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# Renewed Federal Effort to Promote Accountable Care Organizations

**May 20, 2011**

In a continued effort to encourage health care providers to sign on to the campaign to achieve better health, better care, and lower per-capita costs, the Centers for Medicare and Medicaid Services ("CMS") announced on May 17, 2011 three new Affordable Care Act[1] initiatives: (1) a new "Pioneer Accountable Care Organization" Program ("Pioneer ACO"); (2) a possible Advance Payment Initiative to pre-pay a portion of future ACO savings; and (3) a set of ACO Accelerated Development Learning Sessions.

**The Pioneer ACO Model: A "Mature" ACO**

The CMS Center for Medicare and Medicaid Innovation (the "Innovation Center") is accepting nonbinding letters of intent by June 10, 2011 and applications by July 18, 2011 from health care providers with established administrative and clinical infrastructure who wish to coordinate care for a significant portion of patients under financial risk-sharing contracts. CMS indicated that it seeks to accelerate contracting with these so-called "mature" ACOs that are already positioned to transform their care and financial models from fee-for-services to a value-based model.

The Pioneer ACO Program is complementary but separate from the Medicare Shared Savings Program for Accountable Care Organizations (the "Shared Savings Program") described in CMS's proposed rule dated March 31, 2011 and discussed in Proskauer's prior client alert dated April 5, 2011: Long-Awaited Guidance on Accountable Care Organizations Issued. The Pioneer ACO Program will be more flexible than the Shared Savings Program to accommodate the specific organizational and market conditions in which the Pioneer ACOs work. Among other differences, Pioneer ACOs will have greater opportunity for shared savings and risk compared to the Medicare Shared Savings Program, and they may elect to have program beneficiaries aligned prospectively rather than retrospectively. The Innovation Center's request for application (accessible in the Innovation Center link above) provides a useful point-by-point comparison of the Medicare Shared Saving Program ACO and the Pioneer ACO Program.

According to the Innovation Center, Pioneer ACOs must work “in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers and patients.” Before December 31, 2013, Pioneer ACOs must commit to entering outcomes-based contracts[2] with private and other public payers so that at least 50 percent of their revenues are derived from these outcomes-based contracts. Additionally, by the end of 2012, Pioneer ACOs must attest that at least 50% of the ACO’s primary care providers have met the requirements for meaningful use of certified electronic health records.

During the first two years, the Pioneer ACO will have a shared savings payment policy with “generally higher levels of shared savings and risk” than the levels under traditional ACOs. During the third year, the Pioneer ACOs that have shown a specific level of savings over the first two years will be eligible to move a substantial portion of their payments to a population-based model.

The Innovation Center anticipates entering Pioneer ACO participation agreements with 30 organizations.[3] CMS requires ACOs to have a minimum of 15,000 aligned Medicare beneficiaries with an exception for rural ACOs (requires 5,000 Medicare beneficiaries). Applicants are encouraged to propose alternative payment models in their applications and CMS will review the proposed models and select one alternative payment arrangement. Pioneer ACOs will be able to choose between the two payment arrangements.

The Pioneer ACO applicants will be evaluated based on the strength of their care improvement plans, leadership and commitment to outcomes-based contracts with non-Medicare purchasers (i.e., private health plans, state Medicaid agencies, and/or self-insured employers). The application finalists should plan on being interviewed at CMS’s headquarters in Baltimore, MD.

The Pioneer ACO Program will start in September or October 2011. Those selected for the Program will be required to survey their aligned beneficiaries annually and CMS will publicly report on its Website the performance of Pioneer ACOs on quality metrics, including patient experience ratings. CMS may review the status of a Pioneer ACO and terminate their agreement if the Pioneer ACO fails to meet the threshold requirements; fails to have at least 50% of their total revenues derived from outcomes-based contracts by the end of the second performance period (December 31, 2013); and fails to comply with the physician self-referral prohibition, civil money penalties law, anti-kickback statute and other antifraud law, or any other applicable Medicare laws.

The official *Federal Register* Pioneer ACO Model Program Notice will be published on May 20, 2011.

**Request for Comments on Advance Payment Initiative**

The second initiative announced by CMS on May 17, 2011 is the Advanced Payment Initiative, which is in response to comments that CMS has received concerning health care organizations and providers' lack of capital to invest in the required infrastructure for coordinating care. CMS is seeking input on whether they should provide certain ACOs participating in the traditional ACO Medicare Shared Savings Program up-front access to their potential shared savings. The ACOs would receive monthly payments for each aligned Medicare beneficiary. In order to receive the advance payment, the ACO must provide a plan for using the funds in connection with building its care coordination infrastructure.

CMS requests comments on the Advanced Payment Initiative by June 17, 2011.

**ACO Accelerated Development Learning Sessions:  Free Training for Senior Leadership**

Finally, CMS announced that they will offer four free ACO Accelerated Development Learning Sessions for teams of between two and four senior leaders from health care delivery organizations interested in forming an ACO. The first CMS Learning Session is scheduled on June 20–22, 2011 in Minneapolis, MN.

According to CMS, they have developed a focused curriculum on core competencies for ACO development. The curriculum topics include the following: leadership and priority-setting; the clinical and operating challenge of transforming care delivery; use of health information technology; managerial and financial challenge of assuming and managing risk; and meeting patient needs while reducing the total cost of care. The goal of these Learning Sessions are to prepare executive leadership teams to (1) understand the current readiness to become an ACO; (2) identify organization-specific goals for achieving the three-part aim of improving care delivery, improving health, and reducing costs through improvement; and (3) begin to develop an action plan for establishing essential ACO functions.

Each Learning Session will involve four steps: (1) pre-session planning; (2) an intensive in-person working meeting to jump-start ACO formation by identifying shared goals, key challenges, and core competencies; (3) follow-up Webinars; and (4) the completion of a comprehensive ACO implementation plan with year-by-year benchmarks over the next three years.

Registration will be on a first-come, first-served basis. CMS noted that the completion of the Learning Sessions will not be a factor for selection or participating in a CMS ACO program.

*If you have any questions about the Pioneer ACO Program, CMS's initiatives or ACOs, please contact Richard J. Zall, Elizabeth M. Mills, Ryan P. Blaney, or a member of Proskauer's Health Care Team.*

[1] The "Affordable Care Act" means The Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 ("HCERA"). For more information about the Acts, please visit our Health Care Reform Task Force Web site at http://www.proskauer.com/practices/health-reform-task-force.

[2] Outcomes-based contracts are defined as those that include financial accountability (shared savings and/or financial risk), evaluated patient experiences of care, and include substantial quality performance incentives.

[3] CMS also noted that more awards may be available if compelling reasons exist.