ACCOUNTABLE CARE ORGANIZATIONS: AFTER THE REGULATIONS: AN OPPORTUNITY OR DISTRACTION?

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Friday, May 20, 2011

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11:30 a.m. – 1:00 p.m. CT

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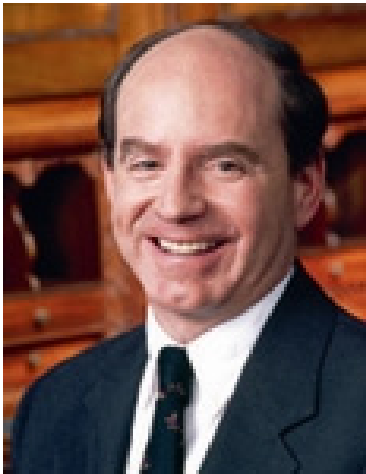

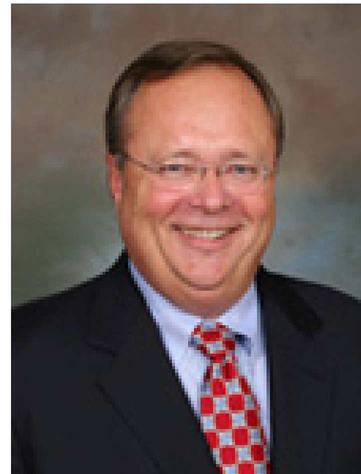

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TOPICS

- Brief Summary of Regulatory Scheme
- Should Your Organization Participate – Matters To Consider
- Issues Warranting Comment
- What Is Required With an Application
- Alternatives To The Medicare Shared Savings Program

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Considerations in Decision of Whether to Participate in the MSSP

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Proposed Regulatory Approach

Proposed Regulations Issued March 31

- Comments Due June 6
- CMS/OIG Proposed Regulations On Legal Waivers - - Comments Due June 6
- FTC/DOJ Proposed Policy - - Comments Due May 31
- IRS Proposed Notice - - Comments Due May 31

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Regulatory Approach

- Not An HMO (Controlled Network) Model
- No Steerage and No Narrow Network
- Preserve Beneficiary Free Choice of Provider
- Retroactive Assignment of Beneficiaries
  - Beneficiaries Do Not Sign Up
  - Beneficiaries Included if Receive Plurality of Primary Care Services From A Participating Primary Care Physician
- Primary Care Physician Exclusive To An ACO

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Regulatory Approach (cont.)

- Hospitals, Specialists, Others Cannot Be Required To Be Exclusive
- Application To Be An ACO For 3 Year Agreement
- Governance: Board 75% Control By Participants, Proportionate Control By Participants and Beneficiary on Board
- Requirements For: Leadership Structure, Data Gathering, Transparency, Marketing, Compliance
- Quality Standards and Reporting
- Payment: FFS But Potential To Earn Share of Savings Against a Benchmark – Share Based on Quality and Reductions In Cost
- Must Take Down Side Risk in Either of 2 Models
- Legal Waivers: Fraud and Abuse and Antitrust

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Considerations For Participation As An ACO Benefits vs. Costs

- What Are Potential Financial Benefits?
- Are Financial Benefits Sufficient To Change Behavior?
- Are There Other Benefits of Participating?
- What Are Costs of Participation?

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What Are Potential Financial Benefits?

Depends Upon

- Number of Expected Beneficiaries
- Average Medicare Part A and Part B Costs of Care for Expected Beneficiaries
- Ability to Deliver Reduced Cost of Care Significantly Below the Expenditure Benchmark
- Ability To Meet Quality Measures

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Financial Benefits (cont.)

- Number of Beneficiaries
  - Assigned Retroactively
  - Primary Care Physician Participation
  - Degree of Beneficiary Loyalty to Primary Care Physicians
- Average Per Capita Cost of Care
  - Benchmark Based on 3 Prior Years
  - Does Your State Have High or Low Medicare Costs (30% Variation In Cost Between States)

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Financial Benefits (cont.)

- What Will Make-Up of Your Beneficiaries Be?
- Other Special Medicare Costs In Your Benchmark
- Attributes of Your ACO Provider Participants
  - DSH
  - IME
  - Medicare Incentive Payments

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Financial Benefits (cont.)

- Can You Deliver Care At a Cost Significantly Below Benchmarks:
  - Do You Coordinate Care Well?
  - What Are Relative Components of Your Benchmark? If Hospital Care, Have You Already Been Efficient With DRGs? How Will You Generate More Savings?
  - Will Your Participating Providers Cooperate To Coordinate Care
    - What Controls Do You Have Over Them
    - Are FFS Payments Likely To Outweigh Any Other Incentives To Be Accountable
    - Are They Committed To Coordinated Care
    - Can You Get Timely Reports on Care They Provide

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Financial Benefits (cont.)

- Will Beneficiaries Receive Care From Your Participant Providers?
  - Do They Now?
  - Free Choice of Beneficiaries
  - What of Second Opinions?
  - Specialty Hospital Draw for Sicker Patients?
  - What of Snow Birds?
  - Will Beneficiaries Like To Be in An ACO?

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Financial Benefits (cont.)

- If Cannot Reduce Costs, May Owe Money Back in Shared Loss Years (Percent of Loss Sharing Likely Higher Than Percent of Savings)

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Financial Benefits (cont.)

- How Will You Perform on Quality Measures (Affects Sharing Rate)
  - 65 Measures in 5 Domains
  - Have You Performed Well Historically
  - Are the Measures Things You Have and Can Track
  - How To Drive Consistent Quality Scoring From All ACO Participants
  - Need for Continued Improvement

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Financial Benefits (Example)

Two Examples: Assumes 10,000 and 60,000 Beneficiaries; Assume Medicare Per Capita Cost of Care $8,000

Number of Beneficiaries	10,000	60,000
Average Per Capita Cost	$8,000	$8,000
Total Benchmark	$80,000,000	$480,000,000
Minimum Savings Rate (MSR)	3% ($2.4 million)	2% ($9.6 million)
Floor/Threshold in (One-Sided Model) (Two-Sided Model)	 2% ($1.6 million) 0	 2% ($9.6 million) 0
Percent of Savings Based on Quality (One-Sided) (Two-Sided)	 Potential 50% Potential 60%	 Potential 50% Potential 60%
Cap (One-Sided) (7.5% of Total Benchmark) (Two-Sided) (10% of Total Benchmark)	$6.0 million $8.0 million	$36 million $48 million
Required Cost Savings To Reach $6.0 million (for 10,000 Beneficiaries) and $36 million (for 60,000 Beneficiaries) (Assuming Max Sharing Percentage) (One-Sided) (50% Rate) (Two-Sided) (60% Rate)	$13.6 million (17%) $13.33 million (16.6%)	$81.6 million (17%) $79.68 million (16.6%)
Cost Reduction To Reach $6.0 million (for 10,000 Beneficiaries) and $36 million (for 60,000 Beneficiaries) at Half the Maximum Sharing Rate (One-Sided) (25% Rate) (Two-Sided) (30% Rate)	$25.6 million (32%) $18 million (23%)	$153.6 million (32%) $108 million (23%)

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Costs: Governance

- New Board?
- 75% Control By ACO Participants
- Proportionate Control By ACO Participants
- Beneficiary Representation On Board
- What if Board Does Not Want to Follow Required Steps for Quality and Enhanced Efficiency?
- Will ACO Have Sufficient Funds to Implement Required Steps?

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Costs: Infrastructure and Operating Costs

- Shared IT: EHR, Linking Health Information
- Structure To Measure and Control Costs/Claims
- Full-Time Medical Director On-Site
- Hire Executive Director
- Care Coordination, Quality Improvement and Utilization Management
- Reporting and Collecting Data From All
- Data Analytics
- Completing Application
- Develop Compliance Plan and Retain Compliance Officer (Not Legal)

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Costs: Infrastructure and Operating Costs (cont.)

- Prepare Antitrust Analysis
- Develop Contracts and Network
- Ongoing Reporting
- Effective and Enforced Care Management
- Down-Side Risk May Require State Insurance Regulation – Reserves, Regulations, Reporting – Added Expense
- CMS Can Change Requirements
- CMS Data May or May Not Be Available

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Cost Estimates

CMS Estimate of Cost: $1.7 Million

American Hospital Association/McManis Consulting: Cost Analysis

Categories of Cost

- Network Development and Management
- Care Coordination, Quality Improvement and Utilization Management
- Clinical Information Systems
- Data Analytics

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Cost Estimates (cont.)

– Estimates:

	One Hospital 80 PCPs and 150 Specialists		Five Hospitals 250 PCPs and 550 Specialists
Start Up	$5.315 million	to	$12 million
And Ongoing	$6.3 million	to	$14.9 million

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Costs: Infrastructure and Operating Costs (cont.)

- How To Pay Costs (Shared Savings Only Known and Paid At Year-End)
- Will There Be A ROI?
- Where Will Investment Capital Come From?
- Who Will Make An Investment, if Don't Have Control and Return Known Only at Year-End?

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How To Share Any Savings

- Develop Plan To Share Savings as Part of Application
- Will Amount Shared As Measured Against Continued FFS Be Meaningful? Will ACO Participants Have Sufficient Incentive To Be Committed To Care Coordination?

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What Happens After 3 Years?

- Resetting of Costs and Expenditures To Determine Benchmark
- If Use Same Method, Then Expenditure Benchmark Reduced By Prior Success
- If Quality Improves in First 3 Years, Is Continued Improvement Quality Going To Be Possible?
- Harder to Realize Shared Savings After 3 Years and Shared Losses May Be More Likely

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Antitrust

- Must Measure PSA Share of Independents
- PSAs Include Each Physician Specialty With Independents and Independent Hospitals' Major Diagnostic Groups
- If More Than 50% Share in Any PSA, Mandatory Approval of FTC or DOJ to Participate
- What of a Tertiary Hospital, COE or Other Provider With High PSA Share

One Advantage: if Participate in Medicare SSP and Meet Antitrust Safe Harbor, Can Jointly Contract in Commercial Markets (if Similar Governance and Operations)

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Other Issues

- Commitment of Participants?
- Independent Hospitals and Specialists: Little To Lose By Participating But Why Would They Be Committed to Success?
- CMS Can Change Rules

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Requirements for Inclusion with an Application to Participate in the MSSP

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Application Requirements

	Requirement
Governance / Leadership Requirements	
1.	Evidence that the ACO is recognized as a legal entity in ___________ (the State in which it was established) and that it is authorized to conduct business in _____________, _______________, ________________ (each State in which it operates). *(19540-19541, 19543; 42 CFR § 425.5(d)(7)(ii))*
2.	Evidence that the governing body is a separate legal entity. (19643; 42 CFR § 525.5(d)(8)(v)(C))
3.	Description of the ACO's organizational and management structure, including: • an organizational chart, • a list of committees (including names of committee members) and their structures, and • job descriptions for senior administrative and clinical leaders. (19543, 19643, 19644; 42 CFR § 525.5(d)(9)(ix)(C))
4.	Evidence that the ACO has a board-certified physician as the ACO's medical director. The medical director must be licensed in the State in which the ACO resides. (19543, 19644; 42 CFR § 525.5(d)(9)(ix)(D))

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Application Requirements

	Requirement
5.	Evidence that the ACO's leadership structure identifies an individual to serve as the ACO's principal CMS liaison. (18543, 19644; 42 CFR § 525.5(d)(9)(ix)(D)).
6.	Evidence that the governing body includes persons who represent ACO participants, and that these representatives hold at least 75% control of the governing body. (19543, 19644; 42 CFR § 525.5(d)(9)(ix)(E))
7.	Evidence of patient involvement in ACO governance. (19645, 42 CFR § 425.5(d)(15)(ii)(B)(2)
8.	A description of how the ACO will partner with community stakeholders. ACOs that have a community stakeholder organization serving on their governing body would be deemed to have satisfied this criterion. (19541, 19644; 42 CFR § 525.5(d)(9)(ix)(H))
9.	Upon request from CMS, documents effectuating the ACO's formation and operation, including: charters, by-laws, articles of incorporation, and partnership, joint venture, management, or asset purchase agreements. (19543, 19644; 42 CFR § 525.5(d)(9)(ix)(F))

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Application Requirements

	Requirement
Compliance and Quality	
10.	Request for beneficiary claims data (if desired). If beneficiary claims data is requested, include a description of how the ACO intends to use these data to: • evaluate the performance of ACO participants and ACO providers/suppliers, • conduct quality assessment and improvement activities, and • conduct population-based activities to improve the health of its assigned beneficiary population. (19557, 19652; 42 CFR § 425.19(d)(1))
11.	Documentation of the ACO's plans to promote evidence-based medicine, including a description of the evidence-based guidelines the ACO intends to establish, implement, and periodically update. (19547; 19545-46; 42 CFR § 425.5(d)(9)(ix)(A); (42 CFR § 425.5(d)(15)(i))
12.	Documentation of the ACO's plans to promote beneficiary engagement, including a description of the patient engagement processes the ACO intends to establish, implement and periodically update. (19546, 19645; 42 CFR § 425.5(d)(15)(i))

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Application Requirements

	Requirement
13.	Documentation of the ACO's plans to internally report quality and cost metrics, including a description of the process to report internally on quality and cost measures, how the ACO will use this process to meet the needs of the ACO’s Medicare population and make modifications in the ACO’s care delivery. (19546, 19645; 42 CFR § 425.5(d)(15)(i))
14.	Documentation of the ACO's plans to coordinate care. (19546, 19645; 42 CFR § 425.5(d)(15)(i); 42 CFR § 425.5(d)(15)(ii)(B)(5))
15.	A copy of the ACO’s compliance plan or documentation describing the plan that will be put in place at the time the ACO’s agreement with CMS becomes effective. (19552, 19644; 42 CFR § 425.5(d)(9)(ix)(G))
16.	Description of the scope and scale of the quality assurance and clinical integration program, including documents that describe all relevant clinical integration program systems and processes, such as the internal performance standards and the processes for monitoring and evaluating performance. (19543, 19644; 42 CFR § 425.5(d)(9)(ix)(B))

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Application Requirements

	Requirement
17.	Description of the beneficiary experience of care survey (using the Clinician and Group CAHPS survey, including an appropriate functional status survey module) and how the ACO will use the results to improve care over time. (19548-19549, 19645; 42 CFR § 425.5(d)(15)(ii)(B))
18.	Description of the ACO's process for evaluating the health needs of the ACO's population, including considerations of diversity and a plan to address the needs of the ACO's Medicare population. (19548, 19550; 42 CFR § 425.5(d)(15)(ii)(B)(3))
19.	Description of the ACO's individualized care program, along with sample care plans and an explanation of how this program is used to promote improved outcomes for, at minimum, the ACO's high-risk and multiple chronic care patients; describe additional populations that would benefit from individualized care plans (19548, 19551; 42 CFR § 425.5(d)(15)(ii)(B)(4))
20.	Written standards for beneficiary access and communication, which must include ACO's process for beneficiaries to access their medical record (19548, 19644; 42 CFR § 425.5(d)(9)(ix)(I); 42 CFR § 425.5(d)(15)(ii)(B)(8))

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Application Requirement

	Requirement
Shared Savings and Losses, Repayment Obligations	
21.	Description of how the ACO's proposed plan will distribute savings, including: • the criteria the ACO plans to employ for distributing shared savings among participants, • how the ACO will achieve the specific goals of the MSSP, • how the ACO will achieve the general aims of better health for populations, and lower growth of expenditures. (19544-19545, 19644; 42 CFR § 425.5(d)(11))
22.	Documentation of the ACO's ability and mechanism (reinsurance, escrowed funds, surety bonds, letter of credit that the Medicare program can draw upon, another appropriate repayment mechanism) to ensure repayment of any losses to the Medicare program. Required in initial application for both one- and two-sided models. (10615, 19623, 19643; 42 CFR § 425.5(d)(6)((B)(iv))
23.	Provide copies of signed agreements with ACO participants establishing their liability, including the percentage of shared losses that each ACO participant would be responsible for. (19622)

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Application Requirements

	Requirement
Anti-Trust Analysis	
24.	Letter from the reviewing Antitrust Agency confirming no present intent to challenge or recommend challenging proposed ACO. Required for any ACO with a PSA share above 50 percent for any common service that two or more ACO participants provide to patients from same PSA (except those who qualify for rural exception). (19629, 19631, 19642, 19653; 42 CFR § 425.21(a)(3)(iii))
ACO Participants' Rights and Obligations	
25.	ACO documents (for example, participation agreements, employment contracts, and operating policies) that describe: • ACO participants' and ACO providers/suppliers' rights and obligations in the ACO, • the shared savings that will encourage ACO participants and ACO providers/suppliers to adhere to the quality assurance and improvement program, and • evidenced-based clinical guidelines. (19543, 19644; 42 CFR § 425.5(d)(9)(ix)(A))

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Application Requirements

	Requirement
26.	Certification by an ACO executive who has the authority to bind the ACO that ACO participants are willing to become accountable for, and to report to CMS on, the quality, cost, and overall care of ACO beneficiaries. (19544, 19552, 19642; 42 CFR § 425.5(d)(1))
27.	Provide copies of signed agreements with ACO participants establishing their liability, including the percentage of shared losses that each ACO participant would be responsible for. (19622; 42 CFR 425.5(d)(9)(ix)(A))
28.	Upon request from CMS, descriptions of the remedial processes that will apply if an ACO participant or an ACO provider/supplier fails to comply with the ACO's internal procedures and performance standards, including a CAP and the circumstances under which expulsion from the ACO could occur. (19543, 19644; 42 CFR § 525.5(d)(9)(ix)(F)(8))

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Submission Deadlines

- ACO applications must be submitted by the deadline established by CMS. (42 CFR § 425.18(a))
- CMS will determine whether to approve or deny applications from eligible organizations prior to the end of the calendar year in which the applications are submitted. (42 CFR § 425.18(a))
- FTC/DOJ antitrust review (application must be submitted at least 90 days prior to the date of submission to CMS)
- Footnote 35 states that "if CMS sets November 1 as the last date for accepting applications to begin participation in the Shared Savings Program on January 1, 2012, then the Agency must receive all of the above documents and information on or before August 3, 2011." The "above documents" include the proposed application for participation to be submitted to CMS.

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Aspects of the Proposed Rules and Policies Warranting Comments

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Comments - Process

- To be assured of consideration,
  - comments must be received at one of the addresses provided in rules.
  - no later than 5 p.m. on June 6, 2011.
- In commenting, refer to file code CMS–1345–P.
- Fax comments will not be accepted.

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Comments - Process

- Comments may be submitted in one of four ways:
  - 1. Electronically.
  - 2. Regular mail.
  - 3. Express or overnight mail.
  - 4. Hand or courier.

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Comments – SSP Overview

- CMS believes Medicare Shared Savings Program (SSP) should provide entry point for all willing organizations who wish to move in a direction of providing value-driven healthcare.

- Therefore, CMS is proposing for comment creating and implementing both a shared savings model (one-sided model) and a shared savings/losses model (two-sided model).

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Comments – ACO Participants

- CMS specifically requests comments on:
  - (1) Kinds of providers and suppliers that should or should not be included as potential ACO participants;
  - (2) Potential benefits or concerns regarding including or not including certain provider or supplier types;
  - (3) Administrative measures that would be needed to effectively implement and monitor particular partnerships;
  - (4) Other ways for CMS to allow independent participation of providers and suppliers not specifically mentioned in statute, for example, through an ACO formed by a group of FQHCs and RHCs; and
  - (5) any operational issues associated with CMS proposal.

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Comments – Distinct Legal Entity

- CMS solicits comment on whether it should require all ACOs participating in SSP to be formed as a distinct legal entity
  - Appropriately recognized and authorized to conduct its business under applicable State law.
  - Could an existing (as opposed to new) legal entity be permitted to participate in SSP as an ACO, including entities that have similar arrangements with other payors.
- CMS proposes that if an existing entity, such as a hospital, employing ACO professionals would like to include as ACO participants other providers of services and suppliers who are not already part of its existing legal structure,
  - a separate entity would have to be established
  - to provide all ACO participants a mechanism for shared governance and decision making.

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Comments - Structure

- CMS solicits comment on proposal for required legal structure and other suitable legal structure requirements.
- CMS intends to encourage not-for-profit, community-based organizations to participate in SSP.
- Would requirements for creation of separate entity create disincentives for formation of ACOs?
- Is there an alternative that could be used to achieve aims of shared governance and decision making and the ability to receive and distribute payments for shared savings?

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Comments - Structure

- CMS wishes to provide potential ACOs with some flexibility on corporate governance and ACO formation.

- CMS is concerned that allowing existing entities to be ACOs would complicate monitoring and auditing.

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Comments - Structure

- CMS requests comment on whether more or less than 75 percent control of the governing body being held by ACO participants is appropriate percentage.
- Stakeholders have told CMS that in the private sector, entrepreneurial management companies and health plans have expressed interest in forming or participating in ACOs.
- Lack of infrastructure and capital are issues.

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Comments – Participation Agreement

- For first round of SSP, CMS proposes to limit participation agreements to a 3-year period.

- CMS seeks comments on whether a longer agreement period should be considered initially.

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Comments – Obligations of ACO Participants

- CMS intends that
  - all ACOs, ACO participants, and ACO providers/suppliers with direct or indirect obligations under SSP be subject to requirements of agreement between the ACO and CMS.
  - all certifications submitted on behalf of ACO in connection with SSP application, agreement, shared savings distribution, or otherwise extend to all parties with obligations to which the particular certification applies.
- CMS asks for comments on best way to achieve this.

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Comments - Payments

- CMS proposes to make shared savings payments directly to ACO, identified by its taxpayer identification number (TIN).
- TIN may, or may not, be enrolled in Medicare program, unlike ACO participant TINs that are Medicare enrolled groups of providers of services and suppliers.
- Because statute contemplates payment directly to ACO, CMS proposes to pay ACO TIN directly.
- Program integrity concerns: payments to a non-Medicare-enrolled entity could impede recoupment of overpayments.
- This is part of rationale for payment withhold, as well as other safeguards.
- CMS solicits comments on proposal to make shared savings payments directly to ACO, as identified by its TIN.
- CMS also solicits comment on proposal to make shared savings payments to a non-Medicare-enrolled entity.

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Comments – Number of ACO Professionals

- CMS proposes that ACO would be determined to have a sufficient number of primary care ACO professionals to serve the number of Medicare beneficiaries assigned to it if number of beneficiaries historically assigned over three-year benchmarking period exceeds 5,000 threshold for each year.

- CMS solicits comment on this proposal and any additional guidance that could be considered for meeting these requirements.

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Comments – Consequences of Falling Below 5,000

- If during first year, an ACO’s assigned population fell below 5,000, CMS would issue a warning
  - notifying ACO of variation in their assigned population.
- ACO would be placed on a corrective action plan which could
  - include, for example, a plan to add more primary care providers to ACO.

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Comments – Drop Below 5,000

- ACO would remain eligible to share in savings for year one.
- If ACO stayed below 5,000 by end of second year, then ACO's agreement would be terminated and it would not share in savings for second year.
- CMS would reserve right to review status of ACO while on corrective action plan and terminate agreement on basis that ACO no longer meets eligibility requirements.
- CMS requests comment on this proposal and on other potential options for addressing situations where the assigned beneficiary population falls below 5,000.

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Comments – Patient Centeredness

- CMS proposes criteria for patient centeredness and asks comments on whether criteria contain redundancies.
- CMS also asks comments on whether patient centeredness criteria are sufficient or whether there should be additional criteria so as to meet the goals of improving quality of health care delivery and improving patient satisfaction with their care.
- CMS seeks comments on whether these criteria are burdensome and whether they might create disincentives to participate or make it difficult for small entities to participate in SSP.

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Comments – Beneficiaries in Governance

- Beneficiary involvement in governance.
- There may be concerns or differences in the ability of some ACOs to include a beneficiary on governing board under State law.
- CMS seeks comment on the inclusion of a Medicare beneficiary serviced by the ACO on the governing body.
- CMS concern about conflicts of interests:
  - any patient(s) included in ACO's governing body, or an immediate family member, must not have any conflict of interest,
  - may not be related to an ACO provider/supplier within ACO's network.

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Comments – Is There Time to Start up on 1/1/12?

- The clock is ticking!
- CMS is concerned about ACOs getting applications submitted in time to meet 1/1/12 start date.
- CMS solicits comments on alternatives that would allow greatest number of qualified organizations to apply to participate in first year of program.
- One example: first year could have additional start date of July 1 and a 3.5 year agreement period.

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Comments – Claims Data

- Accurate claims data is essential.
- CMS is balancing need to ensure accurate and complete claims data to determine shared savings with need to provide timely feedback to ACOs.
- Regardless of whether a 3-month or 6-month claims run-out period is used, CMS is concerned that some claims (for example, high cost claims) may be filed after the claims run-out period which would affect the accuracy of the amount of the shared savings payment.

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Comments – Claims Data

- CMS asks for comments on ways to address claims issue, including
  - applying an adjustment factor determined by CMS actuaries to account for incomplete claims, and
  - termination of ACO's agreement if ACO found to be holding claims back, or attributing claims submitted after the run-out period to the following performance period.

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Comments – Claims Data

- CMS proposes using a 6-month claims run-out to calculate the benchmark and per capita expenditures for the performance year.
- 6-month claims run-out will allow more accuracy in determination of the per capita expenditures associated with each respective ACO.
- Use of a 6-month claims run out will delay the computation of shared savings payments and the provision of feedback to participating ACOs.
- CMS believes trade-off for a more accurate calculation of per capita costs is warranted.
- CMS seeks comment on whether there are additional considerations that might make a 3-month claims run-out more appropriate.

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Comments - Data

- Rules contain extensive and very important provisions for
  - Timing and process for evaluating share savings.
  - Data sharing.
  - Sharing aggregate data.
  - Sharing beneficiary identifiable claims data.
- CMS understands rules are far from optimal and is very interested in comments from industry to improve access and use of data within legal boundaries.

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Comments – Privacy Issues

- Medicare Act generally bars the disclosure of information absent patient authorization unless a statute or regulation provides for disclosure.

- CMS believes that
  - HIPAA Privacy Rule permits disclosure for purposes of sharing Medicare Part A and B claims data with ACOs participating in SSP.
  - Regulations governing sharing of Part D data would permit CMS to share information regarding prescription drug claims with ACOs.
  - Proposed disclosures of claims data under Parts A, B, and D are consistent with the purposes for which the data were collected.

- Thus, disclosures would be permitted under the Privacy Act if an appropriate Privacy Act System of Records ''routine use'' is in place prior to making any disclosures.

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Alternatives to Participation for Providers

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Hot Off The Press

- Advance Payment Initiative
  - An advance on shared savings based on expected earnings as a monthly payment
  - Based on each "aligned" Medicare beneficiary
  - Requires a plan to build care coordination capabilities
  - To be recouped from savings

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The Pioneer ACO Model

- Designed for organizations and providers experienced in care coordination
- To "allow these provider groups to move…from a shared savings payment model to a population-based payment model
- On a track consistent with, but separate from MSSP
- To work in coordination with private payers
- Higher share of savings than currently proposed
- "Strong patient protections"

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PPACA Based Alternatives

- Health homes for enrollees with chronic conditions (Sec. 2703)
- PACOs (Sec. 2706)
- Innovation Center projects (Sec. 3021)
- Other demonstration projects (e.g. Sec. 399-Z-`1 – School Based Health Centers; Sec. 3023-- Payment Bundling; Sec. 2704– Hospitalization
- Structures which fit into the AKS and Stark Exceptions
  - Managed care exceptions
  - The other stuff: co-management, gainsharing, practice acquisition, etc.

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Clinical Integration Today

- Statements of Antitrust Enforcement Policy in Health Care
  - Statements 8 and 9
- The FTC Advisory Opinions
  - TriState Health Partners, Inc. (April 13, 2009)
  - Greater Rochester IPA, Inc. (September 17, 2007)

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Statement 9: Multiprovider Networks

- Rule of reason treatment
- A comment on messenger model arrangements
- The PHO examples

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The Health Home: A leading PPACA alternative

- Eligible individuals
- The services to be provided
- The Health home or designated provider
- A comparison with the ACO

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The Managed Care and Other Available AKS/Stark Exceptions

- 42 C.F.R. – 1001.952
  - (m) – Price reductions offered to health plans
  - (t) – Price reductions offered to eligible managed care organizations
- 42 C.F.R. 411.355(c) – Services to enrollees of prepaid plans
- 42 C.F.R. 411.357
  - (d)(2) – Physician incentive plan exception
  - (n) – Risk-sharing arrangements

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Questions and Answers

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