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Final Rule for the Medicare Shared Savings Program Could Make ACOs More Attractive to Potential Participants

The Centers for Medicare & Medicaid Services (CMS) recently made significant changes to the rules governing Accountable Care Organizations (ACOs) that are intended to make ACOs and the Shared Savings Program more attractive to healthcare providers. Healthcare industry response to the proposed rule, released by CMS in the spring of 2011, raised a number of concerns. The final rule, which was published in the Federal Register last fall, features a number of changes and clarifications aimed at decreasing the risk and increasing the flexibility associated with forming an ACO. A few of the key modifications are highlighted below.

Under the proposed rule, ACOs could choose between two three-year tracks. Track 1 entailed two years of one-sided shared savings during which the group would only share savings but not losses if costs actually increased. After the second year, the group would share in both savings and losses through a two-sided model. Under Track 2 all three years would follow the two-sided model. The final rule eliminates the two-sided risk from Track 1 to allow one-sided shared savings during all three years. ACOs willing to share in losses may still opt for Track 2 and will enjoy higher sharing rates. In addition, the proposed rule contemplated sharing under the one-sided risk model only after a savings of 2 percent was achieved and then only on savings above that 2 percent threshold. Under the two-sided model, sharing began from the first dollar. The final rule amended this structure to allow sharing from the first dollar under both models as soon as a minimum savings rate has been achieved.

Initially, CMS proposed assigning beneficiaries to ACOs retrospectively based upon their utilization of primary care services. Many commentators raised

concerns that ACOs would not be able to coordinate and manage beneficiaries' care effectively without knowing who would ultimately be assigned to the ACO. In response to these concerns, the final rule adopted a more prospective approach to beneficiary assignment that assigns an initial list of beneficiaries to the ACO at the beginning of the performance period and updates the list every quarter thereafter. Although CMS will still determine the final beneficiary assignments at the end of the performance period, the group will receive some data throughout the year. Determining which beneficiaries will be assigned to which ACO will still be based on the primary care provider who provided a preponderance of primary care services to the beneficiary over the year. The final rule also expanded the beneficiary assignment methodology to include consideration of primary care services received from specialists and other non-primary care physicians.

The proposed rule called for three-year ACO agreements with uniform annual start dates and performance years coinciding with calendar years. Under the final rule, the first ACO agreements will start in April or July 2012, with first performance "years" of 18 or 21 months and reconciliation at the end of calendar year 2013. For ACOs that begin agreements in 2013 or subsequent years, the term will be three calendar years, and the agreements will start on January 1.

Another major concern in the proposed rule related to the extensive list of quality measures. The proposed rule required ACOs to report on 65 quality measures in five domains. Many potential participants viewed this burden as a deterrent to forming an ACO. In response, the final rule features just 33 measures in four domains. Further, CMS eliminated the requirement that 50 percent of an ACO's primary care physicians be meaningful users of electronic health records (EHR). Instead, EHR is now just one of the 33 quality measures (though it is weighted higher than the others). In yet another effort to reduce the administrative costs to new ACOs, CMS will be providing (and paying for) standardized patient survey forms during 2012 and 2013. Starting in 2014, ACOs will be required to purchase their own survey forms from a CMS-approved vendor.

What This Means to You

The changes in the final rule may make forming an ACO more attractive to a greater number of healthcare organizations, including organizations that decided they would not participate in the program outlined in the proposed rule.

Contact Info

If your healthcare group or organization is interested in forming an ACO, or pursuing any range of physician integration activities, or would simply like more information on ACOs and physician integration options, please contact Curt Chase at 816.983.8254 or Winn Halverhout at 303.749.7210.

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