Accountable Care Organizations: Notice of Proposed Rulemaking

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Accountable Care Organizations (ACOs)

- An ACO is an organization of eligible providers and suppliers who are accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
  - Authorized as a Shared Savings Program (ACA 3022)
- ACOs can share Medicare savings with the federal government IF:
  - The ACO complies with all the ACO requirements, AND
  - The ACO meets quality standards, AND
  - The ACO has measured savings below a calculated threshold

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Triple Aim of ACOs

- 1) **Better care for individuals** (ie, safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity)
- 2) **Better health for populations** (ie, educating beneficiaries about importance of healthy lifestyles and clinical preventive services)
- 3) **Lower growth in expenditures** (ie, eliminating waste and inefficiencies without withholding needed care)

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Eligibility and Governance Requirements (42 CFR 425.5)

- a) General requirements:
  - An ACO is a group of ACO participants that work together to manage and coordinate care and are eligible for shared savings if they meet quality and savings requirements
- b) Eligible providers and suppliers
- c) Report Tax Payer Identification Numbers (TINS) and National Provider Identifiers on annual basis for ACO and participating providers
- d) Other requirements

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Eligible Providers to Participate as ACOs

- ACO professions in group practice arrangements
- Network of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Other providers of services and suppliers as the Secretary determines appropriate
  - Note: FQHC, RHCs, and many CAHS can not create their own ACOs, but can participate as part of another ACO.
  - ACOs that include FQHCs/RHCs eligible for higher savings

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42 CFR 425.5(b).

Other Requirements (42 CFR 425.5(d))

- 1) Accountability: must certify that providers and suppliers have agreed to assume accountability for and report on quality, cost, and care of Medicare FFS beneficiaries
- 2) Anti-trust review.
  - Must request expedited review and show letter that federal agency not likely to challenge ACO if 2 or more of the participants in the ACO provide 50%+ of common services to patients in the primary service area (PSA).*
  - Slightly lower standard if 2 or more participants account for 30-50% of the services in PSA.

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*Rural exception.

Other Requirements (42 CFR 425.5(d))

- 3) Agreement requirements. ACO must agree to participate for at least 3 years
  - Primary care physicians upon which assignment is made must commit to 3-year agreement with CMS and be exclusive to one ACO
  - Other participants must also agree to a 3-year commitment, but need not be exclusive to one ACO.
- 4) Marketing materials. ACOs marketing materials must be approved by CMS before use.

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Other Requirements (42 CFR 425.5(d))

- 5) Notice to ACO participants. Medicare beneficiaries must be notified if providers/suppliers participating in ACO, and must be given option to opt out of sharing their individual data with ACO.
- 6) Shared savings options. Two shared savings models:
  - **One sided-ACO**: shares in the savings, but does not assume any financial risk. Must agree to 2-sided shared savings by Year 3.
  - **Two-sided ACO**: shares in both the financial risk and the potential savings. Must have reinsurance to ensure payment of losses.

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Other Requirements (42 CFR 425.5(d))

- 7) Legal Structure. Must be a legal entity recognized under state law able to receive and distribute shared savings, repay losses, and ensure provider compliance with quality performance standards.
- 8) Shared governance. All participants must be able to participate in governance with appropriate proportionate control over decision making process.
  - ACO participants (eg hospitals, doctors) must have at least 75% control over governing body.
  - Should include Medicare participants on governing board.

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Other Requirements (42 CFR 425.5(d))

- 9) Leadership and management structure.
  - Participating providers must agree to comply with these guidelines and be subject to performance evaluation and corrective action plan, if needed.
  - Must have infrastructure, such as EHR, that can capture quality performance data and provide feedback to ACO participants.
- 10) Compliance plan, with compliance officer.
- 11) Description of distribution plan for shared savings that shows how it will provide savings to participants and use savings to support triple-aim.

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Other Requirements (42 CFR 425.5(d))

- 12) Individual with legal authority must certify accuracy of data used to determine ACOs eligibility for shared savings.
- 13) Sufficient number of primary care providers and beneficiaries. ACO must have at least 5,000 assigned Medicare FFS beneficiaries.
- 14) Annual reporting on TIN and NPI for each participating ACO professional.
- 15) Patient-centeredness requirements .

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Patient Centeredness

- Medicare beneficiaries retain their right to see any provider of their choice
- To show that the ACO is patient centered, ACO must:
  - Conduct CAHPS beneficiary experience of care survey and show how ACO will use results to improve care over time
  - Patient involvement in ACO governance
  - Process to evaluate health needs of the ACO's assigned population, including consideration of diversity
  - Systems to identify high-risk individuals and processes to develop individualized care plans.

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Patient Centeredness

- To show that the ACO is patient centered, ACO must:
  - Have a mechanism for coordination of care
  - Have a process to communicate clinical knowledge/evidence-based medicine to beneficiaries in way that is understandable to them
  - Measure clinical performance by physicians across practices and use the information to improve care over time. 42 CFR 425.5(d)(15).

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Assignment of Medicare Beneficiaries to ACOs (42 CFR 425.6)

- Beneficiaries assigned to ACO if they received their plurality of primary care services in the prior year from a participating ACO primary care ***physician*** (retrospective assignment) .
  - Based on total allowable charges for primary care services.
  - Primary care services identified through HCPCS codes 99201-99215, 99304-99340, 99341-99350, G0402, G0438, G0439.

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Payments to Providers

- Providers continue to be paid under Medicare FFS payment structure (1899(d)(1)(A) of the Social Security Act)
- In addition, ACO can receive shared savings (or must pay part of the losses) under the shared savings plan if meets quality and savings standards. (Sec. 1899(d)(1)(A)).
  - One-sided: one sided approach for first 2 years, two-sided approach for Year 3.
  - Two-sided: two-sided approach all 3 years

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Payment and Treatment of Savings (42 CFR 425.7)

- Benchmark will be based on per capita expenditures for beneficiaries who *would have been assigned* to ACO in any of prior three years (adjusted for overall growth and beneficiary characteristics)
- CMS updates this fixed benchmark based on the projected absolute growth in national per capita expenditures for Parts A and B from CMS Office of Actuary.
- To qualify for shared savings, must meet minimum savings rate, quality performance standards, and other program requirements.

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One-sided Savings (42 CFR 425.7(c))

- CMS will determine whether ACO's average per capita Medicare expenditures meets a **Minimum Savings Rate (MSR)**

Number Beneficiaries	MSR
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%

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One-sided Savings (42 CFR 425.7(c))

- Net savings threshold: ACO that exceeds minimum savings rate is eligible to share savings net 2% of benchmark.
- Eligible for shared savings of up to 50% if meet maximum quality performance.
- Eligible for up to 2.5 percentage points more if beneficiaries make visit to RHCs/FQHCs.
- The amount of shared savings an eligible ACO receives may not exceed 7.5 percent of benchmark.

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Two-sided Savings (42 CFR 425.7(d))

- Minimum savings rate: ACOs per capita expenditures must be below its benchmark costs by at least 2 percent.
- Eligible for shared savings of up to 60% if meet maximum quality performance.
- Eligible for up to 5 percentage points more if beneficiaries make visit to RHCs/FQHCs.
- The amount of shared savings an eligible ACO receives may not exceed 10 percent of benchmark.

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ACOs Eligible for Additional Payment if Beneficiaries Visit FQHC/RHC

Percentage of ACOs Assigned Beneficiaries with 1 or More Visits to FQHC/RHC During Performance Year	Percentage Point Increase in Shared Savings Rate (One-Sided Model)	Percentage Point Increase in Shared Savings Rate (Two-Sided Model)
1-10%	0.5	1.0
11-20%	1.0	2.0
21-30%	1.5	3.0
31-40%	2.0	4.0
41-50%	2.5	5.0

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42 CFR 425.7(c)(7), 425.7(d)(7)

Two-sided Savings (42 CFR 425.7(d))

- If ACO loses money, it must share losses with Medicare expenditures over the benchmark (based on inverse of the shared savings rate)
- Loss recoupment limit:
  - 5 percent in the first year of a 2-year participation model
  - 7.5% in second year
  - 10% in third year

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Quality Performance Measures (42 CFR 425.8-425.10)

- CMS will establish performance measures on five domains:
  - Patient/care giver experience
  - Care coordination
  - Patient safety
  - Preventive health
  - At-risk population/frail elderly health
- CMS will set minimum attainment level and benchmarks for each measure. level.

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Quality Performance Measures (42 CFR 425.8-425.10)

- In first performance year, will be measured on complete and accurate reporting.
- In subsequent years will be based on quality performance against minimum attainment level and benchmarks.
  - ACO gets no points for measure unless it meets minimum attainment, and then gets sliding scale up to full amount of points for reaching benchmark.
  - All measures within a domain must have a score above the minimum attainment level in order for the domain to be eligible for shared savings.

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Physician Quality Reporting System and EHR (42 CFR 425.11)

- To qualify for a physician quality reporting system incentive grant, ACO and participating professionals, must submit the quality data required by CMS in 42 CFR 425.10.
  - PQRS incentive equal to 0.5 percent of ACO's eligible Medicare Part B physician fee schedule allowed charges

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Monitoring, Audit, Record Keeping (42 CFR 425.12, 425.16)

- CMS has a range of methods to monitor and assess performance of ACOs, including but not limited to:
  - Analysis of financial and quality data, site visits, analysis of beneficiary and provider complaints, audits.
  - Will monitor specifically to determine if ACO avoiding at-risk beneficiaries. Will not receive any shared savings if determined that providers avoided at-risk individuals.
  - If fail to meet minimum attainment levels for one or more domain, will be given warning. May be terminated following year if still failing to meet minimum standards.
- CMS can audit ACOs. ACOs must maintain records at least 10 years, but may be longer.

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Sanctions (42 CFR 425.13-425.14)

- If problems found, CMS may take a range of different actions:
  - Provide a warning, request a corrective action plan, place the ACO on a special monitoring plan.
  - CMS may also terminate or suspend ACO for avoiding at-risk beneficiaries, failing to meet quality standards, failing to accurately report information or make timely correction, or otherwise failing to meet requirements.

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Reconsideration Review Process (42 CFR 425.15)

- ACO does not have a right to reconsideration, appeal or review of:
  - Quality and performance standards, assessment of quality of care, assignment of FFS beneficiaries, determination whether ACO eligible for shared savings (or amount), termination of ACO for failure to meet quality performance standards, or determination from antitrust agency that it is likely to challenge the ACO.
- Other decisions may be reviewed.

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Minimum 3-year Agreement (42 CFR 425.18)

- To participate in shared savings program, ACO must agree to participate for at least three years.
- Start dates: January 1st of each year, beginning Jan. 1, 2012.
  - May have second start date of July 1 in first year

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Data Sharing with ACOs (42 CFR 425.19)

- CMS will provide data to ACO on potentially assigned beneficiary population
  - Individual data:
    - Name, data of birth, sex and health insurance claim number of historically assigned beneficiary population
    - Claims data to understand totality of care provided both inside and outside ACO (unless beneficiary opts out of providing information)
    - Beneficiaries must be provided information about opt-out of data sharing from primary care provider
  - Aggregate data that include aggregated metrics on assigned beneficiary population, including:
    - Financial performance, quality performance scores, metrics on assigned beneficiary population, utilization data at start of agreement period used to calculate benchmark,

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Public Reporting and Transparency (42 CFR 425.23)

- Each ACO must publicly report:
  - Name and location, primary contact, and organizational information (including participating providers), and governing board.
  - Quality performance standard scores.
  - Shared savings or losses information.
  - Total proportion of shared savings distributed among ACO participants and proportion used to support triple aim.

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Other Provisions

- Proposed regulations include provisions related to:
  - New program standards established during 3 year agreement period (42 CFR 425.20)
  - Manage significant changes to ACO during agreement period (42 CFR 425.21)
  - Future participation of previous Shared Savings Program participants (42 CFR 425.22)
  - Overlap with other CMS Shared Savings initiatives (42 CFR 425.24)

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Accountable Care Organizations

- Notice of Proposed Rulemaking released April 7, 2011
- Commits must be submitted no later than June 6, 2011
- 76 Fed. Reg. 19528-19654 (April 7, 2011)

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Other Information

Proposed Quality Measures

- Patient/Care Giver Experience
  - Timely care, appointments and information (CAHPS)
  - How well does doctor communicate (CAHPS)
  - Helpful, courteous, respectful office staff (CAHPS)
  - Patients' rating of doctor (CAHPS)
  - Health promotion and education (CAHPS)
  - Shared decision making (CAHPS)
  - Health status/functional status (CAHPS)

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Proposed Quality Measures

- Care Coordination/Transitions
  - Rate of readmission within 30 days of discharge (claims)
  - 30 day post discharge physician visit (Group practice reporting option (GPRO) data tool)
  - Medication reconciliation (GPRO data tool)
  - Self-reported survey that measures quality of preparation for care transition (GPRO data tool)
  - Ambulatory sensitive conditions (ASC) admissions for short-term complications from diabetes (Claims)
  - ASC admissions: uncontrolled diabetes (claims)
  - ASC admissions: chronic obstructive pulmonary disease (claims)
  - ASC admissions: Congestive Heart Failure (claims)
  - ASC admissions: Dehydration (claims)

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Proposed Quality Measures

- Care Coordination/Transitions
  - ASC admissions: Bacterial pneumonia (claims)
  - ASC admissions: Urinary infection (claims)
  - Percent physicians meeting stage 1 HITECH meaningful use (GPRO tool, EHR incentive reporting prgm)
  - Percent PCPs meeting stage 1 HITECH meaningful use requirements (GPRO, EHR incentive reporting program)
  - Percent PCPs using clinical decision support (GPRO, EHR incentive reporting program)
  - Percent PCPs who are successful electronic prescribers under eRx Incentive program (GPRO, eRX incentive program reporting)
  - Patient registry use (GPRO)

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Proposed Quality Measures

- Patient Safety
  - Health care acquired conditions composite (ie, foreign object after surgery, air embolism, blood incompatibility, pressure ulcer, falls and trauma, catheter associated UTI, manifestations of poor glycemic control, central line associated blood stream infection, surgical site infection, AQHR patient safety indicator 90 complication/patient safety for selected indicators (claims or CDC national healthcare safety network)
  - Health Care Acquired Conditions: CLASBI Bundle (claims or CDC national healthcare safety network)

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Proposed Quality Measures

- Preventive Health
  - Influenza immunization (annual for 50+ population) (GPRO)
  - Pneumococcal vaccination (65+ who ever rec'd)(GPRO)
  - Mammogram screening (within 2 years 40-69)(GPRO)
  - Colorectal cancer screening (periodic, 50-75)(GPRO)
  - Cholesterol Management (LDL-C <100 mg/dL) for patients with cardiovascular conditions (GPRO)
  - Adult weight screening and follow up (GPRO)
  - Blood pressure measurement (GPRO)
  - Tobacco use assessment and intervention (GPRO)
  - Depression screening (GPRO)

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Proposed Quality Measures

- At Risk Population
  - Diabetes composite (all or nothing)(GPRO)
  - Diabetes: HbA1C control (<8%)(GPRO)
  - Diabetes: LDL-C control (<100 mg/dl) (GPRO)
  - Diabetes: Aspirin use (GPRO)
  - Diabetes: HbA1C Poor control >9%)(GPRO)
  - Diabetes: High blood pressure control (<140/90 mmHg)(GPRO)
  - Diabetes: urine screening for microalbumin or medication attention for nephropathy in diabetic patients (GPRO)
  - Heart Failure: Left Ventricular Function (GPRO)
  - Heart Failure: Weight measurement (GPRO)
  - Heart Failure: patient education (GPRO)

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Proposed Quality Measures

- At Risk Population
  - Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction (GPRO)
  - Heart Failure: ACE Inhibitor or ARB therapy for Left Ventricular Systolic Dysfunction (GPRO)
  - Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (GPRO)
  - Coronary Heart Disease (CAD) Composite: All or Nothing (GPRO)
  - CAD: Oral Antiplatelet Therapy Prescribed for patients with CAD (GPRO)
  - CAD: Drug Therapy for Lowering LDL-Cholesterol (GPRO)
  - CAD: Beta Blocker Therapy for CAD Patients with Prior Myocardial Infarction (GPRO)

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Proposed Quality Measures

- At Risk Population
  - CAD: LDL level < 100 mg/dl (GPRO)
  - CAD: ACE or ARB therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (GPRO)
  - Hypertension (HTN): Blood Pressure Control (GPRO)
  - HTN: Plan of Care (GPRO)
  - Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation (GPRO)
  - COPD: Smoking Cessation Counseling Received (GPRO)
  - COPD: Bronchodilator Therapy based on FEV1 (GPRO)
  - Falls: Screening for Fall Risk (GPRO)
  - Osteoporosis Management in Women who had a Fracture (GPRO)
  - Monthly INR for Beneficiaries on Warfarin (Claims)

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Sliding Scale Measure Scoring Approach

ACO Performance Level	Quality Points
90+ percentile FFS/MA Rate or 90+ percent	2 points
80+ percentile FFS/MA Rate or 80+ percent	1.85 points
70+ percentile FFS/MA Rate or 70+ percent	1.7 points
60+ percentile FFS/MA Rate or 60+ percent	1.55 points
50+ percentile FFS/MA Rate or 50+ percent	1.4 points
40+ percentile FFS/MA Rate or 40+ percent	1.25 points
30+ percentile FFS/MA Rate or 30+ percent	1.10 points
<30 percentile FFS/MA Rate or <30 percent	No points

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Quality Performance Calculation

- CMS will Calculate percentage of points an ACO earns for each domain by dividing the points earned by total points available—yielding a percentage.
  - Example: If ACO earns 16.2 out of 18 points in the preventive health domain, ACO earned 90% of the points for the preventive health domain. If the ACO achieves 90 percent among all domains, then it would receive:
    - 54% of savings (90% * 60 percent) in 2-sided model
    - 45% of savings (90% * 50 percent) in 1-sided model
  - Each domain is weighted equally, regardless of number of measures in the domain.

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