Many Changes Made in Final Rule on ACOs

The rules relax requirements for the Shared Savings Program and the Advanced Payment Model.

BY ALICIA AULT

Use of electronic health records is no longer a condition for participating in an accountable care organization, according to the Oct. 20 final rule that will govern how ACOs are constructed and how they will be paid. The change is just one of many in the long-awaited regulation.

The 696-page final rule contains many significant changes that were made in response to the 1,320 comments the Centers for Medicare and Medicaid (CMS) received on its proposed rule, issued in late March and published April 7 in the Federal Register.

Many physician groups and hospitals complained about various aspects of the proposed rule. They met repeatedly with the agency, CMS Administrator Don Berwick said during a press briefing.

The rules for ACO credentialing may not be something that neurologists and other physicians are accustomed to.

DR. BLACK

"Thanks to the generous input of ideas from so many Americans, we've been able to fine-tune and improve these rules to better meet the needs of a range of stakeholders," Dr. Berwick said.

"When folks see the rules and see the many changes, they will see that CMS listened," Jonathan Blum, CMS deputy administrator and director of the Center for Medicare, said during the briefing.

In the proposed rule, half of primary care physicians in an ACO had to meet the meaningful use criteria for electronic health records (EHRs) by the second year of what will be three-year contracts with the CMS. Under the final rule, EHRs will not be required, but instead be heavily weighted as a measure of quality of care.

The final rule also pushes back the program's starting dates. Originally, the CMS envisioned a start date of January 2012 for organizations that wanted to participate.

Now, the program will be established by January 2012 with the initial agreements starting in April or July of that year. The first performance "year" will be 18 or 21 months in length, rather than 12 months.

Under the final rule, there are two components to the ACO program: the Shared Savings Program and the Advanced Payment Model.

To be eligible to participate in the Shared Savings Program, ACOs must be able to be held accountable for at least 5,000 beneficiaries a year for each of the 3 years of the agreement. Only certain parties may sponsor an ACO: physicians in group practices, individual practitioner networks, or hospitals. That list was expanded in the final rule to include collaborations between Rural Health Clinics and Federally Qualified Health Centers.

To earn shared savings, ACO participants will have to report on measures that span four quality domains: quality standards, care coordination, preventive health, and at-risk populations. The final rule substantially reduces the number of quality measures, from 65 in five domains to 33 in four domains. In the first year, ACOs that are sharing savings only will be required to report on these measures to receive payment. In the second year, they will need to meet pay-for-performance standards on 25 of the measures, growing to 32 measures in the third year.

In the proposed rule, ACOs could only share savings in the third year of the 3-year agreement. Now, they can share beginning in the first. The CMS says this will help less-experienced organizations gain know-how before they more fully participate in the program. Fuller participation would have ACOs sharing losses, as well.

The savings-only route has ACOs splitting up to 50% of the savings with the CMS. If an ACO chooses to also share losses, it will get up to 60% of the savings. Under the proposed rule, the CMS could withhold 25% of pay-for-performance bonuses, but that has been removed from the final rule.

Also, under the proposed rule, ACOs would only start sharing in the savings after they had passed a minimum threshold set by the CMS. That threshold was established to ensure that the savings weren't just random, Dr. Berwick said. The minimum still exists under the final rule, but now, if the savings aren't just due to a random variation in costs, the ACO can share in savings starting with the first dollar, Dr. Berwick said.

The final rule made some changes to how Medicare beneficiaries would be assigned to ACOs, noting that "determination of whether an Accountable Care Organization was responsible for coordinating care for a beneficiary will be based on whether that person received most of their primary care services from the organization."

To spur participation in the Shared Savings Program, the CMS also announced that it would make money available to physicians, hospitals, and others for major capital investments under the Advanced Payment Model.

This model will pay a portion of future savings to eligible participants. Once they begin sharing in savings, they will have to repay the money. According to the final rule, eligible ACOs will either receive an upfront, fixed payment; an upfront, variable payment; or a monthly payment of varying amount depending on of the number of Medicare beneficiaries historically attributed to the ACO. More information on eligibility and requirements is at the agency's innovation center's website.

Dr. Stuart B. Black, chief of neurology and co-director of the Neuroscience Center at Baylor University Medical Center at Dallas, thought that the newly released rules have some significant and noteworthy changes which may ease many of the requirements to forming ACOs.

The new design for the final rules may make it more attractive for hospitals to consider organizing an ACO. This could put more pressure on staff physicians, including neurologists, to participate in the new health care models. While primary care physicians may only be able to participate in one ACO, it is possible that neurologists and other specialists who are in short supply would be able to belong to more than one ACO, Dr. Black said in an interview.

The rules for credentialing of ACOs may not be something that neurologists and other physicians are accustomed to. Dr. Black, who is chairman of the Texas Neurological Society Medical Economics Committee, emphasized that to maximize the opportunity for shared savings in an ACO, economic criteria will need to be evaluated even more carefully. He indicated that because ACOs are composed of groups of providers who work together to manage and coordinate the care of beneficiaries, cost effectiveness, as well as quality, becomes an integral element in the overall care of patients. If the cost of a physician is excessive relative to his or her peers while providing the same or similar services, this becomes a collective burden to all the ACO members. Dr. Black pointed out that in an ACO, physicians in a leadership position may need to impose economic credentialing criteria on their peers.

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Simultaneously with the announcement of the final rule, several federal agencies issued additional guidance on how ACOs could steer clear of violating antitrust laws and other measures designed to keep medicine competitive.

The Department of Health and Human Services Office of Inspector General also issued an interim final rule on how the ACOs could stay within the antikickback rules.

In the proposed rule, ACOs were required to seek antitrust review from the Federal Trade Commission and the Department of Justice. The final rule lifts that requirement, and instead advises potential ACOs to seek review. Those two agencies issued a final policy statement outlining enforcement plans and indicating that voluntary reviews would likely take about 90 days.

The full text of the final rule is available at http://bit.ly/oXwIV3. ■