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The ACO Final Rule: Seven Changes of Interest to Physicians



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Introduction

On Oct. 20, the Centers for Medicare and Medicaid Services (CMS) released the final accountable care organization (ACO) regulations (final rule) implementing the Medicare Shared Savings Program (MSSP) under Section 3022 of the Patient Protection and Affordable Care Act of 2010 (PPACA). The MSSP was authorized by PPACA in an effort to increase health care quality while reducing costs. ACOs are organizations of health care providers that agree to be accountable for cost, quality, and the overall care of Medicare beneficiaries.

The final rule reflects CMS's response to the comments it received regarding the proposed ACO regulations published on April 7 (proposed rule). The proposed rule generally was not well received by health care providers, including physicians. Included among its many criticisms were that it would require exorbitant start-up costs, contained burdensome data collection requirements, uncertain savings, and possible monetary losses. Based on this critical reception and the more than 1,300 comments received, CMS has made some important changes to the ACO regulations in an effort to reignite interest in the MSSP and spur participation.

The general takeaway from the final rule is that it has made the MSSP more user-friendly to providers. This article examines the changes in the final rule from the proposed rule that will be of most interest to physicians. Further, simultaneously with the issuance of the final rule, CMS and the Office of Inspector General of the Department of Health and Human Services (OIG) jointly issued an interim final rule with an opportunity for comment, implementing waivers of certain fraud and abuse laws for those participating in the MSSP, and the Federal Trade Commission (FTC) and Department of Justice (DOJ) jointly issued a final policy statement concerning antitrust guidance for those participating in the MSSP. A discussion of the waivers and the antitrust guidance is beyond the scope of this article, but two general points of interest to physicians will be briefly discussed in this article.

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1. Assignment of Medicare Fee-for-Service Beneficiaries

In order to participate in the MSSP, an ACO must agree to have at least 5,000 beneficiaries assigned to it during each performance year. To determine which patients the members of an ACO are to be held accountable for, under the proposed rule, CMS used a retrospective assignment process, which would have identified beneficiaries after the fact, based upon which providers provided the most primary care services to those beneficiaries at the end of the year, after care had been delivered. Providers would have been able to estimate which patients they may or may not be responsible for at the beginning of the three-year agreement

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based on which providers those patients would have received care from in the past. The final rule modified the retrospective approach to the assignment of beneficiaries in favor of a prospective assignment with a retrospective reconciliation of the assignment at the end of a performance year. ACOs will receive a preliminary list of assigned beneficiaries at the beginning of the performance period that is updated quarterly. After the end of the performance period, CMS will determine the final assignment of beneficiaries based on the actual treatment data from that year. CMS adopted this hybrid approach of prospective assignment with retrospective reconciliation in response to the overwhelming number of comments received in support of a prospective approach. Those commenting argued that the prospective approach was important for beneficiaries to have full knowledge of their inclusion within an ACO in advance and for ACO participants to effectively coordinate care and implement a care management program for its assigned beneficiaries. Although the actual assignment of beneficiaries still will remain retrospective for purposes of calculating the savings, an ACO now will have a better idea of who its assigned beneficiaries are in advance, which likely will afford it a better opportunity to coordinate and manage the care of its beneficiaries.

Additionally, in determining the assignment of beneficiaries to an ACO, the final rule requires that a beneficiary be assigned to an ACO in which they receive a plurality of primary care services, as determined by accumulated allowed charges (evaluation and management Current Procedural Terminology codes). In other words, a beneficiary is assigned to an ACO if the allowed charges for primary care services furnished by primary care physicians who are participants of that ACO are greater than the allowed charges furnished by primary care physicians who are participants of other ACOs, or who are unaffiliated with any ACO. Beneficiaries who receive a plurality of primary care services from an ACO are included in the determination of shared savings calculations of that ACO.

In determining the plurality of primary care services, CMS adopted a ''step-wise'' method to beneficiary assignment. In step one, beneficiaries who received at least one primary care service from a primary care physician who is an ACO participant are identified. The beneficiary will be assigned to the ACO in which he or she receives a plurality of primary care services. In step two, if a beneficiary has not received any primary care services from a primary care physician, the beneficiary will be assigned to an ACO if he or she has received at least one primary care service from any physician (regardless of specialty) in the ACO. If this condition is met, the beneficiary will be assigned to an ACO in which he or she receives a plurality of primary care services (including from specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists).

The use of the plurality standard to determine how beneficiaries are assigned is intended to ensure that patients are assigned to an ACO in which they receive more primary care services than from any other provider. In addition, the ''step-wise'' approach recognizes that specialists, and not just primary care physicians, provide primary care services to Medicare beneficiaries.

2. Reduction in Quality Measures

The proposed rule required ACOs to measure and report on 65 quality measures from five quality domains. The final rule reduces the number of quality measures to 33 and the number of quality domains to four. The four domains include:

i. Patient/Caregiver Experience (seven measures);

ii. Care Coordination/Patient Safety (six measures);

iii. Preventative Health (eight measures); and

iv. At-Risk Populations (12 measures).

As discussed in more detail below, the final rule has eliminated the requirement that 50 percent of the ACO's primary care physicians be meaningful users of electronic health records (EHR) by the beginning of the second year. However, the percentage of primary care physicians who successfully qualify for an EHR incentive program payment still is a quality measure that must be reported. This measure will be double-weighted for purposes of determining shared savings eligibility.

As initially proposed, if an ACO did not meet the quality performance thresholds for all of the proposed measures, it would not be eligible for shared savings, even if it was able to reduce costs. Under the final rule, an ACO must only score above the minimum attainment level on 70 percent of the measures in a domain to be eligible to share in the savings. The proposed rule structured payments in the first year based on reporting and in subsequent years based on performance, while in the final rule, eligibility for shared savings in the second year will be based on achieving minimum attainment levels for 25 measures, and reporting only for the other eight measures. In the third year, eligibility will be based on achieving minimum attainment levels for 32 measures, and reporting only for the final measure.

The less burdensome reporting on quality measures and domains is beneficial to physicians who participate in ACOs. The reduction in quality measures and domains likely will ease the administrative burden and encourage participation in the MSSP. In addition, the change in the thresholds and phase-in of payment for performance to determine eligibility for savings will hopefully make it easier for ACOs to share in the savings. However, physicians should be aware that CMS has left open the possibility that the quality measures may be revised and that ACOs will be required to comply with such revisions.

3. Change in Electronic Health Record Participation Requirement

The proposed rule required that at least 50 percent of an ACO's primary care physicians be ''meaningful users'' of EHR by the start of the second performance year of the three-year ACO agreement in order to continue in the MSSP. The final rule eliminated this, making EHR a quality measure. The quality measure requires ACOs to report the percentage of primary care providers who successfully qualify for an EHR incentive program payment.

It is apparent that CMS recognized in the final rule that the 50 percent meaningful use requirement may be a roadblock to participation in the MSSP and eliminated meaningful use as a requirement. Despite this, in an effort not to shy away from its emphasis on the importance of EHR adoption, CMS has adopted the

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double-weighted measure for purposes of scoring and determining an ACO's performance. CMS's decision to waive the initial 50 percent requirement probably will help spur greater interest by physician practices that currently are not on EHR platforms or currently are in the process of transitioning to EHR platforms. On the other hand, to illustrate the importance of the double weight applied to the EHR measure, should an ACO fail to completely and accurately report the EHR measure, it will be difficult for the ACO to overcome the loss of this measure through the other quality measures and may result in the ACO not being eligible to share in savings.

4. Clarification on Exclusivity of Primary Care Physicians to a Single ACO

A key clarification reflected in the final rule relates to the ability of participants and providers/suppliers to change ACOs or participate in more than one ACO. Since beneficiaries are assigned and incentive payments are determined as a result of primary care services received, based on billing tax identification number (TIN), many commenters objected to the proposed rule, which required that ACO primary care practitioners had to be exclusive to a single ACO for the three-year agreement period. In the final rule, CMS has clarified that this exclusivity requirement was not intended as a blanket rule for all primary care providers; instead, it only would apply where the provider is using his or her own TIN to bill for services. The practical effect of this clarification is that providers billing through the different TINs of one or more group practices could participate in multiple ACOs; however, solo practitioners, including specialists who provide primary care services upon which beneficiary assignment is based, billing under their personal TIN would need to be exclusive to a single ACO. This clarification may be viewed as creating a narrow exception to a vexing provision of the proposed rule, but, as a practical matter, for the large number of physicians who are solo practitioners, nothing has changed.

5. Ability to Eliminate Risk Sharing During Initial Term

Under the proposed rule, ACOs could choose Track 1 or Track 2, with Track 1 allowing the ACO to avoid sharing in the losses until the third year and Track 2 exposing the ACO to the risk of financial loss, but allowing it to potentially share in greater savings. This could result in the ACO losing money if it did not produce savings. In the final regulations, ACOs who opt for Track 1 will share only in the savings during the entire term of the initial agreement and will not bear any downside risk of losses. Notwithstanding this limitation of risk during the first three years, Track 1 ACOs still will be required to participate in the two-sided, Track 2, model upon the expiration of the initial agreement.

This change allows physicians to determine whether or not to accept shared-loss risk during the term of the initial agreement. By selecting Track 1, ACOs would have some time to get up and running and work out any kinks. However, physicians must keep in mind that if the ACO is formed and approved prior to their participation, they need to make sure which track the ACO is taking and recognize if it is Track 2, there is downside risk. Further, even if the physicians are involved in the start-up of the ACO, they may not have enough votes to effectively choose whether or not their ACO will share in the risk, so physicians need to be careful and ensure that the members of the ACO are in agreement about risk sharing before they decide to join.

6. Track 1 ACOs Share in First Dollar Savings

An ACO only is eligible to receive payment for shared savings if its estimated average per capita Medicare expenditure is at least the percentage specified by CMS below the applicable benchmark, which will be the minimum savings rate (MSR). The MSR for ACOs participating under Track 1 will be established using a sliding scale based on the size of the ACO's assigned beneficiary population. A flat two percent MSR will apply to all ACOs participating under Track 2. The proposed rule included a requirement under which ACOs participating under Track 1 would have to produce savings of at least two percent over the MSR in order to be eligible for any shared savings payments, while ACOs participating under Track 2 would share first dollar savings once the MSR was exceeded. Under the final rule, however, ACOs participating under either track will share in the first dollar of savings once savings exceed the MSR. This change was due to comments which persuaded CMS that a higher threshold could deter participation in the MSSP. The approach adopted maximizes the reward that ACOs can realize, and should ensure that ACOs receive needed capital.

7. No Withholding of Performance Payments

CMS originally proposed in the proposed rule to withhold 25 percent of any shared savings earned by an ACO to offset potential future losses. One of the most common complaints from physicians about the proposed rule was the uncertainty of receiving any shared savings. In response to comments suggesting that the proposed withhold would adversely affect participation and/or restrict necessary capital, CMS, under the final rule, will not withhold shared savings payments in order to help ensure repayment of future losses. This change increases the likelihood that physicians will receive shared savings payments, and is deemed a positive change from the physician perspective.

Fraud and Abuse Waivers and Antitrust Guidance

As noted above, CMS and the OIG jointly issued an interim final rule implementing waivers of certain fraud and abuse laws for those participating in the MSSP, and the FTC and DOJ jointly issued a final policy statement concerning antitrust guidance for those participating in the MSSP. A discussion of the waivers and the antitrust guidance is beyond the scope of this article, but two general points of interest to physicians deserve mention:

1. The fraud and abuse waivers have been significantly expanded to provide more protection for arrangements designed to meet the defined purposes of the MSSP. Further, the waivers may offer certain physicians incentives for participation in the MSSP, as they allow alignment strategies between participating hospitals and physicians that may not otherwise be available, which may have the net effect of reducing capitalization costs for physicians.

2. The final rule and the antitrust guidance eliminate the earlier requirement that certain ACOs be subject to

mandatory review by antitrust agencies prior to their enrollment in the MSSP. As a review can be a very expensive endeavor, the elimination of such a requirement should reduce start-up costs for ACOs and may remove another barrier to initial participation by physicians. Physicians are cautioned, however, that the elimination of this requirement will not reduce the scrutiny placed by the antitrust agencies on the competitive effects of ACOs.

Conclusion

The final rule makes a number of revisions that add flexibility and may encourage greater participation in the MSSP. Nevertheless, despite these modifications, physicians will continue to face large start-up costs and uncertain savings in establishing and participating in ACOS.

The jury is still out on whether or not ACOs will be embraced by the physician community. Many physicians likely will take a wait-and-see approach as to how those physicians who do initially participate work within the confines of the MSSP. Until actually put into practice, the MSSP cannot be considered to be fully vetted.

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