Becoming a Medicare ACO
How to Submit Questions

Lessons Learned from ACA Early Implementation: Exchanges, Medicaid Expansion and System Transformation

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History of Medicare ACOs

• ACA provision for shared savings program
  “to establish a Shared Savings Program that promotes accountability for a patient population, coordinates items and services under Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”
Number of Medicare ACOs

- Pioneer program started 1/1/12 with 32 participants
- 4/1/12- 27 shared savings ACOs
- 7/12 – 87 shared savings ACOs
- 1/13 – 106 shared savings  ACOs
- 1/14 – 123 Shared savings ACOs
- Total of 375 ACOs
What is an ACO (per CMS)?

- Providers and suppliers of services (doctors, hospitals, and others involved in patient care) who come together voluntarily to coordinate care to their Medicare fee-for-service patients.
- With seamless coordinated care the ACO ensures that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
What is an ACO (continued)?

• Goal is to constrain health care costs while improving quality. When an ACO succeeds both in delivering high-quality care and providing less costly care, it will share in the savings it achieves for the Medicare program.

• ACOs can choose a one-sided approach, sharing in savings but not in risk, or a two-sided approach, sharing in both savings and risk.

• In the one-sided track CMS shares 50% of savings; in a two-sided track CMS shares 60%.
What is an ACO (continued)?

• Not a managed care plan
• Providers choose to participate in the ACO
• Beneficiaries participate in original Medicare (FFS) and retain the right to obtain care from any provider of their choosing
• Parts A and B Medicare
• Does not include those enrolled in Medicare Advantage
• Need 5000 beneficiaries (15,000 for Pioneer ACOs)
Medicare ACO Elements of Application

- Separate legal entity
- Board committees – e.g., quality, finance
- Board composition
  - Medicare beneficiary that uses system
  - ACO participants control at least 75% of board;
  - CEO and CMO
- Compliance plan
Medicare ACO Elements (cont.)

- Contractual agreements with ACO participants (physician practices, hospitals, FQHCs, pharmacies).
- ACO participants must have at least 5000 Medicare beneficiaries assigned to them. Beneficiaries are assigned to the physician that provides the plurality of their care primary care.
- How does the ACO intend to share savings with ACO participants and providers?
Medicare ACO Elements (cont.)

• Quality Assurance and Improvement Program
  – Evidence-based medicine
  – Beneficiary engagement
  – Internal reporting on quality and cost metrics
  – Promoting coordination of care
# Minimum Savings Rates

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<th>Beneficiaries</th>
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MSSP Shared Savings Options

• Track 1 shared savings only model (one-sided model)
• Track 2 shared savings and losses model (two-sided model)
33 Quality of Care Measures in 4 Domains
Each domain weighted 25%

- Patient/caregiver experience (7)
- Care coordination/patient safety (6)
- Preventive health (8)
- At-risk population:
  - Diabetes (6)
  - Hypertension (1)
  - Ischemic vascular disease (2)
  - Heart failure (1)
  - Coronary artery disease (2)
Assessing ACO Readiness

• Core Capabilities
• Predictors of Readiness
  – Source: “Measuring Progress Toward Accountable Care”
    Eugene Kroch
    The Commonwealth Fund
    December 2012
• Partner Engagement
Core Capabilities

- People-centered foundation
- Patient centered medical home functionality
- High-value network
- Payer partnership
- Population health data management
- ACO leadership
High Predictors of Readiness

- Full or partial ownership of a health plan
- Existing collaboration with other health systems or as part of a larger corporate entity
- Positive relationships with primary and specialty care providers
- Investment in PCMH with employed or community providers
High Predictors of Readiness

• Clinical integration across the continuum
• Information technology infrastructure that integrates and analyzes disparate data, provides actionable tasks, stratifies risk and measures intervention impact
• Existing risk-based contracts with payers
• Active governance that includes physician leaders
Medicare ACO Model for Success

**Beneficiary Engagement**
- Beneficiary notification letter
- General outreach
- Engagement strategies
- Self-management
- Motivational interviewing/health literacy

**Hospital Engagement**
- Care transition model
- Readmission prevention strategies
- Relationship development and coordination between hospital/PCP

**Culture Change**
**Leadership Support**
- Staffing tool with instructions
- Care management training (with CM tool kit)
- Care team role and communication routines
- Community outreach

**Provider Engagement/Team Development**
- Provider awareness and commitment to model
- Scripts about program
- Team roles and communication routines set
- Development of standing orders for particular diseases/conditions
- Virtual visits

**Optimizing Savings**
- Development of quality metrics and routine reviews
- Use of Evidence-based practices (built-in auto functions, electronically as much as possible)
- High impact/low value tests/services
- Better management of utilization of HC, LTC/SNF, and Urgent Care

**Care Management**
- Staffing tool with instructions
- Care management training (with CM tool kit)
- Care team role and communication routines
- Community outreach

**Systems Changes**
- IT
  - Registries
  - Care management tools
  - Gaps of care lists
  - Coding/Optimizing rules

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Why an ACO?

• Care is moving from volume to value
• Low risk in Medicare ACOs – upside only for initial three-year agreement
• ACO permits FFS payments, with shared savings payment in addition (less change en route to capitation)
Experience of Medicare ACOs

- Pioneer model: 13 of 32 ACOs shared savings (18 of 32 had below budget spending). Costs for Pioneer beneficiaries grew 0.3% v. 0.8% in 2012 for similar beneficiaries.
- All 32 reported quality measures and met the performance goal for year 1. All 32 outperformed industry benchmarks on 15 measures for year 1.
- All 32 challenged CMS on 19 quality measures; CMS agreed to reset thresholds.
- 7 Pioneer ACOs left Pioneer and joined MSSP; 2 dropped out entirely.
Experience (continued)

One-year interim results for ACOs starting in April and July, 2012

- 29 of 114 Track 1 and Track 2 ACOs generated shared savings (54 had lower than projected expenditures)
- 2 ACOs in Track 2 ACOs generated shared losses
Experience of Private Sector ACOs

- CalPers pilot in 2010, global budget with an ACO. ACO saved 1.6% from baseline in year 1. Half due to health care resource use; half due to reductions in unit prices. $37 million savings in year 2. (Paul Markovich, Health Affairs Sept 2012, Vol 31, no 9 1969-1976)

- Data analytics firm Treo Solutions found measurable improvements among its clients who are early adopters. Reduced spending 2.5 percent in the first year and decreased inpatient admissions by 5 percent. ACOs and PCMH programs showed a 13.2 percent drop in potentially preventable initial admissions and a 9.7 percent decline in readmissions. (Mary Mosquera, “Aetna, Cigna, Blues add ACOs as positive results mount”, Healthcare Payer News, January 16, 2014)
Timeline for 2015 Medicare Shared Savings Program Application

• Notice of Intent will be accepted beginning May 1, and must be submitted no later than May 30, 2014

• 2015 application will be posted no later than May 30, 2014

• Application will be accepted beginning July 1, and must be submitted no later than July 31, 2014

• 2015 ACOs will begin operations January 1, 2015

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Application.html
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