

Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model

Moderator: Leah Nguyen

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Podcast 1 of 4: Introduction by Dr. Donald Berwick

Leah Nguyen: Welcome to the first of four podcasts from the Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application National Provider Call. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Tuesday, November 15, 2011.

The first podcast features an introduction by Dr. Donald Berwick, former Administrator for the Centers for Medicare & Medicaid Services, followed by a question and answer session.

Operator: At this time I would like to welcome everyone to the Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application National Provider Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call. I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

Introduction

Leah Nguyen: Hello. I am Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application National Provider Call.

On October 20, 2011, the Centers for Medicare & Medicaid Services issued a final rule under the Affordable Care Act to establish the Medicare Shared

Savings Program, and a notice for the Advance Payment Initiative that will provide additional support to physician-owned and rural providers.

The new Shared Savings Program and Advance Payment Initiative will help providers participate in Medicare Accountable Care Organizations (ACOs) to improve quality of care for Medicare patients. During this national provider call, CMS subject-matter experts will discuss the application process for the Shared Savings Program and the Advance Payment Model. A question and answer session will follow the presentation. We are fortunate to have with us this afternoon our Administrator, Dr. Donald M. Berwick, who will provide us with opening remarks.

Before we get started I have a few announcements. This call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Teleconferences and Events section of the Medicare Shared Savings Program Web site following this call.

There is a slide presentation for this session. If you have not already done so, you can download this handout now from the Shared Savings Program website located at www.cms.gov/sharedsavingsprogram. At the left side of the Web page, select CMS Teleconferences and Events and scroll down the page to the Downloads section for the slide presentation.

Also, the Shared Savings Program Application section of the Shared Savings Program website is now updated with a Notice of Intent to Apply (NOI) and the complete Shared Savings Program application package. From the Shared Savings Program Web site at www.cms.gov/sharedsavingsprogram, select Shared Savings Program Application from the left side of the webpage and scroll down the page to the Downloads section for these documents.

Without further delay, I would like to introduce Dr. Donald Berwick. Dr. Berwick is the Administrator for the Centers for Medicare & Medicaid Services. As Administrator, Dr. Berwick oversees the Medicare, Medicaid, and Children's Health Insurance programs. Together, these programs provide care for nearly one in three Americans.

Before assuming leadership of CMS, Dr. Berwick was President and Chief Executive Officer of the Institute for Healthcare Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor of Health Policy and Management at the Harvard School of Public Health. He also served as a consultant in pediatrics at Massachusetts General Hospital and Adjunct Staff in the Department of Medicine at Boston's Children's Hospital.

Dr. Berwick is a pediatrician and holds a Master in Public Policy degree from the John F. Kennedy School of Government. He received his medical degree from Harvard Medical School, where he graduated cum laude. Now it is my pleasure to turn the call over to Dr. Berwick.

CMS Administrator Donald Berwick

Donald Berwick: Thank you very much. Thank you to the hundreds of you on the call, for your interest in the Medicare Shared Services Program, ACOs, and the topic of today: how to apply. I'm thrilled by your interest and excited by this program.

I'm going to take a few minutes for background. Before Tricia walks you through the actual application process, I want to go back to why we're doing this, and why this program was originally created by Congress in the Affordable Care Act.

As you know, American medical care delivery tends to be highly fragmented. Ask a person with chronic illness, and you'll find that they're sometimes lost between the slats as they go between the hospital and home, or between a specialist and a primary care doctor. We didn't build a system for truly coordinated and seamless care. That has to do not just with people with chronic illness, but with the simple deeds of effective prevention in health care, or the episodic challenges we face as well. People with intermittent illness still challenge the system to create seamlessness and coordination.

The consequences for patients are not good. People have complications they could have avoided, they get confused, and the consequences for cost are not good. When care isn't coordinated, efforts are duplicated, balls are dropped,

and complications increase in frequency. So, one of the great and important solutions for the problem of America's health care value is to better coordinate care over time and space.

One way to do that is with traditional forms of managed care. Many beneficiaries in Medicare, those who choose Medicare Advantage, want that. They join health plans that have the job, under contract, of maintaining the health and taking care of people over time and space. They do that in network systems, where a person agrees to stay within the network of a Medicare Advantage plan in order to get the care they want and need.

But three out of four Medicare beneficiaries don't choose Medicare Advantage. They are in normal Fee-For-Service, what we call traditional Medicare, in which fees are paid for services, and those services do not normally include coordination. They are embedded in some of the primary care and evaluation and management payments, but coordination remains sort of an orphan challenge for care. Good doctors, good nurses, and good hospitals work hard on it, but the reward systems are inconsistent, and the supports and payment are not there, or not there well enough.

With the creation of the Affordable Care Act, Congress has put into play a number of changes in systems of payment and measurement for Medicare that are intended to encourage coordinated care. Some are not within the ACO realm, things such as bundled payments, which are now being tested through our Innovation Center and begun in the ESRD program; and supports to medical homes and health homes to pay for primary care to get invested in coordination of care.

One of the big ideas in the Affordable Care Act is the Accountable Care Organization. The ACO idea pedigree goes back I think to the work of scholars who have been very interested in seamless care. Elliott Fisher, Glen Hackbarth (the Chair of MedPAC), Mark McClellan, and others have invested their time and energy in helping to answer the question of how we can encourage more seamless and coordinated care in the country, especially within the Fee-For-Service environment of traditional Medicare.

The ACO was born as an idea to try to foster coordination of care and the benefits to patients and to costs that come from coordinated care in a Fee-For-Service payment environment. That's the edgy and interesting idea here.

The concept is to encourage the formation of organizations of providers who are willing to take responsibility for panels of attributed patients. Attribution means the functions through which we in CMS are able to decide that Ms. Jones apparently has chosen Dr. Berwick to be her primary care provider and therefore is "attributed" to Dr. Berwick.

The ACO, once formed, has such an attributed panel of patients, and we in Medicare have the data to predict what the costs of care for this group of people ought to be over, say, the subsequent year. This organization that's formed, the Accountable Care Organization, stands to gain in shared savings if the total costs of care for the attributed patients are less than predicted for the subsequent year. The sharing of savings varies with the amount of risk the organization is taking on the downside, but it's on the order of 50 or 60 percent.

In the Medicare Shared Savings rule, we have to attend to many variables that allow such a program to be effective and attractive, as well as safe and effective for beneficiaries. For example, if you're a beneficiary and you know your primary care provider has joined an ACO or formed an ACO, and therefore will share in savings, are you worried about skimping on care? Well, maybe not if you trust the provider as you should, but we also need to have some other forms of guarantee. In the ACO rule there are forms of accountability and surveillance of quality so that the shared savings don't exist. There can't be shared savings if quality deteriorates. We have quality metrics, then, in the rule that allow us to watch the quality of care obtained by beneficiaries and also to hear directly from beneficiaries, because some of the metrics are beneficiary driven.

There are issues around thresholds for savings. We don't want to reward random variation in costs so we have to have rules that apply, which allow us

to know and allow the providers of care to know when they've saved enough, that it's a non-random variation in savings.

There are issues of antitrust and market discipline, so that we're sure that the kinds of cooperative behaviors we want to encourage among clinicians and with hospitals occur, but without collusive effects on pricing and market forms. So there are issues concerning antitrust behaviors of ACOs.

There are issues around the burden of setting up an ACO—how to make it simple, but also make sure that it is truly responsive to patients, families, and communities. There are concerns around governance: Will the governing structures be responsive to the interests and needs of the beneficiaries? Issues around marketing: How can appropriate disclosure occur so people know their doctor or hospital has joined an ACO?

There are issues around sharing of data. To properly help coordinate care, the Accountable Care Organizations of course want information that CMS has in our claims data. On the other hand, beneficiaries and others are justifiably concerned about privacy. So there are rules and procedures for how much data can be shared and when.

When we went out with our preliminary rule, the proposed rule in the spring of 2011, we received, as we expected, many comments on all of these and many other variables in describing what an ACO is. Over 1,200 comments were received formally, and many more ideas came in through listening sessions and dialogue with all stakeholders in health care. That led to the final rule, issued about a month ago, which has received, I think justifiably, a lot of positive response, because it was responsive. We crafted a better rule as a result of the incoming information.

Now the opportunity exists for organizations to form as Accountable Care Organizations—provider led, organized around primary care, with attributed populations. We've added increased flexibility to this rule, such that Rural Health Centers, Critical Access Hospitals, Federally Qualified Health Centers, and others can participate more effectively in the ACO world. Also, we've

adjusted the saving percentages and other rules for savings essentially to make the business case a little more attractive than in the proposed rule.

In the final rule, as you will see, there are two tracks for possible participation in the ACO program.

Track one is more or less for newcomers, organizations not terribly experienced perhaps in coordinating care but confident they can do it, and they want a period of time to ramp up into the kind of risk bearing that an ACO might take at a mature level. Track one is three years (or because we're having rolling entry into the program, in some cases a little more than three years) of shared savings only, in which the organization only has upside potential. That is, if the costs are lower than predicted, they share in the savings. But if the costs are higher than predicted, there's no downside risk for the ACO. Since there's no downside risk, the amount of shared savings is somewhat lower in track one than in track two.

Track two in the Medicare Shared Savings Program has both upside and downside risks. These organizations are a little more capable perhaps of bearing some of that risk because they may already have onsite care coordinators, or they may already have information systems that will allow them to better track and coordinate care with patients. Maybe they began by already being an ACO in the private sector, because there's a lot of private sector activity here. So track two has a little more gain but also some downside exposure for organizations that want to engage in this.

All this is to be done transparently with the beneficiary. Because this is traditional Medicare, in neither model does the beneficiary lose any choices at all. Beneficiaries still can go anywhere they want for their care, which means the ACOs that form under the Medicare Shared Savings Program will have to be organized around the notion of attraction instead of restriction as a way to keep beneficiaries involved with the work of the ACO, so the ACO can give them better care.

There is another ACO model out there that is already announced, and that's by the Innovation Center. The Center for Medicare & Medicaid Innovation began

its Pioneer ACO Program application process a couple of months ago. Quite a large number of organizations came in as applicants, many more than we had thought—indeed, many more than the pioneer program can accept. We are now in the final stages of identifying the Pioneer ACOs. This program is for the much more advanced organizations, those able to take on the overall job of care coordination for attributed populations because they have the experience, data, cultures, and relationships that allow them to do this.

That's the basics, that's what the ACO program is designed to do. It's designed to do what now CMS is intending to do, which is to help improve American healthcare, to make things better for beneficiaries. And, at the same time, by improving care, to reduce the cost of care. Better care, better health, and lower costs—that's what we call the three-part aim here at CMS. There's no better example of an attempt to foster new care delivery for the three-part aim than the ACO program itself.

It's not the only game in town. There will be others interested in many other programs like bundled payment, primary care homes, and advanced primary care, but this ought to be of great interest to people ready to move into the era of coordinated care for Medicare beneficiaries.

Finally, let me say this has all been done with very much awareness and alertness about how much of the same activity is going on in the private sector. Major insurers in the country have moved aggressively into forms of Accountable Care Organizations that hopefully MSSP in CMS is well aligned with, but we know this is part of a much broader front of progress toward seamless care for all Americans.

I will stop there. I understand we can open the line for a couple of questions before I turn it over to Tricia to take us into a description of the application process. Operator, is it possible to take a couple of questions now?

Question and Answer Session with Dr. Berwick

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before asking the question to assure clarity.

Please note: Your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Jay Chowdappa.

Jay Chowdappa: As the Accountable Care Organizations mature, will the ACOs, like the Medicaid Advantage Plans, be able to enter into fee schedule arrangements with other providers attached to diagnostic centers or hospitals?

Donald Berwick: I'm not quite sure what you mean by fee schedule arrangements. The Accountable Care Organization can help guide beneficiaries toward providers of care it believes will do better for the beneficiaries, but beneficiaries retain absolute rights to go anywhere they want.

The internal arrangements within the ACO—and between the ACO and other providers who are not in or with the ACO—are up to the ACO to arrange. In the rule there are waivers from normal Stark and anti-kickback provisions, because we want to allow lots of flexibility and creativity on the part of the ACOs as relationships are built among providers, although this will be under extremely strong scrutiny. We are absolutely committed that if collusive behaviors begin to occur, the degree of permissiveness will decrease.

Other questions, Holly?

Operator: Yes. Your next question comes from Peter Aran.

Peter Aran: My name is Peter Aran; I'm with the Saint Francis Health System in Oklahoma. I have much the same question, Dr. Berwick, which is: If we're trying to design a health care system that would encompass care and provide

care to our patients and their families, it would seem helpful to us if the patients would stay within our network of care. It's harder for us to track how their care is delivered when it's outside our network of care. I think you just touched on that, but it's an issue we are still grappling with.

Donald Berwick: That's a great question. That is the concept here. Let's be clear that what Congress contemplated in the ACO environment is that the beneficiary has lost no choice. They can still go anywhere they want, and that is the way we've written the rule. Now, it is a challenge. Unlike a pure managed care environment like Medicare Advantage, there are not the financial incentives now for the patient to stay within your network.

What are you to do about that? Well, for one thing, don't participate in an ACO. Find another framework where you think you can thrive more, like bundled payment, or maybe develop better relationships with the Medicare Advantage plan.

But if you think you can do it, this is a very thrilling idea. It means you will then be working with your patients, the ones attributed to you, to keep them by attraction with you, to convince them, to basically help them understand why you would be the best place to get their care from.

To make it easier to do that, a couple of changes were made in the final rule. For example, we will be providing ACOs upfront, when they become an ACO, with a list of the patients who are attributed to them at that point and who are likely to be attributed at the end of the reconciliation year. We will update those lists every three months so you'll have a pretty good idea of which patients are staying with you, and which ones, therefore, at the end of the year will be part of the settling up process as we decide whether there are savings to share or not.

We also are sharing beneficiary claims information with the ACO. The beneficiaries have an opt-out option—that is, they have to be informed that they can stop the sharing of CMS data with the ACO. But the claims data would include the experience of the patients no matter where they go. If they're seeing providers outside the ACO structure and Medicare is paying

those claims, this would be in the data set, which, absent beneficiary opt-out, the ACO would have access to. So you can actually know quite a bit about the patients, where they're going, what's happening to them, and what the costs and experience of care are like. Hopefully, that will make it more attractive and more feasible to coordinate care even in an open-choice environment like the ACO.

Peter Aran: Thank you very much.

Operator: Your next question comes from the line of Clint McKinley.

Clint McKinley: My name is Clint McKinley, and I'm with Ability Prosthetics and Orthotics. My question is: Where in the ACO model do ancillary providers like our company, Prosthetics and Orthotics, fit, and to what degree can we participate?

Donald Berwick: Well, the ACO is a primary care model. The lead is the attribution. There are a few exceptions here. I won't go into the details, but the general lead is attribution of patients according to where they get their primary care services. Patients who cannot be attributed based on their primary service-seeking behavior can be attributed through certain forms of specialty care behavior, but that's a small matter.

The relationship between any other supplier of care and the ACO is between that supplier of care and the ACO. The ACO undoubtedly would be looking for providers of, in your case, equipment or other supplies that they would regard as favorable to the outcomes, quality of care, coordination of care, and cost for the beneficiaries attributed to it. This gives you a new business case, a new business model might be the way to think about it. But the lead in establishing an ACO is the provider of care, not another stakeholder in the system.

Clint McKinley: Can an ancillary provider participate in multiple ACOs?

Donald Berwick: Clint, I believe the answer is yes. I'm going to take that offline, though, and we'll check it. At the end of the call, we will give you a way to contact us, and we'll follow up with you if that's not the right answer.

Clint McKinley: Thank you.

Leah Nguyen: Thank you for listening to this Medicare Shared Savings Program national provider education podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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