CMS Finally Speaks (Again): The Medicare Shared Savings Program Final Rule and its Relevance to Anesthesiologists

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In the Summer 2011 issue of the Communique, we analyzed the then-new Medicare Shared Savings Program ("MSSP") accountable care organization ("ACO") proposed rule ("Proposed Rule") (issued by the Centers for Medicare and Medicaid Services ("CMS") on April 7, 2011) as it related to anesthesiologists.

At that time, physicians' desire for involvement in the MSSP (which was born as part of President Obama's healthcare reform law) was bleak, at best. The Proposed Rule introduced barrier after barrier after barrier that left the medical community disappointed and angry. Anesthesiologists were left with no clear understanding of the role they would play in the new push for better care for individuals, better health for populations, and lower growth in expenditures—CMS' three-part aim for ACOs. Anesthesiologists were dubious as to whether they would actually enjoy a piece of the Medicare shared savings pie. But they were also confident that the anesthesia community would certainly not reap such benefits if the MSSP final rule ("Final Rule") mirrored the Proposed Rule.

Fortunately, CMS received 1,320 comments on the Proposed Rule from various physician advocates, including the American Society of Anesthesiologists ("ASA"). As noted above, the Proposed Rule was not received well by the

healthcare community and, accordingly, a large percentage of these comments were laden with criticisms. In response to the feedback it received, CMS made some "significant" modifications to the MSSP in the Final Rule published on November 2, 2011, including the following:

- Greater flexibility in participation eligibility;
- Multiple start dates in 2012 and longer agreement period for those starting in 2012;
- Greater flexibility in the governance and legal structure of an ACO;
- Simpler quality performance standards;
- Adjustments to the financial model to increase financial incentives (and decrease in disincentives) for participation; and
- Greater flexibility in timing for the evaluation of sharing savings and the repayment of losses.

This article will examine each of these significant modifications in more depth, comparing the provisions of the Final Rule to the provisions of the Proposed Rule and setting forth the impact this will have on the anesthesia community, as a whole.

Greater Flexibility in Eligibility

Consistent with the Proposed Rule, CMS determined that the following entities (or combinations of entities) may form ACOs:

- ACO Professionals (physicians or practitioners) in group practice arrangements;
- Networks of individual practices of ACO Professionals;
- Partnerships or joint venture arrangements between hospitals and ACO Professionals;
- Hospitals employing ACO Professionals;
- Certain critical access hospitals;
- Rural health centers; and

- Federally qualified health centers.

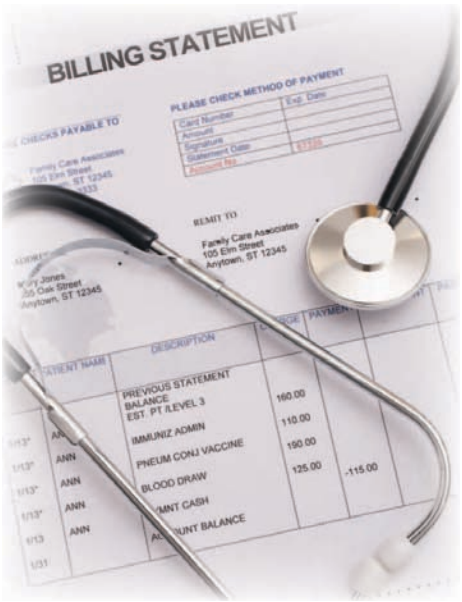
Moreover, CMS maintained that Medicare enrolled entities not specified in the list above may participate in the MSSP by joining an ACO formed by one or more of the organizations listed above.

Multiple Start Dates and a Longer Agreement Period in 2012

According to Section 3022 of the Patient Protection and Affordable Care Act ("PPACA"), the MSSP is to be established no later than January 1, 2012, and ACOs in such program must participate for a period of not less than three years (i.e., three performance years). However, CMS, recognizing its short timeframe in implementing the MSSP, will accept ACO applications in early 2012 and established two start dates for this first year. The first start date, April 1, 2012, will have a 21-month long first performance year, while the second start date, July 1, 2012, will have an 18-month long first performance year. Irrespective of the start date, the first performance year will end on December 31, 2013 and all ACO participation agreements will terminate on December 31, 2015.

Greater Flexibility in Governance and Legal Structure

CMS proposed that ACOs exhibit shared governance (in which the ACO participants would have appropriate control over the decision-making process) in the form of governing boards (e.g., a board of directors, board of managers, etc.) ("Board"). The Board would be tasked with executing the functions of the ACO, including promoting evidenced-based medicine, coordinated care and patient engagement. Seventy-five percent of the Board would be comprised of ACO participants (with this 75% being comprised of a representative from each ACO participant organization) and



25% of the Board would consist of the Medicare beneficiaries served by the ACO, non-providers, etc. This proposal was met with both criticism and praise.

Proponents of the proposal supported the 75% Board composition resting with the ACO participants as they believe the ACOs should be provider driven. Opponents of the proposal, however, contended the 75% threshold "is overly prescriptive, will prevent many existing integrated systems from applying, fails to acknowledge that governing bodies will balance representation across all the populations it covers for multiple payers that may, for instance, encourage participation of local business on the governing body, and will be unnecessarily disruptive to many organizations, especially those with consumer-governed boards." Opponents believed that there should not be a one-size-fits-all approach to governance and that each governing body would need to be structured differently depending on its historical makeup, the interest in participation and other market dynamics.

In its Final Rule, CMS solidified the 75% ACO-participant representation and the 25% "other" representation on the Board. However, in order to provide the Board and the ACO with greater flexibility, CMS eliminated its requirement that a representative from each ACO participant be included on the Board. CMS stated, "we believe that ACOs should have flexibility to construct their governing bodies in a way that allows them to achieve the three-part aim in the way they see fit." Consequently, CMS has also allowed for a degree of innovation for ACOs unable to meet the 75% threshold or the beneficiary representation on the Board. Boards seeking varying Board representations (due to their inability to meet the requirements) must describe how the proposed-ACO governance will involve ACO participants in innovative ways and/or why the different governance structure will provide for meaningful participation by Medicare beneficiaries. In this respect, CMS has made participation in the ACO more capable of meeting the needs of both those who participate in the ACO, as well as those beneficiaries receiving care from the ACO.

Anesthesiologists interested in joining an ACO should be attentive to the ACO's governance structure, the opportunities for anesthesiologists to become actively involved in ACO leadership and the mechanisms in place for distributing shared savings to anesthesiologists and others. The shared savings available to anesthesiologists under the MSSP through their respective ACO will be dependent upon the collective performance of the ACO and not the anesthesiologists alone. Because participants will be *sharing* in cost savings, all providers and suppliers will be dependent upon each other to maximize savings and, in turn, maximize their individual return on their efforts to promote efficiency and integration of medical care. As such, anesthesiologists should be aggressive in their representation in the ACO and on its Board to ensure their interests are adequately represented.

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Simpler Quality Performance Standards

In its Proposed Rule, CMS called for 65 quality performance standards, spanning five quality domains (patient experience of care, care coordination, patient safety, preventive health, and at-risk population/frail elderly health) that, if achieved, would result in greater savings to the ACO and, thus, greater return in the shared savings. After reviewing the comments received, CMS removed what it called "redundant, operationally complex or burdensome measures," reducing the number of quality performance standards to a more-manageable 33 quality performance standards, spanning four quality domains that are very similar to the proposed domains (patient/caregiver experience, care coordination/patient safety, preventive health and at-risk populations). Of these 33 measures being finalized, 22 will be collected using the Group Practice Reporting Option interface, seven will be collected using patient surveys, three will be collected using claims, and one will be calculated from electronic health record ("EHR") incentive program data.

CMS recognized that requiring ACOs to achieve all 33 measures may not be feasible and may result in unreasonable burdens upon ACOs. As such, in the Final Rule, CMS requires that ACOs need only achieve the prescribed quality performance standard on 70% of the measures in each of the four domains. Those ACOs that do not reach the 70% mark will trigger a corrective action plan and re-evaluation. Continuing to fall short of the 70% performance standard will result in being terminated from the MSSP.

It is important to note that even if a particular quality performance standards does not target anesthesiology, the quality of anesthesiology services provided to patients will directly impact performance on standards relating to patient experience and will indirectly impact performance in other areas. Irrespective of whether the standards specifically address anesthesiology services, anesthesiologists will play an important role in the performance of their ACOs.

Beneficial Adjustments to the Financial Model

Under the Proposed Rule, CMS outlined two financial models. ACOs would choose one of these two models and then participate in the MSSP under such model during its *first* three-year participation agreement.

The first model—the one-sided risk model ("Track 1")—allowed for limited downside risk; the ACO would share in the savings (sharing beginning at a savings of 2%, with some exceptions) in the first two years of the agreement without being responsible for the losses above the expenditure target. During the third year, the ACO would have been required to share in any losses and savings. CMS designed Track 1 to be most appropriate for and desirable to less experienced ACOs.

The second model—the two-sided risk model ("Track 2")—provided that the ACO would share in both the losses and the savings for all three years, with sharing beginning at the first dollar. After an ACO's first three-year-term agreement to participate in the MSSP has terminated, CMS proposed all ACOs participate in Track 2. Track 2 is a viable option for more-experienced ACOs that are prepared to share in both losses and savings.

Many in the healthcare community expressed concern regarding the shared risk in the third year of Track 1. Under the Final Rule, CMS finalized its two-model approach to ACOs participating in the MSSP. However, notably, those ACOs electing to participate in Track 1 will not share in any risk. Track 2 remains a risk-

sharing model for all three years of the initial participation agreement. For both Track 1 and Track 2, savings would begin on the first dollar once a Minimum Savings Rate ("MSR") has been achieved; however, the MSR will vary based on size for ACOs choosing to participate in Track 1 and will be a flat 2% for ACOs choosing Track 2.

Other important changes made by CMS to the MSSP financial model under the Final Rule include the elimination of the performance payment withhold as a mechanism to offset future losses of each ACO. Under the Proposed Rule, CMS would apply a mandatory flat 25 percent withhold each year to any shared savings payment earned by an ACO. In response to concerns expressed by many commentators, CMS elected not to adopt the proposed withhold of shared savings. CMS determined that such withhold was unnecessarily burdensome to ACOs and that CMS had other sufficient mechanisms available to ensure that ACOs who assume risk will be accountable for the shared losses they may incur.

Before participating in an ACO, anesthesiologists should gather information regarding the experience of the ACO and its ACO participants, the track selected by the ACO and its MSR, if applicable, the individual obligations that anesthesiologists will be required to fulfill and the collective benchmarks that the ACO participants as a group will need to achieve. Anesthesiologists should take the time and expend the effort necessary to understand their individual down-side risk to ACO participation before committing.

Greater Flexibility with Respect to Timing Constraints

PPACA provides that ACOs that participate in the MSSP shall be eligible to receive shared savings payments on an annual basis if the ACO has met the quality performance standards and has achieved the required percentage of cost savings. Such calculation is made based upon claims submitted by providers and suppliers for services and supplies furnished to ACO beneficiaries. However, PPACA does not provide a period during which CMS must make such shared savings determination. In the Proposed Rule, CMS suggested a six-month claims run-out period to calculate shared savings payments but acknowledged that the length of such run-out period must be determined after weighing CMS's interests in gathering more accurate and complete claims data (which factor favors a longer period) with its interest in providing timely feedback to ACOs (which factor favors a shorter period). After deliberation, CMS elected to use a three-month claims run-out period.

The Final Rule also offers ACOs who assume risk flexibility in the repayment of shared losses. The Proposed Rule provided that ACOs would be required to repay CMS in full for any shared losses within 30 days of receipt of notification of the shared losses. However, under the Final Rule, CMS extended such period to 90 days.

Conclusion

As a result of the MSSP and similar programs adopted by Medicare and other third party payors, anesthesiologists today find themselves facing a new health care payment regime, which increasingly pays them for value (i.e., the quality and efficiency of medical services provided) as opposed to volume alone. Affiliating with an ACO that participates in the MSSP is one means for anesthesiologists to work with other health care providers and suppliers to improve the quality and efficiency of care and share in the resulting savings.

That being said, certainly not all anesthesiologists will participate in the MSSP through an ACO. However, in light of the changing reimbursement environment (evidenced by the MSSP and similar initiatives), all anesthesiologists, irrespective of whether they participate in an ACO or not, should continue and strengthen efforts to ensure that patients receive the highest quality of care practicable and collaborate with other health care providers and suppliers to promote patient-centered care. Whether through an ACO or otherwise, anesthesiologists will be better positioned in the future if they play an active role in the changes that are occurring within their hospitals and their healthcare communities more generally. Anesthesiologists must ensure that their voices are heard and their value to the healthcare delivery system continues to be appreciated and acknowledged.

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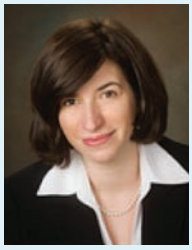

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