Medicare Shared Savings Program – Accountable Care Organizations

- Shared savings (*and losses*)
- ACOs are the vehicle
- ACO rules *proposed* April 7, 2011
- Rules *finalized* October 20, 2011
- To be effective next year
  - 2 start dates: 4/1/2012 (initial term is 3 years, 9 months) or 7/1/2012 (initial term is 3 years, 6 months)
Common Misconceptions

- Hospitals and physicians are not required to be part of ACO formation
- Patients do not enroll in an ACO and cannot opt out of an ACO (only no data sharing)
- Patients retain complete freedom of choice in selecting providers for care
- FFS payments continue to providers – this is not a new payment methodology
So what is the concept underlying the Shared Savings Program?

- Intended to create incentives for providers to collaborate to treat patients across health care settings - reduce cost and inefficiencies, increase quality
- ACO participants can receive shared savings if ACO reduces cost and meets quality measures
- Concerns only Medicare fee-for-service patients (not non-Medicare or Medicare Advantage/Part C beneficiaries)
General ACO Structure

- ACOs may be formed by:
  - ACO professionals (physicians and practitioners such as NPs, PAs, CNPs) in group practice arrangements (no hospital)
  - networks of individual practices of ACO professionals
  - partnerships or joint venture arrangements between acute care hospitals and ACO professionals
  - acute care hospitals employing ACO professionals
- Providers/suppliers such as IRFs, LTCHs, skilled nursing facilities, may not form ACOs, but may participate in established ACOs
- Health plans and investment companies may be necessary to help fund infrastructure
Final rule clarified that PCPs are not limited to participating in only 1 ACO – limit applies only when provider’s own TIN is being used to bill. Multiple ACOs OK if different TINs of group practices are used to bill (due to patient assignment to an ACO)

- ACOs must apply and meet CMS criteria
- ACOs to enter into agreements with DHHS for a minimum period of not less than 3 years to care for at least 5,000 Medicare beneficiaries
- ACO must have a formal legal structure with a federal tax ID number
ACO Governing Body

- ACO participants must have at least 75% control
- Patient representation on Board
- Board members have a fiduciary duty to ACO
- Conflict of interest policy required
- Transparency of governing process
How will a beneficiary be assigned to an ACO?

- Patients do not enroll in a specific ACO
- Patients have no limits or restrictions on providers, can get treatment from any provider they want
- Beneficiaries to be informed that PCP is part of an ACO
- Assignment ("alignment") is \textit{prospective with retrospective reconciliation}
  - ACO will receive a preliminary list of assigned beneficiaries based on prior history
  - Final assignment to be based on actual treatment data for the year – 2 step process
  - Based on PCP in an ACO who provided plurality of charges for primary care services
Two-Step Assignment Process

1. If a PCP in an ACO rendered services to patient, assigned to ACO if charges for primary care services are greater than charges for primary care services rendered by a PCP in another ACO or no ACO

2. If no primary care services from PCP (whether in an ACO or not), assigned to an ACO only if primary care services received from an ACO physician (regardless of specialty) during year. Assigned to ACO of physician rendering plurality of primary care charges.

How can ACO be financially responsible for coordinating care & controlling costs for services outside ACO?
Payment Model – Set Benchmark

- Benchmark is an estimate of what total Medicare FFS Parts A and B payments would have been in absence of ACO for beneficiary in any 3 years prior to ACO agreement period
- Regardless of whether or not all services are rendered by providers in ACO
- Compared to actual expenditures in current year
Payment Model - Shared Savings

- ACOs will receive a share of any savings if the \textit{actual per capita} expenditures of their assigned Medicare beneficiaries are below the \textit{benchmark + minimum savings rate}

- ACOs will select either:
  - A \textit{one-sided} risk payment model/Track 1 (sharing of \textit{savings only} for first agreement period, and sharing of savings and losses in later periods); or
  - A \textit{two-sided} risk payment model/Track 2 (sharing of savings and losses for all years). More risk = more reward

- CMS has no authority to specify how shared savings will be distributed by ACOs (or how losses are paid)
Payment Model – Shared Savings

- To be eligible for shared savings ACOs are required to:
  - Meet all contractual requirements of ACO Agreement
  - Meet quality performance standards
  - Realize savings, compared to the expenditure benchmark, that exceed the minimum savings rate

- One-sided model – shares up to 50% of savings after MSR exceeded from first dollar based on maximum quality score (limit =10% of benchmark)

- Two-sided model – shares up to 60% of savings from first dollar based on maximum quality score (limit =15% of benchmark)
Payment Model – Shared Losses

- Losses for two-sided model must exceed 2% of benchmark

- Shared losses are capped:
  - 5% of the benchmark in the first year
  - 7.5% in the second year
  - 10% in the third year
Quality Measures and Performance Thresholds

- 33 quality measures (reduced from 65) in the following 4 areas:
  1. Patient/Caregiver Experience (7 measures)
  2. Care Coordination/Patient Safety (6 measures)
  3. Preventative Health (8 measures)
  4. At-Risk Population (12 measures)

- ACOs which do not meet the quality performance thresholds for all proposed measures would be *ineligible* for shared savings even if they reduce costs.

- Patients may refuse to have data shared.
Projected costs and savings

- CMS estimates:
  - average ACO start-up investment of $580,000
  - Annual operating cost of $1.26m
  - 2012-2015 = $5.62m expenditure
  - Average ACO bonus payment during 2012-2015 = $16.4m
Coordination with other federal agencies

- OIG interim final rule on waivers to a number of fraud & abuse laws, like Stark self-referral, anti-kickback, and CMP (which prohibits payments to induce physicians to reduce or limit services to Medicare or Medicaid patients)
- Antitrust – Federal Trade Comm. issued a statement on enforcement
- Tax-exempt entities – IRS issued notice providing guidance and fact sheet addressing questions
Mass. Health Payment Reform Timeline

- 2006 – universal health insurance mandate (no cost controls)
- 2008 – new law with focus on cost control creates Special Commission on Health Care Payment System
- Blue Cross Alternative Quality Contract (AQC) uses global budget
- 2009 – Special Commission releases recommendations for global payments, ACOs
- 2011 – Governor’s bill filed/legislative hearings
Mass. Special Commission on the Health Care Payment System

- Report released July 2009
- Findings:
  - Health expenditures skyrocketing but care lacking in many areas
  - FFS rewards volume rather than outcome and efficiency, incentives not aligned
  - Alternatives should be considered
  - System should balance cognitive, preventive, behavioral, chronic and interventional care
  - Support more primary care providers
  - Minimize administrative costs
Recommendations:

- Implement a *global payment* model, i.e., prospectively compensate providers for all care over a contract period (either by month or year)
- Consistent among *all payers* (including governmental payers, will need Medicare waiver)
- Incentives for efficiency, encourage improvements in quality and access to appropriate, coordinated care
- Strong focus on primary care/medical homes
Mass. Special Commission, cont.

- Recommendations, cont.
  - Develop accountable care organizations – hospitals, physicians, other clinicians and non-clinicians to accept responsibility and coordinate and manage care for full range of services that patients are expected to need.
  - Shared risk between ACOs and insurers
  - Transition over 5 years – give support to build infrastructure – learn to integrate successfully, measure performance against standards, manage financial risk
Mass. Special Commission, cont.

- Recommendations, cont.
  - Improved risk adjustments are key for high risk, complex patients
  - Oversight entity to monitor access, quality, and cost at both population level and individual patients
  - Global payments must reward providers systematically for excellent performance
  - Health information technology infrastructure and support
  - Payments to follow patient choice of PCP
Governor’s Bill


- Timeline:
  - EOHHS immediately to begin process to obtain necessary federal waivers
  - By 6/1/2012, DHCFP to develop regulations to guide ACO formation
  - By 1/1/2014, all state-funded insurance programs (GIC, MassHealth, Comm. Connector, etc.) must use ACOs and implement alternative payment methodologies (APMs) instead of FFS. 1.7m people, ~¼ of state
  - By 6/2015, ACOs must be established throughout state, all payers must transition to APMs
4 major areas addressed:

1. **ACO development:**
   - No patient selection - ACOs must accept patients regardless of payer source or medical condition
   - ACOs must meet minimum functional capacities, such as clinical services, communication, behavioral health, quality measurement
   - DHCFP to develop standardized quality measures to evaluate ACO and APM performance across all health plans
1. **ACO development, cont.**

- Contracts must include quality-based rewards/penalties
- DoI to monitor risk arrangements to ensure ACOs are not subject to excessive risk
- Contracts with insurers to require any savings must be shared with consumers
- AG to monitor to prevent antitrust violations
- Physician participation in ACOs is voluntary
- PCPs may belong to 1 ACO; no limit for specialists
- Hospitals are not required to be only organizing body for ACOs
2. **Lower health care premiums:**
   - Carriers cannot increase payment rates beyond amount established annually by Ins. Comm’r.
   - In establishing allowable rate increases, Ins. Comm’r to consider factors such as:
     - Rate of increase in state’s GDP
     - Rate of increase in total medical expenses in region
     - A provider’s rate of reimbursement, especially in relation to carrier’s statewide average relative price
     - Whether the carrier and provider are transitioning from FFS contract to alternative contract
   - As provider rates decline, carriers required to factor savings into premiums charged consumers
3. **Transition from FFS to Alternative Payment Methodologies (APMs)**

- DHCFP to develop regs to decrease use of FFS and facilitate APMs industry-wide
- APMs to include *global payments* with limits on ACO risk; *partial global payments* with PFP; *capitation* with gain sharing; *episode-based payments*
- DHCFP to develop cost containment benchmarks and growth rates and annually collect data to see if contracts with providers meet the standards
Governor’s Bill, cont

4. Medical malpractice reform
   - Providers’ *apologies* (activities and conduct suggesting mistake or error, expressions of regret, sympathy, apology, etc) will be *inadmissible* as evidence in malpractice litigation
   - Patient must give notice of intent to file claim 180-days before filing suit (cooling-off period)
   - Amends peer review laws to include ACOs
   - Providers and patients to exchange relevant medical records and documents prior to litigation to try to resolve disputes
Questions?