



July 2015

## CMS Encourages Continued Participation in Medicare Shared Savings Program with Final Rule



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**T**he Centers for Medicare & Medicaid Services (CMS) issued a final rule to the Medicare Shared Savings Program (MSSP) regulations to encourage continued and enhanced accountable care organization (ACO) participation in the MSSP, including participation in performance-based risk arrangements.

In finalizing the modifications to the MSSP regulations, CMS considered more than 270 comments received in response to its December 2014 notice of proposed rulemaking. Some key changes to the MSSP regulations in the Final Rule include:

- Creating a new two-sided risk model (Track 3) with certain features of the Pioneer ACO Model such as prospective beneficiary assignment and higher shared savings rates;
- Establishing a waiver of the three-day skilled nursing facility (SNF) rule for beneficiaries prospectively assigned to Track 3 ACOs;
- Removing the requirement for an ACO to transition to a two-sided model for the second agreement period by permitting eligible ACOs to renew participation in the one-sided risk model (Track 1);
- Adding new requirements related to renewal of an ACO’s participation agreement in the MSSP, changes to the ACO participant list and ACO provider/supplier list, and required terms in the ACO participant agreement between an ACO and an ACO participant;
- Increasing emphasis on primary care services by adding transitional care management and chronic care management codes to the definition of primary care services, clarifying the use of non-physician provider services and specialist physicians in the beneficiary assignment



methodology, and clarifying ACO participant exclusivity requirements; and

- Streamlining the process for ACOs to access Medicare beneficiary claims data and the opportunity for the beneficiaries to decline data sharing.

Below is a general summary of these and other primary changes made by CMS in the Final Rule:

## A. ACO Eligibility Requirements

**1. Requirements for ACO Participant Agreements.** The Final Rule adds a new § 425.116, which outlines requirements for the ACO participant agreements between the ACO and its ACO participants. For 2017 and subsequent performance years, among other requirements, ACO participant agreements must:

- Expressly require the ACO participant to agree, and to ensure that each ACO provider/supplier billing through the TIN of the ACO participant agrees, to participate in the MSSP and to comply with the requirements of the MSSP and all other applicable laws and regulations;
- Be for a term of at least one performance year and articulate potential consequences for early termination from the ACO;
- Require the ACO participant to update its enrollment information, including the addition and deletion of ACO professionals and ACO providers/suppliers billing through the TIN of the ACO participant, on a timely basis in accordance with Medicare program requirements and to notify the ACO of any such changes within 30 days after the change;
- Permit the ACO to take remedial action against the ACO participant, and require the ACO participant to take remedial action against its ACO providers/suppliers, to address noncompliance with the requirements of the MSSP and other program integrity issues; and
- Require completion of a close-out process upon

termination or expiration of the agreement that requires the ACO participant to furnish all data necessary to complete the annual assessment of the ACO's quality of care and addresses other relevant matters.

The new § 425.116 also provides that an ACO has the option to contract directly with its ACO providers/suppliers. These agreements generally must have the same elements as the participant agreements with ACO participants.

CMS noted that ACOs are ultimately responsible for ensuring that each ACO provider/supplier billing through the TIN of an ACO participant has agreed to participate in and comply with the MSSP rules. CMS further noted that although it will not routinely request an ACO to submit copies of executed agreements the ACO or its ACO participants have with ACO providers/suppliers as part of the ACO's application or continued participation in each performance year, CMS does reserve the right to request such information during the application or renewal process and at any other time for audit or monitoring purposes. As such, ACOs strongly should consider obtaining written agreements from each of their ACO providers/suppliers.

**2. Changes to ACO Participant List and ACO Provider/Supplier List.** The Final Rule adds a new § 425.118, which discusses the requirements and processes for maintaining, updating, and submitting the required ACO participant and ACO provider/supplier lists. Under § 425.118, ACOs must report changes in ACO participant and ACO provider/supplier enrollment status in PECOS within 30 days after such changes have occurred, and ACOs must notify CMS no later than 30 days after the termination of an ACO participant agreement. To add a new ACO participant, an





ACO must submit a request to CMS, and CMS must approve additions to the ACO participant list before they can become effective on January 1 of the following performance year.

For new ACO providers/suppliers, the ACO must notify CMS within 30 days after the individual or entity becomes a Medicare-enrolled provider/supplier that bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a billing number assigned to the TIN of an ACO participant, and such individual or entity will become an ACO provider/supplier no earlier than 30 days before the date of notice.

Finally, an ACO must notify CMS no later than 30 days after an individual or entity ceases to be a Medicare-enrolled provider or supplier that bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a billing number assigned to the TIN of an ACO participant.

**3. Descriptions for Promoting IT Development and Partnerships with Post-Acute Providers.** The Final Rule adds a new MSSP eligibility requirements at § 425.112(b)(4)(ii)(C), which requires an ACO to describe in its application how it will encourage and promote the use of enabling technologies, such as electronic health records, data aggregation, telehealth and health information exchange services, for improving care coordination for beneficiaries and engaging patients in their care. Additionally, the Final Rule adds a new provision at § 425.112(b)(4)(ii)(D) to require the MSSP applicant to describe how the ACO intends to partner with long-term and post-acute care providers to improve care coordination for the ACO's assigned beneficiaries.

**4. Leadership and Management Requirements.** The Final Rule provides additional flexibility regarding the qualifications of the ACO medical director at § 425.108. For example, the requirement that the medical director be an ACO provider/supplier is removed. The Final Rule also eliminates the provision permitting ACOs to request consideration to enter the MSSP without satisfying the requirements at § 425.108(b) and (c) for operations and clinical management.

## B. Establishing and Maintaining the ACO Participation Agreement

### 1. Criteria for Renewal of the ACO Participation Agreement.

The Final Rule adds new § 425.224 to establish procedures for renewing the ACO participation agreements. Under § 425.224(a), an ACO will be permitted to request renewal of its participation agreement prior to its expiration in a form and manner and by a deadline specified by CMS in guidance. An ACO executive who has the authority to legally bind the ACO must certify that the information contained in the renewal request is accurate, complete and truthful. Further, an ACO that seeks to renew its participation agreement and was newly formed after March 23, 2010, must agree that CMS can share a copy of its renewal request with the Department of Justice or Federal Trade Commission. CMS will evaluate an ACO's participation agreement renewal based on all of the following factors:

- Whether the ACO satisfied the criteria for operating under the selected risk model;
- The ACO's history of compliance with the requirements of the MSSP;
- Whether the ACO established that it is in compliance with the eligibility and other requirements of the MSSP, including the ability to repay losses, if applicable;
- Whether the ACO met the quality performance standards during at least one of the first two years of the previous agreement period;
- Whether an ACO under a two-sided model repaid losses





owed to the MSSP that it generated during the first two years of the previous agreement period; and

- The results of a program integrity screening of the ACO, its ACO participants, and its ACO providers/suppliers.

Under the Final Rule, the ACO must submit both the renewal request and any additional information needed to evaluate the request in the form and manner and by the deadlines specified by CMS. CMS will notify each ACO in writing of its determination to approve or deny the ACO's renewal request.

**2. Changes to Program Requirements during the Three-Year Agreement.** CMS finalized its modification of § 425.212(a) to provide that ACOs are subject to all regulatory changes "that become effective during the agreement period," except for regulations regarding certain specified program areas, "unless otherwise required by statute."

### C. Data Sharing and Assignment of Beneficiaries

**1. Claims Data Sharing.** CMS finalized its processes and policy for claims data sharing and expanding the data set made available to ACOs. Specifically, CMS finalized § 425.704 to begin sharing beneficiary identifiable claims data with ACOs participating under Tracks 1 and 2 that request claims data on beneficiaries who are included on their preliminary prospective assigned beneficiary list or that have received a primary care service from an ACO participant upon whom assignment is based during the most recent 12-month period, at the start of the ACO's participation agreement period, provided all other requirements for claims data sharing under the MSSP and HIPAA regulations are met. Additionally, CMS finalized its proposal to share beneficiary identifiable claims data with ACOs participating under Track 3 that request beneficiary identifiable claims data on beneficiaries who are included on their prospectively assigned beneficiary list. Finally, CMS will now require ACO participants to use CMS-approved template language to notify beneficiaries regarding participation in an ACO and the opportunity to decline data sharing, and, to honor the request to decline data sharing.

**2. Basic Criteria for Beneficiaries for ACO Assignment.** CMS codified specific criteria that a beneficiary must meet to be eligible for assignment to an ACO, including that the beneficiary:

- Has least one month of Part A & 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 (defined as other than Part A & B enrollment, including Medicare Advantage under Part C, eligible organizations under Section 1876 of the Act, and Programs of All Inclusive Care for the Elderly under section 1894 of the Act);
- Is not assigned to any other Medicare shared-savings initiative;
- Lives in the United States or U.S. territories and possessions as determined based on the most recent available data in the CMS beneficiary records regarding the beneficiary's residence at the end of the assignment window.

**3. Definition of Primary Care Services for Beneficiary Assignment.** Under the current rules, beneficiaries are required to be assigned based on their utilization of primary care services provided by a physician. CMS revised several of its current policies for defining primary care services for purposes of assignment and the definition of primary care services. For example, CMS updated the definition of primary care services to include both Transitional Care Management codes (CPT codes 99495 and 99496) and Chronic Care Management codes (CPT code 99490), and will





include these codes in the beneficiary assignment methodology under § 425.402. CMS also finalized its proposal to make any additional revisions to the definition of primary care service codes at § 425.20 through the annual Physician Fee Schedule (PFS) rulemaking process.

**4. Physician Specialties and Non-Physician Practitioners in the Assignment Process.** As required by the November 2011 final rule, beneficiary assignment currently occurs in two steps: (a) in Step 1, assignment is based on a comparison of allowed charges for primary care services provided by primary care physicians and (b) in Step 2, assignment of beneficiaries who have not received primary care services from a primary care physician is based on whether the beneficiary received at least one primary care service from a physician participating in the ACO and a comparison of the primary care services from ACO professionals.

CMS finalized its proposal to amend the assignment methodology to include claims for primary care services furnished by NPs, PAs and CNSs in Step 1 of the assignment process (after having identified beneficiaries who received at least one primary care service by a physician participating in the ACO). CMS also modified its proposal to exclude services provided by certain physician specialties by:

- Including pediatric medicine (specialty code 37) in Step 1;
- Including osteopathic manipulative medicine (specialty code 12) and psychiatry specialties (specialty codes 26, 27, 79, 86) in Step 2; and
- Excluding allergy & immunology (specialty code 03), gastroenterology (specialty code 10), hospice & palliative medicine (specialty code 17), infectious diseases (specialty code 44), rheumatology (specialty code 66), and interventional cardiology (C3) from Step 2.

The Final Rule modifies the exclusivity requirement at § 425.306(b) to clarify how the exclusivity rules will be affected by CMS' final policy of excluding certain specialists from Step 2 – specifically, by clarifying that each ACO participant who submits claims for primary care services used to determine

the ACO's assigned population must be exclusive to one MSSP ACO.

The changes in the Final Rule affecting beneficiary assignment will apply at the beginning of the next performance year, Jan. 1, 2016. CMS will not retroactively apply the new beneficiary assignment methodology to the previous performance year. For example, CMS will use the assignment methodology applicable at the start of 2015 to conduct the final retrospective reconciliation of beneficiary assignment for performance year 2015 during mid-2016.

#### D. Shared Savings and Losses

In the November 2011 final rule, published at 76 Fed. Reg. 67802 (November 2, 2011), CMS adopted a conservative approach to the MSSP relative to the use of alternative payment models given that many of the payment models suggested by commentators were untested. Specifically, CMS created two tracks from which ACOs could choose to participate:

- A one-sided risk model (Track 1) under which ACOs qualify to share in savings but are not responsible for losses; and
- A two-sided model (Track 2) under which ACOs qualify to share in savings with an increased sharing rate, but also must take on risk for sharing in losses, resulting in greater reward for greater responsibility.

Under the 2011 final rule, the same eligibility criteria, beneficiary assignment methodology, benchmark and update methodology, quality performance standards, data reporting requirements, data sharing provisions, monitoring







for avoidance of at-risk beneficiaries, provider screening, and transparency requirements applied for ACOs under both Tracks 1 and 2. However, the financial reconciliation methodology was modified for Track 2.

CMS believed the two tracks would create an “on ramp” for the MSSP to attract both providers/suppliers new to value-based purchasing as well as more experienced entities ready to share in losses. The 2011 final rule required that ACOs who participate in Track 1 during their first agreement period must transition to Track 2 for all subsequent agreement periods.

In the December 2014 proposed rule, CMS proposed policy changes intended to both allow ACOs not yet ready to transition to performance-based risk a second agreement period under the one-sided model, and also encourage ACOs to enter performance-based risk models by lowering the risk under the existing Track 2, and offering an additional two-sided model (Track 3).

#### 1. Modifications to the Track 1 Financial Model: Transition from One-Sided Model to Two-Sided Models

- a) Second Agreement Period under Track 1. CMS finalized its proposal to permit ACOs to participate in an additional three-year agreement period under Track 1, for a total of two agreement periods under Track 1. The Final Rule removed the requirement for ACOs to immediately transition to risk after the conclusion of their first agreement period to provide ACOs with an opportunity to gain additional experience under accountable care models before transitioning to performance-based risk, and to permit CMS and Medicare beneficiaries to continue the benefits provided by ACOs (and avoid ACO’s electing to terminate their participation altogether).
- b) Eligibility Criteria for Continued Participation in Track 1. The general criteria described in section B(1) above apply to all renewing ACOs, including Track 1 ACOs applying for a second agreement period under Track 1.

CMS declined to finalize any additional financial performance criteria for determining the eligibility for

Track 1 ACOs to continue under the one-sided model for a second agreement period.

- c) Maximum Sharing Rate for ACOs in a Second Agreement Period under Track 1. CMS declined to finalize its proposal to reduce the maximum sharing rate during an ACO’s second agreement period under Track 1. Given this, an ACO participating under Track 1 for a second agreement period that meets all the requirements for receiving shared savings payments under Track 1 will continue to receive a shared savings payment of up to 50 percent of all savings, as determined on the basis of its quality performance.
- d) Eligibility for Continued Participation in Track 1 by Previously Terminated ACOs. CMS finalized its proposal to permit previously terminated Track 1 ACOs to reapply under the one-sided or two-sided model and to differentiate between those ACOs applying for a first or second agreement period under Track 1 based on when the ACO terminated its previous agreement.

2. Modifications to the Track 2 Financial Model. The Final Rule retained the existing features of Track 2 with the exception of revising certain provisions to allow ACOs entering Track 2 for agreement periods beginning January 2016 or later a choice among several options for establishing their MSR/MLR:

- 0 percent MSR/MLR;
- symmetrical MSR/MLR in a 0.5 percent increment between 0.5 – 2.0 percent; and





- symmetrical MSR/MLR that varies based on the ACO's number of assigned beneficiaries according to the methodology established under the one-sided model.

ACOs must select their MSR/MLR prior to the start of each agreement period in which they participate under Track 2 and this selection may not be changed during the course of the agreement period.

**3. Track 3 Financial Model: Creating Options for ACOs that Participate in Risk-Based Arrangements.** CMS proposed to develop a new risk-based Track 3 that would be based on the current payment methodology under Track 2, but incorporate different elements to make it more attractive for entities to accept increased performance-based risk. CMS modeled Track 3 off the current provisions governing Track 2 (which are themselves modeled on Track 1) (e.g., eligibility requirements, quality performance standards, data sharing requirements, monitoring rules and transparency requirements), but included certain discrete differences in connection with the beneficiary assignment methodology, sharing rate, and performance payment and loss sharing limits.

- a) **Prospective versus Retrospective Assignment.** CMS finalized its proposal to codify at § 425.400(a)(3) a prospective assignment methodology that would use the stepwise assignment methodology in § 425.402 to assign beneficiaries to ACOs in Track 3. Although beneficiaries will be assigned prospectively to Track 3 ACOs, the assignment methodology will be the same as is used to assign beneficiaries to ACOs participating under Track 1 and Track 2, with limited exceptions.
- b) **Exclusion Criteria for Prospectively Assigned Beneficiaries.** CMS finalized its proposed policy of excluding beneficiaries from the prospective assignment list for an ACO participating under Track 3, who meet the exclusion criteria, as specified at § 425.401(b), at the end of a performance or benchmark year, but CMS will perform this exclusion on a quarterly basis during each performance year, and incorporate these exclusions into quarterly reports provided to Track 3 ACOs. Track 3 ACOs will further use recently available assignment data when determining the ACO's quality reporting sample.
- c) **Timing of Prospective Assignment.** The Final Rule specifies the timing of beneficiary assignment, such that Track 3 ACOs will base prospective assignment on a 12-month "assignment window" (off-set from the calendar year) prior to the start of the performance year.
- d) **Interactions between Prospective and Retrospective Assignment Model.** The Final Rule also provides that, once a beneficiary is prospectively assigned to a Track 3 ACO for a benchmark or performance year, the beneficiary will not be eligible for assignment to a different ACO. This is true even if the beneficiary chose to receive a plurality of his or her primary care services from ACO professionals in that ACO during the relevant benchmark or performance year.
- e) **Determining Benchmark and Performance Year Expenditures under Track 3.** Historical benchmarks for Track 3 ACOs will be calculated by determining benchmark year expenditures for Track 3 ACOs using the calendar year expenditures for prospectively assigned beneficiaries, allowing for a three-month claims run out, excluding IME and DSH payments and considering individually beneficiary-identifiable payments made under a demonstration, pilot or time limited program.
- f) **Risk Adjusting the Updated Benchmark for Track 3 ACOs.** Under the November 2011 final rule, the Track 1 and Track 2 risk adjustment methodology differentiates between newly and continuously assigned beneficiaries, and in the December 2014 proposed rule, CMS





proposed applying a similar approach to risk adjusting the updated benchmark for Track 3 ACOs.

In the Final Rule, CMS determined to apply the same general risk adjustment methodology in Track 3, but with certain refinements to incorporate the “assignment window” for the most recent prior benchmark or performance year to the definitions of newly and continuously assigned beneficiaries at § 425.20 to be consistent with the prospective assignment approach for Track 3. Thus, for Track 3, the reference period for determining whether a beneficiary is newly or continuously assigned will be most recent prior prospective assignment window (the 12 months off set from the calendar year) before the assignment window for the current performance year as reflected at a new regulation at § 425.610(a). Conversely, the reference period for determining whether under Track 1 or 2 a beneficiary is newly or continuously assigned will continue to be the most recent prior assignment window (the most recent calendar year).

a) CMS views this approach to risk adjustment as striking a fair balance between accounting for changes in the health status of an ACO’s population while not encouraging changes in coding practices for care provided to beneficiaries who remain continuously assigned to the ACO or avoidance of high risk beneficiaries, and it proposed to apply a similar approach to risk adjusting the updated benchmark for Track 3 ACOs. CMS noted that it is important to ensure that ACOs participating under Track 3 are not encouraged to modify their coding practices in order to increase the likelihood of earning shared savings – rather, shared savings should result from actual reductions in Medicare expenditures for assigned beneficiaries.

g) Final Sharing/Loss Rate and Performance Payment/Loss Recoupment Limit Under Track 3. CMS finalized modifications in order to implement Track 3 under § 425.610:

- Applying a shared savings rate of up to 75 percent in

conjunction with accepting risk for up to 75 percent of all losses, depending on quality performance similar to Track 2 ACOs;

- Track 3 ACOs with high quality performance would not be permitted to reduce the percentage of shared losses below 40 percent; and
- Applying a performance payment limit such that shared savings do not exceed 20 percent of the Track 3 ACO’s updated benchmark, and a loss recoupment limit of 15 percent of the Track 3 ACO’s updated benchmark.

h) Minimum Savings Rate and Minimum Loss Rate in Track 3. CMS finalized a MSR/MLR methodology for Track 3 under § 425.610(b) that will allow ACOs to choose among several options for establishing their symmetrical MSR/MLR:

- 0 percent MSR/MLR;
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 – 2.0 percent; and
- Symmetrical MSR/MLR that varies based on the ACO’s number of assigned beneficiaries according to the methodology established under the one-sided model.

CMS also finalized a requirement that ACOs must select their MSR/MLR prior to the start of each agreement period in which they participate under Track 3 and this selection may not be changed during the course of the agreement period.







#### 4. *Monitoring for Gaming and Avoidance of At-Risk*

*Beneficiaries.* In the 2014 proposed rule, CMS expressed concerns that the prospective assignment of beneficiaries might increase incentives for gaming and avoidance of at-risk beneficiaries, but also stated that the proposed Track 3 model would contain features that would reduce the probability of “cherry-picking” while permitting a prospective assignment system. In the Final Rule, CMS reviewed comments on the proposal generally, including those suggesting that ACOs may limit patient choice, stint on care and engage in patient steerage.

In the Final Rule, CMS stated that it believed ACOs with at-risk arrangements would have strong incentives to ensure beneficiaries receive high quality, low cost care in order to discourage them from seeking care elsewhere. It further observed that ACOs do not have the same lock-in mechanism as in managed care arrangements so beneficiaries reserve freedom of choice to select their providers. Based on consideration of the comments, CMS did not make any additional changes in the final rule, but observed it would be monitoring closely the implementation of prospective assignment and other changes, and would modify policies where warranted.

5. *Modifications to Repayment Mechanism Requirement.* In the November 2011 final rule, CMS imposed a repayment mechanism on Track 2 ACOs to assure CMS that they could repay losses for which they may be liable. The repayment mechanism for an ACO’s first performance year had to be equal or greater than at least one percent of the ACO’s total per capita Medicare Parts A and B fee-for-service expenditures for its assigned beneficiaries based on the expenditures used to establish the ACO’s benchmark. To continue in the MSSP, Track 2 ACOs were required to demonstrate annually the adequacy of the repayment mechanism before the start of each performance year. This resulted in multiple repayment mechanisms with overlapping periods – one that covered a current performance year, including its run off period, and another to cover the next performance year.

a) Amount and Duration of the Repayment Mechanism. The Final Rule eliminates the overlap issue created by the

November 2011 final rule by requiring the ACOs in two-sided models to establish a repayment mechanism only once at the beginning of a three-year agreement period. ACOs must demonstrate an ability to repay shared losses incurred at any time within the three-year agreement period and for a reasonable “tail” after the agreement period ends. The length of this “tail” will be determined in future guidance. The Final Rule establishes the amount of the repayment mechanism to be based on 1 percent of the ACO’s total per capita Parts A and B fee-for-service expenditures for its assigned beneficiaries based on the expenditures used to establish the benchmark for the agreement period.

CMS considered, but declined, to impose a trigger to increase the value of the repayment mechanism in the event of changes to the benchmark during the agreement period. However, if an ACO uses its repayment mechanism to repay to CMS any portion of shared losses, the ACO must replenish the amount of the funds to be available to repay losses within 90 days.

b) Permissible Repayment Mechanisms. The current rules permit ACOs to use a variety of repayment mechanisms including obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit or establishing another repayment mechanism that will ensure an ability to repay losses. The Final Rule limits the types of repayment mechanisms that may be used and removes the options of reinsurance (CMS has found that reinsurance is currently not readily available) and the “other repayment options” which CMS found administratively difficult to use. Thus, under the Final





Rule, the only options for the repayment mechanism are escrow, surety bond or line of credit, or any combination of all three.

**6. Methodology for Establishing, Updating and Resetting the Benchmark.** The December 2014 proposed rule outlined a range of modifications to the benchmarking methodology to expand the methodology for resetting benchmarks to account for factors relevant to continued ACO participation in subsequent agreement periods and to increase incentives to achieve savings in a current agreement period.

- a) **Equally Weighting the Three Benchmark Years.** The Final Rule revises § 425.602(c) to specify that in resetting the historical benchmark for ACOs in their second or subsequent agreement period, it will weight each benchmark year equally.
- b) **Accounting for Shared Savings Payments When Resetting the Benchmark.** The Final Rule modifies § 425.602(c) to specify that in resetting the historical benchmark for ACOs entering their second agreement period, CMS will make an adjustment to reflect the average per capita amount of savings earned by the ACO in its first agreement period, reflecting the ACO's financial and quality performance, and number of assigned beneficiaries, during that agreement period. The additional per-capita amount will be applied to the ACO's rebased historical benchmark for a number of assigned beneficiaries not to exceed the average number of assigned beneficiaries (expressed as person years) under the ACO's first agreement period. If an ACO was not determined to have generated net savings in its first agreement period, CMS will not make any adjustment to the ACO's rebased historical benchmark. Performance data from each of the ACO's performance years under its first agreement period will be used in resetting the ACO's benchmark under its second agreement period.
- c) **Use of Regional Factors in Establishing, Updating and Resetting Benchmarks.** CMS stated it intends to propose and seek comment on the components of and procedures for calculating a regionally trended rebased benchmark

through a proposed rule to be issued later in the summer of 2015.

**7. Technical Adjustments to Benchmark and Performance Year Expenditures.** Although CMS sought comment on whether to exclude from the benchmark and performance year expenditures that are not strictly a fee-for-service payment, such as value-based adjustments, geographic adjustments etc. and received many comments in support of doing so, CMS ultimately decided not to make any change to the current policy for the expenditures used to calculate the benchmark and performance year targets. That policy, which continues under the Final Rule, computes the average per-capita Medicare expenditures during both the benchmark and performance years by taking into account all Parts A and B expenditures, including all payments made under a demonstration or pilot program, value based adjustments, geographic adjustments that are included in Parts A and B claims, but excludes only the IME and DSH adjustments.

CMS did note that other pilot programs, such as BPCI and Next Generation ACO Model, include more flexibility for the benchmarking methodology and will consider modifying the MSSP program policies as lessons emerge from these pilots.

## **E. Waivers of Payment Requirements and Other Options to Encourage ACO Participation in Performance-Based Risk Arrangements**

**1. Waiver of the SNF 3-Day Rule.** The requirement in section 1861(i) of the Act for a three-day inpatient hospital stay prior to the provision of Medicare covered post-





hospital extended care services will be waived for beneficiaries who are prospectively assigned to Track 3 ACOs. The waiver of the SNF three-day rule under part 425 will allow for Medicare payment for otherwise covered SNF services when ACO providers/suppliers participating in eligible Track 3 ACOs admit a prospectively assigned beneficiary to an eligible SNF without a three-day stay prior inpatient hospitalization. All other provisions of the statute and regulations regarding Medicare Part A post-hospital extended care services continue to apply.

All ACOs participating under Track 3 or applying to participate under Track 3 will be eligible to apply for the waiver. The specific criteria for applying for this waiver will be included in the materials for both initial applications and renewals and subregulatory guidance. The waiver will be effective on or after Jan. 1, 2017.

Apart from the SNF three-day rule waiver, CMS declined to adopt any additional waivers in the Final Rule (i.e., the Billing and Payment for Telehealth Services, Homebound Requirement under Home Health Benefit and Waivers for Referrals to Post-acute Care Settings). However, CMS noted it will conduct further development and testing of other selected waivers through the CMS Innovation Center prior to deciding whether it is necessary to incorporate such waivers in the MSSP. For example, CMS intends to focus on further development and testing of a waiver of the billing and payment requirements for telehealth services through the Next Generation ACO Model, and anticipates a telehealth waiver being available to ACOs no earlier than Jan. 1, 2017.

*Other Options for Improving the Transition to Two-Sided Performance-Based Risk Arrangements.* CMS stated it expects to propose to implement a beneficiary attestation for purposes of beneficiary assignment under the MSSP beginning Jan. 1, 2017, in the 2017 PFS rulemaking. Beneficiary assignment has previously been tested in the Pioneer ACO model by asking beneficiaries to confirm whether or not a listed provider or supplier is their “main doctor,” and by aligning those beneficiaries who confirmed a care relationship with the listed provider/supplier and met all other eligibility

criteria to be aligned with the Pioneer ACO for the following performance year, regardless of whether or not the practitioners participating in the Pioneer ACO render the plurality of the beneficiaries primary care services during the alignment year. The delayed timeline is intended to allow for further development and testing of this approach through the Pioneer ACO Model and the Next Generation ACO Model and development of appropriate safeguards against abusive or coercive marketing associated with beneficiary attestation. CMS anticipates limiting the beneficiary attestation process to ACOs participating under Tracks 2 or 3.

CMS also noted that it will explore operational processes to develop a methodology that would permit ACOs to split ACO participants or ACO providers/suppliers into two different risk tracks while also ensuring appropriate beneficiary protections. CMS may revisit this approach in future rulemaking as infrastructure evolves to support this new alternative.

## F. Additional Program Requirements and Beneficiary Protections

**1. Public Reporting.** ACOs are now required to maintain a dedicated webpage on which the ACO must publicly report certain information required by CMS. ACOs must also report to CMS the address of the web page used for disclosures. Information reported on an ACO’s public reporting web page in the standardized format specified by CMS will not be subject to marketing review and approval under § 425.310. Each ACO must publicly report its performance on all quality measures and their use of any waivers under § 425.612.





**2. Terminating MSSP Participation.** The Final Rule modifies § 425.218(b) to permit CMS to terminate an ACO participation agreement for failure to comply with requests for information and documentation by the due date specified by CMS. The modified § 425.218(b) will also permit CMS to terminate an ACO participation agreement for submission of false or fraudulent data. Finally, CMS finalized its proposal to address close-out procedures and consequences of early termination.

**3. Reconsideration Review Process.** CMS finalized § 425.802 to permit only on-the-record reviews of reconsideration requests. CMS finalized its proposal at § 425.804(a)(3) to limit the reconsideration review process to permit the ACO and CMS to submit one brief each in support of its position by the deadline established by the CMS reconsideration official, and CMS will also include in that section that submission of additional briefs or evidence is at the sole discretion of the reconsideration official.



## For More Information

For more information regarding this alert, please contact the author, a member of the Polsinelli's Health Care practice, or your Polsinelli attorney.

- Janice Anderson | *Author* | 312.873.3623 | [janderson@polsinelli.com](mailto:janderson@polsinelli.com)
- Bruce A. Johnson | *Author* | 303.583.8203 | [brucejohnson@polsinelli.com](mailto:brucejohnson@polsinelli.com)
- Jared O. Brooner | *Author* | 816.271.8010 | [jbrooner@polsinelli.com](mailto:jbrooner@polsinelli.com)
- Ryan M. McAteer | *Author* | 310.203.5368 | [rmcateer@polsinelli.com](mailto:rmcateer@polsinelli.com)
- Ken Briggs | *Author* | 602.650.2042 | [kbriggs@polsinelli.com](mailto:kbriggs@polsinelli.com)
- Joi-Lee K. Beachler | *Author* | 214.661.5532 | [jbeachler@polsinelli.com](mailto:jbeachler@polsinelli.com)

To contact a member of our Health Care team, click [here](#) or visit our website at [www.polsinelli.com](http://www.polsinelli.com) > Services > Health Care Services > Related Professionals.

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## About Polsinelli's Health Care Practice

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The Polsinelli Health Care practice comprises one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm offers clients a depth of resources that cannot be matched in their dedication to and understanding of the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

Recognized as the "Law Firm of the Year" in Health Care for 2015 by *U.S. News & World Report*, Polsinelli is ranked no. 1 by *Modern Healthcare* and no. 2 by The American Health Lawyers Association.\* Polsinelli's highly trained attorneys work as a fully integrated practice to seamlessly partner with clients on the full gamut of issues. The firm's diverse mix of seasoned attorneys well known in the health care industry, along with its bright and talented young lawyers, enables our team to provide counsel that aligns legal strategies with our clients' unique business objectives.

\**Modern Healthcare* and *AHLA Connections* (June 2015).

## About Polsinelli

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Polsinelli is an Am Law 100 firm with more than 750 attorneys in 18 offices, serving corporations, institutions, entrepreneurs and individuals nationally. Ranked in the top five percent of law firms for client service and top five percent of firms for innovating new and valuable services\*, the firm has risen more than 100 spots in Am Law's annual firm ranking over the past six years. Polsinelli attorneys provide practical legal counsel infused with business insight, and focus on health care, financial services, real estate, life sciences and technology, and business litigation. Polsinelli attorneys have depth of experience in 100 service areas and 70 industries. The firm can be found online at [www.polsinelli.com](http://www.polsinelli.com). Polsinelli PC. In California, Polsinelli LLP.

\* BTI Client Service A-Team 2015 and BTI Brand Elite 2015

## About this Publication

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