



December 2014

CMS Proposes Changes to the Medicare Shared Savings Program

The Centers for Medicare and Medicaid Services (CMS) recently published a proposed rule (Proposed Rule) that would revise regulations governing accountable care organizations (ACOs) that participate in the Medicare Shared Savings Program (MSSP). The Proposed Rule seeks to codify current CMS operational practice and guidance, and makes technical and substantive changes to the MSSP regulations intended to, among other things, encourage increased participation in two-sided risk models offered under the MSSP, modify the beneficiary assignment process, and simplify the data-sharing opt-out process. CMS is seeking public comment on the Proposed Rule, due by February 6, 2015. The full text of the Proposed Rule is available [here](#). Below are highlights of the Proposed Rule.

1. SECOND TRACK 1 AGREEMENT PERIOD

Currently, the MSSP offers two shared savings payment tracks in which ACOs may participate. Under the one-sided model, known as "Track 1," an ACO is eligible to receive shared savings payments but is not at risk for any losses. Under the two-sided model, known as "Track 2," an ACO is eligible to receive a greater share of shared savings payments than under Track 1, but the ACO is also liable to CMS for a portion of its losses if its expenditures are above its benchmark.

The current MSSP regulations provide that an ACO may participate in Track 1 for one three-year agreement term and then must transition to Track 2 for subsequent agreement terms. The Proposed Rule would permit ACOs that have completed one three-year agreement term under Track 1 to stay in Track 1 for an additional three-year agreement term. To participate in Track 1 for a second agreement term, the ACO must meet the renewal criteria (discussed below) and may have generated losses in excess of the negative minimum savings rate (described below) in only one of the first two performance years. ACOs participating in a second Track 1 agreement period would only be eligible to receive a maximum shared savings payment of 40 percent (compared to 50 percent during the first agreement term).

2. ALTERNATIVES TO ENCOURAGE PARTICIPATION IN TWO-SIDED RISK MODELS

Track 3

According to CMS, of the over 330 ACOs in the MSSP, only five are currently participating in Track 2. To further encourage participation in a two-sided risk model, the Proposed Rule would create a new payment track, "Track 3." Track 3 would use the same general payment methodology as Track 2, but would differ from Track 2 in several respects. The key differences are described below.

Beneficiary Assignment

CMS will assign beneficiaries using the same two-step algorithm currently used for Tracks 1 and 2 (described in more detail below). Track 3 beneficiaries will be assigned to Track 3 ACOs prospectively with reconciliation at the end of the performance year that will remove beneficiaries from the initial list, but no new beneficiaries will be added. A beneficiary assigned to a Track 3 ACO may not be assigned to a different ACO during the performance year, which generally is the 12-month period beginning January 1 of each year in which the ACO is participating in the MSSP. For example, beneficiaries will remain

assigned to a Track 3 ACO even if they receive all of their primary care services during the performance year from another ACO.

Performance Payment and Loss Recoupment Limit

As mentioned above, MSSP ACOs are eligible to receive shared savings payments from CMS. The payment amounts vary depending on which track the ACO chooses. Track 1 ACOs may receive up to 50 percent of the savings generated (40 percent if in a second Track 1 agreement period), with a maximum payment of 10 percent of the ACO's expenditure benchmark. Track 2 ACOs may receive up to 60 percent of savings, with a maximum payment of 15 percent of the ACO's expenditure benchmark. Track 2 ACOs are also accountable for between 40 to 60 percent of all losses under its expenditure benchmark, depending on the ACO's quality performance. A Track 2 ACO's maximum liability for losses increases progressively each performance year from 5 percent of its benchmark in the first performance year to 10 percent during the third performance year.

Under the Proposed Rule, Track 3 ACOs would be eligible to share in up to 75 percent of savings with a maximum payment of 20 percent of the ACO's benchmark. On the downside, Track 3 ACOs may be liable for between 40 and 75 percent of their losses, depending on the ACO's quality performance. In any case, Track 3 ACOs will not be liable for losses that exceed 15 percent of its benchmark.

MSR/MLR

To share in savings under the MSSP, an ACO must have a minimum amount of savings, referred to as the "minimum savings rate" or "MSR." Similarly, before a Track 2 or 3 ACO is liable for any losses, its expenditures must exceed the benchmark by a certain minimum amount, known as the "minimum loss rate" or "MLR." Currently, the Track 1 MSR varies between 2.0 and 3.9 percent, depending on the ACO's size. The MSR and MLR for Track 2 ACOs are fixed at 2.0 percent; however, as discussed below, the Proposed Rule would increase these percentages. The Proposed Rule would set the MSR and MLR for Track 3 ACOs at 2.0 percent.

Benchmarking

In determining a Track 3 ACO's benchmark expenditures, CMS proposes to use the same general methodology used for Tracks 1 and 2. CMS will determine the beneficiaries that would have been prospectively assigned to the ACO in each of the three years prior to the start of the first performance year. CMS will then compute the assigned beneficiaries' expenditures incurred in each calendar year.

Repayment Mechanisms for Two-Sided Risk Models

Lower Track 2 Risk

In contrast to the fixed MSR and MLR currently applicable to Track 2 ACOs, the Proposed Rule would vary the MSR and MLR, depending on the number of beneficiaries assigned to the ACO, similar to the MSR used for Track 1 ACOs. The MSR and MLR would vary from a minimum of 2.0 percent for ACOs with 60,000 or more beneficiaries to a maximum of 3.9 percent for ACOs with 5,000 assigned beneficiaries. By increasing the MSR and MLR for smaller ACOs, CMS hopes to lower the risk associated with normal year-to-year variation in expenditures and thus encourage more ACOs to enter Track 2.

Modifications to Repayment Mechanisms

Track 2 ACOs (and, if approved, Track 3 ACOs) must establish a repayment mechanism equal to at least 1.0 percent of its expenditure benchmark to demonstrate to CMS that the ACO is able to repay potential losses that it may owe after the end of a performance year. An ACO must establish its repayment mechanism when it applies to the MSSP and at the beginning of each performance year. An ACO's annual financial reconciliation, however, during which shared savings/losses are calculated, is not complete until the ACO's next performance year has already begun. This results in an ACO maintaining two separate repayment mechanisms — one for the current year and one for the prior year — until the previous year's finances are reconciled. Thus, the ACO must set aside double the required repayment mechanism until the previous year's reconciliation is complete. Under the Proposed Rule, CMS would require an ACO to establish a single repayment mechanism at the beginning of its participation in the MSSP that covers shared loss payments during the entire agreement period and for a reasonable time period after the end of the agreement. Thus, the Proposed Rule would eliminate the need for duplicate repayment mechanisms.

Current MSSP regulations permit an ACO to use the following repayment mechanisms: reinsurance, escrow accounts, surety bonds, lines of credit, or “another appropriate repayment mechanism.” The Proposed Rule would limit the available repayment mechanisms by no longer permitting ACOs to use reinsurance or the previously ambiguous “appropriate” alternative repayment mechanism. The Proposed Rule would also clarify that ACOs may use a combination of the foregoing to demonstrate their ability to repay potential losses.

Additional Options under Consideration

CMS also seeks public comment on a number of initiatives aimed at increasing participation in two-sided risk models (that is, Tracks 2 and 3). Although CMS states in the Proposed Rule that it is not specifically proposing any of the below initiatives, it may include one or more of the following in the final rule based on the comments it receives:

- waiving the three-day inpatient stay requirement prior to Medicare coverage of inpatient skilled nursing facility care
- waiving certain requirements related to Medicare payments for telemedicine services to encourage greater utilization of these services
- waiving certain requirements for Medicare payments related to home health care that would allow ACOs to provide such care in a broader range of circumstances
- waiving certain Medicare Conditions of Participation to permit hospitals that are ACO participants or ACO provider/suppliers to recommend to patients during the discharge planning process certain high-quality, low-cost post-acute care providers with whom the hospitals have established relationships, including financial and clinical relationships
- permitting beneficiaries to choose an ACO to which they are assigned
- allowing an ACO to permit its ACO participants and ACO providers/suppliers to assume varying degrees of risk

CMS particularly solicits comment on whether it should limit any of the foregoing initiatives to Track 3 ACOs.

3. ACO ELIGIBILITY REQUIREMENTS

Legal Structure and Governing Body

The Proposed Rule seeks to clarify governance requirements for ACOs set forth in the MSSP regulations by issuing three additional requirements. First, an ACO’s governing body must be the same as the governing body of the legal entity that is the ACO. Second, if the ACO is made up of multiple ACO participants, the governing body may not be identical to the governing body of any single ACO participant. Third, the governing body must satisfy all other requirements set forth in the MSSP regulations, including that the governing body has a fiduciary duty to the ACO, which includes the duty of loyalty.

CMS also proposes minor changes to the requirements related to the composition of an ACO’s governing body. Current MSSP regulations give CMS flexibility to allow an ACO to deviate from the requirement that 75 percent of its governing body be controlled by ACO participants. The Proposed Rule would eliminate this flexibility. It would also prohibit an ACO provider/supplier from being the beneficiary representative on the governing body.

Leadership and Management Structure

In the Proposed Rule, CMS proposes certain changes to the leadership and management requirements for ACOs set forth in the MSSP regulations, including removal of the requirement that an ACO’s medical director must be an ACO provider/supplier. In connection with these changes, the Proposed Rule would eliminate CMS’s ability to approve ACO applications from ACOs that do not strictly meet all such leadership and management requirements.

Under the Proposed Rule, ACOs would be required to submit certain documentation to CMS to demonstrate the qualification of the healthcare professional responsible for the ACO's quality assurance and improvement program.

Number of Beneficiaries

The Proposed Rule would codify CMS's current practice concerning the calculation of the number of beneficiaries assigned to an ACO in the benchmark year immediately prior to the ACO's first performance year. The Proposed Rule would provide CMS with discretion on whether to institute a corrective action plan against an ACO whose number of assigned beneficiaries falls below 5,000 during a performance year.

Furthermore, the Proposed Rule would codify current CMS guidance permitting ACOs, for the purpose of beneficiary assignment and historical benchmarking, to include claims and attribute billings of entities that an ACO participant acquires through a purchase or merger. CMS's guidance requires that (1) the ACO participant completely absorb the acquired entity's taxpayer identification number (TIN), including the providers and suppliers that reassigned to the acquired entity their right to receive Medicare payments; (2) all such providers and suppliers reassign their right to receive Medicare payments to the TIN of the ACO participant; (3) the acquired entity no longer bills Medicare using its TIN; (4) the ACO include the acquired entity's TIN on the ACO participant list and provide CMS with an attestation that the acquired entity's providers and suppliers have reassigned their billing rights to the ACO participant; and (5) the ACO submit to CMS documentation that demonstrates the ACO participant's acquisition.

Under the Proposed Rule, ACOs could also annually request, for beneficiary assignment and benchmarking purposes, that CMS include claims submitted by TINs of entities acquired by ACO participants.

Significant Changes to the ACO During an Agreement Period

Under the current MSSP regulations, an ACO must notify CMS within 30 days of a "significant change" to the ACO, which occurs when an ACO is no longer able to meet the MSSP requirements. The Proposed Rule would expand the circumstances in which a significant change occurs to include any time the number or identity of ACO participants changes by at least 50 percent during an agreement period.

Eligible Entities

The Proposed Rule would add elective teaching amendment hospitals to the list of ACO participants eligible to participate in the MSSP.

4. BENEFICIARY ASSIGNMENT METHODOLOGY

Revisions to the Definition of "Primary Care Services"

CMS assigns beneficiaries to MSSP ACOs using a two-step process based on the beneficiaries' historical utilization of "primary care services" furnished by physicians. The Proposed Rule seeks to expand the definition of primary care services to include transitional care management services following a patient's discharge from a hospital or a skilled nursing facility and chronic care management services for patients with two or more chronic conditions. The Proposed Rule would also expand the definition of primary care services to include services provided by nurse practitioners, physician assistants, and certified nurse specialists (collectively, nonphysician practitioners).

Under the current MSSP regulations, a physician must be exclusive to a single ACO if that physician bills any primary care services through an ACO participant's TIN and those primary care services are used in the beneficiary assignment process. Accordingly, if a physician specialist in a physician group practice bills a primary care service that is used to assign a beneficiary through an ACO participant's TIN, the entire physician group may only participate in the ACO that includes such ACO participant. The Proposed Rule would further revise the definition of primary care services to exclude services provided by certain physician specialties unlikely to provide primary care, such as services provided by surgeons, anesthesiologists, dermatologists, and radiologists. Therefore, such services would not be used to assign beneficiaries to ACOs and specialty physician groups could participate in multiple ACOs.

ACOs with FQHCs and RHCs

The Proposed Rule seeks to modify the beneficiary assignment methodology used for ACOs that include

as ACO participants federally qualified health centers (FQHCs) and rural health clinics (RHCs). Currently, ACOs that include FQHCs or RHCs must provide CMS a list of physicians that provide primary care services. CMS uses this list to determine whether a beneficiary is eligible for assignment to an ACO and to assign the beneficiary under the first step of the assignment process. Under the Proposed Rule, CMS will only use the list of physicians to determine whether a beneficiary is eligible for assignment. CMS would then use claims for primary care services provided by all ACO professionals submitted by the FQHC or RHC, including nonphysician practitioners, to determine whether the beneficiary will be assigned to a specific ACO.

5. ACO PARTICIPATION AGREEMENT REQUIREMENTS

Renewal Process

CMS proposes to establish requirements related to renewal of an ACO's participation agreement so that it may continue participation in the MSSP for an additional three-year period without interruption. Under the Proposed Rule, if an ACO wishes to renew its participation agreement, CMS would determine whether to renew the agreement based on a number of performance factors, as opposed to requiring the ACO to submit a new MSSP application. Those factors include the ACO's history of compliance with MSSP requirements, whether the ACO met the quality performance standards during at least one of the first two years of the previous agreement period, and, if applicable, whether the ACO repaid its losses to CMS.

Termination Process

The Proposed Rule would require that ACOs perform certain closeout procedures with CMS when leaving the MSSP. Under the Proposed Rule, ACOs who voluntarily terminate their participation agreement prior to the end of the agreement period may still receive shared savings payments provided that certain requirements are met. The Proposed Rule would also give CMS the ability to terminate an ACO from the MSSP if the ACO does not timely comply with CMS's document requests or submits false or fraudulent data.

Care Coordination

CMS proposes to require that an ACO applying to the MSSP describe in its application how it will promote the use of technology to improve care coordination for beneficiaries. The Proposed Rule would also require that ACO applicants describe their plans for partnering with long-term and post-acute care providers to improve care coordination for assigned beneficiaries. To ensure that ACOs implement the care coordination processes that the MSSP regulations require, the Proposed Rule seeks to mandate that each ACO define and submit to CMS milestones related to implementing its care coordination procedures.

Changes to MSSP Requirements During an Agreement Period

Currently, MSSP ACOs are subject to all changes made to the MSSP during an ACO's agreement period, except changes to eligibility criteria related to ACO structure and governance, the calculation of the shared savings rate, and the beneficiary assignment; however, under the Proposed Rule, CMS proposes to subject ACOs to all changes to MSSP regulations made during an agreement period unless required otherwise by statute. ACOs would thus be subject to changes in regulations made during an agreement period concerning structure, governance, beneficiary assignment, and calculation of the shared savings rate. With respect to changes that affect beneficiary assignment, however, such changes would not become effective until the following performance year.

6. ACO PARTICIPANTS AND PROVIDERS/SUPPLIERS

Reporting Requirements

In the Proposed Rule, CMS proposes to add requirements and processes that ACOs must follow when maintaining, updating, and submitting to CMS the ACO participant and ACO provider/supplier lists. Currently, each ACO must annually provide CMS with a complete list of ACO participants and their TINs, as well as a list of the ACO's providers/suppliers, including its national provider identifiers (NPIs). Under the Proposed Rule, ACOs would still be required to annually submit to CMS a list of ACO participants and their TINs; however, CMS would provide the ACO with a list of NPIs associated with each ACO participant, and the ACO must certify that the CMS-provided list is correct or make necessary revisions.

The Proposed Rule would also require that, within 30 days of occurrence, each ACO report to CMS any changes in the Medicare enrollment status of its ACO participants and ACO providers/suppliers or of termination of any ACO participant agreement. Further, if an ACO intends to add an ACO participant, the ACO would be required to obtain CMS's approval of the addition. The addition of an ACO participant would become effective at the beginning of the performance year following CMS's approval.

Content of ACO Participant and ACO Provider/Supplier Agreements

The Proposed Rule seeks to codify CMS guidance on the content of ACO participant and ACO provider/supplier agreements. In addition to provisions set forth in the current CMS guidance, the Proposed Rule would require ACO participant and ACO provider/supplier agreements to contain the following provisions:

- The ACO participant must agree to update its enrollment information within 30 days of an addition or deletion of a provider/supplier.
- The term must be for at least one MSSP performance year (except that agreements with providers or suppliers may be for less than one year).
- The agreement must require the ACO participant to complete a closeout process upon termination or expiration of the agreement.

7. ADDITIONAL HIGHLIGHTS OF THE PROPOSED RULE

Data Sharing and Opt Out

Under current MSSP regulations, CMS may provide each ACO with certain data related to its assigned beneficiaries, including claims data identifying assigned beneficiaries. The Proposed Rule would allow CMS to share with an ACO certain information of any beneficiary, regardless of whether the beneficiary is assigned to the ACO, as long as the beneficiary received a primary care service at an ACO participant and such service was considered in the beneficiary assignment process during the most recent 12-month period. CMS would also be able to provide each ACO with the minimum data set necessary for the ACO to conduct certain population-based activities. Examples of such data include demographic, risk profile, and utilization information.

Currently, ACOs must enable beneficiaries to opt out of data sharing by providing an opt-out form to beneficiaries either upon the beneficiary's first visit with an ACO participant or by mailing an opt-out form to all prospectively assigned beneficiaries. In the Proposed Rule, CMS proposes a streamlined opt-out process whereby beneficiaries may contact CMS directly to opt out. ACOs would be prohibited from sending or receiving opt-out forms through the mail. The Proposed Rule retains the requirement that ACO participants notify beneficiaries at the point of care that the provider/supplier is participating in the MSSP and that CMS-provided notices be posted at the ACO participants' facilities.

Updating and Resetting the Expenditure Benchmark

CMS is considering a number of technical changes for updating and resetting ACO expenditure benchmarks to account for national trends in Medicare fee-for-service spending. In particular, CMS is concerned about setting the benchmark at a level that accurately reflects cost increases and takes into account an ACO's previous performance while maintaining proper incentives for ACOs to continue participation in the MSSP. CMS is considering a number of alternatives, including incorporating an ACO's shared savings payments into the benchmark calculation to encourage ongoing participation in the MSSP by successful ACOs, using regional factors to adjust the benchmark and holding an ACO's historical costs constant relative to its region.

Public Reporting

The Proposed Rule would create a requirement that ACOs maintain a webpage on which it must report certain required information. CMS expects to make a template available for ACOs to report such information. The Proposed Rule would also add a requirement that ACOs publicly identify key clinical and administrative leaders, as well as the types of the ACO's participants or combinations of participants. Furthermore, ACOs would be required to publicly report their performance on all quality measures used to assess the quality of care furnished by the ACO. Currently, ACOs must report only those quality measures that are claims-based.

Transition of Pioneer ACOs into MSSP

Under current MSSP regulations, an ACO may not concurrently participate in MSSP and in the Center for Medicare and Medicaid Innovation's Pioneer ACO program. Because CMS expects a number of Pioneer ACOs to transition to the MSSP upon conclusion of their Pioneer ACO agreements, the Proposed Rule would allow Pioneer ACOs to apply to participate in Track 2 or Track 3 of the MSSP using a condensed application.

Reconsideration Review Process

Currently, ACOs are permitted to appeal CMS's denial of an application to the MSSP through a reconsideration request. The Proposed Rule would codify current CMS practice by permitting only on-the-record reviews of reconsideration requests in which the ACO and CMS are each permitted one brief supporting their respective positions.

Conclusion

If the Proposed Rule is finalized in its present form, ACOs currently participating in the MSSP may have to make slight changes to the composition of their governing bodies to comply with the new requirements of the Proposed Rule. In addition, the revisions to the beneficiary assignment process would encourage current ACOs to include as ACO participants physician specialty groups previously hesitant to join the MSSP because they were unable to participate in multiple ACOs. Furthermore, the option for ACOs to participate in an additional Track 1 agreement period may allow some ACOs that are unwilling to take on downside risk to remain in the MSSP. Similarly, the proposed revisions to the MSR and MLR under Track 2, as well as the waivers to certain Medicare conditions of payment and participation, may provide incentive for ACOs to enter a two-sided risk model. All comments on the Proposed Rule are due on February 6, 2015.

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