CMS Accountable Care Initiatives

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Discussion

- Introduction to the CMS Innovation Center
- Rationale for Accountable Care
- Innovation Center's ACO Portfolio
- ACO REACH and Beneficiary Protections

CMS Innovation Center Statute

"The purpose of the [CMS Innovation Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

Three scenarios under which the duration and scope of an initial CMS Innovation Center model test may be expanded:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

Vision: What's to Come Over the Next 10 Years

CMS' Vision for Accountable Care

- In October of 2021, CMS outlined a renewed vision and strategy for how the Innovation Center will drive health system transformation to achieve equitable outcomes through high-quality, affordable, person-centered care for all beneficiaries.*
- CMS' ACO models and programs are an important component of achieving this vision.
- CMS wants to work with partners who share its vision and values for improving patient care, guided by three key principles:
  1. Any model that CMS tests within traditional Medicare **must ensure that beneficiaries retain all rights** that are afforded to them, including freedom of choice of all Medicare-enrolled providers and suppliers.
  2. CMS must have confidence that any model it tests works to **promote greater equity** in the delivery of high-quality services.
  3. CMS expects models to **extend their reach into underserved communities** to improve access to services and quality outcomes.

* Link to the White Paper can be found here: https://innovation.cms.gov/strategic-direction-whitepaper

What is an ACO?

- **ACOs are groups of doctors, hospitals, and other health care providers**, who come together voluntarily to give coordinated high-quality care to their Medicare patients.

- **The goal of coordinated care is to ensure that patients get the right care at the right time**, while avoiding unnecessary duplication of services and preventing medical errors.

- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, **the ACO will share in the savings it achieves for the Medicare program.**

- **An ACO is not an insurance plan**. Patients who have Traditional Medicare and have doctors in an ACO retain all of their rights and privileges under Traditional Medicare, including the freedom to see any health care provider that accepts Medicare, even if that provider is not part of an ACO.

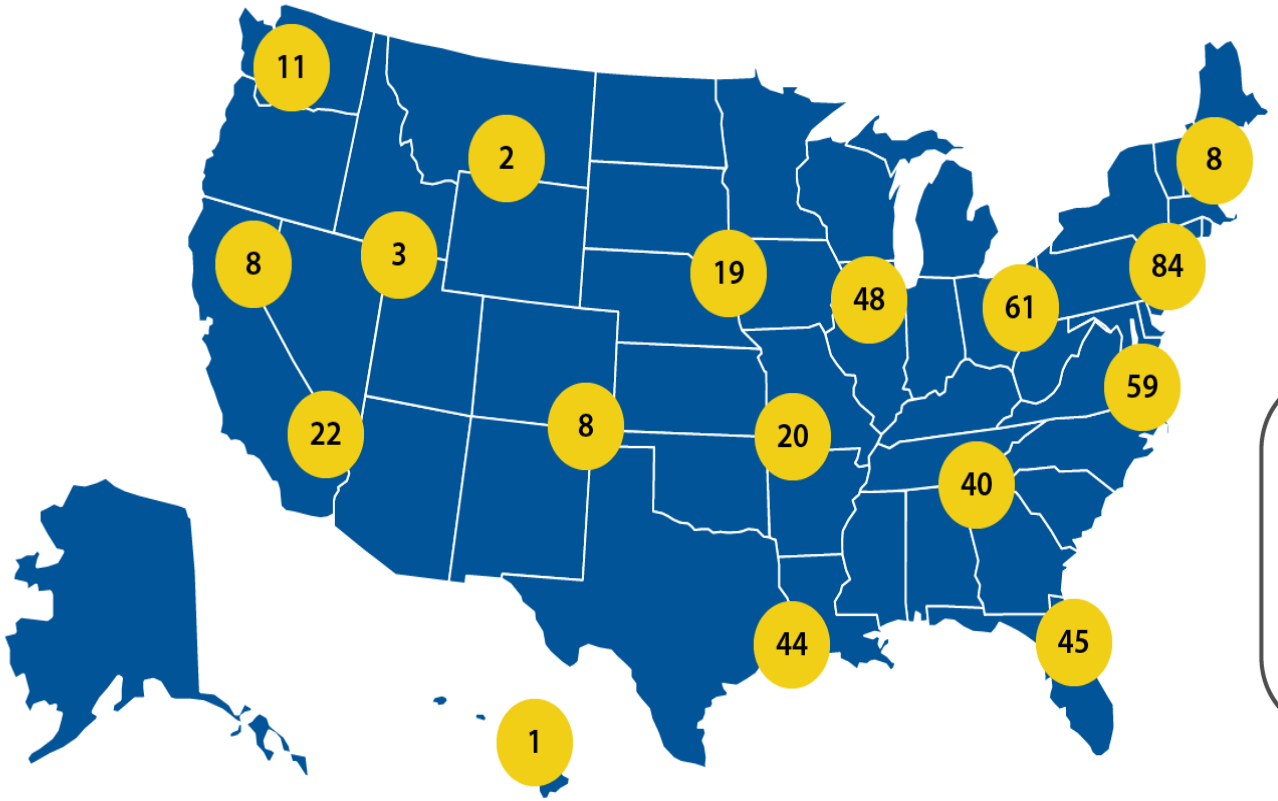
Patient Experience

Shared by a “New Entrant” Participant

- **Beneficiary:**
  - 90-year-old, homebound, with multiple chronic conditions and requires assistance for activities of daily living; increasingly more depressed and anxious, with insomnia, poor appetite and shortness of breath
- **Care Strategy:**
  - In-person home visits, telemedicine visits, and quick phone visits conducted by two providers and a community health worker;
  - Addressed reluctance to depression medication and therapy, including helping him find a language concordant therapist, as well as hearing aid batteries and help with SSI benefits
- **Outcome:**
  - Avoided an ED visit by providing more intensive monitoring and support and building trust with patient to address his underlying condition

Outcome: Fostered a stronger relationship between caregiver and the patient and his family to work together to address his health and well being.

Medicare Shared Savings Program



483 Shared Savings Program ACOs are providing care to 11 million beneficiaries

 # Number of ACOs in the area.

NOTE: This area may cover organizations serving beneficiaries across multiple states.

source: Performance Year 2022 Medicare Shared Savings Program Accountable Care Organizations

2023 Participation in CMS Accountable Care Initiatives

- Over 13 million beneficiaries in Traditional Medicare are served by over 700,000 healthcare providers and organizations

	Shared Savings Program	ACO REACH Model
Number of Medicare beneficiaries	10.9 million	2.1 million*
Number of healthcare providers and organizations	581,792	131,772
Number of accountable entities	456	132

*The number of aligned beneficiaries for PY2023 is estimated pending January beneficiary eligibility

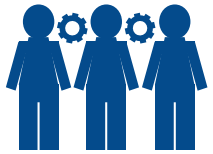
What is ACO REACH?

- **ACO REACH redesigns the Global and Professional Direct Contracting (GPDC) Model to advance Administration priorities**, including our commitment to advancing health equity, and in response to stakeholder feedback and participant experience.
- **ACO REACH will enable CMS to test an ACO model that can inform the Medicare Shared Savings Program** and future models with a greater focus on health equity, health care provider leadership and beneficiary voice in model participant decisions, combined with robust participant screening, monitoring, and transparency.
- **GPDC Model participants with a strong compliance record** that agreed to meet all the ACO REACH Model requirements were permitted to continue participating.
- The ACO REACH Model's **performance period began on January 1, 2023**.

ACO REACH Model

The **ACO REACH Model** will inform the Medicare Shared Savings Program and future models and makes important changes **to redesign the Global and Professional Direct Contracting Model**

Advance Health Equity



the model will use an **innovative payment approach** to better support care delivery and coordination for patients in underserved communities and require participants develop and implement a robust health equity plan to **measurably reduce health disparities** within their beneficiary populations

Promote Provider Leadership & Governance

to ensure **health care providers continue to play a primary role** in accountable care, at least 75% control of each ACO's governing body will be held by participating providers or their designated representatives; ACOs will be required to include at least one **Medicare beneficiary** and at least one **consumer advocate**, both of whom must hold voting rights

Protect Beneficiaries & the Model

through increased up-front screening of applicants, robust monitoring of participants, and **greater transparency** into the model's progress even before final evaluation results, as well as **stronger protections** against inappropriate coding and risk score growth

ACO REACH Model Options

Professional

- ACO structure with Participant Providers and Preferred Providers defined at the TIN/NPI level
- 50% shared savings/shared losses with CMS

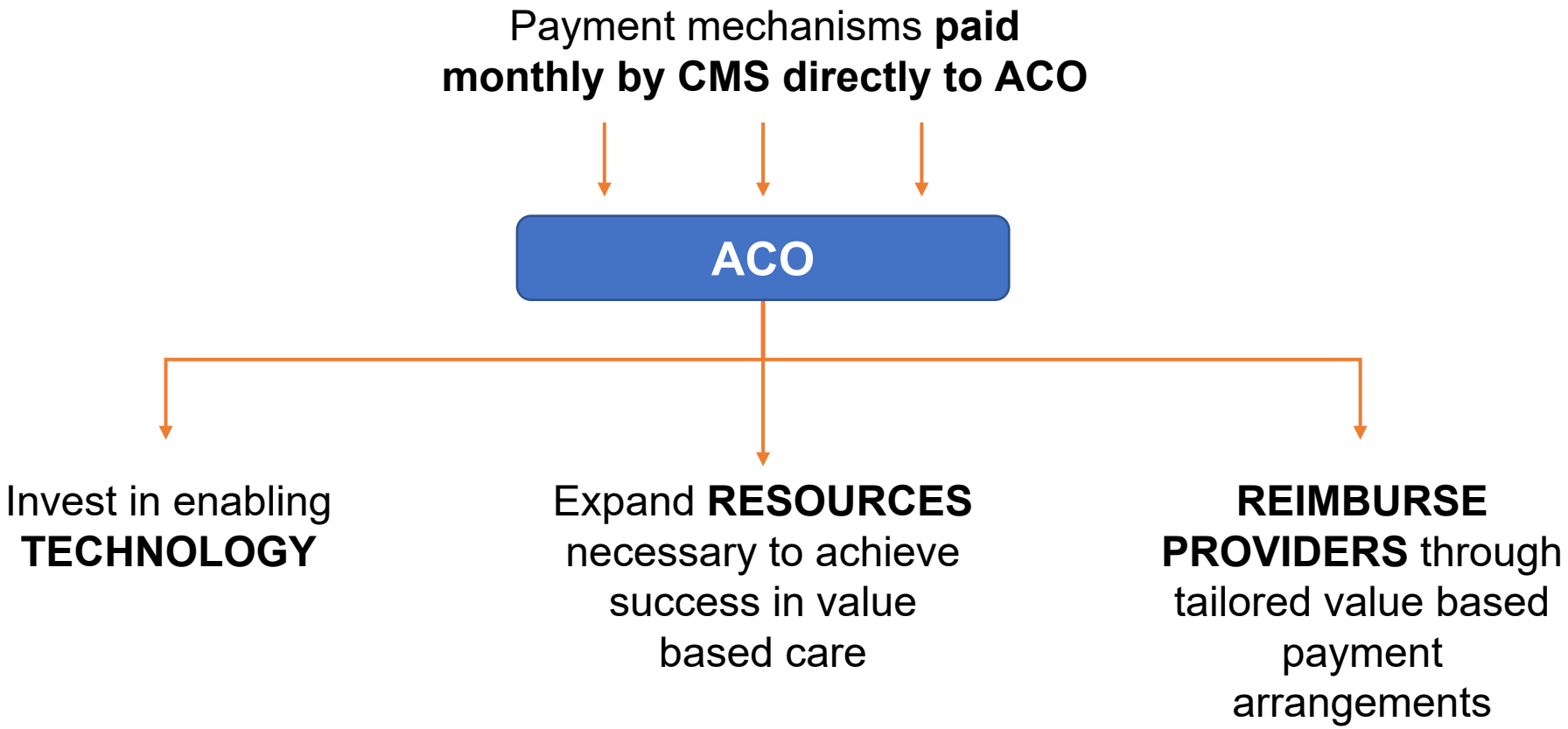
Global

- ACO structure with Participant Providers and Preferred Providers defined at the TIN/NPI level
- 100% shared savings/shared losses with CMS

- **In 2021, 2.5% of total spending was pre-paid** (i.e., 97.5% of all Medicare payments for services flowed through Medicare fee-for-service payment systems).
- **In 2022, data from the first three quarters** (January–September) indicate that about **2.7% of total spending was pre-paid** (i.e., 97.3% of all Medicare payments for services flowed through Medicare fee-for-service payment systems

Payment Mechanism Value Proposition in ACO REACH

REACH ACOs have the flexibility to use the Model's Payment Mechanisms to invest in their population health capabilities, enhance primary care delivery, and reimburse their providers.



Risk Adjustment: An Introduction

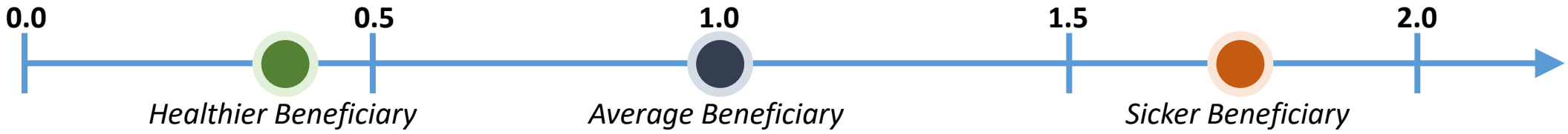
CMS uses risk adjustment to adjust payments based on the demographics and health risk of a beneficiary

Risk scores are derived for a beneficiary using a combination of **demographic** and **disease-based** factors

Demographic Factors
Age, Disabled Status, Medicaid Status, etc.

Disease-Based Factors
ICD-9/10 codes on claims are mapped to Hierarchical Condition Categories (HCCs)

The average Medicare beneficiary with average expenditures will have a risk score equal to 1.0. Sicker beneficiaries with predictably higher costs of care will generally have a higher risk score (e.g.,1.5 or 2.0).



Risk Score Growth Constraints in ACO REACH

- Risk score growth in ACO REACH will be limited by a retrospective Coding Intensity Factor (CIF) combined with a symmetric 3% cap

- Risk scores will be normalized, after which the ACO-level cap will be applied (initially for Standard and New Entrant ACOs only), and finally the program-wide CIF will be applied to all ACO beneficiaries

ACO-Level Cap[1]

At the ACO level, risk scores will be limited from growing / declining by greater than 3% relative to each entity's historical risk scores

Coding Intensity Factor[2]

At the program level (*across all ACOs*), risk scores are reduced by a CIF if growth outpaces the National Reference Population

These policies are designed to address the potential for changes in coding behavior driven by participation in the ACO REACH Model

1. The ACO-level cap will initially apply only for Standard ACOs and New Entrant ACOs; however, High Needs Population ACOs may be subject to a cap later starting in PY2024, if excessive coding growth is observed
2. The CIF will apply for all ACO types, assuming sufficient sample size, for each risk adjustment model used; thus, for Aged & Disabled beneficiaries, one CIF will apply for Standard ACOs and New Entrant ACOs based on the CMS-HCC risk adjustment model and another CIF will apply for High Needs Population ACOs, which use the CMMI-HCC concurrent model

New Focus on Health Equity in ACO REACH

To promote Health Equity and expand the availability of accountable care to underserved communities, ACO REACH includes the following provisions:

Health Equity Provision	Description
Health Equity Plan	REACH ACOs will be required to develop and implement a Health Equity Plan starting in 2023 to identify underserved patients within their beneficiary population and implement initiatives to measurably reduce health disparities
Health Equity Benchmark Adjustment	A beneficiary-level adjustment will be applied to increase the benchmark for those REACH ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve underserved patients by accounting for historically suppressed spending levels for these populations

Health Equity Benchmark Adjustment in ACO REACH

ACO REACH includes a benchmark adjustment that increases benchmarks for ACOs serving higher proportions of underserved beneficiaries

CMS will stratify all beneficiaries aligned to ACO REACH using a composite measure of underservice that incorporates a combination of[1]:

Area Deprivation Index

*Area-level measure of **local socioeconomic factors** correlated with medical disparities and underservice*

Percentile Score from 1-100

Dual Medicaid Status

Beneficiary-level measure of economic challenges affecting individuals' ability to access high quality care

25 Point Adjustment for Full or Partial Dual Eligibility

91st – 100th Percentile (Top Decile)	***+$30 PBPM Adjustment***
51st – 90th Percentile (Middle 4 Deciles)	*No Adjustment*
1st – 50th Percentile (Bottom 5 Deciles)	*-$6 PBPM Adjustment*

New Focus on Health Equity in ACO REACH (Continued)

Health Equity Provision	Description
Health Equity Data Collection Requirement	REACH ACOs will be require to collect and report certain beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries for purposes of Model monitoring and evaluation
Nurse Practitioner and Physician Assistant Services Benefit Enhancement	A new Benefit Enhancement will be offered to help reduce barriers to care access, particularly for beneficiaries in areas with limited access to physicians. Under this Benefit Enhancement, Nurse Practitioners and Physician Assistants will be able to assume certain responsibilities or furnish certain services without physician supervision such as certifying the need for diabetic shoes or hospice care
Health Equity in Application Scoring	To encourage participation by provider groups with demonstrated direct patient care experience and/or demonstrated successful experience furnishing high quality care to underserved communities, discrete points will be attached to application questions related to these categories of experience

Benefits and Protections for Medicare beneficiaries in ACO REACH

- Benefits of the Model include:
  - A **higher quality of care and greater clinical support and care coordination** for beneficiaries
  - **'Benefit Enhancements' and 'Beneficiary Engagement Incentives'** offered under the model (e.g., telehealth, post-discharge home visits and waiver of the home-bound requirement, Part B cost sharing support, concurrent care for beneficiaries that elect hospice care)

- Beneficiary protections in the Model:
  - Beneficiaries **retain full traditional Medicare benefits** and **can see any Medicare physician** (without prior authorization or other constraints or limits)
  - Beneficiaries are **notified on an annual basis that their physician is part of an ACO and that their Medicare benefits have not changed**

- Beneficiaries retain all fee-for-service Medicare channels for raising concerns or reporting complaints

Robust Monitoring and Compliance in ACO REACH

CMS is strengthening its monitoring and compliance through improvements to its auditing, data analytics, claims analyses, and beneficiary outreach in the ACO REACH Model and will:

- Investigate any beneficiary and provider complaints and grievances in coordination with 1-800-Medicare, the Innovation Center liaison on models in the Medicare Beneficiary Ombudsman team, CMS regional offices, and others as appropriate
- Monitor using data analytics the use of services and levels of care provided over time and compared to a reference population to detect changes in beneficiaries' access to care, including potential stinting on care
- Collect beneficiary surveys (CAHPS®[1]) annually to measure changes in beneficiary satisfaction
- Monitor financial and quality performance and use of model payments
- Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data
- Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns
- Assess annually whether beneficiaries are being shifted into or out of MA
- Examine ACOs' risk score growth to identify inappropriate coding practices
- Review marketing materials regularly to ensure information on the Model is accurate and beneficiaries understand their rights and freedom of choice
- Verify that REACH ACO websites are up to date and provide required information

(1) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Patient Experience

Shared by a Safety Net Participant

- **Beneficiary:**
  - 69-year-old African American Male with multiple chronic conditions (e.g., diabetes, heart failure), multiple ED visits
- **Care Strategy:**
  - Monthly in-home visits with a dedicated Nurse Practitioner and Social Worker;
  - Given scale to monitor weight
  - Education on appropriate use of ED
- **Outcome:**
  - Better follow up with primary care provider
  - Improved management of chronic condition
  - Decrease in ED visits

"Having this program has helped save my life"

Where To Go for More Information?

Sign up to receive regular email updates about the CMS Innovation Center, including opportunities to engage with, provide input on and potentially participate in model tests.

Visit the CMS Innovation Center website and Strategic Direction webpage.

Visit the CMS Innovation Center Models webpage (and Medicare Shared Savings Program site) to see current participant geographic and contact information*. You can also see which models are currently enrolling.

Follow us @CMSinnovates on Twitter.

*CMS cannot connect innovators directly with participants