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CMS Aims to Grow ACO Participation

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The Centers for Medicare & Medicaid Services ("CMS") recently published the proposed 2023 Physician Fee Schedule ("PFS"), which contains several important changes affecting Accountable Care Organizations ("ACOs") that participate in the Medicare Shared Savings Program ("MSSP"), including a new Advanced Incentive Program. See Proposed 2023 PFS, 82 Fed. Reg. 45,860 (July 29, 2022).

ACOs enable health care providers to provide coordinated patient care to Medicare beneficiaries, and to share in the savings resulting from improved care. According to CMS, as of January 1, 2022, over 11 million Medicare beneficiaries receive care from 483 ACOs across the country. Id. at 46,093.

The proposed changes are intended to advance "growth, alignment, and equity," and to "increase the percentage of people with Medicare in accountable care arrangements." Id. at 46,093-94. Of note, and as described in a publication preceding the PFS, CMS proposed the changes to increase (i) the number of beneficiaries assigned to MSSP ACOs; (ii) the number of higher spending populations in the program, since the change to regionally-adjusted benchmarks; and (iii) the representation of Black (or African American), Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native beneficiaries assigned to MSSP ACOs, as compared to Non-Hispanic Whites.

Below, we summarize several of the key proposals. CMS is inviting the public to comment on the proposed rules **until September 6, 2022**.

Proposed Changes to Advance Equity

1. Advanced Incentive Payments
   Recognizing the start-up costs required for ACO participation and this burden on small organizations, CMS proposes to provide advance shared savings payments ("Advanced Incentive Payments" or "AIPs") to low revenue ACOs that: (i) are inexperienced with performance-based risk and (ii) serve underserved populations. In 2011, CMS estimated that ACOs participating in the MSSP expend an average of $580,000 in start-up costs and $1.27 million in ongoing annual operating expenses.

According to CMS Innovation Center experiments, payments similar to the Advanced Incentive Payments "encouraged ACOs to form in areas where ACOs may not have otherwise formed and where other Medicare payment and delivery innovations were less likely to be present." Id. at 46,098.

To reduce the financial burden encountered by small providers, CMS envisions that the Advanced Incentive Payments will be distributed to ACOs over two performance years. While the payments may be offset against any shared savings that the ACO ultimately earns, if an ACO does not earn shared savings in its agreement period or a renewed agreement period, the ACO is not responsible for repayment of the AIPs and CMS is not in a position to recoup any of the AIPs from the ACO. Id. at 46,109-10; see also 42 CFR 425.630(g) (as proposed).

AIPs are to be comprised of two types of payments: (i) a one-time payment of $250,000 and (ii) eight quarterly payments based on the number of assigned beneficiaries in the ACO, capped at 10,000 beneficiaries. See id. at 46,103. The quarterly payments would be determined by: (i) a risk factors-based score set to 100 for dually-eligible beneficiaries (Medicare and Medicaid); or (ii) set to the Area Deprivation Index national percentile rank (an integer between 1 and 100) of the census block group in which the beneficiary resides for Medicare-only beneficiaries. Higher quarterly payment amounts would be provided for beneficiaries with higher risk scores.

The proposed rules contain several eligibility criteria, which CMS intends to codify at 42 CFR 425.630(b). Specifically, to be eligible for the AIPs, the ACO: (i) must not be a renewing ACO or re-entering ACO as defined in 42 CFR 425.20; (ii) must apply participate in the MSSP under any level of the BASIC track glide path as specified in 42 CFR 425.600(a)(4)(i)(A); (iii) must be inexperienced with performance-based risk Medicare ACO initiatives as defined in 42 CFR 425.20; and (iv) must be a low revenue ACO as defined in 42 CFR 425.20. Id. at 46,100.

Note, to enable recoupment of the funds where permitted under the proposed regulations, CMS is proposing to modify the definition of "inexperienced with performance-based Medicare ACO initiatives" and "experienced with performance-based risk Medicare ACO initiatives," as defined in 42 CFR 425.20. Id. at 46,109-10. Under the existing regulations, an ACO is deemed to be inexperienced if, in part, less than 40 percent of the ACO's participants participated in a performance-based risk initiative in each of the five most recent performance years *prior to the agreement start date*. See 42 CFR 425.20. The newly proposed regulations, in contrast, adopt a rolling five year lookback period that starts from the then-present performance year. 82 Fed. Reg. at 46,109-10, 46,439.

CMS notes that it "is concerned about the possibility that an ACO may be eligible to receive AIPs and then quickly thereafter seek to add ACO participants experienced with performance-based risk, thereby avoiding… inexperience and low revenue eligibility requirements." Id. at 46,108. The rolling lookback period for example, would enable CMS to recoup AIPs made to an entity that, during the five year lookback period, becomes "experienced" and, thus, ineligible, for receipt of AIPs, unless otherwise remedied by the ACO. See id. at 46,109 (setting forth that under the proposed 42 CFR 425.316(e)(3), an ACO would be obligated to repay spent and unspent AIPs if CMS takes pre-termination action under 42 CFR 425.216 and the ACO continues to be experienced with performance-based or high revenue).

Finally, entities requesting AIPs will be required to submit a spending plan describing how the ACO will utilize the payments. Id.; see also 42 CFR 425.630(d)(1) (as proposed). In addition,

CMS will limit the types of expenses for which the AIPs can be utilized. See 82 Fed. Reg. 46,101 Specifically, CMS proposes to require that all AIPs be used to "improve the quality and efficiency of items and services furnished to beneficiaries by investing in increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries, which may include addressing social determinants of health." Id.

2. Health Equity Adjustment for ACOs Treating Underserved Populations
   CMS is proposing a health equity adjustment that would upwardly adjust an ACO's quality score. The purpose of the adjustment is to reward ACOs that are high performing and to support those ACOs serving a high proportion of underserved beneficiaries while also encouraging all ACOs to treat underserved populations. This proposed adjustment would add up to 10 bonus points to the ACO's quality performance category score. Id. at 46,113-142.

3. Benchmark Adjustment for Providers Treating High-Risk Dual Eligible Beneficiaries
   CMS proposes certain changes to its benchmarking methodology that is intended to encourage ACO participation by health care providers who treat a substantial number of high-risk Medicare/Medicaid beneficiaries. Specifically, the proposed methodology is intended to reduce the effect of ACO performance on ACO historical benchmarks, increase opportunities for ACOs caring for medically complex, high cost beneficiaries, and strengthen incentives for ACOs to enter and remain in the MSSP. See id. at 46,158-218.

Operational Changes & Reductions in Administrative Burdens

1. Term of Participation
   CMS is proposing to allow ACOs applying to the program that are inexperienced with performance-based risk to participate in one five-year agreement under a one-sided shared savings model. This proposal is intended to provide these ACOs with more time to invest in infrastructure and redesigned care processes, before transitioning to performance-based risk. Id. at 46,114-18.

2. Removal of Requirement to Review Marketing Materials
   CMS proposes to eliminate the requirement that ACOs submit marketing materials to CMS for review and approval *prior to* disseminating materials to beneficiaries and ACO participants.

   Under the proposed rules, ACOs would be required to submit marketing materials upon CMS's request and discontinue use of any marketing materials or activities disapproved by CMS. Notwithstanding the foregoing, CMS is not waiving its marketing rules, and ACOs must still comport with all marketing-related requirements. Id. at 46,203-04; see also 42 CFR 425.312 (as proposed).

3. Easing of Beneficiary Notification Rules
   Generally, an ACO is required to annually notify Medicare FFS beneficiaries that: (i) the ACO participates in the MSSP, (ii) the beneficiary may decline claims data sharing, and (iii) the beneficiary may identify or change identification of a primary care provider for purposes of voluntary alignment.

   CMS is proposing to only require the notice to once per agreement period. In addition, to promote beneficiary comprehension of the standardized written notice, CMS is proposing that the ACO follow up with each beneficiary to whom it furnished the standardized written notice.

While such follow-up communication can be verbal or written, it must be provided no later than the earlier of the beneficiary's next primary care service visit, or 180 days from the date the first standardized written notice was provided to the beneficiary. 82 Fed. Reg. 46,204-205; see also 42 CFR § 425.312 (as proposed).

Comments to CMS on the PFS and these proposals to expand access to ACOs are due by September 6, 2022.

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