

Providing Accountable Care: Strategy & Structure Webcast Series

So You Want to Partner with CMS ... Practical Considerations for Medicare ACOs

Lauren N. Haley
Anne W. Hance

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Overview

- Introduction
- Developing and launching a Medicare ACO
- Operating under CMS's guidelines
- Quality metrics and other reporting requirements
- Payment methodologies
- Oversight by CMS and other government agencies
- Some practical considerations
- Comments and questions



Introduction



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General Concepts

- Foster partnerships between physicians, hospitals and other providers designed to coordinate and deliver efficient care
- Similar types of organizations found in the commercial market
- Medicare ACOs that improve quality of care and lower costs should be entitled to “shared savings” with the government



Broad Themes for Today's Presentation

- Using CMS's proposed rule as a starting point for strategic analysis relating to setting up an ACO
- Familiar Medicare Advantage concepts built into the proposed rule
- Operationalizing the Medicare Shared Savings Program requirements at two levels:
 - 1) CMS-ACO relationship
 - 2) ACO-ACO Participant relationship



Statutory Language

- **Section 3022 of the Affordable Care Act**
 - Created a new Section 1899 of the Social Security Act
 - Established a Shared Savings Program intended to
 - Promote accountability for a patient population
 - Coordinate items and services under Medicare Parts A and B
 - Encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery
- **Provides structure around what is an “Accountable Care Organization” eligible to receive payments for “shared savings.”**



Rulemaking Process

- Medicare Shared Savings Program proposals released March 31, 2011
 - Centers for Medicare & Medicaid Services (CMS)
 - Proposed rule on accountable care organizations
 - Notice with comment period issued jointly with the Office of the Inspector General on waiver designs relating to the Civil Monetary Penalties law, Federal Anti-Kickback Statute, and the Federal Physician Self-Referral law
 - Published in the Federal Register on April 7, 2011 (76 Fed. Reg. 19528, 76 Fed. Reg. 19655)
 - Comments due by June 6, 2011



Rulemaking Process (cont.)

- Medicare Shared Savings Program proposals released March 31, 2011 (cont.)
 - Federal Trade Commission and the U.S. Department of Justice jointly issued notice with comment period
 - Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program for the Shared Savings Program
 - Available at <http://www.ftc.gov/os/fedreg/2011/03/110331acofrn.pdf>
 - Comments due by May 31, 2011
 - Internal Revenue Service Notice 2011-20 with comment period
 - Soliciting comments regarding the need for additional tax guidance for tax-exempt hospitals or other health care organizations participating in the Medicare Shared Savings Program
 - Available at <http://www.irs.gov/pub/irs-drop/n-11-20.pdf>
 - Comments due by May 31, 2011



Broad Overview

- What is an ACO under the proposed regulations?
 - Payer?
 - Provider?
 - Coordinator?
- Key concepts and buzz-words
 - “Better care for individuals, better health for populations, and lower growth in expenditures”
 - Patient-centeredness
 - Value-based purchasing
 - Benchmarks (quality and payment)
 - Evidence-based medicine
 - Transparency



Overarching Goals of the Shared Savings Program

- **Better care for individuals**

Improve individual patient experiences of care along the IOM 6 domains of quality: safety, Effectiveness, patient-centeredness, timeliness, efficiency, and equity

- **Better health for populations**

Encourage better health for entire populations by addressing underlying causes of poor health, such as physical inactivity, behavioral risk factors, lack of preventive care and poor nutrition

- **Lower growth in expenditures**

Lower the total cost of care resulting in reduced expenditures



Developing and Launching a Medicare ACO



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Legal Structure

- Must have a legal entity (e.g., corporation, partnership, LLC) that is recognized by the state, has a Tax Identification Number (TIN), and can:
 - Receive and distribute funds;
 - Repay shared losses;
 - Establish, report, and ensure ACO Participant and ACO Provider/Supplier compliance with CMS requirements, including quality performance standards; and
 - Perform other functions as identified in statute.
- Must have mechanism for shared governance that provides all ACO Participants with appropriate proportionate control over ACO decision-making process.



Eligibility

- **Providers eligible to form ACOs independently:**
 - Hospitals employing ACO professionals,
 - ACO professionals in group practice arrangements,
 - Networks of individual practices of ACO professionals,
 - Partnerships or joint venture arrangements between hospitals and ACO professionals, and
 - Critical Access Hospitals under Method II billing.
- **Other providers and suppliers may participate in the ACOs**
 - Specialists, SNFs, IRFs, etc.



Governance

- **Governing body with adequate authority:**
 - Representatives from each ACO Provider/Supplier participant
 - Medicare beneficiary representatives
 - At least 75% of body must be ACO Participants
 - May include non-providers (*e.g.*, health plan management companies)
 - May include community representatives



ACO Participants

Certain ACO Participants Limited to One ACO

- ACO Participants with TIN on which beneficiary assignment is based are limited to one ACO agreement in the Shared Savings Program.
 - Applies only to the **primary care physicians** (internal medicine, geriatric medicine, family practice, and general practice) by whom beneficiary assignment is established.
- **Other ACO Participants May Participate in More Than One ACO**
 - ACO Participants with TIN upon which beneficiary assignment is not dependent (acute care hospitals, surgical and medical specialties, RHCs, and FQHCs) are not restricted to participation in a single ACO.



ACO Application Requirements

- Documents that describe the ACO Participants' **rights and obligations** in the ACO, the shared savings that will encourage Participants to adhere to the quality assurance and improvement program and the evidenced-based clinical guidelines;
- Documents that describe the scope and scale of the **quality assurance and clinical integration** program, including all relevant systems and processes;
- Materials documenting the **organizational and management structure**, including an organizational chart, a list of committees and their structures, and job descriptions for senior administrative and clinical leaders;
- Evidence that a board-certified physician serves as its **medical director** who is licensed in the ACO's state and that a principal CMS liaison is identified in its leadership structure.



ACO Application Requirements (cont.)

- Evidence that the **governing body** includes persons who represent the ACO Participants, and that these ACO Participants hold at least 75 percent control of the governing body; and
- Upon request, the ACO would also be required to provide copies of the following documents:
 - **Formation and operation**, including charters, by-laws, articles of incorporation, and partnership, joint venture, management, or asset purchase agreements.
 - **Remedial processes** that will apply when ACO Participants and ACO Providers/Suppliers fail to comply with the ACO's internal procedures and performance standards.
- Certain ACOs required to obtain anti-trust approval



Contract with CMS

- 3-Year Agreement Period
- Annual start date, beginning on January 1, 2012
 - Considering an alternative start date of July 1, 2012 for the first year of the Shared Savings Program
- An executive with the authority to legally bind the ACO must certify that the ACO Participants agree to CMS requirements
 - That said, the ACO remains ultimately responsible for adhering to and otherwise fully complying with all terms and conditions of its agreement with CMS
- 60-day notice termination provision
- Early termination results in forfeiture of the 25% withhold of shared savings



Operating Under CMS's Guidelines



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Beneficiary Assignment

- Section 1899(c) requires “assignment” of beneficiaries based on primary care services rendered by physicians
- CMS describes its 4-step process for developing the assignment process
 - 1) Developing an operational definition of a Medicare ACO
 - 2) Defining primary care services for purposes of determining the appropriate assignment
 - 3) Timing of the assignment (prospective v. retrospective)
 - 4) Proportion of primary care services that affect assignment



Beneficiary Assignment (cont.)

- **Assignment based on primary care physicians**
 - The physician must fall within one of the four categories of (self-reported) PCPs
 - Internal medicine
 - Geriatric medicine
 - Family practice
 - General practice
 - Must enter into an exclusive relationship with the Medicare ACO
 - PCP TIN will be used in assignment process, although NPI still must be reported



Beneficiary Assignment (cont.)

- Retrospective assignment process based on “plurality” of allowed charges for primary care services
 - Promotes provision of care improvement activities for all Medicare beneficiaries and not just the Medicare ACO subset
 - Promotes Shared Savings based on actual patient population treated
- CMS will distribute aggregate Medicare beneficiary-level data for the assigned population for the benchmark period
 - Supports planning and analysis in advance of and during the Performance Year



Beneficiary Assignment (cont.)

- CMS will develop and launch a Medicare beneficiary communication plan
 - Overview of the Shared Savings Program
 - Potential assignment into a Medicare ACO
 - Potential implications for care
 - Potential data sharing
- CMS expects the ACO, ACO Participants and ACO Providers/ Suppliers to undertake similar notification and education efforts
 - Post signs in Medicare ACO-related facilities
 - Distribution of standardized written materials
 - Distribution of opt-out form



Beneficiary Assignment (cont.)

- Medicare beneficiaries retain their right to see any Medicare provider, regardless of whether the provider is participating in a Medicare ACO (“Freedom of Choice”)
- Medicare beneficiary opt-out
 - Limited to data sharing
 - Opt-out is not applicable to ACO assignment – Medicare beneficiaries would have to vote with their feet to opt out of ACO assignment
 - “Meaningful choice”
 - Advance notice and time to make a decision
 - Information regarding benefits and risks of data sharing
 - Consent is not compelled
 - Choice to share information is not used for discriminatory purposes



Marketing

- **Marketing materials**
 - Defined as including materials that educate, solicit, notify, or contact Medicare beneficiaries regarding the Medicare ACO
 - Exceptions for certain customized materials, non-ACO related pieces, referrals, billing/claims communications, medical condition-related mailings (e.g., flu shots)
- **CMS review and approval required**
 - Marketing materials, community events, telephone calls, internet material, advertisements
 - Includes changes to previously-approved material



Marketing (cont.)

- Marketing materials may not
 - Be misleading or confusing to Medicare beneficiaries
 - Suggest an endorsement from CMS or the Medicare Program
- Marketing may not interfere with Medicare beneficiaries' Freedom of Choice



Interplay of Marketing and Assignment

- Tension between keeping Medicare beneficiaries in the Medicare ACO and complying with Freedom of Choice
 - Steerage into Medicare ACO?
 - Denial of services for beneficiaries who opt-out?
- ACO requirements for ACO Participants and ACO Providers/Suppliers
 - Referrals
 - Customer service and other performance standards
 - Messaging
- Learning from the Medicare Advantage/Part D Programs



Data Sharing

- CMS proposes to disclose three categories of Medicare beneficiary data to Medicare ACOs
 - Aggregate data
 - Medicare beneficiary identifiable data (4 elements)
 - Medicare beneficiary identifiable claims data
- Medicare ACO's execution of data use agreement mandatory component of Shared Savings Program participation
- Medicare ACOs, ACO Participants, and ACO Providers/Suppliers may (continue to) use and disclose PHI consistent with other federal and state laws



Data Sharing (cont.)

- Disclosure of aggregate data
 - Reports based on the historical Medicare beneficiary data used to calculate the benchmark
 - Quarterly reports reflecting the most recent 12 months of data for Medicare beneficiaries that could potentially be assigned to the ACO
 - Reports will include
 - De-identified claims history of service furnished to the ACO's assigned FFS Medicare beneficiaries
 - Financial performance
 - Quality performance scores
 - Aggregated metrics on the assigned population
 - Utilization data based on (historical) Medicare beneficiaries used to calculate the benchmark



Data Sharing (cont.)

- Identification of certain historical Medicare beneficiary data
 - Released upon a Medicare ACO's request for use in connection with certain "health care operations" related activities
 - Four data elements?
 - Name,
 - Date of Birth
 - Health Insurance Claim Number
 - CMS will provide the data
 - At the beginning of each agreement period
 - At the end of each Performance Year
 - Subject to the Medicare ACO's submission of certifications regarding compliance with certain provisions of the HIPAA Privacy Rule, including "minimum necessary" requirement



Data Sharing (cont.)

- **Sharing Medicare beneficiary identifiable data**
 - Monthly disclosure of Part A, Part B and Part D monthly claims data for potentially assigned Medicare beneficiaries, subject to each Medicare beneficiary's election to opt-out
 - The Medicare ACO must
 - Submit a written request for the information
 - Certify to compliance with certain HIPAA Privacy Rule provisions, including “minimum necessary” requirement
 - Complete the data use agreement
 - Data uses
 - Limited to developing processes and engaging in appropriate activities relating to care coordination and improving the quality and efficiency of care
 - May not be used to reduce, limit or restrict care for specific individuals



Program Integrity: Compliance Plan

- A Medicare ACO's compliance plan must include at least the following:
 - Designated compliance officer who
 1. Is not legal counsel, and
 2. Has the ability to report directly to the ACO's governing body
 - Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance
 - Methods for employees and contractors of the ACO, ACO Participants, and ACO Providers/Suppliers to report suspected problems related to the ACO
 - Compliance training
 - An obligation to report suspected violations of law



Program Integrity: Downstream Relationships

- Medicare ACOs are “ultimately responsible” for compliance with their contract with CMS
 - Includes compliance with applicable provisions of law
 - Enumerated examples include civil money penalties law, physician self-referral, False Claims Act
- Medicare ACOs’ contracts with ACO Participants, ACO Providers/Suppliers, and other contracting entities
 - Must require compliance with the Medicare ACOs’ contracts with CMS, including applicable provisions of law
 - 10-year document retention requirements
 - Government audit, evaluation, and inspection rights



Program Integrity: Certification

- Every Medicare ACO must attest to the accuracy, completeness and truthfulness of information submitted to CMS
 - Within the application to participate
 - Quality data
 - Other information
- A Medicare ACO must obtain a similar certification from any downstream entity of the Medicare ACO generating data
- A written request to CMS for payment of the Shared Savings must be submitted to CMS



Program Integrity: Additional Features

- **Conflicts of interest**
 - Medicare ACOs must have a conflicts of interest policy applicable to members of the governing body
 - Disclosure of relevant financial interests
 - Process for evaluating potential conflicts
 - Process for addressing conflicts that arise
- **Screening ACO applicants**
 - Although Medicare ACOs would not be subject to CMS's enrollment/screening process for providers, the agency is contemplating an integrity review as part of the application process
 - Program integrity history
 - Exclusions or sanctions
 - Inclusive of affiliated "individuals and entities"



New and Evolving Program Standards

- Medicare ACOs would be contractually required to comply with new and modified Shared Savings Program requirements during the term of the 3-year agreement
- CMS carves out from the foregoing the following areas:
 - Medicare ACO eligibility requirements pertaining to structure and governance
 - Calculation of the sharing rate
 - Beneficiary assignment
- Corrective action and contract termination are potential agency actions for failure to comply with new requirements



Medicare ACO “Significant Changes”

- CMS proposes to regulate changes to a Medicare ACO’s structure, once an application is approved
 - During the term of the 3-year agreement
 - No ACO Participants may be added
 - ACO Participants (TINs) may be removed
 - ACO Providers/Suppliers may be added or removed
 - Permissible changes must be reported to CMS for review within 30 days so that CMS may re-evaluate the structure
- Other changes also subject to CMS notification and potential review
 - Examples include deviations for the approved application and changes in information within the application



Quality Metrics and Other Reporting Requirements



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Quality

- Medicare ACOs that do not meet Quality Performance Standards (reporting, accuracy and performance) will not be eligible for shared savings.
- 5 aspects to meeting proposed quality and reporting requirements:
 - 1) Measures to assess the quality of care provided by an ACO
 - 2) Requirements for data submission
 - 3) Quality performance standards
 - 4) Reporting requirements
 - 5) Public reporting
- For **Year 1** of an ACO contract, an ACO will be considered to meet the ACO Quality Performance Standards if it has **reported** completely and accurately on all quality measures; there will be an audit process.
- For **Years 2 and 3**, an ACO will have to both completely and accurately **report** quality measures and **achieve** performance minimums.



Submitting Quality Data

- CMS will collect quality measures via:
 - Claims
 - Group Practice Reporting Option (GPRO) Data Collection Tool
 - Survey Instruments
 - EHR technology (in the future)



Quality Performance Measures (cont.)

- Initial 65 quality measures across two dimensions: **improving care, improving health**
- The measures are further divided by five “domains” that are weighted equally:

Better Care for Individuals

- 1) Patient/Caregiver Experience (7 measures)
- 2) Care Coordination (16 measures, including transitions of care and HIT)
- 3) Patient Safety (2 measures)

Better Health for Populations

- 4) Preventive Health (9 measures)
- 5) At-Risk Population/Frail Elderly Health (31 measures) on the following:
 - Diabetes, Heart Failure, Coronary Artery Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Frail Elderly



Scoring of Quality Performance

- Providers are scored on their overall achievement relative to a national or other benchmark
 - Quality performance standards will be issued in future rulemaking
- Performance Scoring
 - CMS sets benchmarks at beginning of each reporting year using FFS, Medicare Advantage or data it has modeled
 - Points are assigned to each measure (and summed by domain) based on performance related to the national benchmark
 - There is a maximum of 2 points per measure, with a maximum of 130 points for 65 measures
 - Domain scores are determined by dividing the actual points by the maximum potential points to determine a % of performance
 - The 5 domain scores are averaged to determine the overall score



Quality Scoring

Table 3: Sliding Scale Measure Scoring Approach

ACO Performance Level	Quality Points
90+ percentile FFS/MA Rate or 90+ percent	2 points
80+ percentile FFS/MA Rate or 80+ percent	1.85 points
70+ percentile FFS/MA Rate or 70+ percent	1.7 points
60+ percentile FFS/MA Rate or 60+ percent	1.55 points
50+ percentile FFS/MA Rate or 50+ percent	1.4 points
40+ percentile FFS/MA Rate or 40+ percent	1.25 points
30+ percentile FFS/MA Rate or 30+ percent	1.10 point
<30 percentile FFS/MA Rate or <30 percent	No points



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Quality Scoring (cont)

Table 4: Total Points for Each Domain within the Quality Performance Standard

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



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Monitoring Compliance with Quality Reporting Standards

- CMS may terminate a Medicare ACO if it does not meet the established quality performance, as determined by:
 - Reviewing the ACO's submission of quality measurement data.
 - Requesting additional documentation from an ACO or its ACO Participants or ACO Providers/Suppliers, as appropriate.
- Where an ACO fails to meet the minimum attainment level for one or more domains, CMS proposes to give the ACO a warning and to re-evaluate the following year.
- If the ACO continues to underperform on the quality performance standards in the following year, the agreement will be terminated.



Public Reporting

- ***“Transparency of information in the health care sector is seen as a means to facilitate more informed patient choice, offer incentives, and feedback that help improve the quality and lower the cost of care.”***
- Timing: By January 1, 2013, the Secretary must implement a plan for making information on quality and patient experience measures publicly available.
- Proposed content:
 - Name and location, primary contact, and organizational information:
 - ACO Participants,
 - Identification of ACO Participants in joint ventures between ACO Professionals and hospitals, and
 - Identification of the ACO Participant representatives on its governing body and associated committees and committee leadership.
 - Shared savings information:
 - Shared savings performance payment received by ACOs or shared losses payable to CMS, and
 - Total proportion of shared savings invested in infrastructure, redesigned care processes and other resources required to support the three-part aim goals of better health for populations, better care for individuals and lower growth in expenditures, including the proportion distributed among ACO Participants.
 - Quality performance standard scores.



Quality Measures: Some Thoughts

- Overlap among quality domains
- Overlap with other Medicare quality initiatives
- ACOs should have the ability to independently measure quality performance and use data to improve quality of care
 - Adequate data systems
 - Analytic tools and resources
- Future rulemaking about quality measure standards creates uncertainties



Payment Methodology



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Shared Savings: The Big Picture

1. Has the ACO met the minimum quality performance standards such that it is eligible to share in generated savings?
2. Has the ACO incurred costs that are lower than its benchmark?
3. Has the ACO generated savings in excess of the Minimum Savings Rate (MSR)?



Shared Savings: The Big Picture (cont.)

- **One-Sided Model**

- Performance Years 1 and 2 (upside payment only)
 - Up to 50% shared savings rate for net savings exceeding the MSR (with some exceptions)
 - Potential 2.5% bump to shared savings rate for FQHC/RHC participation
 - Savings payment capped at 7.5% of the ACO's benchmark
- Performance Year 3 (upside and downside risk)
 - Up to 60% shared savings rate for gross savings exceeding the MSR, with potential 5% bump for FQHC/RHC participation
 - Total value of shared savings capped at 10% of the ACO's benchmark
 - Share losses exceeding Minimum Loss Rate, up to 5% benchmark
- Mandatory 25% withhold of any savings payment, payable upon conclusion of 3-year agreement



Shared Savings: The Big Picture (cont.)

- **Two-Sided Model**
 - Savings
 - Up to 60% shared savings rate for gross savings exceeding the MSR
 - Potential 5% bump to shared savings rate for FQHC/RHC participation
 - Savings payment capped at 10% of the ACO's benchmark
 - Losses
 - Medicare ACO bears losses up to 2% of benchmark
 - Shared losses up to 5%, 7.5%, 10% of benchmark, depending on performance year
 - Mandatory 25% withhold of any savings payment, payable upon conclusion of 3-year agreement
 - Medicare ACO can elect a withhold an addition portion of earned performance payment as a mechanism to demonstrate an adequate repayment plan



Shared Savings: CMS Summary

Table 8: Shared Savings Program Overview

Design Element	One-Sided Model (performance years 1 & 2)	Two-Sided Model
Maximum Sharing Rate	52.5 percent	65 percent
Quality Scoring	Sharing rate up to 50 percent based on quality performance.	Sharing rate up to 60 percent based on quality performance
FQHC/RHC Participation Incentives	Up to 2.5 percentage points	Up to 5 percentage points
Minimum Savings Rate	Varies by population	Flat 2 percent regardless of size.
Minimum Loss Rate	None	Flat 2 percent regardless of size
Maximum Sharing Cap	Payment capped at 7.5 percent of ACO's benchmark	Payments capped at 10 percent of ACO's benchmark
Shared Savings	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 52.5 percent of net savings up to cap.	Savings shared once MSR is exceeded; up to 65 percent of gross savings up to cap.
Shared Losses	None	First dollar shared losses once the minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over three years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3. Losses in excess of the annual cap would not be shared. Actual amount of shared losses would be based on final sharing rate that reflects ACO quality performance and any additional incentives for including FQHCs and/or RHCs using the following methodology (1 minus final sharing rate).



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Shared Savings: The Big Picture (cont.)

- CMS sets out a 4-step process for calculating a Medicare ACO's benchmark
 - 1) Determine the patient population upon which the benchmark will be calculated
 - 2) Identify adjustments to reflect Medicare beneficiaries' characteristics
 - 3) Identify potential other adjustments to the benchmark
 - 4) Determine the methodology for trending the benchmark forward



Shared Savings: The Big Picture (cont.)

- Once the benchmark is calculated, CMS will compare the benchmark to the per capita Medicare expenditures for the assigned individuals for the performance year
- If any savings generated exceed the MSR, CMS will calculate the Shared Savings using
 - The final sharing rate, based on the quality performance sharing rate plus any available increases
 - Subject to the applicable cap
- CMS does not propose to regulate distribution of Shared Savings



Calculating a Medicare ACO's Benchmark

“A useful way to view the benchmark is as a surrogate measure of what the Medicare FFS Parts A and B expenditures would otherwise have been in the absence of the ACO.”

- CMS considered two options for benchmark calculation
 - Option 1: FFS expenditures of Medicare beneficiaries who would have been assigned to the Medicare ACO in each of the 3 years preceding the 3-year agreement period
 - Option 2: For Medicare beneficiaries who are actually assigned to the ACO, the FFS expenditures incurred in the 3 years preceding the 3-year agreement period



Calculating a Medicare ACO's Benchmark (cont.)

- CMS is proposing Option 1
 - Consistent with the methodology for assigning Medicare beneficiaries to a Medicare ACO, CMS would use the same claim records of the ACO Participants to identify Medicare beneficiaries who received a plurality of primary care physicians from an ACO Participant during the 3 years prior to the agreement period
 - The FFS expenditures for these Medicare beneficiaries would be evaluated to calculate a fixed benchmark
 - Benchmark adjustments
 - Overall growth
 - Medicare beneficiaries' characteristics (including health status)
 - CMS would update the benchmark for each year of the 3-year agreement period, based on the growth in national per capita expenditures for Part A and B services



Calculating a Medicare ACO's Benchmark (cont.)

- For example:
 - Year 3 prior to the agreement period
 - 1) Calculate the per capita spending for Parts A and B for the assigned Medicare beneficiaries
 - 2) Calculate the national growth index that will be used to trend the benchmark to current dollars
 - 3) Establish the health status measures for the population, using the CMS-Hierarchical Condition Category (CMS-HCC) model created for the Medicare Advantage Program
 - 4) Modify the per capita spending (Item 1) by the growth index and health status measures (Items 2 and 3) to create the risk-adjusted per capita expenditures for individuals historically assigned to the ACO
 - 5) Weight (10%) the value of the risk-adjusted per capita expenditures for calculating the final benchmark



Calculating a Medicare ACO's Benchmark (cont.)

- For example (cont.)
 - For Year 2 prior to the agreement period, repeat the Year 3 calculation, but apply a 30% weighting value to the risk-adjusted per capita expenditures of the assigned population
 - For Year 1 prior to the agreement period, repeat the Year 3 calculation, except
 - No national growth index needs to be calculated or applied
 - Apply a 60% weighting value to the risk-adjusted per capita expenditures of the assigned population
 - The combined benchmark value (Years 3, 2, and 1) is the fixed benchmark, which is updated annually during the 3-year agreement



Calculating a Medicare ACO's Benchmark (cont.)

- The benchmark calculate is adjusted to reflect the assigned Medicare beneficiaries' health status and other characteristics
 - Using the CMS-HCC model, CMS will calculate a single benchmark risk score for each Medicare ACO
 - This risk score will be applied to the benchmark throughout the agreement period
- Other potential adjustments to the benchmark amount
 - CMS proposes to retain the indirect medical education (IME) and disproportionate share hospital (DSH) adjustments
 - CMS proposes to omit any geographic payment adjustment or Medicare expenditures or savings for incentive payments available for Medicare providers



Determining the Minimum Savings Rate

- CMS proposes different Minimum Savings Rates (MSRs) for the payment models
 - One-sided model
 - MSR for the first two years is based on increasing nominal confidence intervals
 - Smaller Medicare ACOs receive an MSR of 3.6-3.9% (5,000-5,999 beneficiaries)
 - Larger Medicare ACOs receive an MSR closer to (but in no event lower than) 2%
 - Two-sided model has a flat 2% MSR
- Recall that the one-sided model provides for Shared Savings for net savings, defined as 2% of the applicable benchmark (certain exceptions apply)



Minimum Savings/Loss Rates: CMS Summary

Table 6. Minimum Savings Rate and Confidence Intervals by Number of Assigned Beneficiaries (One-Sided Model)

Number Beneficiaries	MSR (low end of assigned beneficiaries)	MSR (high end of assigned beneficiaries)
5,000 - 5,999	3.9%	3.6%
6,000 - 6,999	3.6%	3.4%
7,000 - 7,999	3.4%	3.2%
8,000 - 8,999	3.2%	3.1%
9,000 - 9,999	3.1%	3.0%
10,000 - 14,999	3.0%	2.7%
15,000 - 19,999	2.7%	2.5%
20,000 – 49,999	2.5%	2.2%
50,000 – 59,999	2.2%	2.0%
60,000 +	2.0%	



Minimum Loss Rate

- The Medicare Program will share in losses for Medicare ACOs with a two-sided model whose per average per capita Medicare expenditures for the Performance Year exceed 2% of the applicable benchmark
 - Shared Loss Rate is determined based on the final sharing rate, inverted
 - *E.g.*, $1 - (\text{shared savings rate})$
 - Shared losses are capped similar to Shared Savings (*e.g.*, 5%, 7.5%, 10% of benchmark)



Oversight of CMS and Other Government Agencies



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CMS Oversight

- CMS will use various tools to conduct oversight activities
 - Data analysis
 - Site visits
 - Complaints
 - Audits
- CMS will monitor
 - Systematic avoidance of “at-risk” beneficiaries
 - Compliance with quality performance standards
 - Changes to ACO eligibility requirements
 - Medicare beneficiary notification and availability of data sharing opt-out
 - ACO marketing
- A Medicare ACO may be subject to a corrective action plan to address deficiencies



CMS Contract Termination

- CMS sets out a series of occurrences that provide the agency with grounds for termination of a Medicare ACO's contract, such as the following
 - Avoidance of at-risk Medicare beneficiaries
 - Failure to meet quality performance standards
 - Inability to effectuate required regulatory changes
 - Material noncompliance or pattern of non-compliance with public reporting and other CMS reporting requirements
 - Submission of false, inaccurate or incomplete data or information to CMS
 - Failure to offer beneficiaries the opportunity to opt-out of sharing their claims information



CMS Contract Termination (cont.)

- **Involuntary termination**
 - A Medicare ACO may not reapply if terminated for being unable to achieve savings in a previous agreement (net loss)
- **Withdrawal prior to agreement completion**
 - If a Medicare ACO elects to withdraw from the Shared Savings Program, it must provide CMS with 60 days advance notice
 - It must also notify all of its ACO Participants and ACO Providers/Suppliers, who would in turn be required to notify beneficiaries in a timely manner of the ACO's decision to withdraw
 - The ACO would forfeit its 25 percent withhold of Shared Savings



CMS Contract Termination (cont.)

- ACO Participants may apply again after the end of the original 3-year agreement period, but must demonstrate in the new application
 - That it has corrected the deficiencies leading to the termination
 - Processes in place to ensure compliance under a new agreement



Proposed Waivers

- **Stark Law and Anti-Kickback waivers**
 - Waives application of prohibitions to distribution of Shared Savings to or among ACO Participants and ACO Providers/Suppliers
 - Also waives application of prohibitions to distribution of Shared Savings for activities “necessary for and directly related to” the ACO’s participation in the Shared Savings Program
- **Stark Law waiver**
 - Limited to the ACO’s distribution of Shared Savings, not other financial relationships
- **Anti-Kickback Statute waiver**
 - Waiver authority extends to any financial relationship between or among the ACO, ACO Participants and ACO Providers/Suppliers



Proposed Waivers (cont.)

- CMP law prohibition on hospital payments to induce physicians to reduce or limit services (the Gainsharing CMP)
 - Waives application of CMP prohibitions to an ACO's distribution of Shared Savings where the distributions are made by a hospital to a physician, provided, that such payments are not made knowingly to induce a physician to reduce or limit medically necessary items or services



Proposed Antitrust Review

- Rule of reason analysis will be applied
 - CMS eligibility criteria are consistent with criteria for clinical integration
 - CMS monitoring and Medicare ACO reporting requirements may further enhance future analysis of ACO arrangements
- FTC/DOJ propose to focus on each ACO Participant's share of services within their Primary Service Area (PSA)
 - The greater the PSA share, the greater the risk that the ACO will be anticompetitive
 - Depending on the PSA shares, an ACO may elect or be required to seek antitrust review
- Proposed Antitrust Safety Zone
 - ACO Participants providing the same service must have a combined share of 30% or less of each common service in each Participant's PSA
 - PSA for each service is defined as the lowest number of contiguous postal zip codes from which the ACO draws at least 75% of patients for the service
 - Certain exceptions may apply



Planning and Moving Forward



Providing Accountable Care: Strategy & Structure
A Webcast Series

Some Considerations for ACO Formation

- Gap analysis
- Initiating conversations with potential partners
- Payor communications
- Providers' "tipping point" for patterns of care



Comments and Questions

Lauren N. Haley
202.756.8170
lhaley@mwe.com

Anne W. Hance
202.756.8270
ahance@mwe.com



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