Medicare ACO Frequently Asked Questions

The Network is applying to participate in Track A of the Medicare Shared Savings Program starting January 1, 2024. It will also apply for the Advanced Investment Payment model (AIP) created by CMS to provide start-up funding for new ACO applicants. The Network will create a subsidiary LLC to house the ACO and will recruit both Network and non-Network health centers who are interested to participate.

1. **What is the likelihood of the Network getting an advance from the Advanced Investment Model.**

The Medicare AIP model is not competitive this round. Every ACO applicant who meets the requirements and applies correctly will be awarded the funding. The program is targeted to new low-revenue ACO applicants. We meet that criteria.

2. **Can you speak to the alignment of coding efforts between HCC groups and Medicaid CDPS+Rx codes?**

The differences mostly have to do with what kind of conditions are greater risks to Medicare populations compared to Medicaid. Younger patients have different drivers of cost. The CDPS diagnostic codes correlate to HCC designation at a rate of ~50%. The 50% that don't track to HCC are age related diseases.

3. **From the Board governance perspective and the need to have 2 Boards, how do you think the 2 Boards will overlap?**

The ACO Board will be made up of only MSSP participants. It will be smaller, but at least 5 members, one of whom will be a Medicare MSSP consumer who is not an employee of a participating health center, the Network or the OPCA. At least 80% of Board members (the other 4) must be from MSSP provider organizations. Ideally, except for the consumer, all of the Board members will be Board members of the parent organization, though a Board members could be from an MSSP clinic not on the Board of the parent organization. The ACO Board will convene briefly at the end of the parent organization’s Board meeting to conduct the required business.

4. **Can the Annual Wellness Visit be done via telehealth?**

During COVID, telehealth visits were allowed for the Annual Wellness Visit (AWV) and that has not yet been rescinded. But with the provisions offered by the Consolidated Appropriations Act of 2023 the AWV still requires weight and blood pressure be taken during the visit which makes telehealth very difficult to do at scale. During the PHE the patient must be able to collect their vitals at home - if they don't have a way to collect it you wouldn't be able to bill.

5. **In Oregon, who is authorized to provide AWV's?**

Medicare Part B covers the AWV if it is furnished by a:

- •Physician (doctor of medicine or osteopathic medicine)
- •Physician assistant
- •Nurse practitioner
- •Clinical nurse specialist
- •Medical professional (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician (doctor of medicine or osteopathy)

As discussed in the preamble of the calendar year 2011 Physician Fee Schedule rule, CMS is not assigning particular tasks or restrictions for specific members of the team. We believe it is better for the supervising physician to assign specific tasks to qualified team members (as long as they are licensed in the State and working within their state scope of practice). This approach gives the physician and the team the flexibility needed to address the beneficiary's particular needs on a particular day. It also empowers the physician to determine whether specific medical professionals who will be working on his or her wellness team are needed on a particular day. The physician is able to determine the coordination of various team members during the AWV.

6. **Are there advantages to the ACO being a subsidiary of the PCA rather than the Network?**

Our consultant, Andy Principe from the Starling Advisors recommends that the LLC be a subsidiary of the Network, and that was the unanimous recommendation of the Network Strategy Committee as well. The Network already has the committee structures in place to participate in shared value based payment programs, to carry out its withhold and distribution strategies. It soon will have the data platform needed for the ACO. The OPCA does not have these structures in place. It is a common division of roles in other states that the CIN is responsible for VBP contracting and management and the PCA is responsible for education, advocacy, HRSA and other governmental affairs.

7. **Can you confirm how long you have to participate if you receive the AIP funds? Is that length of participation by ACO or does each CHC also need to participate for that length of time or have to pay something back?**

The ACO must particpate in the MSSP program for five years. It must maintain a minimum of 5000 members. Individual health centers can drop out as long as the number of members in the ACO does not drop below 5000. If the ACO terminates before 5 years, it must pay back any amount of the advance payment which has not already been recuped through the shared savings revenue to date.

8. **Does a CHC have to not participate in ACO for a certain amount of time in order to count towards the 5k lives or for the AIP (i.e. can you go directly from one to participate in this one and be included for the 5k lives and count towards benefiting for the AIP application?**

CMS allows a CHC to go directly from one ACO to another and to remain in the first ACO while you are applying with another. But then you must immediately switch when the new one begins the program. (You can only be in one FFS ACO at a time.) HOWEVER some ACOs, such as Aledade, have contracts with their providers that require them to sit out a calendar year after leaving before they can join another ACO. You have to abide by that contract.

9. **Is your most recent Medicare Cost Report and good way to predict how many lives each of us might bring into the Medicare ACO?**

Our actuarial consultants, the Wakely Group, have prepared a preliminay analysis of the MSSP potential, from the "100% Medicare" data set showing the number of FFS Medicare lives for every health center in Oregon. That preliminary analysis is attached. A more comprehensive analysis, predicting revenue, will be done for us by Wakely in the next phase of our MSSP application process.

10. **Since the AIP is upfront support, what other funds, if any, can the ACO expect to bring in until paid off? Is that everything to expect for funding for a couple years to support the needed ACO infrastructure and for distribution payments?**

Though the AIP model requires the ACO to remain in the program for 5 years, the advance is only of the first two years. It is assumed by CMS that an ACO will make at least $2,250,000 in the first two years. Shared savings is withheld during the first two years until that amount is met. Any savings above that amount will be paid to the us. All of the shared savings in years 3-5 will be paid to the us with no withholding by CMS.

11. **Can new members join the ACO at any time? i.e. Are there any barriers to entry if health centers aren't in the ACO at the start?**

There are two chances this summer before we submit the final application to sign up to particiapte in 2024. Then new health centers will have an opportuntiy to join each calendar year. So any health centers who want to join for 2025 or beyond will have a chance to enroll in the fall before those years begin.

12. **Is there interest paid on AIP funds?**

The is no interset charged by CMS to an ACO AIP recipient on the unreoupced balance if they choose to drop out before the 5 years required for debt forgiveness.

13. **What other ACOs are operation in Oregon?**

We are looking to become a fee-for serveice (FFS) ACO not a Medicare Advantage ACO. Aledade is a FFS ACO that Winding Waters is currently using. It takes too high a % of their shared savings in payment and so Winding Waters would like to leave them for us. CMS at data.cms.gov lists 12 ACOs in Oregon as of January 2023. (All but one are headquartered in other States). We are not aware of other FFS ACOs working with health centers in Oregon. Adapt and some other health centers are contracting with P3 which is a Medicare Advantage ACO. Most helath centers serve some patients who have a Medicare Advantage plan. That is not in competition with our proposed ACO and you could do both. The MSSP program just reopened this year for the first time since COVID. Many third parties are reaching out to health

centers to get them to join or form a new ACO. You may have received some of those sales calls.

14. Do you have to move levels each year?

Our leadership and consultants are recmmending that we enroll in MSSP Track 1. This Track would run for the the full five years of the contract and would be upside only. There would be no downside risk. If we decided to reapply in five years we would have to move into higher tracks and accept increasingly higher levels of downside risk. We are not obligated to reapply, and would only do so if we were confident of the value.