ACO OVERVIEW
MAKING SENSE OF THE FINAL MEDICARE SHARED SAVINGS PROGRAM REGULATIONS

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John Redding, MD is a Manager at Blue Consulting Services. John brings over 15 years of healthcare experience to HCS and has served as a trusted advisor to providers and healthcare executives for the last 6 years. In his role at Blue, John works with health systems, hospitals, and physician organizations to develop collaborative physician-hospital working relationships and business ventures. John has extensive experience leading and supporting a broad spectrum of physician-hospital alignment initiatives, from developing and implementing physician employment strategies to providing interim management for a Clinically Integrated Physician Network / Accountable Care Organization.
Objectives

1. Present a high level overview of the Medicare Shared Savings Program and the requirements to participate in the Program as an ACO.

2. Describe key characteristic of ACOs that will increase their probability of realizing an ROI from their initial and ongoing ACO-related investments.

3. Enable participants to evaluate the short-term and long-term fit of the ACO model for their organization and identify alternative strategies to short-term adoption of the ACO model.
Agenda

- Definitions
- Eligibility
- Options
- Operations
- Anticipated Impact
- ACO Activity
- ACO Insights
- Questions & Answers
“Like unicorns. No one has ever really seen one locally, but everyone seems to know what they look like.”

Jim Fitzpatrick, VP MA Hospital Association
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<th>Medicare Shared Savings Program</th>
<th>Accountable Care Organization</th>
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<td>“A shared savings program that promotes accountability for a patient population, coordinates items and services under Medicare Part A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient care.”</td>
<td>“An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.”</td>
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*Center for Medicare and Medicaid Services.*
For practical purposes, the Medicare Shared Savings Program (MSSP) can be considered a hybrid shared savings / pay for performance incentive model.

Estimated savings

\[ X \]

50\% – 60\% share
(max 10\% - 15\% forecast expenditures)

\[ X \]

Organizational quality score

= Annual shared savings distribution to ACO
Eligibility
ACOs can be formed by one or more of the following participants:

1. ACO professionals in group practice arrangements
2. Networks of individual practices of ACO professionals
3. Partnerships or joint venture arrangements between hospitals and ACO professionals
4. Hospitals employing ACO professionals
5. CAHs that bill under Method II
6. RHCs
7. FQHCs

Legal entity under State, Federal or Tribal law

May not participate in a duplicative shared savings program
**Eligibility Participation**

- Must include enough primary care professionals to cover at least 5,000 Medicare beneficiaries

- ACO participants upon whom beneficiary assignment is determined must be exclusive to one ACO

- Must provide list of TINs & NIPs

- Must notify when adding or removing ACO providers or suppliers within 30 days

- Must describe how shared savings will be distributed
Eligibility

Governance

75% ACO Participants

≥ 1 Medicare Beneficiary

Community Stakeholder (Optional)

- Must maintain an identifiable governing body with the authority to execute the functions of the ACO

- Has the following responsibilities:
  - Provide oversight & direction
  - Hold ACO management accountable and defines processes for evidence-based medicine, quality & cost reporting, and coordinating care.

- Governing bodies governing process must be transparent

- Must have a conflict of interests policy
Eligibility

Leadership

- Leadership & management structure
  - Organizational charts
  - Committee lists with names of committee members
  - Job descriptions

- Documents effectuating formation
  - Charters, by-laws
  - Articles of incorporation
  - Partnership, joint venture, management, or asset purchase agreements

- Participants’ and ACO providers / suppliers’ rights and obligations
  - Participation agreements
  - Employment contracts
  - Operating policies

Governing Body

Executive Lead

Compliance Officer

Medical Director

Quality Assurance & Improvement

Executive Lead

Compliance Officer

Medical Director

Quality Assurance & Improvement
Eligibility

Promotion Of Evidence-Based Medicine

- Must describe how it will establish and maintain ongoing quality assurance & improvement efforts

- Must provide documentation describing its plans to:
  - Promote evidence-based medicine
  - Promote beneficiary engagement
  - Report on quality and costs and
  - Coordinate care

- Must document its plans to:
  - Ensure provider / supplier compliance
  - Remediate non-compliant parties
  - Assess and continuously improve cost & quality performance
Options
Options
Start Dates

Three options for participation:

1. April 1, 2012
   - Term of Agreement is 3 years and 9 months
   - First period 21 months

2. July 1, 2012
   - Term of agreement is 3 years and 6 months
   - First period 18 months

3. January 1, 2013 and beyond
   - Term of agreement is 3 years
   - First period is 12 months
Options
Tracks

**Track 1**  
(One-Sided Model)
- Shared savings only (no risk)
- Maximum of 50% share or 10% of benchmark performance
- Minimum savings rate based on a sliding scale determined by the number of beneficiaries
- No shared losses
- First dollar savings if minimum thresholds are met

**Track 2**  
(Two-Sided Model)
- Shared savings & losses (risk)
- Maximum of 60% share or 15% of benchmark performance
- Minimum savings rate set at a flat 2%
- Shared loss potential set at 1 minus the calculated shared savings rate
- Minimum loss rate set at a flat 2%
- Loss sharing limit increases over the 3 year term (5%, 7.5%, 10%)
- First dollar savings and losses if minimum thresholds are met
Operations
Operations
Beneficiary Assignment

- Beneficiaries enrolled under Medicare fee-for-service parts A & B
- Preliminary attribution
- Retrospective assignment
- Stepwise process
  1. Plurality of primary care services from ACO affiliated PCP
  2. Primary care services provided by other ACO affiliated professionals (specialists, NPs, Pas, etc.)
  3. Retrospective assignment
- Primary care services defined by
  - HCPCP codes
  - FQHC & RHC revenue center codes
Operations
Expense Benchmarks

- Based on Medicare Part A & B expenditures
- Calculation based on 3-month run-out of claims with a completion factor

Benchmark years weights:
- BY3: 60%
- BY2: 30%
- BY1: 10%

Adjustments made for:
- Newly assigned beneficiaries
- Changes in health status (CMS-HCC risk score)
Operations
Quality & Reporting Standards

- 33 measures in four domains
  1. Patient / caregiver experience
  2. Care coordination / patient safety
  3. Preventative health
  4. At-risk population

- Pay-for-performance phased in over years 2 & 3

- Multiple reporting methodologies

- 5 step process to calculate score
  1. Determine points earned for each measure
  2. Sum the total points for all measures in each domain
  3. Divide the total points earned in each domain by the total available points in each domain
  4. Multiply each domain by the 25% weight
  5. Sum all weighted domain scores
Operations

Shared Savings Calculation

Estimated savings

$\times$

50\% – 60\% share

(max 10\% - 15\% forecast expenditures)

$\times$

Organizational quality score

= Annual shared savings distribution to ACO
Operations
Marketing & Notification

- Marketing materials defined as materials, “used to educate, solicit, notify, or contact Medicare beneficiaries or providers and suppliers regarding the Shared Savings program

- May use marketing materials 5 days after filing them with the CMS and certifying that they comply with all requirements

- Must notify beneficiaries of participation at point-of-care

- Must post signs at their facilities

- Must make standardized written notices available
Coordination With Other Agencies

Federal Trade Commission & The US Department of Justice
- Guidance applies to all ACOs
- No mandatory anti-trust review
- Voluntary expedited review (90 days)
- CMS to share application & data
- Safe harbor for ACOs with less than 30% market share in their PSA or under the rural exception
- “Will vigilantly monitor complaints about ACO formation or conduct and take whatever enforcement action may be appropriate.”

Internal Revenue Service (for comment)
- ACOs engaged exclusively in the MSSP would still qualify for tax exempt status under 501(3)(c)
- Participation in the MSSP through an ACO will further the charitable purposes of the tax exempt organization
- The tax exempt organization does not have to have control over the ACO
- In general, will not consider participation inurement or impermissible private benefit

Office of the Inspector General (for comment)
- Do not want to unduly limit impede development of beneficial ACOs
- Applies to Physician Self-Referral Law, Federal Anti-Kickback Statute, and the Civil Monetary Penalties Law
- Five proposed waivers
  1. ACO Pre-Participation Waiver
  2. ACO Participation Waiver
  3. Shared Savings Distribution Waiver
  4. Compliance with Physician Self-Referral Law
  5. Patient Incentive Waiver

Center for Medicare & Medicaid Innovation
- Advanced Payment ACO Model
- Start up capital for physician-only ACOs and rural ACOs
- Up to 50 ACOs ($170 M in funding)
- Must indicate interest in CMS filing
- Recipients selected based on formula
Anticipated Impact
ACO’s Estimated Impact

Center for Medicare & Medicaid Services

- **Participants**: 50 to 270 ACOs
- **Federal Savings**: $470M
- **Bonus Payments**: $1.31B
- **Start Up Costs**: $29M to $157M
- **Operating Costs**: $63M to $342M
ACO’s Estimated Impact
Congressional Budget Office

Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment

An important part of the national debate about how to manage federal spending in the decades ahead has focused on spending for Medicare, which is expected to account for a large and ever-increasing share of the federal budget. Medicare provides health insurance to almost everyone who is 65 or older and to people under age 65 who receive Social Security Disability insurance benefits (after a waiting period) or have certain serious health conditions. Many observers point out that improving the effectiveness of Medicare spending might allow both for reductions in federal spending from its projected path and for improved health care for Medicare beneficiaries.

Since 1997, the program has had the authority to conduct demonstrations that examine new ways to deliver and pay for health care. That authority was extended in 2010, under the Patient Protection and Affordable Care Act (Public Law 111-148), with the creation of the Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS). Under this law, CMS can expand a demonstration—and even implement it nationwide—without further approval from the Congress if the Secretary of Health and Human Services determines that such expansion would either reduce spending without reducing quality of care or improve quality of care without increasing spending.

In the past two decades, CMS has conducted two broad categories of demonstrations aimed at enhancing the quality of health care and improving the efficiency of health care delivery in Medicare's fee-for-service program.

- Disease management and care coordination demonstrations have sought to improve the quality of care of beneficiaries with chronic illnesses and those whose health care is expected to be particularly costly.
- Value-based payment demonstrations have given health care providers financial incentives to improve the quality and efficiency of care rather than payments based strictly on the volume and intensity of services delivered.

This Congressional Budget Office (CBO) issue brief reviews the outcomes of 10 major demonstrations—6 in the first category, 4 in the second—that have been evaluated by independent researchers. The types of programs in those demonstrations could be implemented nationally through the innovation center or through further legislation.

The evaluations show that most programs have not reduced Medicare spending. In nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program. In the few cases in which the costs of the program were included in the payment to the participating organizations, savings were relatively small, even when bundled payments were used.

Key Takeaways
1. The ACO model remains unproven
2. Physician & patients must be engaged in care management efforts
3. Incentive payment design matters

*Lessons Learned from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment. January, 2012.*
ACO Activity
Types Of ACOs

**Governmental**
- Pioneer ACOs
- Medicare Shared Savings Program

**Commercial**
- Provider Sponsored ACOs
- Payer Sponsored ACOs
- Provider-Payer Sponsored ACOs
Pioneer ACOs
January 1, 2012

• Organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements

• First two performance years, shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program

• Third performance year, those Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model (per-beneficiary per month payment amount) intended to replace some or all of the fee-for-service (FFS) payments with a prospective monthly payment

1. Allina Health
2. Atrius Hospitals
3. Banner Health Network
4. Beacon, LLC
5. Bellin Thedacare Healthcare Partners
6. Beth Israel Deaconess Physician Organization
7. Brown & Toland Physicians
8. Dartmouth-Hitchcock ACO
9. Fairview Health System
10. Franciscan Alliance
11. Genesys Alliance
12. Healthcare Partners Medical Group
13. Healthcare Partners of Nevada
14. Heritage California ACO
15. JSA Medical Group
16. Michigan Pioneer ACO
17. Monarch Healthcare
18. Montefiore ACO
19. Mount Auburn Cambridge Independent Practice Association
20. OSF Healthcare System
21. Park Nicollet Health Services
22. Partners Healthcare
23. Physician Health Partners
24. Plus!
25. Presbyterian Healthcare Services
26. Primecare Medical Network
27. Renaissance Health Network
28. Seton Health Alliance
29. Sharp Healthcare System
30. Steward Healthcare System
31. Trinity Pioneer ACO, LC
32. University of Michigan
Medicare Shared Savings Program ACOs

April 1, 2012

1. Accountable Care Coalition of Caldwell County, LLC
2. Accountable Care Coalition of Coastal Georgia, LLC
3. Accountable Care Coalition of Eastern North Carolina, LLC
4. Accountable Care Coalition of Greater Athens Georgia, LLC
5. Accountable Care Coalition of Mount Kisco, LLC
6. Accountable Care Coalition of Southeast Wisconsin, LLC
7. Accountable Care Coalition of Texas, Inc.
8. Accountable Care Coalition of the Mississippi Gulf Coast, LLC
9. Accountable Care Coalition of the North Country, LLC
10. AHS ACO, LLC
11. AppleCare Medical ACO, LLC
12. Arizona Connected Care, LLC
13. Chinese Community Accountable Care Organization
14. Catholic Medical Partners
15. Costal Carolina Quality Care, Inc.
16. Crystal Run Healthcare ACO, LLC
17. Florida Physicians Trust, LLC
18. Hackensack Physician-Hospital Alliance ACO, LLC
19. Jackson Purchase Medical Associates, PSC
20. Jordon Community ACO
22. Optimus Healthcare Partners, LLC
23. Physicians of Cape Cod ACO, Inc.
24. Premier ACO Physician Network
25. Primary Partners, LLC
26. RVG ACO Health Providers, LLC
27. West Florida ACO, LLC
Medicare Shared Savings Program ACOs

July 1, 2012

1. Arizona Health Advantage, Inc.
2. John C Lincoln Accountable Care Organization, LLC
3. Fort Smith Physicians Alliance ACO, LLC
4. ApolloMed Accountable Care Organization Inc.
5. Golden Life Healthcare LLC
6. John Muir Physicians Network
7. Meridian Holdings, Inc.
8. North Coast Medical ACO, Inc.
9. Torrance Memorial Integrated Physicians, LLC
10. MPS ACO Physicians, LLC
11. PriMed, LLC
12. Accountable Care Coalition of Northwest Florida, LLC
13. Accountable Care Partners, LLC
14. Allcare Options, LLC
15. Florida Medical Clinic ACO, LLC
16. FPG Healthcare, LLC
17. HealthNet, LLC
18. Integrated Care Alliance, LLC
19. Medical Practitioners for Affordable Care, LLC
20. Palm Beach Accountable Care Organization, LLC
21. Reliance Healthcare Management Solutions, LLC
22. Wellstar Health Network, LLC
23. Advocate Health Partners
24. Chicago Health System ACO, LLC
25. Deaconess Care Integration, LLC
26. Franciscan AHN ACO, LLC
27. Indiana University Health ACO, Inc.
28. Genesis Accountable Care Organization, LLC
29. Iowa Health Accountable Care, L.C.
30. One Care LLC
31. University of Iowa Affiliated Health Providers, LC
32. Owensboro ACO
33. Quality Independent Physicians
34. Southern Kentucky Health Care Alliance
35. TP-ACO LLC
36. Central Maine ACO
37. Maine Community Accountable Care Organization, LLC
38. MaineHealth Accountable Care Organization
39. Accountable Care Organization of Maryland, LLC
40. Greater Baltimore Health Alliance Physicians, LLC
41. Maryland Accountable Care Organization of Eastern Shore LLC
42. Maryland Accountable Care Organization of Western MD LLC
43. Circle health Alliance, LLC
44. Harbor Medical Associates, PC
45. Accountable Healthcare Alliance, PC
46. Oakwood Accountable Care Organization, LLC
47. Southern Michigan Accountable Care, Inc.
48. Essential Health
49. Medical Mall Services of Mississippi
50. BJH Healthcare ACO, LLC
51. Heartland Regional Medical Center
52. Nevada Primary Care Network ACO, LLC
53. Concord Elliot ACO LLC
54. Barnabas Health ACO-North, LLC
55. Accountable Care Coalition of Syracuse, LLC
56. Asian American Accountable Care Organization
57. Balance Accountable Care Network
58. Beacon Health Partners, LLP
59. Chautauqua Region Associated Medical Partners, LLC
60. Healthcare Provider ACO, Inc.
61. Mount Sinai Care, LLC
62. ProHEALTH Accountable Care Medical Group, PLLC
63. WESTMED Medical Group, PC
64. Cornerstone Health Care, PA
65. Triad Healthcare Network, LLC
66. Mercy Health Select, LLC
67. ProMedica Physician Group, Inc.
68. Summa Accountable Care Organization
69. University Hospitals Coordinated Care
70. North Bend Medical Center, Inc.
71. Coastal Medical, Inc.
72. Accountable Care Coalition of The Tri-Counties, LLC
73. AnewCare LLC
74. Cumberland Center for Healthcare Innovation, LLC
75. MissionPoint Health Partners
76. St. Thomas Medical Group, PLLC
77. Summit Health Solutions
78. BHS Accountable Care, LLC
79. Memorial Hermann Accountable Care Organization
80. Methodist Patient Centered ACO
81. Essential Care Partners, LLC
82. Physicians ACO, LLC
83. Texoma ACO LLC
84. Central Utah Clinic, P.C.
85. Accountable Care Coalition of Green Mountains, LLC
86. Polyclinic Management Services Company
87. Aurora Accountable Care Organization, LLC
88. Dean Clinic and St. Mary’s Hospital Accountable Care Organization
89. ProHealth Solutions, LLC
ACO Development Trends

Five Trends In ACO Development

1. The number & types of ACOs are expanding
2. Growth is centered in larger population centers
3. Hospitals continue to be the largest backers of ACOs, but physician groups are playing an increasingly larger role
4. Non-Medicare ACOs are experimenting with more diverse models that Medicare backed ACOs
5. The success of any particular ACO model is still undetermined

*David Muhlenstein et al., Growth and Dispersion of Accountable Care Organizations June 2012 Update, White Paper, (Leavitt Partners, June 2011).
ACO Insights
Likely Characteristics Of Successful ACOs

### 3 Most Essential Elements of a Successful ACO*

- A deep understanding & vigilant management of costs
- Sophisticated clinical analytics
- An elegant methodology for sharing savings

### 3 Other Essential Elements of a Successful ACO

- Robust care / disease management
- Practice-oriented operational redesign
- Culture of continuous learning

Likely ACO Evolution

Short-Term
(1st Contractual Period)
Waste Reduction & Inpatient Operational Excellence
- Length of stay
- Imaging
- Pharmaceuticals
- Readmissions
- Supplies

Mid-Term
(2nd Contractual Period)
Appropriateness-Of-Care & Physician Practice Redesign
- Avoidable admissions
- Gaps-in-care
- Referral patterns
- Site-of-care
- Transitions in care

Long-Term
(≥ 3rd Contractual Period)
Disease Management & Population Health
- Disease avoidance
- Disease progression
- Disease specific PMPM costs
- Patient engagement / compliance
- Risk stratified outcomes
The ACO Model
_Viable For Some And Likely To Impact Many_

- The CMS & HHS have made significant modifications to their proposed regulations to increase the value proposition of the MSSP to hospitals and health systems
- Hospitals & health systems that dismissed the ACO model based on the proposed regulations would be wise to reconsider the opportunity provided by the program under the final regulations
- Although the MSSP will not be universally attractive, it is likely to impact a number of local and regional healthcare markets
- Hospital leaders should evaluate and begin planning for the potential impact of ACOs in their markets
- Whether or not participation in the MSSP is right for your organization at this time, “business as usual” will not be a sustainable long-term strategy
Questions & Answers