Navigating Opportunities for ACOs in the Medicare Shared Savings Program

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Overview

- Reimbursement & Regulatory Environment
- Medicare Shared Savings Program ("MSSP") Model
- Questions

REIMBURSEMENT AND REGULATORY ENVIRONMENT

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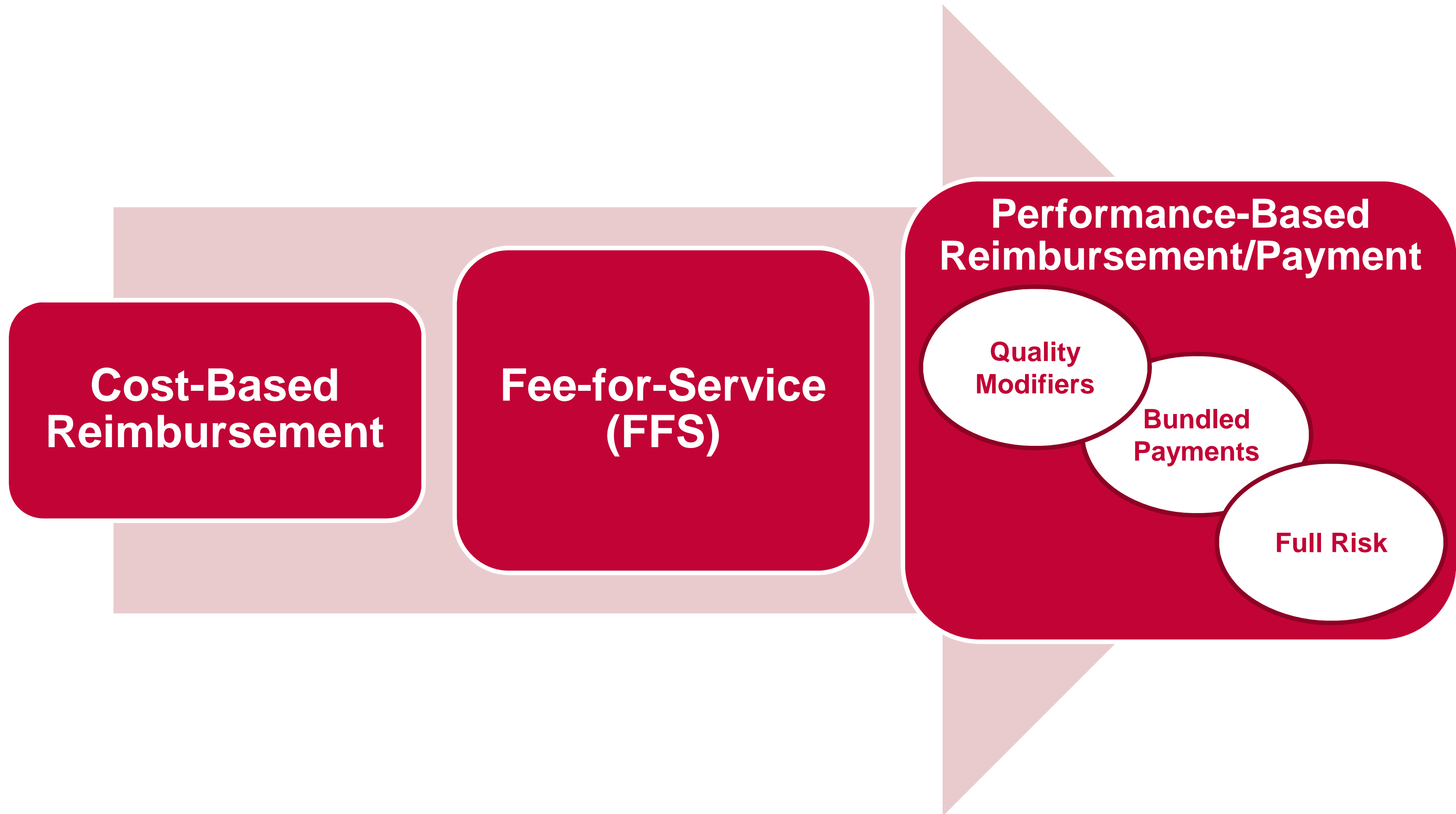
Changing Payment Models



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PPACA Payment Models

- Medicare Shared Savings Program (§ 3022)
- Hospital Value-Based Purchasing Program (§ 3001)
- Value-Based Payment Modifier under the Physician Fee Schedule (§ 3007)
- Payment Adjustment for Conditions Acquired in Hospitals (§ 3008)
- Hospital Readmissions Reduction Program (§ 3025, as amended)
- National Pilot Program on Payment Bundling (§ 3023, as amended)
- And additional demonstration projects . . .

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Recent Developments - October 2011

- Regulatory agencies shifted approach by publishing more flexible guidance
  - CMS published final MSSP regulations outlining requirements for participating in the MSSP
  - OIG and CMS issued final interim rule on MSSP waivers to the Anti-Kickback Statue, the Stark Law and Civil Monetary Penalty Law
  - FTC and DOJ published final antitrust enforcement policy regarding ACOs
  - IRS published Fact Sheet discussing tax-exempt organizations participating in the MSSP

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MEDICARE SHARED SAVINGS PROGRAM ("MSSP") MODEL

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MSSP Overview

- Medicare Shared Savings Program ("MSSP") Purposes
  - Promote accountability for the quality, cost, and overall care for a Medicare patient population
  - Improve the management and coordination of care for Medicare fee-for-service beneficiaries
  - Encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery
- Under the MSSP reimbursement model, CMS will share a percentage of shareable savings with accountable care organizations ("ACOs") that:
  - Generate shareable savings; and
  - Meet quality performance standards
- ACOs elect to participate in the MSSP under one of two tracks
  - Track 1 = sharing rate up to 50%, with no sharing in potential losses
  - Track 2 = sharing rate up to 60% and higher sharing cap, but ACO assumes risk for sharing in potential losses

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Calculating Savings

- Establishing the benchmark
  - CMS determines the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years, more heavily weighting recent years
- Updating the benchmark and additional adjustments
  - CMS updates the historical benchmark annually based on projected growth in national per capita expenditures
  - CMS makes additional adjustments based on the HCC prospective risk scores of an ACO's newly assigned beneficiaries
  - CMS uses demographic factors to adjust for changes in an ACO's continuously assigned population
- Savings determination
  - For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark
  - Additional factors (e.g., whether an ACO exceeded its minimum savings rate, an ACO's quality performance, etc.) determine an ACO's share of such savings

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Comparison of Tracks 1 & 2

Consideration	Track 1	Track 2
Minimum savings rate threshold	2.0-3.9% (3.0% for ACO w/10,000 beneficiaries)	2.0%
Potential sharing rate	Up to 50%*	Up to 60%*
Sharing cap	10% of benchmark	15% of benchmark
Minimum loss rate threshold	N/A	2.0%
Potential loss rate	N/A	40-60%*
Loss cap	N/A	5% in Year 1; staggered to 10% by Year 3
Insurance/financing considerations	No	Yes

* Actual rates based on 33 quality measures that begin as pay-for-reporting and convert to pay-for-performance

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Core Structure/Governance Requirements

- Separate legal entity required for ACOs formed by multiple ACO Participants
- 75+% control of the ACO's governing body must be held by ACO Participants
- ACO Participants must have "meaningful participation" in the composition & control of the ACO's governing body
- Additional second-tier requirements, such as:
  - ACO governing body must include at least one disinterested Medicare beneficiary
  - Conflict of interest policy requirements
  - Senior-level medical director must be responsible for ACO's clinical management and oversight

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Delineating an ACO

- Defined terms "ACO Participant" and "ACO Provider/Supplier" guide which entities can be 'in' an ACO for purposes such as beneficiary assignment (see next slide)
  - E.g., entities lacking a Medicare-enrolled TIN cannot be ACO Participants
  - If beneficiary assignment to the ACO is dependent on the ACO Participant, such participant may only be an ACO Participant in one ACO
- MSSP regulations contemplate an ACO will have relationships with 'ACO Affiliates'

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Overview of Beneficiary Assignment Process

- Identify all Medicare FFS beneficiaries who have had at least one primary care service with a physician who is an ACO provider/supplier.
- Step 1:
  - Applies to beneficiaries who received at least one primary care service from a primary care physician
  - Beneficiary assigned to an ACO if the primary care services furnished to the beneficiary by the primary care physicians who are ACO providers/suppliers in the ACO are greater than those furnished by primary care physicians outside the ACO (i.e., with another ACO or unaffiliated with an ACO).
- Step 2:
  - Applies to the remainder of beneficiaries who received at least one primary care service from an ACO physician (regardless of specialty) and did not receive any primary care services from any primary care physician.
  - Beneficiary assigned to an ACO if the primary care services furnished to the beneficiary by all ACO professionals* who are ACO providers/suppliers in the ACO are greater than the allowed charges of those furnished outside the ACO.

* Physicians, NPs, PAs and certified nurse specialists

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Key Regulatory Dimensions

- Civil-Monetary Penalty Statute ("CMP")
- Anti-Kickback Statute ("AKS")
- Physician Self-Referral Law ("Stark")
- Antitrust price-fixing and monopoly dimensions
- Tax-exempt laws

Waivers of Fraud & Abuse Provisions

- Five separate waivers available to waive Stark, AKS and CMP provisions for qualifying arrangments
- Self-implementing in that no individual application to CMS required
  - Certain waivers have procedural requirements (e.g., board resolution requirements)
- Several of the waivers use flexible “reasonably related to the purposes of the Shared Savings Program” standard
  - Breadth of those purposes underscores breadth of the waivers themselves

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Summary of ACO Waivers

	Pre-Participation Waiver	Participation Waiver	Shared Savings Distribution Waiver	Physician Self-Referral Law Waiver	Waiver for Patient Incentives
Law(s) waived	Stark, AKS and Gainsharing CMP	Stark, AKS and Gainsharing CMP	Stark, AKS and Gainsharing CMP	AKS and Gainsharing CMP	AKS and Beneficiary Inducements CMP
Qualifying activities	Start-up arrangements reasonably related to the purposes of the Shared Savings Program	Arrangements reasonably related to the purposes of the Shared Savings Program	Distributions of shared savings	Financial relationships reasonably related to the purposes of the Shared Savings Program fully compliant with a Stark exception	Provision of items & services provided to beneficiaries that are reasonably connected to beneficiaries' medical care
May cover arrangements w/ACO affiliates?	Yes, but must include at least one ACO Participant of the type eligible to form an ACO	Yes, but one party must be the ACO, an ACO Participant, or an ACO Provider/Supplier	Yes, if reasonably related to the purposes of the Shared Savings Program	Apparently	No (items/services must be provided by ACO, its ACO Participants, or its ACO Providers/Suppliers)
Board documentation & disclosures required?	Yes, including documentation of the diligent steps to develop the ACO	Yes	No	No	No
Time coverage	May begin up to one year prior to application due date; ceases at start of ACO's participation agreement w/CMS	Runs concurrent with ACO's participation agreement with CMS plus 6 months (unless CMS terminates ACO)	Extends to distributions made after participation agreement w/CMS ends	Runs concurrent with ACO's participation agreement with CMS	Runs concurrent with ACO's participation agreement with CMS (and remainder of initiated services may be completed)

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Strategic Considerations: Additional Business Lines

- Potential synergies in integrating other business lines (or aligning other initiatives) into an ACO, such as:
  - Commercial payor network
  - Self-insured plan
  - Broad quality initiatives
- Legal issues loom large here, however including:
  - Tax-exempt issues
  - Antitrust issues
  - Scope of the MSSP fraud & abuse waivers

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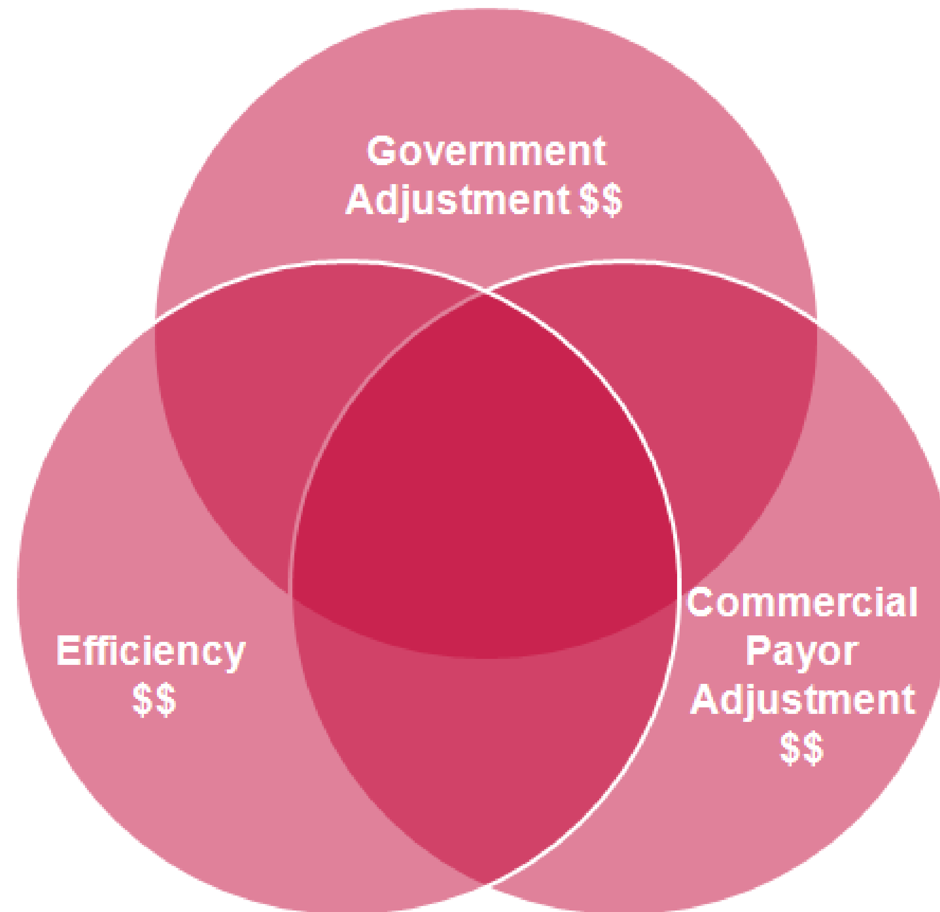
Strategic Considerations: Where Does an ACO Fit in Your Broader Financial Strategy?



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Application Key Dates

START DATE	APRIL 1, 2012	JULY 1, 2012
2012 applications posted on CMS website	Fall 2011	Fall 2011
NOIs accepted	Nov 1, 2011 – Jan 6, 2012	Nov 1, 2011 – Feb 17, 2012
CMS User ID Forms accepted	Nov 9, 2011 – Jan 12, 2012	Nov 9, 2011 – Feb 23, 2012
2012 applications accepted	Dec , 1 2011 – Jan 20, 2012	March 1 – 30, 2012
2012 application approval or denial decision	March 16, 2012	May 31, 2012
Reconsideration review deadline	March 23, 2012	June 15, 2012

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Questions?

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