Role of Specialists in the Medicare Shared Savings Program (MSSP) Establishing Accountable Care Organizations (ACOs)

Background
On Oct. 20, 2011, CMS released the final rule creating the Medicare Shared Savings Program (MSSP) establishing accountable care organizations (ACOs) for Medicare beneficiaries. As outlined by CMS, ACOs consist of groups of providers who agree to work together to manage and coordinate the care of Medicare beneficiaries. They are jointly accountable for achieving measured quality improvement and reductions in the rate of spending growth.

ACOs are required to have primary care physicians (emphasis added) caring for at least 5,000 Medicare beneficiaries and have the ability to report data on cost, quality and overall patient care experience for Medicare beneficiaries. Participating groups must agree to enroll for at least three years and demonstrate the legal structure that permits them to receive payments for shared saving from CMS and distribute a portion of those payments to the groups of providers. The shared savings would be generated when the group provides care to beneficiaries for less than a Medicare benchmark cost while also meeting criteria for patient service and quality of care.

Overall Role of Specialists
As evident by CMS’s summary, the focus of the MSSP is on the role of primary care physicians in providing care to Medicare beneficiaries. However, specialists may continue to participate in the MSSP, either as an owner, an ACO CEO, an ACO participant, a member of the ACO governing body, a senior level medical director, or part of the physician-directed quality assurance and improvement program. In addition, outside of the Medicare program, specialists may opt to participate in private sector ACO initiatives.

Owner. As part of its proposed rule, CMS estimated the total average start-up investment and first-year operating expenditures for each ACO participating in the MSSP at $1.7 million, but other sources estimate that the costs will be considerably higher — $11.6 million to $26.1 million.1 Given the need for capital investment, specialists may opt to participate in the MSSP by putting real “skin in the game” and becoming part owners of the ACO.

ACO CEO. CMS finalized the requirement that the ACO’s operations be managed by an executive, officer, manager or general partner, whose appointment and removal are under the control of the organization’s governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes and outcomes.

ACO participant. A specialist may also opt to participate directly in the formation of an ACO and be defined as an ACO participant. For specialists who are not part of the beneficiary assignment process (as described below), he or she may NOT have an exclusive relationship with an ACO. Therefore, he or she will need to continue to see patients outside the ACO, which may include seeing other ACO patients or simply seeing patients who have not been assigned to an ACO.

Member of the ACO governing body. To fulfill CMS’s legal requirements, an ACO must establish a governing body. While the total number of members of the board is not defined, at least 75 percent control of the ACO’s governing body must be held by the ACO’s participants. In addition, the governing body of the ACO must be separate and unique to the ACO in the cases where the ACO comprises multiple, otherwise independent entities that are not under common control (for example, several independent physician group practices). CMS also encourages each ACO to provide for beneficiary representation on its governing body. Therefore, either as an ACO participant or as an interested community member, a specialist may opt to participate in an ACO governing body.

Senior Level Medical Director. CMS requires each ACO to establish a senior-level medical director in charge of clinical management and oversight. The director must be a board-certified physician, licensed in the state in which the ACO operates, and physically present on a regular basis in an established location of the ACO.

Physician-directed quality assurance and improvement program. CMS also requires that, as part of its application, an ACO describe how it will establish and maintain an ongoing quality assurance and improvement program, led by an appropriately qualified health-care professional. Therefore, a specialist could provide such support for an ACO.

Changes to the CMS Proposed Rule in Acknowledgement of Specialty Physicians

Although the focus of the MSSP is still on the provision of primary care services to Medicare beneficiaries, CMS made a variety of changes from the proposed rule to the final rule in acknowledgement of the crucial role of specialty physicians. These key changes include: adding the “stepwise” beneficiary assignment process, which acknowledges the role of specialty physicians; maintaining key quality measures that emphasize the need for specialty care and announcing the development of a specific module related to specialist care; and clarifying referral relationships.

Stepwise Beneficiary Assignment. Given CMS’s acknowledgment that “specialists do necessarily and appropriately provide primary care services for many beneficiaries with serious and/or chronic conditions,” CMS adopted in the final rule a stepwise beneficiary assignment process. Once CMS identifies all patients who received a primary care service from a physician who is a provider/supplier in the ACO (and who are thus eligible for assignment to the ACO under the statutory requirement to base assignment on “utilization of primary care services”), CMS will apply this two step process:

1. CMS will identify beneficiaries who had received at least one physician primary care service from a primary care physician who is a provider/supplier in an ACO. In this step, a beneficiary can be
assigned to an ACO only if he or she has received at least one primary care service from a primary care physician who is an ACO provider/supplier in the ACO during the most recent year (for purposes of preliminary prospective assignment, as discussed later in this final rule), or the performance year (for purposes of final retrospective assignment). If this condition is met, the beneficiary will be assigned to the ACO if the allowed charges for primary care services furnished by primary care physicians who are providers/suppliers of that ACO are greater than the allowed charges for primary care services furnished by primary care physicians who are providers/suppliers of other ACOs, and greater than the allowed charges for primary care services provided by primary care physicians who are unaffiliated with any ACO (identified by Medicare-enrolled tax identification number or other unique identifiers, as appropriate).

2. This step would consider only beneficiaries who have not received any primary care services from a primary care physician, either inside or outside the ACO. Under this step, a beneficiary will be assigned to an ACO only if he or she has received at least one primary care service from any physician (regardless of specialty) in the ACO during the most recent year (for purposes of preliminary prospective assignment), or the performance year (for purposes of final retrospective assignment). If this condition is met, the beneficiary will be assigned to an ACO if the allowed charges for primary care services furnished by ACO professionals who are ACO providers/suppliers of that ACO (including specialist physicians), are greater than the allowed charges for primary care services furnished by ACO professionals who are ACO providers/suppliers of each other ACO, and greater than the allowed charges for primary care services furnished by any other physician, nurse practitioner, physician assistant or clinical nurse specialist (identified by Medicare-enrolled tax identification number or other unique identifiers, as appropriate) who is unaffiliated with any ACO.

In making this adjustment, CMS further clarified that tax identification numbers, but not the national provider identifiers, under which the services of specialists are included in the assignment process, would have to be exclusive to one ACO for purposes of the MSSP.

**Quality Measures for Specialists.** After considering commenter concerns, CMS has finalized 33 of the 65 proposed quality measures. Of the 33 finalized measures, those that may have a direct impact on specialty care include:

- Consumer assessment of health providers and systems: access to specialists
- Colorectal cancer screening

In addition, CMS outlined several measures for at-risk populations, including those with diabetes, hypertension, ischemic vascular disease, heart failure and coronary artery disease.

**Access to specialists module.** In response to comments recommending that a care coordination and specialty care construct be added, CMS announced its intent to add an access to specialists module to emphasize the importance of specialty care for patients served by the ACO.
Referral relationships. While the MSSP maintains the beneficiary’s freedom under the Medicare fee-for-service program to choose any participating Medicare provider, CMS acknowledged that there will be an incentive for the ACO to require that referrals be retained among the ACO, ACO participants and ACO providers/suppliers. CMS’s initial proposal restricted any specific referral arrangements. However, in light of comments regarding the potential to disrupt arrangements that are permitted under the physician self-referral law, thereby requiring the restructuring of many legitimate arrangements, CMS modified its initial proposal to provide limited exceptions for such referral, provided:

- The referral is without restriction or limitation if the patient expresses a preference for a different provider, practitioner or supplier.
- The patient’s insurer determines the provider, practitioner or supplier.
- The referral is not in the patient’s best medical interests in the judgment of the referring party.

In addition, as part of the ACO monitoring process, CMS intends to monitor the actions of ACOs, including the results of beneficiary experience of care surveys, to determine whether an ACO, its ACO participants or its ACO providers/suppliers are interfering with the beneficiary’s freedom of choice by improperly limiting or restricting referrals and care to ACO participants or ACO providers/suppliers in the same ACO.