

# An Update on Payment Reform

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# Payment Reform – Levels of Activity

## Federal

- CMS Shared Savings
- Pioneer ACO, Pediatric ACO, CMMI

## State

- Gov. Patrick's cost control bill
- PCMH, APCD, others

## Private

- BCBS Alternative Quality Contract
- Steward, Atrius, Mt. Auburn
- Others: Partners, HPHC, Tufts?

# Eligibility and Governance

ACOs must be a legal entity with a TIN comprised of eligible participants:

- ACO professionals in group practice;
- Networks of ACO professionals in individual practices;
- Partnerships between hospitals and ACO professionals; and
- Hospitals employing ACO professionals.

“ACO professionals” means doctors of medicine or osteopathy, physician assistants, nurse practitioners, and clinical nurse specialists.

“Hospital” means acute care hospitals paid under the IPPS.

FQHCs and RHCs use payment methodologies and payment systems that limit their ability to participate in the CMS Shared Savings Program.

ACO participants must have at least 75% control of the ACO’s governing body.

# Eligibility and Governance

## Topic 1 - Eligibility and Governance [Pages 39 – 102]

1. Eligible Entities
2. Legal Structure and Governance
- 3. Leadership and Management Structure**
4. Accountability for Beneficiaries
5. Agreement Requirement
- 6. Distribution of Savings**
7. Sufficient Number of Primary Care Providers and Beneficiaries
8. Required Reporting on Participating ACO Professionals
9. Processes to Promote Evidence-Based Medicine, Patient Engagement, Reporting, and Coordination of Care
- 10. Patient Centeredness Criteria**
- 11. ACO Marketing Guidelines**
12. Program Integrity Requirements

# Establishing the 3-Year Agreement with the Secretary

Establishing the 3-Year Agreement with the Secretary [Pages 103 – 139]

1. Options for Start Date of the Performance Year
2. Timing and Process for Evaluating Shared Savings
- 3. Data Sharing [108-110]**
- 4. Sharing Aggregate Data [110-113]**
- 5. Identification of Historically Assigned Beneficiaries [113-118]**
- 6. Sharing Beneficiary Identifiable Claims Data [118-132]**
7. New Program Standards Established During 3-Year Agreement Period
8. Managing Significant Changes to the ACO During the Agreement Period
9. Future Participation of Previously Terminated Program Participants

# Assignment of Medicare Fee-For-Service Beneficiaries

Assignment of Medicare Fee-For-Service Beneficiaries [Pages 139 – 165]

1. Operational Identification of an ACO
2. Definition of Primary Care Services
- 3. Prospective vs. Retrospective Beneficiary Assignment to Calculate Eligibility for Shared Savings**
- 4. Majority vs. Plurality Rule for Beneficiary Assignment**
5. Beneficiary Information and Notification

# Quality and Other Reporting Requirements

Quality and Other Reporting Requirements [Pages 166 – 229]

65 quality measures across 5 domains:

- Patient/caregiver Experience (7)
- Care Coordination (16)
- Patient Safety (2)
- Preventive Health (9)
- At-Risk Population/Frail Elderly (31)

Required to submit on all measures. Year one is submission only, years 2 and 3 performance scores are factored into shared savings percentage.

# Shared Savings Determination

Shared Savings Determination [Pages 230 – 282]

1. Background
2. Overview of Shared Savings Determination
3. Establishing an Expenditure Benchmark
4. Adjusting the Benchmark and Average Per Capita Expenditures for Beneficiary Characteristics
- [5-9] Technical Adjustments to the Benchmark
10. Minimum Savings Rate (MSR) and Sharing Rate
11. Net Sharing Rate
12. Additional Shared Savings Payments
13. Withholding Performance Payments to Offset Future Losses
14. Performance Payment Limit

# Two-Sided Model

Two-Sided Model [Pages 282 – 311]

1. Risk-Based Payment Models
2. Two Tracks Provide Incremental Approach to Incorporating Risk
3. Elements of the Two-Sided Model
4. Verification of Savings and Losses

# Shared Savings Summary Table

Design Element	One-Sided Model (performance years 1 & 2)	Two-Sided Model
<b>Maximum Sharing Rate</b>	52.5 percent	65 percent
<b>Quality Scoring</b>	Sharing rate up to 50 percent based on quality performance.	Sharing rate up to 60 percent based on quality performance
<b>FQHC/RHC Participation Incentives</b>	Up to 2.5 percentage points	Up to 5 percentage points
<b>Minimum Savings Rate</b>	Varies by population	Flat 2 percent regardless of size.
<b>Minimum Loss Rate</b>	None	Flat 2 percent regardless of size
<b>Maximum Sharing Cap</b>	Payment capped at 7.5 percent of ACO's benchmark.	Payments capped at 10 percent of ACO's benchmark.
<b>Shared Savings</b>	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 52.5 percent of net savings up to cap.	Savings shared once MSR is exceeded; up to 65 percent of gross savings up to cap.
<b>Shared Losses</b>	None	First dollar shared losses once the minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over three years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3. Losses in excess of the annual cap would not be shared. Actual amount of shared losses would be based on final sharing rate that reflects ACO quality performance and any additional incentives for including FQHCs and/or RHCs using the following methodology (1 minus final sharing rate).