

# The Medicare Shared Savings Program

November 2011

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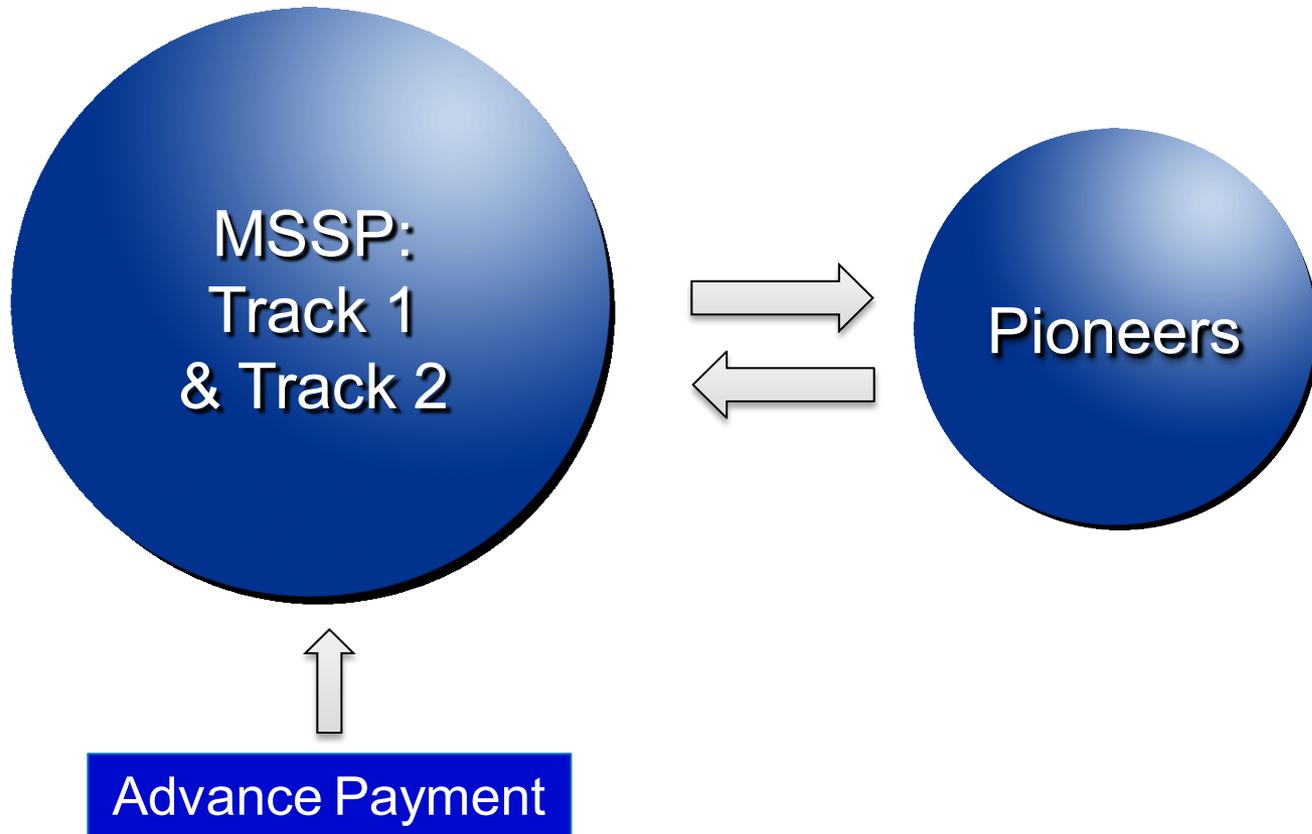
# Overview

- CMS vision and goals
- Major changes in final rule
- Next steps

# ACO Vision

- An ACO promotes seamless coordinated care
  - Puts the beneficiary and family at the center
  - Remembers patients over time and place
  - Attends carefully to care transitions
  - Manages resources carefully and respectfully
  - Proactively manages the beneficiary's care
  - Evaluates data to improve care and patient outcomes
  - Innovates around better health, better care and lower growth in costs through improvement
  - Invests in team-based care and workforce

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



# Operating Principles

- Creating multiple pathways and on-ramps for organizations to participate
- Strong data partnership
- Beneficiary notification and engagement
- Maintain strong partnership with federal anti-trust agencies
- Robust quality measurement and performance monitoring
- Stronger business case to participate
- Excitement and momentum

# Proposed vs. Final Rule

Topic	Proposed Rule	Modifications in Final Rule
<b>Transition to risk in Track 1</b>	Choose from two 3-year tracks. Track 1 would comprise 2 years of one-sided shared savings with a mandatory transition in year 3 to two-sided risk model of shared savings and losses. Track 2 would comprise 3 years all under the two-sided model.	Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.
<b>Prospective vs. Retrospective assignment</b>	Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.	A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year, made on the basis of patients served by the ACO.

# Proposed vs. Final Rule

Topic	Proposed Rule	Modifications in Final Rule
<b>Proposed measures to assess quality</b>	65 measures in 5 domains, including patient experience of care, utilization claims-based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years.	33 measures in 4 domains. (Note: Claims-based measures not finalized to be used for ACO-monitoring purposes.) Longer phase-in of measures over course of agreement: first year, pay for reporting; second and third years, pay for reporting and performance.
<b>Sharing savings</b>	One-sided risk model: sharing beginning at savings of 2%, with some exceptions for small, physician-only, and rural ACOs. Two-sided risk model: sharing from first dollar.	Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.

# Proposed vs. Final Rule

<b>Topic</b>	<b>Proposed Rule</b>	<b>Modifications in Final Rule</b>
<b>Sharing beneficiary identification claims data</b>	Claims data shared only for patients seen by ACO primary care physician during performance year; beneficiaries given opportunity to decline at the point of care.	The ACO may contact beneficiaries from provided quarterly lists to notify them of data sharing and opportunity to decline.
<b>Eligible entities</b>	The four groups specified by the Affordable Care Act, as well as critical access hospitals paid through Method II, are eligible to form an ACO. ACOs can be established with broad collaboration beyond these providers.	In addition to groups included in the proposed rule, Federally Qualified Health Centers and Rural Health Clinics are also eligible to both form and participate in an ACO.

# Proposed vs. Final Rule

<b>Topic</b>	<b>Proposed Rule</b>	<b>Modifications in Final Rule</b>
<b>Start date</b>	Agreement for 3 years with uniform annual start date; performance years based on calendar years.	Program established by January 1, 2012; first round of applications are due in early 2012. First ACO agreements start April 1, 2012, and July 1, 2012.
<b>Aggregate reports and preliminary prospective list</b>	Reports will be provided at the beginning of each performance year and include: name, date of birth, sex, and health insurance claim number.	Additional reports will be provided quarterly.

# Proposed vs. Final Rule

Topic	Proposed Rule	Modifications in Final Rule
<b>Electronic health record (EHR) use</b>	50% of primary care physicians must be defined as meaningful users by start of second performance year.	No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.
<b>Assignment process</b>	One-step assignment process: beneficiaries assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians	Two-step assignment process: <b>Step 1:</b> for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services <b>Step 2:</b> for beneficiaries who have not received any primary care services from a physician, use plurality of allowed charges for primary care services rendered by any other ACO professional.

# Proposed vs. Final Rule

Topic	Proposed Rule	Modifications in Final Rule
<b>Marketing guidelines</b>	All marketing materials must be approved by the Centers for Medicare and Medicaid Services.	“File and use” 5 days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language.

# Proposed vs. Final Rule

Topic	Proposed Rule	Modifications in Final Rule
<b>Coordination with Antitrust Agencies (DOJ/FTC)</b>	Proposed that the ACO meet certain clinical integration criteria in order to be eligible for participation. Also proposed ACOs undergo review by an Antitrust Agency if certain market power thresholds are met.	Maintain policy goal, but modify the process to address legal concerns. Provide for a <u>voluntary</u> review process and clinical integration criteria.  Worked with FTC/DOJ to streamline our requirements while ensuring ACOs can participate without running afoul of antitrust laws.

# Questions?

For more information:

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# Appendix: Financial Model

Topic	Proposed Rule		Final Policy
<b>Sharing Rate</b>	One-Sided Risk Model	Two-Sided Risk Model	<p>Finalize our proposal for establishing the MSR which protects the trust fund from paying out incentives for normal variations in cost rather than for real improvements made by the ACO.</p> <p>Modify our proposals to:</p> <ul style="list-style-type: none"> <li>• Eliminate the 2.5% and 5% FQHC/RHC add on but continue to make the two-sided model more attractive for organizations willing to take on performance-based risk.</li> <li>• Increase the cap on shared savings (to 10% and 15%, respectively).</li> <li>• Share on first dollar for all ACOs in both models once the MSR has been overcome.</li> </ul>
	Up to 52.5%, sliding scale based on quality performance and inclusion of FQHC/RHCs	Up to 65%, sliding scale based on quality performance and inclusion of FQHC/RHCs	
<b>Minimum Savings Rate (MSR)</b>	One-Sided Model	Two-Sided Model	
	Varies according to number assigned	Flat 2%	
<b>Performance Payment Cap</b>	One-Sided Model	Two-Sided Model	
	7.5%	10%	
<b>Sharing from 2%</b>	One-Sided Model	Two-Sided Model	
	Sharing from 2% with some exceptions for small, physician only, and rural ACOs	Sharing from first dollar	

# Appendix: Financial Model

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<b>HCC Risk Adjustment and Cap</b>	Proposed using prospective HCC risk scores to adjust for beneficiary characteristics in both benchmark and performance years. We further proposed to cap the risk adjuster at zero growth.	Modify recommendation to use prospective HCC risk scores to allow for increases in risk scores for newly assigned beneficiaries each year. For beneficiaries that are continuously assigned, demographic factors only will be used to adjust risk scores - unless the HCC risk score declines for the group, in which case it will be reset at the lower score.
<b>IME/DSH Adjustments</b>	Proposed not to adjust the benchmark for IME/DSH or any other payments.	Modify recommendation to adjust both the benchmark and performance year expenditures for IME/DSH payments.
<b>Benchmarking methodology</b>	Proposed setting a benchmark based on the expenditures of beneficiaries who would have been assigned to the ACO in each of the 3 years prior to the start of an agreement period.	Finalize our proposal to set a benchmark based on the expenditures of beneficiaries who would have been assigned to the ACO in each of the 3 years prior to the start of an agreement period.