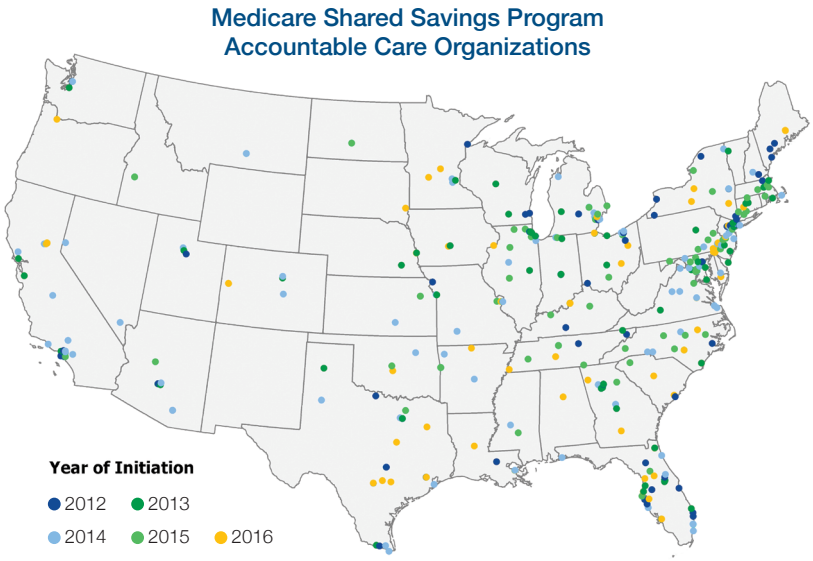
Medicare ACO Road Map

THIRD EDITION | MARCH 2016

As of January 1, 2016, there are now 434 accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). These ACOs are comprised of more than 180,000 physicians and other practitioners and serve more than 7.7 million Medicare beneficiaries. With the new Medicare Merit-Based Incentive Payment System (MIPS) coming online, interest in MSSP participation is at an all-time high.



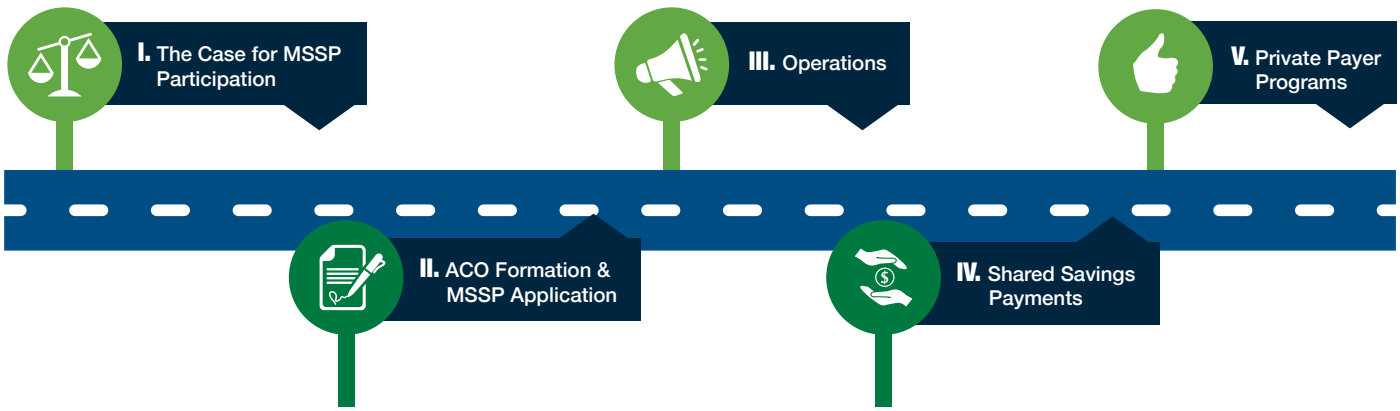
The Centers for Medicare & Medicaid Services (CMS) accepts applications for the MSSP only once a year. *An ACO wanting to participate in the MSSP starting* ***January 1, 2017****, must file a formal Notice of Intent to Apply with CMS by* ***May 31, 2016,*** *and submit a completed application by the* ***July 29, 2016*** *deadline.* 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 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 details, 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.

ACO Road Map



Mark Your Calendar

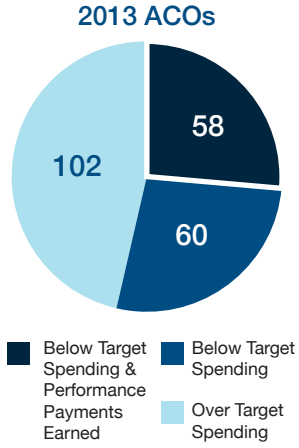
May 31, 2016 Deadline to file a Notice of Intent to Apply	The NOI is non-binding and relatively simple, but missing this deadline disqualifies the ACO from 2017 participation in the MSSP. Thus, an organization with any interest in the MSSP – even if it has not made a final decision to participate – should submit the NOI by this deadline.
Early June 2016 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 29, 2016 Deadline to submit the completed MSSP application package	By way of example, the 2016 application is available **here**. 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 2016 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 2016 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, 2017 Start of three-year performance period	Soon after this date, a new MSSP ACO will receive its final beneficiary attribution list and begin receiving CMS claims data

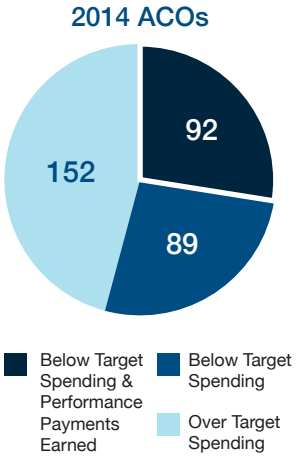
The Case for MSSP Participation

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.

A. Potential To Earn Shared Savings

We now have two years' worth of financial performance results for MSSP ACOs. For performance year 2013, 58 ACOs (26.4% of the 220 then-participating ACOs) held spending $705 million below their targets and earned performance payments of more than $315 million. An additional 60 ACOs (27.3%) reduced health costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold. The remaining 102 ACOs (46.3%) exceeded their targets.





For performance year 2014, 92 MSSP ACOs (27.6% of the 333 then-participating ACOs) held spending $806 million below their targets and earned performance payments of more than $341 million as their share of program savings. An additional 89 ACOs (26.7%) reduced healthcare costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold. The remaining 152 (45.7%) ACOs exceeded their targets.

Importantly, ACOs with a longer tenure in the MSSP were more likely to generate shared savings. Among ACOs that entered the program in 2012, 37% generated shared savings in 2014, compared to 27% of those that entered in 2013, and 19% of those that entered in 2014.

There has been much criticism regarding the manner in which CMS calculates an ACO's benchmark, with many arguing that the formula results in unreasonable spending targets. In response to these concerns, CMS has promulgated a proposed rule revising the formula. The agency anticipates its proposed new benchmarking methodology will make it easier for MSSP ACOs to realize shared savings.

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.

B. On-Ramp for Value-Based Reimbursement

To be eligible for shared savings, an ACO must hold spending below their assigned target **and** achieve a certain level of performance on specified quality measures. An ACO is also 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 other value-based reimbursement models with governmental or commercial payers.

C. 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.

D. 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 costs.

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.

E. 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 better understand the cost of care across the continuum and identify opportunities for cost savings throughout the care lifecycle, as opposed to only having glimpses into silos of care settings. This expanded view of a populations' consumption of healthcare resources also provides the opportunity to better manage the coordination of care, improving patient satisfaction, provider satisfaction, and improving quality. The ability to analyze such data effectively will be synonymous with the ability to manage risk.

F. Fraud and Abuse Waivers

Participants in an MSSP ACO can utilize waivers to pursue financial arrangements that might otherwise be prohibited by 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) afford 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.

G. The Best Defense is a Good Offense

With the rapid growth of the MSSP, now more than 50% 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, 2017, will be notified of CMS' decision in late 2016. 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.

   Upon application, an ACO must elect to participate in Track 1, 2, or 3. The differences between these tracks are addressed below.

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 non-compliant 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 (i.e., an ACO consisting of 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 compliance program**.
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,[1] 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 providers/suppliers 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 providers/suppliers do 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.

E. 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.
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[1] 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 and non-physician practitioners 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 non-physician practitioners during that time period is greater than the allowed charges for primary care services furnished by all physicians and non-physician practitioners outside the ACO. The regulations exclude certain types of specialists from being the basis for attribution of beneficiaries to an ACO.

1 The MSSP regulations define "primary care services" to include CPT 99201-99215, 99304-99340, 99341-99350, 99495, 99496, and 99490; G0402, G0438 and G0439; and revenue center codes 0521, 0522, 0524, and 0525 submitted by FQHCs (for services furnished prior to January 1, 2011) or by RHCs.

3. For Track 1 and Track 2 ACOs, CMS provides an ACO with a list of attributed beneficiaries at the beginning of the year based on the primary care services received during the preceding 12 months. Each quarter, CMS updates that list based on a rolling 12-month period. A beneficiary initially attributed to an ACO may roll off its ranks if he or she receives primary care services from a provider outside the ACO, while new beneficiaries may be attributed to the ACO during the performance year. Three months after the end of the year (to allow sufficient time for all claims to be filed and paid), CMS makes a final, retrospective assignment of beneficiaries who received the plurality of their primary care services from the ACO during that year.
4. As a result of this retrospective assignment, a Track 1 or Track 2 ACO does not know for which beneficiaries it will be accountable during the performance year. CMS reports that ACOs experience an average "churn" rate of 24%. That means nearly a quarter of the names on the first attribution list are different than the names on the end-of-the-year list.
5. By contrast, CMS attributes beneficiaries to a Track 3 ACO prospectively, i.e., the ACO knows at the beginning of each performance year those beneficiaries for whom the ACO will be financially accountable at the end of that year.
6. 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.
7. 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 2017 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 2018).
8. Neither an ACO nor any ACO Participant 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.

F. Fraud and Abuse Waivers

Under statutory authority, CMS and OIG have promulgated five specific waivers of the requirements of the Stark Law, the Federal Anti-Kickback Statute, and the Civil Monetary Penalties Law of which ACO Participants may take advantage in structuring financial relationships.

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 MSSP 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 for free or below fair market value by an ACO or an ACO Participant to a beneficiary.

CMS and OIG have provided specific directions for an ACO to invoke the waivers with respect to a specific financial arrangement, and compliance with those requirements is necessary to ensure waiver protection.

G. Waiver of Payment Rules

CMS also has the authority to waive specific Medicare reimbursement rules for ACO participants. To date, however, there is only one such waiver in place, and it applies only to Track 2 and Track 3 ACOs. For these ACOs, CMS has waived the rule that requires an inpatient hospital stay of no less than three consecutive dates for a beneficiary to be eligible for Medicare coverage of inpatient skilled nursing facility care. CMS still is considering waivers relating to telehealth, the homebound requirement for home health services coverage, and the prohibition against hospitals steering patients to specific, high-quality Medicare providers of post-hospital care services.

H. Antitrust Analysis

Concurrent with the publication of the final rule, the Federal Trade Commission and Department of Justice 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 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. 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 34 specified quality measures. This prerequisite is intended to prevent ACO Participants from achieving savings by withholding necessary services.

1. Each measure has National Quality Forum endorsement or is currently used in other CMS quality programs. The measures span four quality domains:
   a. Patient/Caregiver Experience
   b. Care Coordination/Patient Safety
   c. Preventive Health
   d. At-Risk Population

   Of the 34 measures, 8 measures of patient/caregiver experience are collected via patient satisfaction surveys conducted at the ACO's expense using a CMS-approved vendor; 7 are calculated by CMS based on claims data; 1 is calculated from Medicare and Medicaid Electronic Health Records Incentive Program data; and 18 are reported by the ACO via the Group Practice Reporting Option (GPRO) Web Interface. The collection of data from ACO Participants for these measures has proven challenging and time-consuming for many ACOs.
2. During its first performance year, an ACO that *reports* on all measures will receive the highest percentage of shared savings available to it.
3. 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 34 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.

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. ACO Participants must notify beneficiaries of their opportunity to opt out of having their data shared with the ACO by posting a CMS-specified notice at their facilities. This notice also informs beneficiaries that the provider is participating in the MSSP. An ACO Participant also must provide a more detailed written explanation of the data-sharing opt-out procedures in response to a beneficiary's specific request.

C. Secret Sticky Sauce – Chronic Care Management Services

1. One of the biggest criticisms of the MSSP is that an ACO is unable to control the provider from whom a beneficiary receives services. Without some means of controlling network leakage, it is difficult to manage the beneficiary's total cost of care, especially for high-cost, high-risk patients. One of the keys to ACO success, therefore, is a robust care management program.
2. Beginning in January 2015, CMS now pays a monthly fee to physicians and non-physician practitioners who supervise clinical staff members' provision of 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. Please refer to PYA's white paper, **Providing and Billing Medicare for Chronic Care Management**, for a more detailed explanation of these requirements.
3. An ACO should consider developing the capabilities to support its physicians and non-physician practitioners 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.

D. 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 materials at any time.
3. An ACO must utilize CMS-developed templates (e.g., notices to beneficiaries, press releases) to the fullest extent possible.

E. 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 names)
- 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

F. 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 (includes webinars and case studies) geared toward improving quality and reducing costs. 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. Payments By Track

As noted above, an MSSP applicant must elect to participate in Track 1, 2, or 3. The key differences between these tracks relate to payment of shared savings and liability for losses.

Track 1

A Track 1 ACO is eligible to receive a performance payment of up to 50% of savings, but does not pay any penalty if actual expenditures exceed the benchmark. A Track 1 ACO's performance payment 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).

The actual percentage of shared savings an ACO receives as its performance payment depends on its scores on the 34 performance measures. In its first performance year, a Track 1 ACO will be eligible for the full 50% of achieved savings if it reports on all required measures. In subsequent years, however, the percentage of savings will depend on the ACO's actual scores on the measures. (The same is true for Track 2 and Track 3 ACOs, although the maximum percentages are different, as discussed below.)

At the end of its first three-year participation agreement, an ACO may remain in Track 1 for a second three-year participation agreement, but only if the ACO (1) satisfied quality performance requirements in at least one of its first two performance years, and (2) did not generate losses in both of its first two performance years.

Track 2

Under Track 2, an ACO is eligible to receive a performance payment of up to 60% of savings. However, a Track 2 ACO bears the risk of having to repay up to 60% of any loss (i.e., actual total cost of care in excess of the ACO's benchmark). A Track 2 ACO's performance payment limit is 15% of its benchmark, and its upper loss limit is 10% of the benchmark.

Track 3

A Track 3 ACO is eligible to receive a performance payment of up to 75% of savings, but also is at risk for up to 75% of losses. A Track 3 ACO's performance payment limit will be 20% of its benchmark, and its upper loss limit would be 15% of its benchmark.[2]

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, (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 an ACO's 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.

2 The Center for Medicaid and Medicare Innovation sponsors two programs similar to the MSSP, the **Pioneer ACO Program** and the **NextGen ACO Program**. Under both, an ACO has greater downside risk than an MSSP ACO, but it is also eligible to receive a greater percentage of any achieved savings. A detailed comparison of these programs with the MSSP is beyond the scope of this publication.

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. As noted previously, the MSSP benchmark methodology has been subject to criticism, and CMS has issued a proposed rule making changes to the formula. At present, it is not known when that rule will be finalized.

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 Track 1 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. Track 2 and Track 3 ACOs have a choice among several options for establishing their MSRs and minimum loss rates (MLRs): (1) 0% MSR/MLR; (2) symmetrical MSR/MLR in a 0.5% increment between 0.5 – 2.0%; and (3) symmetrical MSR/MLR that varies based on the ACO's number of assigned beneficiaries according to the methodology for Track 1 ACOs. (If an ACO exceeds its benchmark by less than its MLR, it does not owe any penalty).
3. All ACOs receive first-dollar savings if they meet MSR; CMS does not withhold the initial savings for itself.

D. 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 Track 2 and Track 3 ACOs whose expenditures exceed the benchmark by more than the applicable minimum loss rate, 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, a Track 2 or Track 3 ACO is required to establish a repayment mechanism equal to at least 1% of its total per capita Medicare Parts A and B expenditures for its assigned beneficiaries, as determined based on expenditures used to establish the ACO's benchmark at the beginning of a performance period. An ACO must demonstrate its ability to repay losses through the use of an escrow account, line of credit, or surety bond.
4. There is no right of appeal with respect to CMS' determinations relating to the amount of shared savings or losses.

Private Payer Programs

Since 2010, **Leavitt Partners** has tracked the growth of provider-led organizations that assume responsibility for the cost and quality of care for a defined population. In March 2012, Leavitt Partners identified 157 ACOs covering approximately 7 million lives. According to the firm's latest report, issued in December 2015, those numbers have grown to 782 ACOs covering more than 23 million lives – with many ACOs participating in private payer programs instead of, or in addition to, the MSSP.

Private payers are developing products similar to the MSSP. Several incorporate some form of partial capitation payment. 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.

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.

How We Can Help

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 management 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:

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