ACO REVIVAL

Medicare Shared Savings Program

Final Regulation Overview

Blue & Co., LLC Healthcare Reform Symposium

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Introductions
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John Redding, MD is a Manager in Blue Consulting Services' Healthcare Consulting Practice. John brings over 15 years of healthcare experience to Blue and has served as a trusted advisor to providers and healthcare executives for the last 6 years. In his role at Blue, John works with health systems, hospitals, and physician organizations to develop collaborative physician-hospital working relationships and business ventures. John has extensive experience leading and supporting a broad spectrum of physician-hospital alignment initiatives, from developing and implementing physician employment strategies to providing interim management for a Clinically Integrated Physician Network / Accountable Care Organization.

Relevant Acronyms
Short List

ACO = Accountable Care Organization

APM = Advanced Payment Model

CAH = Critical Access Hospital

CI = Clinical Integration

CMS = Center for Medicare and Medicaid Services

DOJ = US Department of Justice

DSH = Disproportionate Shares Hospital

FQHC = Federally Qualified Health Center

FTC = Federal Trade Commission

HHS = Department of Health & Human Services

IME = Indirect Medical Education

LVRH = Low Volume Rural Hospital

MSSP = The Medicare Shared Savings Program

OIG = The Office of the Inspector General

PSA = Primary Service Area

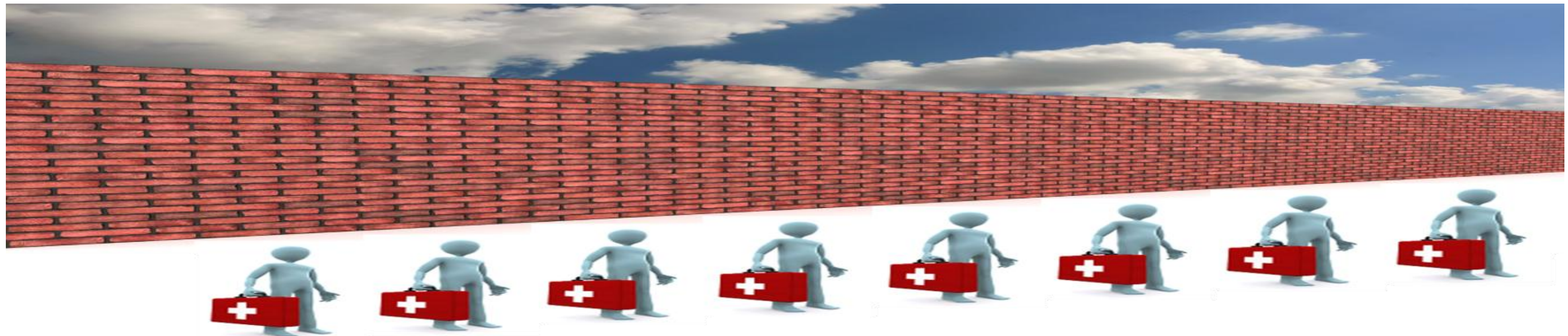
RHC = Rural Health Center

Agenda

- Context
- Modifications to the Proposed Regulations
- Coordination with Other Agencies
- Impact Analysis
- Conclusions

Context

The Proposed ACO Regulations Were A Non-Starter For Most Hospitals & Health Systems



- Proposed regulations published in the Federal Registry April 7th, 2011
- Comment period opened though June 5th, 2011
- Received 1320 comments during the 60 day period
- “Serious concern over the direction of the Proposed Rule…On its face, it [the Proposed Rule] is overly prescriptive, operationally burdensome, and the incentives are too difficult to achieve to make this voluntary program attractive.” – American Medical Group Assoc.

Modifications To The Proposed Regulations

Eligibility
The MSSP Is Now A More Inclusive Program

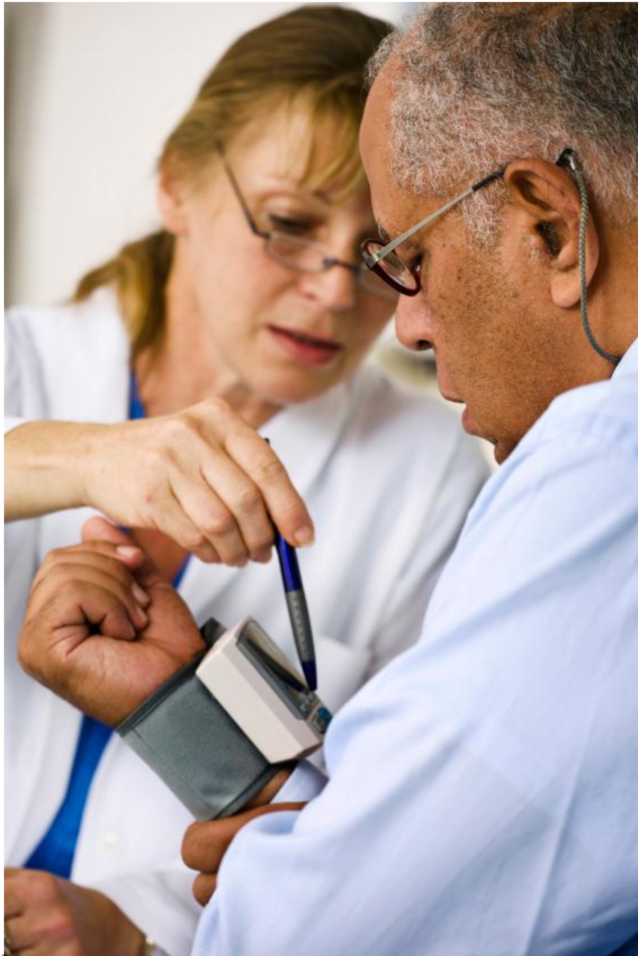
- Provided a means for RHCs and FQHCs to establish ACO independently
- Allow additional participants to join an ACO that is formed by one or more of the following participants:
  - ACO professionals in group practice arrangements
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Hospitals employing ACO professionals
  - CAHs that bill under Method II
  - RHCs
  - FQHCs
- Removed requirement that 50% of the ACO's primary care physicians must be meaningful users of the electronic health record by the second year of the program

Start Dates
ACOs Are Being Given Time To Ramp Up

Three options for participation:

1. April 1, 2012
   - Term of Agreement is 3 years and 9 months
   - First period 21 months
2. July 1, 2012
   - Term of agreement is 3 years and 6 months
   - First period 18 months
3. January 1, 2013 and beyond
   - Term of agreement is 3 years
   - First period is 12 months

Beneficiary Assignment
ACOs Will Be Accountable For Patients They See



- Preliminary attribution
- Retrospective assignment
- Stepwise process
  1. Plurality of primary care services from ACO affiliated PCP
  2. Primary care services provided by other ACO affiliated professionals (specialists, NPs, Pas, etc.)
- Must notify of adding or removing ACO providers or suppliers within 30 days

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Expense Benchmarks

A Better Reflection Of The Population Served

- General methodology as proposed
- Adjustments made for:
  - Newly assigned beneficiaries
  - Changes in health status of continuously assigned beneficiaries
- IME & DSH payments excluded

Quality & Reporting Standards
New Program Is More Fair & Manageable

- Reduced measure set from 65 t0 33 measures in four domains
- Must report all measures in each domain
- Must achieve satisfactory performance on 70% of the measures within each domain
- EHR adoption included as a quality measure
- Must complete a patient experience survey based on CHAPs

Finance
The MSSP's Value Proposition Has Increased

- ACOs have the option to request interim payment
- Removed risk from the one-sided model
- Capped share at:
  - One-sided model: 50% or 10% of prospective benchmark
  - Two-sided model: 60% or 15% of prospective benchmark
- Shared savings provided on a first dollar basis
- Shared losses recouped on a first dollar basis
- Removed the 25% withhold of shared savings
- Extended timeframe for repayment of losses from 30 to 90 days

Coordination With Other Agencies

Coordination With Other Agencies
Agencies Do Not Want To Impede ACO Adoption

Federal Trade Commission & The US Department of Justice

- Guidance applies to all ACOs
- No mandatory anti-trust review
- Voluntary expedited review (90 days)
- CMS to share application & data
- Safe harbor for ACOs with less than 30% market share in their PSA or under the rural exception
- "Will vigilantly monitor complaints about ACO formation or conduct and take whatever enforcement action may be appropriate."

Internal Revenue Service (for comment)

- ACOs engaged exclusively in the MSSP would still qualify for tax exempt status under 501(3)(c)
- Participation in the MSSP through an ACO will further the charitable purposes of the tax exempt organization
- The tax exempt organization does not have to have control over the ACO
- In general, will not consider participation inurement or impermissible private benefit

Office of the Inspector General (for comment)

- Do not want to unduly limit impede development of beneficial ACOs
- Applies to Physician Self-Referral Law, Federal Anti-Kickback Statute, and the Civil Monetary Penalties Law
- Five proposed waivers
  1. ACO Pre-Participation Waiver
  2. ACO Participation Waiver
  3. Shared Savings Distribution Waiver
  4. Compliance with Physician Self-Referral Law
  5. Patient Incentive Waiver

Center for Medicare & Medicaid Innovation

- Advanced Payment ACO Model
- Start up capital for physician-only ACOs and rural ACOs
- Up to 50 ACOs ($170 M in funding)
- Must indicate interest in CMS filing
- Recipients selected based on formula

Impact Analysis

Impact Analysis
The CMS Anticipates Changes Will Spur Adoption

Participants

- 50 to 270 ACOs

Federal Savings

- $470M

Bonus Payments

- $1.31B

Start Up Costs

- $29M to $ 157M

Operating Costs

- $63M to $342M

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Conclusions

The ACO Will Be A Viable Model For Some And Will Impact Many

- The CMS & HHS have made significant modifications to their proposed regulations to increase the value proposition of the MSSP to hospitals and health systems
- Hospitals & health systems that dismissed the ACO model based on the proposed regulations would be wise to reconsider the opportunity provided by the program under the final regulations
- Although the MSSP will not be universally attractive, it is likely to impact a number of local and regional healthcare markets
- Hospital leaders should evaluate and begin planning for the potential impact of ACOs in their markets
- Whether or not participation in the MSSP is right for your organization at this time, "business as usual" will not be a sustainable long-term strategy

Questions & Answers

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