The ABC's of ACO’s
Value-based Payment Models

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CMS Goals By 2030

- “100% Of Medicare patients will be in a VALUE-BASED relationship”
- The “vast majority” of Medicaid patients will be in a VALUE-BASED relationship

CMS Definition of a Value-based Relationship

- Health Equity
- Outcome and Cost Accountability
- Access
- System Transformation and Innovation
- Provider Payment Reform
- Patient Relationships/Experience

Brief History Of The CMS Path From Volume To Value

2009

CMS/CMMI Has Experimented With a Number of "Pilot Programs." Since 2008

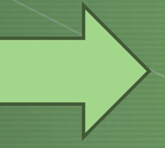
Merit-Based Incentive Payment System- MIPS

CMS Payment Models: MIPS

MIPS (APM)

Traditional MIPS Reporting

2023: MIPS Value Pathways (MVPs)



Multiple disease Specific Best Practices

- Heart Disease
- Cancer Care
- Promoting Wellness
- Kidney Health
- 8 others

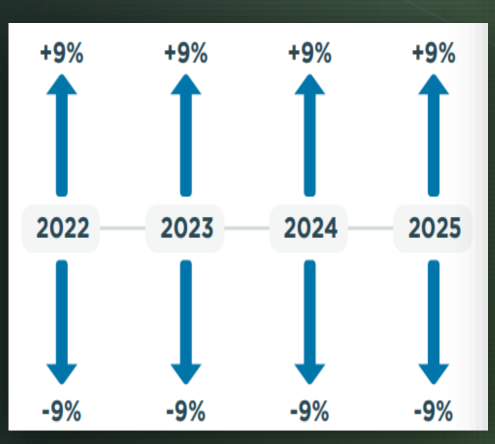
Merit-Based Incentive Payment MIPS Alternative Payment Model (APM):

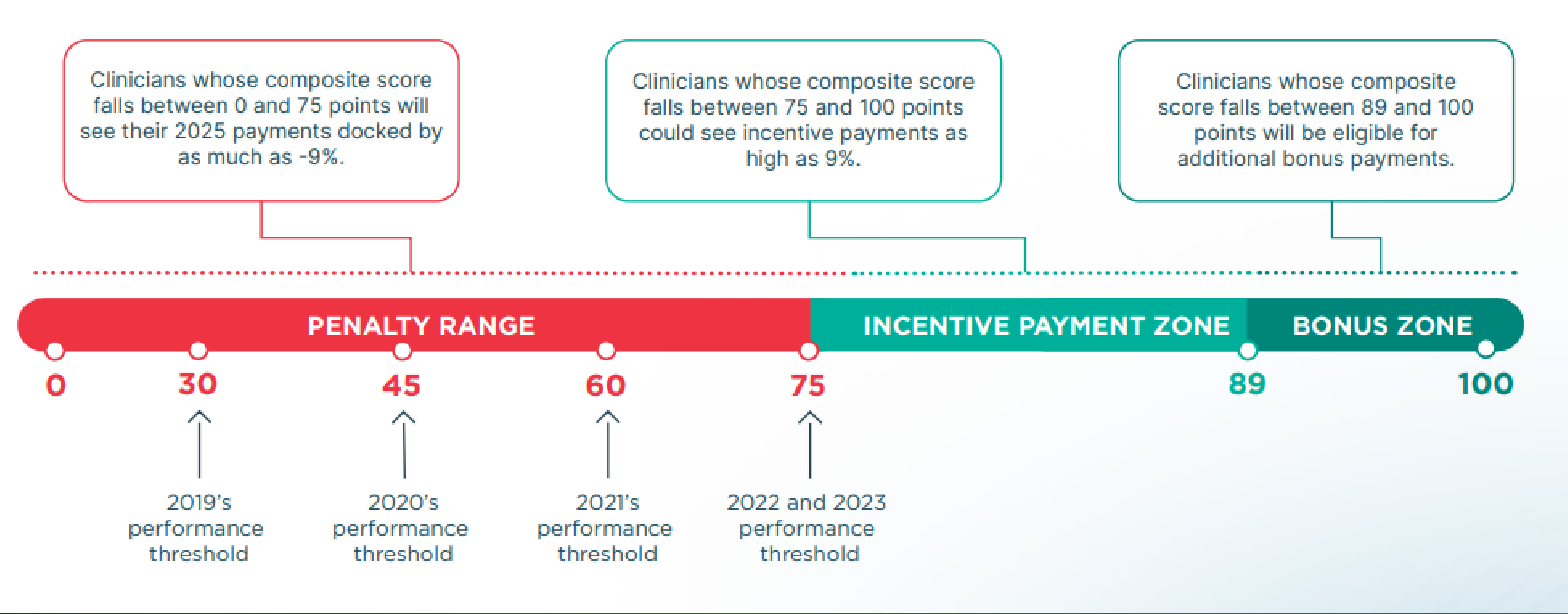
Clinicians are NOT eligible for Year 7 of MIPS if they:

- ✖ Are not a MIPS-eligible clinician type on Medicare Part B claims
- ✖ Enrolled as a Medicare provider after Jan. 1, 2023
- ✖ Are a Qualifying Alternative Payment Model Participant (QP)
- ✖ Meet any of the following low-volume threshold criteria:
  - Bill less than $90,000 for Medicare Part B-allowed services
  - See 200 or fewer Medicare Part B patients
  - Provide 200 or fewer covered professional services under the Physician Fee Schedule

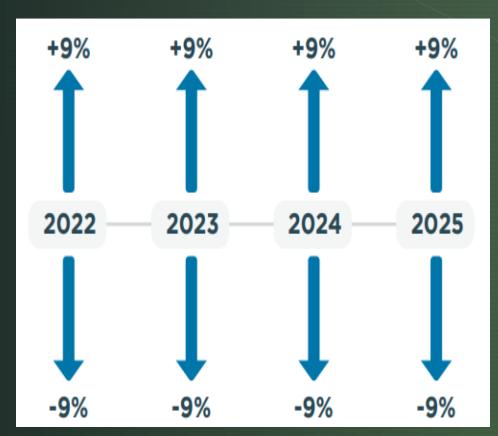
CMS estimates that approximately 978,771 clinicians will not be eligible for MIPS in 2023.

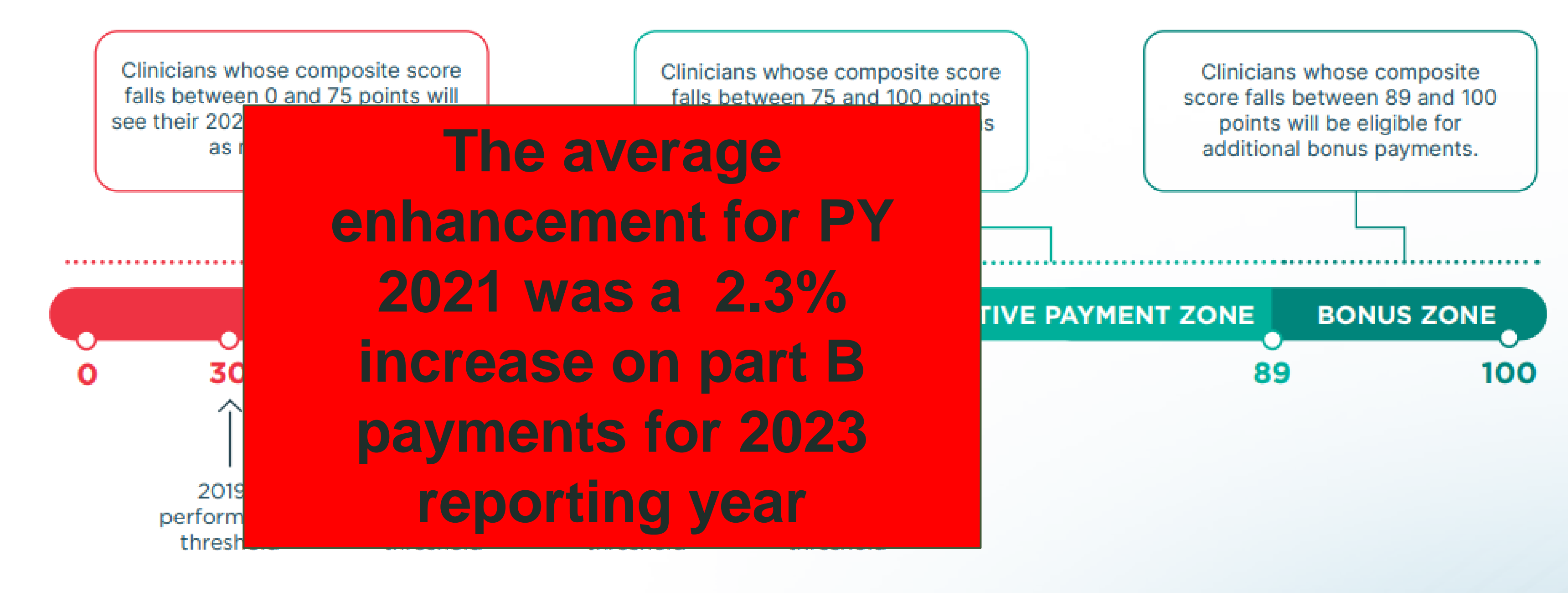
Merit-Based Incentive Payment MIPS: Why You Don't Want to Participate





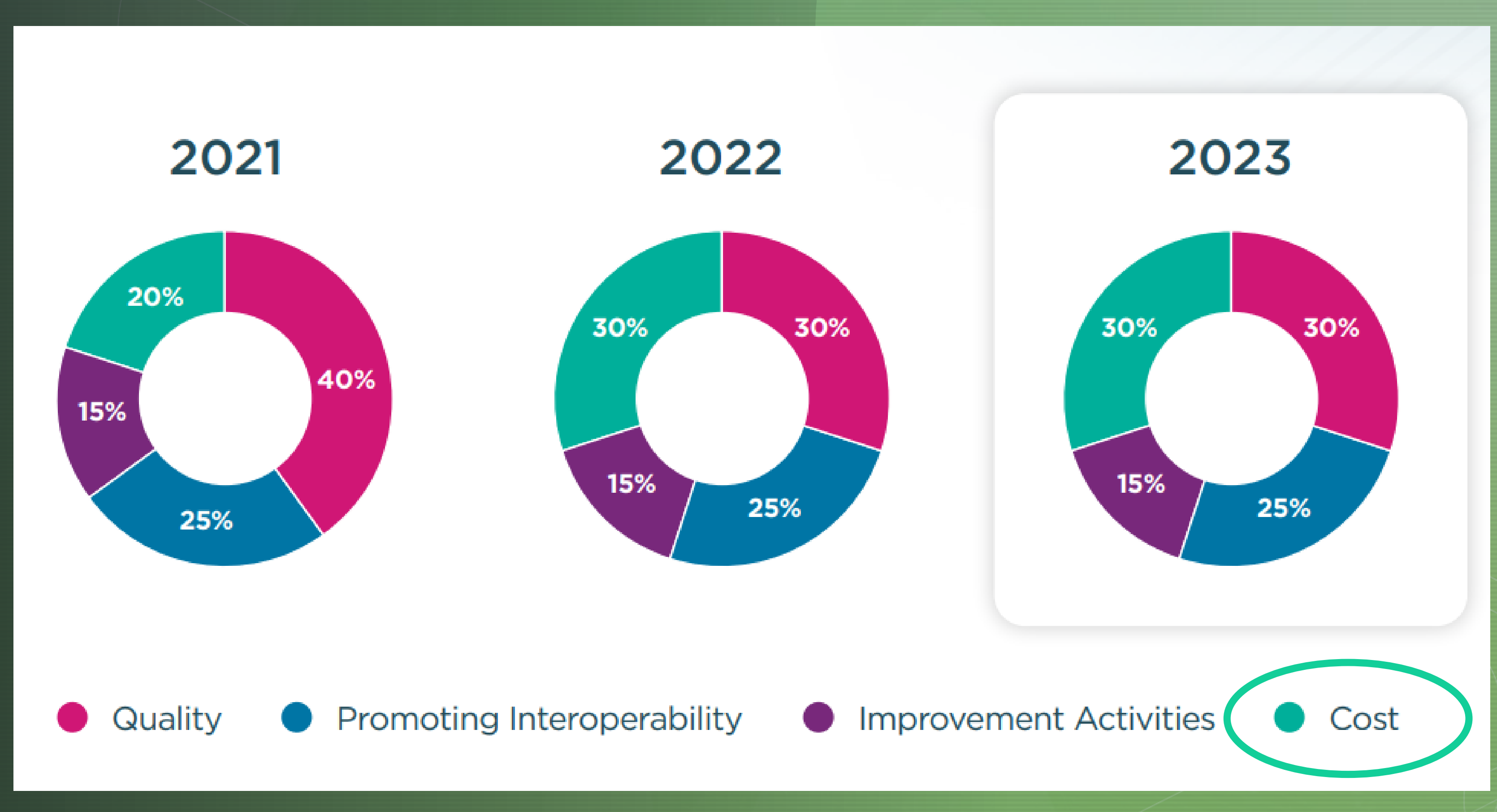
Merit-Based Incentive Payment MIPS: Why You Don't Want to Participate





The average enhancement for PY 2021 was a 2.3% increase on part B payments for 2023 reporting year

Merit-Based Incentive Payment MIPS: 2023



Advanced Alternative Payment Models

Advanced Alternative Payment Model

- Anything that is not a FFS payment model
- Advanced APM Require: Use of a Certified EHR, assume financial risk, payment based on quality/cost measures
- Exempt From MIPS
- You can check your status on the QPP website
  - https://qpp.cms.gov

CMS Payment Models

Advanced Alternative Payment Models (over 80)

- CPC-Primary Care First
- ACO
  - Medicare Shared Savings Model -ACO
  - ACO REACH
  - NextGen ACO
  - ACO Investment Model
  - Advanced Payment ACO Model
  - Comprehensive ESRD Care Initiative ACO
  - Pioneer ACO Model
  - Vermont All-Payer ACO Model
- Disease Specific & Episode-based
- Health Plan Models
- Statutory Models
- State & Community-based Models
- Pharmacy Models

Medicare Advantage

Medicare Advantage: The “Other” Value-Based Care Model

- Medicare Advantage Plans (Medicare Part C) were established under the Medicare Prescription Drug, Improvement and Modernization Act of 2003
- Medicare + private health plans = MA. Allows Medicare patients options to traditional Medicare FFS.
- The relationship is between the payer (Health Plan) and the provider may include financial risk.

CMS Models of Accountable Care

- Episodes of Care/Bundled Payment (BPCI)
- MIPS/Quality Payment Program (QPP)
- MSSP/ACO's
- Primary Care First
- Several Specialty Focused Programs
- Medicare Advantage
  - PPO or HMO

CMS Models of Accountable Care

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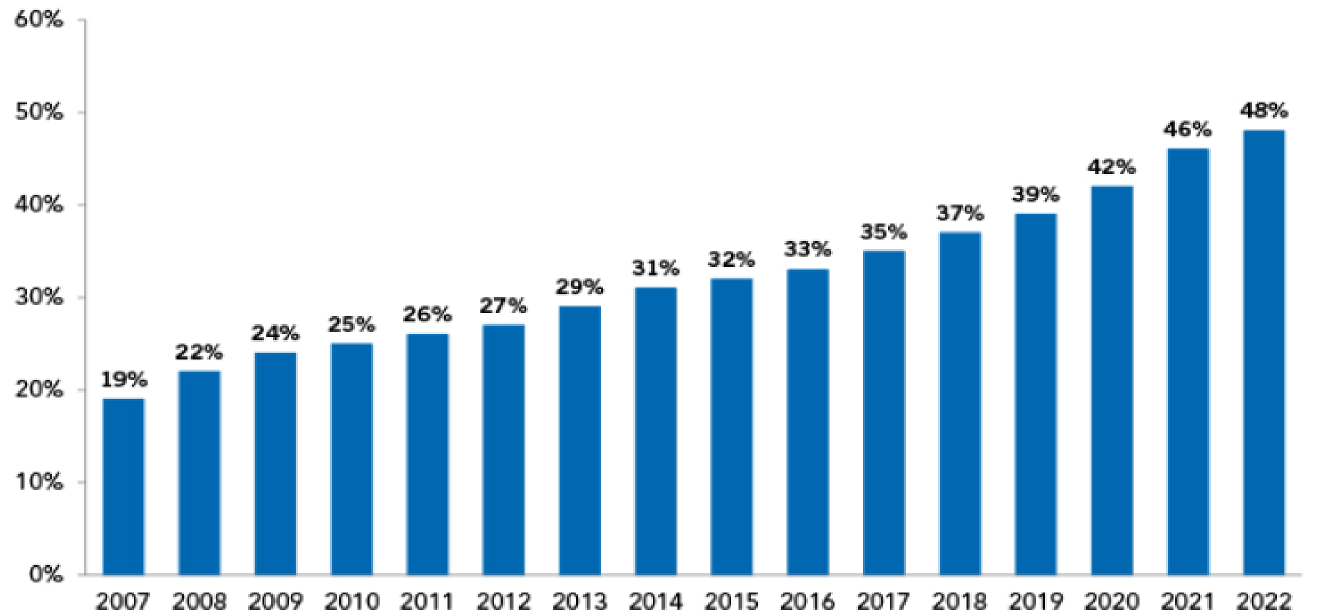
- Several Specialty Focused Programs

• Patient informed they are participants
• No network restrictions

- Medicare Advantage

• Patient selects the Health Plan they wish to be Included
• They may have a restricted network.

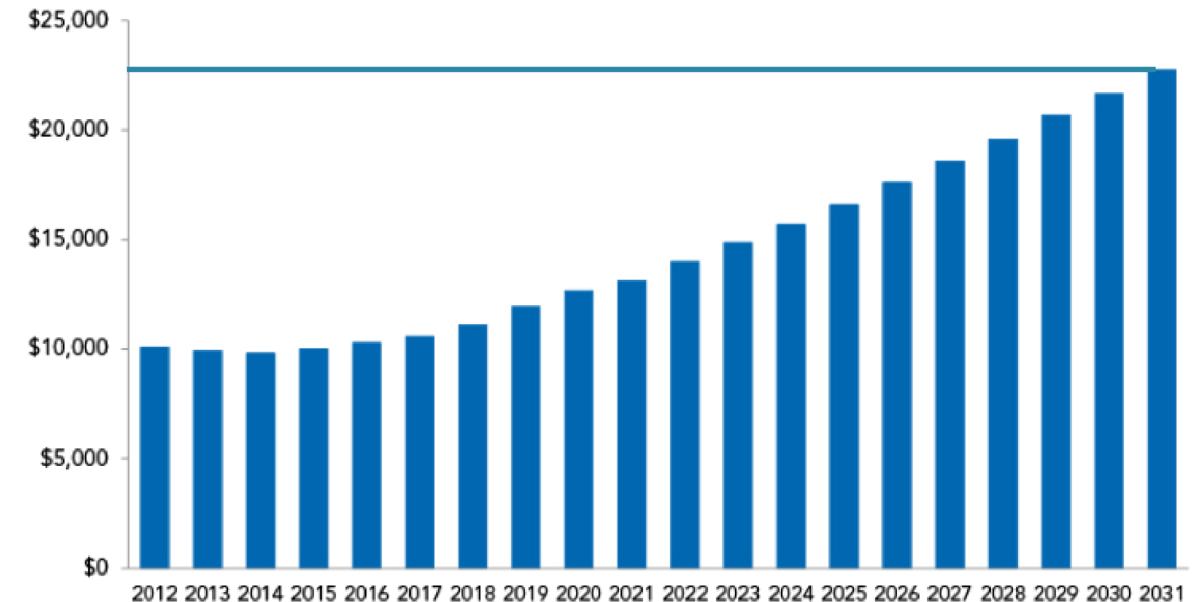
MA plans continue to grow and are projected to Increase to 51% by 2025



Medicare Advantage Programs Have Driven Healthcare Costs Up

The cost per enrollee for Medicare Advantage is projected to continue increasing

INCURRED EXPENDITURES PER PRIVATE HEALTH PLAN ENROLLEE (DOLLARS)



SOURCES: Centers for Medicare & Medicaid Services, *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 2022.
NOTE: Data is collected using the actuarial methodology.

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Accountable Care Organization: ACO Basics

What is an ACO?

- Accountable Care Organization Definition:
  - A healthcare organization that ties provider reimbursement to quality and cost metrics to provide value to a defined population of patients.
  - Can include Hospitals, Physicians, APP’s, Pharmacies, other healthcare providers identified by their TIN
  - An advanced alternative payment model (APM) for CMMI

What Are the Origins of the ACO

Affordable Care Act (ACA) March, 2010

- Section 3022 of the ACA Title XVIII of the Social Security Act by adding a new section (Section 1899) titled the "Shared Savings Program"
- Create alternatives to a FFS payment model to lower the TCOC while holding organizations accountable for quality
- The Primary Care Provider is generally the center of any ACO

What Is Required To Form An ACO?

- Governance and formal legal structure (A legal entity)
- Minimum number of attributed Medicare FFS patients attributed to the ACO-**5,000 patients**
- Have a TIN and NPI for every provider
- Ability to submit data electronically via a certified E.H.R.
- Create a Care Plan and formal Coordination of Care
- The ability to submit quality measures to CMS
- 5 year participation agreement (options out)

There Are Six Types of ACO's

- MSSP: Various levels of risk
- ACO Investment Model:
- Next Generation ACO Model: Allow for higher levels of risk
- Vermont All-payer Model- Limited to Vermont payers
- Medicare-Medicaid ACO Model
- REACH ACO

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ACO Governance

- CMS Requires:
  - The governing body must have responsibility for the oversight and strategic direction of the ACO and holding the ACO management accountable for the ACO activities
  - 75% of the control of the ACO's governing body must be held by ACO participants or designated representatives
  - Must include a Medicare beneficiary who does not have a conflict of interest
  - A consumer advocate role for ACO REACH

ACO Governance: Multiple Options

Single Contract Management

Multi-Contract Management

Health System Owned

Physician Owned

Joint Ventures, Investor Owned, Other Arrangements

MSSP ACO Tracks

	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Number of ACOs	27	124	9	10	125	161	24	108
Length of contract	Five years						2021 starters = 5 years + 9 months 2022 starters = 5 years 2023 starters = 4 years	
Participation opportunities	Annual MSSP application cycle opens each spring. ACOs must submit a notice of intent to apply (NOIA) in order to be eligible to submit a full application.						No future application cycles planned at this time.	
Status under MACRA	MIPS APM				Advanced APM			
Governance requirements	ACO participants must hold at least 75% control over the governing board. Each ACO's governing board must include at least one Medicare FFS beneficiary who is served by the ACO, and this beneficiary representative must have full voting rights.						Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights.	
Financial Structure								
	MSSP Basic Level A	**MSSP Basic Level B**	**MSSP Basic Level C**	**MSSP Basic Level D**	**MSSP Basic Level E**	**MSSP Enhanced**	**REACH Professional**	**REACH Global**
Risk-sharing arrangement	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 75% 1st dollar losses at 40– 75%	1st dollar savings and losses at 50%	1st dollar savings and losses at 100%
Shared savings cap	10% of updated benchmark					20% of updated benchmark	Gross (S/L): < 5% — Cap (S/L): 50% 5%-10% — 35% 10%-15% — 15% > 15% — 5%	Gross (S/L): < 25% — Cap (S/L): 100% 25%-35% — 50% 35%-50% — 25% > 50% — 10%
Shared losses cap	Not applicable		Lesser of 2% of total Medicare Parts A & B FFS revenue or 1% of updated benchmark	Lesser of 4% of total Medicare Parts A & B FFS revenue or 2% of updated benchmark	Lesser of 8% of total Medicare Parts A & B FFS revenue or 4% of updated benchmark	15% of updated benchmark		
Discount or MSR/MLR	MSR will be 2% to 3.9% depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR, (2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.		Prior to entering a two-sided model, the ACO must select its MSR/MLR as part of the application cycle. The choices are: • 0% MSR/MLR • Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO.				• No MSR/MLR • No discount	○ No MSR/MLR ○ Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026)

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Increasing levels of risk and reward

							...CH Professional	REACH Global
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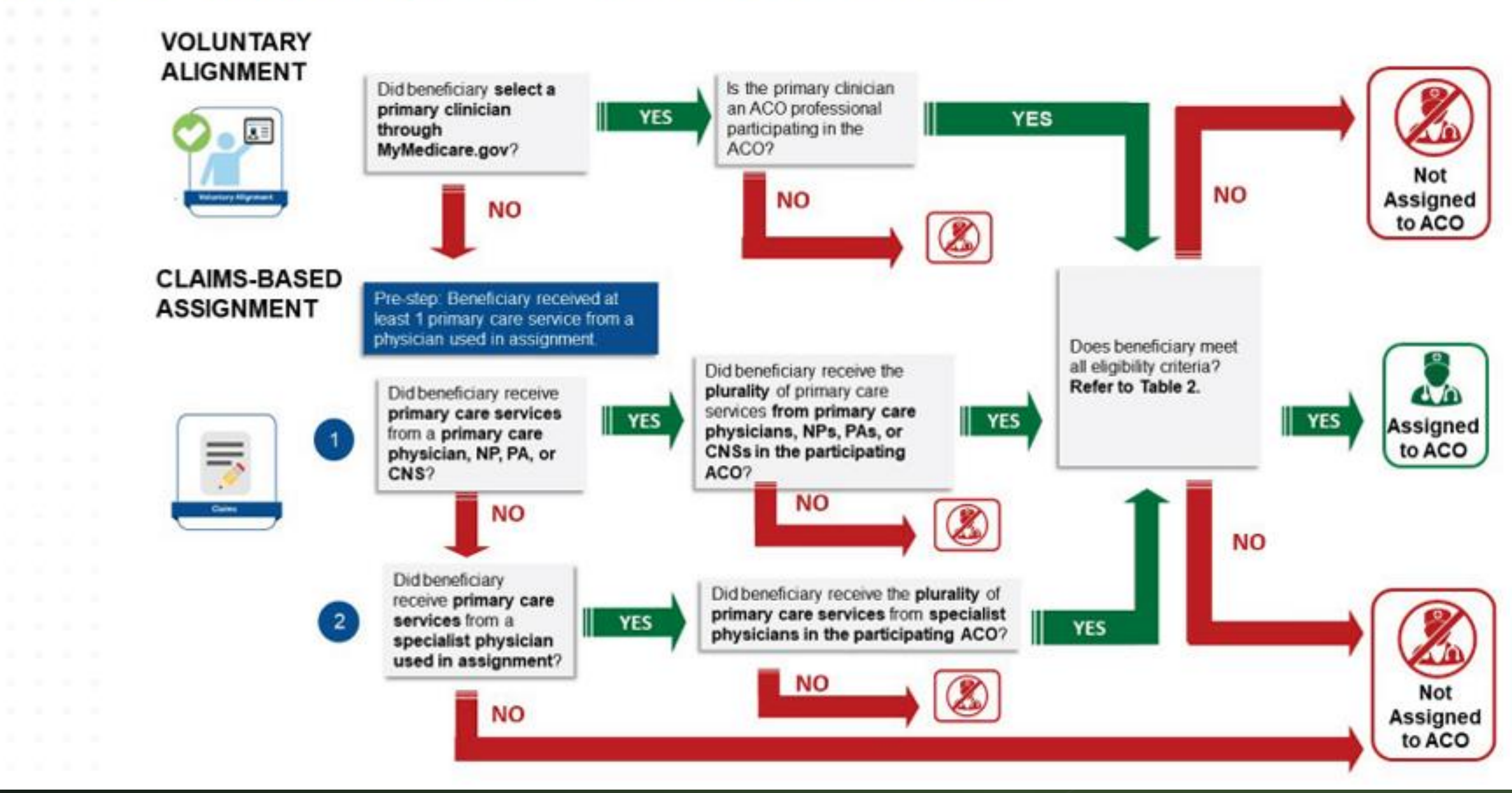
The Conundrum of Assignment



Attribution Challenges

- PCP Definitions
- Retrospective v Prospective
- Specialist Attribution

Primary Care Definitions: Taxonomy

PCP Specialty Codes (Step 1)

- 01 – General practice
- 08 – Family practice
- 11 – Internal Medicine
- 37 – Pediatric Medicine
- 38 – Geriatric Medicine

Specialty Codes Used in Attribution (Step 2)

Only if patient had no visits with PCP

- 06 – Cardiology
- 12 – Osteopathic manipulative medicine
- 13 – Neurology
- 16 – OB/GYN
- 23 – Sports Med
- 25 – Physical medicine and rehabilitation
- 26 – Psychiatry
- 27 – Geriatric psychiatry
- 29 – Pulmonary disease
- 39 – Nephrology
- 46 – Endocrinology
- 70 – Multispecialty clinic or group practice
- 79 – Addiction medicine
- 82 – Hematology
- 83 – Hematology/Oncology
- 84 – Preventive medicine
- 86 – Neuropsychiatry
- 90 – Medical oncology
- 98 – Gynecology/oncology

Prospective v Retrospective

	Assignment Window	Pros	Cons	Other Differences
Prospective	12 month period ending September 30 prior to the Performance Year For PY2023: CMS will use dates of service October 1, 2021 – September 30, 2022	Clarity about who the ACO is accountable for at start of year	Accountable for patients who ACO may not have a care relationship with during the performance year (e.g., patients that move out of state or switch PCPs)	Attribution numbers typically slightly lower Population typically slightly older, more expensive (also reflected in the benchmark years)
Retrospective	12 month period corresponding to performance year (calendar year) For PY2023: CMS will use dates of service January 1, 2023 – December 31, 2023	More accurately reflects who the ACO actually saw during the performance year	Patient list is a "moving target" for care management and other clinical operations, gaps in care closure efforts	Attribution numbers typically slightly higher Population typically slightly younger, less expensive (also reflected in the benchmark years)

Other considerations:

- Mid-year billing TIN changes
- Financial reporting is different – rolling 12 vs YTD
- You can change selection annually but it could make it harder to compare point in time performance year over year when you change

Challenges

- CMS assigns patients to the ACO, not to a specific PCP or practice
- MSSP requires full Taxpayer Identification Number (TIN) participation so you do not have the option to select PCPs for attribution if you have large TIN with multiple practices, specialties, etc.
- Specialist attribution
  - May have patients attributed to specialties that don't see themselves as responsible for broader preventive care
  - Advanced practitioners (NPs, PAs, CNSs) are treated as PCPs regardless of the type of practice; if these provider types do a lot of Medicare billing in your organization/practices, be aware that they may drive attribution (even if working in a specialty setting)

How Does an ACO Measure Quality

- Patient/Caregiver Experience
- Care Coordination/Safety
- Preventative Health
- At-Risk Populations
  - DM, HTN, IVD, HF, CAD

ACO 33 Quality Measures

Domain	Measure	Description	Pay-for-Performance Phase In R= Reporting P= Performance		
			PY1	PY2	PY3
Patient/Caregiver Experience	ACO #1	Getting Timely Care, Appointments, and Information	R	P	P
Patient/Caregiver Experience	ACO #2	How Well Your Doctors Communicate	R	P	P
Patient/Caregiver Experience	ACO #3	Patients' Rating of Doctor	R	P	P
Patient/Caregiver Experience	ACO #4	Access to Specialists	R	P	P
Patient/Caregiver Experience	ACO #5	Health Promotion and Education	R	P	P
Patient/Caregiver Experience	ACO #6	Shared Decision Making	R	P	P
Patient/Caregiver Experience	ACO #7	Health Status/Functional Status	R	R	R
Care Coordination/Patient Safety	ACO #8	Risk Standardized, All Condition Readmissions	R	R	P
Care Coordination/Patient Safety	ACO #9	ASC Admissions: COPD or Asthma in Older Adults	R	P	P
Care Coordination/Patient Safety	ACO #10	ASC Admission: Heart Failure	R	P	P
Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	P
Care Coordination/Patient Safety	ACO #12	Medication Reconciliation	R	P	P
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Fall Risk	R	P	P
Preventive Health	ACO #14	Influenza Immunization	R	P	P
Preventive Health	ACO #15	Pneumococcal Vaccination	R	P	P
Preventive Health	ACO #16	Adult Weight Screening and Follow-up	R	P	P
Preventive Health	ACO #17	Tobacco Use Assessment and Cessation Intervention	R	P	P
Preventive Health	ACO #18	Depression Screening	R	P	P
Preventive Health	ACO #19	Colorectal Cancer Screening	R	R	P
Preventive Health	ACO #20	Mammography Screening	R	R	P
Preventive Health	ACO #21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P
At-Risk Population Diabetes	Diabetes Composite ACO #22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	P	P
At-Risk Population Diabetes	ACO #27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P
At-Risk Population IVD	ACO #29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	P	P
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P
At-Risk Population HF	ACO #31	Beta-Blocker Therapy for LVSD	R	R	P
At-Risk Population CAD	CAD Composite ACO #32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P

Notes: PY = Performance Year

How is Shared Savings Rate Calculated

Simple Government Math!

The regression model is estimated using ordinary least squares regression and following is the general specification of the DID model:

$$Y_{itc} = \beta_0 + \beta_1 * Treat_{it} + \beta_2 * After_t + \beta_3 * After_t * Treat_{it} + \beta_4 * X_{itc} + \beta_5 * HRR * Year_t + \varepsilon_{it}$$

Here, Y_{itc} is per member per year total Parts A and B expenditures for beneficiary "i" in year "t" and residing in county "c".

Shared Savings Calculation

1. Establish a risk-adjusted* historical benchmark cost per beneficiary per year

   *HCC Risk Adjustment and Demographic Factors

2. Compare current cost per beneficiary
3. The difference must Exceed the Minimum Savings Rate (MSR) defined by the ACO.
4. If the difference if greater that the MSR, that delta is multiplied by the ACO's Savings Rate (ranged from 40% to 100%)
5. Quality Scoring thresholds required for shared savings

Shared Savings Calculation

Baseline Cost*: 998$/PBPY

Current Performance: 963.7$/PBPY

Delta: 963/998 = 3.5% lower cost

If MSR is 2 %: The ACO savings exceeded 2% by 1.5%

If the ACO had a Savings Rate of determined to be 40%

Shared Savings Calculation = 1.5% x .40 or a 0.6% bonus

Shared Savings Calculation

Estimated PMPY Part A-B Savings: $35

Total Attributed Member Years: 7,000

$35 x 7000 member years: $245,000

$245,000 x 0.6 = $147,000 bonus

What Are The Downsides Of Being In An ACO

- The ACO claims a percentage of the shared savings when achieved
- There is a cost associated with performing outreach, care coordination, data entry etc.
- Providers are expected to eventually take on risk
- Time commitment

What Are The Benefits Of Being In An ACO

- Additional income IF shared savings are achieved
- Claims Data
  - How are your patients using their healthcare dollars?
  - Who are your most expensive patients?
  - Where are your patients going?
- Quality Data –Potentially Better quality with more info.
- Partnership opportunities-More expertise and resources
- Will submit MIPS Data for you: ACO Level A-D

ACO REACH
Realizing Equity, Access and Community Health

- Evolution from previous GPDC (Global and Professional Direct Contracting)
- ACO Model funded 1/1/2023 through 12/31/2026 with increased risk. **Primary care capitation for some services**
- Only 2 sided model
- Tangible accountability for Health Equity. Produce a plan to identify and address HE's specific to that underserved community
- Offer In-Kind Services (b/p kits, transportation, otc meds, wellness vouchers)
- Increase governance requirements to increase provider participation to 75% and required a patient advocate on the Board.
- Minimum number of patients lowered from 5K to 4 K patients

2022 ACO Performance

- 1.8 Billion dollars saved, a 9% increase in net savings compared to 2021 baseline savings
- Represented over 10.4 million Medicare Patients
- 63% of ACO’s earned payments
- 59% were in upside/downside risk models

The Impact of ACO’s in the US

- MSSP, Kidney Care Choices and ACO Reach-13.2 million patients
- 704K physicians and non-physicians are in an ACO
- 1450 Hospitals were in an ACO
- 1.8 billion dollars saved in 2022
- 63% of the participants earned shared savings.
- 482 ACOs in 2023-Down from a peak of 561 in 2018

Critical ACO Success Factors

- A Certified EHR and a robust patient database. The EHR must present data to CMS in a meaningful way.
- An aggressive Annual Medicare Wellness Visit (AWV) Program and a Transition of Care program (TCM).
- Knowledge of HCC coding and the capability to recapture coding from the previous year.
- Care Coordination Capabilities
- Advanced Care Planning and Behavioral Health

Questions