ACO ROAD MAP

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The Affordable Care Act directs CMS to create the Medicare Shared Savings Program to make available financial incentives for providers to work collaboratively through accountable care organizations "to promote accountability for a patient population, coordinate items and services furnished to [Medicare beneficiaries], and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery."

The October 20, 2011, final rule implementing the MSSP now offers a clearer vision of what lies ahead. However, one can be easily detoured by all the detail in the 696-page regulation and the 100+ pages of additional agency guidance.

To help health care businesses find the on-ramp sooner, we have merged the regulation and guidance down to their core requirements. We have arranged the information in a manner to facilitate substantive discussions and decision-making, rather than hand-wringing over every last regulatory provision.

The final rule is a significant improvement on the proposal CMS published in March 2011, eliminating perceived obstacles to and enhancing financial rewards for participation. However, comparing and contrasting the proposed and final rules only serves as a distraction. What's done is done, and today's focus should be on the road ahead.

Organizational form should follow strategic function. ACOs and other shared savings models are not the end game. Instead, they are a transitional tool to build relationships and structure to support real commitment to improving quality and lowering costs. In the long run, the process of building your ACO will be more valuable than any shared savings you may realize under the MSSP.

PART I – FORMATION AND OPERATIONS

A. Getting Started

An ACO is a distinct legal entity involving one or more Medicare-enrolled providers (referred to as ACO participants) "who agree to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

An ACO that meets certain requirements (as demonstrated through an application process) may enter into a three-year agreement with CMS to participate in the MSSP. Each year of the contract is called a performance year.

1. For 2012, there will be two start dates: April 1 and July 1. The first performance year will be 21 or 18 months, respectively. Thereafter, all ACO agreements entered into during a calendar year will have a start date of January 1 of the following year.

2. The application form and submission deadlines will be established by CMS at a later date.

3. An ACO that elects early termination shall be subject to specified penalties.

4. The regulation lists specific grounds on which CMS may impose a corrective action plan or terminate an ACO's agreement for cause.

B. Required ACO Functions (Required Documentation for the Application in Parentheses)

An application to participate in the MSSP must show how the ACO will perform four core functions: promote evidence-based medicine, report cost and quality metrics, promote patient engagement, and coordinate care.

1. Establish and maintain an ongoing quality assurance and improvement program led by an appropriately qualified health care professional (describe scale and scope of program, including remedial processes for non-compliant ACO participants).

2. Promote evidence-based medicine (describe evidence-based guidelines the ACO intends to establish, implement, enforce, and periodically update; identify diagnoses with significant potential for the ACO to achieve quality improvements).

3. Promote patient engagement (identify measures for promoting patient engagement taking into account patients' unique needs and preferences, *e.g.*, decision support tools and shared decision-making methods).

4. Report on quality and cost measures (describe process to monitor internally, provide feedback, and take action based on such measures).

5. Promote care coordination across physicians and acute and post-acute providers (identify mechanisms to promote, improve, and assess integration and consistency of care, *e.g.,* information technology, transition of care programs, deployment of case managers in PCP offices, use of predictive modeling; describe individualized care program for high-risk and multiple chronic condition patients; and identify target populations for program expansion).

6. Drive patient-centeredness (use of patient satisfaction survey results to improve care; process for evaluating health needs of assigned population with consideration of diversity; system to identify high-risk patients and develop individualized care plans integrating community resources; policies on beneficiary access to services and medical records).

C. ACO Governing Body

1. With the exception of a single-entity ACO, an ACO must have a separate and unique governing body with responsibility for oversight and strategic direction through a transparent process.

2. ACO participants must hold 75 percent of voting rights on the governing body, and at least one member must be a Medicare fee-for-service beneficiary. However, these requirements may be waived for good cause.

3. Members owe a fiduciary duty to the ACO and must be subject to conflicts of interest policy requiring disclosure of financial interests.

D. ACO Management

1. The governing body must appoint a manager to have operational oversight.

2. An ACO must have a medical director who is a board-certified physician licensed and present in one of the states in which the ACO operates to provide clinical oversight.

3. An ACO must have a compliance officer responsible for maintaining a compliance program that incorporates the OIG's seven elements of an effective program.

4. An ACO must adhere to specific audit and record retention requirements.

E. ACO Participants

1. An ACO must include a sufficient number of primary care physicians ("PCPs")[1] to maintain 5,000 assigned Medicare beneficiaries (*see* Section II.C). An ACO may include any other Medicare-enrolled provider or supplier as a participant.

2. The ACO's application must list all participants including the tax identification number (TIN) under which each is participating. The ACO must notify CMS within 30 days of an addition or removal of any ACO participant during the term of the agreement.

3. The beneficiary assignment methodology is based on the TIN under which a provider submits Medicare claims (*see* Section II.C). A PCP cannot participate in multiple ACOs under the same TIN. (A PCP billing under multiple TINs could participate in multiple ACOs, each under a different TIN.) All other providers and suppliers may participate in multiple ACOs.

4. Each ACO participant must make a written three-year commitment to remain in the ACO. Written agreements or documents should describe ACO participants' rights and obligations in the ACO.

5. The IRS has issued guidance on the manner in which a tax-exempt organization may participate in an ACO without jeopardizing its tax-exempt status or having to pay unrelated business income tax on its shared savings distribution.

F. Fraud and Abuse Waivers

The Secretary has statutory authority to waive requirements of the Stark law, the federal anti-kickback statute, and the civil monetary penalties law as necessary to carry out the MSSP. Concurrent with the publication of the final rule, CMS and OIG promulgated five specific waivers. The following arrangements will not be subject to the fraud and abuse laws (provided all requirements listed in the waivers are satisfied):

1. ACO pre-participation waiver. Board-authorized and properly documented arrangements undertaken as part of a diligent effort to develop an ACO.

2. ACO participation waiver. Board-authorized and properly documented arrangements between ACO participants reasonably related to the purposes of the MSSP.

3. Shared savings distribution waiver. Distribution of shared savings among ACO participants and/or use of such monies to support ACO operations.

4. Compliance with Stark law waiver. An arrangement between ACO participants that meets an existing Stark law exception also is deemed to comply with the anti-kickback statute and the civil monetary penalties law.

5. Patient incentive waiver. Items or services offered to a beneficiary by an ACO or an ACO participant for free or below fair market value that are reasonable related to the beneficiary's medical care.

[1] Defined as physicians with specialty designations of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, physicians listed on an attestation submitted with the ACO's application.

G. Antitrust Analysis

Concurrent with the publication of the final rule, the FTC and DOJ published their statement of antitrust enforcement policy regarding MSSP ACOs.

1. Antitrust safety zone. If (a) none of an ACO's primary service area shares exceed 30 percent (as calculated in the manner specified in the statement and subject to certain exceptions), and (b) none of the ACO's hospitals or ASCs are exclusive to that ACO, the agencies will not challenge that ACO absent extraordinary circumstances.

2. Conduct to avoid. The agencies warn ACOs outside the safety zone from engaging in certain potentially anti-competitive conduct including improper exchanges of prices and other competitively sensitive information among ACO participants and pursuing certain arrangements with private payers.

3. Expedited voluntary antitrust review. A newly formed ACO desiring further antitrust guidance regarding its structure and operations may request a 90-day expedited review from the agencies prior to its entrance into the MSSP

H. Interactions with Medicare Fee-for-Service Beneficiaries

1. Every ACO participant must give each Medicare beneficiary to whom that ACO participant furnishes services (excluding those enrolled in a Medicare Advantage Plan) a standard written notice stating the ACO participant is part of an ACO, as well as a data use opt-out form (*see* Section II.C.3 below). Also, each ACO participant must post a similar notice at its facility.

2. Neither an ACO nor its participants may (a) impose restrictions on a beneficiary's right to seek services from non-ACO participants, or (b) attempt to avoid at-risk (high cost) beneficiaries.

3. Any marketing materials an ACO intends to use (and any revisions to those materials) must be submitted to CMS prior to any use. Such materials will be deemed approved following expiration of a 5-day review period.

PART II – SHARED SAVINGS PAYMENTS

An ACO participant will receive the same Part A and Part B fee-for-service payments as a provider who does not participate in an ACO. An ACO is eligible for an annual payment based on Medicare savings, *i.e.*, the difference between Medicare's projected total expenditures for the ACO's assigned beneficiaries (benchmark) and Medicare's actual total expenditures for those same beneficiaries.

Keep in mind the savings are not based exclusively on fee-for-service payments to ACO participants; they are based on fee-for-service payments to *all* providers, including those who are not ACO participants.

A. One-Sided vs. Two-Sided ACOs

In submitting its application, an ACO must state whether it wishes to participate initially as a one-sided or two-sided ACO.

1. A one-sided ACO is eligible for an annual shared savings payment, but does not pay any penalty if actual expenditures exceed the benchmark. An ACO may elect the one-sided model for its first three-year agreement period only.

2. A two-sided ACO pays a penalty based on a percentage of actual expenditures in excess of its benchmark. In exchange for accepting this risk, a two-sided ACO receives a higher percentage of the shared savings if actual expenditures are less than its benchmark.

B. Beneficiary Assignment

1. The first step in determining whether and how much of a shared savings payment an ACO will receive is the assignment of Medicare fee-for-service beneficiaries to the ACO. CMS notes "the term 'assignment' … in no way implies any limits, restrictions, or diminishment of the rights of [beneficiaries] to exercise complete freedom of choice in the [providers] from whom they receive their services." CMS "characterize[s] the process more as an 'alignment' of beneficiaries with an ACO" based on a beneficiary's utilization of primary care services.

2. CMS will use the following step-wise process for beneficiary assignment:

   (a) Assign to an ACO each beneficiary who received a primary care service[2] from one of the ACO's PCPs during the most recent 12 month period if the total allowed charges for primary care services furnished to that beneficiary by the ACO's PCPs during that time period are greater than the allowed charges for primary care services furnished by PCPs who are part of another ACO and not affiliated with any ACO.

   (b) Assign to an ACO each beneficiary who received primary care services from an ACO participant but has not had such services rendered by a PCP either inside or outside the ACO during the most recent 12-month period if the total allowed charges for primary care services furnished by all ACO professionals[3] during that time period is greater than the allowed charges for primary care services furnished by ACO professionals who are part of another ACO and not affiliated with any ACO.

3. Employing this step-wise process, CMS will make preliminary assignments at the beginning of a performance year for the ACO's planning purposes based on most recent available data. CMS then will update those assignments quarterly based on the most recent 12 months of data. Final assignment, which is used to calculate shared savings, will be based on actual data from the performance year.

4. Upon request, CMS will furnish the following information to an ACO: (a) aggregate claims data for those beneficiaries preliminarily assigned to the ACO; and (b) certain beneficiary identifiable claims data, but only if (i) the ACO has signed a data use agreement, and (ii) the beneficiary has not formally opted out of such data sharing.

C. Expenditure Benchmark

1. The ACO's contract with CMS will state the ACO's specific expenditure benchmark. The formula for arriving at this benchmark is complicated, and involves the following:

   (a) CMS will calculate a preliminary benchmark based on actual Part A and Part B expenditures (excluding IME and DSH payments) for beneficiaries who would have been assigned to the ACO for the prior three-year period.

   (b) The initial benchmark then will be trended forward to current year dollars and adjusted each performance year for overall growth and beneficiary characteristics. Also, technical adjustments will be made to eliminate the financial impact of current value-based purchasing initiatives.

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[2] Defined as HCPSC codes 99201-15; 99304-40; 99342-50; G0402; G0438 and 39; and revenue center codes 0521, 0522, 0524, and 0525 submitted by FQHCs (for services furnished prior to January 1, 2011) or by RHCs.

[3] Defined as a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

2. CMS will update an ACO's benchmark annually based on the projected absolute amount of growth in national per capita expenditures under Parts A and B.

D. Minimum Savings (Loss) Rate

An ACO must achieve a minimum savings rate (MSR) (a set percentage by which actual expenditures are less than the ACO's benchmark) to be eligible for shared savings payments.

1. For one-sided ACOs, the MSR ranges from 3.9 percent for ACOs with 5,000 assigned beneficiaries to 2.0 percent for ACOs with 60,000 or more beneficiaries.

2. For two-sided ACOs, a flat 2 percent MSR applies, regardless of the number of assigned beneficiaries. On the flip side, these ACOs will not share in a loss of less than 2 percent.

Both one-sided and two-sided ACOs receive first-dollar savings; CMS does not withhold the initial savings for itself.

E. Performance Standards (Quality Measures)

To be eligible for any shared savings payment for a given year, the ACO must meet minimum performance standards based on 33 specified quality measures. This prerequisite is intended to prevent ACO participants from achieving savings by withholding necessary services.

1. Seven of the 33 measures address patient/caregiver experience of care; 6 relate to care coordination/patient safety; 8 are categorized as preventive health; and 12 concern at-risk populations (diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease). Each measure has NQF endorsement or is currently used in other CMS quality programs.

2. For Year 1, an ACO that reports on all measures will receive the highest percentage of shared savings available to it (*see* Section F). For Year 2, the ACO's performance score (and thus its percentage of shared savings) will be based on a combination of reporting on some measures and the ACO's actual performance on others.

3. Thereafter, the ACO's actual performance on all 33 quality measures (expressed as a percentage of total points available) will determine the percentage of shared savings the ACO will receive. If the ACO's scores fall below a specified level, it will not receive any shared savings payment.

F. Savings (Loss) Sharing Rate and Savings (Loss) Cap

1. One-sided ACO

   (a) In its first year, a one-sided ACO will have a savings sharing rate of 50 percent (*i.e.*, it will receive 50 percent of the savings, with CMS retaining the rest) if it submits reports on all 33 quality measures, regardless of its scores on those measures.

   (b) In its second year, a one-sided ACO with a 100 percent performance score also will have a 50 percent savings sharing rate. ACOs with lower performance scores will have correspondingly lower savings sharing rates (*i.e.*, receive less than 50 percent of the savings).

   (c) A one-sided ACO's shared savings payment (actual dollars) cap is an amount equal to 10 percent of the ACO's expenditure benchmark (*i.e.*, if the benchmark is $10,000,000, the ACO's payment could not exceed $1,000,000).

2. Two-sided ACO

(a) A two-sided ACO with a 100 percent performance score will have a savings sharing rate of 60 percent (*i.e.*, it will receive 60 percent of the savings). During the first year, a two-sided ACO will receive a 100 percent performance score if it reports on all 33 measures, regardless of its scores. Again, ACOs with lower performance scores will have correspondingly lower savings sharing rates.

(b) A two-sided ACO's shared savings payment (actual dollars) is capped at an amount equal to 15 percent of the ACO's expenditure benchmark (i.e., if the benchmark is $10,000,000, the ACO's payment could not exceed $1,500,000).

(c) In the event of a loss (actual expenditures exceed benchmark by more than 2 percent), the ACO's loss sharing rate will equal 1 minus the ACO's savings sharing rate based on its percentage performance score. For example, if the ACO's performance score would have resulted in a 45 percent savings sharing rate, the ACO's loss sharing rate would be 55 percent. In that event, the ACO would owe CMS an amount equal to 55 percent of the amount by which the actual expenditures exceeded the benchmark.

(d) For two-sided ACOs, the shared loss cap (i.e., the upper limit on the ACO's liability to CMS for losses) would be phased in over a three-year period starting in the year the ACO first participates in the two-sided model: 5 percent of the benchmark in Year 1, 7.5 percent in Year 2, and 10 percent thereafter.[4]

G. Payments From and To CMS

1. CMS will notify an ACO in writing if it is entitled to a shared savings payment and, if so, the amount of that payment. Upon receipt, the ACO must distribute the funds using the pre-determined formula specified in its application.

2. For a two-sided ACO whose expenditures exceed the benchmark by more than 2 percent, CMS will make a written demand for repayment. The ACO must make payment in full within 30 days, and submit a certification of compliance and accuracy of information.

3. As part of its application, an ACO that elects the two-sided model must identify an acceptable method for repaying losses equal to at least 1 percent of per capita expenditures from the most recent year of data. Such methods may include recouping funds from Medicare payments to ACO participants, reinsurance, placing funds in escrow, obtaining surety bonds, or establishing a line of credit or other repayment mechanism.

4. There is no right of appeal with respect to CMS' determinations relating to the amount of shared savings or losses.

[4] See Appendix D, *Examples of Shared Savings/Loss Calculations.*

PART III – OTHER ACO OPTIONS

A. Advance Payment Model

On the same day the final rule was published, the CMS Innovation Center announced its sponsorship of the Advance Payment Model. The Innovation Center will partner with up to 50 ACOs participating in the MSSP to receive advance payments to cover up-front costs associated with forming an ACO. To be eligible, an ACO must (a) not include any inpatient facility and have less than $50 million in total annual revenue; or (b) include only inpatient facilities that are critical access hospitals or low-volume rural hospitals and have less than $80 million in total annual revenue.

An APM ACO will receive (a) an up-front payment of $250,000; (b) an up-front variable payment equal to the number of assigned beneficiaries multiplied by $36.00; and (c) a monthly payment equal to the number of assigned beneficiaries multiplied by $8.00. For example, "[a]n ACO with 5,000 assigned beneficiaries that begins participation in July 2012 would receive an up-front payment of $430,000 and $960,000 in monthly payments…over 24 months."

If the ACO does not generate sufficient savings by the time of final settlement in June 2014 to fully repay the advance payments, CMS will recoup the amount owing from the ACO's future shared savings payments. If the ACO elects not to continue in the program following expiration of its initial agreement period, CMS will not pursue recoupment against the ACO or its participants.

To apply, an ACO must be approved to participate in the MSSP beginning in April or July 2012. The ACO also must submit a spend plan demonstrating how it will apply the advance payments.

B. ACO Pioneer Model

On May 17, 2011, the CMS Innovation Center announced the ACO Pioneer Model. Letters of Intent were due June 30, 2011, with applications postmarked by August 19, 2011. Designed for the organizations with substantial experience in delivering care across settings for a defined population of patients as well as managing financial risk, the Pioneer Model seeks to test advance payment models that "include escalating levels of financial accountability through successive performance periods."

C. Private Insurance

Private insurers are developing products similar to the MSSP, such as the Blue Cross Blue Shield of Massachusetts Alternative quality Program. Several products incorporate partial capitation, virtual partial capitation, condition-specific capitation, and medical home payments. Most involve prospective assignment of beneficiaries, thus creating an incentive to manage those specific patients more aggressively, as opposed to the MSSP, which gives ACO participates the incentive to improve overall quality and efficiency in providing services to their entire patient population.

It is the mission of Spencer Healthcare Strategists to be the trusted advisors to leaders seeking practical solutions in transforming their health care delivery systems in this era of change.

SHS provides value-based consulting, education, and advocacy services in a cost-effective, quality-oriented, and timely manner to guide providers who are committed to building the strategic alliances or partnerships necessary to improve health care quality and efficiency.

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APPENDIX A

EXAMPLE OF SHARED SAVINGS/LOSS CALCULATIONS

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ONE-SIDED ACO	
Number of Beneficiaries	5,000
Adjusted Per Capita Benchmark	$9,000
Aggregate Benchmark	$45,000,000
Actual FFS Expenditures	(42,750,000)
Total Savings (5 percent)	***$2,250,000***
Minimum Savings Rate @ 5,000 Benef. (3.9%)	$1,657,500 (exceeded)
Savings Sharing Rate (*Assume 100% Performance Score*)	50%
ACO Share of Savings	***$1,125,000***

TWO-SIDED ACO (SAVINGS)	
Number of Beneficiaries	5,000
Adjusted Per Capita Benchmark	$9,000
Aggregate Benchmark	$45,000,000
Actual FFS Expenditures	(42,750,000)
Total Savings (5 percent)	***$2,250,000***
Minimum Savings Rate (Flat 2%)	$900,000 (exceeded)
Savings Sharing Rate (*Assume 100% Performance Score)*	60%
ACO Share of Savings	***$1,350,000***

TWO-SIDED ACO (LOSS)	
Number of Beneficiaries Attributed to ACO	5,000
Adjusted Per Capita Benchmark	$9,000
Aggregate Benchmark	$45,000,000
Actual FFS Expenditures	(47,250,000)
Total Loss (5 percent)	***$2,250,000***
Minimum Loss Rate (Flat 2%)	$900,000 (exceeded)
Loss Sharing Rate (*Assume 100% Performance Score)*	40%
Refund Owed to CMS by ACO	***$900,000***