KING & SPALDING

Health Headlines

May 23, 2011

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CMS Announces Pioneer ACO Model, Seeks Comment On Advance Payment To ACOs – On May 17, 2011, CMS's Center for Medicare and Medicaid Innovation announced a series of initiatives designed to increase provider participation in accountable care organizations (ACOs). First, CMS unveiled its plans for a Pioneer ACO Model, providing an opportunity to more experienced ACOs for higher levels of shared savings (and risk of losses). Second, CMS has begun accepting comments on a possible Advance Payment Initiative that would pay ACOs a certain percentage of their expected shared savings at the beginning of their participation period to defray startup costs. Third, beginning June 20 in Minneapolis, CMS will hold a series of Accelerated Development Learning Sessions for ACO leadership teams to exchange best practices.

Pioneer ACO Model. The Pioneer ACO Model is available to ACOs willing to accept greater risk of shared losses in exchange for a larger portion of shared savings during the first two years of their participation agreement, with the potential to receive a "population-based payment model" in their third year of participation. Pioneer ACOs will have the option to have their aligned beneficiaries assigned prospectively or retrospectively.

Under the "core" payment options, a Pioneer ACO is eligible for up to 60 percent of shared savings or losses, with a shared savings/loss limit of 10 percent of their projected expenditure benchmark. In the second year, a Pioneer ACO is eligible for up to 70 percent of shared savings or losses, with a savings/loss limit of 15 percent. CMS will also offer Pioneer ACOs the option to receive slightly more or less shared savings/losses during the first two participation years. If after the first two participation years the Pioneer ACO realizes a minimum amount of shared savings (to vary by the historical Medicare expenditure levels in the State where the plurality of the ACO's beneficiaries reside), the ACO will be eligible for a population-based payment for future participation years. Under the population-based payment model, Pioneer ACOs will receive 50 percent of their expected fee-for-service payments for aligned beneficiaries, as well as a per-beneficiary per-month payment equal to the remainder of the ACO's expected fee-for-service revenue for those aligned beneficiaries. CMS states in its Request for Application that this payment model will provide ACOs with added flexibility to invest in care coordination infrastructure. In addition to the population-based payment, Pioneer ACOs will still be eligible for 70 percent of shared savings or losses realized during the participation year.

Applicants are also encouraged to recommend alternative payment models. If CMS determines that any of the proposals would result in shared savings equivalent to its existing models, CMS will make the proposals available to all participating Pioneer ACOs in lieu of the population-based payment model. Applicants also must agree to enter into outcomes-based contracts with private payers by December 2013.

Pioneer ACOs will be subject to the final quality performance requirements of the Shared Savings Program. CMS will permit approved Pioneer ACOs to withdraw from the program by January 2012 if the Pioneer ACO finds the final Shared Savings Program requirements unacceptable.

Organizations interested in participating in the program must submit a letter of intent to CMS by June 10, 2011, which is available **here**. Applications are due by June 18, 2011, and are available **here**. The Request for Application is available **here**.

Advanced Payment Initiative and Accelerated Development Learning Sessions. CMS also is accepting comments on a possible Advance Payment Initiative to provide ACOs with up-front payments based on a portion of their expected shared savings. ACOs would need to submit a plan to CMS showing how the advanced payments would improve care coordination infrastructure. Comments may be submitted via email to advpayACO@cms.hhs.gov by June 17, 2011. CMS's request for comments is available **here**.

Lastly, CMS will hold its first of four Accelerated Development Learning Sessions from June 20-22, in Minneapolis. ACO leadership teams will have the opportunity to meet with ADLS "faculty"—representatives from other provider organizations experienced in care coordination—to learn best practices as they plan for the Shared Savings Program. Attendance is free, and registration details are available **here**.

Reporter, *Christopher Kenny*, Washington, D.C., +1 202 626 9253, ckenny@kslaw.com**.**

United States Supreme Court Determines That Allegations Based On FOIA Responses Are Public Disclosures Under The FCA – On May 16, 2011, the United States Supreme Court issued its decision in *Schindler Elevator Corp. v. United States ex rel. Kirk*, 563 U.S. ___ (2011) holding that allegations based on federal agency responses to requests made under the Freedom of Information Act (FOIA), 5 U.S.C. § 552, constitute public disclosures under the federal False Claims Act's (FCA) public disclosure bar. The relator, a former employee of Schindler Elevator Corporation (Schindler), alleged that Schindler had submitted false claims for payment under the company's government contracts which were subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1972 (VEVRAA). According to the relator, Schindler violated VEVRAA's reporting requirements by failing to submit certain required reports and submitting false information in other reports made to the government. The relator alleged that these violations constituted false claims under the FCA.

The relator's allegations, however, were based on information received in response to FOIA requests made by the relator's wife. Schindler filed a motion to dismiss contending, among other things, that the district court was deprived of jurisdiction under the FCA's public disclosure bar because the FOIA responses constituted a governmental "report" or "investigation." The district court agreed with Schindler and dismissed the relator's complaint. The Second Circuit vacated and remanded, concluding that a federal agency's response to a FOIA request did not constitute a "report" or an "investigation." After concluding that the plain and ordinary meaning of the term "report" included a federal agency's response to a FOIA request, the Supreme Court reversed the Second Circuit's decision and remanded the case to the district court for further proceedings. In holding that FOIA responses are reports under the FCA public disclosure bar, the Court noted that the relator's lawsuit appeared to be a "classic example of the 'opportunistic' litigation that the public disclosure bar is designed to discourage." Although this case was based on the pre-PPACA version of the public disclosure bar, the decision should continue to have applicability since PPACA did not delete the term "report" from the provision. It remains to be seen, however, whether Congress will step-in, as it did in response to the Supreme Court's decision in *Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662 (2008), to further narrow the scope of potential defenses under the FCA. Indeed, in her dissenting opinion, Justice Ginsburg suggested that Congress should intervene to correct the Court's decision. Such action appears unnecessary since PPACA has already weakened the public disclosure bar defense by removing its jurisdictional status and permitting an otherwise barred relator to remain in the case if the government opposes the defendant's motion to dismiss.

The Supreme Court's decision is available by clicking **here**.

Reporter, *Adam Robison*, Houston, + 713 276 7306, arobison@kslaw.com.

CMS Issues Final Rule Requiring Review Of Rate Increases Of 10 Percent Or More – On May 19, 2011, the Secretary of Health and Human Services (HHS) issued a final regulation implementing a provision in the health reform law that required the agency to develop an annual process for reviewing "unreasonable increases in premiums for health insurance coverage." *See* Section 1003 of the Patient Protection and Affordable Care Act. Under the final rule, effective

September 1, 2011, insurers that seek to increase rates 10 percent or more for individual and small group plans must publicly disclose the proposed increases and the justification for them. In addition, increases of 10 percent or more are required to be reviewed by State and federal officials. Beginning September 1, 2012, the 10 percent threshold will be replaced with a state-specific threshold, using data that reflect trends in each particular state. Those state-specific thresholds will be updated on an annual basis, and the 10 percent threshold would apply if a specific threshold has not been implemented for a state.

If the state has an effective rate review system in place, then the state will conduct the rate reviews, but if HHS determines that the state does not have an effective review process, then HHS would conduct the reviews. HHS will make its determination of the effectiveness of state review processes by July 1.

The rule does not apply to large group insurance plans or to grandfathered plans that were begun prior to the effective date of the health reform legislation. The final rule seeks comments on how individual and small group coverage sold through associations should be treated in the rate review process.

A copy of the final rule is available **here**.

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CMS Announces EHR Incentive Payments To Eligible Hospitals, Physicians Expected Next Week; Provides Additional Guidance On Medicaid EHR Incentive Program Funding – In the first of two recent developments related to electronic health record (EHR) incentives, CMS announced via an e-mail notification that it would begin paying Medicare EHR incentives to eligible professionals and hospitals within a week (*see* Modern Healthcare, CMS to Issue First Medicare EHR Incentive Payments This Week, available **here**). According to Modern Healthcare, CMS also explained in the notification that eligible professionals can expect to receive payments based on 75 percent of their total Medicare allowed charges submitted no later than February 2012, and reminded providers that a payment incentive contractor—rather than the Medicare administrative contractors—would make the incentive payments.

In a second development, CMS issued a May 18, 2011 letter to state Medicaid directors providing additional guidance on qualifying for enhanced federal funding for administrative expenses related to the Medicaid EHR incentive program. The American Recovery and Reinvestment Act provides for 100 percent federal financial participation (FFP) for incentive payments to eligible Medicaid providers to adopt, implement, upgrade and meaningfully use certified EHR technology through 2021, and 90 percent FFP for state administrative expenses related to the program. Specifically, the May 18 letter provides further detail on criteria that health information exchange (HIE) promotion activities: (1) equitably divide costs across payers based on the "fair share principle," (2) leverage efficiencies with other federal HIE funding, and (3) are developmental and time-limited. CMS previously issued a letter on August 17, 2010, that provided guidance to states on allowable administrative expenses for activities supporting Medicaid EHR incentive program administration and provided initial direction on the role of state Medicaid agencies in promoting EHR adoption and HIE exchanges. For a copy of the May 18, 2011, letter, click **here**. For a copy of the August 17, 2010 letter, click **here**.

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King & Spalding Upcoming Roundtable On Medicare Value-Based Purchasing For Hospitals On May 24, 2011 – On Tuesday, May 24, 2011, we will be hosting a new Webinar focused on the final rule implementing the new Value-Based Purchasing program for Medicare-participating hospitals. The Webinar will take place from 1:00 p.m. to 2:30 p.m. Eastern. You can read additional information on the agenda and register to attend the Webinar by clicking **here**.

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