HealthExec Learning

Accountable Care

A learning resource on Accountable Care Organizations for healthcare executives

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ACO Basics

An Accountable Care Organization (ACO) is a local health care organization, designated by an applicable purchaser (such as Medicare) to be accountable for all applicable expenditures and care of a defined population of beneficiaries.

CMS states that "an Accountable Care Organization (ACO) is a group of health care providers in a care delivery system who agree to accept joint responsibility for the medical care and management as well as the cost and quality outcomes of a designated population of patients. An ACO transforms the organization, delivery, and financing of care; it replaces fragmented, uncoordinated care with an arrangement in which providers work together to achieve shared goals of better care at a lower total cost. An ACO also preserves the ability of patients to choose and form an active partnership with the providers that best meet their own needs."

There is not one sole, rigid standard or regulation for how ACOs may be structured or operation. The Affordable Care Act and subsequent rulemaking and regulations developed during the past decade addresses operation of ACOs via Medicare programs, thus considerable current focus is on Medicare's ACO regulations and guidelines to serve the Medicare FFS population, but ACOs may contract with other public or private purchasers as well. As such, there is considerable flexibility in how an ACO could be operated and structured.

ACO Key Features include:

- *Local Accountability*: An ACO would be a local provider entity accountable for the local care according to local cost and quality benchmarks
- *Purchaser Designation*: An ACO would be designated by a purchaser to be accountable to serve its covered population assigned to the ACO
- *Shared Savings or Risk*: The ACO would modify provider payment structures in some form to incorporate a spectrum of savings or risk sharing, from payment incentives such as partial sharing of savings or risk with applicable stakeholders, up to full risk arrangements for specified services.
- *Performance Measurement*: An emphasis would be placed on performance measurement, including evidence-based quality metrics
- *Organizational Capacity*: The ACO would be a formal legal entity with capacity to arrange and coordinate care, administer payments, set benchmarks, measure performance and distribute shared savings.

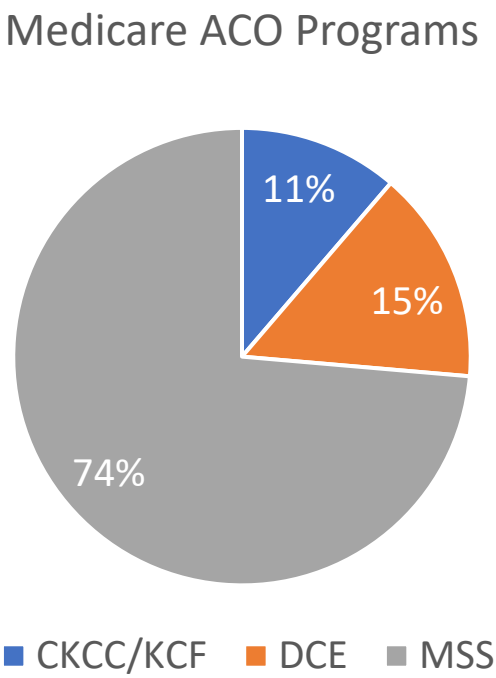
Accountable Care success factors can include:

- Clinical transformation encouraging clinical integration
- Improved data capture and data mining
- Sound Purchaser partnerships with sound benefit design
- Strong organizational commitment, capacity and leadership
- Payment structures that reward higher performance
- Prior existence of some elements before ACO formation

ACOs by the Numbers

Medicare 2022 ACO Participants by Category

2022 CMS Medicare ACO Program	Participants
CKCC: Global	3
CKCC: Graduated Level 1	4
CKCC: Graduated Level 2	7
CKCC: Professional	33
DCE High Needs Population Global	5
DCE High Needs Population Professional	3
DCE New Entrant Global	5
DCE New Entrant Professional	5
DCE New Entrant Global	3
DCE Standard Global	59
DCE Standard Professional	19
KCF	27
MSSP Basic Track A	29
MSSP Basic Track B	170
MSSP Basic Track C	25
MSSP Basic Track D	15
MSSP Basic Track E	98
MSSP Enhanced Track High Revenue ACO	69
MSSP Enhanced Track Low Revenue ACO	77
Vermont All-Payer ACO Model	1
Grand Total	**657**



Source: HealthQuest Accountable Care Directory 2022

ACO Library

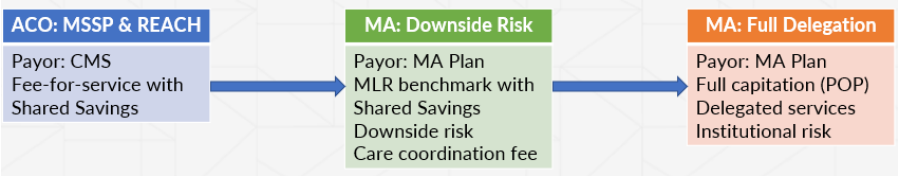
Achieving Success Through MSSP to Medicare Advantage Transition

Accountable Care Organizations participating in the Medicare Shared Program have already progressed through the spectrum of value based care arrangements, with many achieving measurable levels of success. A HealthcareWebSummit event earlier this May 2022 addressed the potential to leverage that success further by transitioning to Medicare Advantage participation, including examination of a case study on enabling providers through a multiprogram IPA and ACO infrastructure forward/

During the webinar, Collaborative Health Systems' Mike Barrett and Andrew Gil discuss leveraging Medicare Shared Savings Program Success to transition to Medicare Advantage. Mike was a co-founder of NAACOs and has spent twenty years in highly managed Medicare, including seven years as either a HMO CEO or CFO. Andrew has ten years of managed care contracting experience, was co-chair of America's Physician Groups and was a contributor to APG's contracting manual.

Collaborative Health Systems current partnerships across the country include six MSSP ACOs, three direct contracting entities, three IPAs and a Maryland CTO, with their affiliated networks covers 25 states. In the most recent Medicare performance year with data released (PY20), CHS affiliates cared for 160,000 Medicare beneficiaries, and yielded a 19% reduction in hospitalizations, a 26% reduction in SNF utilization and an average 97% quality score. In aggregate, their affiliates yielded $34 million in shared savings in PY18, $51 million in PY19 and $66 million in PY20.

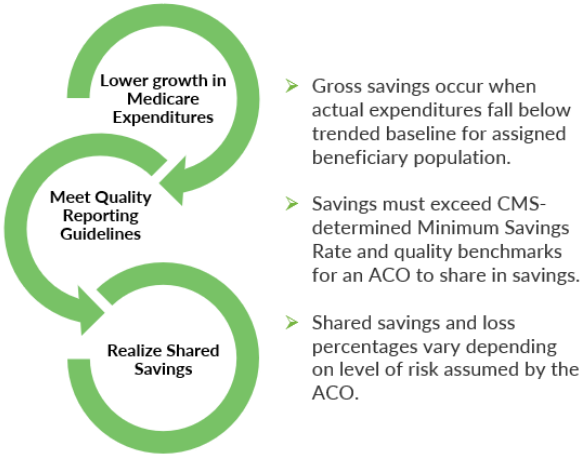
The path from MSSP to Medicare Advantage they described starts with MSSP and ACO REACH, progress to a payor Medicare Advantage downside risk relationship using a Medical Loss Ratio benchmark with shared savings and shared downside risk, plus a care coordination fee. This ultimately would mature to a full delegation model with the Medicare Advantage plan would provide full capitation, delegated services and institutional risk.



Barrett and Gil provider these reminders about MSSP ACO elements:

- Attribution: Patients assigned to ACO based on plurality of primary care services
- Billing: Providers bill normally, receive standard fee-for-service payments
- Reconciliation; CMS compares quality performance and total cost of care for assigned population
- Shared Savings: Achieved based on variance of expenditures from benchmark and quality performance
- Minimum of 5,000 assigned beneficiaries
- Primary Care Providers can only participate in one ACO

Barret and Gil discussed this path to MSSP shared savings:



They outlined that under the MSSP ACO Pathways progression, ACOs must move through Pathways into higher-risk tracks. CHS's actuarial modeling shows readiness to optimize Track selection.

	Basic Track's Glide Path				Enhanced Track
	Level A & B	Level C	Level D	Level E	
Shared Savings once MSR met or Exceeded	40% Sharing Rate	50% Sharing Rate	50% Sharing Rate	50% Sharing Rate	75% Sharing Rate
	Based on Quality Performance Not to exceed 10% of updated Benchmark				Based on Quality Performance Not to exceed 20% of updated Benchmark
Shared Losses once MSR met or exceeded	Upside Only	1st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of BM	1st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of BM	1st dollar losses at 30%, not to exceed 8% of FFS revenue capped at 4% of BM	1st dollar losses 40-75%, not to exceed 15% of BM
	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM

APM = Alternative Payment Model

Barrett and Gil highlighted the complexities and regulations that do accompany the transition to risk-based Medicare Advantage plan relationships. They noted that a Medicare Advantage Managed Care Manual includes a 132 page marketing chapter is 132, the Marketing Guidelines 'further guidance' comprises 53 pages, and the enrollment chapter consumes 304 pages. Instead of simply accumulating attributed members, Medicare Advantage success requires significant marketing and enrollment resources, with high member acquisition costs

Barret and Gil elaborated on the prevalence of expanded benefit plan design as Medicare Advantage supplemental benefits have taken hold, particularly in high payment rate book counties. The benefit enhancements are typically funded by waivers or reductions of out of pocket cost requirements, which ultimately reduce total provider payments.

Providers always pay for benefit plan enhancements.

KFF reported in 2016 FFS beneficiaries averaged $5,776 in OOP

5 Star MA HMO Max OOP in Orlando FL 2022 $2,750

$3,026 in reduced OOP! Who pays this and plan administration?

CMS 5% bonus rate book for Orange County FL is $11,889

Simplified Plan Economics

CMS Rate Book	$ 11,889
KFF OOP	$ 5,776
Allowable Plan Admin	$ (1,783)
Out of pocket reduction	$ (3,026)
Net available for care	$ 12,856
RAF Needed to Equalize	1.374

CMS Rate Book	$ 11,889
KFF OOP	$ 5,776
Allowable Plan Admin	$ (1,783)
Risk Pool	$ 15,882
Out of Pocket Reduction	$ (3,026)
Net Available for care	$ 12,856

The explained the complexities of Division of Financial Responsibility (DOFR): in risk model contracting arrangements, that come into play in determining plan vs. provider organization responsibility for each service line item:

Over 9,000 lines of adjustment in WellCare DOFR tables

Physician Incentive Regulations, some bonuses can be too high!

Credible populations, catastrophic, and in system vs. out

Fixed vs. variable costs

Panel size	Single combined limit	Separate institutional limit	Separate professional limit
1-1000	$6,000	$10,000	$3,000
1,001-5000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	none	none	none

https://www.law.cornell.edu/cfr/text/42/417.479

Finally, Barnett and Gil noted these Medicare Advantage revenue considerations for provider organizations:

Top-Line: Revenue:

- CMS Revenue Definition – Are rebates included?
- Sequestration, Taxes, & Fees – Which ones are deducted from your revenue?
- RAF & STARS – Maximizing the value of your members
- Upside/Downside Risk – How much risk can you afford to take?

Bottom Line: Costs

- *DOFR – What risk should you be taking? Out-of-area, transplants, new benefits & technology*
- *Delegated Services – Are you running efficiently?*
- *Reinsurance – Mitigating insurance risk*

This article originally appeared in Accountable Care News

CMS Executive Profiles

In alphabetical order by name

The Executive Profiles contain contact and biographical information for selected Centers for Medicare and Medicaid Services staff

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Profile:

Jeff Grant serves as the Acting Deputy Administrator & Director and Deputy Director. In CCIIO he leads the implementation of health insurance marketplaces and associated financial provisions, advising staff and management on payment methodology, policy, and operations. As one of the original Marketplace financial team members commencing in July 2010, Jeff has provided strategic and technical direction for all financial programs that impact the individual and small group private insurance markets, including premium tax credits, cost sharing reductions, user fees, reinsurance, risk adjustment, and risk corridors.

Jeff has over 22 years of experience in federal health insurance programs, previously having led the development of the policy, systems and operations to implement Medicare Advage and Medicare Part D payments. Jeff previously served as Senior Vice President for Client Services at Health Risk Partners, LLC, where he supported clients on risk adjustment and enrollment and payment reconciliation. He has a Bachelor of Arts degree in History from the University of Michigand a Master of Public Administration degree from George Washington University. Jeff is a retired Naval reservist with 22 years of service.

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Profile:

Dr. Mary G. Greene is the Director of the Office of Burden Reduction & Health Informatics. She is responsible for unifying CMS's efforts to reduce regulatory and administrative burden for beneficiaries and the medical community, enabling the health system to focus on providing higher quality care at lower cost and to foster innovation in health care delivery. She oversees initiatives to modernize regulations, drive interoperability, and improve the adoption and enforcement of HIPAA Administrative Simplification national standards and operating rules, and engages external stakeholders through listening sessions and onsite observational visits.

Previously, Dr. Greene served as senior advisor to the CMS Office of the Administrator leading and supporting CMS's burden reduction initiatives. Prior to that, Dr. Greene was the Director of the Governance Management Group in the CMS Center for Program Integrity (CPI), where she led CPI's vulnerability management, program risk assessment, regulation development, strategy development, and performance oversight functions.

Before joining CMS, Dr. Greene led strategy and operational support projects to stand up new programs, improve operational efficiencies, build collaborations, and foster professional development. Dr. Greene, a pediatrician and Fellow of the American Academy of Pediatrics, completed her medical education at the Yale School of Medicine, clinical training at the Johns Hopkins Hospital, Masters in Public Health at the Yale School of Public Health, and Masters in Business Administration at Loyola College in Maryland.

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