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Understanding the Medicare ACO and Its Potential Impact on Ohio and the Nation: Considerations of CMS Draft Rules

Introduction

The Patient Protection and Affordable Care Act (ACA) requires that the Secretary of the Department of Health & Human Services (HHS) establish a Medicare Shared Savings Program (MSSP) by January 1, 2012. The MSSP encourages physicians, hospitals, and certain other types of providers and suppliers to form accountable care organizations (ACOs).

Under the ACA, HHS is authorized to determine the details of the MSSP through rulemaking. On April 7, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a notice in the Federal Register for public comment on a Proposed Rule detailing the Medicare Shared Savings Program (MSSP).² The proposed rule addresses policy and operational issues associated with the formation of an ACO. Public comment on the Proposed Rule is due by **June 6, 2011**.

What is an Accountable Care Organization (ACO)?

Generally speaking, an accountable care organization is an integrated network of providers that are collectively held accountable for delivering coordinated, high-quality, cost-effective care to a group of patients. While the operational details may vary across ACOs, all of them share a system of health care delivery that ties provider reimbursements to quality metrics and reductions in the total cost of care to a set of patients.

What is the Medicare Shared Savings Program (MSSP)?

Established under federal health reform law, the Medicare Shared Savings Program (MSSP) provides financial incentives for health care providers to form ACOs to manage and coordinate the care of Medicare fee-for-service beneficiaries. An ACO that meets certain operational and clinical requirements may share in savings achieved in Medicare expenditures for assigned beneficiaries. CMS estimates that up to 5 million Medicare beneficiaries will benefit from the MSSP.

Who Can Form a Medicare ACO?

Medicare ACOs may be formed by professionals in practice group arrangements, networks of individual practices, multi-specialty group practices, independent practice associations, partnerships or joint ventures between hospitals and providers, and also integrated hospital systems. While Federal Qualified Health Centers, Rural Health Center, and certain Critical Access Hospitals may not form their own ACOs, the rules offer incentives for ACOs to include these entities as participants.

To participate in the MSSP, an ACO must commit to a three-year agreement in which the ACO participants agree to be accountable for the care of beneficiaries assigned to it. An ACO must have at least 5,000 assigned beneficiaries, and enough primary care providers to serve that population.

How is the Medicare Shared Savings Program relevant to Ohio policymakers?

Although Medicare, unlike Medicaid, is a federally funded program, 1.3 million Ohioans receive coverage through Medicare and may benefit from the Shared Savings Program. In addition, throughout its history, Medicare has been a forerunner for new health care reimbursement strategies. Typically, when Medicare adopts a change to its payment policies, private health plans and state Medicaid programs follow. Federal authorities have also given guidance that ACOs formed under the Shared Savings Program will be in compliance with federal anti-trust, self-referral and anti-kickback laws even if they also serve Medicaid and commercially insured patients. This would suggest that the outcomes-based pay and shared savings mechanisms that are part of the proposed Medicare Shared Savings Program could be adopted by other insurers as well.

In addition, some experts believe that ACOs have the potential to improve quality of care while controlling costs and improving population health. The system reform concepts in the Shared Savings Program may provide Ohio policymakers with valuable insight into quality-improvement and cost-containment strategies that have the potential to improve the health of Ohioans.

Key questions, concerns and considerations about the MSSP

Issue	ACO Proposed Regulations
Open provider network/ preservation of patient choice	Medicare beneficiaries will be able to seek care from any provider, even if the provider is outside of their assigned ACO
Quality measures/ reporting requirements	<ul style="list-style-type: none">• Measures quality of care using 65 nationally-recognized measures in five domains: care coordination, patient safety, preventive health, patient experience and care of at-risk and frail elderly populations• Outlines a monitoring and reporting plan that includes analyzing claims and specific financial and quality data, producing quarterly and annual aggregated reports, performing site visits, and conducting beneficiary surveys
Shared Savings methodology	<ul style="list-style-type: none">• If an ACO chooses "Track 1" (one sided approach), it will share in savings for the first two years, but not in losses. If an ACO chooses "Track 2" (two sided approach), it will share in both savings and losses at the outset. In year 3, all ACOS share in both cost and savings.• The amount an ACO can receive in savings depends on the amount of the savings, the track chosen, performance on quality reporting standards, and whether the ACO has expanded into rural areas or included FQHCs and RHCs as participants
Retroactive assignment of beneficiaries/ primary care	<ul style="list-style-type: none">• Beneficiaries are assigned to an ACO retrospectively based on utilization of primary care services - by only primary care physicians - during the previous year.• The ACO must include sufficient numbers of primary care providers to serve the assigned beneficiaries.
Timeline and uncertainty	The public comment period closes on June 6, 2011; ACO operations are to begin January 1, 2012
Start-up costs and operational requirements	<ul style="list-style-type: none">• CMS assumes ACO start up costs equal to the average start-up costs of the Medicare Physician Group Practice (PGP) demonstration of \$1.76 million.• Requires that 50% of ACO primary care providers in year 2 be meaningful electronic health record users.• Imposes a significant financial surety requirement on ACOs formed by primary care physicians• Requires that CMS withhold 25% of each year's saving share until the end of the contract period (less any losses) to ensure ACOs participate for the full three years

Considerations

- May limit an ACO's ability to control the cost and quality of care delivered to their assigned beneficiaries
 - May increase risk to an ACO because it is still financially and statistically responsible for the care and outcomes of an assigned beneficiary that receives care elsewhere
 - Recognizes and preserves the patient's right to choose his or her own provider already allowed under fee-for-service
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- Such reporting requirements may pose a significant administrative burden and cost to ACOs.
 - Only 11 of the 65 quality measures can be met using claims data. The others require the resource-intensive process of culling data from medical records and /or surveys. Would it be better to focus instead on quality improvement in a limited number of high impact areas?
 - Will focusing on so many measures detract and/or prohibit targeted clinical improvement efforts?
 - Performance-based payment model holds providers accountable for care quality and patient outcomes
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- Track 2's added risk may outweigh potential benefits. Since the percentage that determines downside losses exceeds the percentage that determines upside gains, there may not be an adequate level of shared savings to incentivize ACOs to transform their care practices.
 - Track 1's intent was to offer newly formed ACOs time to learn from the first 2 years before shared losses would begin. Realistically, given the time it would take for CMS to collect and analyze first year claims and performance data, the feedback would not even be available before the start of year 3; thus, the ACO would have to assume the risk before it had any idea of how it performed and how to address deficiencies.
 - Track 2 may favor ACOs operating in low-cost or high growth rate regions because CMS will use (higher) national growth rates to set budget targets; inflated budget targets lessen the risk of losing money.
 - ACOs will individually have to decide how to distribute shared savings across participating providers. The proposed regulations offer no guidance on this issue.
 - Encourages providers to render services that increase efficiency of care and improve patient health rather than on services for which they are routinely paid under the fee for service model.
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- Designing explicit performance targets is difficult for an ACO if it does not know in advance who its assigned patients are.
 - Since an ACO will not know which beneficiaries are assigned to it until the year has ended, the ACO has an incentive to implement care coordination strategies for all beneficiaries, not just for those on whom it will be evaluated.
 - Non-primary care physicians, mainly specialists, provide 60% of all primary care services to Medicare beneficiaries, many of whom have multiple chronic conditions. To exclude their services from the assignment decision underestimates the level of primary care services needed by the ACO's pool of beneficiaries.
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- The timeline for implementation is very aggressive for such a complex process of change that will require a fundamental change in provider culture.
 - The ability to measure financial and quality performance is constrained by the time it takes to collect and analyze claims and other data (6 months after the close of the year to collect claims, plus time for analysis.) If results in year 1 are not known until year 3, an ACO faces substantial operational uncertainty and risk that may be a deterrent to participation in the shared savings program.
 - The potential for significant cost savings and improved health quality and outcomes makes ACO implementation a matter of urgency.
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- Eight of the ten PGP sites already had electronic health records in place. Start-up costs for ACOs lacking EHRs would be significantly higher and, in some cases, prohibitive.
 - The EHR requirement may also disqualify a lot of potential ACOs.
 - The ACO must fund initial operating expenses for a year before any savings are received. The 25% savings withhold may further hamper cash flow and reduce savings distribution payments to providers.
 - Newly created physician ACOs are not likely to have sizeable capital reserves or access to letters of credit necessary to meet the financial surety requirements.

What Are the Program Requirements for Medicare ACOs?

Solid corporate governance, a commitment to efficient care and outcomes, and a strong technology infrastructure are the hallmarks of the MSSP. To participate in the MSSP, an ACO must promote evidence-based medicine, support beneficiary engagement, report internally on quality and cost metrics, and coordinate care. An ACO must also meet threshold requirements for 65 quality performance standards covering five domains: (1) Patient/Caregiver Experience, (2) Care Coordination, (2) Patient Safety; (4) Preventive Health and (5) At Risk Population/Frail Elderly Health. Savings will be awarded based on how well the ACO scores on these standards.

How Can An ACO Share in Medicare Savings?

ACO participants are paid for services provided to beneficiaries on a fee-for-service basis just like any other Medicare provider. However, if an ACO meets the MSSP requirements, it can receive additional payments for savings achieved in Medicare expenditures for beneficiaries assigned to it. The ACO then distributes these additional savings to its ACO provider participants.

The amount an ACO can receive in shared savings depends on a number of factors including the amount of the savings, how well the ACO has performed on the quality reporting standards, whether the ACO has expanded into rural areas or included FQHCs and RHCs as participants, and whether the ACO is Track 1 or Track 2. If an ACO chooses "Track 1", known as the "one sided approach", it will share in savings for the first two years, but not in losses. If an ACO chooses "Track 2", known as the "two sided approach", it will share in both savings and losses at the outset. In short, ACOs that save more, choose to share in losses, do better on the quality standards, expand into rural areas, and include FQHCs and RHCs as participants will receive more in savings.

How Do the Shared Saving Program Rules Relate to Medicaid?

Because Medicare is the largest single payer of health services nationally (accounting for approximately 23% of all spending on personal health care), changes in how Medicare pays for services are often followed by other payers, including Medicaid. In fact, the Affordable Care Act established the Pediatric Accountable Care Demonstration Project to allow pediatric medical providers to form ACOs and receive incentive payments from Medicaid in the same manner as provided for under the Medicare Shared Savings Program.⁵⁵ Although the pediatric ACO demonstration project had been scheduled to begin on January 1, 2012 and end on December 31, 2016, the project was not funded in the current federal budget. However, according to Barbara Edwards, director of the Disabled and Elderly Health Programs Group at CMS, "...we [CMS] are currently working with children's hospitals (individually and at national association level) to explore how other... Medicaid authorities might accommodate care integration models for children ([for example], health homes, global budgets, other payment reforms)."

Sources for key questions table

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