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CMS Accountable Care Organizations (ACO) Proposed Rule to Extend One-Sided Risk Track While Incentivizing Performance-Based Risk

Article By:

Ariane Tschumi

On December 1, 2014, the U.S. **Centers for Medicare & Medicaid Services (CMS) released a 429-page Proposed Rule** setting forth significant changes that will affect the **evolution of the Medicare Shared Savings Program (MSSP)** and opening discussions that could improve the financial sustainability of Medicare accountable care organizations (ACOs).

The Proposed Rule shows CMS's awareness of the challenges facing many MSSP ACOs and the likely need for further changes to improve MSSP ACOs' return on investment through modifications to the financial methodology and additional tools to manage Medicare fee-for-service populations. Most notably, CMS has proposed to allow MSSP ACOs to continue with MSSP's one-sided risk track for a second three-year term, but at a lower maximum shared savings rate, and to add a modified two-sided risk track that offers greater potential financial rewards and, for the first time, prospective beneficiary assignment. CMS has also requested comments on certain waivers under consideration to Medicare's payment and program requirements for risk-bearing MSSP ACOs and an attestation process that would enable Medicare beneficiaries to affirmatively designate an MSSP ACO to coordinate their care.

Comments on the Proposed Rule are due by 5 pm EST on February 6, 2015. CMS's extensive discussion of options and its emphasis on requested comments provide a significant opportunity for stakeholders to inform the next iteration of the program.

Financial Performance Tracks

Track 1: Option to Renew for Second Agreement Period Under One-Sided Risk Track, with Lower Sharing Rate

In the preamble to the Proposed Rule, CMS acknowledges stakeholder concerns that many MSSP ACOs are not yet prepared to transition from one- to two-sided risk after the first three-year agreement period, as would be required under current MSSP regulations. Further, CMS estimates that, absent changes to the MSSP ACO regulations, fewer than one in four MSSP ACOs would opt to participate in downside risk under MSSP Track 2.

Consequently, CMS proposes to offer Track 1 MSSP ACOs the option to renew their participation for a second three-year term under the Track 1 one-sided risk model. However, in order to incentivize such ACOs to move to two-sided risk, and simultaneously emphasize that downside risk promotes more meaningful systematic long-term change in provider behavior, CMS proposes to reduce the maximum MSSP Track 1 shared savings rate from 50 percent to 40 percent for the second three-year term. CMS proposes a low threshold to remain in Track 1: an ACO must have achieved quality performance standards in one of its first two performance years and must not have generated losses in excess of the minimum loss rate in both such years.

CMS also requests comment on extending the Track 1 agreement period for an additional two years; allowing ACOs to renew under Track 1 for a second three-year term, with no change to the maximum shared savings rate; and offering multiple Track 1 extensions with progressively diminishing maximum shared savings rates.

Track 2: Increase Performance Threshold Before an ACO May Incur Shared Losses and Accrue Shared Savings

CMS proposes to maintain Track 2 as is, except to revise the minimum savings rate and minimum loss rate from a fixed 2 percent to variable 2 percent to 3.9 percent based on the number of assigned beneficiaries. CMS's stated goal for this modification is to make the Track 2 option more attractive by reducing the downside exposure for ACOs that are less experienced with performance-based risk. However, this change would also make it more difficult for ACOs to achieve shared savings payouts, which could paradoxically make Track 2 less appealing. At present only five ACOs are participating in Track 2.

Track 3: New Two-Sided Track with Higher Risk and Reward and Prospective Assignment

To strengthen incentives for ACOs to choose two-sided risk arrangements, CMS proposes a new Track 3 that would offer ACOs a higher maximum shared savings rate in exchange for accepting greater downside risk. Track 3 would be based on the payment methodology of Track 2 but would also integrate certain aspects of CMS's more aggressive Pioneer ACO Model.

Track 3 would establish a maximum shared savings rate of up to 75 percent based on quality, with a performance payment limit of 20 percent of the benchmark. The current Track 2, by contrast, caps maximum shared savings at 60 percent, with a performance payment limit of 15 percent. Under Track 3, an ACO's shared loss rate would range from 40 percent to 75 percent based on quality, with a loss sharing limit of 15 percent of the benchmark. CMS proposes a fixed 2 percent minimum savings rate and minimum loss rate.

Under Track 3, CMS would prospectively assign the target beneficiary population to the Track 3 ACO at the beginning of the performance year, in order to enable the Track 3 ACO to focus its care redesign efforts. The only adjustments that would be made to the prospective list at the end of the performance year would be to exclude beneficiaries who no longer meet eligibility criteria.

Heightened Flexibility Through Medicare Payment and Program Rule Waivers

In order to provide ACOs that choose a two-sided risk model with additional opportunities to realize cost savings and to improve care coordination, CMS requests comment on (but does not propose) a variety of waivers of payment and programmatic rules that would provide new flexibility compared to traditional fee-for-service Medicare. These waivers would be promulgated under section 1899(f) of

the Social Security Act, which offers the Secretary broad authority to waive certain statutory requirements as "necessary" to carry out the provisions of MSSP. The waivers under consideration underscore CMS's recognition that the long-term viability of MSSP will depend on successfully incentivizing ACOs to shift to two-sided risk.

Specifically CMS discusses the following waivers:

- **SNF three-day rule:** Under this waiver, CMS would permit ACO participants and ACO providers/suppliers to refer ACO beneficiaries to approved skilled nursing facilities (SNFs) without a prior inpatient hospitalization or with an inpatient hospital length of stay of fewer than three days, where medically appropriate.

- **Telehealth:** CMS would waive the originating site requirements for ACO beneficiaries, which limit telehealth payment to those services furnished within specific types of geographic areas and specify the sites where an eligible telehealth individual must be located.

- **Homebound requirement under the home health benefit:** Under the waiver, CMS would permit an ACO beneficiary to have home health care visits from approved home health agencies, even if the beneficiary is not considered home-bound, providing an additional tool to minimize unnecessary hospital admissions and readmissions.

- **Waivers for referrals to post-acute care settings:** CMS would waive the requirement that hospitals not limit the qualified providers that may provide post-hospital home services. The waiver would enable ACOs and their ACO providers/suppliers to recommend specific SNFs and home health agencies, providing opportunities to direct ACO beneficiaries to higher quality care providers and potentially reduce hospital readmission rates.

CMS suggests that each of the above waivers, if promulgated, would specifically apply to Track 3 ACOs, in light of the greater downside risk they would incur, and thus the stronger incentive they have to restrain over-utilization. CMS also requests comment on whether broader application of these waivers to other ACO tracks would be appropriate.

Beneficiary Assignment

Greater Emphasis of NPs, PAs and CNSs in Beneficiary Assignment

CMS proposes to ascribe greater importance to primary care services provided by nurse practitioners (NPs), physician assistants (PAs) and certified nurse specialists (CNSs) in MSSP's beneficiary assignment methodology. Specifically, CMS proposes to use NP, PA and CNS primary care services in the Step 1 calculation of plurality of services, after it has determined whether a primary care physician provided primary care services to a beneficiary. CMS also would refine Step 2 of the assignment methodology to exclude certain specialties that are not likely to be associated with primary care.

CMS also proposes to use the Transitional Care Management and new Chronic Care Management codes for purposes of ACO beneficiary assignment, and to revise the definition of primary care service codes in the future through the Physician Fee Schedule rulemaking.

Beneficiary Attestation

CMS acknowledges the significant beneficiary “churn” that MSSP ACOs have experienced under the current assignment methodology, calculating that on average only 76 percent (a range of 58 percent to 88 percent) of beneficiaries assigned to an ACO at the end of one performance year have been reassigned to the same ACO at the end of the next performance year. CMS requests comment on an attestation process for ACOs that elect two-sided risk, whereby a Medicare beneficiary could prospectively assign the coordination of his or her care to the ACO.

Updates to Benchmarking Methodology, Including Through Use of Regional Factors

CMS acknowledges stakeholder concern that resetting benchmarks at the start of additional agreement periods might disadvantage MSSP ACOs that have successfully lowered costs. CMS also recognizes that reliance on the existing benchmark methodology on national fee-for-service costs does not recognize the impact of regional and local cost trends on an ACO’s performance.

CMS does not propose any change to the benchmarking or rebasing methodologies in the Proposed Rule, relying heavily on findings from CMS’s Physician Group Practice demonstration. Nonetheless, CMS discusses in detail and requests comments on five alternative benchmarking and rebasing methods:

- Equally weighting the three prior performance years
- Including shared savings payments in any reset benchmarks
- Using regional, instead of national, fee-for-service factors to establish and update benchmarks
- Adjusting future benchmarks to hold an ACO’s historical costs constant relative to its region
- Transitioning ACOs from their current benchmarks to benchmarks based solely on regional fee-for-service costs over multiple agreement periods

CMS emphasizes that, under the requirements of the Affordable Care Act, any alternative methodology must both improve quality and efficiency of care and result in program expenditures equal to or lower than those contemplated under the statutory payment model.

Data Sharing

CMS proposes to expand the scope of beneficiaries on which it provides quarterly limited data sets (name, date of birth, health insurance claim number and sex) to include each beneficiary that had a primary care service visit with an ACO participant during the most recent 12-month assignment period, rather than merely those who were preliminarily prospectively assigned to the ACO. CMS also proposes to expand the data provided to ACOs on preliminarily prospectively assigned beneficiaries to include additional information relevant to population-based activities.

Furthermore, CMS proposes to manage the beneficiary data sharing opt-out process, acknowledging the beneficiary confusion and administrative burden resulting from the current opt-out process. Under the Proposed Rule, ACO participants would provide written notice at the point of care through

sign displays at their facilities that include CMS-provided opt-out language and reference the 1-800-MEDICARE informational telephone number.

Additional Proposed Changes

CMS also proposes various other regulatory changes, including the following:

- Definitional changes at § 425.20, including to the previously confusing term “ACO professional”
- Addition of teaching hospitals as eligible providers and suppliers (§ 425.102)
- Changes to shared governance (§ 425.106) and leadership and management (§ 425.108), including the addition of an explicit duty of loyalty and the removal of the requirement that the ACO medical director be an ACO provider/supplier
- Flexibility should an ACO’s attributed beneficiary count drop below 5,000 (§ 425.110)
- New application questions on processes and patient-centeredness criteria, including regarding the use of health information technology and partnerships with post-acute care providers (§ 425.112)
- New requirements for downstream participation agreements (§ 425.116)
- New requirements on ACO participant and ACO provider/supplier lists and reporting changes (§ 425.118)
- Condensed application process for Pioneer transitioning to MSSP (§ 425.202)
- Changes to the MSSP application, including ACO repayment mechanisms and merged/acquired TINs (§ 425.204)
- Effectuation of changes to program requirements during the agreement period (§ 425.212)
- Termination for failure to comply with CMS documentation deadlines, or submission of false or fraudulent data or information (§ 425.218)
- Close-out procedures and payment consequences of early termination (§ 425.221)
- Processes around renewal (§ 425.224) and reapplication after termination (§ 425.222)
- Exclusivity of ACO participants (§ 425.306)
- Additional public reporting and transparency requirements (§ 425.308)
- Special assignment conditions for ACOs including FQHCs and RHCs (§ 425.404)
- On-the-record reconsideration review process (§ 425.804, .802)

Conclusion

The Proposed Rule makes a series of significant modifications to Medicare's ACO program and demonstrates that CMS is placing substantial emphasis on the MSSP ACO program by proposed significant changes that are intended to maintain interest in the MSSP ACO program while developing incentives to shift participants towards two-sided risk.

Although the MSSP is still in its early stages, one of the paramount questions for current and prospective MSSP ACOs will be whether the program can provide adequate financial incentives for ACOs to recoup their investment costs and to make a compelling business case for the model. CMS's in-depth consideration of updates to the benchmarking methodology, including by integrating regional costs and/or including shared savings in rebasing, as well as waivers of payment and program rules, are notable for their potential positive financial implications and provide ample opportunity for constructive stakeholder commentary that can inform the final rule. ACOs also may realize significant opportunities to create efficiencies and maximize potential return on investment should commercial and public payers more actively align their payment approaches. Further, MSSP ACOs should be aware of new opportunities from CMS to receive upfront payments of shared savings through the second iteration of the Advance Payment ACO Model, the ACO Investment Model, which significantly expands eligibility criteria. Such upfront payments could provide MSSP ACOs with substantially more upfront capital to invest in the infrastructure and redesigned care processes necessary for successful population health management.

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