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Medicare Shared Savings Program Final Rule

OVERVIEW

On June 4th, the Centers for Medicare and Medicaid Services (CMS) released a final rule updating the Medicare Shared Saving Program (MSSP), in which over 400 Accountable Care Organizations (ACOs) now participate. The final rule aims to make it more attractive for participants to take on additional risk and incorporates successful elements of the Pioneer ACO model through the creation of a new "Track 3" option. The rule goes into effect August 3, 2015, though certain provisions have later implementation dates.

This document summarizes the major provisions of the final rule and highlights changes from CMS's proposed rule, originally released in December 2014. The final rule is available here.

MAJOR CHANGES FROM THE PROPOSED RULE

In response to comments from stakeholders, CMS made several significant revisions to its proposed rule.

Extension of One-Sided Risk Option with Existing Savings Opportunity

CMS originally proposed to allow ACOs participating in Track 1 (with only upside risk) to continue in a one-side risk model, but with progressively diminishing shared savings opportunities over time.

The final rule allows Track 1 ACOs to continue in the program for one additional three-year agreement period with their current shared savings rate of 50 percent.

Alternative Minimum Savings/Loss Rates for Track 2 ACOs

ACOs entering Track 2 (upside and downside risk) for agreement periods beginning January 2016 or later will have the ability to choose from multiple options for setting the minimum loss rate and minimum savings rate prior to the start of the agreement period. The minimum savings rate (MSR) is the level of savings that an ACO must achieve before it is able to share in any savings. The minimum loss rate (MLR) is the level of savings than an ACO must achieve before it is exposed to any shared losses.

The options for establishing the MSR/MLR are:

- 0 percent MSR/MLR;
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 – 2.0 percent; and
- Symmetrical MSR/MLR that varies based on the ACO's number of assigned beneficiaries according to the methodology established under the one-sided model.

In its proposed rule, CMS only offered the final of these three options as an alternative to the current MSR/MLR policy, which is a fixed rate of 2 percent. The options for an ACO to select first dollar savings and losses or to select its own MSR/MLR are new.

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POLICIES FINALIZED FROM THE PROPOSED RULE

CMS finalized the following policy changes from the proposed rule without major modifications.

Development of an Additional Two-Sided Model: Track 3

CMS finalized its proposal to establish a new two-sided risk model, Track 3, which integrates some elements from the Pioneer ACO model. Features of Track 3 include:

- Higher potential for shared savings and shared losses (75 percent);
- Prospective attribution of beneficiaries; and
- The opportunity to use new care coordination tools.

The final rule establishes a waiver of the three-day inpatient hospital stay requirement for skilled nursing facility eligibility for beneficiaries prospectively assigned to the ACO under Track 3. It does not, however, offer a waiver of the rural location requirement for telehealth services or the homebound requirement for home care services, though both were discussed in the proposed rule. CMS announced its intention to return to these waivers in coming rulemaking. The final rule does not implement voluntary beneficiary attestation as a method for alignment to Track 3 ACOs, or any other MSSP ACOs.

Beneficiary Assignment

Currently, beneficiaries are assigned to ACOs in two steps based on the plurality of primary care services. Step 1 uses primary care physicians, and Step 2 uses specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists.

CMS finalized its proposed policy to:

- Include in Step 1 primary care services provided by nurse practitioners, physician assistants, and clinical nurse specialists; and
- Remove from Step 2 certain specialty types that very rarely offer primary care services, such as radiology, interventional cardiology, and surgery.

Additionally, CMS added pediatric medicine as a specialty designation used in Step 1, and added psychiatry and osteopathic manipulation as specialties used for assignment in Step 2.

Methodology for Rebasing ACO Benchmarks

In establishing the MSSP, the Affordable Care Act required CMS to create a methodology for periodically rebasing the benchmarks for ACOs to ensure continual efficiency and improvement.

CMS finalized its proposals to make this methodology more sustainable for ACOs by giving them credit for previous financial performance. These changes apply to setting an ACO's benchmark in its second (and subsequent) agreement periods. They include:

- Equal weighting of each of the three historic benchmark years, instead of an emphasis on the most recent year;

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- Applying a 'bonus' to the rebased benchmark based on the amount of shared savings earned by the ACO the previous agreement period;

CMS also announced that it intends to provide further updates to the benchmarking methodology later in the summer of 2015.

Data Sharing

CMS finalized its proposal to streamline the process for ACOs to obtain beneficiary claims data to support quality improvement and care coordination. Instead of the current process that requires ACOs to notify beneficiaries by mail that they may opt out of data sharing and then collect any subsequent "opt-out" preferences from patients, ACOs will now simply provide patients written notification about data sharing options at the point of care. Beneficiaries will express their data sharing preferences directly to CMS through 1-800-Medicare rather than passing the information through the ACO.