**Medicare Accountable Care Organizations (ACOs) Outlook**

ACOs are a primary focus of the Centers for Medicare and Medicaid Services’ (CMS) goal to lower healthcare spending and improve quality of care. CMS continues to invest time and resources into ACOs suggesting a continued focus on the program. Because the program is new and continues to evolve, ACOs will continue to experiment with how to achieve the established quality measures, interpret risk formulas, and juggle new model opportunities. It is important for distributors to understand how quality requirements need to be met as the number will continue to grow.

CMS has designated four types of Medicare ACOs; three with escalating opportunity for financial risk and reward which are described below. MSSP ACOs are designed for organizations without prior ACO experience. MSSP ACOs may apply to be recognized as Pioneer ACOs once they meet the MSSP requirements. This move increases the potential for both risk and reward. The Next Generation ACO model continues to build on prior models, offering the highest reward potential but also carrying the highest risk.

<table>
<thead>
<tr>
<th>How are the savings/losses established?</th>
<th>Medicare Shared Savings Program</th>
<th>Pioneer ACO</th>
<th>Next Generation ACO</th>
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<tbody>
<tr>
<td>How much savings are at risk?</td>
<td>Medicare fee-for-service (FFS) claims will be compared to the established benchmark goal.</td>
<td>A minimum savings rate (MSR) and a minimum loss rate (MLR) will be established. In order for the ACO to share in the savings, the ACO must exceed the MSR; similarly the ACO will not be accountable for losses until they exceed the MLR.</td>
<td>A set benchmark will be established based on the guidelines below. The ACO will share in savings for the first dollar saved under the benchmark and will be accountable for the first dollar spent over the benchmark.</td>
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<tr>
<td>ACO Results</td>
<td>92 of 333 met savings and quality benchmarks, $341 million in savings</td>
<td>15 of 20 saw savings, 11 exceeded the MSR, 5 incurred losses, 3 exceeded the MLR</td>
<td>Information not yet available</td>
</tr>
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<td>How are the benchmarks set?</td>
<td>Medicare Part A &amp; B will use historical FFS expenditures for beneficiaries. Results will be reevaluated after every three-year agreement period. Data for the benchmark will not include disproportionate share hospitals (DSH) or indirect medical education (IME) payments in calculations.</td>
<td>Retrospective payments will be used and finalized at the end of the performance period. Payment will be recalculated in the fourth performance year. The formula will include DSH and IME payments. Rates will be adjusted by removing claims from non-active participants.</td>
<td>A prospective benchmark will be used. Set at the start of the performance year. IME and DSH are included. Includes discounts that incorporate quality, efficiency, and rewards goal achievement and improvement.</td>
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<td>How are ACOs Paid?</td>
<td>Payments will be made in the traditional Medicare FFS model.</td>
<td>Most claims will be paid under FFS. However, ACOs can qualify to transition to population-based payments where they would receive a per-beneficiary per month (PBPM) payment.</td>
<td>2016 Options: 1. FFS 2. FFS/PBPM mix 3. Population-Based Payments Additional 2017 Option: 4. Capitation-monthly PBPM payments and must pay claims to participating ACO providers.</td>
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**MSSP, Pioneer, & Next Generation ACO Quality Measures:**

MSSP and Pioneer ACOs will measure quality achievement based on 33 quality measures as defined by CMS. These measures fall into four equally weighted quality categories. Next Generation ACOs will also use these quality metrics with the electronic health record (EHR) measure removed, since they have previously demonstrated EHR capabilities through their Next Generation application.

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<td>• Access to specialists</td>
<td>• Percent of PCPs who qualified for EHR incentive payment</td>
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<td>• Health promotion and education</td>
<td>• Medication reconciliation</td>
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**Preventive Health**
- Influenza immunizations
- Pneumococcal vaccination
- Adult weight screening and follow up
- Tobacco use assessment and cessation intervention
- Depression screening
- Colorectal cancer screening
- Mammography screening
- Proportion of adults who had blood pressure screened in past two years

**At-Risk Population**
- Diabetes
  - Hemoglobin A1c control
  - Low density lipoprotein
  - Blood pressure
  - % of beneficiaries with diabetes whose HbA1c in poor control>9%
- Hypertension: percent of beneficiaries with hypertension whose blood pressure is < 140/90
- Ischemic vascular disease (IVD)
  - Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl
  - Percent of beneficiaries with IVD who use antithrombotics
- Heart failure: Beta-blocker therapy for left ventricular systolic dysfunction (LVSD)
- Coronary artery disease
  - Drug therapy for lowering LDL cholesterol
  - ACE inhibitor or ARB therapy for patients with CAD and diabetes and/or LVSD

**Comprehensive End-Stage Renal Disease Care (CEC) Model**

The CEC ACO is the fourth ACO model and is designed to bring nephrologists and dialysis centers together to focus on beneficiaries who suffer from ESRD. The program was designed to incentivize looking beyond the approach of traditional dialysis. Because the CEC model is built on the MSSP and Pioneer ACO models, the reimbursement formula will be similar. Benchmarks are established based on previous Medicare Part A & B spending. Under CMS’ proposed rule, CECs would qualify as APMs under the Medicare physician pay system.

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**ESRD Reimbursement Tracks**

**Large Dialysis Organization (LDO):** An LDO is an organization that owns over 200 dialysis centers. LDOs will share in both savings and losses. LDOs could qualify as APMs under CMS’ proposed rule.

**Small Dialysis Organizations (non-LDOs):** A non-LDO is an organization with less than 200 dialysis centers. Non-LDOs will share in savings but will not be responsible for losses. Non-LDOs would not qualify as APMs under CMS’ proposed rule.