MEMORANDUM

TO: AHCA Members
FROM: James Michel, Director of Medicare Research & Reimbursement
RE: Accountable Care Organization (ACO) Update #2013-01
DATE: January 30, 2013
CC: Mike Cheek, Vice President of Medicaid and Long Term Care Policy
    Elise Smith, Senior Vice President, Finance Policy and Legal Affairs

Editor’s Note: The purpose of this transmittal series is to provide an overview of accountable care organizations (ACOs), the unfolding marketplace, and AHCA efforts related to ACOs. In brief, ACOs are a service delivery system. Bundling, while often discussed in tandem with ACOs, is a payment methodology, not a delivery system. Currently, federally-approved, Medicare ACOs must use fee-for-service methods and may not use bundled payment methods. Thus, a separate transmittal series will be made available to members on bundling.

The Patient Protection and Affordable Care Act (ACA) established a number of health care reform delivery innovations to help move the industry away from a volume-based fee-for-service system toward a system that incentivizes lower costs and improved quality. The ACA specifically outlines two of these innovations targeting the Medicare program: Accountable Care Organizations (ACOs).

Given how quickly the ACO market is evolving, this memo will serve as the first in a new series providing the most current information and issues pertinent to the post-acute care and long term care (PAC/LTC) sector relating to each topic. We will also discuss where the market is moving to help prepare providers to adapt in this new environment. Additionally, AHCA is convening an ACO work group and will be launching an ACO website which will house this issue brief series, basic ACO information, and AHCA-developed tools for working with ACOs.

Accountable Care Organizations – An Overview

Very generally, ACOs are networks of providers who participate in population-oriented, value-based care delivery and reimbursement models. Key elements of an ACO are:

1. An ACO defines an organizational structure -- In Medicare ACOs, there are types of providers that are required to form an ACO, and they are outlined in the final rule. While SNFs and other PAC/LTC providers may not form an ACO on their own, they may be part of the ACO entity if the required entities are already in it, or they may contract with an ACO to provide a specific set of services.
2. **ACOs are population-based** – While payment model innovations, such as bundled payments, normally pertain to the individual patient, ACOs are a model that exists at the level of a population of patients. Typically these populations are linked to a specific type of payer (Medicare patients, or beneficiaries of a specific private insurance plan, for example) or disease state (cancer patients, for example). Therefore, the focus of the ACO is on the health of the population rather than the health of the patient.

3. **Medicare ACOs must pay fee-for-service rates** – This is true, at least for now. While Medicare ACOs may be gearing up for capitated or global payments from CMS, they cannot yet set rates with other providers. The Pioneer ACOs will be the first group of Medicare ACOs to operate on global payments; they may begin to do so starting in 2014\(^1\). Providers may see other types of ACOs, specifically private payer ACOs, experiment with global payments first.

The ACO model is becoming increasingly popular in both the public and private sector payer markets, with as many as 31 million people, or 10 percent of the U.S. population, having access to at least one ACO in their market, according to a recent study published by the consulting firm Oliver Wyman\(^2\). The research describes ACO participation by payer source as follows\(^3\):

- 2.4 million patients in Medicare ACOs;
- 15 million non-Medicare patients in Medicare ACOs;
- 8-14 million patients in non-Medicare ACOs

Below, ACO type by payer is described in more detail.

**A. Medicare ACOs**

In October, 2011, CMS issued the Medicare Shared Savings Program (MSSP) final rule for ACOs. AHCA had submitted comments on the proposed rule *(see Appendix)*. The MSSP rule outlines the types of arrangements ACOs may have with CMS to be reimbursed for their Medicare patients’ care. In the rule, CMS outlines three Medicare ACO models:

1. **MSSP Model** (*192 ACOs*) – Typically, an ACO enters into a three-year contract with CMS after which it will have the option to continue on to a more risk-bearing payment model. The MSSP rule implements both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses in all three years). In both models, should the ACO meet predetermined cost and quality targets, they are entitled to split the savings with the government. To date, most of the Medicare ACOs have opted for the one-sided risk model.

2. **Pioneer Model** (*32 ACOs*) – a select group of organizations that already had significant experience in coordinating care for patients across care settings. These

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\(^1\) Pioneer ACOs may accept prospective, global payments from CMS in their third year if they were able to demonstrate savings in the first two years. Pioneer ACOs began Jan. 1, 2012, and so may be eligible for global payments beginning Jan 1, 2014.


\(^3\) These numbers are as of October, 2012, and are now likely higher.
organizations can move more rapidly from shared savings to fully risk-bearing, population-based payment arrangements, and often have risk-based contracts with private payers in addition to Medicare.

3. **Advanced Payment Model** (35 ACOs) – physician-based and rural providers who wish to become an ACO but lack the necessary staff and infrastructure to adopt the model. They receive upfront and monthly payments which they can use to make investments in their care coordination infrastructure.

**B. Private Sector ACOs**

Private sector ACOs are integrated networks of providers who have negotiated some kind of risk-bearing, value-based payment contract with one or more private sector payers. ACOs in the private sector are more difficult to track, because there is no specific approval or requirement for a provider network to deem itself an “ACO.” As such, any organization can call itself an ACO, making it difficult to know the exact number of private ACOs in the market, or what that means; industry experts estimate that there are approximately 200 ACOs operating in the private sector. About 31 ACOs, mostly the Pioneer ACOs, have contracts with private payers in addition to Medicare, creating an additional “mixed model” ACO.

**C. Medicaid ACOs**

The National Academy of State Health Policy (NASHP), which tracks state-level accountable care activities in the Medicaid and Children’s Health Insurance Program populations, finds that 11 states are experimenting with accountable care arrangements. Because efforts to test Medicaid accountable care models vary considerably from state to state, NASHP has identified three core characteristics and capabilities that must be consistent across all designs to be considered an “ACO:”

1. Organizations or structures should assume responsibility for a defined population of patients across a continuum of care, including across different institutional settings;
2. Participants should be held accountable through payments linked to value, emphasizing dual goals of improving quality and containing costs; and
3. Accountability should be facilitated by reliable performance measurements that demonstrate savings and are achieved in conjunction with improvements in care.

Additionally, Medicaid ACOs typically do not use attribution approaches for patient assignment. Rather, most use geographic coverage.

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5 AHCA staff conversations with Leavitt Partners analysts.
AHCA and Next Steps

AHCA has advocated strongly for the inclusion and expansion of opportunities for PAC/LTC providers in any ACO initiatives driven by CMS. When the MSSP proposed rule was released in 2011, AHCA partnered with the Alliance for Quality Nursing Home Care (Alliance) to submit comments that focused the noticeable lack of attention paid to the PAC/LTC sector and recommendations for how to engage it.

AHCA is closely monitoring the activities of ACOs and will continue to provide a flow of relevant information to state executives and member organizations. In the meantime, should you have any questions or concerns, please contact your AHCA ACO Team:

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APPENDIX

Selected AHCA Memoranda – available upon request.

1. May 31, 2011 – AHCA/Alliance Comments to FTC/DOJ on Antitrust Enforcement Policy Regarding ACOs Participating in the MSSP

2. May 31, 2011 – AHCA Comments to IRS Requesting Guidance and Solicitation of Comments

3. June 6, 2011 – AHCA/Alliance Comments to CMS on ACO Final Rule

4. June 6, 2011 – AHCA/Alliance Comments to CMS on MSSP Waiver Designs

5. October 20, 2011 – Comparison of Proposed and Final Rules

6. November 10, 2011 – Differences Between ACOs and Bundled Payments


External Resources

   Website contains a wealth of information on Medicare ACOs, including tools, maps, and informational documents.

