SATINSKY CONSULTING

SUMMER 2012 NEWSLETTER

Margie Satinsky

Is an Accountable Care Organization (ACO) in your future? On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS) finalized new rules under the Medicare Shared Savings Program. Now is the time to focus on the concept, the changes in the Final Rule, and on an appropriate strategy for your practice.

Refer to our Summer 2011 newsletter to understand the essentials of ACOs – from goals and timing, to terminology and relationship to other programs, to measurements, and IT challenges. This newsletter will inform you about updates to the Final Rule and other related information that you should consider. Rarely will there be a practice that will not somehow be affected by the existence of ACOs or conceptually similar entities. Use the topical links below to navigate quickly to updates on topics of greatest interest to you.

FACE UP TO THE REALITY OF THE ACO

ACOs: The Underlying Concept

To briefly review…Accountable Care Organizations (ACOs) are provider-based organizations that assume the responsibility for meeting the healthcare needs of a defined population. They coordinate the treatment of patients across the continuum of care, and there's an opportunity for participating providers to share financial gains and losses that are compared to benchmark data. ACOs target the Medicare population. Less important than this particular program is the underlying concept – that of shifting to value-based purchasing by both public and private payers. ACOs are just one brand of what will be many programs that have similar goals for defined populations, not necessarily Medicare beneficiaries.

Return to menu of topics

Changes in the Final ACO Rule

The Final Rule made important changes to the ACO program. We've listed ten of them. The list is not exhaustive, so if you want to know more, refer to the **CMS website information**.

1. How does the Final Rule change formation of and participation in ACOs?

Entities that are eligible to apply to CMS to qualify as an ACO and to participate in it now include Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) as well as professionals in group practice arrangements, individual practices of ACO professionals that form a network, partnerships or joint ventures between hospitals and ACO professionals, hospitals that employ ACO professionals, and certain critical access hospitals.

SATINSKY CONSULTING

2. The Proposed Rule offered ACOs two tracks for financial risk-sharing over a three year period. Does the Final Rule change these two options?

The Final Rule offers ACOs a choice of two tracks, only one of which involves risk. Under Track 1, which is called a one-sided model, ACOs share savings for the full term of the initial agreement period and may earn up to 50% of the savings based on quality performance. There's a ceiling on the payment amount of the savings – 10% of the applicable year's Part A and Part B updated benchmark. ACOs that begin participation under Track 1 and decide to continue participation in the program beyond the term of the first agreement must switch to Track 2.

Track 2 is a two-sided model that requires ACOs to share in both savings and losses. ACOs that begin the program under Track 2 and continue participation remain in Track 2. These ACOs can share in a higher percentage of savings – 60% – and their payment ceiling is 15% of the applicable year's Part A and Part B updated benchmark. There's a Minimum Loss Rate (MLR) of 2%, and a flat 2% Minimum Savings Rate (MSR) for these ACOs. Once an ACO achieves or exceeds the MSR, it can share in first dollar savings – a change requested by many critics of the Proposed Rule. For Track 2 ACOs, there's no change in the three year phasing in of any losses.

3. How did CMS respond to many requests that it accelerate the start date of ACOs that were already well underway with their activities?

For 2012, the first year of the Shared Savings Program, CMS offered two application start dates, April 1, 2012 and July 1, 2012**.** ACOs that started in 2012 have agreement periods that terminate at the end of 2015**.** CMS made this change with several goals in mind**.** The addition of a second start date allowed ACOs to apply when ready**.** The new timing also meant that ACOs could immediately begin to receive historical and quarterly data and information on prospective beneficiaries assigned to them**.** They therefore had a better understanding of the population assigned to them than they would have had under the Proposed Rule. ACOs that begin in 2012 are eligible to receive PQRS financial incentive payments for each calendar year in which they fully and completely report the Group Practice Reporting Option (GPRO) measures**.** Thus they have the opportunity to gain some working capital right away**.** CMS's final goal with this change was to prevent beneficiary double counting in those geographic areas with more than one ACO.

4. Does the Final Rule change beneficiary assignment to an ACO?

The Final Rule corrects several objectionable features of assigning beneficiaries to ACOs based only on allowed charges for primary care services provided by physicians in internal medicine, general practice, family practice, or geriatric medicine. The new process for assigning beneficiaries recognizes the role of specialists and certain non-physician primary care providers (e.g. nurse practitioners, clinical nurse specialists, and physician assistants) in providing primary care for some beneficiaries**.**

CMS also added a feature to beneficiary assignment to ACOs**.** The new methodology includes preliminary prospective assignment with final retrospective reconciliation**.** The Proposed Rule featured only prospective assignment, making it difficult for ACOs to know anything about the population for which they were responsible. With the new prospective feature, the ACO must request the information from CMS; the data is not provided automatically.

SATINSKY CONSULTING

5. Did the Final Rule change the calculation and distribution of shared savings?

This question has a two-part answer. First, the calculation of shared savings compares expenditures by the ACO with benchmark expenditures – i.e., those Medicare Part A and B fee-for-service expenditures of beneficiaries who would have been assigned to the ACO in any of the three years prior to the start of the ACO. There's basically no change in the method of determining those prior year expenditures. Beneficiaries will still be divided into the categories of End Stage Renal Disease, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries. The methodology applies to Rural Health Canters and Federally Qualified Health Centers that are now eligible to form and participate in ACOs. There's also no change in the notion of updating the benchmark expenditures to account for changes in severity and case mix.

A big change in the Final Rule is the allowance of ACOs participating in either Track 1 (sharing of only savings in years 1 and 2; sharing savings and loss in year 3) or Track 2 (sharing in both savings and loss for 3 years) to share in first dollar savings.

With respect to the distribution of shared savings, the Final Rule doesn't change CMS's intention to make savings payments directly to the ACO without dictating the way in which those savings should be distributed to ACO members. However, the Final Rule does remove a provision by which CMS would have withheld 25% of the savings to ensure repayment of future losses.

6. If CMS establishes new program standards during the ACOs agreement period, must the ACO continue its participation?

Like the Proposed Rule, the Final Rule holds ACOs responsible for regulatory changes in policy, with exceptions of eligibility requirements, the structure and governance of ACOs, calculation of sharing rate, and assignment of beneficiaries. However, the Final Rule gives an ACO the flexibility to voluntarily terminate its agreement in instances where new regulatory standards during an agreement period are likely to impact the ACO's ability to participate in the shared savings program.

7. Does the Final Rule recognize the possibility that an ACO may experience "significant changes" during an agreement period?

Yes – and the changes made in the Final Rule are significant. ACO participants and suppliers can now be added or subtracted during the period of the agreement. CMS must receive notice within 30 days. If a change is significant and results in an ACO's inability to meet eligibility or program requirements, again CMS requires 30 days notice. Here are two hypothetical scenarios. If a large primary care group terminated its relationship with the ACO, the ACO might not be able to meet its requirement for a minimum of 5,000 beneficiaries. In this type of case, the ACO might need to terminate its agreement. In a different type of situation, a change might require an adjustment to the ACO's benchmark but still allow it to continue participating in the program.

8. Does the Final Rule make any major changes to the anti-trust requirements in the Proposed Rule?

The Proposed Rule contained an Antitrust Policy Statement that would have mandated review by the Antitrust Agencies of certain ACOs before CMS would approve their participation in the Shared Savings Program. Under the Final Rule, ACOs are not required to obtain such a letter, and if they do obtain one, acceptance into the ACO program is not contingent upon the contents of the letter from the Antitrust Agencies. As suggested in

comments to the Proposed Rule, CMS will provide the Antitrust Agencies with data and information that is sufficient for them to identify potentially anticompetitive conduct**.** The result of the change is an expedited review process for ACOs and additional cooperation with the Antitrust Agencies by CMS.

9. Does the Final Rule change the quality measures contained in the Proposed Rule?

There are two important changes in the quality measures. First, the Final Rule reduced the number of quality measures from 65 to 33 and eliminated one of the categories**.** The four categories of measures, called domains, now include Patient Experience of Care, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population**.** Within each domain, ACOs must report all measures and score above the minimum attainment level as determined by CMS on 70% of the measures. Second, an ACO's receipt of shared savings is no longer contingent on meeting the quality performance thresholds for all of the proposed measures**.** ACOs that achieve the minimum requirement level for at least one measure in each of the four domains and satisfy the requirements for realizing shared savings can receive that portion of the shared savings for which they qualify.

10. Does the Final Rule require that 50% of an ACO's primary care physicians be determined to be meaningful use EHR users by the start of the second performance year in order to participate in the shared savings program?

No**.** A minimum level of EHR meaningful use by primary care physicians is no longer a condition of participation**.** Nonetheless, EHR use is still part of quality measurement and will be weighted higher than other measures with respect to quality scoring.

Return to menu of topics

National ACO Activity

As of July 1, 2012, a total of 154 Accountable Care Organizations (ACOs) were serving more than 2.4 million Medicare beneficiaries. These numbers included 89 new ACOs, Pioneer ACOs that got an early start with the program in December 2012, and six Physician Group Practice Transition Demonstration organizations that started in January 2011.

Return to menu of topics

Value-Driven Purchasing Initiatives in North Carolina

Our listing of value-driven purchasing programs in North Carolina includes both programs that meet the official CMS definition of ACO and those that do not. The concept of value-driven purchasing is by no means limited to Medicare beneficiaries. All of the NC efforts to date have been undertaken by organizations whose formation pre-dated the development of the ACO concept and that already have strong physician leadership and infrastructure.

- North Carolina organizations that meet the official CMS definition of ACO include: **Cornerstone Health Care, P.A.** in High Point and surrounding communities (group practices that include 313 physicians); **Triad Healthcare** in Greensboro, (networks of individual ACO practices and a hospital employing ACO professionals; total 759 physicians); **Coastal Carolina Quality Care and Accountable Care Coalition, LLC** of Eastern North Carolina in New Bern; and **Accountable Care Coalition of Caldwell County, LLC** in Lenoir.

SATINSKY CONSULTING

- **North Carolina Community Care Networks, Inc.**, in partnership with Carolinas Medical Center in Charlotte, Duke University Health System, University of North Carolina Hospitals, Vidant Medical Center-East Carolina, Wake Forest Baptist Health, and the children's units at Cape Fear Valley Health, Cone Health, Mission Hospital, New Hanover Regional Medical Center, Presbyterian Healthcare, and WakeMed Hospitals, is receiving a $9.3 million innovation grant to build a statewide child health accountable care collaborative. Specialty care managers in the offices of specialists and "parent navigators" who work with patients in their homes are key program components. The program addresses the shortage of both pediatric primary care physicians and subspecialists.
- **Blue Cross and Blue Shield of North Carolina and Wilmington Health**, a well-established multi-specialty physician group practice in southeastern North Carolina, are establishing a physician-led ACO. Wilmington Health, which has provided care for almost 40 years, includes 19 locations and 30 specialties.
- **CIGNA**, also a private insurer, has expanded its collaborative accountable care program by adding 10 new initiatives with physicians in several states. In NC, the collaborations are with Cornerstone Health Care and Key Physicians IPA.

Return to menu of topics

Additional Resources on ACOs

- **The North Carolina Medical Society** and 24 other North Carolina medical societies and organizations are launching the Toward Accountable Care Consortium and Initiative to provide the medical community with the knowledge and tools needed to understand, participate in, navigate, lead, and succeed in a value-driven health care system. Resources that will be available over the next 18 months and beyond are listed below. The website address is: **http://www.ncmedsoc.org/pages/advocacy_govt_affairs/accountable_care.html**
  - White paper developed by Smith Anderson Law Firm that contains information for physicians in independent practice and physicians employed by a hospital or health system
  - Specialty-specific tool kits developed by physicians in each specialty
  - Merit-based shared-savings pool distribution guide
  - Physician's guide to negotiating bundled payments
  - Webinars and educational sessions
  - Articles, podcasts, short videos
  - Social media communications
  - FAQs
- **The Carolinas Center for Medical Excellence: http://www.thecarolinascenter.org**
- **EHR vendors:** check with your vendor about webinars and other educational programs
- **Medical Group Management Association** (MGMA): **http://www.mgma.com**
- **National and state specialty societies**

Return to menu of topics

SATINSKY CONSULTING

What's Your Next Step?

We expect public and private insurers to continue to introduce more opportunities for value-based purchasing, including but not limited to ACOs. We encourage you to regularly review your own options and business strategy. Here are questions you can ask to help you determine an approach that's right for you.

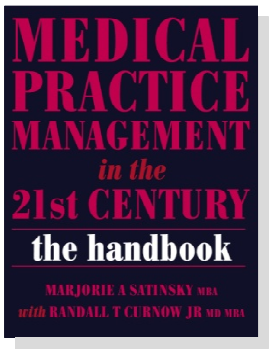
- If I'm a primary care physician, do I currently provide care or plan to provide care to a significant number of Medicare beneficiaries? If so, are there organizations in my community with which I might want to collaborate to form an ACO or similar program?
- If I'm a primary care physician and serve a significant number of children and adolescents, am I already part of Community Care of North Carolina, the organization that is developing an ACO with a pediatric focus?
- If I'm a specialist who depends heavily on referrals from primary care physicians, should I join one or more ACOs or similar organizations to retain my referral base? If so, which ones and how many?
- If I'm a specialist who is less dependent on physician referrals than on patient self-referral, what is the appropriate way for me to relate to developing ACOs and similar organizations?

If we can help, please contact us by phone (919.383.5998) or by email (margie@satinskyconsulting.com).

Yoga for Cancer Survivors

Beginning in the fall, Margie Satinsky, President of Satinsky Consulting, LLC, will offer Yoga for Cancer Survivors classes to those who have been diagnosed with and/or treated for cancer. **Full program details** and forms are available at **www.satinskyconsulting.com/yoga**. Please help us spread the word to those who might benefit.

Ideas for Managing Your Practice



If you are looking for new ideas to improve your bottom line and practice operations, order The Handbook for Medical Practice Management in the 21st Century. The book and the companion website offer concrete suggestions and practical tools. Authored by Marjorie A. Satinsky, M.B.A., with Randall T. Curnow, Jr., M.D., M.B.A., the handbook is available from Radcliffe Press.

To order the book, call 800.247.6553 or visit **www.radcliffe-oxford.com**.

Satinsky Consulting, LLC
201 Cedar Ridge Way
Durham, NC 27705-1981
919.383.5998
Fax 919.309.0109
www.satinskyconsulting.com