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Summary of Major Issues Addressed in the Medicare Shared Savings Program Proposed Rule

Background

The Medicare Shared Savings Program (MSSP) now includes more than 330 ACOs and more than 125,000 Medicare enrolled practitioners. They function in 47 states, in addition to DC and Puerto Rico. Roughly 4.9 million beneficiaries are assigned to these ACOs (while assigned, such beneficiaries are free to seek services from non-ACO providers under traditional Fee-For-Service Medicare).

The following are the first year results for the first 220 Medicare Shared Savings Programs that were released by CMS in November, 2014:

- 58 Shared Savings Program ACOs (26 %) held spending $705 million below their targets and earned performance 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 about $383 million in shared savings, including repayment of losses for one Track 2 ACO.
- An additional 60 ACOs (27%) reduced health costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.
- Shared Savings Program ACOs improved on 30 of 33 quality measures. Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, health promotion and education, screening for tobacco use and cessation, and screening for high blood pressure.

Current	Proposed Change	Comment
ACO Application Requirements, Participation Agreements and Renewal	The proposed rule addresses a number of issues related to ACO application and participation requirements that include: • the required nature of the participation agreement between the ACO and its ACO participants--- particularly that the agreement gives ACO the legal authority to ensure that its ACO participants, its ACO providers /suppliers, and other individuals or entities performing functions or services related to ACO activities are required to comply with the requirements of the Shared Savings Program. • clarifies requirements for the submission by each ACO of its ACO participants and related providers and suppliers, and	These all seem reasonable and appropriate. Agreed to by most stakeholders.

	establishes revised regulations defining requirements for changes in participants and reporting them to CMS.
	• formalizes its methodology to ensure that the ACO meets the requirement of at least 5,000 beneficiaries for each of the 3 contractual years.
	• clarifies and make limited revisions to requirements regarding the structure of the ACO's legal entity and governance including
	  ○ that ACO governance must be different from that of ACO participants.
	  ○ removing any exception to requirement that at least 75 % of governance is controlled by the ACP participants (i.e. those actually providing service)
	• Clarifies the need for the ACO to specify its process for coordinating care, requiring ACOs to articulate how they will encourage and promote the use of enabling technologies for improving care coordination
	• removes the protection from any changes to beneficiary assignment methodology during the 3-year contractual period. Maintains protections from any changes during contract years to:
	  ○ ACO structure and governance requirements
	  ○ Sharing rate calculations
	unless specifically mandated by statute.
	• formalizes a review and approval of	

	participation agreement renewal requests, taking into account such things as the ACO's history of compliance with the requirements of the Shared Savings Program and the ACO's history of meeting the quality performance standard during the first 2 years of program participation.	
Encouraging ACOs to take on greater performance based risk Currently ACOs can participate in the program under two options: • Track 1---the ACO operates under a one-sided shared savings only model (no loss risk) for its initial 3-year agreement period and must transition to Track 2 for all subsequent agreement periods. (98 % of ACO have chosen Track 1) • Track 2 ---the ACO operates under a two-sided shared savings/losses model beginning with the first 3-year agreement period in exchange for a greater share (60% vs 50%) of any savings.	The rule proposes to permit ACOs to participate in one additional agreement period under Track 1, but at a lower sharing rate (from 50 % to 40%) than the previous agreement period to encourage progression along the performance risk continuum. This policy would be available to ACOs that have met the quality performance standard in at least one of the first two years and have not generated losses that exceed the negative minimum savings rate (MSR) in both of the first two years of the previous agreement period.	The College should support the proposal to allow at least a 2nd 3-year contract for ACOs under the one-sided risk option. There is a learning curve to operating as an ACO ,and many ACOs will not be ready or willing to take on risk only after 3-years of experience. A number of stakeholders are also suggesting that contracts should be for 5 rather than 3 years . The reduction in rate sharing proposed with assuming a 2nd one-sided risk option will make it more difficult for the small ACO programs (the majority) to recoup their substantial start-up costs and lessen the "business case" to remain in the program. The share rate should not change --- the other requirements are reasonable and adequately ensure that programs entering into

		a 2nd 1-sided contract are progressing towards value-based delivery of care.
	The rule proposes to modify Track 2 to increase its attractiveness by making the minimum savings and loss rates variable based on number of assigned beneficiaries (smaller the number of assigned beneficiaries, higher the threshold) rather than the current flat 2 percent required to trigger shared savings or losses. This would have the effect of providing some increased protection ---- particularly for smaller ACOs---from having to pay CMS losses, but would also increase the threshold required to share in savings.	Discussions with stakeholders reflect a consensus that ACOs should minimally have the option of a flat 2 % minimal rate or the proposed variable rate. There is also discussion regarding a rolling threshold that changes over the length of the contract.
	The finale rule proposes to implement an additional performance risk-based model (Track 3) for ACOs to participate in the Shared Savings Program that would further encourage acceptance of risk. Track 3 would • Offer a higher savings sharing rate (75%) and maximum payment limit rate (up to 20 % 0f benchmark) than under Tracks 1 and 2. (Potential for loss would also be increased) • Prospectively assign beneficiaries to the ACO to provide a more "targeted" population than under Tracks 1 and 2. The attribution will be the same stepwise method as under Tracks 1 and 2, but without retroactive reconciliation. (Only beneficiaries that lose their eligibility for the program will be excluded). The	Discussions with ACO participants indicate that operating under a retrospective vs a prospective assignment methodology are quite different --- there is discussion regarding allowing ACOs to choose to operate under Track 2 either under prospective or retrospective assignment ---- and that risk be gradually introduced under Track 2.

	proposed rule makes minor changes to risk-adjustment and benchmarking methodology (compared to tracks 1 and 2) required as a result of prospective attribution. (**See appendix for a more detailed comparison among the three tracks**) The final rule seeks comment on other possible design elements that would encourage organizations to consider taking on greater financial risk, including options to: ○ Augment the current assignment methodology by including beneficiaries on the assignment list when the beneficiary attests that a practitioner participating in the ACO is responsible for his or her care coordination. ○ Allow different participants under an ACO, or different providers within an ACO participant to assume different levels of risk. ○ Waive certain FFS payment and regulations related to qualifying hospital stays for SNF admission, telehealth, qualifications for home health services, and qualifications for post-acute referrals. ○ Reduce requirements for use of and payment for various telehealth and other remote services assisted by present day technology.	These waivers seem quite positive --- and may likely reflect a reasonable incentive to encourage the acceptance of risk. Some stakeholders believe that that assignment by beneficiary attestation should be available under all 3 track options.

	○ Reduce requirements for use of and payment for home health services e.g. waive the homebound requirement ○ Allow hospitals to recommend specific high quality/low cost post-acute care providers, rather than representing all available providers as equal.	
Beneficiary Assignment The existing methodology assigns beneficiaries to ACOs in two steps (after satisfying the statutory requirement by identifying beneficiaries who have received a primary care service from a physician in the ACO) based on the plurality of primary care services furnished by 1) primary care physicians, and 2) by specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists. More specifically, Step 1: The beneficiary would be assigned to the ACO if the allowed charges for primary care services furnished to the beneficiary by	The proposed rule codifies beneficiary eligibility determination for assignment to include that the beneficiary : • Has at least 1 month of Part A **and** Part B enrollment and does not have any months of Part A only or Part B only enrollment. • Does not have any months of Medicare group (private) health plan enrollment (e.g. Medicare Advantage; PACE program). • Is not assigned to any other Medicare shared savings initiative. • Lives in the U.S. or U.S. territories and possessions The proposed rule expands the definition of	The services under these codes are

primary care physicians who are ACO professionals are greater than the allowed charges for primary care services furnished **by primary care physicians** who are ACO professionals in any other ACOs, and greater than the allowed charges for primary care services billed to Medicare by any other solo practice/group containing primary care physicians, identified by a Medicare-enrolled TIN that is unaffiliated with any ACO. Step 2: This step applies **only for beneficiaries who have not received any primary care services from a primary care physician**. A beneficiary is assigned to an ACO in this step if the beneficiary received at least one primary care service from a non – primary care **physician** participating in the ACO, and more primary care services (measured by Medicare allowed charges) from ACO professionals (physician regardless of specialty, nurse practitioner, physician assistant or clinical nurse specialist) at the ACO than from ACO professionals in any other ACO or solo practice/group of practitioners identified by a Medicare-enrolled TIN or other unique identifier. Note that currently under this approach 92 % of attributed beneficiaries are assigned during step 1.	"primary care services" used in the attribution process to include the TCM and CCM codes. The proposed rule revises Step 2 of the assignment methodology to remove certain specialty types (34) whose <u>services are not likely to be indicative of primary care services</u> (e.g. surgery, psychiatry, dermatology, urology), despite the fact that they employ the defined primary care codes. Additionally, the rule proposes to include nurse practitioner, physician assistant, and clinical nurse specialist primary care services in Step 1 in order to recognize the primary care services delivered by these professionals.	consistent with the delivery of primary care and should be included within the definition. The exclusion of designated specialty areas that use defined primary codes, but clearly do not provide primary care services, from the attribution process is appropriate. There should be processes for various societies to be taken off, or added to this list. This does not address the problem of our internal medicine subspecialties in ACO participating practices that are restricted to participation in one ACO, <u>who want to</u> be excluded from the attribution process --- and thus not be exclusive to one ACO. We will offer both opt-in and opt-out alternatives to CMS to allow this to happen . This is likely appropriate, but only if the TIN under which these non-physicians delivered services are provided include a designated primary care physician.

Data Sharing Currently, ACO are provided with de-identified aggregate information and limited patient identifiable information regarding beneficiaries specifically preliminarily prospectively assigned to them --- this patient identified information consists of beneficiary name, date of birth, health insurance claim number, and sex.	The proposed rule expands the information provided to ACOs at the beginning of their contract year and at regular intervals afterwards regarding their attributed beneficiaries to improve population health planning. This expansion would: • include providing information on beneficiaries not specifically assigned to the ACO, but who have a primary care service visit with an ACO participant during the last 12 months (only under participation options where beneficiaries are preliminarily prospectively assigned with retrospective reconciliation (i.e. Tracks 1 and 2) • include additional patient identifiable data points including enrollment status, health status information , Medicare service utilization rates and expenditure information.	The additional information is appropriate and very helpful for planning purposed for the ACO. CMS makes a strong case for their authority to provide this additional information --- e.g. it is aligned with relevant federal statutes (e.g. HIPAA)
Current policy permits CMS to share claims data with ACOs that is necessary for health care operations, but only after ACOs have notified beneficiaries and provided them an opportunity to decline to have their data shared with the ACO among other requirements. ACOs can either mail notices to beneficiaries, wait 30 days before requesting data, and then follow up with the beneficiary at the next primary care office visit, or they may notify beneficiaries at the point of care and request data immediately. This process	The propose rule also streamlines the process for ACOs to access beneficiary claims data (Medicare Parts A, B and D) necessary for health care operations while retaining the opportunity for beneficiaries to decline to have their claims data shared with the ACO. Specifically, it proposes that ACO participants would 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. Under this proposal, beneficiaries would express their data sharing preferences directly to CMS	The reduction in administrative burden regarding release of this information to the ACO is also very helpful.

has created beneficiary confusion, delays in data sharing, and administrative complexity.	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. CMS also proposes to take responsible to provide provide beneficiaries with advance notification about the opt-out opportunity (e.g. Notice in yearly *Medicare and You* Handbook)	
	CMS will continue to exclude the provision of alcohol and substance abuse records to the ACO.	If alcohol and substance abuse patient identified data cannot be provided by statute, then at least de-identified aggregate data in these areas should be provided for the attributed population to assist in program planning.
Establishing, updating, and resetting ACO financial benchmarks: CMS is not proposing any changes to their current methodology for establishing ACO financial benchmarks used for determining shared savings and losses.	Through this proposed rule, CMS is seeking comment on a number of alternative methodologies for establishing, updating, and resetting ACO financial benchmarks. CMS highlights that any modification of the benchmarking methodology must balance the desire to make the program more financially attractive to ACOs, against the need to protect the Medicare Trust Funds. Alternatives that CMS mentions for considerations include:	Complicated issue --- working with other stakeholders to develop a potential recommendation.

	• using regional FFS expenditures instead of national FFS expenditures in establishing and updating the benchmark, • transitioning to using regional FFS cost data to make ACO benchmarks gradually more independent of the ACO's past performance and gradually more dependent on the ACO's success in being more cost efficient relative to its local market, • Changes in methods of resetting the ACO's benchmark in subsequent agreement periods such as equally weighting the three benchmark years and/or accounting for shared savings payments received by an ACO in its prior agreement period. In addition, CMS is seeking comment on related changes to calculations related to the benchmark that would support these options, including changes to risk adjustment normalization and coding intensity adjustments, comparison group definitions, adjustments for ACO composition changes, the timeline for transition to regional FFS costs, and other adjustments.	