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CMS Announces Proposed Rule on Accountable Care Organizations

On March 31, 2011, CMS issued proposed regulations on Accountable Care Organizations (ACOs). There is a 60-day comment period, after which time, CMS will issue final regulations. ACO implementation is scheduled for January 1, 2012.

I. ELIGIBILITY

A. The following may form an ACO, either separately or in combination:

- ACO Professionals in group practice arrangements
  - ACO Professional = doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist
- Networks of individual practices of ACO Professionals
- Partnerships or joint ventures between hospitals and ACO Professionals
- Hospitals employing ACO Professionals

B. Sufficient number of primary care providers and beneficiaries

- ACO must provide primary care to at least 5,000 Medicare Fee-For-Service (FFS) beneficiaries
- Beneficiaries are assigned to an ACO retrospectively based on utilization of services from **primary care physicians** within the ACO during the previous year
  - If less than 5,000 at the end of the year, ACO will be issued a warning and placed on a corrective action plan
  - If less than 5,000 at the end of the next year, agreement terminated and ACO is not eligible for shared savings
- Primary care physicians are those specializing in general practice, family practice, internal medicine or geriatric medicine
- Primary care physicians must be exclusive to one ACO
- Beneficiary issues:
  - ACO participants must notify beneficiaries regarding participation in ACO
  - Medicare FFS beneficiaries have freedom of choice in physicians and other health care practitioners. Not limited to providers within the ACO
  - Beneficiaries can opt-out of having their claims data shared with the ACO

C. Three-year commitment.

- ACO will enter into a 3-year agreement with CMS
- ACO chooses a risk model track to follow during the agreement period:
  - Track 1: One-Sided Risk Model
    - Share in savings during Years 1 and 2 of agreement
    - Share in savings and losses during Year 3
    - Provides an entry point for ACOs that cannot immediately take on the risk
  - Track 2: Two-Sided Risk Model
    - Share in savings and losses for all 3 years
    - By taking on risk, can get a higher percentage of the shared savings

II. GOVERNANCE

A. Governing Body Composition
- ACO participants or their representatives (75% control) and Medicare beneficiaries
- May also include entrepreneurs and/or health plans partnered with ACO participants to assist with capital and infrastructure

III. SHARED SAVINGS

A. CMS will calculate an expenditure benchmark for each ACO based on the ACO participants' past claims

B. ACO must exceed a minimum savings rate (MSR) based on a percentage of the benchmark to qualify for shared savings each year
- One-Sided Risk Model: MSR varies based on the number of beneficiaries served
- Two-Sided Risk Model: Flat MSR of 2%

C. If ACO achieves savings above the MSR, ACO will share in savings based on the quality score earned through reporting on designated quality measures
- One-Sided Risk Model: up to 50%
- Two-Sided Risk Model: up to 60%

D. Additional shared savings available for ACOs that include rural health centers (RHCs) and federally qualified health centers (FQHCs)

IV. SHARED LOSS

A. Amount of shared losses based in part on the quality score

B. Shared loss cap in Two-Sided Risk Model:
- 5% in Year 1 (Year 3 in One-Sided Risk Model)
- 7.5% in Year 2
- 10% in Year 3

V. QUALITY REPORTING

A. Quality measured in 5 key areas (65 proposed measures spread over 5 key areas):
- Patient experience
- Care coordination
- Patient safety
- Preventive health
- At-risk populations/frail elderly health

B. Standard for 1st quality performance period is **reporting only**
- 1st quality performance period: January 1, 2012 – December 31, 2012
- Incentive for providers to participate in 2012

VI. COORDINATION WITH OTHER AGENCIES

A. FTC/DOJ
- Rule of Reason treatment if ACO meets the CMS criteria for ACO approval
- Safety Zone: 30% or less of common service provided within a common Primary Service Area (PSA)
- Mandatory Review: Over 50% of a common service provided within a common PSA
- Optional Review: 31%-50% of a common service provided within a common PSA

B. IRS: proposes no private inurement or benefit related to the distribution of shared savings if ACO meets certain requirements

C. CMS/OIG/HHS: Waiver of Stark/Anti-Kickback/Civil Monetary Penalties for distribution of shared savings to ACO participants, or for activities related to the ACO's participation and operation