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FALL 2011 NEWSLETTER

As 2011 draws to a close, we would like to wish you a happy holiday season and encourage you to carefully set your priorities for 2012. Managing a successful medical practice remains a challenging undertaking, so make sure you are well-positioned to thrive in an ever-changing regulatory and reimbursement climate.

Speaking of regulatory environment, this newsletter focuses on important changes in the Final Rule on Accountable Care Organizations (ACOs). Our Summer 2011 newsletter describes the essential features. Responding to comments and suggestions by the medical community, the Centers for Medicare & Medicaid (CMS) has made significant changes that should enhance provider interest in participating in this shared savings program.

Margie Satinsky

WHY THE ACO IS WORTH A SECOND LOOK

1. Did the Final Rule change the original definition and goals of Accountable Care Organizations (ACOs)?

No – the ACO concept remains the same as it was in the Proposed Rule. ACOs are provider-based organizations that assume the responsibility for meeting the healthcare needs of a defined population. ACOs are expected to coordinate the treatment of patients across the continuum of care, including physician practices, hospitals, skilled nursing facilities, long term care facilities, and other providers and suppliers of Medicare-covered services. Like the concept, the goals of ACOs remain unchanged: promote accountability for a patient population comprised of Medicare fee-for-service beneficiaries; coordinate covered items and services in Medicare Parts A and B; and encourage investment in the infrastructure and redesigned care processes that lead to high quality and efficient service delivery.

2. Does the Final Rule expand the types of providers that can apply to become ACOs?

Yes - now Federally Qualified Health Centers, Rural Health Clinics, and Community Health Centers can apply to become ACOs.

3. Is there an opportunity for small and mid-sized physician practices to become ACOs?

Yes – in fact, the Final Rule specifically states that there is no requirement that an ACO include a hospital. CMS supports flexibility in the types of organizations that participate in the program.

4. The concept of shared savings puts providers of care at risk for the cost of care that they deliver to a defined population. What changes did the Final Rule make to physician risk?

The Final Rule reduces physician financial risk. There are now two tracks for assuming risk. Under track #1, a one-sided model, physicians can share in the first dollar savings of any savings that they generate. Previously, the savings could be shared only after 2 percent had been withheld. The change allows physicians to redirect their share of the savings to enhanced quality efforts. Under track #2, a two-sided model, ACOs share in both savings and losses and ACOs are eligible for a higher percentage of savings than they had been under the Proposed Rule.

5. How have the reporting requirements for ACOs changed?

The Final Rule reduces the reporting burden by decreasing the required quality reporting from 65 measures in 5 domains to 33 measures in 4 domains. ACOs can now phase in their reporting over a three-year period.

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6. Are all primary care providers who participate in ACOs required to have EHRs in place?

No – CMS dropped the requirement that 50 percent of participating PCPs have EHRs by the end of the second performance year. Now the quality measures are heavily weighted in favor of PCPs having EHRs.

7. The Proposed Rule did not allow ACOs to prospectively know which Medicare beneficiaries were assigned to them. Has this feature changed?

Yes – and in a way that is far more favorable to providers. CMS will prospectively make a preliminary assignment of patients to an ACO at the beginning of each performance year and also provide quarterly updates. At the end of the performance year, CMS will make a retrospective adjustment. With this change, ACOs will have some idea of the population for which they are responsible.

8. The Proposed Rule didn't recognize the fact that subspecialists provide primary care to many people. Has that feature been modified?

Yes – the Final Rule recognizes the role that many subspecialists can play as primary care providers.

9. Can primary care physicians participate in more than one ACO?

Yes – the Final Rule recognizes that many primary care physicians have privileges at more than one hospital and may want to participate in more than one ACO. Specialists have always been able to participate in multiple ACOs.

10. The ACO concept has implications far beyond the delivery of care. In fact multiple federal agencies are involved in its implementation. What changes have occurred with the Final Rule?

The Department of Health and Human Services and the Office of the Inspector General have released an Interim Final Rule waiving provisions of Physician Self-Referral Law, Federal Anti-Kickback Statutes, and Civil Monetary Penalty laws. Also, an ACO no longer needs to obtain mandatory anti-trust clearance by the Federal Trade Commission and the Department of Justice.

11. A concern of many potential ACOs was that without historical claims data, they would have difficulty setting and achieving targets for savings. How has CMS addressed this issue?

CMS is now committed to provide Medicare Parts A, B, and D claims data to ACOs for initial benchmarking.

12. How does the Final Rule address the concern that many providers expressed about the cost of setting up an ACO?

When CMS announced the Final ACO Rule it also announced a program directed toward physician-owned and rural providers participating in the Medicare Shared Savings Program. CMS now offers financial support for up to 50 ACOs that need capital to participate in the ACO program. Participating ACOs will receive both up front and monthly bundled payments that will be recouped from their earned shared savings distributions. ACOs that participate in this program will not be liable to repay Medicare if their earned shared savings do not equal the advanced payments and they complete the full, initial agreement period.

13. When can ACOs begin?

The Final Rule provides flexible start dates – April 1, 2012 and July 1, 2012 – based on submission of a Notice of Intent (NOI) by either January 6 (for the April starting date) or February 17 (for the July starting date).

14. Where can I get more information about ACOs?

a. American Medical Association Health System Reform Insight e-newsletter (**http://www.ama-assn.org**)

b. American College of Physicians (**http://www.acponline.org**)

c. The Commonwealth Fund (**http://www.commonwealthfund.org**)

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d. North Carolina Medical Society (**http://www.ncmedsoc.org/pages/advocacy_govt_affairs/accountable_care.html**)

e. The Carolinas Center for Medical Excellence (**http://www.thecarolinascenter.org**)

f. Medical Group Management Association (MGMA) (**http://www.mgma.com**)

g. Healthcare IT News (**http://www.healthcareitnews.com**)

h. Shared Savings Program (ACO) Final Rule (**http://www.HealthCare.gov/law/resources/regulations/index.html**)

i. Advance Payment ACO Model (**http://innovations.cms.gov/initiatives/aco/advance-payment/index.html**)

j. Smith Anderson - The ACO Guide, 2011 (**http://www.smithlaw.com/publications/ACOG.pdf**)

How Satinsky Consulting, LLC Can Help Your Medical Practice

As you determine where your organization fits into the world of value based payment, let us help you with the following important tasks:

- **Practice Assessment:** Request an outside view of your organization and management structure; financial management (including managed care and revenue cycle management); planning and marketing; human resources; operations; and compliance.
- **Compliance with HIPAA Privacy and Security Rules:** Make sure you comply with HIPAA Privacy and Security Rules and with the 2009 updates. Our customized materials guide you through the requirements, provide policies and procedures, and help you train your staff. Penalties are stiffer, and they are enforced, so don't delay. (See our **Winter 2011 newsletter**.)
- **Revenue Cycle Management:** As methods of payment change, make sure you understand all the steps involved in maximizing revenue. We help with managed care contracting, work flow analysis, and efficiency in billing and collections.
- **Revenue Enhancement through Participation in Incentive Programs:** We can help you meet the requirements for Meaningful Use and understand the implications of ACOs for your practice. Get more details on the Meaningful Use incentive in three of our previous newsletters – **Summer 2010**, **Fall 2010**, and **Spring 2011**.
- **Software Companies:** More and more software companies are finding themselves needing to address HIPAA requirements. We now provide consulting services to help software companies understand the ins and outs of HIPAA Compliance.

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