EHRs No Longer a Requirement for ACOs

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 agency 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.

"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 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.

The final rule reduces the number of quality measures from 65 in five domains to 33 in four domains: quality standards, care coordination, preventive health, and at-risk populations.

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 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. More information on eligibility and requirements is at the agency's innovation center's website. ■

CMS Says Final 2012 Physician Fee Cut Is 27%, Not 29%

BY ALICIA AULT

If current law stands, physician fees will be cut by 27% in 2012, not the 29% originally projected, according to the final payment rule issued Nov. 1 by the Centers for Medicare and Medicaid Services.

The slight decrease is due to lower-than-expected Medicare cost growth, CMS officials said in a statement. Unless Congress steps in, the reduction will go into effect Jan. 1 as mandated by Medicare's Sustainable Growth Rate (SGR) formula.

Both President Obama, in his budget, and CMS officials have called for an overhaul of the SGR. The agency repeated that call with the issuing of the fee rule.

"This payment rate cut would have dire consequences that should not be allowed to happen," CMS Administrator Donald Berwick said in a statement. "We need a permanent SGR fix to solve this problem once and for all."

"Almost every year for more than a decade, doctors have faced this annual threat and the Congress has in turn acted to temporarily prevent these deep reductions from taking effect," Kathleen Sebelius, Health and Human Services secretary, said in a statement. "We have not and will not let deep cuts to doctors' payments occur. The Obama administration is 100% committed to fixing the flawed Medicare payment system and protecting Medicare beneficiaries' access to doctors."

The American Medical Association also urged Congress – yet again – to fix the SGR. "The Joint Select Committee on Deficit Reduction must include repeal of the formula in [its] recommendation to Congress to protect access to care for seniors and stabilize the Medicare program," AMA President Peter W. Carmel said in a statement. Dr. Carmel added that physician payments are so low that "there is a 20% gap between Medicare payment updates and the cost of caring for seniors."

Under the final rule, Medicare will issue some $80 billion in payments next year, according to CMS estimates.

In addition to addressing physicians' fees, the final rule includes many cost-cutting and efficiency-oriented provisions. For instance, the CMS is expanding its look at codes that may be overvalued. Previously, the agency focused on high-cost codes in cardiology and radiology. In 2012, it will take a broader look, focusing on codes in each specialty that lead to the highest Medicare expenses.

The goal is to rebalance payments so that primary care is not undervalued, according to the final rule.

The agency is also taking a knife to payments for imaging services by going after multiple images taken of the same patient at the same practice on the same day. The CMS had proposed a 50% cut in the professional component; the final rule makes a 25% reduction.

The final rule made several changes to the electronic health records incentive program and also to the Physician Quality Reporting System (PQRS). For EHRs, physicians now have the option to submit data through several different portals, not just one established by the CMS. The agency also more closely aligned the PQRS requirements with the meaningful use requirements under the EHR Incentive Program.

The rule also establishes measures to be used in the future to pay physicians for higher quality and more efficient care. Payment adjustments will begin in 2015 and be applied to all physicians by 2017.

Under the rule, the so-called "value-based modifier" will use the PQRS core set (which focuses on cardiovascular conditions) and the core, alternative core, and additional EHR Incentive Program measures (which focus on several chronic conditions and preventive measures). Payments to group practices will be based on the core set of the Group Practice Reporting Option measures and measures of preventable hospital admissions for heart failure and chronic obstructive pulmonary disease.

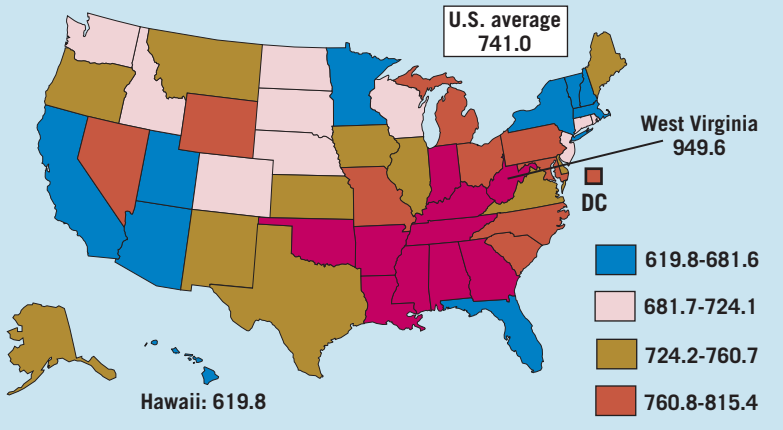
The cost measures will be both total per capita cost and per capita cost for selected conditions including chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes.

The final rule will be published in the Federal Register Nov. 28.

For provisions that are open to comment, the CMS will accept comments until Jan. 3, 2012, and then respond in the 2013 fee rule. ■

DATA WATCH

Mortality Varied Considerably Among States in 2009
(deaths per 100,000 population)



Note: Based on data from the National Vital Statistics System.
Source: Centers for Disease Control and Prevention

Elsevier Global Medical News