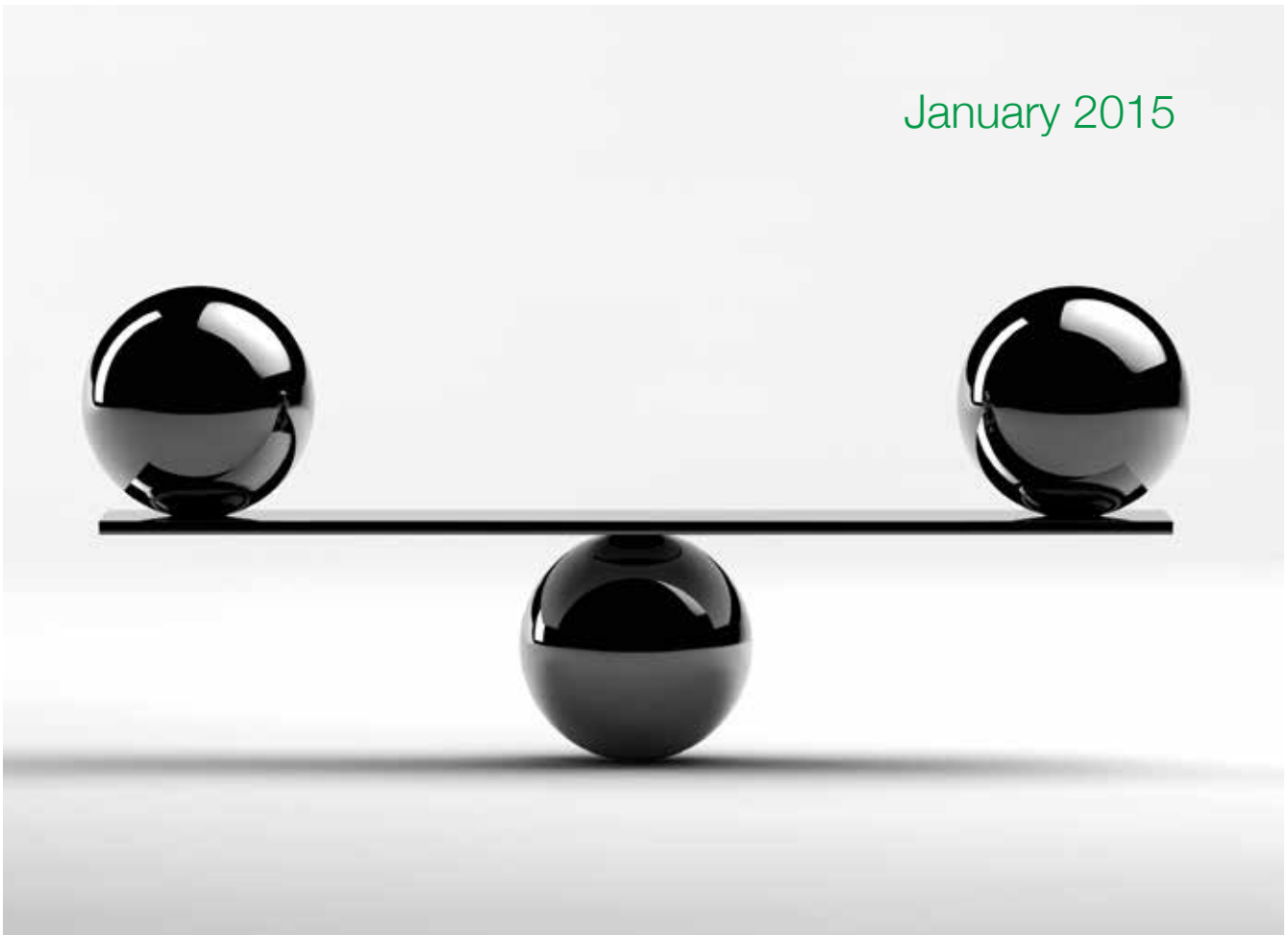


A DANGEROUS BALANCING ACT

Proposed Changes to the Medicare Shared Savings Program

January 2015



OVERVIEW

On December 8, the Centers for Medicare & Medicaid Services (CMS) published a massive proposed rule to overhaul the Medicare Shared Savings Program (MSSP). The agency seeks public comment on a wide-range of proposals to improve program operations and enhance incentives, to encourage accountable care organizations (ACOs) to accept risk.

Of the more than 330 ACOs participating in the MSSP as of December 22, 2014, only five have elected Track 2¹. Unlike the other 98% of MSSP participants, Track 2 ACOs share in losses (spending in excess of the benchmark) as well as savings (spending under the benchmark).

CMS wants to make the MSSP attractive to more organizations, and especially wants more ACOs to elect Track 2. CMS strongly believes those ACOs that accept performance-based risk are more likely to redesign care processes to achieve greater efficiencies. To achieve these goals, CMS is trying to strike a delicate balance:

- Offer sufficient incentives to recruit new MSSP participants.
- Keep in the program those ACOs that are presently unprepared or unwilling to accept risk.
- Convince more mature ACOs to accept risk.

A miscalculation could undermine the progress about which CMS has boasted: millions of dollars in savings during the inaugural performance period.

The summary that follows describes key provisions of the proposed rule. CMS will accept comments through February 6, 2015. When the current regulations were published in 2011, CMS took to heart strong public criticism of many burdensome requirements the agency had included in its proposed rule. Hopefully, CMS will do the same here: make the MSSP a better vehicle to assist in moving many providers to value-based payment models, rather than an exclusive program attractive to only the most sophisticated organizations.

The proposed rule is divided into seven sections:

- | | |
|------------------------------|---|
| 1 Definitions | |
| 2 Eligibility Requirements | 5 Beneficiary Assignment |
| 3 Participation Agreements | 6 Shared Savings & Losses |
| 4 Beneficiary Data | 7 Additional Program Requirements & Beneficiary Protections |

The significant, substantive proposed changes to the MSSP are found in three of the middle sections 4 - *Beneficiary Data*, 5 - *Beneficiary Assignment*, and 6 - *Shared Savings and Losses*. PYA has unpacked this very substantive proposed rule by arranging its content into the following Top Ten to Watch – the proposed changes detailed in these three sections that we believe would have the greatest impact on the future of the MSSP, as well as other payment and delivery system reforms.

¹ On December 22, 2014, CMS announced 89 additional ACOs had been accepted into the MSSP effective January 1, 2015. However, CMS did not specify whether any of these ACOs had elected Track 2.

1. CMS-Provided Data on Assigned Beneficiaries

Near the beginning of every performance year, all ACOs receive from CMS information on each of their prospectively assigned beneficiaries including name, sex, date of birth, and health insurance claim number. Additionally, CMS provides each ACO with aggregated expenditure and utilization data for its entire beneficiary population.

CMS now proposes to significantly expand the breadth and depth of the information provided. First, the agency proposes to expand these reports to include all beneficiaries for whom any ACO participant has provided a primary care service in the last 12-month period, not just those beneficiaries prospectively assigned to the ACO.

Second, CMS wants to provide additional data points for each beneficiary that are “necessary for purposes of the ACO’s population-based activities related to improving health or reducing health care costs”

CMS does not identify specific data points it proposes to provide, leaving that for later “operational guidance.” The agency, however, suggests the information would fall under four categories:

- 1 | Additional demographic information
(e.g., enrollment status)
- 2 | Health status information (e.g., chronic conditions)
- 3 | Utilization rates of Medicare services
- 4 | Expenditure information related to utilization
of services

But wait, there's more. Currently, if an ACO wants to receive from CMS individually identifiable claims data for its prospectively assigned beneficiaries on a monthly basis, it must (among other things) mail to each such beneficiary a CMS-approved notice regarding his or her opportunity to opt-out of such disclosure of his or her information. Thirty days after sending the notices, the ACO can request from CMS individually identifiable claims data. It's an expensive, time-consuming process which often creates confusion for beneficiaries.

CMS proposes to eliminate this process. ACO participants would still be required to provide written notice at the point of care, but CMS' disclosure of claims data would not be dependent on any prior notification.

The agency also proposes to no longer limit claims data sharing to prospectively assigned beneficiaries. Instead, an ACO could request and receive monthly data relating to any beneficiary who has received a primary care service from an ACO participant during the past 12-month period.

Many organizations identify access to claims data as the greatest benefit to participating in the ACO, as it opens the door for effective population health management. Now, with CMS promising to provide additional data in a more timely manner with reduced administrative hassle, this benefit of MSSP participation seems even more significant.

2. Beneficiary Assignment, Part 1

Beneficiaries are not assigned to an ACO in a traditional sense, as a beneficiary still may receive services from any Medicare provider he or she chooses, regardless of whether that provider is associated with the ACO. Instead, CMS assigns beneficiaries to an ACO for the purposes of setting spending benchmarks, and calculating whether the ACO has been successful in reducing total costs of care.

Under the current regulations, CMS uses a two-step process to assign beneficiaries to an ACO for this purpose:

Step One: Assign to an ACO any beneficiary who received any primary care service (as defined in the regulation) 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.

Step Two: 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.

CMS proposes four key improvements to the current two-step assignment process.

First: The agency would expand the definition of *primary care services* to include transitional care management and chronic care management services.

Second: CMS wants to revise Step One to include services furnished by non-physician practitioners (*i.e.*, nurse practitioners, physician assistants, and clinical nurse specialists).

Under the new Step One as proposed by CMS, a beneficiary would be assigned to an ACO if any PCP in the ACO furnished a primary care service to that beneficiary 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 the ACO's non-physician practitioners* during that time period are greater than the total allowed charges for primary care services furnished by the same types of providers outside the ACO.

Third: Step Two of the current beneficiary assignment process would be revised to limit the types of specialist physicians whose services would be considered for assignment purposes.² CMS notes that while many specialists bill for services that meet the definition of primary care services, they are not in fact serving as a beneficiary's primary care provider.

Fourth: CMS proposes changes to how services furnished in rural health clinics (RHCs) and federally qualified health centers (FQHCs) are considered in the assignment process. While highly technical, the changes would ensure beneficiaries who receive services in such a facility are properly assigned to the ACO in which the facility participates.

CMS notes any changes in the beneficiary assignment process would not become effective until the beginning of 2016, and all benchmarks would be adjusted to reflect the new population of assigned beneficiaries.

² Primary care services furnished by the following specialists would continue to be included for purposes of beneficiary assignment: allergy/immunology; cardiology; gastroenterology; neurology; obstetrics/gynecology; hospice and palliative care; sports medicine; physical medicine and rehabilitation; pulmonary disease; pediatric medicine; nephrology; infectious disease; endocrinology; rheumatology; multispecialty clinic or group practice; hematology; hematology/oncology; preventive medicine; medical oncology; and gynecology/oncology.

3. Extension of Track 1

As discussed above, nearly all ACOs have opted for the one-sided risk model (Track 1) with the opportunity to receive 50% of any savings. Under current regulations, these ACOs would be required to move to Track 2 – with its downside risk – at the end of their first three-year participation agreement – or leave the program.

Rather than running the risk of a mass exodus by ACOs unable or unwilling to accept downside risk at the present time, CMS proposes to permit Track 1 ACOs to continue under the one-sided shared savings model. However, CMS proposes to limit this option to those ACOs that satisfied quality performance requirements in at least one of its first two performance years and did not generate losses in both of its first two performance years.

Eager to transition ACOs to accepting downside risk, CMS proposes that second-term Track 1 ACOs be eligible to receive only 40% of any savings, down from 50% during the first term. This number would be reduced to 30% for a third-term Track 1 ACO (*i.e.*, years 7-9 in the MSSP) and 20% for a fourth-term Track 1 ACO.

CMS appreciates the risk this involves, and invites comment on whether this reduced opportunity will be “sufficient to incentivize an ACO that may need more time to prepare to take on two-sided, performance-based risk while also encouraging ACOs that are ready to take on performance-based risk to choose ... [the] two-sided model.”

4. Modifications to Track 2

Under Track 2, an ACO is eligible to receive 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).

For the handful of ACOs currently participating in Track 2, the minimum loss rate (MLR) protects them from having to repay a portion of any loss of less than 2%. Based on the association that ACOs with smaller assigned populations will be more hesitant to accept risk, CMS proposes a higher MLR for these ACOs, thus providing greater downside protection.

However, CMS also proposes a corresponding increase in the minimum savings rate (MSR) – applying the current formula used under Track 1 - making it more difficult for smaller Track 2 ACOs to qualify for any shared savings.



For a thorough explanation of the current MSSP Program, please refer to [PYA's Medicare ACO Road Map](#).

5. New Track 3

Rather than proposing additional changes to Track 2 to make it more attractive to potential risk-takers, CMS instead proposes a new Track 3. Track 3 ACOs would be eligible to receive up to 75% of savings, but also would be at risk for up to 75% of losses. CMS also proposes a 2% MLR and MSR for Track 3 ACOs, meaning greater exposure to risk and greater opportunity to receive savings than ACOs in Tracks 1 and 2.

A Track 3 ACO's upper loss limit would be 15% of its benchmark. For example, if an ACO's benchmark was \$10,000, it would not be at risk for more than \$1,500 of losses. By contrast, a Track 2 ACO's upper loss limit is capped at 10% (\$1,000 in the above example).

6. Beneficiary Assignment, Part 2

CMS also proposes to use a different beneficiary assignment methodology for Track 3 ACOs, borrowing from the Pioneer ACO Model. As discussed herein, CMS currently uses a two-step process to identify those beneficiaries to be assigned to an ACO.

CMS provides an ACO with a list of prospectively assigned 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 prospectively assigned to an ACO may roll off its ranks if he or she receives primary care services from a provider outside the ACO.

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. CMS then calculates the total cost of care for these beneficiaries, compares that amount to the benchmark, and determines whether the ACO is eligible for shared savings (or is liable for shared losses).

As a result of this retrospective assignment, an 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 prospective assignment list are different than the names on the end-of-the-year list.

By contrast, Track 3 ACOs would be accountable for the cost of care for those beneficiaries identified at the beginning of the year, with no end-of-the-year adjustments based on where these beneficiaries actually receive primary care services. CMS explains this would allow Track 3 ACOs to focus on high-cost patients to reduce their potential risk.

It seems logical Track 1 and 2 ACOs also would benefit from prospective assignment for the same reason, but CMS believes it would discourage these “less mature” ACOs from pursuing broader initiatives to redesign overall care processes. CMS may be forced to reconsider its reasoning in the face of critical comments.

Finally, CMS invites comments on a possible beneficiary attestation process. Although it offers no specific proposal, CMS is willing to consider allowing beneficiaries to commit in writing to an ACO. A beneficiary who makes such an election would be automatically assigned to the ACO, without need to analyze primary care services.

7. Risk Rewards

For many, the chance to receive shared savings no sooner than two years after making the decision to join an ACO is not a sufficient incentive to jump into the game, especially given the immediate out-of-pocket costs to form and operate the ACO. The decision becomes even more challenging when one adds the risk of having to repay a portion of any losses.

CMS now wants to sweeten the pot, proposing four waivers of Medicare reimbursement rules for ACO participants. The legislation creating the MSSP gives CMS broad authority to waive statutory and regulatory requirements as needed to achieve the program's purposes.

Telehealth. Today, Medicare reimbursement for telehealth is limited to certain patients—those in rural areas and health professional shortage areas—who are present at specific locations, not including their homes. A number of other reimbursement restrictions severely limits the use of telehealth. CMS proposes waiving these restrictions, albeit with many safeguards in place to prevent any abuse. CMS requests comment on a number of specific questions regarding the scope and operation of this proposed waiver.

The three-day skilled nursing facility (SNF) rule. CMS proposes to waive 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 SNF care. CMS has experimented with this waiver in the Pioneer ACO Model and appears willing to extend this opportunity to MSSP ACOs.

Home-Bound. CMS proposes to waive the requirement that a physician certifies a patient is home-bound to be eligible for home health services coverage. This waiver is intended to facilitate wider use of home health services to keep beneficiaries out of the hospital.

Post-acute referrals. Finally, CMS proposes to waive the prohibition against hospitals steering patients to specific, high-quality Medicare providers of post-hospital care services.

CMS proposes not to extend these waivers to Track 1 ACOs, as it believes these waivers are needed to incentivize organizations to accept risk, not just participate in the MSSP. CMS also expresses a willingness to consider proposals for additional waivers, provided the proposal explains how the waiver is needed to accomplish the purposes of the MSSP.

8. Split Track ACOs

CMS notes many ACOs have expressed a desire to split their participants into two tracks, allowing a subset of the ACO to move into a risk arrangement. These ACOs emphasize the advantages of providers continuing to work together through the ACO infrastructure, even though some providers remain unwilling to accept risk.

CMS lists a number of challenges associated with administering and operating a split track ACO, but invites comments on the advantages of these arrangements and solutions to potential obstacles.

9. Repayment Mechanisms

Under current regulation, a Track 2 ACO must 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. An ACO may demonstrate its ability to repay losses by obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit, or establishing another appropriate repayment mechanism that will ensure its ability to repay the Medicare program.

CMS seeks comments on formulas to determine the proper amount for an ACO's repayment mechanism, given changes to beneficiaries and benchmarks. CMS proposes to limit the repayment mechanisms to reinsurance, escrow accounts, and surety bonds, noting other mechanisms have proven impractical.

10. Benchmark Adjustments

Several pages of the proposed rule are devoted to the methodology for establishing, updating, and resetting an ACO's spending benchmark, with CMS detailing the pros and cons of the numerous options it considered.

By statute, CMS is required to use a weighted average of historical expenditures trended forward to current year dollars to establish an ACO's benchmark. The statute also requires CMS to update the benchmark for each year of the agreement period based on the projected absolute amount of growth in national per capita expenditures.

A critically important discussion occurs here, in the midst of the detailed explanation of regional vs. national benchmarks. That discussion involves the resetting of ACO benchmarks at the start of each agreement period.

CMS acknowledges these resets run the risk of disadvantaging those ACOs that have generated shared savings, as they will face a lower benchmark due to their successful efforts to reduce costs. Absent an alternative method for resetting a successful Track 1 ACO's benchmark, it is likely these ACOs will not elect Track 2 for their second performance period – or may even abandon the MSSP altogether. CMS, therefore, asks for alternative formulas for resetting benchmarks.

Also Worth Noting

The first three sections of the proposed rule: 1- *Definitions*, 2 - *Eligibility Requirements*, and 3 - *Participation Agreements* - delve into the minutia of how an ACO must be organized and operated to qualify for the MSSP. Of note here are CMS' efforts to resolve numerous technical issues that have arisen in the application and approval process.

Also with regard to that process, CMS proposes new applicants provide additional information regarding their processes to coordinate care. Specifically, applicants will need to explain how they will encourage and promote the use of health information technology and how they will partner with long-term and post-acute care providers. An applicant also will have to define and submit major milestones or performance targets it will

use to assess participants' performance each year. With regard to an ACO that wants to continue its participation in the MSSP after the expiration of its current agreement period, CMS proposes that it will not be required to submit a new or condensed application. Instead, the agency would have the ACO go through a yet-to-be-defined renewal process.

The final section of the proposed rule: 7 - *Additional Program Requirements & Beneficiary Protections* - includes new procedures relating to termination of participation in the MSSP and revisions to ACO monitoring and reporting requirements. CMS proposes each ACO be required to maintain a web page to publicly report specified organizational information and performance measures.

CONCLUSION

When CMS published the original proposed rule for the MSSP in April 2011, it was flooded with comments. It took CMS five months following the close of the comment period to publish the final rule. It is likely the floodgates will open once again, but this time CMS will be under pressure to publish the final rule as soon as possible. An organization that wants to join the MSSP for 2016 must submit its notice of intent by the end of May 2015. If CMS wants to grow the program, it will want to allow potential participants adequate time to evaluate the impact of program changes.

Of course, the million (probably billion) dollar question is whether CMS will succeed in balancing the competing interests of moving Track 1 ACOs to Track 2 or 3 while also attracting more organizations to the MSSP. It is critically important for stakeholders to submit comments to inform CMS' decision-making process.

PYA's Opportunity Forecasting & Positioning Team can assist your organization in analyzing the impact and developing strategies in response to new payment and delivery models. Also, our team prepares comments on behalf of organizations for submission to federal agencies on regulatory proposals.

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