hfma
healthcare financial management association

Medicare Shared Savings Program Proposed Rule Fact Sheet

In the Dec. 8, 2014, *Federal Register*, CMS issued a proposed rule that would update and improve policies governing the Medicare Shared Savings Program (MSSP). The rule addresses proposed changes to several program areas including beneficiary assignment, data sharing, available risk models, eligibility requirements, participation agreement renewals, and compliance and monitoring. Additionally, the proposal seeks comment on issues related to financial benchmarking and waivers for program and other payment rules. Changes to the Shared Savings Program quality reporting requirements were finalized in the CY15 Medicare Physician Fee Schedule on Oct. 31, 2014.

Definitions
Federal Register, pages 72763-72765

CMS proposes some additions and a few revisions to the existing definitions of key terms that it adopted for purposes of the Shared Savings Program in the November 2011 final rule. Following is a list of the proposed new terms to the definitions:

- *ACO Participant*: Clarifies that an "ACO Participant" is an entity, not a practitioner. An ACO participant may be composed of one or more ACO providers/suppliers whose services are billed under a Medicare billing number assigned to the Taxpayer Identification Number (TIN) of the ACO participant. An ACO participant is an entity identified by a Medicare-enrolled TIN.

- *ACO Professional*: Removes the requirement that an ACO professional be an ACO provider/supplier. Revises the definition to indicate that an ACO professional is an individual who bills for items or services he or she furnishes to Medicare fee-for-service (FFS) beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with Medicare regulations.

- *ACO Provider/Supplier*: Clarifies that an individual or entity is an ACO provider/supplier only when it bills for items and services furnished to Medicare FFS beneficiaries during the agreement period under a Medicare billing number assigned to the TIN of an ACO participant and is included on the list of ACO providers/suppliers that is required under proposed regulation 425.118.

- *Assignment*: Modifies the definition of assignment to reflect that CMS assignment method takes into account claims for primary care services furnished by ACO professionals, not solely claims for primary care furnished by physicians in the ACO.

- *Hospital*: Revises the definition of hospital for purposes of the MSSP to mean hospital as defined in section 1886(d)(1)(B). This will include Maryland acute hospitals so they can now participate in the MSSP.

CMS proposes revisions to existing definitions, including ***Continuously Assigned Beneficiary and Newly Assigned Beneficiary*** *(p. 24).* These revisions are discussed in greater detail in section II.F.3.b. of the proposed rule.

ACO Eligibility Requirements
Federal Register, pages 72765- 72780

Proposed Revisions
The proposed rule adds new requirements for agreements between an ACO and an ACO participant or ACO provider/supplier. Under the proposal, an ACO must satisfy the following criteria in order to be a participant:

- The ACO and the ACO participant are the only parties to the agreement.
- The agreement must be signed on behalf of the ACO and the ACO participant by individuals who are authorized to bind the ACO and the ACO participant, respectively.
- The agreement 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 Shared Savings Program and comply with the requirements of the Shared Savings Program and all other applicable laws and regulations.
- The agreement must set forth the ACO participant's rights and obligations in, and representation by, the ACO, including without limitation, the quality reporting requirements, the beneficiary notification requirements, and how participation in the Shared Savings Program affects the ability of the ACO participant and its ACO providers/ suppliers to participate in the other Medicare demonstration projects or programs that involve shared savings.
- The agreement must describe how the opportunity to receive shared savings or other financial arrangements will encourage the ACO participant to adhere to the quality assurance and improvement program and evidence-based medicine guidelines established by the ACO.
- The agreement must require the ACO participant to update enrollment information with its Medicare contractor using the Provider Enrollment, Chain, and Ownership System (PECOS), including the addition and deletion of ACO professionals billing through the tax identification number (TIN) of the ACO participant, on a timely basis in accordance with Medicare program requirements. The Agreement must also require ACO participants to notify the ACO within 30 days after any addition or deletion of an ACO provider/ supplier.
- The agreement must permit the ACO to take remedial action against the ACO participant, and must require the ACO participant to take remedial action against its ACO providers/suppliers, including the imposition of a corrective action plan, denial of shared savings payments, and termination of the ACO participant agreement, to address noncompliance with the requirements of the Shared Savings Program and other program integrity issues, including those identified by CMS.

- The term of the agreement must be for at least one performance year and must articulate potential consequences for early termination from the ACO. However, early termination is not prohibited.
- The agreement must require completion of a close-out process upon the termination or expiration of the ACO's participation agreement that requires the ACO participant to furnish data necessary to complete the annual assessment of the ACO's quality of care and address other relevant matters.

New Additions to ACO
CMS proposed that the executed ACO participant agreement must be submitted when an ACO seeks approval to add new ACO participants.

Sufficient Numbers of Primary Care Providers and Beneficiaries
Federal Register, pages 72768-72769

The proposed rule clarifies that the data used during the application process to estimate the number of beneficiaries would be calculated using the assignment methodology. For benchmark year 3, CMS would use the most recent data available with up to a three-month claims runout to estimate the number of assigned beneficiaries. CMS notes that while a final assignment determination can be made for the first two benchmark years (BY1 and BY2, respectively) for an ACO applying to participate in the MSSP, it is not possible to determine the final assignment for the third benchmark year (BY3), that is the calendar year immediately prior to the start of the agreement period, because application review and determination of whether the ACO has met the required 5,000-beneficiary assignment must take place during BY3 before all claims are submitted for the calendar year.

Further, there is a lag period after the end of a calendar year during which additional claims for the year are billed and processed. Therefore, the final historical benchmark for the 3-year period and the preliminary prospective assignment for PY1 must be determined after the ACO's agreement period has already started. CMS currently estimates the number of historically assigned beneficiaries for BY for Tracks 1 and 2 by using claims with dates of service for the last three months of benchmark year 2 (October through December) and the first nine months of benchmark year 3 (January through September, with up to three-months claims run out, as available).

If an ACO falls below 5,000 assigned beneficiaries at any time during the agreement period, it will be allowed to continue in the program, but CMS must issue a warning letter and place the ACO on a corrective action plan (CAP). Under the CAP, the ACO will remain eligible to share in savings for the performance year in which it fell below 5,000, and the Minimum Savings Rate (MSR) will be adjusted according to the number of assigned beneficiaries determined at the time of reconciliation. Therefore, the assignment methodology is prospective attribution with retrospective reconciliation.

Certified Lists of ACO Participants and ACO Provider/Suppliers
CMS proposes to create new section 425.118 which would consolidate other related provisions in sections 425.204(c)(5), 425.214(a), and 425.304(d):

- At § 425.118(a), prior to the start of the agreement period and before each performance year thereafter, the ACO must provide CMS with a complete list of its ACO participants and their Medicare-enrolled TINs.
- CMS will provide ACOs with its list of ACO provider/suppliers' National Provider Identifiers (NPIs) which it has identified as billing through the ACO. ACOs will need to review and make corrections.
- Requires ACOs to report changes in ACO participant and ACO provider/supplier enrollment status in PECOS within 30 days after changes have occurred. This will have to be done through the provider/supplier because an ACO typically doesn't have access to PECOs, as it does not bill Medicare directly.
- Proposes to remove requirement that ACOs report which physicians are primary care providers as CMS does this through claims analysis.

Managing Changes to ACO Participants

If finalized, ACOs must submit a request to add a new entity to its ACO participant list as specified by CMS. CMS must approve additions to the list. If the entity is approved, it will be added at the beginning of the next performance year. ACOs must notify CMS no later than 30 days after the date of termination of an entity's participation agreement. Changes made by an ACO to its annually certified participant list would result in adjustments to the benchmark, assignment, quality, reporting sample, and obligation to report on behalf of eligible professionals for certain quality initiatives. Removal of an ACO from the ACO participant list during the performance year must not affect certain program calculations for the remainder of the year (e.g., beneficiary assignment, historical benchmark, financial calculations for quarterly or annual reporting).

Managing Changes to ACO Providers and Suppliers

ACOs must continue to report changes to providers/suppliers within 30 days via PECOS. The proposed rule also requires ACOs to notify the shared savings program (via email) directly since lists of ACO providers can't be maintained in PECOS.

ACOs may add an entity to the ACO provider/supplier list if it notifies CMS within 30 days after the individual or entity becomes a Medicare-enrolled provider or supplier that bills for items or services under a billing number assigned to the TIN of an ACO participant.

CMS is considering whether to delay the effective date of any additions to the ACO provider/supplier list until after it has completed a program integrity screening of the individuals or entities that the ACO wishes to add. CMS would delay until the start of the next performance year, similar to the timing for adding TINs of ACO participants. Under this scenario, the provider/supplier's claims from prior to being an ACO provider would still be used for assignment for the performance year in which the change will take place.

Significant Changes to an ACO
ACOs are required to notify CMS within 30 days of a significant change. Further, CMS proposes that a significant change occurs when the ACO:

- Is no longer able to meet the eligibility or other requirements of the shared savings program, or
- When the number or identity of ACO participants included on the ACO participant list changes by more than 50 percent during one agreement period.

Upon receiving notice, CMS will evaluate the ACO's eligibility to continue participating in the MSSP. A determination that a significant change has occurred would not necessarily result in the termination of the ACOs participation agreement. Failure to notify CMS of a significant change must not preclude CMS from making its own determination that a significant change occurred.

Consideration of Claims Billed by Merged/Acquired Medicare-Enrolled Entities
CMS proposes to codify operational guidance provided to ACOs. CMS indicated that under the following circumstances, it may take claims billed under TINs of entities acquired through purchase or merger into account for purposes of beneficiary assignment and the ACO's historical benchmark:

- The ACO participant must have subsumed the acquired entity's TIN in its entirety, including all the providers and suppliers that reassigned the right to receive Medicare payment to that acquired entity's TIN.
- All the providers and suppliers that previously reassigned the right to receive Medicare payment to the acquired entity's TIN must reassign that right to the TIN of the acquiring ACO participant.
- The acquired entity's TIN must no longer be used to bill Medicare.

In order to attribute the claims of merged or acquired TINs to the ACO's benchmark, the ACO applicant must:

- Submit the acquired entity's TIN on the ACO participant list, along with an attestation stating that all providers and/suppliers that previously billed under the acquired entity's TIN have reassigned their right to receive Medicare payment to an ACO participant's TIN;
- Indicate the acquired entity's TIN and which ACO participant acquired it;
- Submit supporting documentation demonstrating that the entity's TIN was acquired by an ACO participant through a sale or merger and submit a letter attesting that the acquired entity's TIN will no longer be used to bill Medicare.

CMS notes that it requires an applicant's list of ACO providers/suppliers must include all individuals who previously billed under the acquired entity's TIN to have reassigned their right to receive Medicare payment to an ACO participant's TIN. CMS will modify these provisions to add the option for ACOs to request consideration of claims submitted by the Medicare-enrolled TINs of acquired entities as part of their application.

Legal Structure and Governance
CMS proposes clarifications to its rules related to the ACO's legal entity and governing body. The revised regulation provides that an ACO formed by "two or more ACO participants, each of which is identified by a unique TIN" must be a legal entity separate from any of its ACO participants.

- The governing body must satisfy three criteria:
    - The governing body of the ACO must be the same as the governing body of the legal entity that is the ACO.
    - In the case of an ACO that comprises multiple ACO participants, the governing body must be separate and unique to the ACO, and must not be the same as the governing body of any ACO participant.

CMS precludes the delegation of all ACO decision-making authority by a parent company to a committee of the governing body or retention of ACO decision making authority by a parent company. ACO governing bodies may organize committees that address certain matters pertaining to the ACO but such committees cannot constitute the governing body of the ACO.

Fiduciary Responsibilities of Governing Body Members
CMS clarifies an ACO governing body must not have divided loyalties.

Composition of Governing Body
If finalized CMS removes the flexibility for ACOs to deviate from the requirement that at least 75 percent control of an ACO's governing body must be held by ACO participants, and would prohibit an ACO provider/supplier from being the beneficiary representative on the governing body.

Leadership and Management Structure
CMS would remove the requirement that the medical director be an ACO provider/ supplier. Alternatively, CMS is considering maintaining the requirement but permitting ACOs to request approval of a medical director who is not an ACO provider/supplier, but is closely associated with the ACO and satisfies all other requirements.

Required Process to Coordinate Care
HHS believes all patients, their families, and their healthcare providers should have consistent and timely access to their health information in a standardized format that can be securely exchanged among the patient, providers, and others involved in the patient's care. CMS proposes the following changes, which would:

- Require ACOs to describe in their application how they will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries. This requirement may include EHRs and other IT tools (population health data aggregation and analytic tools), telehealth services, and health information exchange services.

- Require the applicant to describe how the ACO intends to partner with long-term and post-acute care providers to improve coordination for assigned beneficiaries.
- Require ACOs to define and submit major milestones or performance targets it will use in each performance year to assess progress of its ACO. For example, providers would be required to submit milestones and targets such as: projected dates for implementation of an electronic quality reporting infrastructure for participants, the number of providers expected to be connected to health information exchange services by year, or the projected dates for implementing elements of their care coordination approach (e.g., alert notifications on ED visits/hospitalizations, or e-care plan tools for virtual care teams).

Transition of Pioneer ACOs into the MSSP

CMS proposes to use a process similar to the Physician Group Practice Demonstration (PGPD). ACOs will be allowed to use a condensed application if three criteria are satisfied:

1. An applicant must be the same legal entity as the Pioneer ACO.
    - All of the TINs on the applicant's participant list must have appeared on the "Confirmed Annual TIN/NPI List" for the applicant's full performance year in the Pioneer model.
        - CMS will only compare TINs not National Provider Identifiers (NPIs)
        - If the applicant ACO includes TINs that were not on the confirmed annual TIN/NPI list for the last full performance year, the applicant must use the standard application.
2. The applicant must also be applying to participate in the two-sided model.
3. Pioneers using a condensed application will be required to include a narrative description of the modifications they need to make to fulfill MSSP requirements (e.g. changes to governing body, revising agreements with ACO participants, providers/suppliers).

Establishing and Maintaining the Participant Agreement with the Secretary
Application Deadlines

The proposal clarifies that CMS approves or denies an application on the basis of the following:

- Information contained in and submitted with the application by the deadline specified by CMS.
- Any supplemental information submitted by a deadline specified by CMS in response to a request by CMS for additional information.
- Other information available to CMS.

The proposal specifies CMS may deny an application if an ACO applicant fails to submit information by the deadlines specified by CMS.

Renewal of Participation Agreements
CMS proposes an ACO can request a renewal of its participation agreement prior to its expiration. CMS anticipates that operational guidance will outline a process permitting renewal requests during the last performance year of an ACO's participation agreement. CMS also proposes to determine whether to renew a participation agreement based on the following:

- Did the ACO satisfy the criteria for operating under the selected risk model?
- The ACO's history of compliance with the requirements of the MSSP.
- Is the ACO in compliance with the eligibility and other requirements of the MSSP, including the ability to repay losses?
- Has the ACO met the quality performance standards during at least one of the first two years of the previous agreement period?
- Has an ACO under a two-sided model repaid losses owed to the program it generated during the first two years of the previous agreement period?
- The results of a program integrity screening of the ACO, its participants, and its provider/suppliers.

Changes to Program Requirements During the 3-Year Agreement
The proposed rule provides 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."

CMS clarifies that ACOs would be subject to regulatory changes regarding ACO structure and governance, and calculation of the sharing rate during an agreement period if CMS is mandated by statute to implement such changes. The rule modifies the term "agreement period," which currently means "the term of the participation agreement which begins at the start of the first performance year and concludes at the end of the final performance year." The amended definition provides that an agreement period would be three performance years unless otherwise specified. ACOs would be required to be subject to any regulatory changes regarding beneficiary assignment that becomes effective during an agreement period. Changes would not be effective until the start of the following performance year. Also, benchmarks for that performance year would be updated as well.

Provision of Aggregate and Beneficiary Identifiable Data
Federal Register, pages 72783-72790

CMS notes that ACOs should have or at least be moving toward having complete information for the services its ACO providers/suppliers furnish to Medicare FFS beneficiaries. CMS also recognizes that the ACO may not have access to information about services provided to its assigned beneficiaries by outside providers.

Aggregate Data Reports and Limited Identifiable Data
ACOs have requested the following additional information from CMS:

- Frequency of hospitalization (including the specific names of the beneficiary and the name of the hospital) for not only all assigned beneficiaries but anyone who received a primary care service from the ACO in the past 12 months.
- Risk profiles.

In response, CMS proposes to expand the information available to ACOs to include:

- Name, date of birth, health insurance claim number, and sex for each beneficiary who has a primary care service with an ACO participant in the most recent 12-month assignment period.
- For prospectively assigned beneficiaries CMS would expand data provided to include:
    - Demographic data such as enrollment status.
    - Health status information such as risk profile and chronic condition subgroup.
    - Utilization rates of Medicare services such as Evaluation & Management, hospital, emergency, post-acute services. The list would include dates and places of service.
    - Expenditure information related to utilization of services.

Claims Data Sharing and Beneficiary Opt-Out

CMS proposed to provide beneficiaries with the opportunity to decline claims data sharing directly through the 800-MEDICARE telephone service rather than the ACO. Advance notification would be given to all FFS beneficiaries about data sharing (and the opportunity to decline) though materials such as the "Medicare and You" handbook.

CMS also proposes to:

- Remove the option for ACOs to mail notifications to beneficiaries.
- Continue to require ACO participants to notify beneficiaries in writing at the point of care that their providers and suppliers are participating in the MSSP, requirement to post signs remains would continue as well. The notifications would include updated language regarding data sharing.

For tracks one and two, CMS proposes to make beneficiary identifiable claims data available on a monthly basis for beneficiaries that are either preliminarily prospectively assigned or who have received a primary care service during the past 12 months from an ACO participant.

Previously recorded beneficiary preferences would remain standing unless the beneficiary changes his or her preference. The beneficiary identifiable information would still exclude information related to the treatment of alcohol or substance abuse. Due to federal law, CMS may revisit as technology in the area of consent management advances.

Assignment of Medicare FFS Beneficiaries
Federal Register, pages 72790-72802

CMS proposes to clarify that a beneficiary may be assigned to an ACO if he/she:

- Has at least one month Part A and Part B enrollment and doesn't have any months of only Part A or Part B enrollment;
- Does not have any months of Medicare Advantage coverage;
- Is not assigned to another Medicare shared savings initiative;
- Lives in the United States or U.S. territories and possessions as determined by the more recently available data in the beneficiary records regarding residence.

Definition of Primary Care Services
CMS proposes to update the definition of primary care services, to include both transitional care management codes (CPT 99495 and 99496) and chronic care management codes (HCPCS GXXX1), and also include those codes in the assignment methodology.

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process
Under the rule, nurse practitioners, physician assistants, and clinical nurse specialists would be included in Step 1 of beneficiary assignment. Sub-providers do not self-report specialty codes, so this opens up the possibility that some beneficiaries may be attributed inaccurately.
Physician specialty codes that would continue to be included in Step 1 of the beneficiary assignments are listed in the table below (Table 1 of the proposed rule).

TABLE 1—CMS PHYSICIAN SPECIALTY CODES THAT WOULD CONTINUE TO BE INCLUDED IN ASSIGNMENT STEP 1

Code	Specialty name
01	General Practice.
08	Family Practice.
11	Internal Medicine.
38	Geriatric Medicine.

The physician specialty codes that would continue to be used in Step 2 are listed in a table found in ***Appendix 1*** of this document (Table 2 of the proposed rule). The Physician specialty codes that would be excluded from Step 2 assignment can be found in ***Appendix 2*** of this document (Table 3 of the proposed rule).

The non-physician specialty codes that would be included in Step 1 are listed in the table below (Table 4 of the proposed rule).

TABLE 4—CMS NON-PHYSICIAN SPECIALTY CODES THAT WOULD BE INCLUDED IN ASSIGNMENT STEP 1

Code	Specialty name
50	Nurse practitioner.
89	Clinical nurse specialist.
97	Physician assistant.

Each ACO participant that submits claims for primary care services used to determine the ACO's assigned population must be exclusive to one MSSP ACO. However, a specific ACO provider/supplier may participate in multiple ACOs as long as he or she is billing under each ACO participant's TIN.

Assignment of Beneficiaries to ACOs that include FQHCs, RHCs, CAHs, or ETA Hospitals

The rule would continue to require ACOs that include Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to identify through attestation the physicians that provide direct patient primary care services. However, CMS proposes to use this information only to determine whether a beneficiary is assignable to the ACO. If a beneficiary is identified as an "assignable" beneficiary in the assignment pre-step, then CMS would use claims for primary care services furnished by all ACO professionals submitted by the FQHC or RHC to determine whether the beneficiary received a plurality of his or her primary care services from the ACO under Step 1. CMS provides an example of this on page 72800 of the rule.

Assignment of Beneficiaries to ACOs that Include CAHs

Under the proposal, Method I critical access hospitals (CAHs) can participate in the MSSP if they form partnerships or joint ventures with other ACO professionals like other hospitals. Method II CAHs may form an independent ACO if they meet eligibility requirements as specified. CMS is not proposing any specific changes regarding the use of services billed by Method II CAHs into the assignment methodology.

Assignment of Beneficiaries to ACOs that Include ETA Hospitals

Electing Teaching Amendment (ETA) hospitals are those that have elected to receive payment on a reasonable cost basis for the direct medical and surgical services of their physicians in lieu of patient financial services physician fee schedule (PFS) payment. ETAs don't bill separately for physician services provided in their hospitals. There is sufficient data on the outpatient service claims to assign beneficiaries. However, these claims don't have the charge related to a specific service on them, so it's difficult to determine the proportion of primary care provided by the ETA hospital. CMS proposes to use the amount payable under PFS for the specified HCPCS code as a proxy for the amount of the allowed charge for the specific service.

Effective Date for Finalizing Proposals Affecting Beneficiary Assignment

CMS proposes any policies finalized impacting beneficiary assignment are applicable beginning with the next performance year after the rule is finalized. All benchmarks will

be adjusted at the start of the first performance year in which the new assignment rule are applied so that the benchmark for the ACO reflects the use of the same assignment rules as would apply in the performance year. CMS would not retroactively apply any new beneficiary assignment policies to a prior performance year.

Shared Savings and Losses
CMS notes specific concern about the slope of the "on ramp" for smaller ACOs, and that given the choice between taking risk they're not ready for and dropping out of the program, they would drop out.

Proposals Related to Transition from the One-Sided to Two-Sided Model
CMS proposes to allow Track 1 ACOs to contract for another agreement period under shared savings only. However, the rule reduces the shared savings rate by 10 percentage points to 40 percent. CMS would not allow an ACO that participated in a two-sided model to regress to a one-sided model for a second agreement period.

CMS proposes to permit previously terminated Track 1 ACOs to reapply under the one sided model. Consistent with existing regulations, an ACO that was terminated less than halfway through the initial agreement period would be allowed to reapply to share savings at 50 percent. In the case of an ACO that was terminated past the halfway point in the agreement period, it would reapply as if it were applying for the second agreement period at the lower (40 percent) shared savings rate.

Proposals for Modifications to the Track 2 Financial Model
CMS proposes to eliminate the flat 2 percent minimum loss rate (MLR)/minimum savings rate (MSR) for Track 2 ACOs in favor of a sliding scale MLR/MSR that is similar to Track 1. The table below (Table 6 of the proposed rule) contains these thresholds.

TABLE 6—PROPOSED MINIMUM SAVINGS RATE AND MINIMUM LOSS RATE FOR TRACK 2

Number of beneficiaries	MSR/MLR (low end of assigned beneficiaries) (percent)	MSR/MLR (high end of assigned beneficiaries) (percent)
5,000–5,999	3.9	3.6
6,000–6,999	3.6	3.4
7,000–7,999	3.4	3.2
8,000–8,999	3.2	3.1
9,000–9,999	3.1	3.0
10,000–14,999	3.0	2.7
15,000–19,999	2.7	2.5
20,000–49,999	2.5	2.2
50,000–59,999	2.2	2.0
60,000 +	2.0	

Creating Options for ACOs that Participate in Risk-Based Arrangements
Unless otherwise stated, CMS is proposing to model Track 3 off of the current provisions governing Track 2.

Proposals for the Assignment of Beneficiaries Under Track 3
CMS proposes to implement a prospective assignment model for a newly created "Track 3." The model will use the same stepwise methodology as is used in Tracks 1 and 2. The

attribution model would be similar to the Pioneer program but incorporate the following differences:

- Beneficiaries would be assigned at the start of the performance year and there would be no retrospective reconciliation that adds beneficiaries at the end of the year.
- The only adjustments that would be made would be to exclude beneficiaries that appeared on the prospective assignment list at the start of the performance year that no longer meet eligibility criteria.

Proposed Exclusion Criteria for Prospectively Assigned Beneficiaries

CMS will perform a limited reconciliation where beneficiaries would be removed from the prospective assignment list at the end of the year if they were not eligible for assignment at that time. For example, if a prospectively assigned beneficiary enrolled in a Medicare Advantage plan during the year, they would be removed from the assignment list at the end of the year and not used to calculate financial performance for the year. Beneficiaries will not be removed from the prospective reconciliation if they choose to receive their primary care during the course of the year from non-ACO physicians.

Proposed Timing of Prospective Assignment

CMS considered several options for establishing the 12-month period for prospective assignment under Track 3. CMS proposes to base assignment on the most recent 12-month period prior to the relevant performance year for which data are available. Thus, CMS would use a 12-month assignment window that is offset from the calendar year.

Proposals for Addressing Interactions between Prospective and Retrospective Assignment Models

CMS proposes that a beneficiary prospectively assigned to a Track 3 ACO will continue to be assigned to that ACO even if, over the course of a performance year, he or she received the preponderance of their primary care from a Track 1 or 2 ACO.

Proposals for Determining Benchmark and Performance Year Expenditures Under Track 3

CMS proposes to determine the beneficiaries that would have been prospectively assigned to the ACO during each of the three most recent years prior to the start of the agreement period. The benchmark would be based on an offset (described above) 12 month assignment window. CMS would still determine Parts A and B FFS expenditures for each calendar year, whether it is benchmark or performance year using a three month claims run out with completion factor for prospectively assigned beneficiaries. CMS would exclude indirect medical education and disproportionate share hospitals and account for individual beneficiary identifiable payments made under a demonstration, pilot, or other time-limited program during the calendar year that corresponds to the benchmark or performance year.

Proposals for Risk Adjusting the Updated Benchmark for Track 3 ACOs
CMS will use the same risk adjustment methodology as in Tracks 1 & 2. It also proposes to refine the definitions of newly and continuously assigned beneficiaries to reflect the offset assignment window.

Proposals for Final Sharing/Loss Rate and Performance Payment/Loss Recoupment Limit under Track 3
CMS proposes that ACOs participating in Track 3 would be subject to a fixed 2 percent Minimum Loss Rate (MLR).

CMS also proposes to:

- Set the sharing rate at 75 percent as a reward for taking on more risk with a fixed MLR. The performance payment amount may not exceed 20 percent of the ACO's updated benchmark.
- Shared losses will be capped at 15 percent of the benchmark. This is not graduated as it is in Track 2.
- Quality performance will not reduce losses below 40 percent.

Seeking Comment on Ways to Encourage ACO Participation in Performance-Based Risk Arrangements
CMS solicits comment on several options that are currently under consideration for inclusion in the Shared Savings Program. CMS first considered options that would implicate the waiver authority under section 1899(f) of the Act, and then considered other options that could be implemented independent of waiver authority. Although it is not specifically proposing these options at this time, it will consider the comments that are received regarding these options during the development of the final rule, and may consider adopting one or more of these options in the final rule.

Waiver of the SNF 3-Day Rule
The proposed rule discusses Center for Medicare and Medicaid Innovation (CMMI) programs testing a waiver for the skilled nursing facility (SNF) three-day acute admission requirement.

It also discusses the terms of the Pioneer ACO, which include:

- Only beneficiaries who are prospectively assigned to the Pioneer ACO are eligible.
- Only those beneficiaries who require skilled nursing and or skilled rehab care are eligible for SNF coverage without the hospitalization requirement.
    - These patients may not reside in nursing facilities for long-term custodial care at the time the decision to admit to a SNF is made.
- Pioneer ACOs must demonstrate that they are capable of identifying and managing patients who would be directly admitted to a SNF or admitted to a SNF after a stay of less than three days.

- Patients must be medically stable, have certain and confirmed diagnoses and therefore not require additional testing or an inpatient evaluation or treatment, and have a SNF need that can't be provided in an outpatient setting.
- Patients must be admitted to the SNF at the direction of a Pioneer provider/supplier (that is not a SNF).
- Pioneer ACOs must identify a SNF or group of SNFs that they are partnering with for this waiver.
    - The SNF must have at least a three-star rating
- CMS would likely limit to Track 3 ACOs due to prospective assignment.
- CMS indicates that it will implement heightened monitoring for fraud and abuse for entities operating under a 3-day waiver.

Billing and Payment for Telehealth

CMS is considering waiving the originating site requirements that limit telehealth payment to services furnished within specific types of geographic areas or in an entity participating in a federal telemedicine demonstration project. CMS would limit waivers to beneficiaries that are assigned to the ACO during the applicable performance year. This would only apply to Track 3. CMS is also considering an option to make available the waivers to any ACO participating in a two-sided model.

Homebound Requirement Under the Home Health Benefit

CMS is considering waiving the homebound requirement for Track 3 ACOs. The reasons for limiting to Track 3 are similar to those described for the SNF 3-day requirement and telehealth. Alternatively, CMS would consider expanding the waiver to all risk bearing ACOs.

Waivers for Post-Acute Settings

ACOs and MedPAC have suggested that there are significant performance variations across sites of post-acute care. They have asked CMS to affirm that if an ACO recommends a particular post-acute care provider to a beneficiary that that recommendation will not violate Medicare regulations related to clear notification of beneficiary freedom of choice. CMS is considering whether it is necessary to waive the requirement that a hospital "not specify or otherwise limit the qualified provider which may provide post-hospital home services" and portions of the conditions of participation. CMS states that it anticipates making it a "very narrow waiver most appropriately implemented under Track 3 due to prospective assignment. Other options include:

- Applying the wavier to any FFS beneficiary cared for by an ACO and the waiver it could be available to all ACOs participating in two-sided risk.
- Applying the waiver to beneficiaries who appear on the quarterly lists of preliminary prospective assigned beneficiaries.

CMS anticipates that:

- Any organization that uses the waiver would face additional documentation requirements.

- Discharge planners would need to document the specific rationale used for the basis of recommending a specific post-acute care (PAC) provider.
- PAC providers meet a certain star threshold (e.g., three out of five)

Other Options for Improving the Transition to Two-Sided Performance Based Risk Arrangements

Beneficiary Attestation:
CMMI, through the Pioneer program, is testing the administrative burden of attribution by attestation by asking beneficiaries to attest to their "main doctor." CMMI will conduct claims based attribution using the Pioneer method (prospective) but will include in a Pioneer's population, not only those beneficiaries aligned through claims but those who return the form attesting that an ACO provider/supplier is their main doctor.

- Beneficiaries who do not return the form or who return the form, but indicate the provider listed is not their main doctor, will not be included in the ACO's assigned beneficiary population unless they are assigned through the existing claims-based attribution methodology. CMS is not recommending at this time, but would consider implementing in a two- sided risk model–Track 2–but would not impact Track 3 churn due to prospective assignment.

Seeking Comment on Step-Wise Progression for ACOs to Take on Performance Based Risk
CMS is not proposing to allow separate participants within the same ACO to engage in different risk tracks (e.g. ABC ACO is comprised of a medical group owned by a hospital and an independent multi-specialty group practice. The hospital participates under Track 2, while the independent MSGP participates under Track 1). However, CMS is seeking comment on the concept to encourage ACO participants to take risk. If CMS were to go this route, it anticipates needing to modify the following:

- The ACO must have completed a full agreement period under Track 1 and meet requirements for renewing its agreement under Track 1, as proposed in this proposed rule.
- The ACO must submit an ACO participant list in the form and manner designated by CMS and by a deadline established by the agency.
- The ACO must indicate, in the form and manner specified by CMS, which ACO participants would continue under Track 1 and which would participate under a performance based risk track. We would consider this list to be a "segmented list" of ACO participants. The ACO as a whole would be required to meet the eligibility requirements to participate in the program, including the requirement that the ACO have at least 5,000 assigned beneficiaries and the governance requirements.

Regarding quality measures submission, CMS considered whether the ACO as a whole would be responsible for submitting quality data in accordance with the Shared Savings Program regulations. Also, regarding benchmarking and assignment of beneficiaries,

CMS considered whether each half of the segmented list of ACO participants would have its own benchmark and list of assigned beneficiaries.

- The two groups of ACO participants would each receive their own performance reports from CMS and be subject to the data-sharing rules appropriate for their track, and the determination of shared savings would occur according to the rules of the chosen track.
- Another option would be to develop one benchmark and list of assigned beneficiaries for the ACO as a whole. This option would require a uniform assignment methodology to be applied, regardless of which track the segmented lists are participating in.

Regarding changes in the ACO participant lists during the agreement period, CMS is considering whether an ACO would be permitted to add or delete ACO participants from the segmented lists.

Modification to Repayment Mechanisms
CMS proposes to modify the repayment mechanism requirements to cover the required amount (1 percent of Parts A and B expenditure for the attributed beneficiaries) for the entire agreement period (instead of three separate payment mechanisms – one for each agreement period) and a reasonable period of time after the end of the agreement period. CMS will establish the length of tail coverage in guidance. If the repayment mechanism is used to cover shared losses, the ACO must replenish it. CMS is considering whether it should adjust the amount in the repayment mechanism annually to reflect changes in the benchmark and the number of attributed beneficiaries.

Proposals Regarding Permissible Payment Mechanisms
CMS proposes removing the reinsurance option or alternative mechanisms. To date, no MSSPs have obtained reinsurance for this purpose. This limits the mechanisms ACOs may use to demonstrate their ability to repay shared losses to the following:

- Placing funds in escrow
- Establishing a line of credit
- Obtaining a surety bond

Seeking Comment on Method for Establishing, Updating, and Resetting the Benchmark
CMS continues to receive feedback that resetting the benchmark every three years makes it challenging for ACOs to achieve savings in the out years (as additional efficiencies are harder to find) and makes the program less attractive. CMS is considering the following changes to update its benchmark methodology:

Equally Weighting all Three Benchmark Years:
Currently the benchmark is set by weighting Benchmark Year (BY3) (most recent year prior to performance period) at 60 percent, BY2 at 30 percent, and BY1 at 10 percent.

CMS believes equal weighting would more gradually lower ACO benchmarks making it more likely that ACOs achieve shared savings. CMS believes interventions put in place

in the first and second performance year will have the most impact in the third performance year of a contracting period. PY3 of the prior contracting period becomes BY3 in the next contracting period and is therefore most heavily weighted in the benchmark setting under the current model. This makes it increasingly difficult for ACOs to continue to generate savings.

Accounting for shared savings payments in the benchmarks

CMS would upward adjust benchmarks in subsequent periods to reflect any shared savings payments, based on the final savings rate. CMS believes the prospect of an inflated benchmark would encourage participation in two-sided risk models as the higher sharing rate would be reflected in the adjustment. Only ACOs that receive shared savings payments in their prior agreement period would benefit. ACOs that achieved savings but didn't exceed their MSR would be left out. Due to the timing of the reconciliation, this would delay the finalization of the ACO's historical benchmark for its first performance year. CMS is also considering downward adjustments for shared losses in the benchmark calculation.

Use of Regional (as Opposed to National) Factors in Establishing and Updating Benchmarks

CMS would use the regional FFS Parts A and B expenditure trend to make adjustments to a specific ACO's benchmarks between performance years. CMS would still recalculate new benchmarks based on the ACO's attributed population at the start of each new agreement period. CMS states that it favors the approach used for the PGPD. Under the PGPD, a comparison group was created in the PGPD participant's service area. The growth rate of comparison expenditures was calculated and used as the growth rate for updating the benchmark. The service area was determined by using the assigned beneficiary population. All counties where 1 percent or more of the attributed population resided were included in the service area. The service area was re-determined each year based on changes in the assigned beneficiary population. The method was used over the five year life of the PGPD, so CMS is confident that it could be implemented.

Alternative Benchmark Resetting Methodology: Holding the ACO's Historical Cost Relative to the Region

At the start of a new agreement period, CMS considered updating the existing benchmark from the prior performance period according to FFS cost trends in the region. This in effect would hold an ACO's benchmark constant relative to the rest of the region.

- Regional cost trends would be calculated using an approach based on the PGPD (described above) and the ACO's historical benchmark would be updated by increasing it by a percentage equal to the percentage increase in regional costs.
- CMS is also considering an approach that uses the ACO's historical costs to adjust regional FFS benchmarks developed for future agreement periods.

CMS would develop a scaling factor which would be the ratio of :1) An ACO's historical benchmark under its first agreement period (using existing methodology) divided by 2) The regional FFS benchmark that would have been calculated for the ACO for the

third benchmark year (the year prior to the start of the first agreement period) of the first agreement period.

The ACO's benchmark for subsequent performance years would be calculated by multiplying this scaling factor by the ACOs regional FFS benchmark for that performance year to account for the difference originally exhibited between the ACO's expenditures and the regional FFS benchmark expenditures in the year prior to the beginning of the ACO's first agreement period. The regional benchmark would be calculated using the PGPD method (discussed above). CMS considered the following two approaches to adjusting the benchmark for changes in ACO participants.

- Use the current method of adjusting the benchmark to reflect changes in ACO participants.
    - For each historical year that the ACO's participant list changes, CMS will re-compute its historical benchmark or scaling factor using cost information from the benchmark period corresponding to the initial agreement period. While this is an approach that MSSPs are familiar with it poses the challenge that not all participants joining the ACO will have historical claims data from the three years prior to the ACO's agreement period.
- Use a method that reflects the historical cost experience of any ACO participant TINs that are added and remove the influence of those that leave, but don't incorporate updated cost information for participants that remain in the ACO (continue using historical baseline).

Alternative Benchmarking Methodology: Transition ACOs to Benchmarks Based Only on Regional Costs Over the Course of Multiple Agreement Periods

CMS is considering transitioning ACOs from ACO-specific historical cost benchmarks to benchmarks based on regional cost only. MedPAC has suggested this approach.
CMS would transition to this over several agreement periods using an average that was increasingly weighted to the regional benchmark. The regional benchmark would include the ACO's beneficiaries. This transition would advantage low cost ACOs in high cost regions while disadvantaging high-cost ACOs in low-cost regions. CMS is considering normalizing the risk scores for the ACO and the regionally based comparison group. Following are questions that CMS would like answered:

- Should the transition take two agreement periods, five, or longer?
    - Should the pace of transition be impacted by the ACO's prior performance (e.g., delay downward adjustments if the ACO fails to achieve shared savings)?
- Should the ACO's historical cost be considered? For example, should a low-cost ACO (those below the regional risk-adjusted Medicare FFS per capita benchmark) be transitioned faster?

Additional Program Requirements and Beneficiary Protections
Federal Register, pages 72845-72849

Proposed Revisions to Terminating Program Participation
CMS proposes termination for failure to timely comply with requests for documents and other information and for submitting false or fraudulent data. It also proposes to add close-out procedures and payment consequences of early termination. An ACO whose participation agreement is terminated prior to expiration either voluntarily or by CMS must implement close out procedures in a form, manner, and deadline specified by CMS. The procedures will address data sharing issues (e.g. data destruction), beneficiary notification (e.g. removal of marketing material, ensuring care is not interrupted), compliance with quality reporting, record retention, and other issues. They would also apply to ACOs that elect not to renew their participation agreements. Any ACO that fails to comply would not be eligible for shared savings. Finally, CMS proposes to permit an ACO that voluntarily terminates its agreement to qualify for shared savings if the effective date of the term is Dec. 31 of the current performance year and it completes its close-out process by the date specified by CMS.

Proposed Changes to Reconsideration Review Process
CMS proposes to permit only on the record reviews of reconsideration requests. Additionally, it proposes modify § 425.804 and also clarify that the reconsideration process allows both ACOs and CMS to submit one brief each in support of its position by the deadline established by the CMS reconsideration official.

Monitoring ACO Compliance with Quality Performance Standards
CMS proposes to remove § 425.316(c)(3), which sets forth various required actions the ACO must perform if it fails to report one or more quality measures or fails to report completely and accurately on all measures in a domain. CMS also proposes to remove § 425.316(c)(4), which sets forth the administrative action CMS may take against an ACO if it exhibits a pattern of inaccurate or incomplete reporting of quality measures or fails to make timely corrections following notice to resubmit.

More Information
The final rule is available in the *Federal Register*.

Appendix 1: Physician Specialty Codes Included in Step 2

TABLE 2—CMS PHYSICIAN SPECIALTY CODES THAT WOULD CONTINUE TO BE INCLUDED IN ASSIGNMENT STEP 2

Code	Specialty name
03	Allergy/immunology.
06	Cardiology.
10	Gastroenterology.
13	Neurology.
16	Obstetrics/gynecology.
17	Hospice and palliative care.
23	Sports medicine.
25	Physical medicine and rehabilitation.
29	Pulmonary disease.
37	Pediatric medicine.
39	Nephrology.
44	Infectious disease.
46	Endocrinology.
66	Rheumatology.
70	Multispecialty clinic or group practice.
82	Hematology.
83	Hematology/oncology.
84	Preventive medicine.
90	Medical oncology.
98	Gynecology/oncology.

Appendix 2: Physician Specialty Codes Excluded from Step 2

TABLE 3—CMS PHYSICIAN SPECIALTY CODES THAT WE PROPOSE TO EXCLUDE FROM ASSIGNMENT STEP 2

Code	Specialty name
02	General surgery.
04	Otolaryngology.
05	Anesthesiology.
07	Dermatology.
09	Interventional pain management.
12	Osteopathic manipulative therapy.
14	Neurosurgery.
18	Ophthalmology.
20	Orthopedic surgery.
21	Cardiac electrophysiology.
22	Pathology.
24	Plastic and reconstructive surgery.
26	Psychiatry.
27	Geriatric psychiatry.
28	Colorectal surgery.
30	Diagnostic radiology.
33	Thoracic surgery.
34	Urology.
36	Nuclear medicine.
40	Hand surgery.
72	Pain management.
76	Peripheral vascular disease.
77	Vascular surgery.
78	Cardiac surgery.
79	Addiction medicine.
81	Critical care (intensivists).
85	Maxillofacial surgery.
86	Neuro-psychiatry.
91	Surgical oncology.
92	Radiation oncology.
93	Emergency medicine.
94	Interventional radiology.
99	Unknown physician specialty.
C0	Sleep medicine.