

Considering the Medicare ACO Demonstration Project

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On March 31, 2011, CM released the long awaited rule defining the ACO Demonstration Project. In the rule, CMS clearly stated the goal of promoting the “Three-Part Aim” of better care for individuals, better health for populations and lower growth in expenditures for Medicare. The lengthy proposed rule spelled out all aspects of participation and shared savings opportunity. It also presented administrative and operational requirements that were perhaps greater than expected by most, particularly around quality measurements and reporting and expected cost of complying with ACO start up and operation. Throughout, CMS is seeking comment on numerous provisions of the rule, to determine whether proposed guidance is too prescriptive or creates disincentive for smaller entities to participate.

Requirements to be an ACO

- Eligible organizations are groups of physicians in group practices or networks, with or without a hospital partner.
- 3 year agreements, with first agreements beginning January 1, 2012, and additional participants beginning January 1 of subsequent calendar years
- The ACO must be a legal entity with a TIN, and its governing body must include at least 1 Medicare beneficiary and at least 75% control by ACO providers
- Specific requirements for management team including an Executive Officer, full-time board-certified Medical Director and a Compliance Officer
- Will have to submit an application showing governance, leadership, how the ACO will meet requirements and achieve savings, and how it will distribute savings payments to participants
- 50% of PCPs in the ACO must meet Meaningful Use criteria by end of Year 1 for the ACO to be eligible for shared savings

Risk and Shared Savings

- Offering both a one-side savings only option and a 2-side (up and down risk) option.
- Greater shared savings amount for 2-side option; 60% of savings vs 50% for 1-side
- Even those ACOs that initially apply for upside only will be accountable for both savings or losses in year 3 – can’t remain as an upside shared savings model only
- Meet all minimum quality performance standards
- Achieve spending less than benchmark, and savings greater than minimum savings requirement

Beneficiary Assignment

- Beneficiaries assigned based on plurality of primary care services with a PCP in an ACO; (based on allowed charges, not simple count of services)
- Since assignment is based on primary care services, PCPs can only participate with 1 ACO
- Beneficiaries will be assigned retrospectively for calculating savings but CMS will provide names of beneficiaries used to set the baseline at the beginning of year 1
- Beneficiaries may opt out of ACO assignment. Providers participating in the ACO are required to notify Medicare patients at the time they seek care. Beneficiaries may also prohibit sharing of their personal health data within the ACO.

Quality Measures and Reporting

- The rule defines 65 quality measures across 5 domains. The quality measures are mix of claims based, PQRS-type measures to be reported using a CMS-provided registry, and survey based measures
- To be eligible for shared savings, the ACO must successfully report on all measures in Year 1, and meet threshold levels in Years 2 and 3.
- An organization that does not meet quality threshold (or does not report satisfactorily) cannot earn shared savings, no matter how much costs are reduced.
- Some of the measures require data not available from claims datasets, requiring an electronic health record or manual chart review

Antitrust and other legal guidance

- Antitrust “safety zone” for organizations with no more than 30% share of services in their service area, with some exceptions allowed for rural areas and for individual providers within the ACO with a more dominant position
- Mandatory review for ACOs with greater than 50% share; those organizations will have to apply to the antitrust agencies and provide detailed information about competition and calculation of service share. The agencies will provide an expedited review within 90 days
- ACOs with 30%-50% shares do not have to seek a review but may do so

Since the release of the proposed rule, response from the provider community has been less than enthusiastic. Criticism has come for the complexity of the quality measurement formula, for the attribution method, and for some of the governance and organizational requirements. The shared savings model itself has been criticized both by those that complain no upside only model is available as well as those who say the risk/reward opportunity isn't great enough. High profile provider organizations including Geisinger, Mayo Clinic, Intermountain Health and Advocate Health Care have expressed support for the concept of ACOs, but said they are unlikely to participate as the rule stands now.



In response to these comments, Department of Health and Human services Secretary Kathleen Sibelius has publicly reiterated that CMS will take comments very seriously and that the proposed rule will incorporate the feedback received.

Additionally, on May 17, the CMS Center for Innovation announced three program opportunities aimed at bringing in more groups to participate in the Shared Savings program

- **Pioneer ACO Program** – a “fast-track” opportunity for some 30 health systems that already provide a high level of coordinated care; these groups would be able to begin the Shared Savings program by September or October of 2011 and will have opportunity for higher percentage of savings and/or consideration of alternative payment arrangements
- **Accelerated Payments** –potential for some organizations to receive some upfront payments to help fund development of the program in the start up phase.
- **Accelerated Development Learning Sessions**—a series of free sessions to assist organizations with knowledge and expertise to set up their ACO programs, emphasizing improved care delivery, reducing costs, and using health information technology and data

The comment period for the ACO proposed rule closed June 6. The ACO program is a key element of the Obama Administration’s plan for health care reform and no one should expect it to fade away in the face of concerns expressed thus far. We should expect to see changes in the final rule as well as further efforts from CMS to entice provider organizations to enter into the program.