

MSSP ACO Program—Proposed Rule

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Accountable Care Organization Task Force

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Introduction

On December 1, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule which, if adopted, would modify the regulatory requirements for Accountable Care Organizations (ACOs) that participate in the Medicare Shared Savings Program (MSSP).¹ In the proposed rule, CMS addresses a broad array of issues including data sharing, beneficiary attribution, and performance-based risk tracks for ACOs.

While some of the changes proposed by CMS are merely technical, there are several changes that could have a significant impact on ACOs and their participating providers. For example, some of the more significant changes include: (1) more-stringent eligibility requirements for ACO participants, including restrictions on governing bodies and the creation of separate legal entities; (2) modified risk tracks for ACO participants and the creation of a third track involving prospective assignment of beneficiaries; and (3) a broader beneficiary assignment methodology for attribution to ACOs.

This Executive Summary is intended to provide a high-level overview of the proposed rule and to highlight some of the more significant changes included therein. Toward this end, this Executive Summary follows the structure of the proposed rule and includes page numbers as guideposts.

Proposed Changes to the MSSP ACO Program

ACO Eligibility Requirements

Codification of Prior Guidance (pgs. 24-58)

CMS proposes to codify a number of changes relating to the logistics of applying for, and operating, an ACO based on CMS' observations. For example, CMS encountered numerous application problems at the outset of the MSSP ACO Program and issued interim guidance to address such issues, which it now proposes to codify in regulations.

¹ 42 CFR Part 425.

CMS also relaxed rules regarding the minimum term of a participant agreement with ACO providers/suppliers, added rules governing situations where an ACO falls below its minimum 5,000 assigned beneficiaries, and added specificity to the requirements for submitting and reporting on ACO participant and ACO provider/supplier lists.

Legal Structure, Leadership, Management, and Governance (pgs. 58-71)

CMS' changes to the legal entity and governance structure requirements for MSSP ACOs are aimed at ensuring that ACO decision-making is controlled by individuals whose fiduciary duties are to the ACO exclusively and not to any particular ACO participant or other persons. Below is a summary of some of the key changes that CMS proposes to make:

- The proposed rule provides that whenever an ACO is formed by two or more participants having unique Taxpayer Identification Numbers, the ACO must be an entity that is separate and distinct from the participants;
- The governing body of an ACO that comprises multiple ACO participants must be separate and unique to the ACO and may not be the same as the governing body of any ACO participant;
- Fiduciary duties of ACO governing body members must include duty-of-loyalty provisions that emphasize the fundamental requirement that ACO governing body members must not have divided loyalties;
- CMS proposes to eliminate the current exception to the general requirement that at least 75% control of the governing body must be vested in ACO participants because CMS has determined that the rationale for providing the flexibility is not a problem in reality; and
- An ACO provider/supplier is prohibited from being the required Medicare beneficiary representative on the ACO governing board.

Coordinating Care (pgs. 71-75)

In addition to the existing eligibility requirements which shall continue in effect,² the proposed rules would require an applicant ACO to describe how it will engage in the following aspects of care coordination:

- How it will encourage and promote the use of enabling technologies such as electronic health records and other health information technology tools for improving care coordination for beneficiaries;
- How the ACO intends to partner with long term and post-acute care providers to improve care coordination for the ACO's assigned beneficiaries; and
- Major milestones or performance targets it will use in each performance year to assess the progress of its ACO participants in implementing the requirements.

Transitioning Pioneer ACOs to the MSSP (pgs. 75-84)

In the proposed rule, CMS intends to streamline the transition of Pioneer ACOs into the MSSP by permitting Pioneer ACOs to utilize a condensed application, provided that, among technical requirements: (1) the applicant MSSP ACO is the same legal entity as the Pioneer ACO; and (2) the applicant is applying to participate in a two-sided risk model. Pioneer ACOs can only apply to the MSSP for an agreement period starting after their participation in the Pioneer ACO Model has ceased.³

Establishing and Maintaining the Participation Agreement with the Secretary (pgs. 81-92)

CMS is proposing, among other technical changes, a process renewing existing ACOs' participation agreements rather than requiring such ACOs to submit new applications for continued participation. CMS also will be able to adjust the benchmark to account for

² 42 CFR § 425.112(b)(4)(ii)(C), 42 CFR § 425.112(b)(4)(ii)(D), 42 CFR § 425.112(b)(4)(ii)(E).

³ 42 CFR § 425.202(b).

regulatory changes regarding beneficiary assignment methodology that become effective during an agreement period.

Provision of Aggregated and Beneficiary Identifiable Data (pgs. 92-118)

CMS proposes to improve the ability of ACOs to access beneficiary identifiable claims data by expanding access to data of each beneficiary that has a primary care service visit with an ACO participant that bills for primary care services considered in the assignment process in the most recent 12-month period.

This access goes beyond sharing claims data on beneficiaries who are only included on an ACO's preliminary prospective assigned beneficiary list under Tracks 1 and 2. This latter information would also be made available to Track 3 ACOs who request it. Other proposed changes streamline the process for beneficiaries to be notified of the opportunity to decline claims data sharing and to honor any beneficiary request to decline claims data sharing.

Assignment of Medicare FFS Beneficiaries (pgs. 119-164)

Currently, beneficiaries are assigned to an ACO "based on their utilization of primary care services." CMS seeks to broaden the criteria for assignment to include transitional care management services for a patient following their discharge from an inpatient hospital or SNF, as well as chronic care management services.

CMS also seeks to revise the basic assignment methodology to include primary care services provided by nurse practitioners and physician assistants, not just physicians. In addition, CMS seeks to exclude the services of certain physicians (including surgeons, dermatologists, and radiologists) from the assignment process because although such physicians may submit claims using codes that are commonly utilized by primary care providers, they nonetheless typically do not provide a significant amount of primary care, if any.

Shared Savings and Losses

Reforming the MSSP ACO Participation Tracks (pgs. 164-212)

CMS employs a three-pronged approach in its proposed changes to risk-based performance tracks:

- (1) Ease the transition to risk for participants on “Track 1”;
- (2) Reduce the requisite levels of risk under “Track 2”; and
- (3) Adopt an alternative risk-based model by creating a new “Track 3” for ACOs that can handle a greater level of risk.

Under the current rule, participants can only remain under Track 1 for their first three-year contract term during which the participants bear no downside risk and can share in 50% of shared savings. The proposed rule would permit Track 1 ACOs to continue under a one-sided shared savings model for an additional contract term, but would balance that opportunity with a reduced share of savings for such second term (i.e., 40%) and also require ACOs to achieve certain minimum savings during the first contract term to qualify for a second Track 1 term.

As currently addressed in CMS regulation, Minimum Savings Rate (MSR) under Track 2 is a fixed number. Through the proposed rule, CMS will base MSR for Track 2 on the size of the ACO’s assigned population. CMS thinks this step will statistically protect ACOs with smaller populations. CMS will use a similar methodology for calculating Minimum Loss Rate (MLR) for Track 2 ACOs.

Lastly, CMS proposes the creation of Track 3 to offer ACOs an additional opportunity to accept greater responsibility for beneficiary care and correspondingly opens up the possibility of greater rewards. Track 3 participants will:

- (1) Be assigned beneficiaries on a prospective basis as opposed to the retrospective approach used for other tracks;

- (2) Be subject to a fixed rather than variable MLR;
- (3) Be able to share in 75% of savings as opposed to the 60% cap for other tracks; and
- (4) Be limited to a 20% performance payment limit as opposed to the 15% limit for other tracks.

Encouraging Participation in Performance-Based Risk Sharing (pgs. 212-268)

In response to suggestions that CMS consider relaxing certain specific Fee-for-Service (FFS) Medicare payment and other rules under two-sided performance-based risk models in the MSSP, CMS has solicited comment regarding proposed waivers of:

- The three-day Skilled Nursing Facility (SNF) rule which requires an inpatient hospital stay of no fewer than three consecutive dates in order for a beneficiary to be eligible for Medicare coverage of inpatient SNF care;
- Certain Medicare telemedicine payment requirements;
- The requirement that a beneficiary be “home-bound” to be eligible for home health services coverage; and
- The prohibition against ACOs specifying certain high-quality Medicare providers of post-hospital care services to patients and their families.

CMS indicates that such waivers may be more appropriate in the case of ACOs in Track 3 where participants bear additional risk. Finally, CMS solicited general comments on a potential step-wise progression for ACOs to take on performance-based risk.

Modifying Repayment Mechanisms⁴ (pgs. 268-273)

CMS monitors and requires ACOs under a two-sided risk-bearing model to demonstrate an ability to repay shared losses, but has set forth proposals to streamline the repayment mechanism requirements. Under the current rule, CMS requires Track 2 ACOs to establish a repayment mechanism to repay shared losses under the MSSP and demonstrate the adequacy of the repayment mechanism before each performance year. Under the proposed rule, CMS will require ACOs entering into a two-sided contract to demonstrate the ability to repay shared losses for the entire contract period at the onset as well as for a tail period following the three-year contract term. Similarly, CMS will restrict the forms of repayment mechanisms that ACOs may utilize to: (1) escrow funds; (2) a line of credit; or (3) a surety bond.

Methodologies for Establishing, Updating, and Resetting the Benchmark (pgs. 273-312)

Under the current rule, ACO benchmarks are determined based on the national growth rate for Medicare Parts A and B expenditures for FFS beneficiaries. In the past, CMS has expressed concerns regarding this methodology as it may give preference to ACOs in higher-cost or lower-cost markets. CMS indicates its desire is to establish incentives that are as equal as possible for all participants. In addition, CMS wants successful ACO participants to be able to continue to participate and be given appropriate benchmarks that encourage continued savings when existing benchmarks have already been met. Therefore, CMS is seeking comments on alternative approaches for adjusting the methodology for ACO benchmarks as further detailed in the proposed rule.

Technical Adjustments to Benchmark and Performance Year Expenditures (pgs. 313-324)

Under the current rule, the methodology for calculating the average per-capita Medicare expenditures for an ACO takes into account all Medicare Part A and Part B

⁴ 42 CFR § 425.204(f).

expenditures, including payments made under a federal demonstration or pilot program. While CMS considered whether certain adjustments to Part A and B expenditures should be excluded from such calculations, it ultimately decided against excluding any such amounts except for Disproportionate Share Hospital payments and Indirect Medical Education payments. CMS seeks comments regarding standardization of payments, including adjusting various elements, impact of value-based payment adjustments, and other considerations.

Additional Requirements for Beneficiary Protections (pgs. 324-341)

In the current MSSP regulations, CMS finalized certain policies regarding program compliance. In the proposed rule, CMS proposes certain refinements and clarifications including the following:

- Public reporting through an ACO-maintained website that displays requisite information in a standard form;⁵
- Additional grounds for ACO participant agreement termination to address an ACO's submission of false/fraudulent data or failure to comply with document requests;
- The implementation of certain close-out procedures on termination and payment consequences for early termination.⁶
- CMS plans to eliminate the possibility of oral review for decisions not subject to administrative or judicial review but will still permit on-the-record review.⁷

Conclusion

The proposed MSSP rule represents a substantial change in the MSSP and offers stakeholders a renewed and enhanced opportunity to participate in the development of the future structure of federal ACOs.

⁵ 42 CFR § 425.308.

⁶ 42 CFR §§ 425.220, 425.221, 425.218.

⁷ 42 CFR § 425.802.

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