HEALTH REFORM IMPACT

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ACOs Part III: Three Key Ingredients for Your ACO - Quality, Quality and Quality

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Introduction

The Centers for Medicare & Medicaid Services ("CMS") published a proposed rule in the *Federal Register* on April 7, 2011 (the "Proposed Rule"), to implement provisions of the Patient Protection and Affordable Care Act ("PPACA") relating to the Medicare "Shared Savings Program." As reported in previous issues of *Health Reform IMPACT*,[1] the Proposed Rule defines and explains the functional elements of an Accountable Care Organization ("ACO"), which is a collaborative vehicle for providers and suppliers to make patient care more efficient (while simultaneously improving quality) and then to share the savings generated as a result of such increased efficiency. This issue of *Health Reform IMPACT*, the third in our series discussing the major components of the Proposed Rule, will focus on the quality reporting by, and monitoring of, ACOs.

PPACA laid the groundwork for quality reporting and monitoring by requiring CMS to analyze quality of ACOs in such areas as clinical processes and outcomes, patient and caregiver experience of care, and utilization. PPACA also requires CMS to create a reporting system to ensure that data on quality measures from ACOs are received and analyzed on a regular basis. In the Proposed Rule, CMS has attempted to clarify the mechanisms that the Shared Savings Program will use to continually measure quality and monitor the performance of each ACO.[2] The Proposed Rule is part of an overall effort by CMS to link reimbursement to quality and outcomes rather than volume.

Quality Reporting

According to the Proposed Rule, CMS will define specific "quality and continuous improvement goals" that ACOs must meet to qualify for shared savings. With the stated goals of "promoting the aims of better care for individuals, better health for populations, and lower growth in expenditures" the Proposed Rule sets forth explicit quality measure standards on which ACOs must submit data. The five domains on which CMS will evaluate ACOs are:

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[1] See "ACOs Part I: "Assembly Instructions" and "ACOs Part II: Oasis or Mirage? The FTC and DOJ Proposed Statement on ACOs."
[2] 76 Fed.Reg. 19528 *et seq.* (Apr. 7, 2011).

(1) Patient/Caregiver Experience;

(2) Care Coordination, Transitions, and Information Systems;

(3) Patient Safety;

(4) Preventive Health; and

(5) At-Risk Population/Frail Elderly Health.

In the guidance documents released with the Proposed Rule, CMS has proposed and specified 65 nationally recognized measures that span the five domains. The measures range from general process-oriented items such as "Getting Timely Care, Appointments, and Information" to specific clinical areas including immunizations, cancer screenings, and heart failure prevention. CMS has divided the measures into two sub-categories listed as "aims of better care for individuals" and "better health for populations."

CMS will designate standards for each measure, including a benchmark and minimum attainment level and scoring system. Performance below the minimum attainment level would earn zero points for that measure under both the one-sided and two-sided models of ACOs.[3] Performance equal to or greater than the minimum attainment level but less than the performance benchmark shall receive points on a sliding scale based on the level of performance. Performance at or above the benchmark for a particular quality measure receives the maximum quality score for that measure.[4]

There will be a tiered roll-out of this system. For the initial performance period, ACOs merely must engage in complete and accurate reporting, but for subsequent years CMS actually will assign quality scores for each measure. CMS will compute a score for each domain by looking at the quality scores for all measures in that domain and dividing the total points earned for all measures by the maximum points available for all measures in that domain. Upon computing scores for each domain, CMS will then aggregate the domain scores on an equally weighted basis into an overall ACO performance score that will determine whether and on what percentage basis an ACO will be eligible to receive a portion of the shared savings.

Aligning ACO Quality Measures with Other Programs

The Proposed Rule also attempts to align in certain respects the reporting requirements from the Physician Quality Reporting System ("PQRS") and the electronic health records ("EHR") incentive program with the ACO reporting requirements. For example, CMS has proposed using the Group Practice Reporting Option ("GPRO") under the PQRS for collection of data on certain ACO quality measures. Eligible professionals within an ACO can qualify as a group practice for this purpose, and ACOs can potentially be eligible for a bonus of additional incentive funds equal to 0.5 percent of the total estimated Medicare Part B Physician Fee Schedule allowed charges of the ACO's eligible professionals for each calendar year. At this time, CMS is not proposing to make such additional incentive payments available for the EHR or electronic prescribing incentive programs, although CMS

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[3] For a description of the "one-sided" and "two-sided" models, please see our earlier issue of *Health Reform IMPACT* "ACOs Part I: Assembly Instructions."

[4] There are certain "all or nothing" measures related to diabetes and coronary artery disease on which ACOs receive the maximum available points if all criteria are met and zero points if even one of the criteria is not met. "The intent of all or nothing scoring is to signal to providers that failing to perform any element of a process is unacceptable and will result in a 'zero' score for that quality measure." 76 Fed. Reg. at 19595.

does include in the Proposed Rule several quality measures that are also included in the EHR program.

CMS recognizes the potential for "confusion and administrative burdens" for parties due to the fact that CMS has already proposed, in addition to the ACO quality measures, quality measures under the inpatient hospital value-based purchasing program and the Medicaid program (i.e., under Medicaid, CMS has proposed the "Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults"). In light of the fact that all of these proposed programs "overlap in a number of areas," CMS seeks comments from affected parties on the best and most appropriate way to align quality domains.

Monitoring Mechanisms

In addition to the comprehensive quality reporting mechanisms, CMS intends to actively monitor ACOs, along with their providers and suppliers, throughout each performance year. CMS will look to several indicators of performance, including financial and quality data, site visits, beneficiary/provider complaints, and audits. Of prime concern to CMS is an ACO's compliance with quality performance standards. If an ACO fails to meet the minimum attainment level in a given domain, the ACO will receive a warning for the first time it fails to meet this level. CMS will reevaluate the ACO's compliance with the standard during the following year, but if there is still noncompliance then the ACO could be terminated from the program. Similarly, if an ACO simply fails to report required data or reports it inaccurately, CMS will request a correction and a written explanation for the shortfall. If the ACO fails to respond within the time requested by CMS or if the explanation is not "reasonable," CMS has indicated that it will terminate the ACO.

There are a few specifically described key areas of CMS' monitoring priorities. First, CMS wants to ensure that ACOs do not avoid at-risk beneficiaries. CMS will look to all reported data for trends or patterns of avoidance and could take punitive actions and will require the ACO to submit a corrective action plan ("CAP"). During the CAP, the ACO will not receive any shared savings payments nor will it earn any additional amounts; CMS could also potentially terminate the ACO if it determines that the ACO has continued to avoid at-risk beneficiaries during the CAP.

Second, CMS will continually monitor an ACO's compliance with eligibility requirements that are the threshold for participating in the Shared Savings Program. Third, each ACO must notify beneficiaries of the provider and supplier's role in the ACO and the beneficiary's freedom to opt-out of sharing his or her individual claims data. Finally, CMS will be monitoring the marketing materials and activities of each ACO to ensure that it complies with the set forth requirements.

CMS also reserves the rights to audit and review information that an ACO uses to report its data. There are sanctions in place for improper reporting, including termination from the ACO program and loss of any earned savings.

Looking Forward

The debate continues in the healthcare industry and the media as to whether the envisioned effects of ACOs will materialize into concrete implementation by providers. While there has been criticism and praise for the Proposed Rule, CMS continually reminds observers that these rules are proposed and also holds various forums to discuss potential changes. Anyone wishing to submit an official comment must do so by June 6, 2011 (note that the period for public comment on the FTJ and DOJ Proposed Statement of Antitrust Policy Regarding ACOs is May 31, 2011).

As mentioned earlier, this issue of *Health Reform IMPACT* is the third in a series dedicated to ACOs. The final installments of this series will discuss the waiver provisions, including fraud and abuse, tax, and data sharing issues contained in the Proposed Rule.

If you have questions, please contact any of the attorneys in our Healthcare Practice Group listed below.

Also, please click here to visit our special webpage on Health Reform IMPACT.

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