Medicare Shared Savings Program: Accountable Care Organizations

Centers for Medicare and Medicaid Services Final Rule Provisions

The Centers for Medicare and Medicaid Services (CMS) published a final rule on June 9, 2015, making changes to the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs) currently in the program, and to those that will be participating in the future. CMS states that the modifications of the final rule are intended to make refinements to the MSSP that will encourage continued participation in the program, reduce administrative burdens to ACOs, facilitate efforts to improve healthcare outcomes, and maintain program integrity. The final rule also creates a new Track 3 for ACOs that are prepared to share in savings of up to 75%, while taking commensurate risk, and caring for a prospectively attributed patient population. AMGA’s summary of key provisions of the final rule follows in the paragraph below.

Payment and Program Rule Waivers: In the proposed rule, CMS considered what additional flexibilities they could offer to encourage ACO participation in performance-based risk arrangements, such as granting certain waivers to ACO participants. The proposed rule discussed the possibility of waivers for the skilled nursing facility (SNF) 3-day rule, certain Medicare telemedicine billing requirements, the homebound requirement under the home health benefit, and referrals to post-acute care settings. CMS solicited stakeholder feedback on all of these waiver proposals. AMGA, and others, strongly urged the expansion of their use across all ACO tracks.

Although CMS sought to incentivize MSSP participants to move into risk-bearing tracks and acknowledged that various payment waivers would be a way to encourage participants to take additional risk, they only finalized one waiver that applies to Track 3 ACOs. The final rule provides Track 3 ACOs only the opportunity to apply for a waiver of the SNF 3-day rule (available in 2017).

AMGA’s comments stated that all Medicare patients who are attributed to ACOs should have access to these benefit design changes that would permit clinical-decision making to appropriately inform the healthcare they receive. AMGA also believes that risk-taking is inherently a part of participating in ACOs, no matter which track they are in. These investments represent considerable financial risk at the outset.

CMS explains that Medicare Advantage (MA) plans may waive the SNF 3-day rule because they operate under a capitated payment arrangement and therefore have incentives to control the total cost of patient care, yet all ACOs, whether they are taking performance-based risk, or not, have incentives to control the total cost of care. The Pioneer ACO model has recently begun testing whether a waiver of the SNF 3-day rule would enable them to improve the quality of care for a subset of beneficiaries.
requiring SNF care. AMGA strongly believes that more work must be done to extend the ability of all ACOs to use waivers.

**Adjustments for Health Status and Demographic Changes:** CMS did not change the methodology with respect to risk-adjustment of an ACO’s attributed beneficiaries. CMS allows an increase in the risk adjustment only for demographic changes, but not for changes in the acuity of the health status of ACO’s attributed patient population. Yet CMS allows reductions in the risk score adjustment based on demographic factors and health status for the continuously enrolled. AMGA believes this method of risk-adjustment disadvantages ACOs by not accurately reflecting the health status of their enrolled patient population, and we were disappointed that no modification to the risk-adjustment methodology was made in the final rule. CMS states that they believe this approach discourages changes in coding practices for care provided to beneficiaries who remain continuously assigned to the ACO.

The Center for Medicare and Medicaid Innovation Next Generation ACO program (announced after the comment period for the MSSP had concluded) will test a methodology that will allow CMS-HCC scores to increase up to 3%, based on the acuity of attributed patients.

**Benchmarking Process:** CMS sought public comment on ways to modify the rebasing methodology in order to enhance the program’s viability. AMGA recommended weighting each benchmark year equally for subsequent agreement periods, giving MSSP participants the option to transition to a benchmark based on regional fee-for-service expenditures instead of national fee-for-service expenditures, or a blend of regional and national expenditures; and moving forward with the CMS proposal to add back earned shared savings to historic benchmark calculations beyond the first year to provide a pathway for ACOs to realize shared savings for those who saved money but did not meet their minimum savings rate (MSR). In the final rule, CMS finalized a policy that will equally weight each benchmark year, and will make an adjustment to account for the average per capita amount of savings generated during the ACO’s previous agreement period.

CMS also states that the methodology for (re)basing part of the benchmark on regional expenditures will be the subject of rulemaking this summer.

**Minimum Savings Rate (MSR):** The MSR for Track 1 remains a variable 2.0% to 3.9% depending on the number of assigned beneficiaries. Tracks 2 and 3 have a choice of a symmetrical MSR/minimum loss rate (MLR), no MSR/MLR, MSR/MLR in 0.5% increment between 0.5% and 2.0%, or symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1). AMGA suggested to CMS in comments that they reduce the MSR to a flat 2% in Track 1, since it would help some ACOs reach the point of sharing in the savings they generate. In the final rule, CMS states that they will continue to maintain the MSR in its current form for Track 1 to protect against paying shared savings based on changes in cost that result from normal variation in expenditures, and to continue to provide greater rewards to ACOs that are in risk-bearing arrangements.
**Data Sharing Opt-Out:** CMS finalized its proposal to have beneficiaries call 1-800 MEDICARE directly to opt-out of data sharing. AMGA strongly supported this proposal in comments to CMS, and is pleased to see that it was finalized. ACOs will be required to post signs advising their beneficiaries of this new method to opt-out of data sharing. This provision should reduce administrative burdens for ACOs and help clear-up beneficiary confusion.

**Transition to Two-Sided Model:** The final rule removes the requirement for Track 1 ACOs to transition into a two-sided model at the end of the first performance period. Track 1 ACOs can elect to stay in Track 1 for another agreement period without any reduction in shared savings. CMS had proposed to permit Track 1 ACOs to remain for an additional agreement period, but take a 10% cut in shared savings for doing so. AMGA, and other stakeholders, strongly objected to the proposed penalty for remaining in Track 1 for another agreement period. CMS was persuaded by public comments from AMGA, and the vast majority of commenters, that ACOs could benefit from another performance period in an upside-only risk arrangement to gain experience. AMGA believes this will be of assistance to Track 1 ACOs that need to gain more experience with the program’s requirements before transitioning into a risk-bearing track. However, as noted above, this does not address key operational and financial challenges to ACOs currently in the MSSP program.

**Assignment/Beneficiary Attestation:** No changes were made to the methodology for preliminary prospective assignment of ACO beneficiaries, followed by retrospective assignment for an ACO’s financial reconciliation. In the proposed rule, CMS asked for stakeholder input about the implementation of a beneficiary attestation process. AMGA, and other commenters, supported the idea of beneficiaries being able to voluntarily align themselves to any ACO, however, voluntary beneficiary attestation was not finalized for any ACO track. CMS cites the need for additional development and testing of the beneficiary attestation approach before it can be incorporated into the MSSP.

CMS states that beneficiary attestation is being tested in the Pioneer ACO Model and the agency plans to revisit this topic during the 2017 Medicare Physician Fee Schedule rulemaking process.

**Including Primary Care Services Furnished by Non-Physician Practitioners in Step 1 of Assignment Process:** CMS finalized its proposal to use primary care services furnished by primary care physicians, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) under step 1 of the assignment process, instead of the current process where they are included in step 2. CMS reasoned that including services furnished by NPs, PAs, and CNSs in determining the plurality of primary care services in step 1 of the assignment process would ensure that beneficiaries are assigned to the ACO that is actually providing primary care for that beneficiary. AMGA supported this proposal because it will improve the accuracy of the assignment process. This new methodology will be used for operations related to payment year 2016. The current methodology will apply to payment year 2015, including reconciliation.
Assignment of Medicare Fee-For-Service Beneficiaries: CMS proposed that a beneficiary would be eligible to be assigned to a participating ACO, for a performance year or benchmark year, if the beneficiary meets all of the following criteria during the assignment window:

- Has at least 1 month of Part A and Part B enrollment and does not have any months of Part A only or Part B only enrollment.
- Does not have any months of Medicare group (private) health plan enrollment.
- Is not assigned to any other Medicare shared savings initiative.
- Lives in the U.S. or U.S. territories and possessions as determined based on the most recent available data in our beneficiary records regarding the beneficiary's residence at the end of the assignment window.

CMS finalized this proposal.

The agency also explored suggestions from commenters that beneficiaries who move out of the ACO's service area be removed from assignment. CMS decided, after analysis, that only a small number of beneficiaries would ever be excluded for that reason and do not represent a significant portion of the ACO's list. CMS also argued that for Tracks 1 and 2, beneficiaries who move may drop off an ACO's assignment list since the lists are retrospectively reconciled. For the suggestion that beneficiaries who opt-out of sharing their data should not be assigned to an ACO, CMS argued that the assignment methodology adequately indicates which beneficiaries should be assigned to an ACO on the basis of the primary care services furnished by ACO professionals but that it would monitor and assess the impact of not excluding these beneficiaries from assignment and, if appropriate, may consider making adjustments in future rulemaking.

Final Sharing Rate: CMS finalized the following sharing rates for each of the MSSP tracks:

- Track 1: Up to 50% based on quality performance (for Track 1 ACOs electing another performance period in Track 1, as well)
- Track 2: Up to 60% based on quality performance
- Track 3: Up to 75% based on quality performance

Shared Savings: For all three tracks, CMS finalized first dollar sharing once the MSR is met or exceeded.

Application Deadlines: CMS proposed consolidating two similar provisions regarding application review. Currently, CMS determines whether an applicant satisfies requirements and is qualified to participate in MSSP. Another provision provides that CMS approves or denies applications accordingly.

CMS also proposed to revise existing provisions to better reflect the application review process and the meaning of the reference to "application due date." The revision would clarify that CMS approves or denies an application on the basis of:
• Information contained in and submitted with the application by a deadline specified by CMS.
• Any supplemental information submitted in response to CMS' request for information and by a deadline specified by CMS.
• Other information available to CMS (including information on the ACO's program integrity history).

CMS proposed clarifying its process for requesting supplemental information and to adding new language to specify that CMS may deny an application if an ACO applicant fails to submit supplemental information by the deadlines specified by CMS. CMS believes that additional clarity may result in more timely submission of the information necessary to evaluate applications.

**CMS finalized its proposal to consolidate the two similar provisions regarding application review.** It also finalized its proposal to clarify that it approves or denies an application on the three aforementioned bases. The clarification of its process for requesting supplemental information and adding new language specify that it may deny an application if an ACO applicant fails to submit information by the deadlines specified by CMS.

**Renewal of Participation Agreements:** An ACO would be permitted to request renewal of its participation agreement prior to its expiration in a form and manner and by a deadline specified by CMS in guidance. CMS proposed that an ACO executive who has the authority to legally bind the ACO must certify that the information contained in the renewal request is accurate, complete, and truthful. CMS also proposed that an ACO that seeks renewal of its participation agreement, and was newly formed after March 23, 2010, must agree that CMS can share a copy of its renewal request with antitrust agencies.

CMS would evaluate an ACO's participation agreement renewal based on all of the following factors:

• Whether the ACO satisfies the criteria for operating under the selected risk model.
• The ACO's history of compliance with the requirements of the Shared Savings Program.
• Whether ACO established that it is in compliance with the eligibility and other requirements of the Shared Savings Program, including the ability to repay losses, if applicable.
• Whether the ACO met the quality performance standards during at least 1 of the first 2 years of the previous agreement period.
• Whether an ACO under a two-sided model repaid losses to the program that it generated during the first 2 years of the previous agreement period.
• The results of a program integrity screening of the ACO, its ACO participants, and its ACO providers/suppliers (conducted in accordance with §425.304(b)).

CMS would approve or deny a renewal request based on the information submitted in the request, and other information available to CMS. It would notify the ACO when the initial request is incomplete or inadequate and provide an opportunity for the ACO to submit supplemental information to correct the
deficiency. The ACO must submit both the renewal request and any additional information needed to evaluate the request in the form and manner, and by the deadlines, specified by CMS.

CMS would notify each ACO in writing of its determination to approve or deny the ACO's renewal request. If CMS were to deny the renewal request, the notice would specify the reasons for the denial and inform the ACO of any rights to request reconsideration review.

CMS believes that a simple renewal process would reduce the burden for ACOs that wish to continue in the program and minimize the administrative burden on CMS, which would allow us to focus our attention on new applicants that have not yet established their eligibility to participate.

**CMS finalized its proposals for the renewal process.**

**ACO Agreement Requirements:** CMS finalized proposals that will require that each ACO provider/supplier billing through the Tax Identification Number (TIN) of an ACO participant has agreed to participate in and comply with MSSP rules. The final rule further states that ACOs can accomplish this in one of two ways: by direct contracting with each ACO provider/supplier (NPI level); or contractually requiring the ACO participant to ensure that all ACO providers/suppliers that bill through its TIN have agreed to participate in, and comply with, the requirements of the MSSP. CMS encourages ACOs to incorporate the requirements as soon as possible, but will not require them for 2016 since the agency acknowledges that contracting for 2016 is already underway at this point in the year. ACOs that submit requests to add ACO participants for inclusion on the 2017 performance year list of ACO participants will be required to have participant agreements that comply with the new requirement. CMS will provide the ACO with a list of all ACO providers/suppliers (NPIs) that they have identified in the Provider Enrollment Chain Ownership System (PECOS) as being associated with each ACO participant’s Medicare-enrolled TIN. The ACO is then required to review the list, make any necessary corrections, and certify the lists of all of its ACO participants and ACO providers/suppliers ensuring that they are true, accurate, and complete. The ACO will then provide CMS with a complete and certified list of its ACO participants.

Changes to the ACO participant and ACO provider/supplier enrollment status must be made in PECOS within 30 days, in addition to notifying CMS in a form and manner specified by the agency. An ACO must also submit a request to add a new entity to its ACO participant list in the form and manner specified by CMS and CMS must approve additions to the ACO participant list before they can become effective on January 1 of the following performance year.

**ACO agreements must also include an ACO’s plan for distributing shared savings, and the process the ACO plans to use for coordinating the care of their ACO patient population.**

**Transition of Pioneer ACOs into the Shared Savings Program:** CMS finalized a process for Pioneer ACOs to transition into the MSSP. Pioneer ACOs may use a condensed application if three criteria are met, as follows:

- The applicant ACO must be the same legal entity as the Pioneer ACO.
• All of the TINs on the applicant’s ACO participant list must have appeared on the “Confirmed Annual TIN/NPI List” (as defined in the Pioneer ACO Model Innovation Agreement with CMS) for the applicant ACO’s last full performance year.
• The applicant must be applying to participate in a two-sided model.