New proposed Medicare rules for ACOs: What they mean for physicians

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Your webinar host

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Medicare Shared Savings Program

- Authorized in the Affordable Care Act (ACA)
- It is a voluntary program to further develop and test the ACO concept for Medicare beneficiaries
- Physicians and hospitals are not required to be a Medicare ACO as a condition of participating in Medicare
- Efforts in the private market are also occurring around the provision of accountable care
Medicare Shared Savings Program

- Proposed rule released March 31st and published in Federal Register April 7th
- 60-day public comment period provided with deadline for comments to CMS of June 6th
- AMA will be developing comment letter
- Will solicit comments from state and specialty societies
- Purpose of webinar is to describe the key elements of the proposed rule
- We will allow a lot of time for Q & A

Proposed Rule follows Nov. 2010 “Request for Information”

NPRM follows outreach by FTC and OIG

- FTC Chairman addresses American Medical Association at June 2010 Annual Meeting
- FTC-OIG-CMS Workshop on ACOs held Oct. 5, 2010
Key Elements of Proposed Rule

- Governance
- Beneficiary Assignment
- Provision of Data
- Application Process
- Payment Structure
- Quality Measurement and Reporting
- Antitrust Waivers
- Anti-kickback Waivers

Governance

- Accountable Care Organizations (ACOs) must have or create governing body representing all participants, including hospitals and physicians
- Infrastructure to allow collection and analysis of data across the entire organization
- Clinical integration with a medical director and quality assurance committee
- Application must describe process to promote evidence-based care, patient engagement, reporting and care coordination
- Proposal allows ACO flexibility, no one-size-fits-all

Beneficiary Assignment

- ACOs must include primary care physicians that provide care to a minimum 5,000 Medicare patients
- Primary care defined as family physicians, internists, geriatricians and general practitioners
- CMS will look at 3 years of claims data to give ACOs an idea of who is assigned to them
- Actual patient assignments determined retrospectively based on who got care from the ACO
- Primary care physicians must be exclusive to one ACO but other physicians can be in multiple ACOs
- AMA had asked for prospective, voluntary assignment
**Provision of Data**
- CMS proposes to prospectively give ACOs aggregated data reports for potentially assigned patients
- On request, CMS will provide monthly Part A, B and D claims data to assist care coordination
- Beneficiaries able to opt out of data release
- Based on PQRS experience, AMA questions whether data will be provided in a timely manner and be sufficient for managing patient care and financial risk

**Application Process**
- There will be an annual application process with initial ACO agreements of 3 years
- Initial agreements to commence Jan. 1, 2012
- Additional start date of July 1, 2012 with 3.5-year initial agreement period
- ACOs can also apply to start subsequent years

**ACO Payment Structure**
- Physicians and hospitals in an ACO will be paid by Medicare according to the same Part A and Part B payment schedules currently used
- Growth in Medicare fee-for-service costs for the patients in the ACO will be compared to a benchmark level of “expected” costs
- If per capita spending on the ACO patients is less than the “expected” level, the ACO will be able to retain a share of the “savings” for distribution among physicians and hospitals in the ACO
How “Shared Savings” Works

- Baseline costs for ACO computed using actual per capita costs in prior 3 years, weighted toward most recent year
- CMS calculates expected costs by adding projected national per capita growth to baseline costs
- Savings achieved if actual costs are less than expected
- In general, first 2% of savings goes back to Medicare, ACO receives up to half of savings beyond 2%, but no more than 7.5% total
- ACO share of savings also depends on quality performance

Based on a presentation by Harold Miller, CHQPR

Shared Savings Bonus Increases If Cost Growth Remains Low

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Based on a presentation by Harold Miller, CHQPR
What Happens if Costs Increase Above Expected Growth Rate?

Healthcare Spending

Projected Spending

Baseline Spending

Actual Spending

2010 2011 2012 2013 2014

In Year 3, ACO Must Repay Medicare for Part of Cost Increases

Healthcare Spending

Projected Spending

Baseline Spending

Actual Spending

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How Much Would an ACO Owe Medicare if its Costs Increase?

- ACOs only responsible to pay Medicare for cost increases exceeding a certain threshold
- Loss threshold varies with ACO size as small ACOs may achieve savings or losses due to random variation, not ACO performance
- Amount ACO is responsible for paying is initially limited to 5% of total costs
- As with shared savings, share of losses that ACO must pay also tied to quality performance
Withholding of Shared Savings

- CMS will withhold 25% of shared savings to ensure ACO could repay share of Medicare losses in future if necessary
- ACOs will also be required to show credit worthiness, provide CMS access to line of credit or similar mechanisms to ensure that ACO share of losses can be repaid

Two Payment Approaches Proposed

- Track 1: Shared Savings only for 2 Years, Risk of Shared Losses in Year 3
  - Medicare pays ACO up to 50% of savings in Years 1-3
  - ACO pays Medicare up to 50% of losses in Year 3
  - Limits on share of savings and share of losses
- Track 2: Savings and Losses in Years 1, 2, and 3
  - Medicare pays ACO up to 60% of savings in Years 1-3
  - ACO pays Medicare up to 60% of losses in Years 1-3
  - Limits on shared savings and losses are higher

Initial Observations on Proposed Payment Structure

- AMA had proposed that CMS provide models in addition to shared savings, as law permits “partial capitation” and other models
- Rule indicates partial capitation would allow ACO to take accountability for a portion of Medicare A and B services but not all
- Partial capitation and other models to be handled by Center for Medicare Innovation
Initial Observations on Proposed Payment Structure

- Shared savings approach makes it difficult to recoup investments
- CMS estimates start-up costs of $1.8 million
- Requirement to repay a portion of losses above the “expected” cost threshold may inhibit ACO participation
- ACOs that reduce hospital admissions and emergency dept use are most likely to achieve savings, but other improvements in care may improve hospital margins without producing any shared savings

Quality Measurement & Reporting

- 65 measures proposed to calculate ACO quality performance across 5 key domains: patient/caregiver experience; care coordination; patient safety; preventive health; and at-risk populations/elderly
  - 30 Physician Quality Reporting System (PQRS) measures
  - 28 new measures – National Quality Forum (NQF) endorsed and/or CMS adopted
  - 26 from Electronic Health Record Meaningful Use
  - 1 “measure” incorporating 9 hospital acquired conditions
Quality Measurement & Reporting

- In ACO Year 1, ACOs only required to successfully report on the required measures
- In Years 2 and 3, ACOs evaluated on performance on measures, with thresholds for success not yet determined
- ACOs that do not meet quality performance thresholds for all measures would not be eligible for shared savings, regardless how much costs were reduced
- CMS will give ACOs that fail to meet minimum attainment level for one or more quality domains a warning, but continued underperformance can lead to termination of ACO agreement

Quality Measurement & Reporting

- AMA views reporting on measures in year one as a transitional step
- However, the number and breadth of the measures will be difficult for many physician groups to report and ultimately be measured on
- Significant gaps in measures, ie, none for surgery
- How could ACO without a hospital report on hospital acquired condition measure?
- AMA had sought greater flexibility for ACOs in choosing metrics

Health Information Technology

- By Year 2 of ACO agreement, “at least 50 percent of an ACO’s primary care physicians” must be “meaningful electronic health records users”
- May be difficult to achieve as do not yet know how Stage 1 is working or how many primary care physicians will have adopted electronic health records by December 2011
Antitrust Enforcement

- FTC and DOJ draft statement applies to collaborations among independent providers, including physicians, formed after 3/23/2010 seeking to participate in Shared Savings Program as ACOs.
- Medicare approved ACOs that use “the same governance and leadership structure and the same clinical and administrative processes” in the commercial market as they used to qualify for and participate in the Medicare Shared Savings Program will be able to jointly negotiate their fees without incurring per se antitrust liability for price-fixing.
- ACOs remain subject to a rule of reason analysis that relies on calculations of the ACO participants’ share of their Primary Service Areas (“PSAs”), defined as “the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients]” for that service.

Antitrust Enforcement Safety Zone

- “Safety Zone” for an ACO whose participants, such as physician group practices, provide the same service (a “common service”) and have a combined share of 30% or less of each common service in each participant’s PSA. FTC/DOJ will not challenge the ACO absent extraordinary circumstances.
- Two exceptions to the Safety Zone:
  - Rural exception -- an ACO may include one physician per specialty from each rural county on a non-exclusive basis and qualify for the safety zone, even if the inclusion of these physicians causes the ACO’s share of common service area to exceed 30 percent in any ACO participants’ PSA for that service. Rural hospitals may also be included on a nonexclusive basis.
  - Dominant Provider Limitation -- any ACO that includes a participant with a greater than 50 percent share in its PSA of any service that no other participant provides in the PSA. The participant provider must be non-exclusive to the ACO to fall within the safety zone.

Antitrust Enforcement: Outside of Safety Zone

- An ACO that exceeds shares of 50% for any common service that 2 or more independent ACO participants provide the same patients in the same PSA must seek mandatory FTC-DOJ approval (unless meets rural exception).
- Agencies will conduct expedited 90-day review of these potential ACOs.
- Such entities cannot be a Medicare ACO unless the ACO provides CMS a letter from FTC or DOJ stating that the reviewing agency has no intention to challenge the ACO under the antitrust laws.
Antitrust Enforcement: Outside of Safety Zone

- Entities that fall between 30% and 50% threshold may proceed without antitrust review
- However, if it appears that ACO formation or conduct may be anticompetitive, one of the agencies may investigate the ACO during any time of its participation in the ACO program
- Entities in this “gray area” may seek FTC-DOJ expedited review to ensure they do not run afoul of the law
- Agencies have proposed certain conduct that potential ACOs that fall between 30% and 50% thresholds can avoid to reduce likelihood of investigation: avoid exclusive contracting with physicians, hospitals, ASCs or other providers (except primary care physicians, who must be exclusive to a Medicare ACO)

Antitrust Enforcement: Comments

- AMA requested ability for physician networks qualified as Medicare ACOs to be able to jointly contract with commercial payers. AMA also urged safe harbors and rule of reason analysis of ACOs to provide physicians with confidence as they pursue innovative arrangements.
- While safety zone is welcome, the “gray area” of those who fall into the 30% to 50% share still leaves much uncertainty with regard to antitrust review.
- 90-day expedited review is an improvement over past agency reviews that can take months or years.
- While proposal represents some movement by the antitrust enforcement agencies, it is tied to an entity being “essentially the same” as the structural requirements of the Medicare ACO program.

Anti-Kickback Waivers

- Affordable Care Act authorizes HHS to waive certain fraud and abuse laws in implementing the Shared Savings program.
- CMS and HHS Inspector General proposed to waive certain aspects of self-referral law, anti-kickback statute, and gainsharing civil monetary penalties.
- Proposed waivers allow distributions of ACO shared savings among the ACO participants and providers.
Anti-Kickback Waivers

- Proposed waivers also apply to distributions of shared savings to providers not formally affiliated with the ACO for “activities necessary for” and “directly related to” ACO operations
- Gainsharing waiver applies to hospitals distributing shared savings to a physician as long as payments are not made knowingly to induce the physician to reduce or limit services
- Duration of waivers limited to initial 3-year ACO agreement
- Waivers extend to shared savings from private payers

Anti-Kickback Waivers: Comments

- AMA had actively sought these waivers and is pleased they were proposed
- AMA also pleased that shared savings can be distributed to physicians outside the ACO
- Will comment that waivers should apply to distributions of underlying fee-for-service payments, not just shared savings
- Also think they should apply to activities involved in ACO formation and extend beyond 3-year initial agreement period

The Regulation is a PROPOSED Rule

- Proposed regulation describes in detail many options CMS considered for dozens of specific decisions
- Invites comments on whether it should choose different options in the final regulation
- No assurance than anything in the proposed rule (good or bad) will be included in final rule
- No assurance that new things (good or bad) will not be added to final rule that were not proposed
- Comments need to focus on preserving elements physicians like and changing those that will not work well
Questions?

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