Accountable Care Organization (ACO) and UW Health ACO FAQs

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UW Health ACO Information - General

1. **Why did UW Health form an ACO?**
   UW Health ACO, Inc. was formed as a partnership with UWHCA, UWMF and UWSMPH on June 15, 2012 in order to apply for participation in the Medicare Shared Savings Program (MSSP). On December 11, 2012, UW Health ACO was notified that it was accepted into the program for a 3-year contract beginning 1/1/13.

   The MSSP is a voluntary program administered by the Center for Medicare and Medicaid Services (CMS) as part of the Affordable Care Act, with the explicit goals of sharing risk with provider groups in order to lower total cost of care for Medicare fee-for-service (FFS) beneficiaries while improving or maintaining quality.

2. **How are patients attributed to be in our ACO?**
   Medicare fee-for-service beneficiaries who receive a plurality of their primary care services from UW Health are attributed to our ACO. In practice, plurality of services is defined as a plurality of payments for primary care evaluation and management (E and M) services by the Center for Medicare and Medicaid Services (CMS). For example, if a beneficiary has visits over the course of a calendar year during the MSSP contact that result in $100 being paid by CMS to UW Health for primary care E and M services, and $99 to Dean Clinic for primary care E and M services, that beneficiary is part of the UW Health ACO. If, on the other hand, CMS pays Dean Clinic $101 for primary care E and M services during that calendar year, that beneficiary is part of the Dean/St. Mary's ACO. If the plurality of payments is to providers who are not part of any ACO, that beneficiary is not attributed to any ACO. Finally, if a beneficiary does not receive any primary care E and M services during a calendar year but does receive specialty services, that beneficiary will be attributed to an ACO according to those specialty services.

3. **How many beneficiaries do we expect to be attributed to UW Health ACO?**
   Approximately 27,000 beneficiaries are attributed to UW Health ACO. Internal data from 2008 suggest that at least 23,000 of these will be attributed according to their primary care affiliation.

4. **What exactly is the ACO accountable for?**
   The ACO is accountable for overall quality and total cost of care for the population of Medicare FFS beneficiaries attributed to us.

Measuring Quality, Costs and Savings

5. **How is the quality measured?**
   There are 33 quality metrics that CMS has chosen for the initial MSSP contracts. These are divided into four 'domains':
   - Better Care for Individuals
     - Patient/Caregiver Experience (7 measures)
     - Care Coordination/Patient Safety (6 measures)
   - Better Health for Populations
     - Preventive Health (8 measures)
     - At-Risk Populations (12 measures)

   In the first year, the ACO is only responsible for reporting these metrics. Performance benchmarks will be established and phased-in over the subsequent two years.

6. **How is UW Health doing on these quality measures now?**
   Much of the work that has occurred over the last few years by the Quality and Safety Innovation Department and through Primary Care Redesign (PCR) has resulted in significant improvements in measured metrics. For

example, our colorectal cancer screening rates have gone from 12th in the state in 2008 to 2nd in 2011. Also, Health Maintenance efforts under PCR have resulted in rates of pneumococcal vaccinations increasing by ~50% in fewer than six months. These health maintenance efforts now target a larger set of nine measures for all UW Health medically homed populations.

For other metrics, the results remain unknown. We, like many organizations, have not traditionally measured all 33 of these metrics (for example, Screening for Fall Risk) and are currently preparing to do so. Others, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey questions, are approximated by other measures, such as Avatar scores.

7. **How is the cost measured?**
   Cost is measured as total cost of care for these beneficiaries over the course of the calendar/performance year paid for by CMS. Moreover, total cost of care to CMS means for all care, regardless of who gets paid. This includes not only claims paid to UW Health for services rendered within our system, but also claims paid to other providers, including other hospitals, specialists, nursing homes, rehab centers, and even care delivered while beneficiaries are wintering in Florida or Arizona.

8. **How much of the care for our Medicare fee-for-service is delivered by UW Health, and how much by other entities (nursing homes, home health, other hospitals, etc.)?**
   Data from 2008 suggest that approximately 43% is delivered by UW Health, and 57% outside our system. This appears to be fairly consistent with other organizations.

9. **How are savings/losses determined?**
   First, baseline costs are determined as the ACO-specific average annual beneficiary cost to CMS. This is calculated using an historical 3-year look back at the population of beneficiaries that would have been part of a UW Health ACO using the same attribution model going back to 2010. Total costs to CMS is then calculated as an average annual per-beneficiary amount over the three years, trended forward to 2013 dollars and weighted more heavily to the current year (2010 – 10%, 2011 – 30%, 2012 – 60%).

   Next, the benchmark or target is set as the baseline plus projected absolute amount of growth in national per capita expenditures for Parts A and B services under Medicare FFS, as determined by the CMS Office of the Actuary.

   Finally, a minimum savings rate (MSR) is established. In each performance year, CMS compares actual per capita spending to the benchmark as determined above, and if the costs are less than the benchmark/target amount by at least as much as the MSR, the ACO may share in some of the savings. Conversely, if costs are higher than the benchmark, the ACO may be required to pay back to CMS some of the difference. Individual ACOs may have different MSRs, with the precise amount determined by factors such as the number of beneficiaries included in the ACO. We estimate that our MSR will be approximately 2.5%.

10. **Do we have to take risk right away?**
    We have two options for the first 3-year contract.
    1. Track 1 is one-sided risk only, such that if costs are lower than the MSR, the ACO shares in a percentage of the savings (as determined by performance on the 33 quality measures).
    2. Track 2 is two-sided risk, where if costs rise the ACO must share in some of the losses.

    The advantages to Track 2 is that the MSR is set at 2% regardless of ACO size, and also the maximum shared savings rate is 60% instead of 50% as in Track 1.

    ACOs choosing Track 1 for the first 3-year contract must switch to Track 2 if they pursue subsequent contracts.

11. **Which track has UW Health chosen for the first three-year contract?**
Track 1 (one-sided risk).

12. **What about the non-medically homed populations?**
As a regional academic health center, UW Health serves multiple populations of patients. While the care model workflows, patient-centered medical home (PCMH) and care management activities address those medically homed at UW Health, we anticipate increasingly being forced to assume additional risk when caring for patients referred from elsewhere for more discrete, episodic care. Moreover, the national market is seeing movement towards partnerships with large employers and integrated centers. Success here, as with the medically homed population, will require delivering the highest quality care at the lowest cost possible if we are to continue to thrive in the increasingly competitive marketplace.

One financial/payment mechanism that is emerging in response to this is **bundled payments**.

13. **What are bundled payments, and how do they fit in with the MSSP?**
From the CMS website:
"There are a number of contexts in which Medicare uses the term "bundled payment" but it generally means that rather than paying separately for each item or service, a single payment is made for a defined group of services. The bundled payment may cover services furnished by a single entity (hospital or other provider) or it may be used to pay for items and services furnished by several providers in multiple care delivery settings. In this context, bundled payment refers to a single negotiated episode payment of a predetermined amount for all services (physician, hospital, and other provider services) furnished during an episode of care. This could be paid prospectively or retrospectively. For example, Medicare and the awardee would agree to a bundled payment target price for acute care hospital services for an inpatient stay plus professional services and post-acute care related to the principal reason for the hospitalization, rather than paying separately for each physician visit and procedure provided during the episode."

Like ACOs, PCMH and other new and emerging payment mechanisms, bundled payments are not the end goals, but rather tools for creating systems-level change, enabling health care delivery to evolve to a coordinated system of managing populations in an safe, timely, effective, equitable, efficient and patient-centered way.

14. **What is UW Health doing about bundled payments?**
Bundled payments offer two important opportunities for UW Health:
- Maintaining and improving market share
- Engaging front-line providers in process/quality improvement

Moreover, effectively preparing bundled payments requires three separate but parallel processes:
- Choosing and defining the Bundle
- Improving the processes that make up the Bundle
- Pricing and potentially marketing the Bundle

UW Health will begin to prepare a number of bundled payments to be available as the market demands. As transplant services already have some elements of bundled payments, an initiative is underway to improve the process. Similarly, a knee replacement bundle has been created, at least in terms of definition and pricing. However, the process improvement work has not been undertaken, and the next step is to engage in a rapid design session to advance this work. Subsequent bundles to be developed will be chosen based upon new CMS definitions (a list of 48 predefined bundles has been released), volume of services currently at UW Health, and relevant market forces.

Finally, the benefits from these activities will be manifest in our medically homed populations under shared savings arrangements, capitation, or other risk-sharing models.

UW Health ACO Priorities and High-level Timeline for Operational Blueprint Implementation

Currently Ongoing Activities

- Prevention - Health Maintenance and Best Practice Advisories
- Transitions in Care
- eVisits
- Access
- Patient and Family Centered Care
- Tele Health
- Shared Savings
- P4P
- PCR/Care Model development/Standardized Workflows/PCMH
- Evidence-Based Medicine/Guidelines – clinical decision support tools (CCKM)
- ACO Legal Structure

Immediate Activities (0 – 6 months)

- High risk disease management – CHF
- Evidence-based practice - CHF registry, tools;
- Quality Metrics - 33 CMS Quality measures
- Cost Metrics - Total cost of care to CMS
- Predictive modeling - Provider inquiry; CHF with admission in previous year;
- Beneficiary opt-out and communications - Letters; HL flag; Clinic visit communications
- Bundled Payments

Near-term Activities (6 – 12 months)

- Acute episodic care - Department/Division/Unit based PI
- High risk disease management - COPD, CAD
- Evidence-based practice - COPD, CAD registry, tools
- Care Management - Centralized/Decentralized
- Palliative Care
- PCP-Specialist Service Agreements - Care Model Design (test with Dermatology)
- Shared Decision Making
- Gainsharing
- Readmissions

Longer-term Activities (12+ months)

- Robust Analytics
- Continuous Learning Institution
- Physician Compacts
- Progressive Compensation Plans