The Law Offices of Jason M. Healy PLLC

Long-Term Acute Care Hospital Legal Alert

June 2011 Vol. 1, No. 2

In This Issue

A health law firm in the nation's capital

www.HealyLawDC.com

Contact Us:

Jason M. Healy
1667 K Street NW
Suite 1050
Washington, DC 20006
(202) 706-7926
(888) 503-1585 fax

jhealy@healylawdc.com

CENTER FOR MEDICARE AND MEDICAID INNOVATION UNVEILS "PIONEER ACO"

In response to broad criticism from physician and provider groups about CMS's proposed rule on Accountable Care Organizations ("ACOs"),[1] the Center for Medicare and Medicaid Innovation ("CMMI")[2] has developed an alternative model which they hope will be more attractive to entities that are ready to enroll. These "Pioneer ACOs" would have an advanced start date in the third or fourth quarter 2011 under the Request for Application ("RFA")[3] issued by CMMI. While many of the features of CMMI's proposed Pioneer ACO Model are identical or similar to CMS's ACO proposed rule, Pioneer ACOs would have higher risk-reward scenarios that might be attractive to some providers. CMMI may also decide to test provider-suggested features that will not be included in the general ACO final rule.

The RFA requires interested providers to submit a non-binding letter of intent[4] no later than **June 10, 2011**. Full applications must be postmarked prior to **July 18, 2011**.[5] Proposed Pioneer ACOs may withdraw their application prior to entering into an agreement. A provider cannot simultaneously participate in a general ACO and a Pioneer ACO.

ACOs are a new model for health care delivery along the continuum of patient care that encourages higher quality and coordination of care in exchange for shared cost savings. Born out of the 2010 health reform law, yet still largely untested, ACOs carry the burden of high expectations that they will deliver on these goals and (along with a few other key demonstrations) lay the path for the future of the Medicare program. It is perhaps because of these high expectations and lofty goals that CMS designed a proposed rule for general ACOs that is laden with regulatory requirements, rendering the ACO model far less attractive to would-be participants than was initially predicted.

While CMS attempts to reengineer the general ACO model through the rulemaking process, CMMI has stepped in to present a more attractive option. The Pioneer ACO differs from the general ACO in some critical ways. The attached chart provides a side-by-side comparison of the two models. "Certain non-IPPS hospitals" are eligible to form Pioneer ACOs, which could include long-term acute care hospitals ("LTACHs"), although the examples given only include cancer hospitals, children's hospitals, and critical access hospitals.

The most significant difference in the two models involves how hospitals earn shared savings. CMS's proposed rule for general ACOs includes a one-sided model, which would allow ACOs to share in up to 50% of savings with no exposure to risk, and a two-sided model which would

allow ACOs to share in up to 60% of savings but be accountable for cost increases. CMMI's Pioneer ACO Model proposes only two-sided models with escalating levels of financial accountability across the performance periods and a transition from fee-for-service to population-based payment by 2014. The core proposal would give Pioneer ACOs up to 60% of shared savings and losses in the first period, 70% in the second period, and then population-based payment with established baselines in the third and successive periods. Specifically, the first period would be subject to a savings or loss cap of 10% of the total projected Medicare Parts A and B expenditures for the Pioneer ACO's aligned beneficiaries. The cap in the second period will be 15%. Payments will be based in part on the ACO's quality performance score, with the Pioneer ACO mirroring the methodology that is selected for the general ACO final rule. For later periods, Pioneer ACOs will receive 50% of the payment on submitted fee-for-service claims, with the remainder coming in a monthly population-based payment.[6] Population-based payment is a per-beneficiary-per-month amount that replaces a significant portion of the ACO's fee-for-service payment with a prospective payment. A minimum threshold savings percentage will be established for every state based on their historical Medicare expenditures, not to exceed 5% or be less than 1%.

Unlike the general ACO, the Pioneer ACO Model proposes to allow the ACO to choose whether to use prospective or retrospective beneficiary alignment. Prospective alignment will be done based upon claims data from the prior three years, with the most recent year weighted most heavily. At the end of the performance period, a limited reconciliation will be performed to exclude certain beneficiaries who are no longer part of the ACO's patient population. By comparison, the retrospective alignment methodology will parallel the general ACO model. The Pioneer ACO Model will consist of three performance periods, with a CMS-held option for two more. The first performance period will span the start date of the program to December 31, 2012, and the following periods will each be one year. Also, the Pioneer ACO Model requires that participants commit to entering into outcome-based contracts with other payors so that the majority of the ACO's total revenues, including those from Medicare, come from such arrangements prior to the end of December 2013.

CMMI's proposed Pioneer ACO Model serves as an alternative to general ACO's described in CMS's proposed rule. Since neither model has been finalized, interested providers should consider both models and weigh the different risk-reward balance. CMMI has not formally solicited comments on the Pioneer ACO Model proposal, but has set up an e-mail account for questions regarding the model or application process at PioneerACO@cms.hhs.gov.

---

1. 76 Fed. Reg. 19528 (Apr. 7, 2011).
2. CMMI was created by the Patient Protection and Affordable Care Act and tasked with testing "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care furnished to individuals …" Section 1115A(a)(1) of the Social Security Act, codified at 42 U.S.C. § 1315a(a)(1). Within the statute the Center is abbreviated CMI, but CMS uses the abbreviation CMMI.
3. Pioneer Accountable Care Organization (ACO) Model, Request for Application, available at: http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco-application/. See also 76 Fed. Reg. 29249 (May 20, 2011).
4. Letter of Intent also available at link in note 3.
5. Application Form also available at link in note 3.
6. See RFA at 34 for detailed population-based payment methodology.

About Us

The Law Offices of Jason M. Healy PLLC is a health care law firm that focuses exclusively on legal issues affecting health care providers. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations. We also represent health care providers in reimbursement audits, appeals, and litigation. Located in Washington, DC, we are well positioned to provide legal support for advocacy efforts. Our principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.

Please feel free to reach us at the phone number or email address above if we can be of assistance. We look forward to working with you and your company.

Comparison of CMS General ACO Model Versus CMMI Pioneer ACO Model

The Law Offices of
Jason M. Healy PLLC

Feature	General ACO	Pioneer ACO
Requirement for participation of other purchasers	Not proposed	>50% of total revenues (including Medicare) derived from outcomes-based contracts by end of second performance period
Expenditure benchmark calculation	Benchmark established using per capita Parts A and B FFS expenditures for beneficiaries historically assigned to the ACO in each of the three baseline years, risk adjusted using the prospective HCC model. Benchmark updated annually by the projected absolute amount of growth in per capita expenditures for Parts A and B services.	Expenditure baseline will be trended forward using a hybrid inflationary factor (50% percentage national average growth, 50% absolute dollar growth)
Expenditure baseline calculation	Establishing the baseline includes weighting the 3 years of the benchmark at 60%, 30% and 10% for base years 3, 2 and 1 respectively	Similar, except with additional months of lag between the most recent baseline year (2010) and the start of the first performance period (anticipated in late 2011)
Length of agreement	Three years	Three performance periods (three years plus end of 2011) with two one-year optional extensions
Core payment arrangement	A) One-sided model for years 1 and 2, two-sided in year 3 B) Two-sided model all three years	Escalating shared savings and shared losses transitioning to population-based payment in year three. Will offer second model based on suggestions
Timing of alignment	Retrospective at end of performance year, prospective population-level data sharing	Prospective or retrospective. Prospective uses claims from prior three years
Minimum number of aligned beneficiaries	5,000	15,000 (5,000 for rural)
Beneficiary attestation	Not proposed	Align beneficiaries who meet certain criteria (new to Medicare, new to area) and attest ACO as primary care coordinator.
Beneficiary choice regarding shared data	Beneficiaries may decline after notification during office visit with primary care provider	Beneficiaries have 30 days to opt out before sharing begins; can opt out at any point thereafter
ACO legal status requirements	Legal entity with own TIN recognized under state law	Same
Alignment algorithm	Plurality of allowed charges for primary care physicians	Same but with non-MD primary care providers also; align with specialist if less than 10% of beneficiary's treatment comes from primary care services
Rapid data feedback	Monthly minimum necessary beneficiary identifiable data, quarterly and annual aggregated reports, baseline ACO spending performance and utilization data	Monthly financial reports, historical claims data, and possibly additional reports based on input. Similar quarterly and annual reports.
Legal and regulatory guidance, waivers	Guidance from FTC, DOJ and IRS. OIG/CMS joint guidance on antifraud waivers.	Rules will be consistent with guidance. Waivers will be consistent.
Minimum Savings Rate	One-sided model – based on number of assigned beneficiaries Two-sided model – flat 2%	Flat rate of 1%
Governance structure requirements	Legal entity, shared governance, governance body with representative membership where ACO participants have at least 75% control and includes patient representation	Similar with additional requirement that board have consumer advocate
Required HIT capabilities	50% of ACO's primary care physicians meaningfully using HER technology by start of second performance year	Same
Patient centeredness criteria	Eligibility criteria and beneficiary experience of care survey	Same
Performance metrics	65 metrics	Same
Primary care capability	Sufficient to assign at least 5,000 beneficiaries	Similar, except 15,000 beneficiary minimum (less those assigned through specialists)
Linkage between quality score and shared savings/loss percentages	Increased savings for higher quality, decreased losses for higher quality	Similar to two-sided model, but shared losses subject to a minimum in certain cases

Adapted from Appendix A of Pioneer ACO RFA