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ACO Compliance

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Banner Health Network

FACT

- ✓ 10,000 new beneficiaries become eligible every day.
- ✓ By 2030, all Baby Boomers will have aged into Medicare.
- ✓ Payroll taxes are not keeping up with the demand.
- ✓ Medicare Trust Fund will be insolvent by 2026.

MedPAC *Report To The Congress: Medicare Payment Policy*, Ch. 1, March 2018

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History of ACOs….Started in 2012

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.

Statutory Basis

Congress enacted the Patient Protection and Affordable Care Act (Pub.L. 111-148) on March 23, 2010. Section 3022 of the Affordable Care Act amended Section 1899 of the Social Security Act (the Act) and established the Shared Savings Program. To learn more, refer to the Affordable Care Act and Social Security Act.

More recently, the requirements for assignment under the program were amended by the 21st Century Cures Act (December 2016). The 21st Century Cures Act amended the Act to require the Secretary to assign beneficiaries to ACOs participating in the Shared Savings Program based not only on their utilization of primary care services furnished by physicians, but also on their utilization of services furnished by Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs), effective for performance years beginning on or after January 1, 2019. In addition, the Bipartisan Budget Act of 2018 (BBA of 2018) established additional tools and flexibilities for ACOs specifically in the areas of new beneficiary incentives, telehealth services, and choice of beneficiary assignment methodology.

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CMS | CMMI: Center for Innovation

CMS

- **Program**
- Medicare Shared Savings Program (MSSP)
- 42 CFR Part 425
- Quality Payment Program (QPP) and Physician Fee Scheduled (PFS) Rulemaking

CMMI

- **1115 Waiver**
- Pioneer | Next Generation ACO | Direct Contracting
- Intended to test
- Many programs

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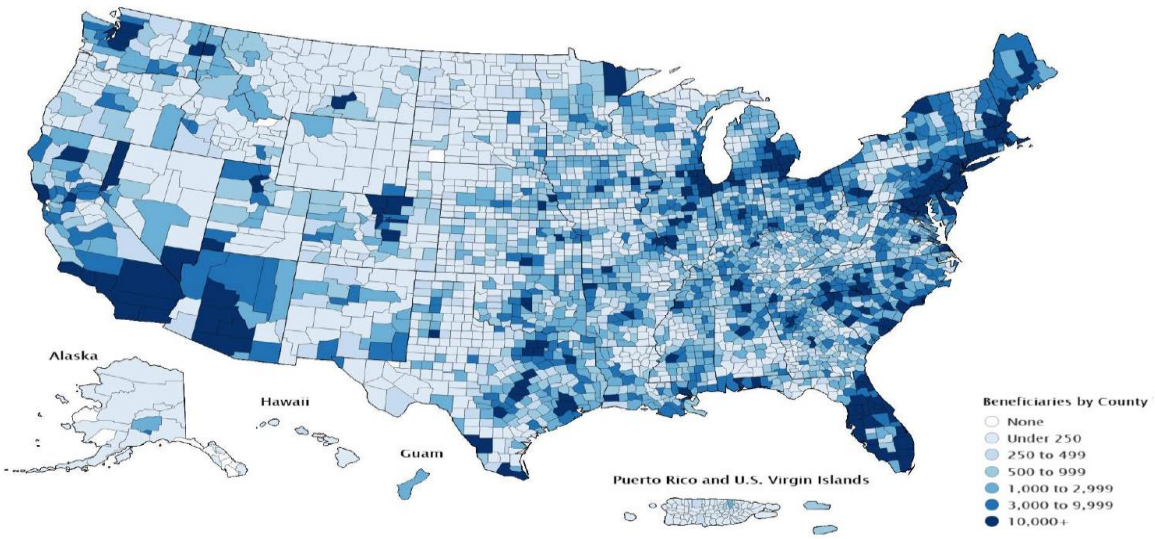
MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program
Fast Facts

January 2018

Medicare Shared Savings Program ACO Assigned Beneficiary Population by County



Shared Savings Program Fast Facts – As of July 1, 2019

MEDICARE SHARED SAVINGS PROGRAM

SHARED SAVINGS PROGRAM INFORMATION

PROGRAM CHARACTERISTICS

Performance Year	ACOs	Assigned Beneficiaries
2019*	518	10.9 million
2018	561	10.5 million
2017	480	9.0 million
2016	433	7.7 million
2015	404	7.3 million
2014	338	4.9 million
2012 / 2013	220	3.2 million

*2019 contains one 12-month performance year and two six-month performance years.

PERFORMANCE YEAR (PY) RESULTS

PY 2017	
Total Earned Shared Savings	$799,420,562
Average Overall Quality Score	92.40%
PY 2016	
Total Earned Performance Payments	$700,607,912
Average Overall Quality Score	94.65%
PY 2015	
Total Earned Shared Savings	$645,543,866
Average Overall Quality Score	91.44%
PY 2014	
Total Earned Performance Payments	$341,246,303
Average Overall Quality Score	83.08%
PY 2012 / 2013	
Total Earned Performance Payments	$315,908,772
Average Overall Quality Score	95.00%

2019 SHARED SAVINGS PROGRAM ACO INFORMATION

ACO TRACKS

	ACOs	Percent
One Sided		
BASIC Track Levels A&B	108	21%
Track 1	258	50%
Two Sided		
BASIC Track Levels C&D	6	1%
Track 1+ Model	28	5%
BASIC Track Level E	41	8%
Track 2	5	1%
ENHANCED Track*	72	14%

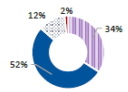
(*Track 3 was renamed the ENHANCED track)

HIGH / LOW REVENUE ACOs

High Revenue	267
Low Revenue	251

ACO COMPOSITION

Physicians Only	176
Physicians and Hospitals	272
FQHCs / RHCs	62
Other Facilities	8



ACO COMPOSITION

SNF AFFILIATES & SNF 3-DAY RULE WAIVER

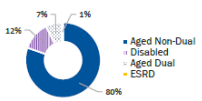
ACOs approved for a SNF 3-Day Rule Waiver	89
Total number of SNF affiliates	1,232

ACO PARTICIPANT LIST COMPOSITION

Participant TINs	18,259
Physicians and non-Physicians	435,809
Hospitals	1,472
Federally Qualified Health Centers (FQHCs)	2,358
Rural Access Hospitals	1,324
Critical Access Hospitals	435

2019 MEDICARE BENEFICIARY DEMOGRAPHIC DISTRIBUTION

Enrollment Type	Beneficiary Person-Years
Aged Non-Dual	8,601,630
Disabled	1,306,426
Aged Dual	719,834
ESRD	79,445



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518 ACOs

10.9 million beneficiaries

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MSSP Application

Application open annually.

Contract is 5 years.

Any applicant that meets the requirements is allowed to participate in MSSP.

Requirements must be in place at the time of application.

Note: CMMI programs have different timelines and requirements.

- ✓ ACO must designate a Compliance official.
- ✓ Compliance official cannot serve as legal counsel to the ACO.
- ✓ Compliance official must report to the ACO governing body.

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Compliance Role

WHAT DO YOU NEED TO DO?

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MSSP Resources

- MSSP Application states or refers to all legal and regulatory requirements.
- Application webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/for-acos/application-types-and-timeline.html

Governing Body / Board

CMS Requirements:
- Board must represent at least 75% of Participants.
- Must have one Medicare Beneficiary (one equal vote) who is served by ACO.
- Board must have Conflict of Interest process.

Compliance Ideas:
- Periodically check to ensure 75% representation.
- Before Beneficiary is brought in, verify that Beneficiary shows up on Alignment list.
- Onboard each new Board member with COI.
- Conduct annual COI process.

HIPAA

CMS Requirements:
- ACO will sign a Date Use Agreement (DUA) during application if ACO elects to receive Part A/B/D claims files for aligned beneficiaries.
- ACO must have HIPAA program in place to ensure protection.

Compliance Ideas:
- Establish process to approve employees and vendors access to claims files and CMS portals to ensure proper access per HIPAA policies.
- Remember to remove employee access after they leave their position.

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Beneficiary Protections

CMS Requirements:
- Beneficiary retains full Freedom of Choice, as any Medicare Fee For Service beneficiary does. [*Exception for 3-day Waiver]*
- Beneficiary retains the right to suppress their claims data from being shared by CMS to the ACO.
- Any item that goes to Beneficiary must be approved by CMS through the File & Use process.

Compliance Ideas:
- Periodically review all beneficiary collateral and ensure that proper CMS approval has been obtained.
- Review ACO communications to ensure proper message around allowing freedom of choice.

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Participants

CMS Requirements:
- Participants offices must always display posters in their offices.

Compliance Ideas:
- Verify that posters are provided to all new Participants within 30 days of each new Performance Period (usually January 1).
- Period check of Participant offices to ensure that posters are displayed in public areas.

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Public Disclosure Page

CMS Requirements:
- Must maintain a Public Disclosure Page.
- Must use CMS template.
- Must keep Participant, ACO contacts, Board information updated.
- Must post quality scores and shared savings each year.

Compliance Ideas:
- Check accuracy of Public Disclosure Page:
  - When key position changes.
  - When Governing Body changes.
  - When CMS provides updated template.

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Quality Submission

CMS Requirements:

- CAHPS survey (ACO-CAHPS) and pay for the survey.
- Data Abstraction process to submit to CMS for quality metrics (similar to MIPS or MA STARs). ACO pays for nurses to collect data from electronic medical records, validate, and submit to CMS.

Compliance Ideas:

- Review ACO's Data Abstraction submission accuracy.
- Check in with Program Manager to ensure that CAHPS vendor was timely selected.
- Check in with Program Manager to ensure that Data Validation resources are clinically appropriate and in place in a timely fashion.

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Other Ideas to Support the ACO Program

- Appoint one person to read all newsletters (*Spotlight*) and ensure distribution to appropriate operational leaders.
- Appoint one person to monitor Proposed and Final Rules to know what is about to change.
- Join the Program Manager on the monthly check-in call with the appointed CMS coordinator.
- Understand applicable program waivers, such as Medicare Beneficiary Inducement, 3-Day SNF Waiver, Telehealth Payment and any others that CMS adds.

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