Becoming an ACO
The Rules and Requirements

Drinker Biddle ACO Workgroup Webinar
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Moderator
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Speakers

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ACO Final Rule – An Overview

Matthew Amodeo
Partner

Top 10 Shared Savings Program Modifications

> Beneficiary Assignment: Preliminary Prospective Assignment/Retrospective Reconciliation
> No Risk Option (Track I)
> Reduced Quality Measures (33)
> Flexible Start Dates
> Streamlined Governance Structure
> 1st Dollar Savings
> Elimination of Withhold
> No Mandatory Antitrust Review
> Benchmark Adjustments
> No 50% Primary Care Provider (PCP) “Meaningful User” Requirement
Key Implications for Hospitals and Physicians

> Barrier of Entry for Smaller, Physician-Driven ACOs Lowered Significantly
  - Advanced Payment Program
  - Elimination of Meaningful Use Requirement for Physicians
  - Flexible Start Dates
  - Reduced Legal Costs (No Antitrust Review)

> On-going Financial Risk for Both Hospitals and Physicians Reduced Significantly
  - No Risk Option (Track I)
  - Elimination of Withhold
  - Losses not Carried Forward
  - Retrospective Reconciliation for Shared Savings Calculation
  - Annual Benchmark Adjustments

> Decreased Administrative Burden
  - No More Full-time Medical Director
  - Community Stakeholder No Longer Required on Board
  - Ability to Waive 75% ACO Participant and Medicare Beneficiary Representation on Board
  - Only 33 Quality Measures
  - No Quality Improvement (QI) Committee

Key Implications for Hospitals and Physicians

> Greater Upside Potential
  - 1st Dollar Savings for Both Tracks
  - Annual Benchmark Adjustments Now Reflect Case Mix, Severity, Chronic Disease for Newly Assigned
  - Withhold Eliminated

> Potential for Greater Hospital Leverage in ACO Operations
  - Elimination of Proportional Representation on Board
  - Broad Fraud and Abuse Waivers May Allow Greater Hospital Control, Particularly for Hospital Funded ACOs
    - PCP Recruitment Incentives
    - IT Subsidies
    - Provision of Infrastructure
ACO Agreement/Application

> CMS Accepting Applications Effective 1/1/12
> Early ACOs May Opt for Either April 2012 or July 2012 Start and Will Have 18 or 21 Month First Performance Periods
> 2012 ACOs May Request Interim Savings Calculation for CY 2012 in their Application
> 5-Day “File and Use” for ACO Marketing Materials
> ACOs which withdrew or were Terminated May Reapply, But only as Track II; unless Termination was Prior to Half-Way Point for Track I ACO
> ACOs No Longer Required to Notify Beneficiaries Upon Termination from Shared Savings Program (SSP)
> Immediate Termination for Serious Violations
> ACOs with Losses May Reapply
Permissible Structures

- Physician Group Practice (PGP)
- Network of Independent Physicians (Independent Practice Association - IPA)
- Joint Ventures Between Hospital and Physicians (Physician-Hospital Organization - PHO)
- Hospital with Employed Physicians (Integrated Delivery System - IDS)
- Method II Critical Access Hospitals (CAH)
- Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs)*
- Others Approved by CMS

*No more shared savings incentives
ACO Operations

> 50% primary care provider electronic health records (EHR) compliance by year 2 no longer required: But EHR compliance reflected in quality score

> ACOs and ACO providers are prohibited from offering inducements to beneficiaries to stay in the ACO or see certain ACO providers

> Except in employer/employee arrangements, ACO providers may not limit or restrict patient referrals to ACO or other providers

> ACO participants can be removed, or added to ACO during 3-year agreement with 30-Day notice to CMS after new participant is added
ACO Governance

Composition of Governing Body:

- Separate legal entity (or part of a legal entity)
  - Board of Directors, Management Committee
  - No “management agreement” – type governance structures
- Medicare beneficiary representative(s) with no conflicts of interest with ACO
  - May be waived if ACO demonstrates in application that Medicare beneficiary has “meaningful opportunity” to participate in ACO governance
- 75% ACO provider representation
  - Management companies, financing companies, etc. cannot exceed 25% of Board
  - May be waived if ACO demonstrates in its application that ACO participants are involved in governance in “innovative ways”
- Single, financially/clinically integrated entities may use entity Board as ACO Board
  - Medicare beneficiary requirement may necessitate separate ACO entity
- Proportional control by ACO participants no longer required
  - ACO participants must have “meaningful” participation in the composition and control of ACO governing body
Leadership/Management Structure

> CEO, Manager or General Partner
  - Character/competence-type review
  - Experienced in developing clinical practices which improve healthcare processes/outcomes

> Medical Director
  - ACO physician
  - Board certified physician
  - Physically present on regular basis (full-time no longer required)

> Quality Improvement/Quality Assurance (QI/QA) Program
  - Formal QA Committee no longer required
  - Internal performance standards
  - Providers held accountable
  - Identify and “rehab” outliers
  - Led by “appropriately qualified” healthcare professional (physician leader no longer required)

Data Sharing
Data Sharing

> CMS to Provide ACOs with three types of data:

- **Aggregate (De-Identified)/Utilization Data**
  - Offers broad view of potential beneficiary population
- **Historically Assigned Data**
  - Name, D.O.B., Gender, Health Insurance Claim Number (HICN)
  - Helps ACO understand which beneficiaries were used to generate aggregate reports
  - Helps ACO identify patients likely to be assigned to ACO who might have special needs, chronic illness
  - ACO can use data (if patient does not opt out) to request claims data generated by other providers; facilitates care coordination
- **Beneficiary Identifiable Claims Data**
  - ACO must sign a data use agreement (DUA) before receiving data
  - Quarterly
  - Available monthly on request
  - Data set limited to beneficiaries who saw an ACO PCP during prior year
  - Beneficiary must not have opted out

> ACO providers may now contact the beneficiary to request data share permission. Patient has 30 days to opt-out. Provider must “re-offer” opt-out opportunity at next patient encounter

Beneficiary Assignment
Beneficiary Assignment

- Beneficiaries retain free choice of providers
- Prospective preliminary assignment based on plurality of PCP services received during prior 3-year period; retrospective reconciliation at end of performance year based on plurality of PCP services received
- Aligned with only one ACO at a time
- ACO providers required to notify/provide information to beneficiaries re: ACO participation
  - Office signs
  - Written materials/handouts
  - Mandatory use of CMS templates when available
- Beneficiaries may “opt-out” of CMS-ACO data sharing, but beneficiary data still counts towards risk share

Two Step Assignment Process

- Applies both to preliminary (data sharing) assignment, and for retrospective reconciliation for shared savings/loss:
  - Did the beneficiary receive at least one “primary care service” from a PCP in an ACO? If yes, the beneficiary is assigned to the PCP’s ACO from whom he/she received the plurality of his/her primary care services
    - If no, then:
      - Did the beneficiary receive primary care services from any physician (regardless of specialty) in an ACO?
        - If yes, the beneficiary is assigned to the ACO from which he/she received the plurality of his/her primary care services from any physician, physician assistant or nurse practitioner
Shared Savings and Losses

> Fee-For-Service Payments Continue
> ACOs Entitled to Share in Savings in Excess of CMS Determined Cost Target (Benchmark) if Quality Measures Are Met

Two-Tracks:
- Track 1: No Downside Risk
  - 50% Shared Savings*
  - Tiered Minimum Savings Rate (MSR) Based on Population Size
  - First Dollar Shared Savings
- Track 2:
  - Day One Downside Risk
  - 60% Shared Savings/Loss*
  - MSR Fixed at 2%
  - First Dollar Shared Savings If MSR Met
  - Shared Loss Rate Inverse to Shared Savings Rate, Capped at 60%

*Additional 2.5%/5.0% shared savings incentive eliminated, since FQHCs/RCHs can now participate as ACOs.
**Benchmark Adjustments**

- Annual Benchmark Adjustments Based on Current Health Status (vs. historic) Reduces Likelihood of Cherry-Picking
- Shared Savings Will Better Reflect Health Risk of Assigned Population
  - Annual Adjustment for Each Performance Period Based on Actual National Per Capita Spending Growth Rate
  - Separate Benchmark Tier/Adjustment for “At-Risk” Populations in the ACO
    - End Stage Renal Disease (ESRD), Disabled, Aged Dually-Eligible, Aged Non-Dually-Eligible
  - Newly Assigned Beneficiaries Only
    - Annual Adjustment for Severity and Case Mix
  - Continuously Assigned Beneficiaries
    - Annual Adjustment Limited to Demographic Changes; unless the Hierarchal Condition Categories (HCC) Score for this Population Decreased, in which case, Health Status also Factored into Benchmark Adjustment
- No More DSH or IME Adjustments

**Risk Sharing Comparison**

<table>
<thead>
<tr>
<th>Design Element</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Sharing Rate</td>
<td>50%*</td>
<td>60%*</td>
</tr>
<tr>
<td>Quality Scoring</td>
<td>Sharing rate up to 50% based on quality performance</td>
<td>Sharing rate up to 60% based on quality performance</td>
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<tr>
<td>Minimum Savings Rate</td>
<td>2%-3.9% (increases inversely to population size)</td>
<td>Flat 2%</td>
</tr>
<tr>
<td>Minimum Loss Rate</td>
<td>N/A</td>
<td>Flat 2%</td>
</tr>
<tr>
<td>Maximum Sharing Cap</td>
<td>Payments capped at 10% of ACO’s benchmark</td>
<td>Payments capped at 15% of ACO’s benchmark</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>Savings shared if MSR is exceeded on First Dollar Basis</td>
<td>Savings shared if MSR is exceeded on First Dollar Basis</td>
</tr>
<tr>
<td>Shared Losses</td>
<td>N/A</td>
<td>Shared Loss Rate = Inverse of Shared Savings Rate (1-Shared Savings Rate), not to exceed 60%. First dollar shared losses once the minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over 3 years: Year 1 = 5% Year 2 = 7.5% Year 3 = 10% Losses in excess of the annual cap would not be shared.</td>
</tr>
</tbody>
</table>

*FQHC/RHC Incentive Eliminated*
Loss Recovery/Recoupment Mechanisms

- Losses Must Be Repaid Within 90 Days
- Unrecouped Losses Exceeding Protection Approved by CMS Will Not Be Carried Forward
- ACO Must Specify How Losses Will Be Allocated Among ACO Providers
- ACOs Incurring Losses No Longer Automatically Terminated from SSP
  - ACO Explains Reasons for Losses
  - ACO Demonstrates Adequate Safeguards Have been Implemented
  - Claims Run-Out Reduced to 90 Days

ACO Evaluation:
Quality and Reporting Measures

Christopher Anderson
Associate
Quality Performance Measures

> CMS Finalized 33 Measures (previously 65)
  - Primarily focused on ambulatory care

> Grouped into 4 Domains
  - Patient/Caregiver Experience (7 Measures)
  - Care Coordination / Patient Safety (6 Measures)
  - Preventative Health (8 Measures)
  - At-Risk Populations (12 Measures)

> 4 Primary Sources of Data

Use of the Physician Quality Reporting System

> Requirements
  - Must submit quality performance measures using the Group Practice Reporting Option (GPRO) web interface (22 Measures)
  - Eligible professionals may only participate in Physician Quality Reporting System (PQRS) as a Group Practice under their ACO Tax ID Number (TIN)
  - ACO Participants cannot earn PQRS incentive outside of the SSP

> Incentive Payment
  - ACO PQRS incentive is equal to 0.5 % of an ACO’s eligible professional’s total estimated Medicare Part B allowed charges for covered professional services
  - ACOs are not required to meet all requirements for SSP to qualify for PQRS Incentive
Electronic Health Record Reporting

> CMS continues to believe that Health IT is critical in ACO development
  - CMS relaxed proposal to require 50 percent of an ACO’s participating physician’s to be meaningful users
  - The quality measure related to EHRs will be measured on a sliding scale
  - Performance under this measure will be given twice the weight as other measures

Scoring Methodology

> Pay for Reporting vs. Pay for Performance

<table>
<thead>
<tr>
<th></th>
<th>Performance Year 1</th>
<th>Performance Year 2</th>
<th>Performance Year 3</th>
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</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td>0</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Pay for Reporting</td>
<td>33</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>33</td>
<td>33</td>
</tr>
</tbody>
</table>

> 13 Measures will be grouped for scoring purposes
  - 6 Patient Experience Survey Modules (0-2 pts)
  - 5 All or Nothing Diabetes Measures (0 or 2 pts)
  - 2 All or Nothing Coronary Artery Disease (CAD) Measures (0 or 2 pts)

> 23 Measures scored on a points basis (0-2 pts)
  - Except for EHR which has a max of 0-4 pts
ACO Overall Performance Score and Sharing Rate

> Measure Score
  - Performance below 30% (Minimum Attainment Level) = 0 pts
  - Performance between 30% and 90% = 1.10 pts - 1.85 pts
  - Performance at or above 90% (Performance Benchmark) = 2 pts

> Domain Score
  - CMS will calculate aggregate score within the domain
  - Each domain is weighted equally (25%)
  - ACOs must achieve the Minimum Attainment Level on 70% of the measures in each Domain to avoid a corrective action plan and potential termination
  - If an ACO earns 0 pts in any of the 4 domains it would not be eligible to share in any savings generated

> Total Potential Score of 48 pts

Advanced Payment Model

Julie Scott Allen
Government Relations Director
Purpose and Eligibility

> **Purpose:** To support physician-owned practices, rural hospitals and other providers to become ACOs
  - Helps offset initial upfront costs and variable costs
  - $170M total available between 2012-2014

> **Eligibility:** ACO participants approved to participate in the Shared Savings Program who can demonstrate promise for generating cost savings

Eligibility Limitations

> ACOs that do not include any inpatient facilities and have less than $50M in total annual revenue

> ACOs with inpatient facilities that are (only) critical access hospitals or Medicare low-volume rural hospitals and have less than $80M in total annual revenue
Payment Structure

Selected participants can receive:

> An upfront, fixed payment for each ACO
> An upfront, variable payment for each ACO (based on the number of historically-assigned Medicare beneficiaries)
> A monthly payment of varying amount based on the size of the ACO (based on the number of historically-assigned Medicare beneficiaries)

Repayment of Advance Payments

> Advanced repayment will be recouped through an ACO’s earned shared savings
> Recoupment to occur during ACO’s second performance year
> An ACO that fails to generate savings or terminates early must repay the advanced payment
IRS Updates ACO Guidance

- Fact Sheet 2011-11 (posted 10/20/2011)
- Confirms basic IRS position announced at time of HHS Proposed Regulation
- Provides nuanced additional interpretation in Q&A format
- Helpful to EOs considering ACO participation, but not a free pass
IRS Updated ACO Guidance

> Confirms that Notice 2011-20 (3/31/2011) continues to reflect IRS view
> Issued in concert with HHS Final Regulations and continues to focus principally on SSP
> Tax implications of ACO activity depend on legal structure—corporation, partnership, LLC
> Continues to focus on:
  - whether ACO activities further an exempt purpose
  - whether EO participation in an ACO gives rise to prohibited inurement or private benefit
  - whether EO participation, if unrelated, is a substantial part of EO’s activities

IRS Updated ACO Guidance

> IRS gives a pass on joint venture (JV) control test due to CMS oversight (for SSP participants)
> For non-SSP, activities are governed by existing law
> Regular unrelated business taxable income (UBTI) rules apply
> New: IRS acknowledges that the ACO itself may qualify under (c)(3) (SSP and non?)
Private Benefit/Inurement Analysis

> IRS will still use five-factor analysis announced in Notice for private benefit/inurement
> But Fact Sheet Q&As provide nuanced “easing” of the standards
> EO participant does not need to satisfy all five factors
> Confirms ability to rely on existing informal guidance regarding EHR assistance

Private Benefit/Inurement Analysis

> Notice said IRS “expects” to not find impermissible private benefit or inurement where:
  - All terms are in a written agreement (but Fact Sheet clarifies that agreement need not state percentage interests or shares)
  - CMS has accepted the ACO into SSP and not terminated
  - EO share of economic benefits is proportional to investment (but Fact Sheet says this is to be viewed on an overall basis)
  - EO’s share of losses does not exceed its share of benefits
  - All contracts between EO and ACO or ACO participants are at fair market value
ACO UBTI Analysis

> Key point in Notice: will analyze SSP participation under “lessening the burdens of government” theory of exemption
  – Government considers provision of Medicare to be its burden
  – SSP established to lessen that burden
  – Hospital/EO participation can help
> May escape many constraints of community benefit analysis

ACO UBTI Analysis

> Not a complete pass
> ACO participation in shared savings programs other than Medicare/Medicaid might not further a charitable purpose or might involve too much private benefit (e.g., to a commercial payor)
> Other issues remain
IRS ACO Guidance

> As good as it’s going to get for now
> IRS understandably most focused on SSP for now
> Our job is to provide input to IRS through comments and experience, esp. non-SSP

Practical Advice

> IRS had trouble approving early HMOs, PSROs, PHOs, RHIOs; ACOs will be no different
> Absent physician ownership, exemption should be available to nonprofit ACO corps controlled by EOs
> Carefully structured joint ventures should be OK (watch control/UBTI issue in non-SSP)
> Carefully manage private benefit to physicians, insurers, and taxable organizations
Antitrust Guidelines

The final Antitrust Guidelines are not different in substance from the proposed guidelines issued in March.

The biggest change is the elimination of mandatory review.

What does it mean in practice?
Few Changes to the Antitrust Guidelines

- Conformed to CMS decision to eliminate mandatory Federal Trade Commission (FTC) review
- The safety zone and review standards are made applicable to any and all ACOs, not just those “newly formed”
- However, expedited review is only available to newly-formed ACOs
- Parties requesting review are invited to submit additional information as they think necessary
- The “rural exception” for physician services under the Safety Zone has been narrowed slightly

Does Voluntary Review Make Sense?

- Agency review is expensive and (unless the ACO qualifies for expedited review) time-consuming
- Any opinion rendered by the Agency is limited to the facts in place at the time – and facts change
Does Voluntary Review Make Sense?

> You don’t need a review letter if:
  - You’re inside the Safety Zone
  - You’re pretty darn close to the Safety Zone
  - You’re pretty sure you know the answer anyway

> Voluntary review may make sense if:
  - You need political cover
  - Your facts and circumstances are truly unusual
  - Counsel has advised that your facts are difficult and there is reluctance to move forward without greater assurance
Fraud and Abuse Waiver Program

Jennifer Breuer
Partner

Waiver Program – Interim Final Rule

> CMS and Office of the Inspector General (OIG) jointly issued an Interim Final Rule establishing criteria for waivers of Stark Law, Anti-Kickback Statute, Gainsharing Civil Monetary Penalties (CMP) Law and Beneficiary Inducement CMP Law applicable to ACO arrangements
> Interim Final Rule is effective upon publication in Federal Register; comments are being accepted for 60 days thereafter
> Waivers are automatic
  - Like an existing Stark Law exception or AKS safe harbor, there is no need to apply
  - If an arrangement meets all criteria, waiver applies
> Waivers apply uniformly to each ACO, ACO participant and ACO provider/supplier participating in SSP
> An arrangement need fit only in one waiver to be protected
> No waiver is necessary if ACO arrangement fits into existing exemption, exception or safe harbor of applicable law
ACO Pre-Participation Waiver

- Waives Stark Law, Anti-Kickback Statute and Gainsharing CMP law
- Applies to bona fide start-up, operating and other arrangements that pre-date an ACO’s participation agreement
- Start up arrangements include items, services, facilities or goods used to create or develop an ACO that are provided by ACO, ACO participants or ACO providers or suppliers
- Start up arrangements may include:
  - creation and provision of infrastructure
  - network development and management
  - care coordination mechanisms
  - clinical management systems
  - quality improvement mechanisms
  - creation of governance and management structures
  - care utilization management
  - creation of incentives for performance-based payment systems
  - hiring of new staff
  - IT
  - consulting and other professional support
  - organization and training costs
  - incentives to attract primary care physicians
  - capital investments

ACO Pre-Participation Waiver – Criteria

- Good faith intent to develop an ACO that will participate in SSP in target year, and to submit completed application to participate in target year
- Diligent steps to develop ACO to be effective in target year, including steps to determine ACO’s governance, leadership and management
- Bona fide determination that arrangement is reasonably related to purposes of SSP
- Contemporaneous documentation of arrangement, authorization and diligent steps
  - Documentation must be retained for 10 years and provided to Secretary upon request
- Public disclosure of arrangement in a manner to be determined by Secretary
- If ACO does not submit application for participation in target year, notification of Secretary as to why ACO was unable to submit application
- Waiver period starts upon publication of Interim Final Rule or one year preceding an application due date for target year 2013 or later
- Waiver period ends upon:
  - Start date of ACO participation agreement;
  - Date of denial notice, for an application that is denied; or,
  - Earlier of application due date or notice as to why ACO was unable to submit application, for ACOs that fail to submit application by due date for target year
ACO Participation Waiver

- Waives Stark Law, Anti-Kickback Statute and Gainsharing CMP law
- Applies to arrangements throughout term of ACO participation agreement
- Criteria:
  - ACO must remain in good standing under participation agreement
  - ACO must meet all requirements applicable to governance, leadership and management
  - Bona fide determination that arrangement is reasonably related to purposes of SSP
  - Contemporaneous documentation of arrangement, authorization and diligent steps
    • Documentation must be retained for 10 years and provided to Secretary upon request
  - Public disclosure of arrangement in manner to be determined by Secretary
- Waiver period starts on start date of participation agreement
- Waiver period ends 6 months following earlier of:
  - Expiration of participation agreement
  - Date ACO voluntarily terminates participation agreement
- If CMS terminates participation agreement, waiver period ends on date of termination notice

Shared Savings Distribution Waiver

- Waives Stark Law, Anti-Kickback Statute and Gainsharing CMP law
- Applies to distributions or use of shared savings earned by ACO
- Criteria:
  - ACO remains in good standing under participation agreement
  - Shared savings are earned by ACO pursuant to SSP and earned during term of participation agreement
  - Shared savings are:
    • Distributed to or among ACO participants or ACO provider/suppliers during year in which shared savings were earned by ACO, or
    • Used for activities reasonably related to purposes of SSP
  - With respect to waiver of Gainsharing CMP law only:
    • Payment of distributions made directly or indirectly by a hospital to a physician are not made knowingly to induce physician to reduce or limit medically necessary items or services to patients under direct care of the physician
    • Arrangements that incentivize provision of alternate and appropriate medically necessary care are protected
      • E.g., coordinated outpatient care rather than inpatient services, use of evidence-based protocols for medically necessary services
**Physician Self-Referral Law Compliance Waiver**

> Waives Anti-Kickback Statute and Gainsharing CMP law
> Applies to any financial relationship between or among an ACO, its participants and its provider/suppliers that implicates the Stark Law
> Criteria:
>   - ACO remains in good standing under a participation agreement
>   - Financial relationship is reasonably related to purposes of SSP
>   - Financial relationship meets requirements of existing Stark Law exception
> Waiver period starts on start date of participation agreement
> Waiver period ends on earlier of:
>   - Expiration of participation agreement
>   - Date on which participation agreement is terminated

**Patient Incentive Waiver**

> Waives Beneficiary Inducement CMP law and Anti-Kickback Statute
> Applies to items or services provided by an ACO, ACO participants or ACO provider/suppliers to beneficiaries for free or below fair market value (FMV)
>   - Does not protect provision of free or below FMV items or services by manufacturers or other vendors to beneficiaries, ACO, ACO participants or ACO providers/suppliers
> Criteria:
>   - ACO remains in good standing under a participation agreement
>   - There is a reasonable connection between free or below FMV items or services and the medical care of the beneficiary
>   - The items or services are in-kind and are for:
>     - Preventative care, or
>     - Advance adherence to a treatment or drug regime or follow-up care plan, or management of a chronic disease or condition
> Waiver period starts on start date of participation agreement
> Waiver period ends on earlier of expiration or termination of participation agreement
> Beneficiaries may keep items or services received during the term of participation agreement and continue to receive services initiated prior to expiration or termination
Thoughts on Waiver Program

> Waivers are very broad
  - Protect wide variety of arrangements that otherwise would be subject to prosecution
> CMS and OIG will closely monitor ACOs entering SSP 2012 through June 2013
  - Will watch activities and review comments to Interim Final Rule with eye toward abuses
> CMS and OIG plan to narrow waivers upon publication of Final Rule
> Modifications will apply to ACO applicants beyond July 2013 and ACOs that renew participation agreements

Questions and Answers