



PYALeadership Briefing

Medicare ACO Road Map

SECOND EDITION

APRIL 2014



© 2014 Pershing Yoakley & Associates, PC ("PYA").

No portion of this white paper may be used or duplicated by any person or entity for any purpose without the express written permission of PYA.

With the addition of 123 new accountable care organizations effective January 1, 2014, there are now 341 ACOs participating in the Medicare Shared Savings Program (MSSP). For a program many considered dead on arrival when the proposed MSSP rule was released three years ago, provider participation in ACOs is the new normal.

Medicare Shared Savings Program Accountable Care Organizations



The Centers for Medicare & Medicaid Services (CMS) accepts applications for the MSSP only once a year. An ACO wanting to participate in the MSSP starting January 1, 2015, must file a formal Notice of Intent to Apply with CMS by May 30, 2014, and submit a completed application by July 31, 2014. **Failure to meet either deadline means waiting another year to apply.**

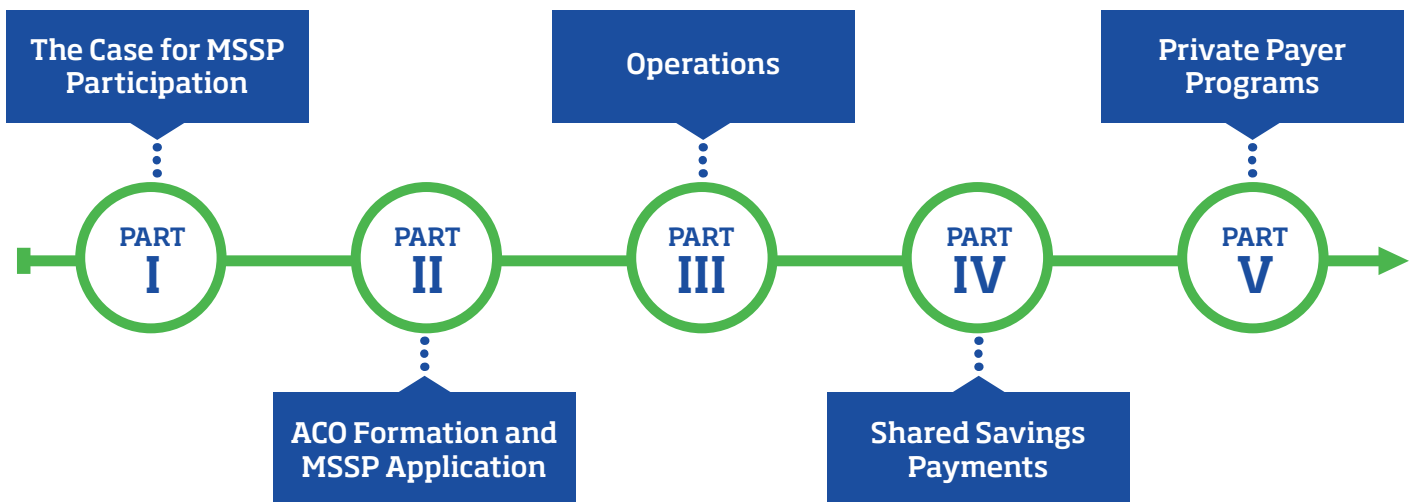
Experience has taught us that completing the MSSP application is no small feat, and interested providers should get started as soon as possible. The first step in the process is a careful and thorough review of MSSP requirements for participation.

The level of detail contained in the hundreds of pages of MSSP regulations and related guidance can be overwhelming. Thus, we have condensed the rules down to the core requirements. We have arranged the information to facilitate substantive discussions and decision-making, rather than hand-wringing over every last regulatory provision.

For those looking for the nitty-gritty detail, the one-stop web shop for information on the MSSP can be found [here](#). CMS maintains all current regulations, guidance, application forms, reference materials, contact information, and press releases under this one website.

Mark Your Calendar

May 30, 2014 Deadline to file a Notice of Intent to Apply	The NOI is non-binding and relatively simple, but missing this deadline disqualifies the ACO from 2015 participation in the MSSP. Thus, an organization with any interest in the MSSP – even if it has not made a final decision to participate – should submit the NOI by the May 30 deadline.
June 9, 2014 Deadline to submit CMS User ID forms	The completed MSSP application and related documentation must be submitted electronically, which requires the applicant to secure a CMS User ID.
July 31, 2014 Deadline to submit the completed MSSP application package	The application form is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Application.html . Don't be fooled by its apparent simplicity; significant work is required prior to checking "yes" for a specific item. The individual submitting the application on behalf of the ACO must certify to CMS the accuracy of all information.
Late Summer and Fall 2014 Respond to CMS inquiries and directives within specified time periods.	For several weeks following submission of the application, CMS will communicate with the applicant to identify errors and require additional information. Failure to provide a timely response to CMS will result in disqualification of the application.
November 2014 Sign MSSP Participation Agreement and Data Use Agreement	Based on prior years' experience, CMS will notify successful applicants sometime in November. There will be a very short period of time for the applicant to formally accept CMS' offer to participate by returning its signed MSSP Participation Agreement.
January 1, 2015 Start of performance period	



The Case for MSSP Participation

The decision whether to apply for and participate in the MSSP requires one to decide whether the potential business opportunity outweighs the known administrative overhead costs. The administrative headaches are detailed in the following sections. Here, we summarize the case for MSSP participation.

Potential to earn shared savings.

There is little empirical data regarding the success of ACOs in earning shared savings payments. On January 30, 2014, CMS released Performance Year 1 interim financial reconciliation results for ACOs that started in April and July 2012.

The MSSP data revealed that 54 of the 114 ACOs included in the analysis had lower-than-projected expenditures in their first 12 months. However, only 29 of those ACOs saved enough to generate bonus payments, which totaled \$126 million, or an average of \$4.3 million per ACO. CMS has identified the 29 ACOs, but has not yet released each ACO's actual savings. (Interestingly, 21 of the 29 ACOs were physician-led (vs. hospital-led) ACOs.)

Final year-one performance data for MSSP participants will be released later in 2014. Keep in mind the earliest an ACO can expect to receive any payment from CMS is 18 months following its start date.

If shared savings payments were the only opportunity presented by the MSSP, it would be hard to make the case for participation at this point in time. The real value of the MSSP is the role it plays in positioning providers for **healthcare transformation**.

On-ramp for value-based reimbursement.

To be eligible for shared savings, an ACO must achieve a certain level of performance on specified quality measures. An ACO also is required to develop, implement, and monitor participants' performance on clinical practice guidelines.

By creating an environment for these quality assurance and improvement activities, an ACO supports its participants in developing competencies critical for success under new value-based reimbursement models.

Learning lab for population health management.

It is no secret that the key to achieving shared savings is to identify high-cost, high-risk patients and provide them with comprehensive care management services. An ACO's care management infrastructure (including staff, processes, and technology) is foundational to successful population health management.

Infrastructure for narrow or tiered networks.

With employers and patients seeking more value for their healthcare dollar, more businesses are offering narrow network products for members to use for more efficient

healthcare alternatives. These networks are not your daddy's HMO; they value quality and efficiency, not just lower cost.

An MSSP ACO is well-positioned to secure commercial narrow network contracts, as the CMS "seal of approval" demonstrates the participating providers are committed to quality and more efficient care.

Access to data.

An MSSP-participating ACO receives from CMS all claims data for the ACO's attributed beneficiaries. Using this data, an ACO can identify opportunities for cost savings as well as quality improvement. The ability to analyze such data effectively will be synonymous with the ability to manage risk.

Fraud and abuse waivers.

Participants in an MSSP ACO may pursue financial arrangements without regard to the Stark Law, the Anti-Kickback Statute, the prohibition on gainsharing, and certain limitations on beneficiary inducements, so long as the governing body approves the arrangement as promoting the MSSP's purposes.

These self-executing fraud and abuse waivers (no submission to any government agency required) affords an enormous opportunity to ACO Participants to enter into new arrangements that incentivize quality and efficiency, even if they do not meet a Stark exception or an Anti-Kickback safe harbor.

The best defense is a good offense.

With the rapid growth of the MSSP, now more than 50 percent of the population lives in an ACO's service area. Existing ACOs are expanding their geographic reach to capture more lives, and more hospitals and physicians are gearing up for the next round of MSSP applications.

A provider who joins an ACO becomes clinically integrated with other ACO Participants, and thus is likely to shift referral patterns to his or her ACO brethren. The provider left on the outside looking in - having not pursued an ACO strategy - risks losing market share.



ACO Formation and MSSP Application

A. The Basics

An ACO is a distinct legal entity involving one or more Medicare-enrolled providers identified by their TIN (referred to as ACO Participants) “who agree to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.”

An ACO that meets certain requirements (as demonstrated through the application process) may enter into a three-year agreement with CMS to participate in the MSSP. Each year of the contract is called a performance year.

1. An ACO that applies to participate starting January 1, 2015, will be notified of CMS’ decision in late 2014. CMS will refuse participation if the applicant fails to meet any regulatory requirement. CMS’ decision is not appealable.
2. An ACO that elects early termination will not be eligible for any shared savings, may be liable for shared losses (if participating in a two-sided agreement, as described below), and will be precluded from re-enrolling for a specified time period.
3. The regulation lists specific grounds on which CMS may impose a corrective action plan or terminate an ACO’s agreement for cause for failure to satisfy ongoing regulatory requirements.

B. Required ACO Functions

An application to participate in the MSSP must show how the ACO will perform four core functions: promote evidence-based medicine, report cost and quality metrics, promote patient engagement, and coordinate care. More specifically, the ACO must:

1. Establish and maintain an ongoing quality assurance and improvement program led by an appropriately qualified healthcare professional.

Required documentation: Describe scale and scope of program, including remedial processes for noncompliant ACO Participants.

2. Promote evidence-based medicine.

Required documentation: Describe evidence-based guidelines the ACO intends to establish, implement, enforce, and periodically update; identify diagnoses with significant potential for the ACO to achieve quality improvements.

3. Promote patient engagement.

Required documentation: Identify measures for promoting patient engagement taking into account patients’ unique needs and preferences, e.g., decision-support tools and shared decision-making methods.

4. Report on quality and cost measures

Required documentation: Describe process to monitor internally, provide feedback, and take action based on such measures.

5. Promote care coordination across physicians and acute and post-acute providers.

Required documentation: Identify mechanisms to promote, improve, and assess integration and consistency of care (e.g., information technology, transition-of-care programs, deployment of case managers in primary care physician offices, use of predictive modeling; describe individualized care program for high-risk and multiple chronic condition patients; and identify target populations for program expansion.

6. Drive patient-centeredness.

Required documentation: Use of patient satisfaction survey results to improve care; process for evaluating health needs of assigned population with consideration of diversity; system to identify high-risk patients and develop individualized care plans integrating community resources; policies on beneficiary access to services and medical records.

C. ACO Governing Body

1. With the exception of a single-entity ACO (all ACO Participants under a single TIN), an ACO must have a distinct and separate governing body with responsibility for oversight and strategic direction through a transparent process.
2. ACO Participants must hold 75% of voting rights on the governing body. At least one member of the governing body must be a Medicare fee-for-service beneficiary who receives services from an ACO Participant. CMS may waive these governing body requirements if the ACO demonstrates good cause for non-compliance.
3. Members of the governing body owe a fiduciary duty to the ACO and must be subject to a conflict-of-interest policy requiring disclosure of a member's financial interests.

D. ACO Management

1. The governing body must appoint a manager to have operational oversight.
2. An ACO must have a medical director, who is a board-certified physician licensed and present in one of the states in which the ACO operates, to provide clinical oversight.

3. An ACO must have a compliance officer responsible for maintaining a compliance program that incorporates the Office of the Inspector General's (OIG) seven elements of an effective program.
4. An ACO must adhere to specific audit and record retention requirements.

E. ACO Composition

1. An ACO is comprised of one or more ACO Participants. An ACO Participant is an individual or group of providers/suppliers that is identified by a Medicare-enrolled TIN. An ACO's MSSP application must list the TIN for each of its ACO Participants.
2. An ACO must have a signed Participation Agreement with each ACO Participant describing the parties' respective rights and responsibilities. Among other things, the Participation Agreement must obligate the ACO Participant to remain in the ACO for three years. With its MSSP application, an ACO must submit its standard Participant Agreement, along with a copy of the signature page for each ACO Participant.
3. An ACO provider/supplier is a Medicare-enrolled provider or supplier that bills for items or services furnished to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO Participant (e.g., solo practice, group practice, hospital, federally-qualified health center). Each and every ACO provider/supplier billing under an ACO Participant's TIN must individually agree in writing to comply with all MSSP requirements in advance of the ACO submitting its MSSP application.
4. The MSSP regulations do not specify the types of providers/suppliers an ACO must include as ACO Participants, except that an ACO must have a sufficient number of physicians to maintain 5,000 attributed Medicare fee-for-service beneficiaries (see the following section for a discussion of the attribution rules).

5. If an ACO Participant bills Medicare for any physician-rendered primary care services (defined to include HCPCS codes 99201-15; 99304-40; 99342-50; G0402; G0438 and 39; and revenue center codes 0521, 0522, 0524, and 0525 submitted by Federally Qualified Health Centers (FQHCs) for services furnished prior to January 1, 2011), that ACO Participant is limited to participating in one MSSP ACO. However, a physician billing under multiple TINs (i.e., a physician who has reassigned his/ her billing rights to more than one entity) could participate in multiple ACOs, each under a different TIN.
 6. Any Medicare-enrolled provider/supplier may be identified on an application as an "other entity" affiliated with an ACO (although not included as an ACO Participant). Such provider/supplier still may be involved in the ACO's activities and receive shared savings distributions. CMS will not consider any "other entity" for beneficiary attribution, and thus such provider/supplier does not have to be exclusive to one ACO.
 7. The IRS has issued guidance on the manner in which a tax-exempt organization may participate in an ACO without jeopardizing its tax-exempt status or having to pay unrelated business income tax on its shared savings distribution.
2. CMS uses the following step-wise process for beneficiary attribution:
 - PCP-based attribution: Attribute to an ACO any beneficiary who received any primary care service (as defined previously) from one of the ACO's primary care physicians (PCPs) during the most recent 12-month period but only if the total allowed charges for primary care services furnished by the ACO's PCPs during that time period are greater than the total allowed charges for primary care services furnished by PCPs outside the ACO.
 - Specialist-based attribution: Attribute to an ACO any beneficiary who did not receive primary care services furnished by any PCP (inside or outside the ACO) during the most recent 12-month period but did receive primary care services furnished by one of the ACO's specialist physicians during that period but only if the total allowed charges for primary care services furnished by all ACO physicians and mid-level providers during that time period is greater than the allowed charges for primary care services furnished by all physicians and mid-level providers outside the ACO.

F. Beneficiary Attribution

1. Beneficiaries are attributed - not assigned - to an ACO. According to CMS, attribution "in no way implies any limits, restrictions, or diminishment of the rights of [beneficiaries] to exercise complete freedom of choice in the [providers] from whom they receive their services." CMS "characterize[s] the process more as an 'alignment' of beneficiaries with an ACO," based on a beneficiary's utilization of primary care services.
3. Employing this step-wise process, CMS will make preliminary attributions at the beginning of a performance year for the ACO's planning purposes, based on the most recent available data. CMS then will update those assignments quarterly, based on the most recent 12 months of data. Final attribution, which is used to calculate shared savings, will be based on actual data from the performance year.
4. Analyzing the number of unique Medicare beneficiaries for whom ACO Participants have provided services in the last year is not an accurate predictor of the number of beneficiaries to be attributed to the ACO. As a rule of thumb,

approximately one-third fewer beneficiaries will be attributed to the ACO, due to the step-wise attribution process. **Thus, a group of providers should have at least 7,500 Medicare beneficiaries in their combined panels to consider MSSP participation.**

5. During the course of its participation in the MSSP, an ACO will see significant changes to the makeup of its attributed population due to several factors: (a) the ACO no longer provides the plurality of primary care services for the beneficiary; (b) the beneficiary was not enrolled in Medicare Part A or Part B for at least one month; (c) the beneficiary elected to participate in Medicare Advantage; or (d) the beneficiary died.
6. CMS restricts the ability of an ACO to increase its attributed population by adding more participants:
 - Once the ACO submits its initial application at the end of July, CMS and the ACO begin a series of back-and-forth checks verifying the information in the application is correct. In previous application cycles, CMS has allowed one opportunity - normally occurring a month-and-a-half following the initial submission - to add additional ACO Participants (and thus increase its number of attributed beneficiaries).
 - Once this one-time addition period occurs following the ACO's submission, an ACO cannot add additional ACO Participants in an attempt to attribute additional lives until the completion of the first year within the MSSP (i.e., a January 2015 start date ACO would be first able to add new ACO Participants for the purposes of those providers' patients being attributed to the ACO in January of 2016).

G. Fraud and Abuse Waivers

The Secretary of Health and Human Services has statutory authority to waive requirements of the Stark Law, the Federal Anti-Kickback Statute, and the Civil

Monetary Penalties Law as necessary to carry out the MSSP. Concurrent with the publication of the final rule, CMS and OIG promulgated five specific waivers.

1. **ACO pre-participation waiver.** Board-authorized and properly documented arrangements undertaken as part of a diligent effort to develop an ACO up to one year prior to the MSSP application deadline.
2. **ACO participation waiver.** Board-authorized and properly documented arrangements between ACO Participants reasonably related to the purposes of the MSSP.
3. **Shared savings distribution waiver.** Distribution of shared savings among ACO Participants and/or use of such monies to support ACO operations.
4. **Compliance with Stark Law waiver.** An arrangement between ACO Participants that meets an existing Stark Law exception also is deemed to comply with the Anti-Kickback Statute and the Civil Monetary Penalties Law.
5. **Patient-incentive waiver.** Items or services reasonably related to a beneficiary's medical care and offered to a beneficiary by an ACO or an ACO Participant for free or below fair market value.

CMS and OIG have provided specific directions for an ACO to invoke the waivers with respect to a specific financial arrangement.

H. Antitrust Analysis

Concurrent with the publication of the final rule, the Federal Trade Commission (FTC) and Department of Justice (DOJ) published their statement of antitrust enforcement policy regarding MSSP ACOs.

1. **Antitrust safety zone.** If (a) none of an ACO's primary service area shares exceed 30% (as calculated in the manner specified in the

statement and subject to certain exceptions), and (b) none of the ACO's hospitals or Ambulatory Surgery Centers (ASCs) are exclusive to that ACO, the agencies will not challenge the agreement absent extraordinary circumstances.

2. **Conduct to avoid.** The agencies warn ACOs outside the safety zone from engaging in certain potentially anti-competitive conduct, including improper

exchanges of prices and other competitively sensitive information among ACO Participants and the pursuit of certain arrangements with private payers.

3. **Expedited voluntary antitrust review.** A newly formed ACO desiring further antitrust guidance regarding its structure and operations may request a 90-day expedited review from the agencies prior to its entrance into the MSSP.



Operations

A. Performance Standards (Quality Measures)

To be eligible for any shared savings payment for a given year, the ACO must meet minimum performance standards based on 33 specified quality measures. This prerequisite is intended to prevent ACO Participants from achieving savings by withholding necessary services.

1. Seven of the 33 measures address patient/caregiver experience of care; six relate to care coordination/patient safety; eight are categorized as preventive health; and 12 concern at-risk populations (diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease). Each measure has National Quality Forum endorsement or is currently used in other CMS quality programs.
2. The patient/caregiver experience of care measures requires the ACO to conduct patient satisfaction surveys at its own expense using a CMS-approved vendor.
3. For Year One, an ACO that reports on all measures will receive the highest percentage of shared savings available to it. For Year Two, the ACO's performance score (and thus its percentage of shared savings) will be based on a combination

of reporting on some measures and the ACO's actual performance on others.

4. Thereafter, the ACO's actual performance on all 33 quality measures (expressed as a percentage of total points available) will determine the percentage of shared savings the ACO will receive. If the ACO's scores fall below a specified level, it will not receive any shared savings payment.
5. The reportable measures align with other CMS quality programs, including Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive program. By reporting on the 33 measures, all ACO participating physicians satisfy their PQRS reporting requirements. ACOs are required to use a CMS-certified vendor to report on quality measures, and ACOs must report the first quarter of the following fiscal year (e.g. ACO reporting for a start date of January 1, 2015, will occur during Q1 of 2016).

B. Data Sharing and Data Use Agreement

1. On a quarterly basis, CMS sends each MSSP ACO aggregated metrics, utilization, and expenditure data derived from claims data for the ACO's

attributed beneficiaries. At the ACO's request, CMS also will provide identifying information for those beneficiaries whose information was used to generate these aggregate reports.

2. To obtain individually identifiable claims data regarding its attributed beneficiaries, an ACO must sign and adhere to a Data Use Agreement with CMS. This agreement will be provided by CMS to the ACO along with the Participation Agreement. CMS will not provide any claims data for substance abuse treatment.
3. However, an ACO must afford an individual beneficiary the opportunity to opt out of such data sharing between CMS and the ACO. To accomplish this, the ACO must send to each beneficiary a standard written notice supplied by CMS informing the beneficiary how he/she may decline data sharing. (Note that CMS provides an ACO with the names of its attributed beneficiaries, but not the addresses; the ACO will have to compile this information to send out required notices.) The ACO may request and receive a beneficiary's claims data from CMS if the beneficiary does not decline data sharing within thirty days after the notice is sent.
4. Additionally, a written notification explaining the opportunity to decline data sharing must be furnished to a beneficiary during his or her first primary care service visit with an ACO Participant.

C. Interactions with Beneficiaries

1. In addition to the notifications an ACO must provide if it elects to receive individually identifiable claims data, an ACO Participant must (a) provide attributed beneficiaries with a written notice that it is participating in the MSSP, either at the point of care or by sending the notice in advance to the beneficiaries; and (b) post signs in its facility providing the same notice.

2. Neither an ACO nor its participants may (a) impose restrictions on a beneficiary's right to seek services from non-ACO providers, or (b) attempt to avoid at-risk (high-cost) beneficiaries.

D. Secret Sticky Sauce - Chronic Care Management Services

1. One of the biggest criticisms of the MSSP is an ACO's inability to control from what providers a beneficiary receives services. Without some means of control, it is difficult to manage the beneficiary's total cost of care, especially for high-cost, high-risk patients.
2. Another big knock on the MSSP is the fact it requires participants to develop certain capabilities without any funding source to support those efforts. One of the keys to ACO success is a robust care management program, but today there is no Medicare reimbursement for such services.
3. Beginning in January 2015, CMS will pay a monthly fee to physicians and certain mid-level practitioners who furnish specified care management services for beneficiaries with chronic conditions. As a condition of payment, the provider will have to obtain the beneficiary's prior written consent to receive these services from the provider. Refer to PYA's white paper on chronic care management for a more detailed explanation of these requirements.
4. An ACO should consider developing the capabilities to support its physicians and mid-level providers in furnishing chronic care management services for qualifying beneficiaries. In addition to offering a new source of income for those providers, care management services provide "stickiness" to keep beneficiaries within the ACO network and other preferred providers.

E. Marketing

1. An ACO may not engage in marketing activities without CMS' approval. The regulations define "marketing" broadly to include a wide-range of communications with attributed beneficiaries as well as the general public.
2. An ACO must submit all publishable marketing materials to CMS for prior approval. CMS has within five business days to review, reject, or allow the ACO's marketing material. If CMS does nothing within five business days, an ACO may publish the material. CMS reserves the right to revoke any previously allowed marketing material at any time.
3. An ACO must utilize CMS-developed templates (e.g., letters to beneficiaries, press releases) to the fullest extent possible.

F. Ongoing Reporting Requirements

An MSSP ACO is required to publicly report the following information. If the ACO maintains a website (which CMS strongly recommends), this information must be available on the website:

- ACO name and location
- ACO primary contact
- Composition of ACO
- Current list of ACO Participants (legal business name)
- Membership of ACO governing body
- ACO committees and key leadership personnel
- Aggregate amount of shared savings/ losses (by performance year)
- Explanation of how shared savings are distributed
- Disclosures relating to fraud and abuse waivers

G. CMS Resources for MSSP ACOs

1. Upon acceptance into the MSSP, an ACO is assigned a CMS Regional Office contact person. This individual serves as the primary source of contact for the ACO.
2. As part of the MSSP "club," an ACO gains access to CMS' resources geared to improving quality and reducing costs, including webinars and case studies. Also, CMS regularly publishes guidance and helpful hints for compliance with program requirements, such as quality reporting. These materials are available through a secure portal that requires a CMS-issued user ID for access.



Shared Savings Payments

An ACO Participant will continue to receive the same Part A and Part B fee-for-service payments as a provider who does not participate in an ACO. An ACO is eligible for an annual payment based on Medicare savings, i.e., the difference between Medicare's projected total expenditures for the ACO's assigned beneficiaries (benchmark) and Medicare's actual total expenditures for those same beneficiaries.

Keep in mind the savings are not based exclusively on fee-for-service payments to ACO Participants; they are based on fee-for-service payments to all providers, including those who are not ACO Participants.

For example, an ACO that includes only physician practices as ACO Participants would realize shared savings through reduced hospitalizations, reduced utilization of independent diagnostics testing facilities, etc.

A. One-Sided vs. Two-Sided ACOs

In submitting its application, an ACO must state whether it wishes to participate initially as a one-sided or two-sided ACO.

A **one-sided ACO** is eligible for an annual shared savings payment, but does not pay any penalty if actual expenditures exceed the benchmark. An ACO may elect the one-sided model for its first three-year agreement period only.

A **two-sided ACO** pays a penalty based on a percentage of actual expenditures in excess of its benchmark. In exchange for accepting this risk, a two-sided ACO receives a higher percentage of the shared savings if actual expenditures are less than its benchmark.

B. Expenditure Benchmark

1. An ACO does not receive any benchmark data until after it has been formally accepted into the MSSP, sometimes early in its first performance year. The ACO's attributed beneficiaries are grouped into four categories: (1) end-stage renal disease (ESRD), (2) disabled, (3) aged/dual, and (4) aged/non-dual. The ACO will receive a benchmark (stated as a single dollar amount) for each category.
2. Highly summarized, CMS calculates the preliminary benchmark based on actual Part A and Part B expenditures (excluding IME and DSH payments) for beneficiaries who would have been assigned to the ACO for the prior three-year period.
3. CMS does not punish an ACO for achieving savings during the three-year term of its agreement by reducing the benchmark to reflect such savings. Instead, the benchmark is adjusted annually in two ways: (a) changes in severity and case mix among the attributed population (both newly assigned and continuously assigned), using the CMS-HCC model; and (b) by the absolute amount of growth in national per capita spending for Part A and Part B.

4. For the 341 ACOs participating in the MSSP in 2014, the unweighted median benchmarks were as follows:

ESRD	\$75,628
Disabled	\$9,300
Aged/dual	\$12,831
Aged/non-dual	\$8,929

C. Minimum Savings (Loss) Rate

An ACO must achieve a minimum savings rate (MSR) – a set percentage by which actual expenditures are less than the ACO's benchmark – to be eligible for shared savings payments.

1. For one-sided ACOs, the MSR ranges from 3.9% for ACOs with 5,000 assigned beneficiaries to 2.0% for ACOs with 60,000 or more beneficiaries.
2. For two-sided ACOs, a flat 2% MSR applies, regardless of the number of assigned beneficiaries. On the flip side, these ACOs will not share in a loss of less than 2%.

Both one-sided and two-sided ACOs receive first-dollar savings if they meet MSR; CMS does not withhold the initial savings for itself.

D. Savings (Loss) Sharing Rate and Savings (Loss) Cap

One-sided ACO

1. In its first year, a one-sided ACO will have a savings sharing rate of 50% (i.e., it will receive 50% of the savings, with CMS retaining the rest) if it submits reports on all 33 quality measures, regardless of its scores on those measures.
2. In its second year, a one-sided ACO with a 100% performance score also will have a 50% savings sharing rate. ACOs with lower performance scores will have correspondingly lower savings sharing rates (i.e., receive less than 50% of the savings).

A one-sided ACO's shared savings payment (actual dollars) cap is an amount equal to 10% of the ACO's expenditure benchmark (i.e., if the benchmark is \$10,000,000, the ACO's payment could not exceed \$1,000,000).

Example:

ONE-SIDED ACO	
Number of Beneficiaries	5,000
Adjusted Per Capita Benchmark	\$9,000
Aggregate Benchmark	\$45,000,000
Actual FFS Expenditures	(42,750,000)
TOTAL SAVINGS (5%)	\$2,250,000
Minimum Savings Rate @ 5,000 Benef. (3.9%)	\$1,755,000 (exceeded)
Savings Sharing Rate (Assume 100% Performance Score)	50%
ACO SHARE OF SAVINGS	\$1,125,000

Two-sided ACO

1. A two-sided ACO with a 100% performance score will have a savings sharing rate of 60% (i.e., it will receive 60% of the savings). During the first year, a two-sided ACO will receive a 100% performance score if it reports on all 33 measures, regardless of its scores. Again, ACOs with lower performance scores will have correspondingly lower savings sharing rates.
2. A two-sided ACO's shared savings payment (actual dollars) is capped at an amount equal to 15% of the ACO's expenditure benchmark (i.e., if the benchmark is \$10,000,000, the ACO's payment could not exceed \$1,500,000).
3. In the event of a loss (actual expenditures exceed benchmark by more than 2%), the ACO's loss sharing rate will equal one, minus the ACO's savings sharing rate based on its percentage performance score. For example, if the ACO's performance score would have resulted in a 45% savings sharing

rate, the ACO's loss sharing rate would be 55%. In that event, the ACO would owe CMS an amount equal to 55% of the amount by which the actual expenditures exceeded the benchmark.

4. For two-sided ACOs, the shared loss cap (i.e., the upper limit on the ACO's liability to CMS for losses) would be phased in over a three-year period starting in the year the ACO first participates in the two-sided model: 5% of the aggregate benchmark in Year One, 7.5% in Year Two, and 10% thereafter.

Example:

TWO-SIDED ACO (Savings)	
Number of Beneficiaries	5,000
Adjusted Per Capita Benchmark	\$9,000
Aggregate Benchmark	\$45,000,000
Actual FFS Expenditures	(42,750,000)
TOTAL SAVINGS (5%)	\$2,250,000
Minimum Savings Rate Flat 2%	\$900,000 (exceeded)
Savings Sharing Rate (Assume 100% Performance Score)	60%
ACO SHARE OF SAVINGS	\$1,350,000

TWO-SIDED ACO (Loss)	
Number of Beneficiaries	5,000
Adjusted Per Capita Benchmark	\$9,000
Aggregate Benchmark	\$45,000,000
Actual FFS Expenditures	(47,250,000)
TOTAL LOSS (5%)	\$2,250,000
Minimum Loss Rate Flat 2%	\$900,000 (exceeded)
Loss Sharing Rate (Assume 100% Performance Score)	40%
REFUND OWED TO CMS BY ACO (less than shared loss cap of \$2.25 million in Year One, \$3.375 million in Year Two, and \$4.5 million in Year Three)	\$900,000

E. Payments from and to CMS

1. CMS will notify an ACO in writing if it is entitled to a shared savings payment and, if so, the amount of that payment. Upon receipt, the ACO must distribute the funds using the pre-determined formula specified in its application.
2. For a two-sided ACO whose expenditures exceed the benchmark by more than 2%, CMS will make a written demand for repayment. The ACO must make payment in full within 30 days, and submit a certification of compliance and accuracy of information.
3. As part of its application, an ACO that elects the two-sided model must identify an acceptable method for repaying losses equal to at least 1% of per capita expenditures from the most recent year of data. Such methods may include recouping funds from Medicare payments to ACO Participants, reinsurance, placing funds in escrow, obtaining surety bonds, or establishing a line of credit or other repayment mechanism.
4. **There is no right of appeal with respect to CMS' determinations relating to the amount of shared savings or losses.**



Private Payer Programs

Private payers are developing products similar to the MSSP, such as the Blue Cross Blue Shield of Massachusetts Alternative Quality Program. Several products incorporate partial capitation, virtual partial capitation, condition-specific capitation, and medical home payments. Most involve prospective assignment of beneficiaries, thus creating an incentive to manage those specific patients more aggressively, as opposed to the MSSP, which gives ACO participants the incentive to improve overall quality and efficiency in providing services to their entire patient population.

Providers who have made the commitment to form an ACO in compliance with the MSSP regulations should not wait for private payers to come knocking. Nor should they permit these payers to “free-ride” on the ACO’s quality improvement and cost-savings initiatives. Instead, there is a tremendous opportunity for even a fledgling ACO to approach private payers and even employers with new contracting opportunities.

We are, as they say, building it as we fly it when it comes to new payment and delivery models. Providers, therefore, should take every opportunity to chart their own course, rather than waiting for a flight plan.

PYA has extensive experience assisting providers in forming and operating accountable care organizations and clinically integrated networks, as well as in applying for and participating in the MSSP. Specifically, our experience includes:

Evaluating specific market opportunities

Developing governance structures and forming organizational entities

Designing participation agreements

Providing physician and stakeholder education and recruitment

Completing MSSP applications and managing CMS inquiries

Creating and implementing care coordination and quality improvement programs

Developing ACO operational and strategic plans, including pro formas

Designing and evaluating private payer offerings

Deploying population-health strategies through data analytics

For more information regarding the MSSP and formation and operation of clinically integrated networks and accountable care organizations, please contact:

Martie Ross, JD

Principal

mross@pyapc.com

David McMillan, CPA

Principal

dmcmillan@pyapc.com

Jeff Ellis, JD

Principal

jellis@pyapc.com

Marty Brown, CPA

Managing Principal of

Consulting Services

mbrown@pyapc.com

All can be reached at (800) 270-9629

© 2014 Pershing Yoakley & Associates, PC ("PYA").

No portion of this white paper may be used or duplicated by any person or entity for any purpose without the express written permission of PYA.