

# Pioneer Accountable Care Organization (ACO) Program

## Frequently Asked Questions for Providers

### ACCOUNTABLE CARE ORGANIZATIONS (ACO) OVERVIEW

#### **What is an ACO?**

Any patient who has multiple doctors probably understands the frustration of fragmented and disconnected care: lost or unavailable medical charts, duplicated medical procedures, or having to share the same information over and over with different doctors.

A failure to coordinate care can often lead to patients not getting the care they need, receiving duplicative care, and being at an increased risk of suffering medical errors. On average, each year, one in seven Medicare patients admitted to a hospital has been subject to a harmful medical mistake in the course of their care. And nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days – a readmission many patients could have avoided if their care outside of the hospital had been aggressive and better coordinated.

*Accountable Care Organizations (ACOs)* are designed to lift this burden from patients, while improving the partnership between patients and doctors in making health care decisions. Medicare beneficiaries will have better control over their health care, and their doctors can provide better care because they will have improved information about a patient's medical history and can communicate more readily with a patient's other doctors.

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated, high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors.

#### **How do ACOs work?**

ACOs enter into an agreement with the Centers for Medicare & Medicaid Services (CMS) to be accountable for the quality, cost, and overall care of traditional fee-for-service Medicare beneficiaries who may be aligned with it. When an ACO succeeds in both delivering high-quality care and spending health care dollars more efficiently, it will share in the savings it achieves for the Medicare program.

Unlike in a Medicare Advantage plan, Medicare beneficiaries whose doctors participate in an ACO will still have a full choice of providers and can still choose to see doctors outside of the ACO, but beneficiaries choosing to receive care from providers outside of the participating ACO reduce the potential for coordinated, high quality care.

#### **What is the Pioneer ACO Model initiative?**

The Pioneer ACO Model is a new national initiative launched by the CMMI (Center for Medicare & Medicaid Services Innovation Center). The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. The initiative involves payment models that incorporate utilization risk and require providers to engage in population management. The 3-year agreement with CMMI can be terminated at any time if the model isn't working.

**How does this affect me and my practice?**

Participating in the Pioneer ACO should not affect how you provide care to your patients. You will continue to care for your patients as you have done in the past.

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**How does this affect billing at my practice?**

The Pioneer ACO is a 3-year agreement with CMS. Providers bill normally, receive standard fee-for-service payments in Years 1&2. If Partners meets all Pioneer ACO program requirements in Years 1&2, in Year 3 there is an option to put a population-based payments system in place. Population-based payment is a per-beneficiary per month payment amount intended to replace 50 percent of the ACO's fee-for-service (FFS) payment with a prospective payment.

**BENEFICIARY RELATED QUESTIONS****How will beneficiaries be affected by the Pioneer ACO Model?**

Medicare beneficiaries will continue to receive care from their care team as they normally do. There are no incentives within the Pioneer ACO model to provide any less care than is already being given. Beneficiary benefits are not changing under Medicare and they can continue to see the same doctors. The goal of the Pioneer ACO is to deliver higher quality, more seamless health care. This is accomplished by encouraging coordination between health care providers, resulting in better care for beneficiaries.

**Who can beneficiaries contact with questions or concerns?**

Beneficiaries participating in the initiative may contact 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

**What is beneficiary medical claims data sharing?**

To effectively coordinate and improve care, ACOs need complete patient medical information. Medicare claims data about patients' medical conditions, prescriptions, and visits to the doctor or hospital will help the ACO keep up with patients' medical needs and track how well the ACO is doing to keep them healthy and getting the right care.

**What if a beneficiary wants to see a provider outside of the system?**

Unlike in a Medicare Advantage plan, Medicare beneficiaries whose doctors participate in an ACO will still have a full choice of providers and can still choose to see doctors outside of the ACO. Beneficiaries choosing to receive care from providers outside of the participating ACO reduce the potential for coordinated, high quality care.

**How are beneficiaries selected for the Pioneer ACO Model?**

In a Pioneer ACO, beneficiaries in the ACO can be identified prospectively, allowing care providers to know in advance which for of their patients they will be held accountable for managing the cost and quality of care. However, a beneficiary cannot opt out of being part of a Pioneer ACO, although they are permitted to opt-out of sharing their medical claims information with the Pioneer ACO. If a patient decides not to share their CMS medical claim data with an ACO, the ACO is still responsible for managing that patient's cost and quality of care.

### **How are beneficiaries identified for the Pioneer ACO Model?**

CMS has identified the Pioneer ACO's beneficiary population through three years of fee-for-service, primary care claims before the performance period, align those beneficiaries with the Pioneer ACO, and measure the Pioneer ACO's success or failure with that pre-identified set of beneficiaries. However, beneficiaries are free to seek care from any provider regardless of whether the provider is affiliated with the Pioneer ACO. Regardless of where beneficiaries receive care, the Pioneer ACO is accountable for their total cost and outcomes.

### **What are the Beneficiary Protections under the Pioneer ACO Model?**

The Pioneer ACO Model contains strong protections designed to ensure that patients will not experience disruptions in accessibility or quality of services. Beneficiaries can call 1-800-MEDICARE (1-800-633-4227) with questions and concerns regarding care received from the providers who are part of the ACO or for more information about the initiative in general.

Pioneer ACOs will also be conducting surveys of their aligned beneficiaries on an annual basis. CMS may investigate the practices of ACOs that generate beneficiary complaints. CMS will publicly report the performance of Pioneer ACOs on quality metrics, including patient experience ratings, on its website.

### ***Access to Care***

CMS emphasizes that payment arrangements in the Pioneer ACO should not reduce necessary care. To safeguard against this possibility, CMS will routinely analyze data on service utilization, and may investigate utilization patterns through comparison surveys of beneficiaries aligned with the ACO and those in the general beneficiary population, medical record audits, or other means. CMS will also determine whether there are systematic differences in health status or other characteristics between patients who remain aligned with a given ACO over the life of the Pioneer ACO Model, and those who do not.

### **What if a beneficiary would like more information on the ACO?**

Beneficiaries participating in the initiative may contact 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048. Our website also has additional information around ACO [www.partners.org/For-Patients/aco/](http://www.partners.org/For-Patients/aco/).

## **REIMBURSEMENT AND QUALITY MEASURES**

### **Pioneer ACO Model vs. Medicare Shared Savings Program**

A section of the Affordable Care Act requires that the CMS establish a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Eligible providers and hospitals may participate in the Shared Savings Program by creating or joining an Accountable Care Organization.

### **How are the savings for the Pioneer ACO program calculated?**

The Innovation Center will develop a target per capita expenditure level (benchmark) based on a prior 3 year average of actual CMS expenditures for the group of patients aligned to the Pioneer ACO. This baseline will be adjusted based on a combination of the average percentage growth rate and an absolute dollar equivalent growth rate for a national reference population

For example, assume that the national average expenditures are \$10,000 per beneficiary per year and the national average increase is 10%. For a Pioneer ACO with average expenditures of \$12,000 per beneficiary per year, the benchmark would include 50% of the national absolute dollar increase of \$1,000 ( $\$10,000 \times .10$ ) and 50% of the percentage increase of \$1,200 ( $\$12,000 \times .10$ ). The increase in the ACO's expected expenditures per beneficiary would be \$1,100 ( $\$500 + \$600$ ) and its benchmark would be \$13,100 ( $\$12,000 + \$1,100$ ).

At the end of each performance period, participating ACOs would be judged against this benchmark, and rewarded with a portion of the savings or held accountable for increased expenditures. The actual expenditures would have to be outside of a threshold of at least 1 percent to trigger savings or obligations. Once this 1 percent trigger is met, it is first dollar sharing of savings and losses.

### **How do ACOs reduce expenditures?**

ACOs can reduce expenditures through systematic efforts to improve quality and reduce costs across the organization such as:

- Improved care coordination
- Chronic disease management
- Health risk assessments
- Informed patient choices
- Health Information Technology
- Point of care reminders
- Physician access to timely data
- Post acute care management
- Appropriate medical management

### **What are the Quality Measures?**

The Pioneer ACO Model will be utilizing the same quality measures and assessments defined in the final rule for the Shared Savings Program. The rule proposes quality measures in five domains that affect patient care:

- Patient/caregiver experience of care
- Care coordination
- Patient safety
- Preventive health
- At-risk population/frail elderly health

## Where can I get additional information?

For further information please visit:

- **ACO Overview Information:**
  - <http://www.cms.gov/ACO/>
  - <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>
- **Results from first and second performance years:**
  - <http://www.partners.org/About/Media-Center/Articles/Pioneer-ACO-Year-1-Results.aspx>
  - <http://www.partners.org/About/Media-Center/Articles/Pioneer-ACO-Results-Year-2.aspx>
  - <http://www.connectwithpartners.org/2014/09/25/pioneer-aco/>
  - [http://www.modernhealthcare.com/article/20141008/NEWS/310089921&utm\\_source=AltURL&utm\\_medium=email&utm\\_campaign=am&AllowView=VXQ0UnpwZTRDdINXL1IzSkUvSHRIRUt wajBRZEErUmM=?mh](http://www.modernhealthcare.com/article/20141008/NEWS/310089921&utm_source=AltURL&utm_medium=email&utm_campaign=am&AllowView=VXQ0UnpwZTRDdINXL1IzSkUvSHRIRUt wajBRZEErUmM=?mh)
  - <http://www.hhs.gov/news/press/2014pres/09/20140916a.html>
  - <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html?DLPage=1&DLSort=0&DLSortDir=descending>