ACO Participants & Financials

**EXECUTIVE SUMMARY**

On October 20, 2011, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the Medicare Shared Savings Program, that will form “Accountable Care Organizations” (ACOs). The American Medical Association said the final rule “includes a number of positive changes” from the proposed rule, and the American Hospital Association commended CMS for “listening to the concerns of America’s hospitals.”

**KEY POLICY CHANGES FROM THE PROPOSED RULE**

CMS made several significant changes from the proposed rule to the final rule in an effort to entice more healthcare providers to participate in ACOs.

- 33 quality measures must be reported, reduced from 65
- Removes requirement that 50% of primary care physicians must be “meaningful users” of electronic health records
- Allows for two “tracks” to participate, with one track allowing an ACO to share savings with CMS without the risk of sharing potential losses
- Eliminated a requirement for every ACO applicant to obtain antitrust preapproval
- Once the minimum savings rate is achieved, the ACO can share the first dollar savings with CMS
- The program will be established by January 1, 2012, but with a rolling application process – the first ACO agreements start on April 1, 2012 and July 1, 2012
- Expanded the list of eligible providers who can convene an ACO to include rural health clinics, FQHCs, and some critical access hospitals

**ELIGIBILITY, STRUCTURE AND GOVERNANCE**

*What is an ACO?* An ACO is a group of providers (e.g., hospitals, physicians, FQHCs, rural health clinics, etc.) that will work together to coordinate care for the Medicare fee-for-service beneficiaries they serve.

*Who can form an ACO?* Hospitals employing ACO professionals, ACO professionals in group practice arrangements, networks of individual practices of ACO professionals, partnerships or joint venture arrangements between hospitals and ACO professionals, FQHCs, rural health clinics, and certain critical access hospitals. Other providers are eligible to participate in an ACO, such as skilled nursing facilities, but would not have convening authority to set up an ACO at this time.

*What are the basic structural requirements?* An ACO must have a legal entity (such as a corporation, partnership, LLC) that is recognized by the state, has a tax identification number, and is capable of the following: receiving and distributing funds, repaying shared losses, establishing, reporting, and ensuring ACO participant and ACO provider/supplier compliance with program requirements. ACOs would have to implement a mechanism for shared governance that provides all participants with appropriate, proportionate control over ACO decision-making processes.

*What other key criteria is outlined by CMS?* ACO providers would serve at least 5,000 Medicare beneficiaries and agree to participate for three years. CMS projects that federal savings from the ACO program may reach up to $940 million over four years.

**BENEFICIARIES**

*What is the Medicare beneficiary benefit of participating in an ACO?* The goal of the ACO is to put the beneficiary at the center by proactively reaching out to patients, coordinating care, focusing on care transitions, appropriately managing resources, and utilizing healthcare data on processes and outcomes to continually improve care.

*Would beneficiaries have a choice?* Yes, CMS states that Medicare beneficiaries must be informed that their provider is participating in an ACO. The beneficiary would then have the option to decline participating in the ACO.

**RISK-MODELS AND SAVINGS BENCHMARKS**

*How would ACO providers share in the savings?* CMS has proposed two tracks – both are based on the current fee-for-service payment system:

- **Track 1** – One-sided risk model where providers would share in savings for the duration of the ACO’s first agreement period, and are then required to transition to **Track 2**. The ACO must first meet a minimum savings rate between 2% and 3.9% (based on the population size). After the minimum savings rate is achieved, the ACO may share in up to 50% of the first dollar savings depending on their quality reporting and performance scores.

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• Track 2 – Two-sided risk model where ACO providers would share in savings and risk all three years (consequently receive a greater share of savings for assuming risk from the beginning). The ACO may share in as much as 60% of the savings and losses after a 2% minimum is achieved and quality reporting and performance standards are met.

QUALITY REPORTING
How would providers be measured on quality? CMS will evaluate ACOs on 33 measures that cover four main areas:
- Patient experience
- Care coordination and patient safety
- Preventive health
- Caring for at-risk populations

The number of quality measures were reduced in order to encourage provider participation. CMS also decided to phase-in the number of quality measures that will be tied to performance. In the first year, an ACO must report completely and accurately on all quality measures. It is not until the second year that payment will be tied to performance, but only on 25 quality measures. In the third year, an ACO must report and meet performance standards on at least 32 of the 33 measures.

THE ADVANCE PAYMENT ACO MODEL
Selected participants in the ACO program will receive advance payments that will later be recouped from the shared savings they earn. The Advance Payment ACO Model, available for ACOs entering the program in April 2012 or July 2012, will test:
- Whether advance payments will increase participation in ACOs
- Whether advance payments will allow ACOs to improve care for beneficiaries and increase Medicare savings at a greater speed

The Advance Payment ACO Model is designed to support organizations that would benefit from additional access to up-front capital, including 1) ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue, and 2) ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals, and have less than $80 million in total annual revenue.

THE PIONEER ACO MODEL
The Pioneer ACO Model is a demonstration program developed by the Centers for Medicare and Medicaid Innovation (CMMI). The model is specifically “designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program.” The first performance period of the Pioneer ACO Model is scheduled to begin by the “end of the fourth quarter, 2011,” according to CMS. The Pioneer model, as proposed in May 2011, is designed to allow coordinated care systems to form ACOs under a program distinct but similar to the Medicare Shared Savings Program for ACOs. The Pioneer ACO Model is also intended to help inform future changes to the Shared Savings Program.

Leading coordinated care organizations such as the Mayo Clinic, the Cleveland Clinic, Geisinger Health System and Intermountain Healthcare have decided not to participate in the Pioneer ACO model.

KEY TAKEAWAYS FOR DISTRIBUTORS
What are future customer needs? Customers will need to develop new competencies in risk management, case management, data capture, analysis and reporting. Expect a focus on:
- Standardization: Both in clinical practices and product selection; evidence-based medicine may drive decisions;
- Opportunity: Products and offerings that decrease and prevent infections and readmissions (Note: reimbursement issues and methods for improving quality resonate with the C-suite);
- Costs: “De-featured” products and services, as well as outcome-based clinical value propositions.

OUTLOOK
CMS estimates that between 50 and 270 ACOs may form in the next three years, impacting the care of 2 million of the 47 million Medicare beneficiaries.” The federal government estimates that it will see as much as $940 million in Medicare savings.

The Advisory Board notes that for hospitals and health systems preparing for risk-based contracting, there is “strategic upside in the commercial environment to more quickly align financial incentives with delivery system transformation.”

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1 “Advance Payment Accountable Care Organization (ACO) Model Fact Sheet,” CMS, October 20, 2011.
4 “Initial Thoughts on the Final Rule and Key Takeaways for Providers,” The Advisory Board Company, October 24, 2011.