

Medicare Shared Savings Program

Shared Savings Program

<http://www.cms.gov/savingsprogram/>

Centers for Medicare & Medicaid Services

February 2012



Medicare Shared Savings Program (Shared Savings Program) Background

- Mandated by Section 3022 of the Affordable Care Act
- Establishes a Shared Savings Program using Accountable Care Organizations (ACOs)
- Must be established by January 1, 2012
- Notice of proposed rulemaking issued March 31st 2011
- CMS sought and received over 1,300 comments on the proposal.
- Issued Final Rule in October 2011.



Congressional Concept



- ACOs grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality
- MedPAC featured the concept in its June 2009 Report to Congress
- During the development of this health care reform provision, Congress drew from these expert sources as well as from the Physician Group Practice (PGP) Demonstration project at CMS

Medicare Shared Savings Program Goals

- The Shared Savings Program is a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures by:
 - Promoting accountability for the care of Medicare fee-for-service beneficiaries
 - Improving coordination of care for services provided under Medicare Parts A and B
 - Encouraging investment in infrastructure and redesigned care processes



Medicare Shared Savings Program Vision

ACOs will promote the delivery of seamless, coordinated care that promotes better care, better health and lower growth in expenditures by:

- Putting the beneficiary and family at the center
- Remembering patients over time and place
- Attending carefully to care transitions
- Managing resources carefully and respectfully
- Proactively managing the beneficiary's care
- Evaluating data to improve care and patient outcomes
- Using innovation focused on the three-part aim
- Investing in care teams and their workforce

Medicare Shared Savings Program Definitions

Accountable Care Organizations:

Legal entity that is recognized and authorized under applicable State, Federal or Tribal law, identified by a Taxpayer Identification Number (TIN), and comprised of groups of eligible providers and suppliers (as defined at §425.102) that, according to statute, “work together to manage and coordinate care for Medicare fee-for-service beneficiaries.”

ACO Participants:

Individuals or groups of Medicare-enrolled providers (as defined in §400.202) or suppliers (as defined at §400.202), identified by a TIN.

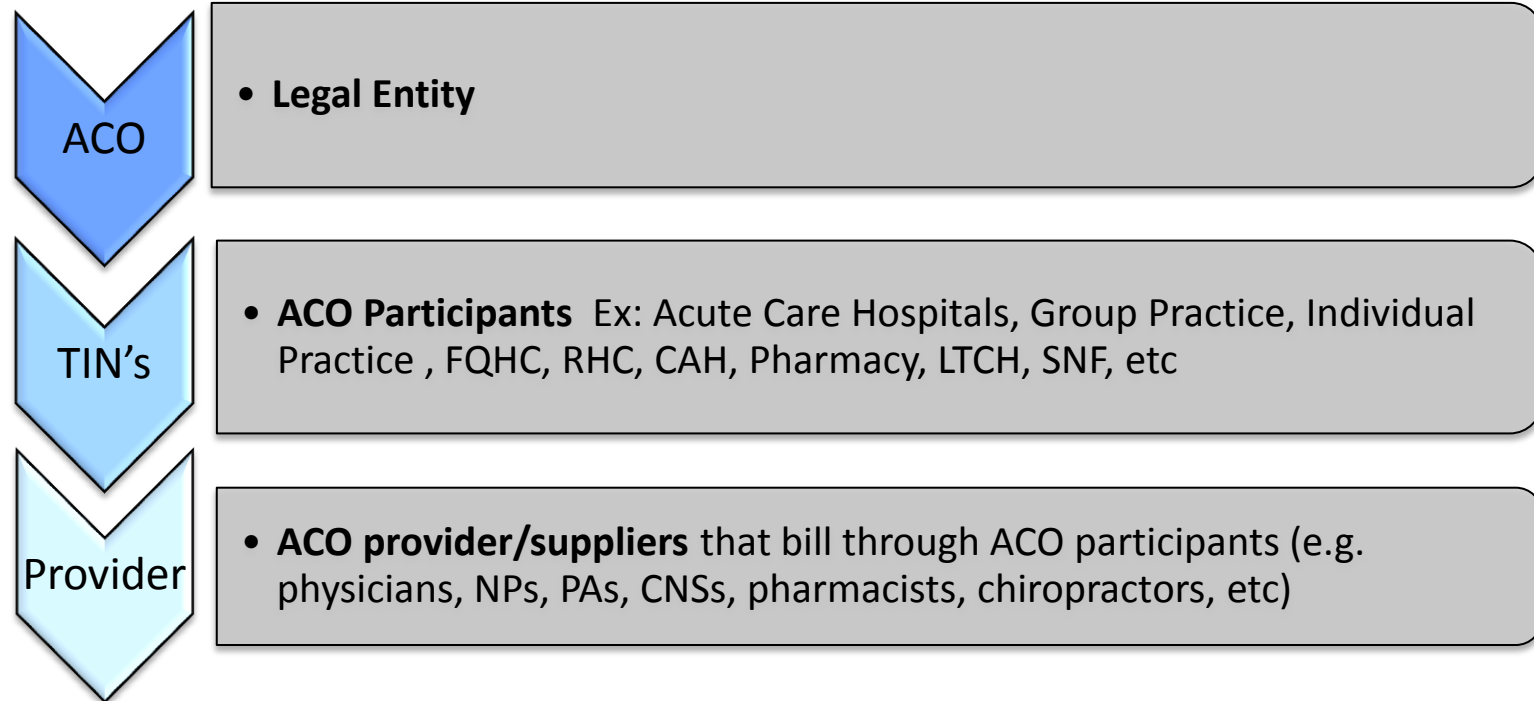
ACO Provider/Supplier:

- (1) A provider or supplier enrolled in Medicare,
- (2) Bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations.

What entities could form an ACO?

- Existing or newly formed organizations may form an ACO:
 - ACO professionals in group practice arrangements
 - Networks of individual practices of ACO professionals
 - Joint ventures/partnerships of hospitals and ACO professionals
 - Hospitals employing ACO professionals
 - Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
 - Critical Access Hospitals (CAHs) that bill under method II
- Secretarial discretion for other providers and suppliers of services
 - Other Medicare-enrolled entities may join the groups above as ACO participants.

Shared Savings Program ACO Structure



Statutory Eligibility Requirements

- 1) Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it
- 2) Agree to participate in the program for at least a 3-year period
- 3) Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
- 4) Have a formal legal structure to receive and distribute payments
- 5) Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
- 6) The ACO shall provide information regarding the ACO professionals as the Secretary determines necessary
- 7) Define processes to (a) promote evidenced-based medicine (b) promote patient engagement, (c) report quality and cost measures and (d) coordinate care
- 8) Demonstrate it meets patient-centeredness criteria

Eligibility Requirement: Patient Centeredness

1. Beneficiary experience of care survey in place and results used to improve care over time
2. Patient involvement in ACO governance
3. A process for evaluating the health needs of the population, including consideration of diversity and a plan to address them
4. Individualized care plans used to promote improved outcomes for high risk and multiple chronic condition patients and any other target patient populations
5. Mechanisms in place for coordinating care throughout an episode of care and during its transitions.

Eligibility Requirements: Patient Centeredness Continued

6. Communicate clinical knowledge/evidence based medicine to beneficiaries in a way that is understandable to them.
7. Written standards for beneficiary access and communication and a process in place for beneficiaries to access their medical record.
8. An infrastructure for internally reporting on cost and quality that enables the ACO to monitor, provide feedback and evaluate, and improve care/service over time.

Medicare Shared Savings Program Agreements— Initial Two Track Approach

- ACOs may choose to participate in one of two tracks:
 - First agreement period of one-sided shared savings OR
 - First agreement period of two-sided shared savings/losses
- Track 1 Provides on-ramp for organizations to gain population management experience before transitioning to risk arrangements
- All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided model.

Patient Population



- ACO accepts responsibility for an “assigned” patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Assignment will not affect beneficiaries’ guaranteed benefits or choice of doctor or any other provider
- A preliminary prospective assignment methodology with a retrospective reconciliation

Patient Population

- Identify all beneficiaries who have had at least one primary care service rendered by a physician in the ACO.
- Followed by a two step assignment process
 - First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
 - Second, for beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any ACO professional



Data Sharing

- Aggregate data reports provided at the start of the agreement period, quarterly aggregate data reports thereafter and in conjunction with year end performance reports.
- Aggregate data reports will contain a list of the beneficiaries used to generate the report.
- Beneficiary identifiable claims data provided for beneficiaries on the preliminary prospective assignment list or who have received primary care services from an ACO provider/supplier.
- Beneficiaries must be notified and given the opportunity to decline to have data shared.

Quality Measurement & Performance

- Quality measures are separated into the following four key domains that will serve as the basis for assessing, benchmarking, rewarding and improving ACO quality performance:
 - Better Care
 1. Patient/Caregiver Experience
 2. Care Coordination/Patient Safety
 - Better Health
 3. Preventative Health
 4. At-Risk Population



Quality Measurement & Performance Continued

ACO Quality Performance Standard made up of 33 measures intended to do the following:

- Improve individual health and the health of populations
- Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement and care coordination
- Support the Shared Savings Program goals of better care, better health and lower growth in expenditures
- Align with other incentive programs like PQRS and EHR
- Exhibit sensitivity to administrative burden

Quality Data Reporting

- Quality data collected three ways:
 - Claims and other internal data
 - ACO-GPRO tool
 - Survey
- Complete and accurate reporting in the first year qualifies the ACO to share in the maximum available quality sharing rate
- Pay for reporting is phased in for the remaining performance years
- Shared savings payments are linked to quality performance based on a sliding scale that rewards attainment
 - High performing ACOs receive a higher sharing rate



Incorporation of Other Data Reporting Requirements

Satisfactorily reporting on GPRO quality measures through the Shared Savings Program qualifies each eligible professional within the ACO for the PQRS payment adjustment.



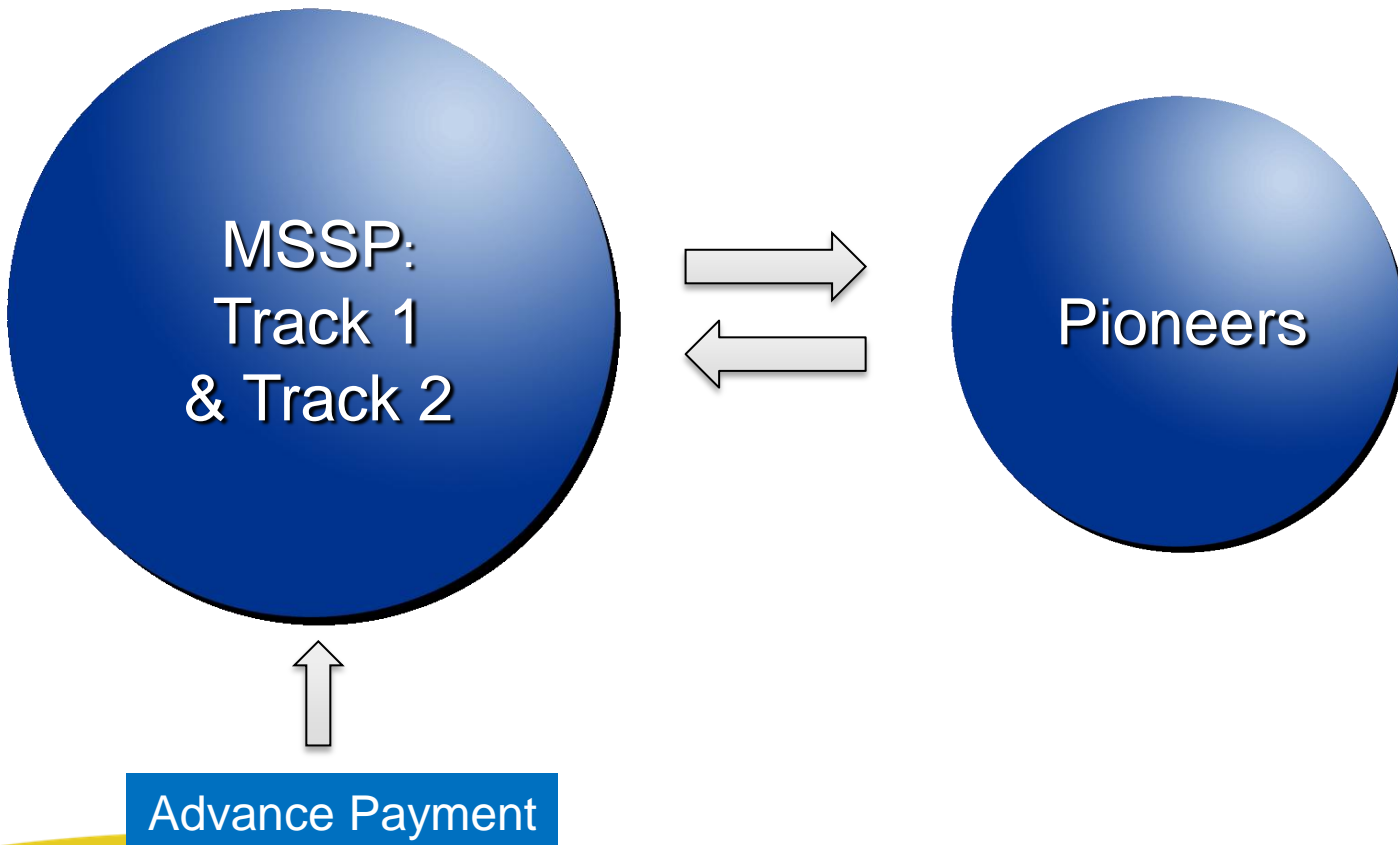
Financial Performance

- ACOs demonstrate savings if actual assigned patient population expenditures are below the established benchmark AND the performance year expenditures meet or exceed the minimum savings rate (MSR).
- The MSR takes into account normal variations in expenditures.
- Under the one-sided model, the MSR varies based on the size of the ACO's population.
- Under the two-sided model, the MSR is 2% of the benchmark for all ACOs.

One-Sided and Two-Sided Risk Models

- One-sided risk model has a maximum share of savings of 50% for quality performance with a cap on shared savings
 - Cap on shared savings (10% of benchmark)
- Two-sided risk model has a maximum share of savings of 60% for quality performance with a cap on shared savings
 - Higher cap on shared savings (15% of benchmark)
 - Shared loss calculation is 1 minus final sharing rate as a function of quality performance (not to exceed 60%)
- All ACOs share in first dollar saved once they meet or exceed MSR

CMS's ACO Strategy: Creating Multiple Pathways with Constant Learning and Improving



Innovation Center Initiatives

- Pioneer ACO Model
- Advance Payment ACO's
- Accelerated Development Learning Sessions

Questions?

For more information:

www.cms.gov/sharedsavingsprogram/

aco@cms.hhs.gov

410-786-8084