger savings threshold for smaller ACOs and vice versa, since random health variation will be greater for smaller ACOs than for larger ones. MedPAC points out, however, that even with a cost savings threshold as a pre-condition to share in any shared savings bonus, the incentive for ACO providers under the bonus-only model to control spending remains relatively weak. This is particularly true of providers participating in the ACO, as opposed to providers outside the ACO. Providers in the ACO would always receive 100 percent of normal Medicare fee-for-service reimbursement, no matter how high spending is for ACO’s beneficiaries. Whereas high utilization and spending by providers outside the ACO will reduce any potential savings bonuses for ACO providers. As such, ACOs would only be incentivized to control costs of providers outside of the ACO.

In order to better incentivize providers in ACOs to reduce costs and improve quality, MedPAC also recommends the addition of a second risk-sharing option under the ACO regulations, though ultimately MedPAC would like the bonus-only model to be completely supplanted by the two-sided risk corridor model.

Under MedPAC’s proposed two-sided risk corridor model, the ACO would share in some portion of any savings, but would also be at risk for a proportionate share of spending that exceeds the target (losses). The risk share would be tiered such that the ACO’s share of any savings would increase as the amount of the total savings increases. The same would be true for the ACO’s share of any potential losses, where the ACO’s share of losses would increase as the amount of the loss increases. In order to protect ACOs from extreme losses, and conversely, to discourage practice patterns that could potentially result in withholding care from beneficiaries in order to generate huge bonuses, the ACO’s share of any savings/loss would begin to taper once savings/losses reached extreme levels. To incentivize ACOs to choose the two-sided risk model versus the bonus-only model, MedPAC further suggests that the percentage savings/loss could be greater for ACOs choosing the two-sided risk model versus the bonus-only model.

II. Prior Notification to Beneficiaries of ACO Assignment.

The RFI also solicited comments on whether Medicare beneficiaries should be assigned to ACOs on a prospective or retrospective basis. Under a prospective model, beneficiaries would be informed of their assignment to an ACO prior to any care being delivered. Under the retrospective assignment model, beneficiaries would not be informed of their participation in an ACO until after the care has been delivered. Prospective assignment would require use of the beneficiary’s claims data from the year prior to assignment in order to calculate cost targets. This would eliminate the need for risk-adjusted targets, since the targets would already reflect beneficiary health care expenses from prior years. Retrospective assignment would use data from the ACO’s performance year to make the assignment. In order to enroll beneficiaries in an ACO on a prospective basis, the ACO would identify its primary care providers to Medicare in advance, and Medicare would then assign beneficiaries to the ACO on the basis of the primary care providers who had treated those beneficiaries during the prior year. Under the retrospective assignment model, however, neither the ACO nor the beneficiary would know at the beginning of the year who was assigned to the ACO.
MedPAC argues that prospective assignment of beneficiaries is better than retrospective assignment for several reasons. First, if beneficiaries know that they are participating in a new incentive structure (ACO), they are more likely to be engaged in their own care management. MedPAC has long held that in order for payment reform to be successful, patients must be actively engaged in the management of their own health. Second, if beneficiaries are not assigned and notified in advance, the Shared Savings Program runs the risk of the same type of “backlash” that was experienced in the managed care era of the 1990s. That backlash resulted from patients feeling that they were being forced into managed care by their employers and that financial rewards were being reaped by their employers and health plans, at the patient’s expense, both financially and health-wise. Third, by pre-notifying the beneficiary of their assignment to an ACO, the primary care provider is better able to educate the beneficiary as to the benefits of participation—receiving higher quality care, improved care coordination, enhanced access—all of which should contribute to meaningful improvements in the beneficiary’s overall health, and build trust in the ACO program.

As a further inducement to beneficiary enrollment in ACO’s and as an additional measure to secure their trust, MedPAC advocates for a reduction in the participating beneficiary’s cost-sharing amounts, or perhaps even giving beneficiaries a share of any savings. Such a measure would also serve to engage the beneficiary in better managing their own health by offering financial incentives for better health choices.

MedPAC also feels that beneficiaries should be given an “opt-out” option from ACOs. That is, upon notification that the beneficiary has been assigned to an ACO, the member would reserve the right to elect not to participate. The beneficiary could then either switch to another primary care provider, or remain with their regular primary care physician, but elect not have their data count toward the ACO’s performance. MedPAC argues that this would result in greater beneficiary acceptance of ACOs by eliminating worries about underlying financial incentives. On the other hand, opt-out provisions could create administrative complexity for CMS, and allow some ACOs to “cherry pick” beneficiaries by inappropriately influencing sicker beneficiaries to opt out. To address this problem, MedPAC suggests that Medicare could monitor, and perhaps eliminate, ACOs with large percentages of beneficiaries who opt out.

### III. Objective Quality Measures.

MedPAC urges CMS to adopt a focused set of quality indicators that reflect the core principles of ACOs—better care, lower costs and better health. To further these goals, MedPAC recommends the adoption of the following population-based outcome measures: ER use; preventable admissions; in-hospital mortality rates and patient safety measures; and re-admission rates. In addition to these outcome measures, MedPAC also recommends that CMS consider adopting patient satisfaction surveys. This may help bolster ACO enrollment if ACO beneficiaries know that their provider’s reimbursement is dependent upon the patient’s satisfaction. MedPAC recommends that the measures should track how well the care is being provided, rather than the volume of services provided.
IV. ACO Growth Targets and Benchmarks.

MedPAC also addresses whether the targeted level of spending growth should be the same for all ACOs, or should vary from ACO to ACO. MedPAC points out that ACOs with beneficiaries who have historically low usage rates (low-use ACOs) may feel that high-use ACOs will have an unfair competitive advantage, because high-use ACOs will have a greater opportunity to reduce spending and therefore a greater bonus potential. MedPAC therefore suggests that CMS adopt an across-the-board, targeted growth amount based upon the expected growth in fee-for-service expenditures per beneficiary across the country. MedPAC argues that this would help eliminate the disparity between high-use and low-use ACOs in that it would result in a larger percentage increase in the targeted growth for low-use ACOs and a smaller percentage increase in targeted growth for high-use ACOs. Another suggested alternative is to use differential growth targets for very high and very low-use ACOs. For example, CMS could set larger growth targets for ACOs with very low usage rates and lower growth targets for ACOs with consistently very high usage. In such a model, CMS could use the savings from the small growth target for the high-use ACOs to fund the expected bonuses for low-use ACOs. For most ACOs, a common growth target based upon expected fee-for-service per beneficiary spending targets would be sufficient, and the differential method could be reserved specifically for very high and very low-use ACOs.

In light of MedPAC’s influence in the development of Medicare payment policies over the years, it is likely that many of the MedPAC recommendations will be seriously considered by CMS regulators as they draft the upcoming ACO regulations.
Health Government Relations Team

Julie Scott Allen  
Government Relations Director  
(202) 230-5126  
Julie.Allen@dbr.com

Brian Altman, JD  
Senior Government Relations Manager  
(202) 230-5185  
Brian.Altman@dbr.com

Greg T. Billings  
Senior Government Relations Director  
(202) 230-5104  
Greg.Billings@dbr.com

Jodie A. Curtis  
Senior Government Relations Director  
(202) 230-5147  
Jodie.Curtis@dbr.com

Hilary M. Hansen  
Senior Government Relations Manager  
(202) 230-5186  
Hilary.Hansen@dbr.com

Rebecca Freedman McGrath, JD  
Senior Government Relations Manager  
(202) 230-5679  
Rebecca.McGrath@dbr.com

Ilisa Halpern Paul, MPP  
Managing Government Relations Director  
(202) 230-5145  
Ilisa.Paul@dbr.com

Rene Y. Quashie, JD  
Associate  
(202) 230-5161  
Rene.Quashie@dbr.com

R. Edwin Redfern  
Government Relations Director  
(202) 230-5151  
Edwin.Redfern@dbr.com

Jeremy R. Scott  
Government Relations Director  
(202) 230-5197  
Jeremy.Scott@dbr.com

James W. Twaddell, IV, MA  
Government Relations Director  
(202) 230-5130  
James.Twaddell@dbr.com

Elaine H. Vining  
Government Relations Director  
(202) 230-5676  
Elaine.Vining@dbr.com

Erin Will Morton  
Government Relations Manager  
(202) 230-5634  
Erin.WillMorton@dbr.com

Courtney Yohe, MPP  
Government Relations Manager  
(202) 230-5649  
Courtney.Yohe@dbr.com

Other Publications

www.drinkerbiddle.com/publications

Sign Up

www.drinkerbiddle.com/publications/signup