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If You Build It, Who Will Come?

How Medicare beneficiaries will be "assigned" to your ACO

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If your organization is considering forming or joining an Accountable Care Organization, you will want to understand which Medicare beneficiaries the ACO will be held accountable for. After all, the ACO's performance in the Medicare Shared Savings Program will be judged by the quality, cost, and overall care furnished to these patients. This advisory focuses on the methodology the Centers for Medicare & Medicaid Services proposes to "assign" Medicare beneficiaries to ACOs, as reflected in the recently proposed ACO regulations.

Section 3022 of the Patient Protection and Affordable Care Act (PPACA) requires the Secretary of the Department of Health and Human Services to determine an appropriate method to "assign" Medicare fee for service (FFS) beneficiaries to an ACO based on their use of primary care services. In commentary to the regulations, CMS notes that the term "assignment" in no way implies any limits, restrictions, or diminishment of the rights of Medicare FFS beneficiaries to exercise complete freedom of choice in the physicians and other health care practitioners and suppliers from whom they receive their services.

In fact, CMS indicates it prefers the term "alignment" of beneficiaries, as opposed to "assignment" or "attribution," because the exercise of free choice by beneficiaries in the physicians and other providers and suppliers from whom they receive their services is a presupposition of the Shared Savings Program.

Under PPACA, CMS can consider beneficiaries' use of primary care services provided by *physicians* only when assigning beneficiaries to ACOs, even though other nonphysician practitioners (e.g., physician assistants or nurse practitioners) are included in the definition of "ACO professionals" for purposes of determining whether an entity can participate in the Shared Savings Program.

To correctly associate physicians with a given ACO, CMS clarifies that it will identify an ACO operationally as a collection of Medicare-enrolled TINs (either employer identification numbers (EINs) or Social Security numbers (SSNs)). Each organization applying to be an ACO will be required to provide the TIN for each ACO participant. Primary care physicians (defined as physicians with a designation of internal medicine, geriatric medicine, family practice, and general practice) must be exclusive to one ACO agreement in the Shared Savings Program.

CMS proposes to "align" beneficiaries with ACOs on a *retrospective* basis—in other words, at the end of the performance year—based on usage data demonstrating the provision of primary care services to beneficiaries by ACO physicians during the performance year. CMS explained its decision to assign beneficiaries retrospectively was based on policy concerns of protecting beneficiaries' freedom to choose their

providers, ensuring accuracy in the assignment process, and encouraging participation in the Shared Savings Program.

CMS stressed its view that the assignment process must accurately reflect the population for whom the ACO actually provides care so the calculation of shared savings, if any, accurately reflects the ACO's success in improving the quality and efficiency of the care provided to the beneficiaries for which it was actually accountable.

Since beneficiary attribution will be made at the end of the performance year, it will not be possible to inform beneficiaries of their assignment to an ACO before they begin seeking ACO services. CMS believes the only practical way such notification could be provided in a timely manner is to require ACOs to notify beneficiaries when they are seeking services from ACO participants. CMS is thus requiring ACO participants to post signs in each of their facilities and provide written notification for beneficiaries about their participation in the Shared Savings Program.

Proposed methodology

CMS proposes the following methods to align beneficiaries with ACOs retrospectively:

For each ACO, CMS will identify all "primary care physicians" who were ACO participants during the performance year.

CMS will assign beneficiaries to ACOs based on primary care services received from "primary care physicians," which include only those physicians with a designation of internal medicine, geriatric medicine, family practice, and general practice. Primary care services furnished by specialists (such as cardiologists, endocrinologists, neurologists, and oncologists) or by nonphysician practitioners (such as PAs or NPs) in the ACO will not count for purposes of beneficiary attribution. As noted above, primary care physicians must be exclusive to one ACO agreement in the Shared Savings Program.

At the end of the performance year, CMS will identify all beneficiaries who received "primary care services" from the primary care physicians in each ACO.

For purposes of beneficiary attribution, CMS defines "primary care services" on the basis of selected Healthcare Common Procedure Coding System (HCPCS) codes (99201 through 99215; 99304 through 99340, and 99341 through 99350) as well as the G-codes associated with Medicare annual wellness visits and "Welcome to Medicare" visits furnished by primary care physicians. CMS acknowledges that its proposed approach may not adequately account for primary care services delivered by specialists and may make it difficult to obtain the minimum number of beneficiaries to form an ACO in geographic regions with primary care shortages. Consequently, CMS invites comments on its proposal and other options that may better address the delivery of primary care services by specialists.

CMS will assign a beneficiary to a given ACO if the beneficiary received a "plurality" of his or her primary care services from primary care physicians who are participants in that ACO.

CMS proposes to use a plurality of allowed charges for primary care services to assign beneficiaries to ACOs. PPACA does not prescribe criteria for the level of primary care services usage that should serve as the basis for beneficiary assignment. CMS considered whether to assign beneficiaries to an ACO when they receive a *plurality* of their primary care services from that ACO, or to adopt a stricter standard under which beneficiaries would be assigned to an ACO only when they received a *majority* of their primary care services from the ACO.

CMS opted for the plurality approach because it feared a majority standard would likely reduce the number of beneficiaries assigned to an ACO and more beneficiaries would be left unassigned to any ACO, potentially undermining the development and sustainability of ACOs. On balance, CMS determined that a majority rule for assignment was too strict a standard to employ in a system where many Medicare beneficiaries may regularly receive primary care services from two or more primary care practitioners (for example, an internal medicine physician and a geriatric medicine physician).

As noted above, CMS has defined "primary care services" to include selected HCPCS codes and G-codes associated with the "Welcome to Medicare" visit and the annual wellness visits. CMS proposes to make the plurality determination based on a calculation of the "total allowed charges" for primary care services furnished by primary care physicians in each ACO.

In other words, CMS will add together the allowed charges for the primary care services furnished to each Medicare beneficiary provided by each primary care physician in each ACO. CMS will assign a beneficiary to an ACO when the beneficiary receives more primary care services (in terms of total allowed charges) from that ACO than from any other. CMS explained that it views allowed charges as a reasonable proxy for the resource use of the underlying primary care services and that consequently, beneficiaries would be assigned according to the intensity of their primary care interactions, not merely the frequency of such services, as would be the case with a simple service count.

Conclusion

In summary, CMS proposes to "assign" or "align" beneficiaries to an ACO on a retrospective basis, based on whether they received a plurality of primary care services from primary care physicians participating in that ACO. This methodology was adopted to promote beneficiary freedom of choice and to encourage robust participation in the Medicare Shared Savings Program.

CMS is soliciting comments on nearly every aspect of the assignment methodology, including ACO reporting of TINs; whether and how to address the delivery of primary care services by specialists in making beneficiary "assignments"; "retrospective" versus "prospective" methods of assignment; the "plurality" approach versus the "majority" approach; whether to count accumulated allowed charges or use a simple services count; and whether there should be a minimum threshold number of primary care services that a beneficiary should receive from physicians in an ACO to be assigned to that ACO. It remains to be seen whether CMS will make any substantive changes to its

assignment methodology in response to public comments.

In our ongoing series on the newly proposed ACO regulations, we will be issuing a number of separate advisories focusing on specific topics raised by the regulations and the affiliated guidance and requests for comments including:

- Shared savings calculations
- State law restrictions
- When things go wrong or circumstances change

Please also see our past installments in this series:

" The New ACO Regs: They're Here (Well, Sort of ...)" (04. 05.11)

"Antitrust Enforcement Agencies Issue Proposed Guidance on ACOs" (04.06.11)

"What the Proposed ACO Regulations Say About Legal Structures and Governance" (04.11.11)

"ACOs: The Fraud & Abuse Waivers – Finding a Path Through the Maze" (04.15.11)

" Proposed Quality Measures for ACOs " (04.18.11)

Stay tuned … and in the meantime, if you have any questions, please contact us.

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