Issue Brief

FEDERAL ISSUE BRIEF • June 5, 2015

KEY POINTS

- More than 400 accountable care organizations are participating in the Medicare Shared Savings Program and serving more than seven million beneficiaries.
- Most policies will take effect in the 2016 performance year.

CMS Finalizes Rules for Medicare Shared Savings Program (ACOs)

The Centers for Medicare & Medicaid Services has issued a final rule updating the Medicare Shared Savings Program, "to encourage the delivery of high-quality care for Medicare beneficiaries and build on the early successes of the program and of the Pioneer Accountable Care Organization Model."

The final rule is scheduled for publication in the *Federal Register* on June 9. A copy of the 592-page document is currently available at http://federalregister.gov/a/2015-14005. After publication, the link will change.

CMS points out that the Medicare Shared Savings Program was created by Section 3022 of the Affordable Care Act to promote better health for Medicare fee-for-service beneficiaries by encouraging physicians, hospitals, and other health care providers to improve patient health and experience of care and to reduce growth in costs. The program is voluntary and accepts applications on an annual basis in which organizations agree to participate for three years.

More than 400 ACOs are participating and serving over seven million beneficiaries. Early results released last November indicated the Medicare Shared Savings Program ACOs starting in the first two years of the program improved quality of care for beneficiaries, as ACOs improved performance in 30 of 33 quality measures.

COMMENT

The rule is well written with concise "Final Action" conclusions and decisions. Nonetheless, the material is extensive and requires in-depth review and analyses.

While CMS acknowledges that program savings have occurred, savings identified in the final rule are somewhat convoluted. Of the 220 ACOs with 2012 and 2013 start dates, CMS says that 58 ACOs generated shared savings during their first performance year. They held spending to $705 million below their targets and earned shared savings payments of more than $315 million as their share of program savings.

One ACO in Track 2 overspent its target by $10 million and owed shared losses of $4 million. Total net savings to Medicare is close to $383 million, including repayment of shared losses by the one Track 2 ACO. An additional 60 ACOs reduced growth in health costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.

As detailed in the final rule's Table 10, the total aggregate median impact would increase to $780 million in net federal savings for calendar years 2016 through 2018. The 10th and 19th percentiles of the estimate distribution, for the same time period, yield net savings of $230 million and $1,430 million, respectively. Such median estimated federal savings are $240 million greater than the $540 million median net savings estimated at baseline absent the finalized changes.

Table 10 notes that for the all change scenario, for CYs 2016 through 2018, the total median ACO shared savings payments

continued

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

MHA
MISSOURI HOSPITAL ASSOCIATION

of $1,130 million, offset by $30 million in shared losses, coupled with the aggregate average start-up investment and ongoing operating costs of $822 million, result in an estimated net private benefit of $278 million.

EFFECTIVE DATES

Most of the policies will take effect for the 2016 performance year. However, CMS says it will defer implementation of some policies, recognizing that ACOs may need more time to come into compliance with the requirements. For example, CMS says it believes that modifying agreements with ACO participants and ACO providers/suppliers to comply with the requirements of new § 425.116 may take time.

Accordingly, CMS will not require ACOs to comply with § 425.116(a) and (b) until the 2017 performance year in the case of ACO participants and ACO providers/suppliers that have already agreed to participate in the Shared Savings Program. Similarly, CMS will not require organizations that are applying or renewing for a Jan. 1, 2016, start date to submit agreements with the updated language as part of the 2016 application and renewal process which occurs the summer and fall of 2015.

The following table lists key changes that have an applicability date or effective date other than 60 days after the date of publication of this final rule – Aug. 3, 2015.

Applicability and Effective Dates of Select Provisions of the Final Rule

Preamble Section	Section Title/Description	Effective Date	Applicability Date
II.B.1.	Agreement Requirements (§ 425.116(a) and (b))		PY 2017 and subsequent performance years
II.D.2	Provision of Aggregate and Beneficiary Identifiable Data (§425.702(c)(1)(ii))		PY 2016 and subsequent performance years
II.D.3	Claims Data Sharing (§425.704)	1/1/2016	
II.D.3	Beneficiary Opportunity to Decline Claims Data Sharing (§425.312 and §425.708)	11/1/2015	
II.E.3	Definitions of Primary Care Physician and Primary Care Services (§425.20)		PY 2016 and subsequent performance years
II.E.4	Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process (§425.402(b))		PY 2016 and subsequent performance years
II.F.2	Modifications to the Track 2 Financial Model (§425.606(b)(1)(ii))		Agreement periods starting on or after Jan. 1, 2016
II.F.7	Waivers of payment rules or other Medicare requirements (§425.612)		PY 2017 and subsequent performance years

SUMMARY OF MAJOR PROVISIONS

A CMS fact sheet provides the following material regarding changes being adopted.

Participation Agreement Renewal and Continued Participation in Track 1

Prior regulations required that ACOs participating in Track 1, which share in savings but not losses, may continue in the program after their initial three-year agreement period only if they enter a performance-based risk (two-sided) track.

The new rule will permit ACOs to participate in one additional three-year agreement period under Track 1 and maintain the same maximum sharing rate applicable in their first agreement period. This policy will be available to ACOs that have met the quality performance standard in at least one of the first two years of their initial three-year agreement period and are otherwise in good standing with the program.

Beneficiary Assignment
The previous methodology assigns beneficiaries in two steps based on the plurality of primary care services furnished 1) by primary care physicians and 2) by specialist physicians, nurse practitioners, physician assistants and clinical nurse specialists.

CMS is revising the assignment methodology to remove certain specialty types whose services are not likely to be indicative of primary care services from Step 2, which places greater emphasis on primary care physicians. Additionally, CMS will include primary care services furnished by nurse practitioners, physician assistants and clinical nurse specialists in Step 1 to recognize the primary care delivered by these professionals. Finally, through rulemaking in the 2017 Physician Fee Schedule, CMS expects to propose that beneficiaries may attest that their main doctor is participating in a performance-based risk track ACO and be assigned to that ACO.

Data Sharing
The previous rule permitted CMS to share claims data with ACOs that is necessary for health care operations, but only after ACOs requested the data from CMS, notified beneficiaries and provided them an opportunity to decline to have their data shared with the ACO among other requirements. ACOs could mail notices to beneficiaries, wait 30 days before requesting data, and then follow up with the beneficiary at the next primary care service office visit, or they could notify beneficiaries at the point of care and request data immediately. This process created beneficiary confusion, and delays in data sharing.

CMS has modified the process for ACOs to access Medicare beneficiary claims data necessary for health care operations, while retaining the opportunity for beneficiaries to decline to have their Medicare claims data shared with the ACO. Specifically, ACO participants will continue to provide written notification at the point of care through signs posted in their facilities that include template language regarding data sharing and the opportunity for beneficiaries to decline data sharing by calling 1-800-Medicare. Beneficiaries can express their data sharing preferences directly to CMS through 1-800-Medicare rather than passing the information through the ACO. This means that ACOs will no longer send letters that may confuse beneficiaries, and beneficiaries will no longer have to sign and return forms to the ACO.

Resetting ACO Financial Benchmarks

CMS is finalizing the following methods for resetting the ACO's benchmark at the

continued

start of its second or subsequent agreement period.

- Equally weighting the historical benchmark years, as opposed to weighting these years 10 percent for BY1, 30 percent for BY2, and 60 percent for BY3.
- Accounting for savings generated by the ACO in its prior agreement period.
- Addressing concerns that rebasing diminishes ACOs' incentives to provide efficient care by reducing future benchmarks for ACOs that succeed in reducing spending, CMS indicated its intent to commence rulemaking later this year to implement a methodology that would reset ACO benchmarks in part based on trends in regional fee-for-service costs rather than solely ACOs' own recent spending.

Encouraging ACOs to Take on Greater Performance-Based Risk

CMS has finalized several modifications to encourage ACOs to accept performance-based risk, which include the following.

- Adding a new performance-based risk model (Track 3) for ACOs to participate in the Shared Savings Program. Track 3 offers a higher sharing rate than Tracks 1 and 2, and beneficiaries will be prospectively assigned to the ACO rather than preliminarily assigned to ACOs with a retrospective reconciliation.
- Modifying Track 2 to allow ACOs to choose from a menu of options for setting their minimum savings rate and minimum loss rate, the thresholds an ACO's expenditures must meet or exceed for the ACO to be eligible to share in savings or be accountable for losses. This same flexibility is extended to Track 3 ACOs.
- Reducing the burden of the repayment mechanism requirement for ACOs applying to enter tracks under the two-sided model.
- Conducting further development and testing of other selected waivers through the Innovation Center prior to implementation in the Shared Savings Program.

Eligibility Requirements

CMS has finalized several minor modifications to the eligibility requirements for ACO participation including the following

- Codifying and expanding requirements related to the agreements the ACOs have with Medicare-enrolled entities so that ACO participants understand their obligations and responsibilities. For example, agreements must include information about how the ACO plans to distribute shared savings and an agreement for the ACO participant to assist with quality reporting.
- Governing body and leadership requirements — for example, currently, the ACO's medical director is required to be an ACO provider/supplier; CMS proposes to remove this requirement to permit more flexibility.
- The process the ACO has for coordinating care, requiring ACOs to articulate how they will encourage and promote the use of enabling technologies for improving care coordination.
- Application procedures, establishing a streamlined process to allow prior Pioneer ACOs to apply for participation in the Shared Savings Program.

Other

Establishing a waiver of the 3-day stay, skilled nursing facility rule for beneficiaries that are prospectively assigned to ACOs under Track 3. CMS has included the following table that provides a summary of the changes being made.

continued

Comparison of One and Two-Sided Performance-Based Risk Models by Track					
	Track 1: One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
Issue	**Current**	**Final**	**Current Track 2**	**Final**	**New Track 3**
Transition to Two-Sided Model	First agreement period under one-sided model. Subsequent agreement periods under two-sided model.	Remove requirement to transition to two-sided model for a second agreement period.	ACOs may elect Track 2 without completing a prior agreement period under a one-sided model. Once elected, ACOs cannot go into Track 1 for subsequent agreement periods.	No change	Same as Track 2
Assignment	Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change	Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change	Prospective assignment for reports, quality reporting and financial reconciliation
Benchmark	Reset at the start of each agreement period	Modifications to rebasing methodology for an ACO's second or subsequent agreement period: equal weighting benchmark years, and including a per capita amount reflecting the ACO's financial and quality performance during prior agreement period.	Same as Track 1	Same as Track 1	Same as Tracks 1 and 2
Adjustments for health status and demographic changes	Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the performance year. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score.	No change	Same as Track 1	No change	Same as Tracks 1 and 2

Comparison of One and Two-Sided Performance-Based Risk Models by Track					
	Track 1: One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
Issue	**Current**	**Final**	**Current Track 2**	**Final**	**New Track 3**
Benchmark and Performance year Expenditures	Payment amounts included in Parts A and B FFS claims using a 3-month claims run out with a completion factor excluding IME and DSH payments including individually beneficiary identifiable payments made under a demonstration, pilot or time limited program	No change	Same as Track 1	No change	Same as Tracks 1 and 2
Final Sharing Rate	Up to 50% based on quality performance	No change. (Up to 50% based on quality performance for second agreement period under the one-sided model)	Up to 60% based on quality performance	No change	Up to 75% based on quality performance
Minimum Savings Rate	Two to 3.9% depending on number of assigned beneficiaries	No change	Fixed 2.0%	Choice of symmetrical MSR/MLR: (i) no MSR/MLR; (ii) symmetrical MSR/MLR in 0.5% increment between 0.5% - 2.0%; (iii) symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)	Same as Track 2
Minimum Loss Rate	Not applicable	No change	Fixed 2.0%	See options under MSR	See options under MSR
Performance Payment Limit	10%	No change	15%	No change	20%
Shared Savings	First dollar sharing once MSR is met or exceeded.	No change	Same as Track 1	No change	Same as Tracks 1 and 2

Comparison of One and Two-Sided Performance-Based Risk Models by Track					
	Track 1: One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
Issue	**Current**	**Final**	**Current Track 2**	**Final**	**New Track 3**
Shared Loss Rate	Not applicable	No change	One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate may not be less than 40% or exceed 60%	No change	One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate may not be less than 40% or exceed 75%
Loss Sharing Limit	Not applicable	No change	Limit on the amount of losses to be shared phases in over 3-years starting at 5% in year 1; 7.5% in year 2; and 10% in year 3 and any subsequent year. Losses in excess of the annual limit would not be shared.	No change	15%. Losses in excess of the annual limit would not be shared.
Payment and Program Rule Waivers under Part 425	Not applicable	No change	Not applicable	No change	ACOs may elect to apply for a waiver of the SNF three-day rule

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting