The Way of the ACO

Understanding and Forming a Medicare Shared Savings Program

By Craig B. Garner

Table of Contents (from the complete presentation*)

*The following information is a sample from the complete presentation.

Introduction

What is an Accountable Care Organization (ACO)?

- An ACO is a shared savings program that **promotes** accountability for a patient population, **coordinates** items and services under Medicare parts A and B, and **encourages** investment in infrastructure and redesigned care processes for high quality and efficient services.

- An ACO is a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN) [Apply for an EIN online at www.irs.gov], and is formed by one or more ACO participants that are defined at § 425.102(a)*. This may also include any other ACO participants described at § 425.102(b).

*Unless stated otherwise, all statutory references can be found in Title 42 of the Code of Federal Regulations.

From Where did ACOs Come?

- An early proponent of ACOs was the Medicare Payment Advisory Commission or MedPAC, established by the Balanced Budget Act of 1997 (P.L. 105-33). MedPAC's role is to advise Congress on all matters pertaining to Medicare, from issues involving payments to private health plans participating in the Medicare program to the assessment of, access to, and quality of Medicare treatment.

- By aligning health care providers that focus on improvement, efficiency, and experience within a particular patient demographic, ACOs connect reimbursement with quality, outcomes, and resource utilization. This is a significant departure from the traditional fee-for-service model that for years has been the standard in American health care.

- According to Donald M. Berwick, M.D., former CMS Administrator: "An ACO will be rewarded for providing better care and investing in the health and lives of patients. ACOs are not just a new way to pay for care, but a new model for the organization and delivery of care."

Who can be an ACO Participant?

- An individual or group of ACO providers/suppliers identified by a Medicare-enrolled TIN, that alone or together with one or more other ACO participants comprise an ACO, the information for which must be included on the list of ACO participants as required in the application process.

Who can be an ACO Professional?

An ACO provider/supplier who is either:

- (1) a physician licensed to practice medicine (in California)
- (2) a practitioner who is one of the following:
  - physician assistant
  - nurse practitioner
  - clinical nurse specialist

Who can be an ACO Provider/Supplier?

A provider or a supplier that:

- Is Enrolled in Medicare;
- 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 the applicable Medicare regulations; and
- Is included on the list of ACO providers/suppliers that is required in the application.

Eligibility

Eligibility Requirements

ACO participants may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO that meets the specified criteria. The ACO must become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.

ACOs that meet or exceed a **minimum savings rate** established under the program, meet the **minimum quality performance standards** established under the program, and otherwise **maintain their eligibility** to participate in the Shared Savings Program are eligible to receive payments for shared savings.

ACOs that operate under the two-sided model and meet or exceed a minimum loss rate must share losses with the Medicare program.

General Criteria

Number of Professionals and Beneficiaries

The ACO must include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO. The ACO must have at least 5,000 assigned beneficiaries.

CMS deems an ACO to have initially satisfied the requirement to have at least 5,000 assigned beneficiaries if the number of beneficiaries historically assigned to the ACO participants in each of the three years before the start of the agreement period is 5,000 or more.

The ACO Application

Agreement With CMS

- ACOs must enter into a participation agreement with CMS for a period not less than three years.
- **2012** Term Start Dates:

  April 1, 2012 (term of the agreement is 3 years, 9 months)

  July 1, 2012 (term of the agreement is 3 years, 6 months)

Agreement With CMS, continued

- **2013** and all subsequent years: The start date is January 1 of that year, and the term of the agreement is 3 years.

- **Performance year**: Except for the 2012 term period, the ACO's performance year is the 12 month period starting January 1 of each year (unless otherwise noted in the agreement). For the 2012 term, ACOs with a start date of **April 1, 2012**, have a performance year defined as **21 months**, and ACOs with a start date of **July 1, 2012,** have a performance year defined as **18 months**.

- **ACOs must always submit measures in the form and manner required by CMS**.

Application Deadlines

Prospective ACOs must submit an application in the form and manner required by CMS by the appropriate **deadlines**:

Item	Deadline for April 1, 2012 Start	Deadline for July 1, 2012 Start
Notice of Intent (NOI) Must Be Submitted to CMS	**November 1, 2011 to January 6, 2012**	**November 1, 2011 to February 17, 2012**
CMS User ID Forms Accepted	**November 9, 2011 to January 12, 2012**	**November 9, 2011 to February 23, 2012**
2012 Applications Accepted	**December 1, 2011 to January 20, 2012**	**March 1–30, 2012**
2012 Application Approval or Denial Decision	**March 16, 2012**	**May 31, 2012**
Reconsideration Review Deadline	**March 23, 2012**	**June 15, 2012**

Calculation of Primary Service Area Shares

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares*

Assumption: Two independent physician practices, two independent hospitals, and an ambulatory surgery center (ASC) propose to form an ACO. For purposes of this example, further assume that the hospitals do not directly employ physicians. If they do, then services provided by the hospitals' employed physicians would need to be taken into account in determining the PSA and calculating the ACO's shares for each common physician service where at least two participants provide that service to patients from the same PSA.

*Original Source (76 Federal Register 67026 (Oct. 28, 2011))

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares*

For the Physician Group -- Step One:

Identify the physician groups' common Medicare Specialty Codes (MSCs). In this example, Physician Group A (''PG A'') has physicians with general surgery (MSC 02) and orthopedic surgery specialties (MSC 20). Physician Group B (''PG B'') has physicians with orthopedic surgery (MSC 20) and cardiology (MSC 06) specialties. The only common service is orthopedic surgery, not general surgery or cardiology, because PG A does not have cardiologists and PG B does not have general surgeons.

For the Physician Group -- Step Two:

Identify the zip codes that make up the PSA for each physician group. In this example, there will be two PSAs: one for PG A (''PSA A'') and one for PG B (''PSA B'').

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares

For the Physician Group -- Step Three:

Determine the ACO's share in each of the PSAs. In this example, both PG A's and PG B's orthopedic surgeons serve patients to be calculated in PSA A and PSA B. The ACO's share of orthopedic surgery in PSA A would be the total Medicare allowed charges for claims billed by the ACO's orthopedic surgeons (which are PG A's and PG B's total allowed charges for claims billed by orthopedic surgeons for Medicare beneficiaries in PSA A's zip codes) divided by the total allowed charges for orthopedic surgery for all Medicare beneficiaries in PSA A. Likewise, the ACO's share of orthopedic surgery services in PSA B would be the total Medicare allowed charges for claims billed by the ACO's orthopedic surgeons (which are PG A's and PG B's total allowed charges for claims billed by orthopedic surgeons for Medicare beneficiaries in PSA B's zip codes) divided by the total allowed charges for orthopedic surgery for all Medicare beneficiaries in PSA B.

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares

For Inpatient Services-- Step One:

Identify the hospitals' common Major Diagnostic Categories (MDCs). In this example, Hospital 1 and Hospital 2 each provide services in 10 MDCs, but only two are common services: cardiac care (i.e., services related to diseases and disorders of the circulatory system—MDC 05) and orthopedic care (i.e., services related to diseases and disorders of the musculoskeletal system and connective tissue—MDC 08).

For Inpatient Services -- Step Two:

Identify the zip codes that make up the PSA for inpatient services for each hospital. In this example, there will be two PSAs: Hospital 1's PSA and Hospital 2's PSA.

Major Diagnostic Categories

Category	Description
01	Nervous System
02	Eye
03	Ear, Nose, Mouth And Throat
04	Respiratory System
05	Circulatory System
06	Digestive System
07	Hepatobiliary System And Pancreas
08	Musculoskeletal System And Connective Tissue
09	Skin, Subcutaneous Tissue And Breast
10	Endocrine, Nutritional And Metabolic System
11	Kidney And Urinary Tract
12	Male Reproductive System
13	Female Reproductive System
14	Pregnancy, Childbirth And Puerperium
15	Newborn And Other Neonates (Perinatal Period)
16	Blood and Blood Forming Organs and Immunological Disorders
17	Myeloproliferative Diseases and Disorders (Poorly Differentiated Neoplasms)
18	Infectious and Parasitic Diseases
19	Mental Diseases and Disorders
20	Alcohol/Drug Use or Drug Induced Mental Disorders
21	Injuries, Poison And Toxic Effect of Drugs
22	Burns
23	Factors Influencing Health Status and Other Contacts with Health Services
24	Multiple Significant Trauma
25	Human Immunodeficiency Virus Infection
NON-MDC	Surgical procedures unrelated to the principal diagnosis

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares

For Inpatient Services-- Step Three:

Determine the ACO's share in each of the PSAs. In this example, Hospital 1 and Hospital 2 both serve cardiac patients located in each hospital's PSA and both serve orthopedic patients in each hospital's PSA. Thus, shares need to be calculated in both PSAs, resulting in four shares. This hypothetical ACO is located in a state for which all-payer hospital discharge data is available, so the ACO's share of cardiac care in Hospital 1's PSA would be the ACO's total number of inpatient discharges for MDC 05 (which are Hospital 1's and Hospital 2's total inpatient discharges for cardiac care in Hospital 1's PSA) divided by the total number of inpatient discharges for MDC 05 for all residents of this PSA. Use the analogous process to calculate the ACO's share of cardiac care in Hospital 2's PSA, the ACO's share of orthopedic care in Hospital 1's PSA, and the ACO's share of orthopedic care in Hospital 2's PSA.

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares

For Outpatient Services -- Step One:

Identify the hospitals' and ASC's common outpatient categories. In this example, Hospital 1 does not provide outpatient services, while Hospital 2 and the ASC each provide services in 10 outpatient categories, but only two are common services: cardiovascular tests/procedures (outpatient category 2) and musculoskeletal procedures (outpatient category 5).

For Outpatient Services -- Step Two:

Identify the zip codes that make up the PSA for outpatient services for Hospital 2 and the ASC. In this example, there will be two PSAs: Hospital 2's PSA for outpatient services and the ASC's PSA.

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares

For Outpatient Services-- Step Three:

Determine the ACO's share in each of the PSAs. In this example, Hospital 2 and the ASC both provide cardiovascular tests/ procedures to patients located in each facility's PSA, and both provide musculoskeletal procedures to patients located in each facility's PSA. Thus, shares need to be calculated in both PSAs, resulting in four shares. The ACO's share of cardiovascular tests/ procedures in Hospital 2's PSA would be the ACO's total Medicare fee-for-service payments/charges for outpatient category 2 (which are Hospital 2's total payments and the ASC's total allowed charges for outpatient cardiovascular tests/ procedures for Medicare beneficiaries in Hospital 2's PSA) divided by the total payments/charges for outpatient category 2 for all Medicare beneficiaries in this PSA. Use the analogous process to calculate the ACO's share of cardiovascular tests/ procedures in the ASC's PSA, the ACO's share of musculoskeletal procedures in Hospital 2's PSA, and the ACO's share of musculoskeletal procedures in the ASC's PSA.

How to Calculate an ACO's Relevant Primary Service Area (PSA) Shares

Application to Antitrust the Safety Zone:

In this example, the ACO would calculate ten PSA shares. If all of the shares are 30 percent or below, and the hospitals and the ASC are non-exclusive to the ACO, then the ACO would fall within the safety zone. In other words, the 30 percent threshold must be met in each relevant PSA for each common service. If that condition is not met, then the ACO does not fall within the safety zone, unless it qualifies for the rural exception.

Assignment of Beneficiaries

Assignment of Beneficiaries

- Medicare fee-for-service beneficiary is assigned to an ACO when the beneficiary's utilization of primary care services meets the criteria established under the assignment methodology.
- CMS applies a step-wise process based on the beneficiary's utilization of primary care services provided by a physician who is an ACO provider/ supplier during the performance year for which shared savings are to be determined.
- Medicare assigns beneficiaries in a preliminary manner at the beginning of a performance year based on the most recent data available.
- Assignment will be updated quarterly based on the most recent 12 months of data.
- Final assignment is determined after the end of each performance year, based on data from that performance year.

Assignment of Beneficiaries, continued

- Beneficiary assignment to an ACO is for purposes of determining the population of Medicare fee-for-service beneficiaries for whose care the ACO is accountable, and for determining whether an ACO has achieved savings, and in no way diminishes or restricts the rights of beneficiaries assigned to an ACO to exercise free choice in determining where to receive health care services.

- Primary care services for purposes of assigning beneficiaries are identified by selected HCPCS codes (99201 through 99215, 99304 through 99340, and 99341 through 99350), G codes (G0402, G0438 and G0439), or revenue center codes (0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011) or by RHCs).

Quality of Care

Measures to Assess the Quality of Care

General: CMS assess the quality of care furnished by the ACO. If the ACO demonstrates it has satisfied the quality performance requirements, and the ACO meets all other applicable requirements, the ACO is eligible for shared savings.

Selecting Measures:

- CMS selects the measures designated to determine an ACO's success in promoting the aims of better care for individuals, better health for populations, and lower growth in expenditures.
- CMS designates the measures for use in the calculation of the quality performance standard.
- CMS seeks to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both.

Calculating the ACO Quality Performance Score

Establishing a quality performance standard in each performance year:

- For the first performance year of an ACO's agreement, CMS defines the quality performance standard at the level of complete and accurate reporting for all quality measures.

- During subsequent performance years, the quality performance standard will be phased in such that the ACO must continue to report all measures but the ACO will be assessed on performance based on the minimum attainment level of certain measures.

Calculating the ACO Quality Performance Score, continued

Establishing a performance benchmark and minimum attainment level for measures:

- CMS designates a performance benchmark and minimum attainment level for each measure, and establishes a point scale for the measures.
- Contingent upon data availability, performance benchmarks are defined by CMS based on national Medicare fee-for-service rates, national Medicare Advantage (MA) quality measure rates, or a national flat percentage.
- The minimum attainment level is set at 30%, or the 30th percentile of the performance benchmark.

Calculating the ACO Quality Performance Score, continued

Methodology for calculating a performance score for each measure:

- Performance below the minimum attainment level for a measure will receive zero points for that measure.
- Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance.
- Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.
- Performance at or above 90% or the 90th percentile of the performance benchmark earns the maximum points available for the measure.

Calculating the ACO Quality Performance Score, continued

In establishing quality performance requirements for domains, CMS groups individual quality performance standard measures into four domains (33 measures in total):

- Patient/caregiver experience.
- Care coordination/Patient safety.
- Preventative health.
- At-risk population.

Electronic Health Records capability is not mandatory, but it is a quality standard with four points rather than two.

Calculating the ACO Quality Performance Score, continued

To satisfy quality performance requirements for a domain:

- The ACO must report all measures within a domain.
- ACOs must score above the minimum attainment level determined by CMS on 70% of the measures in each domain. If an ACO fails to achieve the minimum attainment level on at least 70% of the measures in a domain, CMS will take termination actions.
- If the ACO achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings, the ACO may receive the proportion of those shared savings for which it qualifies.
- If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated.

Risk Models

Selection of Risk Models

For its initial agreement period, an ACO may elect to operate under one of the following tracks:

- **Track 1**. Under Track 1, the ACO operates under the one-sided model for the agreement period.
- **Track 2**. Under Track 2, the ACO operates under the two-sided model, sharing both savings and losses with the Medicare program for the agreement period.
- For subsequent agreement periods, an ACO may not operate under the one-sided model.
- An ACO experiencing a net loss during the initial agreement period may reapply to participate, though in this case the ACO must also

Establishing the Benchmark

Step 1: Computing per capita Medicare Part A and Part B benchmark expenditures:

In computing an ACO's fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, CMS determines the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period using the ACO participants' TINs identified at the start of the agreement period. CMS does all of the following:

(1) **Calculates the payment amounts included in Parts A and B fee-for-service claims using a 3-month claims run out with a completion factor.**

- This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments.
- This calculation considers individual beneficiary identifiable payments made under a demonstration, pilot or time limited program.

Establishing the Benchmark, continued

(2) Makes separate expenditure calculations for each of the following populations of beneficiaries: End stage renal disease (ESRD), disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(3) Adjusts expenditures for changes in severity and case mix using prospective health care cost calculator (HCC) risk scores.

(4) Truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each benchmark year in order to minimize variation from catastrophically large claims.

Establishing the Benchmark, continued

(5)(a) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates, trends, and expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

(5)(b) To trend forward the benchmark, CMS makes separate calculations for expenditure categories for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

Establishing the Benchmark, continued

(6) Restates BY1 and BY2 trended and risk adjusted expenditures in BY3 proportions of ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(7) Weighs each year of the benchmark using the following percentages:

- BY3 at 60%.
- BY2 at 30%.
- BY1 at 10%.

(8) The ACO's benchmark may be adjusted for the addition and removal of ACO participants or ACO providers/suppliers during the term of the agreement period.

Calculation of Savings Under the One-Sided Model, continued

Minimum savings rate (MSR): CMS uses a sliding scale based on the number of beneficiaries assigned to the ACO to establish the MSR for an ACO participating under the one-sided model. The MSR under the one-sided model for an ACO based on the number of assigned beneficiaries is as follows:

Number of Beneficiaries	MSR (low end of assigned beneficiaries)	MSR (high end of assigned beneficiaries)
5,000 – 5,999	3.9%	3.6%
6,000 – 6,999	3.6%	3.4%
7,000 – 7,999	3.4%	3.2%
8,000 – 8,999	3.2%	3.1%
9,000 – 9,999	3.1%	3.0%
10,000 – 14,999	3.0%	2.7%
15,000 – 19,999	2.7%	2.5%
20,000 – 49,999	2.5%	2.2%
50,000 – 59,999	2.2%	2.0%
60,000 +	2.0%	

Calculation of Shared Savings and Losses Under the Two-Sided Model

General Rule.

- For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are above or below the updated benchmark.

- In order to qualify for a shared savings payment under the two-sided model, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate.

Calculation Under the Two-Sided Model, continued

- Newly assigned beneficiaries: CMS uses an ACO's HCC prospective risk score to adjust for changes in severity and case mix in this population.

- Continuously assigned beneficiaries:

    - CMS uses demographic factors to adjust for changes in the continuously assigned beneficiary population.

    - If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust for changes in severity and case mix for this population using this lower prospective HCC risk score.

Calculation Under the Two-Sided Model, continued

Assigned beneficiary changes in demographics and health status are used to adjust benchmark expenditures. In adjusting for health status and demographic changes CMS makes separate adjustments for each of the following populations of beneficiaries:

- ESRD
- Disabled
- Medicare and Medicaid beneficiaries
- Aged/non-dual eligible Medicare and Medicaid beneficiaries

To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each performance year.

Calculation Under the Two-Sided Model, continued

- CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.
- Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.
    - These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.
    - These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.
- In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO.

Calculation Under the Two-Sided Model, continued

Minimum savings or loss rate.

- To qualify for shared savings under the two-sided model, an ACO's average per capita Medicare expenditures for the performance year must be below its updated benchmark costs for the year by at least 2%.

- To be responsible for sharing losses with the Medicare program, an ACO's average per capita Medicare expenditures for the performance year must be at least 2% above its updated benchmark costs for the year.

Calculation Under the Two-Sided Model, continued

Qualification for shared savings payment: To qualify for shared savings, an ACO must meet the minimum savings rate requirement, meet the minimum quality performance standards, and otherwise maintain its eligibility to participate in the Shared Savings Program under this part.

Final sharing rate: An ACO that meets all the requirements for receiving shared savings payments under the two-sided model will receive a shared savings payment of up to 60% of all the savings under the updated benchmark, as determined on the basis of its quality performance (up to the performance payment limit).

Calculation Under the Two-Sided Model, continued

Performance payment:

- If an ACO qualifies for savings by meeting or exceeding the MSR, the final sharing rate will apply to an ACO's savings on a first dollar basis.
- The amount of shared savings an eligible ACO receives under the two-sided model may not exceed 15% of its updated benchmark.

Calculation Under the Two-Sided Model, continued

Shared loss rate:

- For an ACO that is required to share losses with the Medicare program for expenditures over the updated benchmark, the amount of shared losses is determined based on the inverse of its final sharing rate (that is, 1 minus the final shared savings rate; and

- Amount may not exceed 60%.

Calculation Under the Two-Sided Model, continued

Loss recoupment limit: The amount of shared losses for which an eligible ACO is liable may not exceed the following percentages of its updated benchmark:

- 5% in the first performance year of participation in a two-sided model under the Shared Savings Program.
- 7.5% in the second performance year.
- 10% in the third and any subsequent performance year.

For additional information or a complete copy of the presentation, email Craig@CraigGarner.com.