



Summary of AMA Briefing on the Medicare Shared Savings Plan: Accountable Care Organizations Final Rule

On November 7, 2011, The American Medical Association (AMA) hosted CMS officials and medical specialty society staff for an overview of the recently released final rule on the Medicare Shared Savings Plan: Accountable Care Organizations (ACOs).

CMS Presentation

CMS's Director of Performance Based Payment Policy, John Pilotte, provided a high-level overview of the major changes to the ACO regulations as described in the final rule.

He began the presentation with a discussion of CMS' vision and goals for ACOs, explaining that ACOs promoted seamless coordinated care that puts the beneficiary and family at the center; remembers patients over time and place; attends carefully to care transitions; manages resource carefully and respectfully; proactively manages the beneficiary's care; evaluates data to improve care and patient outcomes; innovates around better health, better care and lower growth in costs through improvement; and invest in team-based care and workforce.

CMS' ACO strategy is to create multiple pathways and on-ramps for organization to participate. With this strategy, CMS expects to engage in constant learning and improving.

John Pilotte next described the major points of the final rule as compared to the proposed rule.

Transition to risk in Track 1: CMS has removed the two-sided risk from Track 1. Two tracks are still being offered for ACOs at different level of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.

Prospective vs. Retrospective assignment: A preliminary prospective assignment method with beneficiaries identified quarterly; final reconciliation after each performance year made on the basis of patients served by the ACO.

Proposed measures to assess quality: 33 measure in 4 domains, and a longer phase-in of measure of the course of agreement. For the first year, pay for reporting, the second and third years are pay for reporting and pay for performance.



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Sharing savings: CMS has removed the 2% withhold on savings. Share on first dollar for all ACOs in both tracks once the minimum savings rate has been achieved.

Sharing beneficiary identification claims data: ACOs can contact beneficiaries from quarterly list to notify of them of data sharing an opportunity to decline.

Eligible entities: CMS has added Federally Quality Health Centers (FQHC) and Rural Health Clinics to form and participate in an ACO.

Start date: While the program is established as of January 1, 2012, the start dates will now be either April 1, 2012 or July 1, 2012.

Aggregate reports and preliminary prospective list: CMS will now provide additional reports on a quarterly basis.

Electronic health records use: CMS has removed the requirement that 50% of PCPs must be meaningful users by year two. CMS did retain the EHR quality measure and weighted it higher than other measures.

Assignment process: Created a two-step assignment process. Step 1: for beneficiary's who have received at least one primary care service from a physician use plurality of allowed charges for primary care services. Step 2: for beneficiaries who have not received any primary care services from a physician, use plurality of allowed charges for primary care services rendered by any other ACO professional.

Marketing guidelines: CMS will allow ACOs to file and use 5 days after submission and after certifying compliance with CMS marketing guidelines.

Coordination with Antitrust agencies: Maintains policy goals but modified process to address legal concerns, provides for a voluntary review process and clinical integration criteria. Also, streamlined requirements with FTC/DOJ.

Questions and Answers

"Access to Specialists" Module: CMS states that this module is part of the CAHPS, and they will send more details about the module to the AMA for distribution to the medical societies.



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3-Day Rule: CMS is not able to lift this requirement, even in the context of the ACOs.

Additional ACO Regulations: CMS will issue further regulations about ACOs in the future.

TIN Issues: A given NPI/TIN combination that is used to assign patients to the ACO can only be associated with one ACO. If a provider had a taxpayer ID number associated with the practice where they treated the ACO patient and also was affiliated with an office practice or a different practice where the provider used a different taxpayer ID number, the provider could be in two ACOs. But if the provider only had one TIN, that TIN could only participate in one ACO.

Pediatricians in ACOs: There is an ACO demo in CMMI for Medicaid that would be suitable for pediatricians.