



Accountable Care Organizations: The New ACO Regulations There Is A Light In The Tunnel

Presenter: Charles M. Johnson
Date: June 30, 2011

Shared Savings Program - The Three Part AIM

- An ACO must be willing to become accountable for the quality, cost, and overall care of Medicare fee-for-service (FFS) beneficiaries assigned to it.
- The Shared Savings Program is a new approach to the delivery of health care aimed at:
 - ✓ Better care for individuals
 - ✓ Better health for populations
 - ✓ Lower growth in expenditures

Hx--The Regulation of Accountable Care Organizations

- March, 2010 -- Section 1899 of the Affordable Care Act (the Act”) authorized the Shared Savings Program for Medicare Parts A&B
- March 31, 2011-- CMS Proposes new ACO Rules (the”Rules’)
- March 31, 2011 -- IRS issues guidance for exempt organizations that choose to participate in or form an ACO



Hx--The Regulation of Accountable Care Organizations

- March 31, 2011—DOJ and FTC issue joint guidance as to proposed antitrust “safety zone” for the formation of ACOs and an expedited review process
- March 31, 2011—CMS and the OIG issues guidance as to a proposed waiver of certain requirements of Physician Self-Referral Law, the federal Anti-Kickback Statute, and certain requirements regarding Civil and Monetary Penalties

New initiatives announced this week:

- Pioneer ACO Model
- Advanced Payment Model
- State demonstration projects to integrate care for dual eligible individuals
- Accelerated development learning program

What is an ACO?

1. A legal entity recognized and authorized under applicable State law;
2. Identified by a Taxpayer Identification Number (“TIN”);
3. Comprised of a group eligible ACO participants;
4. ACO participants work together to manage and coordinate care for Medicare Part A&B fee-for-service beneficiaries (“FFS”); and
5. Entity must have a mechanism for shared governance providing ACO participants with appropriate proportionate control over decision making.

Who Can Form an ACO?

- The Act lists the following 5 groups of providers as eligible to FORM an ACO:
 - ACO professionals (physicians and practitioners, which includes physician assistants, nurse practitioners, and clinical nurse specialists);
 - Networks of individual practices of ACO professionals;
 - Partnerships or joint venture arrangements between hospitals and ACO professionals;
 - Hospitals employing ACO professionals; and
 - “Hospital” includes only acute care hospitals paid under IPPS;
 - Other providers and suppliers designated by the Secretary.

Who Can Participate?

- While the Act identifies 5 groups eligible to *participate* in an ACO, the proposed rule makes clear that these are simply the groups that can independently *form* an ACO (eligible ACO participants)
- Other Medicare enrolled providers and suppliers can *participate* in ACOs (other providers/suppliers) as long as such participation is in collaboration with one of the 5 entities that are eligible to independently form an ACO

Other providers/suppliers that may participate in an ACO that contains 1 or more of the 5 groups eligible to form an ACO :

- Federally qualified health centers (“FQHCs”);
- Rural health centers (“RHCs”);
- Skilled nursing facilities (“SNFs”) and nursing homes;
- Long-term care hospitals (LTACs);
- Certain Critical Access Hospitals (“CAHs”);
- Other providers/ suppliers designated by CMS.

Legal Structure/Governance

- ACOs must have a formal legal structure (TIN) that allows the organization to receive and distribute payments for shared savings to participating providers; and
- ACOs must have a mechanism for shared governance to enable all participants proportionate control in decision making.



Governance

- CMS wants ACOs to be provider-driven and patient-centered
- ACO participants must have at least 75% control of the ACO's governing body
- Each ACO participant must should be represented on the governing body
- ACOs must partner with community stakeholders and Medicare FFS beneficiaries, such as having Medicare beneficiary representation on the ACO governing body

Management

- CEO appointed by ACO board
- Medical Director – full time senior-level licensed physician on site
- Compliance officer (separate)
- Quality assurance committee (physician – directed)

Assignment of Beneficiaries

- Assign patients to ACO based on where they receive most primary health care services (dollars)
- ACO (not provider & not patient) responsible for patient care management and quality
- Assigned patient population determines benchmark

Primary Care Physicians

- ACO must have a sufficient number of primary care professionals
- ACOs must have at least 5,000 beneficiaries assigned to it each year
- If the ACO has at least 5,000 beneficiaries assigned to it CMS will assume there are sufficient primary care physicians in the ACO
- If the ACO's assigned beneficiaries falls below 5,000, CMS would issue a warning and place the ACO on a corrective action plan, which could include a plan to add primary care providers to the ACO

Patient Centeredness Criteria

- Written standards for beneficiary access and communication
- Use of patient assessments
- Use of individualized care plans
- Implement a beneficiary experience of care survey and a plan to use the results to improve care
- Medicare beneficiary on the governing board
- Evaluate the health needs of the ACO's assigned population and create a plan to address the needs of the population
- Implement systems to identify high-risk individuals and processes to develop individualized care plans for those individuals
- Measure clinical success and implement quality of care improvements
- Communicate clinical knowledge/evidence-based medicine to beneficiaries that allows for beneficiary engagement and shared decision-making

Basic Rule for Shared Savings

- To be eligible for shared savings, ACOs must:
 - Meet all contractual requirements of the ACO Agreement
 - Meet the quality performance standards
 - Realize savings compared to the Expenditure Benchmark that exceed the Minimum Savings Rate



Calculating the ACO Quality Performance Score

Measure Domains. CMS groups individual quality performance standards into five domains:

1. Patient/Care giver experience
2. Care coordination
3. Patient Safety
4. Preventive Health
5. At-risk population/frail elderly health

Equal Weight of Domains

- Each of the 5 domains is equally weighted in determining an ACO's overall quality performance score, regardless of whether the ACO is in Track 1 or Track 2.
- All measures within a domain must have a score above the minimum attainment level determined by CMS in order for the domain to be eligible for shared savings.

Quality Measures

- Patient/Caregiver Experience – 7 measures
- Care Coordination – 16 measures
- Patient Safety – 2 measures
- Preventive Health – 9 measures
- At-Risk Population/Frail Elderly – 31 measures



Calculation of Shared Savings

- Establish Expenditure Benchmark
- Determine per capita Medicare expenditures in each performance year of the Agreement period
- Determine applicable Minimum Savings Rate
- Determine applicable Sharing Rate
- Determine applicability of Threshold
- Compare Expenditure Benchmark (Adjusted to Year) to Actual Expenditures
- Compare Amount of Shared Savings Payable to ACO to Sharing Cap

Calculating the Benchmark

- Estimate Expenditure Benchmark for each of previous 3 years and normalize to agreement year
- Uses most recent available 3 years of per beneficiary expenditures for Part A and B services for Medicare FFS beneficiaries assigned to ACO
- Adjust Expenditure Benchmark for beneficiary characteristics and such other factors
- Update the Expenditure Benchmark by the projected absolute amount of growth in the national per capita Part A and B expenditures for Medicare FFS beneficiaries for each year of the 3 year agreement

Adjustments to the Expenditure Benchmark

- Adjustment for using CMS-HCC, which uses beneficiary diagnostic information
- Propose no adjustments for IME and DSH
- Propose retaining geographic payment adjustments in calculating Expenditure Benchmark
- Propose different treatment for bonus payments/penalties depending on statutory source
- Adjust for inflation in Years 2 and 3 (flat dollar increase based upon national inflation)

Shared Savings Options

- Reward Only Option (Track 1)
 - pure one sided
 - attract smaller group participation
 - not enough incentive
- Risk Based Option (Track 2)
 - greater reward for greater responsibility
 - risk viewed as only large ACOs could tolerate

Hybrid Model:

- Track 1
 - One-Sided Model (with a twist)
 - No Downside Years 1 and 2
 - Year 3: add Risk (Loss) and higher reimbursement
- Track 2
 - Two-Sided Model
 - Upside and downside Risk starting Year 1
 - Higher reimbursement starting Year 1

One-Sided Morphs into Two-Sided

- Track 1 – Share in Savings only
- Track 2 – Share in Savings and be held accountable for Losses
- Elect for initial 3 year agreement period
- Years 1 and 2 using One-sided Model reimbursement for SS but no loss risk
- Year 3 higher reimbursement potential for SS but at risk for sharing of Losses
- Year 3 for Track 1 – retain quality standards for Year 3 but otherwise SS as if Year 1 of Track 2

Net Sharing Rate

- CMS rejected first dollar share after MSR for Track 1 ACOs
 - Track 1 ACOs -- CMS will use a threshold equal to 2% of the Expenditure Benchmark (i.e., not the savings)
 - Track 2 ACOs -- CMS will share first dollar savings (i.e., savings above MSR)
- Provides adjustments for small ACOs (>10000)
 - If ACO is comprised only of ACO professionals in group practice arrangements or networks
 - If 75% of the ACO's assigned beneficiaries reside outside a MSA
 - If 50% of the ACO's assigned beneficiaries receive a plurality of primary care from Method II CAH
 - If 50% of more of the ACO's assigned beneficiaries had at least one encounter with an ACO Participant FQHC and/or RHC
- CMS will notify ACO of calculated savings rate and ACO must request payment with certification of compliance

The Range of Shared Savings

- Sharing rate is determined based upon quality performance
 - Up to 50% shared savings for Track 1 ACOs
 - Up to 60% shared savings for Track 2 ACOs
- PGP demonstration project shared savings was initially set at 80%
- Opportunity for additional percentage savings

Additional Shared Savings Opportunity

- CMS proposes increasing the net savings rate for the first two years for ACOs with significant assigned beneficiary visits to an ACO Participant FQHC and RHC (0.5 to 2.5% increase)
- Request comments on additional savings for dual eligibles and ACOs in similar arrangements with other payors

Withhold

- CMS proposes an annual 25% withhold of any earned shared savings
- ACO may use the withhold as one option for demonstrating an adequate repayment mechanism in the event they incur sharable losses
- Returned at the end of the 3 year agreement (if meets all requirements)
- If the ACO does not successfully complete its 3 year agreement, the ACO forfeits any withholds

Shared Savings Limit

- Intended to minimize incentives for excessive reductions in utilization
- In the PGP demonstration project, the limit was set at 5% of the organization's expenditure target
- Track 1 ACOs: Proposed 7.5% of the ACO's Expenditure Benchmark for the first two years of the Agreement, which would increase to 10% in the third year once the ACO is operating in the two sided model
- Track 2 ACOs: Proposed 10% of the ACO's Expenditure Benchmark

Two-Sided Model Losses

- ACO accepts downside risk for Losses once the Minimum Loss Rate (MLR) is exceeded
 - actual ACO expenditures exceed the benchmark
- Broad implications for provider relationships leading to heightened monitoring:
 - financial solvency,
 - patient access to care
 - Withhold

Distribution of Savings

- CMS proposes to make any shared savings payments directly to the ACO
- CMS states that while it does not have the authority to direct how shared savings must be distributed, CMS will require the ACO to indicate on its application how it plans to use potential shared savings to promote program plans and distribute savings among the ACO participants

Data Measures/Submission

- Claims Data reporting benchmarks
- Group Practice Reporting Option
- Physician Quality Reporting System
- Electronic Health Record
- Hospital Inpatient Quality Reporting Program
- HITECH Meaningful Use
- Surveys

Risk vs. Reward?



Sources:

- An Overview of the ACO Proposed Regulations (April 14, 20 & 21, 2011)
 - A. Part I --- Eligibility, Patient Attribution and Participation in Medicaid Shared Savings Program (Washlick, Barnes, Turcotte)
 - B. Part II – Quality Measures Payment Methodology, and Risk Sharing in Medicare’s Shared Savings Program (Bartrum, DeMuro & DeSimone)
 - C. Part III – Waiver provisions, Antitrust & IRS Guidance (The Medicare Shared Savings Programs Overlap with Other Payment Provisions) (Homchick, Braun, & Robinson)
- <http://www.frostbrowntodd.com/resources-1311.html>.



Thanks!!!

**Charles M. Johnson, Member
Frost Brown Todd, LLC
Laidley Tower, Suite 401
500 Virginia Street East
Charleston, WV 25301
(304) 348-2420
(304)345-0115 (Fax)
cmjohnson@fbtlaw.com**