

Executive Summary

Notice of Proposed Rulemaking for the Medicare Shared Savings Program

http://www.ofr.gov/OFRUpload/OFRData/2014-28388_PI.pdf

CMS has released a Notice of Proposed Rulemaking for the Medicare Shared Savings Program (MSSP), which proposes updates to the November 2011 Final Rule. These changes would affect ACOs beginning the program in 2016, as well as those choosing to renew their agreement for another performance cycle. The proposed rule makes a number of proposed changes including the addition of a Track 3 option for ACOs that would like to assume increased levels of two-sided financial risk. CMS has also proposed adjustments to the existing Track 1 (one-sided risk) and Track 2 (two-sided risk) to allow program participants to remain in Track 1 for an additional performance cycle in order to gain more experience before moving to two-sided risk. CMS is seeking comments on all of their proposals over the next 60 days, due February 6th, 2015. We can expect a number of changes to be made prior to finalization.

I. Definitions and Codification of MSSP Contracts and Providers

CMS has proposed to change some definitions and guidelines for MSSP participants. These modifications will affect which and how individuals or entities can participate in the MSSP in the upcoming year. They have proposed to revise the definition of an “ACO professional” by removing the requirement for an ACO professional to be an ACO Provider/Supplier, specifying that an ACO professional is an individual or entity that bills for items or services furnished to Medicare FFS beneficiary under a Medicare billing number assigned to a Tax Identification Number (TIN) of an ACO participant. CMS also revised the definition of beneficiary assignment to take into account claims for primary care services furnished by *all* ACO professionals, not solely physicians within an ACO. In addition, they have proposed amendments to clarify the method used to assign beneficiaries to an ACO and allow greater flexibility for when the number of beneficiaries drops below 5,000. However, CMS has also proposed that ACOs provide CMS with a complete and certified list of ACO participants and Medicare TINs at the beginning of their performance cycle, submit a list of providers at any time on request by CMS, and report changes in ACO providers within 30 days. CMS has also proposed revisions to create more flexibility in leadership and management structure by changing the qualifications for the ACO medical director, while requiring that the individual be familiar with the ACO’s clinical operations and organizational culture.

CMS has also proposed a clearer transition path for Pioneer ACOs to move into a two-sided risk MSSP model by using a condensed application if they meet three criteria: the applicant ACO needs to be same legal entity as the Pioneer ACO, all TINS on the participant list appear on a confirmed annual TIN/NPI list for the ACO’s last full Pioneer performance year, and the applicant must apply to participate in two-sided risk. CMS also seeks to revise the renewal participation agreements for existing program participants and commits to notify ACOs if their applications are incomplete, in order to allow time for correction. They have proposed to hold ACOs subject to all regulatory changes that become effective during the agreement period and alert current and prospective ACOs of such changes via CMS communications and updates to guidance.

II. Claims Data Sharing

To enhance transparency and facilitate awareness of services provided to beneficiaries both inside and outside the ACO, CMS has introduced several revisions to claims data sharing. CMS has proposed to aggregate data reports and certain limited identifiable data, as well make additional information

available to an ACO about FFS beneficiaries they serve, such as whether the beneficiary visited an emergency department or was hospitalized. They have also proposed to make additional data needed for population-based activities available at the beginning of the agreement period, each performance year and quarterly thereafter in conjunction with annual reconciliation. CMS has indicated that they will only include data on prospectively assigned patients in Track 3 to prevent incentives for Track 3 ACOs to target only FFS beneficiaries who are on the list for care improvement, rather than redesign care for all FFS beneficiaries. Importantly, Track 3 ACOs would not be able to request any information related to other Medicare FFS beneficiaries who receive primary care services that are considered in the assignment. Beneficiaries would be given the opportunity to decline claims data sharing directly through 1-800-MEDICARE. ACOs must provide advanced notification to all FFS beneficiaries of ability to opt-out through official communication, and opt out must occur through the point of care or phone. ACOs would be required to continue notifying patients in writing at the point of care that their providers and suppliers are participating in the MSSP program.

III. Criteria for Beneficiary Assignment to an ACO

To improve methodology for beneficiary assignment CMS has proposed to include primary care services provided by specialists and non-physicians, including NPs and PAs, for attribution purposes. CMS has proposed to include certain specialists in step one of the assignment process and exclude certain physician specialties from step two of the beneficiary assignment. Additionally, CMS has revised the effective date for finalization of proposals affecting beneficiary assignment so that any policies that affect beneficiary assignment would be applicable starting at the beginning of the next performance year. The assignment methodology used in the beginning of a performance year will also be used to conduct the final reconciliation for that performance year, ensuring that beneficiary assignment will not change during the performance year.

IV. Shared Savings and Losses in MSSP Tracks 1 and 2

CMS understands that some ACOs in Track 1 feel too restricted by their beneficiary size, technological capacities, resource limitations, and clinical or financial experience to accept the risk inherent in Track 2. In order to retain these Track 1 ACOs in the MSSP, CMS has proposed to remove the requirement for Track 1 ACOs to transition to Track 2 after the first agreement period, allowing them to stay in Track 1 for a subsequent period. ACOs who previously terminated their MSSP contract (less than halfway through its first performance period) can also rejoin Track 1 at a reduced sharing rate. To ensure that ACOs strive to advance from one- to two-sided risk, CMS has proposed to drop the sharing rate of ACOs staying in Track 1 by 10 percentage points, from 50 percent to 40 percent. This would allow ACOs to gain additional experience in Track 1 while encouraging them to move beyond a one-sided model.

In order to further attract ACOs to the two-sided risk model, CMS has proposed to move Track 2 from a flat 2 percent MSR and MLR to a variable figure based on the ACO's beneficiary size. This may provide a stepping stone for organizations worried about the potential shared losses assumed possible by accepting a fixed rate with a smaller beneficiary population. CMS is seeking comment on the above proposals, as well as whether the direction of the ACO's performance trend should allow it to participate in Track 1 for a subsequent period. CMS is also interested in hearing any alternative proposals to risk-calculations in Track 2 and what benefits each alternative proposal provides. Additionally, CMS seeks feedback on whether it should implement a prospective assignment approach under Track 2, which they already proposed for Track 3 under Track 2.

V. Creation of MSSP Track 3

CMS also wants to create an additional risk-based option for ACOs ready to take on increased performance-based risk. CMS has proposed a second two-sided model, referred to as Track 3. This Track 3 option is similar to Track 2, with a few modifications in its beneficiary assignment methodology, sharing rate, MSR and MLR, and performance payment and loss sharing limits. CMS has proposed to assign beneficiaries prospectively and perform a limited reconciliation, in which beneficiaries would only be removed if they were no longer eligible at the time of retroactive reconciliation. This prospective assignment would be based on a 12-month assignment window (offset by the calendar year) to allow claims for the 12 months immediately before the program's start.

As previously mentioned, CMS has proposed to give Track 2 a MSR and MLR that varies by an ACO's beneficiary population size—ranging from 3.9 percent for ACOs with less than 6,000 beneficiaries to 2.0 percent for ACOs with more than 60,000 attributed patients. For Track 3, CMS has proposed a fixed 2 percent MSR and MLR to satisfy those ACOs willing to take on additional risk. CMS has proposed setting the sharing rate under Track 3 at 75 percent and the performance payment to 20 percent of the ACO's updated benchmark. Any high performing ACOs cannot reduce their shared losses below 40 percent. CMS is seeking comment on whether it should remove the MSR and MLR completely for ACOs in Track 3, or if it should set a level other than a fixed 2 percent. Additionally, CMS would like comment on any technical changes in its calculations of shared savings and losses, or if there are more appropriate levels to set the sharing rates and performance limits (aside from the 75 and 20 percent respectively mentioned above).

VI. Waivers and Other Incentives for ACOs to Assume Two-Sided Risk

Few organizations have chosen to participate in the Shared Savings Program under two-sided performance risk and CMS believes there needs to be additional program flexibility to increase organizations' willingness to participate in two-sided performance risk. CMS has the authority to waive certain Medicare program rules in order to increase effective implementation of two-sided risk tracks. CMS has identified the following as specific payment and program rules where it may be necessary to use waivers to support ACO efforts under two-sided risk: the skilled nursing facility three-day rule, billing and payment for tele-health services, homebound requirement under the home health benefit, referrals to post-acute care settings. CMS also seeks comments on additional about waivers for other potential payment rules.

Further, CMS seeks to address the churn rate (24%) that MSSP organizations experience on average across the program. While the Pioneer program is currently conducting a test of beneficiary attestation for the 2015 performance year, CMS welcomes comments on whether it would be appropriate to offer a beneficiary attestation process to ACOs that choose to participate in the Shared Savings Program under two-sided risk financial arrangements. In addition, CMS recognizes that different ACO providers/suppliers in the Shared Savings program that bill through the entity's Medicare-enrolled TIN may vary in their ability to accept performance-based risk. For this reason, CMS would like to learn what options the program might consider in the future to encourage organizations to participation the program while permitting the providers and suppliers within that organization to accept varying degrees of risk. Lastly, CMS would like to revisit their repayment mechanism requirements to simplify them and address concerns regarding the transition to risk. They have proposed to remove the option that permits

ACOs to demonstrate their ability to pay using reinsurance or an alternative mechanism and limit repayment mechanisms ACOs may use to demonstrate their ability to repay shared losses to a combination of the following: placing funds in escrow, establishing line of credit, or obtaining surety bond.

VII. Establishing, Updating, and Resetting Financial Benchmarks in MSSP

CMS currently estimates a benchmark for each agreement period for each ACO using the most recent available 3 years of per beneficiary expenditures for parts A and B services for Medicare FFS beneficiaries assigned to the ACO. Benchmarks are reset at the start of each agreement period where CMS establishes ACO-specific benchmarks that account for national FFS trends. Many stakeholders have continued to express their concern that resetting ACO benchmarks at the start of each agreement period may disadvantage ACOs, particularly those that have generated shared savings, and may be financially unattractive despite ACOs offering lower-cost care. Some stakeholders have also expressed concern that the existing benchmarking methodology does not sufficiently account for the influence of cost trends in the surrounding region or local market on the ACO's financial performance. While CMS did not propose changes to benchmark methodology, it is considering whether modifying the methodology to help ensure that the Shared Savings Program remains attractive to ACOs and that it continues to encourage ACOs to improve their performance, particularly those that have achieved shared savings. Potential modifications to the benchmarking methodology include: equally weighting the 3 performance years, accounting for shared savings payments in benchmark, using regional FFS expenditures (as opposed to national factors) to trend and update the benchmark, implementing an alternative that uses the initial historical benchmark in the beginning and then constant relative costs for regions in subsequent years, and transitioning the benchmark to use just regional FFS costs over multiple periods.

CMS additionally is seeking input on the following factors in the case that the methodology is changed: if a combination of the above approaches should be used rather than one; how broadly or narrowly to apply benchmarking approaches to the program Tracks; whether to use regional FFS or national FFS expenditures in establishing or updating the benchmark and/or a methodology for transitioning ACOs; the criteria for defining the comparison group; and if there are other approaches to be considered for establishing, updating, and resetting the benchmark.

VIII. Additional MSSP Requirements

CMS has also proposed to modify some of the specific criteria that ACOs must satisfy in order to be eligible to participate in the Shared Savings Program, including how ACOs will be monitored with respect to program requirements and what actions will be taken against ACOs that are not in compliance with program requirements. CMS has proposed refinements and clarifications to certain policies including public reporting and transparency (e.g., new information for the ACO to disclose and the creation of a dedicated webpage to public report information), termination of the participation agreement (e.g., a standard closeout process and eligibility to share in savings if an ACO voluntarily terminates participation prior to December 31st), a reconsideration process (e.g., permit only on-the-record reviews), and a monitoring of ACO compliance with quality performance standards through some technical revisions.