



The Medicare-Medicaid Accountable Care Organization (MMACO) Model

Welcome to Today's Webinar

We will begin at 1:00 PM ET

Dial-in: 1-800-832-0736

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Note: All attendee phone lines are muted to prevent audio feedback



The Medicare-Medicaid Accountable Care Organization Model



Model Overview and State Application Process

CMS Innovation Center

Tips for a Successful Event

The screenshot shows a webinar window titled "DRAFT Enhanced MTM Webinar (Unofficial Copy 12.07.15).pptx". The main content area features the CMS logo and the following text:

Part D Enhanced Medication Therapy Management (MTM)

Welcome to Today's Webinar

**Medication Therapy Management:
Innovations in HIT-Enabled MTM-Related
Care Coordination or Services**

We will begin promptly at 3:00 PM EST

Please make sure the volume on your computer speakers is turned up and/or you have headphones on so that you can hear the webinar audio.

On the right side, there is a "Q & A" panel with a text input field and a "Send" button. A blue callout box with white text says "Type questions here and hit 'Enter'", with a yellow arrow pointing to the input field.

At the bottom right, there is a "Download Presentation" dialog box with the filename "DRAFT Enhanced MTM Webinar (Un..." and a "Cancel" button. A blue callout box with white text says "Click here to download a PDF copy of the slides", with a yellow arrow pointing to the dialog box.

Agenda

- Model Overview
 - Principles, Scope, Overview
- Shared Savings Program Overview
- Quality Payment Program and MMACO Model
- Model Details
 - Beneficiary Assignment, Financial Methodology, Quality, Data, Learning, Evaluation
- State-specific Development and Application Process
 - State Eligibility, Deadlines, How to Submit a Letter of Intent

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Medicare-Medicaid ACO Model (MMACO)

- A new accountable care opportunity focused on beneficiaries enrolled in Medicare and Medicaid (“**dual eligible individuals**” “Medicare-Medicaid enrollees”)
- Medicare-Medicaid ACO Model seeks to test whether engaging states and ACOs in a **three-way partnership** to take on accountability for Medicare and Medicaid costs for Medicare-Medicaid enrollees can improve quality of care and result in Medicare and Medicaid savings
- Authorized under Section 1115A of the Social Security Act that established the Center for Medicare and Medicaid Innovation Center to test innovative payment and service delivery models to **reduce Medicare, Medicaid, and CHIP expenditures** while preserving or enhancing the quality of beneficiaries’ care

Model Principles

Protecting Medicare and Medicaid fee-for-service beneficiaries' freedom to seek the services and providers of their **choice**

Aligning incentives across Medicare and Medicaid for providers/suppliers, beneficiaries, and the participating state and federal payers

Offering a **range of financial options** to engage ACOs with varying levels of experience managing financial risk and in population health management

Ensuring that Medicare-Medicaid enrollees are **represented in ACO governance**

Generating useful information regarding the **participation of safety-net providers** in ACOs and the effect on the quality and cost effectiveness of care furnished to Medicare-Medicaid enrollees

Model Overview

- Model builds on **Medicare Shared Savings Program**
 - All MMACOs must also participate in the Shared Savings Program
- CMS and interested states jointly develop **parallel Medicaid structure/methodologies**
- CMS provides significant **operational and learning system** support to states and ACOs
- Certain ACOs that qualify as “**safety-net ACOs**” eligible for pre-payment of Medicare shared savings
- **States** may be eligible to share in **Medicare savings**

Model Scope

- CMS will partner with up to six states
- Three year agreement period with states, with potential for up to two “option years”
- Two options for first performance year of Model in state
 - January 1, 2019
 - January 1, 2020

Agenda (Continued)

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Shared Savings Program Overview

- Established under section 1899 of the Social Security Act; regulations at 42 C.F.R. part 425
- **Accountable Care Organizations (ACOs)** voluntarily participate in the program to be accountable for quality and cost of care of assigned Medicare beneficiaries
- Medicare **fee-for-service** (FFS) program
- As of January 1, 2017, there were 480 ACOs participating in the program
- Tracks 2 and 3 of the Shared Savings Program are **Advanced Alternative Payment Models** under the Quality Payment Program

Shared Savings Program Overview

ACO means a legal entity that is recognized and authorized under applicable state or tribal law, as identified by a Taxpayer Identification Number (TIN), and comprised of eligible groups of eligible providers and suppliers (as defined at §425.102) that work together to manage and coordinate care for Medicare FFS beneficiaries

Shared Savings Program Overview

- ACOs demonstrate savings if the actual assigned patient population Parts A and B expenditures are **below the established benchmark** and by an amount (percentage of updated benchmark) that meets or exceeds the minimum savings rate (MSR)
- ACOs have **choice of financial track**:
 - Track 1 –shared savings only (“1-sided”)
 - Track 2, 3 – shared savings and shared losses (“2-sided”)
 - New Track 1+ (Innovation Center model) – 2-sided; less risk than track 2 or 3
- Performance on **quality measures** factors into shared savings or shared loss rate
- More information: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>

Waivers of Shared Savings Program Regulations

CMS will waive the following regulations at 42 C.F.R.

- § 425.114(a) To allow **simultaneous participation** by ACOs, ACO Participants, and ACO Providers/Suppliers in the **Shared Savings Program, MMACO Model**, and Track 1+ ACO Model (as necessary)
- § 425.400(a)(2)(iii) – Instead all MMACOs will have Medicare **beneficiaries assigned prospectively** using the methodology under Track 3
- §§ 425.702(c)(ii)(A) and (B) and 425.704(d)(1)(i) – Instead **data** will be shared only on prospectively assigned beneficiaries

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Quality Payment Program (QPP) and the MMACO Model

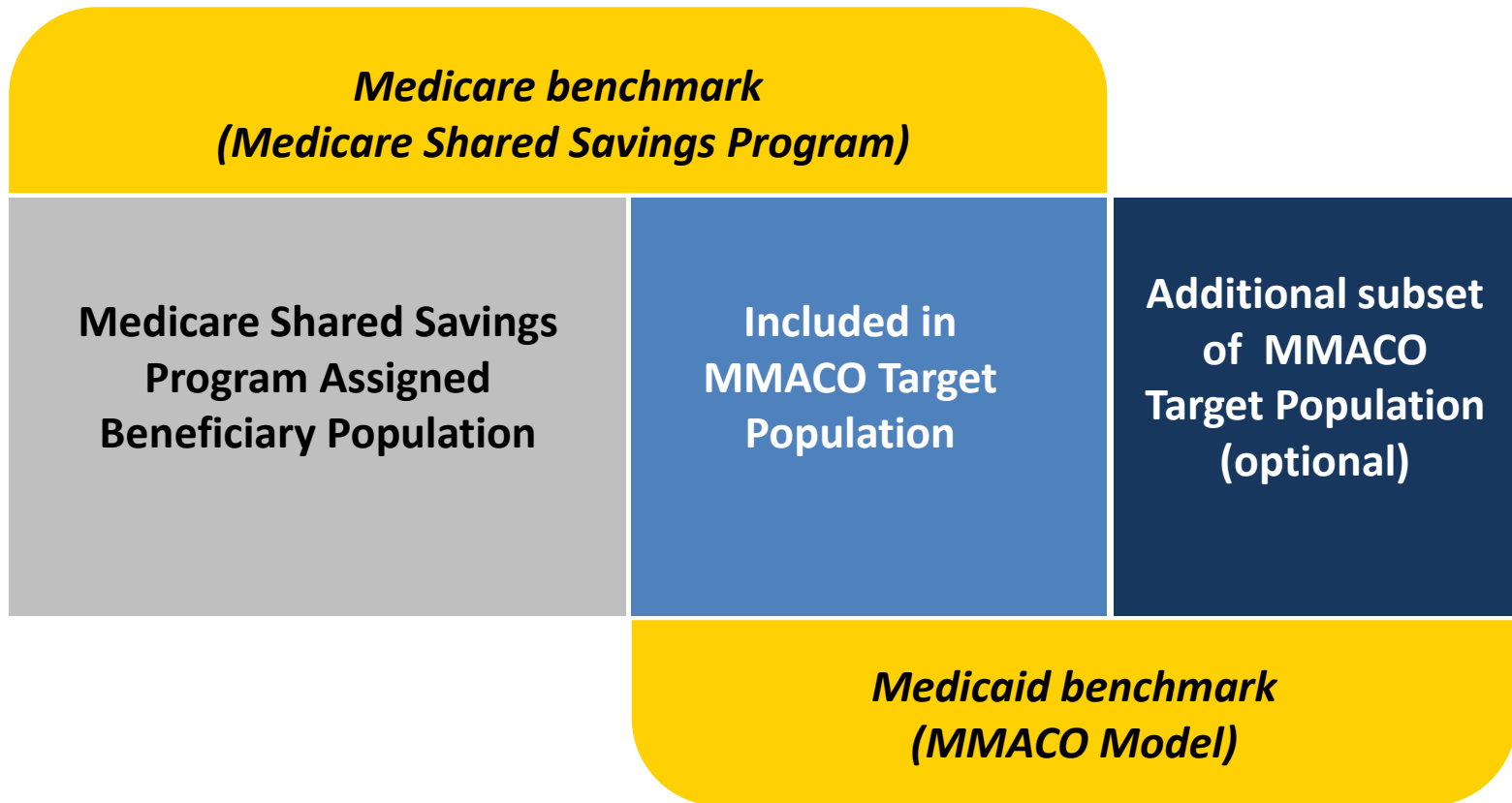
- Whether the MMACO Model is a QPP Advanced Alternative Payment Model (APM) will depend on the Shared Savings Program* financial track selected by the ACO
 - Track 1: not an Advanced APM
 - Track 2, 3, and Track 1+ Model: Advanced APMs
- Medicaid financial tracks will be assessed on a state by state basis to determine if/which tracks meet the criteria to be an “Other Payer Advanced APM” as defined by QPP

** Or in the case of Track 1+ participants, the Innovation Center model financial track*

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Beneficiary Assignment Model Overview



Beneficiary Assignment

Medicare Shared Savings Program beneficiaries included in MMACO Target Population

- Medicare Shared Savings Program assigns beneficiaries to individual ACOs for Medicare accountability (using claims-based methodology in which beneficiaries are assigned based on where they receive the plurality of primary care services)
- MMACO Model applies eligibility criteria to identify which beneficiaries to include for Medicaid accountability as well

Additional subset of MMACO Target Population (optional)

- MMACO Model uses eligibility criteria to identify MMACO-eligible beneficiaries
- MMACO Model assigns eligible beneficiaries to individual MMACOs for Medicaid accountability (using claims-based analysis)

Medicaid Financial Methodology

- CMS and interested states will work together to design the Medicaid financial methodology appropriate for the unique needs of the state
- The MMACO Medicaid Financial Methodology
 - Measures the Medicaid **expenditures** incurred by assigned beneficiaries during the performance year
 - Costs for all covered Medicaid services will be included
 - Compares measured expenditures to a Medicaid **benchmark** to calculate Medicaid savings/losses generated by an MMACO
 - Determines the amount of Medicaid savings or losses to be **shared** with the MMACO

Quality

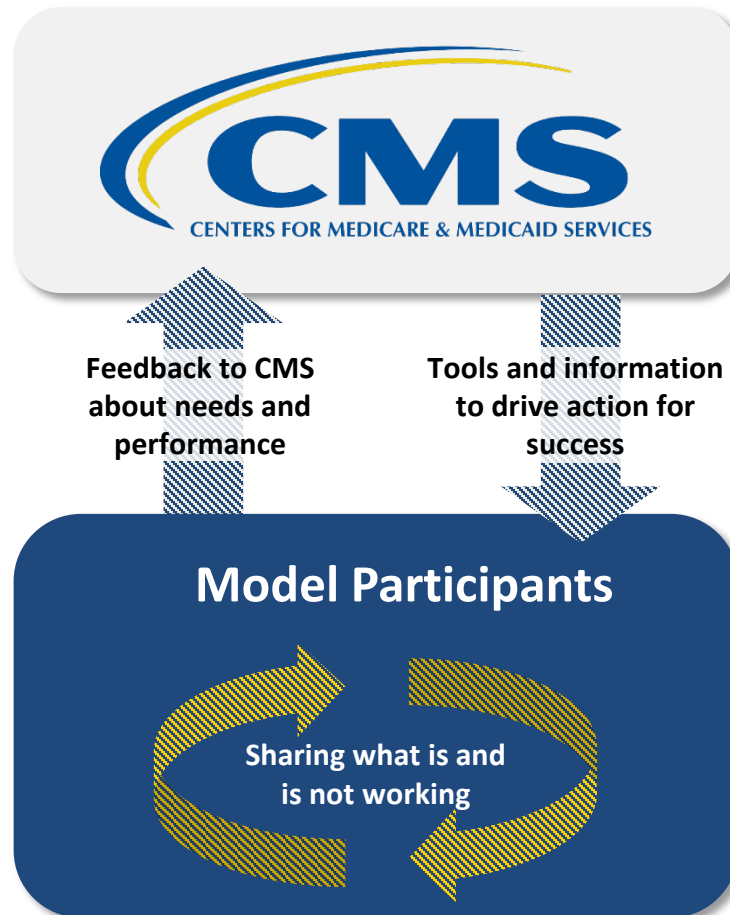
Measure(s)	Population Included	Impact to Shared Savings/Shared Losses
Shared Savings Program Measure Set	Shared Savings Program assigned beneficiaries (Medicare only and dual eligible)	Affects Medicare shared savings (and possibly shared losses)
State-specific Measure Set	MMACO assigned population (dual eligible and possibly Medicaid only)	Affects Medicaid shared savings (and possibly shared losses)
Quality of Life Survey	MMACO assigned dual eligible beneficiaries	Initially for informational purposes only; may be phased in to affect Medicaid shared savings/losses

Data and Reports

- CMS will share **Medicare and Medicaid data** for each assigned beneficiary with ACOs. This includes:
 - Eligibility and enrollment information
 - Claims data
 - Claims-based quality measures
- CMS will use **Medicaid data** submitted by states through the **Transformed Medicaid Statistical Information System (T-MSIS)** to create Medicaid claims files and financial reports
- CMS will continue to share **Medicare data** with ACOs through the Shared Savings Program files and reports
- CMS also intends to link Medicare and Medicaid data and share with ACOs

Learning System

CMS will help the Medicare-Medicaid ACOs and states to accelerate their progress by providing opportunities to learn about performance improvements and share experiences with one another and with participants in other CMS initiatives.



Learning System

The learning system will use various group learning approaches to help states and ACOs track their progress and share and adopt new methods for improving quality, efficiency, and population health

The learning system will include

- Resources to improve ACOs' knowledge and skills
- Opportunities for states to share challenges and best practices
- Access to experts on issues including Medicare/Medicaid claims data
- Sharing promising practices through webinars and structured case studies
- Collaborative activities, including:
 - Facilitated peer mentoring with other ACOs
 - Action groups for focused collaboration and problem-solving
- Assistance in applying improvement methods/testing new ideas
- A virtual online network for states and ACOs to share resources and ideas

Evaluation

Purpose: measure the “what” and the “how” of the model

- **Impact (the “what”)**

- How do cost and quality outcomes differ between those in the model and beneficiaries in the (to be determined) comparison group?
- Are there differential impacts among subgroups of interest, such as rural providers and vulnerable populations?
- Are there differential utilization, quality, and cost effects for certain types of beneficiaries?

- **Context (the “how”)**

- What reasons motivate providers to participate?

- **Model interventions and incentives**

- What are the characteristics of the participants’ approaches to their chosen strategies for implementation?

- **Implementation**

- What are the barriers, if any, to implementing such interventions?

- **Behavior change**

- What are the motivations for participation attributed to financial gains, capacity improvement, or other factors?

Qualitative and Quantitative Analysis

Qualitative Analysis

Primary Data Collection Activities

Site
Visits

Quarterly
Interviews

Key Informant
Interviews

Focus
Groups

Physician
Surveys

Quantitative Analysis

Cost per per-
beneficiary-per-
month (PBPM)

Utilization (i.e.
inpatient stays,
SNF days)

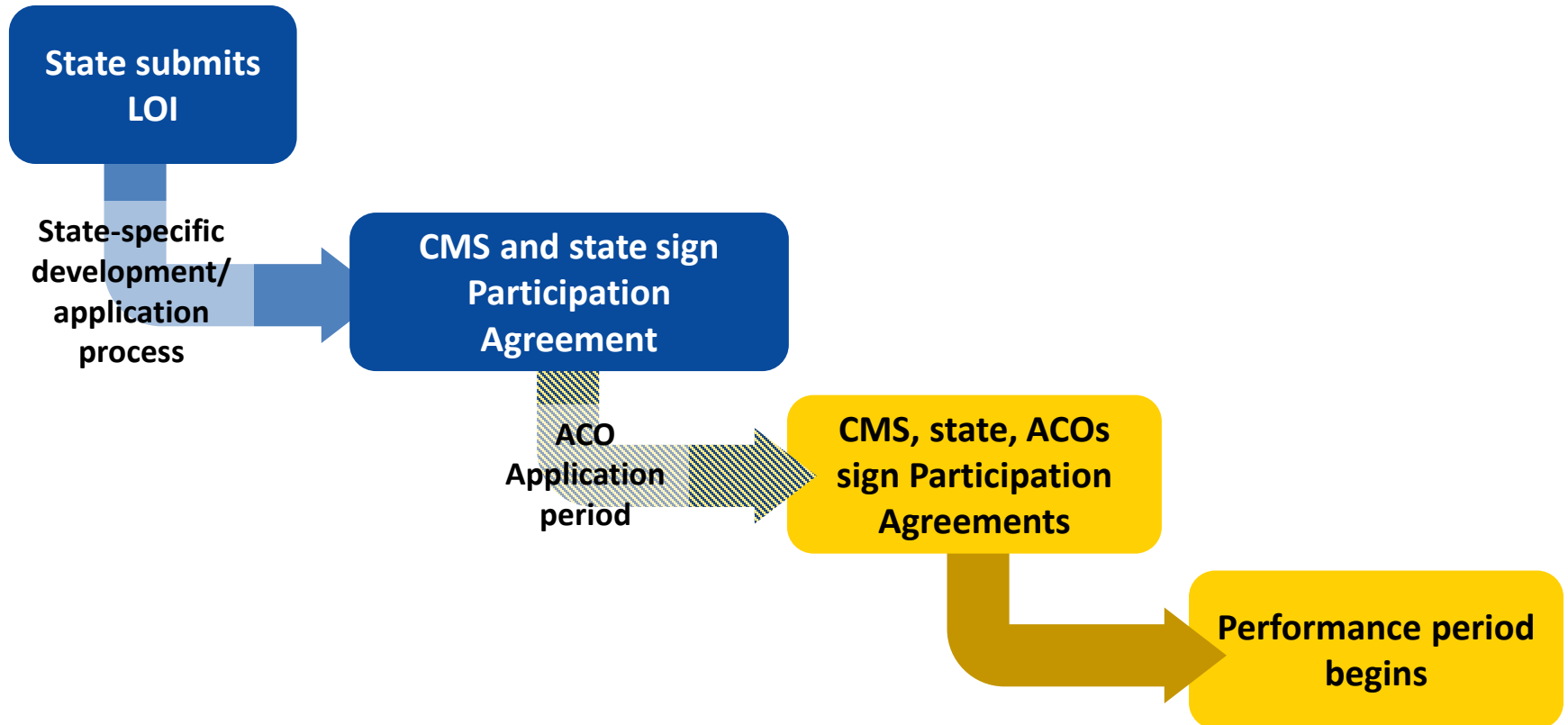
Clinical quality (e.g.,
readmission rate,
diabetes HbA1c
control rate)

Patient experience
(i.e. patient ratings
of care)

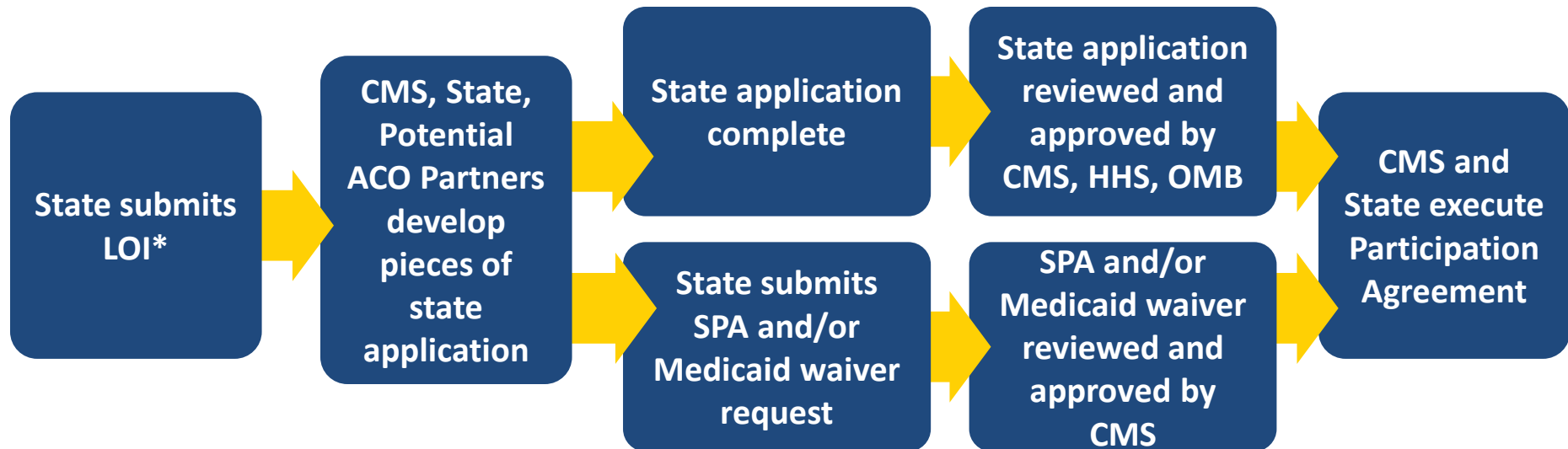
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Application Development and Implementation Overview



State-specific Development/Application Process



* LOI does not need to be submitted to begin engagement process with CMS. CMS/state conversations can begin prior to submission of LOI and interested states are encouraged to contact CMS as early as possible.

ACO Application Process



*ACOs must either apply to begin participation in the Shared Savings Program or apply to renew their Participation Agreement with the Shared Savings Program

**ACOs must also enter into or renew Shared Savings Program Participation Agreement

State Eligibility

- Open to all states and District of Columbia
- Sufficient FFS Medicare-Medicaid enrollee population
- Preference for states with low Medicare ACO saturation

State Eligibility

- State must ensure CMS access to complete and timely Medicaid data through T-MSIS
 - 3 years historical data needed for financial modeling during state-specific development process
 - Ongoing access to data to produce files and reports for ACOs, calculate savings, evaluate Model
- Pass any necessary state-level legislation (e.g. state fraud and abuse law waivers; appropriation to allow for payment of Medicaid savings to ACOs)
- Secure CMS approval of necessary SPA or waiver(s)
- Application (including Medicaid financial methodology) reviewed and approved by CMS, HHS, and Office of Management and Budget

Medicaid Authority

- Appropriate Medicaid authority for implementing MMACO Model may vary by state (existing authorities in place and aspects of the state-specific model design)
 - Some states may be able to use State Plan Amendment (SPA) to authorize Model
 - Some states may require Medicaid demonstration or waiver (1115(a) or other)
- States must follow applicable laws, regulations, and guidance, including those related to Medicaid coverage, payment and fiscal administration that apply under the approach they are approved to offer

State Application

A state's application must include

- Detailed description of the state-specific approach to the MMACO Model, including:
 - Definition and rationale for selecting the state's **Target Population**;
 - **ACO eligibility criteria** (in addition to those set by CMS) including any state-determined care model requirements;
 - Description of any **legislative action** needed to implement the Model including waivers of state fraud and abuse laws, if applicable
- Detailed description of the **Medicaid financial methodology**
- List of **quality measures**, proposed reporting mechanisms, and proposed quality benchmarking approach
- Description of **provider/supplier and beneficiary engagement** activities that the state has conducted/participated in as part of the development process

Deadlines

State's Preferred 1st Performance Year Start Date	Deadline to Submit LOI	Deadline to execute CMS-State Participation Agreement
2019	August 4, 2017	March 30, 2018
2020	August 3, 2018	March 29, 2019

Letter of Intent (LOI)

- LOI is non-binding
- Must be submitted prior to deadline for state to be considered for possible start in corresponding performance year; not a guarantee of approval for that date
- LOI must be submitted by email to MMACO@cms.hhs.gov
- Appendix A of Request for LOIs includes LOI template
- Must be accompanied by at least one (non-binding) letter of interest from Potential ACO Partner
 - Potential ACO partner is NOT required to be an existing ACO

Letter of Intent (LOI)

LOI must include brief descriptions of the following

- State's vision for testing the Model
- State's current approach to payment and care for dual eligible beneficiaries
- Beneficiary and caregiver engagement plan
- Provider engagement plan
- T-MSIS data submission status

More Information

- **Innovation Center website**
<https://innovation.cms.gov/initiatives/medicare-medicaid-aco-model/>
- **Request for Letters of Intent**
<https://innovation.cms.gov/Files/x/mmaco-loi.pdf>
- **FAQs**
<https://innovation.cms.gov/Files/x/mmaco-faq.pdf>
- **Email inbox**
MMACO@cms.hhs.gov

Questions?

We appreciate your feedback on this webinar. You will have the opportunity to complete a brief survey shortly.