

If you proposed an ACO initiative, please fill out this Comparison of Elements for Participation in Medicare Shared Savings Program (MSSP) to State SIM ACO Test Proposal

From Funding Opportunity Announcement: CMS encourages applicants to propose payment models that directly align with one or more existing Medicare programs, demonstrations, and/or models, such as accountable care organizations (ACOs), primary care medical homes, and bundled payment programs. Medicare’s participation is not guaranteed and will be assessed on a case-by-case basis after thorough review of the proposed model.

Guide: Medicare Shared Savings Program is the point of reference.

ACO Type Initiatives

CMS’s Requirements To Participate in the Medicare Shared Savings Program	Connecticut SIM ACO Initiative Proposal
1) Participating Entities:	
Eligible providers include professionals in group practices, IPAs, PHOs, hospital-physician joint ventures, hospitals, CAHs, RHS, FQHCs	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
ACO participant TINs that bill for primary care services must be exclusive to a single Medicare ACO.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
2) Separate Legal Entities:	
ACO must be a legal entity authorized to conduct business under applicable state, federal and tribal law in order to participate in the MSSP.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
If formed by 2+ independent participants must form a new legal entity separate from any of its participants.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.

CMS's Requirements To Participate in the Medicare Shared Savings Program	Connecticut SIM ACO Initiative Proposal
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3) Governance Requirements:	
If ACO is composed of multiple otherwise independent participants, it needs to form a new governing body separate and unique from the ACO.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
75% control of the governing body must be held by ACO participants. If this condition cannot be met, the ACO must describe why it can't meet the requirement and identify alternative ways to meaningfully involve participants and beneficiaries in the governance process.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
4) Medicare ACO Leadership & Management Structure:	
Specific leadership and management requirements, E.g. clinical management/oversight must be managed by a senior-level medical director who is a board-certified physician, licensed in the state in which the ACO operates, and resides in that state.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
5) Must have Established Processes to Promote Evidence Based Medicine, Patient Engagement, Coordination of Care, Reporting, Patient-Centeredness & Community Engagement	
Infrastructure & internal processes for measuring performance by physicians across practices must be established, results improve care and service over time.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.

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Care should be integrated with community resources	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
Should develop individualized care plans, based on a patient's unique needs, preferences, values, and properties, that are regularly assessed and evaluated for improvement opportunities.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
Use the CAHPS survey and use results to improve care over time	State has similar requirement?: <u>Yes</u> /No Our Quality Council will seek to maximize alignment with the 37 Medicare 2015 ACO quality measures.
6) Program Integrity & Compliance Plan Requirements	
ACOs must have a compliance plan that includes a lead compliance official who reports to the governing body; mechanisms for identifying compliance problems; a method for ACO employees or contractors to report suspected problems; compliance training; and a requirement to report suspected violations to appropriate law enforcement agency.	State has similar requirement?: <u>Yes</u> /No We anticipate that this will be the defacto standard by the end of the period of performance.
7) Marketing Guidelines	
All ACO marketing materials must be filed with CMS for approval and must be in compliance with the Plain writing Act of 2010, among other requirements.	State has similar requirement?: Yes/No/ <u>TBD</u> This policy option is under consideration by Medicaid and will be determined by Medicaid in consultation with the Medical Assistance Program Oversight Council, Care Management Committee.
8) Beneficiary Information & Notification	

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<p>ACO participants must post signs in facilities indicating participation in the SSP.</p>	<p>State has similar requirement?: Yes/No/<u>TBD</u> This policy option is under consideration by Medicaid and will be determined by Medicaid in consultation with the Medical Assistance Program Oversight Council, Care Management Committee.</p>
<p>Beneficiaries may opt out of data sharing.</p>	<p>State has similar requirement?: Yes/No/<u>TBD</u> This policy option is under consideration by Medicaid and will be determined by Medicaid in consultation with the Medical Assistance Program Oversight Council, Care Management Committee.</p>
<p>9) Measures</p>	
<p>CMS requires ACOs to report on 33 measures in PY1, which are grouped into 4 domains: Patient/caregiver experience, Care coordination/patient safety, Preventive health & at-risk population.</p>	<p>State has similar requirement?: <u>Yes</u>/No Our Quality Council will seek to maximize alignment with the 37 Medicare 2015 ACO quality measures and will add measures to address Medicaid and commercial population priorities.</p>
<p>Shared savings earned by ACO tied to performance on quality measures (PY1 is pay-for-reporting).</p>	<p>State has similar requirement?: <u>Yes</u>/No There is multi-payer consensus on this requirement. Our Quality Council will seek to maximize alignment with the 37 Medicare 2015 ACO quality measures and will add measures to address Medicaid and commercial population priorities.</p>
<p>Each measure within a domain (EXCEPT EHR measure) is worth between 0-2 points. EHR measure is double-weighted to signal importance of EHR adoption for ACO success.</p>	<p>State has similar requirement?: Yes/<u>No</u> Measure weighting is determined by individual payers.</p>
<p>An ACO is assigned a single score for the domain based on the percentage of total points it achieved. The average of the four domain scores would be the overall score, which determines the percentage of shared savings received.</p>	<p>State has similar requirement?: Yes/<u>No</u> Measure weighting is determined by individual payers.</p>
<p>10) Sufficient # of Primary Care Providers & Beneficiaries</p>	

CMS's Requirements To Participate in the Medicare Shared Savings Program

**Connecticut
SIM ACO Initiative Proposal**

ACOs must have at least 5,000 Medicare beneficiaries assigned for each performance year. If # of beneficiaries falls below 5,000 during performance period, ACO will be placed on a corrective action plan.

State has similar requirement?: Yes/No

Measure weighting is determined by individual payers.

CMS's Requirements To Participate in the Medicare Shared Savings Program	Connecticut SIM ACO Initiative Proposal
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11) Beneficiary Alignment	
Step 1: A beneficiary is assigned to an ACO if the primary care physicians in that ACO account for the largest amount of total Medicare allowable charges for that beneficiary's primary and preventive services in comparison with primary care physicians in any other ACOs or all those not participating with any ACO.	State has similar requirement?: <u>Yes</u> /No Each payer is using a process similar to that described. In the case of Medicaid, they intend to extend the methodology currently in use for their medical home program. We do not intend to pursue standardization unless minor differences in methods create issues for provider participants.
Step 2: CMS will assign beneficiaries to ACOs whose professionals/participants (regardless of specialty) account for the largest total amount of Medicare allowed charges for primary care and preventive services in comparison with professionals in any other ACO or all professionals unaffiliated with an ACO.	State has similar requirement?: <u>Yes</u> /No Each payer is using a process similar to that described. We do not intend to pursue standardization unless differences in methods create issues for provider participants.
ACOs receive a preliminary list of assigned beneficiaries before each performance year using the most recent 12 months of claims data. During the performance period, CMS will update the list quarterly using a rolling 12-month claims history. A final reconciliation is conducted at the end of the performance year using the claims incurred during the performance period.	State has similar requirement?: <u>Yes</u> / <u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.
12) Expenditure Baseline Calculation Methodology	
CMS will use part A and B spending data from Medicare beneficiaries that would have been assigned to the ACO in the most recent available 3-year historical period.	State has similar requirement?: <u>Yes</u> / <u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.

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<p>a) Historical data is indexed to the most recent benchmark year using Medicare growth rates estimated by the OACT. Growth rates will be based on national spending growth levels.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>b) Base year expenditures will be weighted 60%/30%/10% for the third, second, and first historical base years, respectively.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>CMS will use the CMS-Hierarchical Condition Category (CMS-HCC) methodology to adjust for variation in beneficiary health status. Per capita expenditures are truncated at the 99th percentile for each benchmark year to minimize variation from catastrophically large claims.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>CMS will calculate benchmark expenditures separately for certain cohorts based on: ESRD, disability, aged and dually eligible for Medicare and Medicaid, aged and not dually eligible.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>The expenditure baseline resets at the start of each agreement period to adequately represent newly aligned beneficiaries.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>13) Developing Spending Benchmarks using the Baseline</p>	

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<p>Benchmark spending amounts are calculated by updating costs in the baseline period by the projected absolute growth in national per capita expenditures, expressed in absolute dollars, for Part A and B services under the original Medicare FFS program.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>CMS will use national growth without any locality adjustments.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>For newly assigned beneficiaries, CMS will update the ACO's risk score. For the continuously enrolled population, CMS will use only demographic factors to adjust for severity and case mix relative to the historical benchmark period, unless their CMS-HCC risk scores decline.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>CMS will exclude IME, DSH adjustments, and incentive payments made outside the Medicare Part A & B payment systems from BOTH benchmark and performance year calculations.</p>	<p>State has similar requirement?: Yes/<u>No/TBD</u> This requirement does not apply to commercial payers. This policy option is under consideration by Medicaid and will be determined by Medicaid in consultation with the Medical Assistance Program Oversight Council, Care Management Committee.</p>
<p>CMS WILL include incentives and payments adjustments that <i>are</i> captured by claims data in baselines and benchmark calculations.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>a) Examples: Hospital Inpatient VBP Incentives & geographic adjustments to provider payment rates</p>	
<p>14)Shared Savings and Losses Caps</p>	

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<p>One-sided risk model: ACO can share in savings up to a maximum amount that is equal to 10% of the benchmark for a given PY.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants. The Medicaid QISSP will be limited to a one-sided risk model. A maximum savings amount will be under consideration by Medicaid and will be determined by Medicaid in consultation with the Medical Assistance Program Oversight Council, Care Management Committee.</p>
<p>Two-sided risk model: 15% of benchmark cap to the amount of savings that can be shared with ACOs. Cap on shared losses will increase from 5% in PY1, 7.5% in PY2, 10% in PY3.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants. Medicaid QISSP will not include a two-sided risk option.</p>
15) Distribution of Shared Savings & Repayment of Losses	
<p>One-sided model: <i>[Inserted Draft language] Sharing of savings are calculated for each performance year during the term of an ACO's first agreement.</i></p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.</p>
<p>Two-sided model: If ACO's performance year expenditures are less than the benchmark, the ACO must pay back a portion of the losses if the losses are greater than the MSR.</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants. Medicaid QISSP will not include a two-sided risk option.</p>
<p>ACOs establish their own method of repaying losses to Medicare and must establish their ability to repay up to 1% of per capita expenditures of its assigned beneficiaries</p>	<p>State has similar requirement?: Yes/<u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants. Repayment will not apply to Medicaid QISSP.</p>

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16) Methodology for Determining Shared Savings and Shared Losses	
ACOs may elect to participate in one-sided or two-sided risk models. In order to be eligible for shared savings, ACOs need to reduce spending below a MSR.	State has similar requirement?: Yes/ <u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants. Medicaid QISSP will not include a two-sided risk option.
One-sided risk model: CMS will set the MSR as a function of both the number of assigned beneficiaries and a chosen confidence interval. MSRs range from 2-3.9%. Can receive up to 50% of shared savings, based on quality performance.	State has similar requirement?: Yes/ <u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.
Two-sided risk model: Flat 2.0% MSR imposed. Can receive up to 60% of shared savings, based on quality performance. Shared-loss percentage is determined as the inverse of the would-be final sharing rate. Share-loss rate is not to exceed 60%, with actual amount varying based on quality performance.	State has similar requirement?: Yes/ <u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants.
Both one-sided and two-sided ACO models share in all of the savings on a first-dollar basis if the MSR is met or exceeded.	State has similar requirement?: Yes/ <u>No</u> This process is determined by individual payers. We do not intend to pursue standardization unless differences in methods create issues for provider participants. Medicaid QISSP will not include a two-sided risk option.

