ACP Summary and Analysis of Major Provisions of the Medicare Shared Savings Program June 4, 2015 Final Rule Updated 6/15/2015		
CMS states that the intent of this rulemaking was to make refinements to the Medicare Shared Savings Program (MSSP), to encourage continued and enhanced stakeholder participation, to reduce administrative burden for ACOs while facilitating their efforts to improve care outcomes, and to maintain excellence in program operations while bolstering program integrity. Our analysis supports CMS' contentions and reflects a generally favorable response to the finalized rule. A table of the three tracks of the MSSP finalized under this rule and changes implemented is appended at the end of this summary and analysis.		
New Regulation	**Details**	**Comment/Analysis**
Continued Participation in Track 1	Prior regulations required that ACOs participating in Track 1 (one-sided risk), which share in savings but not losses, may continue in the program after their initial 3-year agreement period only if they enter a performance-based risk (two-sided) track. CMS finalized new rules that will permit ACOs to participate in one additional three-year agreement period under Track 1 and maintain the same maximum sharing (rate (50 %) 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.	Approximately 98 % of current ACO entities are operating within Track 1, and most would be unable to transition at this time to two-sided risk and would have to leave the program. Furthermore, CMS indicated in the proposed rule consideration of allowing Track 1 contract renewals, but under a reduced shared-savings rate (40%). The College advocated strongly for allowing programs succeeding under Track 1 to qualify for contract renewal without any reduction in the shared-saving rate. Most entities entering into the MSSP program, particularly the smaller, physician-led ACOs, require the additional time to develop the infrastructure and skills required to succeed under a two-sided risk contract.
Encouraging ACOs to Take on Greater Performance-Based Risk	CMS believes that increased performance-risk acceptance by participating ACOs will result in better quality of care and increase savings. Thus, it has finalized changes to the MSSP program to increase interest in participating entities progressing along the performance-based risk continuum. These modifications include: • Adding a new performance-based risk model (Track 3) for ACOs to participate in the Shared Savings Program. Track 3 offers a higher	The College generally supports the opportunity for increased risk acceptance (accompanied by increased opportunity for financial reward) for those ACOs that have the necessary infrastructure and experience (skills). Track 3 provides a reasonable option for generally larger ACO entities that have had substantial previous experience under Medicare Advantage or similar risk-bearing contracts. The addition

	sharing rate (up to 75% based on quality) than Tracks 1 and 2, and provides the ACO with the choice of several symmetrical Minimal Saving Rate/Minimal Loss Rate (MSR/MLR options from 0 % (first dollar) increasing in .5 % increments between .5 % and 2 %) to control their degree of risk. Under this track, beneficiaries will be prospectively assigned to the ACO rather than preliminarily assigned to ACOs with a retrospective reconciliation; and there will be a phase-in of waivers to selected Medicare payment rules (i.e. SNF 3-day rule; potentially telehealth requirements pending testing by CMMI).	of a prospective attribution methodology will be viewed positively by many qualified entities --- up-front knowledge of their beneficiary panel will facilitate patient engagement and population management efforts. The College, in its previous comments to CMS, has encouraged the consideration of the choice of prospective attribution methodology under Tracks 1 and 2. The College also supports the addition of increased flexibility regarding various Medicare payment rules into this option --- again, the preference would be to expand these waivers into at least Tract 2 and also possibly Track 1. (Note that the rule indicates that CMS will be testing the possibility of allowing additional waivers through CMMI).
	• Modifying Track 2 (the performance-based two-sided risk track established with the November 2011 final rule) to allow ACOs to choose from a menu of symmetrical options ranging for setting their MSR/MLR as present under Track 3.	The College supports the increase flexibility now provided under Track 2 that allows the ACO to choose the thresholds an ACO's expenditures must meet or exceed to be eligible to share in savings or be accountable for losses. Each organization is in the best position to determine the risk for which it is prepared.
	• Reducing the burden of the repayment mechanism requirement for ACOs applying to enter Tracks under the two-sided model;	ACOs under two-sided models are required to demonstrate a repayment mechanism that ensures that they can repay loses to CMS for which they are liable. Under the original rule, the ACO had to demonstrate the adequacy of the repayment mechanism each year of the contract. The final rule reduces this burden by permitting the approval of a repayment mechanism only once --- at the beginning of the 3-year agreement. The College supports all efforts at reducing unnecessary administrative burden.

Beneficiary Assignment (Tables reflecting specialty codes included/excluded from the steps of the attribution process based on the final rule are appended at the end of this summary and analysis.	The previous methodology assigned beneficiaries in an iterative two-step process based on the plurality of primary care services furnished 1) by specified primary care physicians (i.e. internal medicine, family practice, general practice, geriatric medicine), and, if not attributed by step one, 2) by specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists. CMS, while maintaining the emphasis of assignment based on the delivery of primary care services, has revised the assignment methodology in the following ways: • updated the definition of primary care services used within the assignment process to include the transitional care management (TCM) codes and the chronic care management (CCM) code • Inclusion of NPs, PAs and CNSs in the Assignment (Attribution) Process under Step One --- the final rule calls for the inclusion of defined primary care services provided by nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs) who are participants within an ACO within Step 1 of the assignment process contingent on satisfying the requirement that at least one primary care service is received from a physician participating within the attributed ACO.	• The College agrees that these are primary care services and it is appropriate to include within the definition. • The College agreed in it comments to the proposed rule that many advanced practice professionals are engaged in the delivery of primary care and their inclusion within Step 1 can provide for a more accurate primary care-based assignment. The College further contended that this positive effect would require additional assurance (criteria) that the NPs, PAs, and CNSs considered under Step 1 were truly primary care providers. CMS contended that the substantial majority of these practitioners were involved in the delivery of primary care, and did not see the need to creating additional "barriers" to their inclusion.

	• Inclusion of defined primary care services provided by physicians of pediatric medicine under Step 1 • Inclusion of defined primary care services provided by physicians of osteopathic medicine and psychiatry (including its specialty codes) under Step 2. • Removal of certain specialty types whose services are not likely to be indicative of primary care from Step 2. The final rule added to a list included in the proposed rule the following specialties: allergy and immunology; gastroenterology; hospice and palliative medicine; infectious diseases; rheumatology; and interventional cardiology. • Note that CMS plans, through rulemaking in the 2017 Physician Fee Schedule, 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.	• The College agrees that these physicians typically provide primary care. • The College supports the inclusion of these specialty physicians under Step 2. Osteopaths frequently provide primary care and psychiatrists often provide a substantial proportion of primary care services for certain patient groups (e.g. seriously mentally ill). • The College believes that the exclusion of specialties (subspecialties) from the attribution process that rarely provide primary care will improve the accuracy of attribution based on the delivery of primary care. The exclusion of these specialties (subspecialties) from the attribution process will also remove these specialty providers from the exclusivity requirement to one ACO. The College has been a strong advocate of removing this exclusivity requirement for specialty physicians who routinely do not provide primary care. • The College supports attribution by patient self-attestation.
Data Sharing .	The previous rule permitted CMS to share claims data with ACOs that are 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 College supports this more streamlined approach that will effectively provide greater and more timely access to necessary beneficiary data with less confusion by beneficiaries and administrative burden on ACOs. The identifiable data is limited to claims under Part A, Part B

	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. In the final rule, CMS streamlined 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 out letters that may confuse beneficiaries, and beneficiaries will no longer have to sign and return forms to the ACO.	and Part D. Identifiable data related to the diagnosis and treatment of alcohol or substance abuse is excluded based on federal law restricting the disclosure of patient records by federally conducted or assisted substance abuse programs. Such data may be disclosed only with the prior written consent of the patient, or as otherwise provided in the statute and regulations. The College believes this data is important, and has advocated at least for the release of de-identified, aggregate data regarding such diagnoses or treatments.
Resetting ACO Financial Benchmarks	In the previous rule, CMS adopted a methodology for establishing ACO financial benchmarks used for determining shared savings and losses. In this rule, CMS finalized the following methods for resetting the ACO's benchmark at the start of its second or subsequent agreement period: • Equally weighting the historical benchmark years, as opposed to weighting these years	The College supports the methodology finalized for establishing ACO financial benchmarks used to determine shared savings and loses. CMS believes, and the College agrees, that the finalized methodology will encourage continued participation and improvement by ACOs, thereby improving the program's overall sustainability. • The methodology of equal weighting of the historic benchmark during resetting provides appropriate

	10% for benchmark year (BY) 1, 30% for BY2, and 60% for BY3 as will continue to be done in establishing the historical benchmark for an ACO's initial agreement period. • Accounting for savings generated by the ACO in its prior agreement period. The reset historic benchmarks will be adjusted (increased) only for those ACOs that generated total net-savings over the initial 3-year agreement and takes into account quality performance and the average number of assigned beneficiaries under the ACOs first agreement period. No (negative) adjustment will be made if an ACO is determined not to have generated net savings. • CMS further indicated the intention 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.	protection (from inappropriate low benchmarks) to those ACOs that have trended towards improved financial performance over the first 3-year agreement. • The College strongly supports the decision to add back to the reset benchmark savings generated by the ACO. This appropriately addresses the problem of those ACOs who have generated substantial savings having to address a benchmark during the second contract period this is so low that additional savings will be difficult to generate. We further support the decision to include consideration of all savings generated, and not just savings that were above the minimal savings rate (MSR). This will "reward" those ACOs that generated savings, but not enough to have shared in them. The methodology finalized in the rule to add savings to the benchmark also fairly addresses CMS expressed concern regarding a situation where the reset benchmark becomes overly inflated such that ACOs need to do little to maintain or change their care practices in order to generate further savings. • The College supports efforts to take into account during rebasing the influence of cost trends in the surrounding region or local market, rather than just focusing upon the historic performance of the ACO. This will further encourage continued participation in the program.
Eligibility Requirements	CMS finalized several "minor" modifications to the MSSP program related to: the agreement requirements between the ACO and participating	The College supports many of these changes, including the required increased transparency in the agreement between the ACO and their participating entities (e.g. how savings will be shared and

	entities; the governing body and leadership requirements; the defining by the ACO on how it plans to coordinate care; and the application procedure (streamlined) to allow Pioneer ACOs to apply to the MSSP program.	quality reporting requirements) and the removal of unnecessary restrictions regarding the governing body. We do have some concerns regarding whether ACOs will be able to establish new agreements with their participating ACOs in time for the initiation of the second 3-year contract. We appreciate CMS's recognition of this potential problem, and their adjustment of the due dates to conform to the new participating agreement requirements.

APPENDIX: OVERVIEW OF SHARED SAVINGS PROGRAM FINANCIAL MODEL FINAL POLICY CHANGES

Issue	Track 1: One-Sided Model (shared savings only)	Two-Sided Model (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Transition to Two-Sided Model	Remove requirement to transition to two-sided model for a second agreement period.	No change. 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.	Same as Track 2
Assignment	No change. Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change. Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	Prospective assignment for reports, quality reporting and financial reconciliation; Beginning in 2017, beneficiaries may attest that their main doctor is participating in a performance-based risk track ACO and be assigned to that ACO (through PFS rulemaking)

Adjustments for Health Status and Demographic Changes	No change. Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the assigned beneficiary population for 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	Same as Track 1 and 2
Final Sharing Rate	No change. Up to 50% based on quality performance (maintained for second agreement period under Track 1)	No change. Up to 60% based on quality performance	Up to 75% based on quality performance.
Minimum Savings Rate (MSR)/ Minimum Loss Rate (MLR)	No change. 2.0% to 3.9% MSR depending on number of assigned beneficiaries. MLR not applicable.	Instead of a fixed 2% MSR/MLR, ACOs will have a choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in .5% increments from .5% to 2.%; or symmetrical MSR/MLR based upon number of assigned beneficiaries .	Same as Track 2.
Performance Payment Lemit	No change. 10%	No change. 15%	No change. 20 %
Shared Savings	No change. First dollar sharing once MSR is met or exceeded	No change. Same as Track 1	Same as Tracks 1 and 2

Shared Loss Rate	No change. Not applicable	No change. One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 60%	One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 75%
Loss Sharing Limit	No change. Not applicable	No change. Limit on the amount of losses to be shared in 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.	15%. Losses in excess of the annual limit would not be shared.
Payment and Program Rule Waivers and Part 425	Not applicable	Not applicable	Beginning in 2017, ACOs may elect to apply for a waiver of the SNF 3-Day Rule; As early as 2017 begin to phase-in a waiver of certain billing and payment requirements for telehealth services after it is tested in the Innovation Center

CMS PHYSICIAN SPECIALTY CODES THAT ARE NOW INCLUDED AND EXCLUDED FOR BENEFICIARY ASSIGNMENT

TABLE 2—SPECIALTY CODES INCLUDED IN ASSIGNMENT STEP 1

Code	Specialty name
01	General Practice.
08	Family Practice.
11	Internal Medicine.
37	Pediatric Medicine.
38	Geriatric Medicine.

TABLE 3—CMS NON-PHYSICIAN SPECIALTY CODES INCLUDED IN ASSIGNMENT STEP 1

Code	Specialty name
50	Nurse practitioner.
89	Clinical nurse specialist.
97	Physician assistant.

TABLE 4—PHYSICIAN SPECIALTY CODES–INCLUDED IN ASSIGNMENT STEP 2

Code	Specialty name
06	Cardiology.
12	Osteopathic manipulative medicine.
13	Neurology.
16	Obstetrics/gynecology.
23	Sports medicine.
25	Physical medicine and rehabilitation.
26	Psychiatry.
27	Geriatric psychiatry.
29	Pulmonary disease.
39	Nephrology.
46	Endocrinology.
70	Multispecialty clinic or group practice.
79	Addiction medicine.
82	Hematology.
83	Hematology/oncology.
84	Preventive medicine.
86	Neuro-psychiatry.
90	Medical oncology.
98	Gynecology/oncology

TABLE 5—PHYSICIAN SPECIALTY CODES EXCLUDED FROM ASSIGNMENT STEP 2

Code	Specialty name
02	General surgery.
03	Allergy/immunology.
04	Otolaryngology.
05	Anesthesiology.
07	Dermatology.
09	Interventional pain management.
10	Gastroenterology.
14	Neurosurgery.
17	Hospice and Palliative Care.
18	Ophthalmology.
20	Orthopedic surgery.
21	Cardiac electrophysiology.
22	Pathology.
24	Plastic and reconstructive surgery.
28	Colorectal surgery.
30	Diagnostic radiology.
33	Thoracic surgery.
34	Urology.
36	Nuclear medicine.
40	Hand surgery.
44	Infectious disease.
66	Rheumatology.

72 .... Pain management.
76 .... Peripheral vascular disease.
77 .... Vascular surgery.
78 .... Cardiac surgery.
81 .... Critical care (intensivists).
85 .... Maxillofacial surgery.
91 .... Surgical oncology.
92 .... Radiation oncology.
93 .... Emergency medicine.
94 .... Interventional radiology.
99 .... Unknown physician specialty.
CO........... Sleep medicine.
C3............ Interventional Cardiology