Shared Savings Program: Background

- [Shared Savings Program](http://www.cms.gov/sharedsavingsprogram/) web site
- 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 31, 2011
- CMS sought and received over 1,300 comments on the proposal
- Issued Final Rule November 2011
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 (FFS) beneficiaries
  • Improving coordination of care for services provided under Medicare Parts A and B
  • Encouraging investment in infrastructure and redesigned care processes

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

MSSP: Track 1 & Track 2

Advance Payment

Pioneers

2013 Medicare ACOs
Shared Savings Program: Definitions

**Accountable Care Organization (ACO):**
ACO means a legal entity that is recognized and authorized under applicable State or tribal law, as identified by a Taxpayer Identification Number (TIN), and comprised of eligible groups of eligible providers and suppliers (as defined at §425.102) that work together to manage and coordinate care for Medicare FFS beneficiaries.

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

**ACO Provider/Supplier:**
(1) A provider or (2) A supplier and
(3) Bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations.

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**ACO Participant:**
Individual or group of ACO provider(s)/supplier(s) that is identified by a Medicare-enrolled taxpayer identification number (TIN), that alone or together with one or more other ACO participants comprise(s) and ACO.

- E.g. Acute Care Hospital, Group Practice, Individual Practice, Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Critical Access Hospital (CAH), Pharmacy, Long-term Care Hospital (LTCH), Skilled Nursing Facility (SNF), Emergency Room (ER), etc.

**ACO Provider/Supplier:**
(1) A provider (as defined in §400.202), or a supplier (as defined at §400.202)
(2) Enrolled in Medicare
(3) 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.

- E.g. Physicians, Nurse Practitioner (NP), Physician Assistant (PA), Clinical Nurse Specialists (CNS), pharmacists, chiropractors, Physical Therapy/Occupational Therapy (PT/OT), etc.
Shared Savings Program: ACO Professionals

- ACO Professional:
  - Doctor of Medicine (MD)
  - Doctor of Osteopathic Medicine (DO)
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialists (CNS)
- Primary Care Physician:
  - General practice
  - Internal medicine
  - Family practice
  - Geriatric medicine
- Primary Care Services:
  - Certain Evaluation and Management (E&M) Healthcare Common Procedure Coding System (HCPCS) codes
  - Revenue center codes
  - G codes

Shared Savings Program: Statutory Requirements

- By statute ACOs must meet the following eligibility criteria:
  - Agree to participate in the program for at least a 3-year period
  - Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
  - Have a formal legal structure to receive and distribute payments
  - Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
  - Shall provide information regarding the ACO professionals as the Secretary determines necessary
  - Define processes to:
    - promote evidenced-based medicine
    - promote patient engagement
    - report quality and cost measures
    - coordinate care
  - Demonstrate it meets patient-centeredness criteria
Shared Savings Program: ACO Structure

ACO Structure

- Legal Entity

- **ACO Participants** Ex: Acute Care Hospital, Group Practice, Individual Practice, FQHC, RHC, CAH, Pharmacy, LTCH, SNF, ER, etc.

- **ACO providers/suppliers** that bill through ACO participants (e.g. physicians, NP, PA, CNS, pharmacists, chiropractors, PT/OT, etc)

Statutory Requirements: Assignment

- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries

- Assignment is based on primary care services rendered by primary care physicians.
  - This means some of the ACO participants must bill for primary care services (e.g. hospitals employing ACO professionals, group practices of ACO professionals, etc)
Statutory Requirements: Governance & Leadership

- Shared governance through a governing body with representation by ACO participants and beneficiaries
  - ACO participant representation
  - ACO participants hold 75% control of governing body
  - Partners with community stakeholders
  - Beneficiary on the governing body
  - Flexibility for organizations to meet requirements

- Demonstrate an organizational commitment, leadership, and resources necessary to achieve the three-part aim and demonstrate clinical integration
  - Experienced leadership team
  - Medical Director
  - Qualified health professional to lead the quality assurance/improvement process

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

- Finalizing a preliminary prospective assignment with a retrospective reconciliation
Patient Population (cont.)

- 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, identify beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any ACO professional

ACO Assignment: Beneficiary Eligibility

- A beneficiary is eligible to be assigned to an ACO if the following criteria are satisfied during the assignment period:
  - Beneficiary must have a record of Medicare enrollment
  - Beneficiary must have at least one month of Part A and Part B enrollment, and cannot have any months of only Part A or Part B
  - Beneficiary cannot have any months of Medicare group (private) health plan enrollment
  - Beneficiary must reside in the United States including Puerto Rico & Territories
  - Beneficiary must have a primary care service with a physician at the ACO
Other Program Requirements

- No longer participating in other initiatives
- Data sharing
- Beneficiary communication
- Quality
- Benchmarking

Participation in Other Shared Savings Initiatives

- ACO participants cannot participate in multiple Medicare initiatives involving shared savings, including:
  - Independence at Home Medical Practice Demonstration (ACA Sec. 3024)
  - Medicare Healthcare Quality Demonstration (MMA Sec. 646)*
  - Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)*
  - Physician Group Practice Transition Demonstration
  - Pioneer ACO Model demonstration
  - Other ongoing demonstrations involving shared savings

- Additional programs, demonstrations, or models with a shared savings component may be introduced in the Medicare program in the future

*only contracts with shared savings arrangements
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 patients seen by ACO primary care providers who have been notified and not declined to have data shared

Beneficiary Communication

• Beneficiary will be notified that their provider is participating in the program (ACO) via letter from the provider, or during an office visit

• Beneficiary will receive general notification about the program and what it means for their care

• To prevent beneficiary steering, inappropriate advertising and to ensure information about ACOs is consistent and accurate, CMS will provide parameters around marketing materials

• ACOs must give beneficiaries an opportunity to decline data sharing
Quality Measure & Performance

- 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 cost
  - Align with other incentive programs like the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs

Quality Data Reporting

- Quality data collected three ways:
  - Claims data
  - ACO Group Practice Reporting Option (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 linked to quality performance based on a sliding scale that rewards attainment
  - High performing ACOs receive a higher sharing rate
Incorporating Other Data Reporting Requirements

- Reporting on GPRO quality measures through the Shared Savings Program qualifies each eligible professional within the ACO for the PQRS payment incentive.

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
Interagency Coordination

- Three notices were issued with the Shared Savings Program Final Rule:
  - Federal Trade Commission (FTC) and Department of Justice (DOJ): [Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program](#)
  - Internal Revenue Service (IRS): [Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations](#)
  - Office of the Inspector General (OIG) and CMS: [Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center](#) Interim Final with Comment

Application Cycle: Key Dates

<table>
<thead>
<tr>
<th>Start Date</th>
<th>January 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 applications posted on CMS Web site</td>
<td>June 2013</td>
</tr>
<tr>
<td>Notice of Intent to Apply (NOI) forms accepted</td>
<td>May 1, 2013 – May 30, 2013</td>
</tr>
<tr>
<td>CMS User ID forms accepted</td>
<td>May 1, 2013 – June 10, 2013</td>
</tr>
<tr>
<td>2014 applications accepted</td>
<td>July 1, 2013 – July 31, 2013</td>
</tr>
<tr>
<td>2014 application disposition</td>
<td>Fall 2013</td>
</tr>
</tbody>
</table>
Upcoming Application Calls

- Save the date:
  - June 20: 2014 Application Overview National Provider Call
  - July 9: HPMS Submission
  - July 18: Application Process Q&A National Provider Call

Questions?

For more information:

www.cms.gov/sharesavingsprogram/
aco@cms.hhs.gov
410-786-8084
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.
Other Beneficiary Protections

- Monitoring, by a variety of methods, assures general program compliance and focuses on avoidance of at risk beneficiaries and poor quality performance. Methods include, but are not limited to:
  - Analysis of specific financial and quality data as well as annual and quarterly reports.
  - Site visits.
  - Collection, assessment and follow up of beneficiary and provider complaints.
  - Audits (including, for example, analysis of claims, chart review, beneficiary surveys, coding audits).

ACO Beneficiary Assignment

- Preliminary prospective assignment with final retrospective beneficiary assignment
  - An ACO needs to have at least 5,000 preliminarily assigned beneficiaries in order to be in the Shared Savings Program in each of the three years preceding the start of the agreement period (2011, 2012, 2013)
  - A beneficiary assigned in one year of the program may or may not be assigned to the same ACO in the following or preceding years

- CMS uses claims submitted to Medicare for primary care services in the assignment process

- CMS uses information you provide to us on the ACO Participant List to determine which claims to attribute to your ACO
ACO Assignment: Individual Provider Types

- Primary Care Physicians (PCP)
  - Internal Medicine
  - Family Practice
  - General Practice
  - Geriatric Medicine

- Other physicians (M.D., D.O.)

- ACO Professionals include both of the above types of physicians plus:
  - NP
  - CNS
  - PA

ACO Assignment: Definition of Primary Care Services

- Evaluation & Management Services provided at:
  - Office or Other Outpatient settings (CPT 99201 – 99215)
  - Nursing Facility Care settings (CPT 99304 - 99318)
  - Domiciliary, Rest Home, or Custodial Care settings (CPT 99324 - 99340)
  - Home Services (CPT 99341-99350)

- Wellness Visits (HCPCS G0402, G0438, G0439)

- Clinic visits at RHC/FQHCs or by their providers in selected settings (UB revenue center codes 0521, 0522, 0524, 0525)
Assignment of a Beneficiary to an ACO

If a beneficiary meets the eligibility criteria, the beneficiary is assigned to an ACO using a two-step process:

**Assignment Policy Step 1**
CMS will assign a beneficiary to a participating ACO when the beneficiary has at least one primary care service furnished by a primary care physician at the participating ACO, and more primary care services (measured by Medicare allowed charges) furnished by primary care physicians at the participating ACO than from primary care physicians at any other Shared Savings Program ACO or non-ACO individual or group TIN.

**Assignment Policy Step 2**
This step applies only for beneficiaries who haven’t gotten any primary care services from a primary care physician. CMS will assign the beneficiary to the participating ACO in this step if the beneficiary got at least 1 primary care service from a physician at the participating ACO, and more primary care services (measured by Medicare allowed charges) from ACO professionals (physician regardless of specialty, NP, PA, or CNS) at a participating ACO than from any other ACO or non-ACO individual or group TIN.
## Assigned Beneficiaries for Three Typical ACOs

<table>
<thead>
<tr>
<th></th>
<th>ACO 1</th>
<th>ACO 2</th>
<th>ACO 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiaries provided at least one primary care service by a physician in this ACO (beneficiaries assignable to this ACO)</strong></td>
<td>11,839</td>
<td>28,127</td>
<td>24,297</td>
</tr>
<tr>
<td><strong>Assigned Beneficiaries</strong></td>
<td>7,570</td>
<td>10,245</td>
<td>16,588</td>
</tr>
<tr>
<td><strong>Excluded Beneficiaries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO did not provide a plurality of primary care services</td>
<td>4,008</td>
<td>17,211</td>
<td>6,703</td>
</tr>
<tr>
<td>At least one month of Part A-only or Part B-only coverage</td>
<td>93</td>
<td>284</td>
<td>810</td>
</tr>
<tr>
<td>At least one month in a group health plan</td>
<td>241</td>
<td>986</td>
<td>619</td>
</tr>
<tr>
<td>At least one month of non-US residence</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Included in other shared savings initiatives</td>
<td>17</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>

## Assigned Beneficiaries for Three ACOs that did not Achieve the 5,000 Threshold

<table>
<thead>
<tr>
<th></th>
<th>ACO A</th>
<th>ACO B</th>
<th>ACO C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiaries provided at least one primary care service by a physician in this ACO (beneficiaries assignable to this ACO)</strong></td>
<td>7,064</td>
<td>8,486</td>
<td>14,130</td>
</tr>
<tr>
<td><strong>Assigned Beneficiaries</strong></td>
<td>4,817</td>
<td>4,720</td>
<td>4,452</td>
</tr>
<tr>
<td><strong>Excluded Beneficiaries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO did not provide A plurality of primary care services</td>
<td>2,004</td>
<td>3,413</td>
<td>9,187</td>
</tr>
<tr>
<td>At least one month of Part A-only or Part B-only coverage</td>
<td>99</td>
<td>59</td>
<td>608</td>
</tr>
<tr>
<td>At least one month in a group health plan</td>
<td>198</td>
<td>480</td>
<td>368</td>
</tr>
<tr>
<td>At least one month of non-US residence</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Included in other shared savings initiatives</td>
<td>16</td>
<td>27</td>
<td>5</td>
</tr>
</tbody>
</table>
Termination

- **Termination by the ACO:**
  - ACO must give CMS a 60-day notice of its intention to terminate its agreement to participate in the Shared Savings Program

- **Termination by CMS:**
  - Non compliance with eligibility and other program requirements
  - Imposition of sanctions or other actions taken against the ACO by an accrediting organization, State, Federal, or local government agency leading to the inability of the ACO to comply with Shared Savings Program requirements
  - Violations of the physician self-referral prohibition, CMP law, Anti-Kickback statute, or other applicable Medicare laws or rules.