Green Mountain Care Board

Medicare-only Budget Review

Medicare Shared Savings Program

Gather Health ACO LLC

Agenda

- Medicare Shared Savings Program
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Medicare Shared Savings Program: Program History

The Shared Savings Program is a **voluntary program** that encourages groups of **doctors, hospitals, and other health care providers** to come together as an ACO to give **coordinated, high-quality care** to their **Medicare** beneficiaries.

Original Medicare - Non-Value-based	Original Medicare - ACO (SSP + ACO REACH)	Medicare Advantage + PACE Other
24.8M	11.4M	27.5M

Year	SSP ACOs	Total Assigned Beneficiaries	Total Earned Shared Savings	Avg. Overall Quality Score
2022	483	11.0 million	*TBD*	*TBD*
2021	477	10.7 million	$1.6 billion	99%
2020	517	11.2 million	$2.3 billion	97%
2019	487	10.4 million	$1.5 billion	92%
2018	561	10.4 million	$983 million	93%
2017	480	9.0 million	$799 million	92%
2016	433	7.7 million	$700 million	95%
2015	404	7.3 million	$645 million	91%
2014	338	4.9 million	$341 million	83%
2012/2013	220	3.2 million	$315 million	95%

Medicare Shared Savings Program: Statutes and Federal Regulations

The Patient Protection and Affordable Care Act added SEC. 1899: Shared Savings Program to Title XVIII of the Social Security Act.

> ***A shared savings program that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.***

42 CFR § 425 outlines the key federal regulations of the SSP program.

Application/Participation Process

- **Legal Entity:** An SSP ACO is a defined legal entity with a governing body that has responsibility for the oversight and strategic direction of the ACO and holding management accountable. (§ 425.104)
- **ACO participants and agreement:** The ACO must have Medicare-enrolled ACO participants/ACO professionals. Medicare FFS beneficiaries are aligned to the ACO based on primary care claims or voluntary alignment. (§ 425.116)
- **Beneficiary Alignment:** Preliminary prospective assignment with retrospective reconciliation (Initial; updated quarterly) OR Prospective assignment (Initial alignment only). Voluntary Alignment trumps claims-based. (§ 425.400)
- **ACO size:** The ACO must have enough ACO professionals to have at least 5,000 beneficiaries assigned to the ACO throughout the year. (§ 425.110)
- **ACO governing body:** The governing body is comprised of one ACO Medicare beneficiary, ACO participants (at least 75% voting), beneficiary/consumer advocates, and ACO leadership. The ACO's compliance officer reports to the governing body. (§ 425.106)
- **Leadership and management:** ACO executive, senior medical director, quality assurance, compliance (§ 425.108)
- **ACO Agreement:** The ACO will sign a 5-year participation agreement with CMS for a specific risk track. (§ 425.200)
- **ACO Repayment Mechanism/Financial Guarantee:** CMS requires the ACO to secure a financial guarantee, of an amount set by CMS, in the event the ACO incurs losses. (§ 425.204)

Medicare Shared Savings Program: Statutes and Federal Regulations (continued)

Transparency, Beneficiary Protections, and Compliance

- **Public reporting and transparency, marketing, beneficiary protections, and audits and record retention:**

ACOs must make beneficiaries aware, through signs and standardized written notices, that the ACO participant is part of a Medicare SSP ACO and the way a beneficiary may opt-out of Medicare data sharing.

The ACO must maintain a public website with CMS-defined information.

Any and all ACO marketing must meet CMS marketing regulations, as well as be filed and approved by CMS.

CMS, HHS, OIG, and other federal regulatory agencies may audit, inspect, investigate and evaluate the ACO's operations at any time. (§ 425.308) (§ 425.310) (§ 425.314) (§ 425.304)

- **Compliance Plan:** The ACO must have a compliance plan that includes at least the following elements:

(1) A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body.
(2) Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance.
(3) A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer.
(4) Compliance training for the ACO, the ACO participants, and the ACO providers/suppliers.
(5) A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.
(§ 425.300)

Medicare Shared Savings Program: Statutes and Federal Regulations (continued)

Performance-year Care Model and Payment Rule Waivers

- **Patient-centeredness:** The ACO must promote evidence-based medicine, promote patient engagement and shared decision making, help coordinate care, including care transitions, implement care programs for beneficiaries that are at high-risk of events or have multiple chronic conditions, help beneficiaries access their medical record, and understand patient experience through direct beneficiary surveys. (§ 425.112)
- **Beneficiary Incentives:** ACOs are permitted to provide in-kind incentives that are items or services not covered by Medicare for a beneficiary, are preventive care or advance clinical goals for the beneficiary, and are reasonably connected to the beneficiary's medical care. ACO's are also permitted to offer monetary incentives through a beneficiary incentive program. (§ 425.304)
- **SNF 3-day waiver:** ACOs may apply for a waiver to the rule that requires a 3-day inpatient hospital stay prior to a Medicare covered post-hospital extended care service. The ACO must enter into SNF affiliate agreements plus meet additional operational requirements to apply for this waiver. (§ 425.612)
- **Telehealth services:** ACOs may apply for a waiver to telehealth payment rules to consider the home as an originating site. *Note: Given the broad use of telehealth during the COVID-19 PHE, CMS has proposed rulemaking that implements the Consolidated Appropriations Act, 2022 (CAA, 2022). CAA, 2022 includes allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home.* (§ 425.612)

Medicare Shared Savings Program: Statutes and Federal Regulations (continued)

Quality performance standard and tie-in to financial performance

- **ACO Quality performance standard:** For 2022, 2023, and 2024: The ten CMS Web Interface measures OR the three eCQMs/MIPS CQMs, and the CAHPS for MIPS survey. (42 CFR § 425.512)

- **Qualifying for Shared Savings:** ACO must meet the minimum quality performance standards for the performance period in order to achieve shared savings.

- **Range of Incurred Losses:** If an ACO ends a performance year with incurred losses, the ACO's performance in Merit-based Incentive Payment System (MIPS) quality (Achieved Points / Available Points) to determine a final loss sharing rate. The loss sharing rate is a minimum of 40% and maximum of 75% in the ENHANCED SSP Track.

Appendix A: CMS Web Interface Measure Benchmarks for the 2021 Performance Year

Measure-#	Description	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
Quality ID #: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control[2]	70.00	60.00	50.00	40.00	30.00	20.00	10.00
Quality ID #: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan[3]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Quality ID #: 236	Controlling High Blood Pressure	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Quality ID #: 318	Falls: Screening for Future Fall Risk	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Quality ID #: 110	Preventive Care and Screening: Influenza Immunization	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Quality ID #: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention[4]	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Quality ID #: 113	Colorectal Cancer Screening	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Quality ID #: 112	Breast Cancer Screening	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Quality ID #: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease[3]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Quality ID #: 370	Depression Remission at Twelve Months[3]	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Medicare Shared Savings Program: Statutes and Federal Regulations (continued)

Financial Risk Tracks and Reconciliation

- **Reconciliation:** Use of a minimum savings/minimum loss rate (0 - 2% in two-sided tracks). One-sided (upside only) risk tracks with a forced glide path to higher levels of risk. The ENHANCED Track has the greatest financial incentives. (§ 425.610)
- **"Spreadsheet Risk" and Flow of Funds:** SSP represents "spreadsheet risk" only. All beneficiaries maintain their freedom of choice to go to any Medicare provider, all providers continue to submit claims and receive 100% of CMS-defined remuneration from CMS. Every performance year, the ACO will be paid, or will pay, the difference between expected utilization and costs (Benchmark) and actual utilization and costs (Performance). ***SSP is only positive for beneficiaries – incentivization for greater coordination and high-quality care management.***

Characteristic	BASIC Track's Glide Path				ENHANCED Track (risk/reward)
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Shared Savings (once Minimum Savings Rate (MSR) met or exceeded)[1]	1st dollar savings at a rate of 40% if quality performance standard is met; not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if quality performance standard is met, not to exceed 10% of updated benchmark	1st dollar savings at a rate of 75% if quality performance standard is met, not to exceed 20% of updated benchmark
Shared Losses (once Minimum Loss Rate (MLR) met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 8% of ACO participant revenue in 2019-2024, capped at 4% of updated benchmark. The loss recoupment limit is the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (QPP)[2] capped at 1 percentage point higher than the benchmark-based nominal risk amount[3]	1st dollar losses at a rate based on quality performance, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

ACO Background

ACO First Performance Year: 2023

ACO SSP Risk Track: ENHANCED

ACO States: Vermont, New Mexico, California, Florida, Tennessee

ACO Assignment Methodology: Preliminary Prospective with Retrospective Reconciliation

ACO Waivers Used: In-Kind Incentives *(note: telehealth waiver included in proposed rulemaking)*

ACO Governing Body: ACO Participants (80% voting) and Consumer Advocates/Medicare Beneficiaries: (20% voting). *(note: website will maintain governing body members/voting)*

ACO Minimum Savings/Loss Rate: 0.5%

ACO Care Model

90% of all US health care expenditures are in people with chronic and mental health disease.

Chronic Disease: We aim to better address beneficiaries' chronic diseases – diabetes, hypertension, dyslipidemia, chronic kidney disease – through consistent support of our assigned beneficiaries in achieving evidence-based lifestyle interventions, access to enabling technology that allows a beneficiary to monitor and track their health and behaviors at home, and feedback loops with the care provided by our provider partners.

Transitions of Care: Creating provider awareness of patients experiencing transitions of care in acute or long-term care settings. Ensuring medication reconciliation, post-acute care needs are identified and met, and readmission rates are trended and addressed.

Seriously-ill or High-needs: We aim to address needs specifically for beneficiaries that are identified as seriously ill or high-needs, as defined by multiple chronic conditions, multiple hospitalizations, or both. Our approach for these beneficiaries will be the identification of the patient and working to ensure there are plan of cares established by and with our ACO participant.

Access to palliative care: When appropriate, we want beneficiaries to be aware of the option to seek palliative and hospice care when they have end-stage chronic diseases. Additionally, we aim to ensure advance care plans and advanced directives are able to be held digitally by VITL/VHIE to seamlessly follow beneficiaries to ERs and hospitals.

Budget and Financial Model

Green Mountain Care Board - Gather Health ACO LLC

Expenditures and Performance

Traditional Medicare FFS Beneficiaries	$ 5,000
Projected Annual Beneficiary Utilization and Expenditures	$ 9,900
Projected Vermont Provider/Supplier Medicare Billing (Benchmark)	$ 49,500,000

Performance Sensitivity Analysis (Projection)	3%	5%	7%
	$1,485,000	$2,475,000	$ 3,465,000

Medicare Payments to Vermont Providers (@5% Shared Savings)	$ 47,025,000
Net Shared Savings (@5%)	$ 2,475,000
Projected Vermont Beneficiary in-kind Incentives and Shared Savings with Vermont Providers	$ 1,495,000
ACO Care Management for Vermont Medicare Beneficiaries	$ 500,000
ACO Operations Expense	$ 225,000
Estimated Net Shared Savings (Retained by ACO)	$ 255,000

Projected Medicare Funds to Vermont Beneficiaries and Providers	99.0%
ACO Operating Expenses Percent	0.5%
Estimated Shared Savings Retained by ACO	0.5%

Your Questions and Discussion