Medicare Shared Savings Program
Final Rule Overview

June 2015

Overview of Today's Session

- Background
- Summary of June 2015 Final Rule Program Improvements
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- ACO Eligibility Requirements
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Background

- In November 2011, we published the final rule entitled "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" (76 FR 67802).
- In June 2015, we published a final rule entitled “Medicare Shared Savings Program: Accountable Care Organizations” (80 FR 32691).
- The program’s regulation, with references to recent amendments, can be found at 42 C.F.R. part 425, available online: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=9cbc79f8103dc6453574136991 2f044f&ty=HTML&h=L&r=PART&n=42y3.0.1.1.12#42:3.0.1.1.12.4.5.5

Note: The 2014 and 2015 Physician Fee Schedule rules also have certain quality measurement, reporting, and scoring provisions.

Summary of June 2015 Final Rule Program Improvements

- Addressing participation agreement renewals including allowing eligible ACOs to continue participation under the one-sided model (Track 1) for a second agreement period;
- Increasing the emphasis on primary care services in the beneficiary assignment methodology;
- Streamlining data sharing to provide improved access to data necessary for ACO health care operations such as quality improvement and care coordination, while maintaining beneficiary protections;
- Adding a new performance-based risk option (Track 3) that includes prospective beneficiary assignment and a higher sharing rate;
- Providing ACOs choice of symmetric threshold for savings and losses under performance-based risk tracks;

Summary of Final Rule Program Improvements (cont'd.)

- Establishing a waiver of the 3-day stay SNF rule for beneficiaries who are prospectively assigned to ACOs under Track 3;
- Refining the methodology for resetting benchmarks to help ensure that the program continues to provide strong incentives for ACOs to improve the efficiency and quality of patient care, and generate savings for the Medicare Trust Funds;
- Proposing (through rulemaking in the 2017 Physician Fee Schedule) that beneficiaries may attest that their main doctor is participating in a performance-based risk track ACO and be assigned to that ACO;
- Conducting further development and testing of other selected waivers, including a waiver of the billing and payment requirements for telehealth services*; and,
- Refining eligibility and other requirements.

Note: We anticipate a telehealth waiver being available to ACOs no earlier than January 1, 2017, after public comment and formal rulemaking.

Effective and Applicability Dates

- There are several changes that have an applicability date or effective date other than 60 days after the date of publication of this final rule (detailed in the Appendix).
- By indicating a provision is applicable to a performance year (PY) or agreement period, activities related to implementation of the policy may precede the start of the performance year or agreement period or follow the conclusion of the performance year or the agreement period.
- For example, waivers of payment rules or other Medicare requirements will not be applicable until the 2017 performance year and subsequent performance years.

Note: Please refer to the Appendix to view an effective and applicability date table for select provisions in the final rule.

ACO Eligibility Requirements: Major Provisions

Major Provisions:

1. Codified and expanded requirements related to the agreements ACOs have with ACO participants (entities Identified by Medicare-enrolled TINs).
2. Modified governing body and leadership requirements.
3. Expanded requirements for the process the ACO has for coordinating care by encouraging and promoting the use of enabling technologies.
4. Streamlined application procedures for Pioneer ACOs that want to apply for participation in the Shared Savings Program.
5. Established rules and a process for renewing the 3 year agreement, including factors that CMS will use to determine whether an ACO may renew its 3-year agreement.

ACO Eligibility Requirements: Major Provisions

Codified and expanded requirements related to ACO agreements with ACO participants

- Continue to require ACOs to maintain, update and submit to CMS accurate and complete ACO participant and ACO provider/supplier lists.
- Adds specificity to the required reporting of ACO participants and ACO provider/suppliers.
- Requires ACOs to include language in their ACO participant agreements to ensure that changes in ACO participant and ACO provider/supplier enrollment status are made in PECOS within 30 days after such changes have occurred.
- Removes the requirements for ACOs to indicate whether an ACO provider/supplier is a primary care physician* (because this information is derived from the claims submitted under the ACO participant's TINs).

Note: Exception is in the case of FQHC/RHCs. ACOs must provide the NPIs of physicians that have direct contact with patients.

ACO Eligibility Requirements: Major Provisions

Modified governing body and leadership requirements

- Clarifies the reference to “otherwise independent ACO participants” and revised to provide 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.
- Clarifies that the ACO governing body must be the same as the governing body of the legal entity that is the ACO, and the ACO’s governing body must retain the ultimate authority to execute the functions of an ACO.
- Precludes the governing body of a Traditional ACO (multi-TIN) from being the same as the governing body of an ACO participant.
- Prohibits an ACO provider/supplier from being the beneficiary representative on the governing body.
- Removes the requirement that the medical director must be one of the ACO providers/suppliers.

ACO Eligibility Requirements: Major Provisions

Expanded requirements for the process the ACO has for coordinating care

- Requires an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries. Such enabling technologies and services may include electronic health records and other health IT tools.
- Requires the applicant to describe how the ACO intends to partner with long-term and post-acute care providers to improve care coordination for the ACO's assigned beneficiaries.

ACO Eligibility Requirements: Major Provisions

Streamlined application procedures for Pioneer ACOs

- Offers Pioneer ACOs the opportunity to apply to the Shared Savings Program using a condensed application if three criteria are satisfied:
  - The applicant ACO must be the same legal entity as the Pioneer ACO.
  - All of the TINs on the applicant's ACO participant list must have appeared on the "Confirmed Annual TIN/NPI List" (as defined in the Pioneer ACO Model Innovation Agreement with CMS) for the applicant ACO's last full performance year in the Pioneer ACO Model.
  - To determine whether a condensed application is appropriate, CMS will only compare the TINs and not NPIs, and permit these ACOs to drop TINs if they cannot obtain the consent of all NPIs billing through the TIN to participate in the Shared Savings Program.
  - The applicant must be applying to participate in a two-sided model.
- Former Pioneers that do not meet these requirements may apply to the program through the established application process.

Establishing and Maintaining the Participation Agreement: Major Provisions

Major Provisions:

1. Defines the evaluative criteria that will be applied to all renewing ACOs, including Track 1 ACOs applying for a second agreement period under the one-sided model.

Establishing and Maintaining the Participation Agreement: Major Provisions

Established rules and a process for renewing the 3 year agreement

- All renewing ACOs (including Track 1 ACOs applying for a second agreement period under the one-sided model), will be evaluated on all of the following factors:
  - Whether the ACO satisfies the criteria for operating under the selected risk model.
  - The ACO's history of compliance with the requirements of the Shared Savings Program.
  - Whether the ACO has established that it is in compliance with the eligibility and other requirements of the Shared Savings Program, including the ability to repay losses, if applicable.
  - Whether the ACO met the quality performance standards during at least one of the first two years of the previous agreement period.
  - For an ACO under a two-sided model, whether the ACO has repaid losses owed to the program that it generated during the first two years of the previous agreement period.
  - The results of a program integrity screening of the ACO, its ACO participants, and its ACO providers/suppliers.

Provision of Aggregate and Beneficiary Identifiable Data and Beneficiary Notifications: Major Provisions

Major Provisions:

1. Streamlines the process for ACOs to access Medicare beneficiary claims data necessary for health care operations, while retaining the opportunity for beneficiaries to decline to have their Medicare claims data shared with the ACO.
2. Expands the beneficiary-identifiable data elements that will be made available to ACOs in various reports under the Shared Savings Program.

Provision of Identifiable Data and Beneficiary Notifications: Major Provisions

Aggregate and Beneficiary Identifiable Data

- For ACOs in Tracks 1 and 2, the Claims and Claim Line Feeds (CCLFs) data will be made available on all beneficiaries who had a primary care service visit during the previous 12 months with an ACO participant that submits claims for primary care services that are considered in the assignment process (assignable beneficiaries), unless the beneficiary has declined to share his / her data with an ACO.
- For ACOs in Track 3, the CCLF data will be made available for prospectively assigned beneficiaries, unless the beneficiary has declined to share his / her data with an ACO.
- We are also expanding the beneficiary identifiable information made available in program reports for assigned beneficiaries to include additional data points in the following categories: demographic information, health status information, utilization rates of Medicare services, and expenditures related to utilization of services.
  - Track 1 and 2 ACOs will receive select data (name, DOB, HICN, sex) on assignable beneficiaries through program reports. For Track 3 ACOs, the beneficiary identifiable data included in the reports will be limited to the ACO's prospectively assigned beneficiaries.

Provision of Aggregate and Beneficiary Identifiable Data and Beneficiary Notifications: Major Provisions

Beneficiary Notifications

- ACO participants will continue to provide written notification at the point of care through signs posted in their facilities that include template language regarding data sharing and the opportunity for beneficiaries to decline data sharing by calling 1-800-Medicare. Beneficiaries can express their data sharing preferences directly to CMS through 1-800 Medicare rather than passing the information through the ACO.
- This means that ACOs will no longer send out letters that may confuse beneficiaries and beneficiaries will no longer have to sign and return forms to the ACO.
- ACOs will no longer send to CMS data sharing preference and request files (via MFT) to CMS.
- These changes are effective November 1, 2015.

Assignment of Medicare Beneficiaries: Major Provisions

Major Provisions:

1. Expands the CPT codes that will be considered to be primary care services.
2. Modifies the treatment of claims submitted by certain physician specialties, NP, PAs, and CNSs in the assignment algorithm.
3. Clarifies how primary care services furnished in FQHCs and RHCs are considered in the assignment process.

Assignment of Medicare Beneficiaries: Major Provisions

Expands the CPT codes that will be considered to be primary care services

- We updated the definition of primary care services to include both TCM codes (CPT codes 99495 and 99496) and the CCM code (CPT code 99490) and will include these codes in our beneficiary assignment methodology.

Assignment of Medicare Beneficiaries: Major Provisions

Modifies the treatment of claims used in the assignment algorithm

- We will use primary care services furnished by primary care physicians, NPs, PAs, and CNSs under Step 1 of the assignment process, after having identified beneficiaries who received at least one primary care service by a physician eligible for assignment in the ACO.
- We added a physician specialty code to Step 1 of the assignment process.
- We excluded select physician specialty codes from Step 2 of the assignment process.

Note: Please refer to the Appendix to view the inclusion and exclusion tables included in the final rule.

Assignment of Medicare Beneficiaries: Major Provisions

Clarifies how primary care services furnished in FQHCs and RHCs are considered in the assignment process

- We will use FQHC/RHC physician attestation information only for purposes of determining whether a beneficiary is eligible to be assigned to an ACO. If a beneficiary is identified as "assignable" then we will 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.

Assignment of Medicare Beneficiaries: Major Provisions

Important Operational Highlights

- All the beneficiary assignment provisions will be applicable starting at the beginning of the following performance year.
  - The new beneficiary assignment policies issued as part of the 2015 final rule will apply to beneficiary assignment starting with performance year 2016, including preliminary assignment for 2016 applicants.
- We will adjust all benchmarks at the start of the first performance year in which the new assignment rules are applied so that the benchmark for the ACO reflects the use of the same assignment rules as will apply in the performance year.
- We will not retroactively apply the new beneficiary assignment methodology to the previous performance year.

Shared Savings and Losses: Major Provisions

Major Provisions:

1. Modifies one-sided model (shared savings only) requirements.
2. Modifies two-sided model requirements related to:
   - Minimum savings rate (MSR) and minimum loss rate (MLR) selections;
   - A new performance-based risk option (Track 3); and,
   - Repayment mechanism requirements.
3. Modifies the rebasing component of the benchmarking methodology.
4. Provides for considerations to improve the transition to two-sided performance-based risk tracks.

Note: An overview of the Shared Savings Program financial model final policy changes is included in the Appendix.

Shared Savings and Losses: Major Provisions

Modifications to the one-sided model

- Eligible ACOs who entered the program under the one-sided model (Track 1) may continue participating under a one-sided model for a second 3-year agreement.
- Final sharing rate of up to 50% continues to apply for the second agreement.

Shared Savings and Losses: Major Provisions

Modifications to the two-sided models, MSR/MLR requirements

- ACOs entering Track 2 will choose a symmetrical minimum savings rate (MSR) and minimum loss rate (MLR):
  - 0.0% MSR/MLR
  - 0.5% MSR/MLR
  - 1.0% MSR/MLR
  - 1.5% MSR/MLR
  - 2.0% MSR/MLR
  - MSR/MLR that varies based on the size of ACO's assigned population according to the methodology established under the one-sided model: between 2.0 – 3.9%
- MSR/MLR selection made prior to the start of each agreement period and may not be changed during the course of the agreement period.

Shared Savings and Losses: Major Provisions

Modifications to the two-sided models, new performance-based risk track

- Track 3 offers greater risk for greater reward.
  - Higher sharing rates and performance payment limits than Tracks 1 and 2; Higher loss rate & loss sharing limit than Track 2.
    - Sharing rate based on quality performance: up to 50% for Track 1, 60% for Track 2 (loss rate 40% min, 60% max), 75% for Track 3 (loss rate 40% min, 75% max).
    - Payment limits: 10% for Track 1; 15% for Track 2; 20% for Track 3.
    - Loss limits: Phased approach under Track 2 (5% PY1, 7.5% PY2, 10% PY3 and subsequent years); 15% for Track 3.
- Same choice of MSR/MLR as for Track 2 (previous slide).
- Beneficiaries will be prospectively assigned to the ACO rather than preliminarily prospectively assigned to ACOs with a retrospective reconciliation.

Shared Savings and Losses: Major Provisions

Modifications to the two-sided models, new performance-based risk track

- Waiver of the SNF 3-day rule
  - Waiver will be effective on or after January 1, 2017.
  - All ACOs participating under Track 3 or applying to participate under Track 3 will be eligible to apply for the waiver.

Shared Savings and Losses: Major Provisions

Modifications to the two-sided models, repayment mechanism modifications

- Modifications to the repayment mechanism requirement for ACOs applying to enter the two-sided models (Tracks 2 & 3)
  - Reducing the burden on ACOs by requiring a single repayment mechanism that is established for the agreement period, and replenished within 90 days if used to repay losses.
  - Repayment mechanism options are limited to the following:
    - Funds placed in escrow
    - Surety bond
    - A line of credit the Medicare program could draw upon, as evidenced by a letter of credit.

Shared Savings and Losses: Major Provisions

Benchmark Rebasing

- For an ACO's second or subsequent agreement period, the benchmarking methodology will be modified by:
  - Equally weighting the historical benchmark years, instead of weighting BY1 at 10%, BY2 at 30%, BY3 at 60% as used to establish the first agreement period benchmark.
  - Accounting for net savings generated by the ACO in its prior agreement period.
    - If the sum of the per capita benchmark minus expenditure amounts for all 3 performance years is >0 the ACO's rebased benchmark will be adjusted.
    - We will calculate an average per capita amount of savings reflecting the ACO's final sharing rates based on quality performance, and add this amount to the ACO's rebased benchmark not to exceed the average number of assigned beneficiary person-years under the ACO's prior agreement period.
- We indicated our intent for additional notice and comment rulemaking in 2015 for a methodology that would reset ACO benchmarks in part based on trends in regional fee-for-service costs rather than solely ACOs' own recent spending.

Shared Savings and Losses: Major Provisions

Considerations for improving the transition to two-sided performance-based risk tracks

- Beneficiary attestation for purposes of beneficiary assignment – to be proposed in 2017 Physician Fee Schedule rulemaking, with considerations for the following:
  - Potential implementation no earlier than January 1, 2017.
  - Application to performance-based risk tracks.
- Conducting further development and testing of other selected waivers through the Innovation Center prior to implementation in the Shared Savings Program.
  - We anticipate a waiver of the billing and payment requirements for telehealth services being available to ACOs no earlier than January 1, 2017 after gaining experience with the waiver through the Next Generation ACO Model and notice and comment rulemaking.

Additional Program Requirements and Beneficiary Protections: Major Provisions

Major Provisions:

1. Includes additional reasons for termination of the participation agreement by CMS
2. Includes additional rules for public reporting and transparency

Additional Program Requirements and Beneficiary Protections: Major Provisions

Additional termination reasons

- Failure to comply with CMS requests for documentation or other information by a deadline specific by CMS.
- Submitting false or fraudulent data or information.

Additional Program Requirements and Beneficiary Protections: Major Provisions

Additional rules for public reporting and transparency

- Each ACO must maintain a dedicated public webpage to report necessary public information, including:
  - Shared savings and losses;
  - Key clinical and administrative leadership;
  - Types of ACO participants;
  - Amounts of any payments to or from CMS;
  - Savings invested in infrastructure; and,
  - Quality measure performance.
- The public webpages of ACOs will not be subject to marketing review or approval.

Appendix

Effective and Applicability Dates for Select Provisions

Preamble Section	Section Title/Description	Effective Date	Applicability Date
II.B.1.	Agreement Requirements (§ 425.116)		PY 2017 and subsequent performance years
II.D.2	Provision of Aggregate and Beneficiary Identifiable Data (§425.702(c)(1)(ii))		PY 2016 and subsequent performance years.
II.D.3	Claims Data Sharing (§425.704)	1/1/2016	
II.D.3	Beneficiary Opportunity to Decline Claims Data Sharing (§425.312 and §425.708)	11/1/2015	
II.E.3	Definitions of Primary Care Physician and Primary Care Services (§425.20)		PY 2016 and subsequent performance years
II.E.4	Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process (§425.402(b))		PY 2016 and subsequent performance years.
II.F.2	Modifications to the Track 2 Financial Model (§425.606(b)(1)(ii))		PY 2016 and subsequent performance years.
II.F.7	Waivers of payment rules or other Medicare requirements: SNF 3-Day Stay Rule Waiver (§425.612)		PY 2017 and subsequent performance years

Overview of Shared Savings Program Financial Model Final Policy Changes

Issue	Track 1: One-Sided Model (shared savings only)	Two-Sided Models (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Transition to Two-Sided Model	Remove requirement to transition to two-sided model for a second agreement period.	No change. ACOs may elect Track 2 without completing a prior agreement period under a one-sided model. Once elected, ACOs cannot go into Track 1 for subsequent agreement periods.	Same as Track 2
Assignment	No change. Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change. Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	Prospective assignment for reports, quality reporting and financial reconciliation; Beginning in 2017, beneficiaries may attest that their main doctor is participating in a performance-based risk track ACO and be assigned to that ACO (through PFS rulemaking)
Benchmark	Modifications to rebasing methodology for ACO's second or subsequent agreement period: equally weighting benchmark years, and including a per capita amount reflecting savings generated during prior agreement period.	Same as Track 1	Same as Tracks 1 and 2

Overview of Shared Savings Program Financial Model Final Policy Changes (cont'd.)

Issue	Track 1: One-Sided Model (shared savings only)	Two-sided Models (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Adjustments for health status and demographic changes	No change. Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the assigned beneficiary population for the performance year. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score.	No change. Same as Track 1.	Same as Tracks 1 and 2.
Final Sharing Rate	No change. Up to 50% based on quality performance (maintained for second agreement period under Track 1)	No change. Up to 60% based on quality performance	Up to 75% based on quality performance
Minimum Savings Rate (MSR) / Minimum Loss Rate (MLR)	No change. 2.0% to 3.9% MSR depending on number of assigned beneficiaries. MLR is not applicable to Track 1 ACOs.	Instead of a fixed 2.0% MSR/MLR ACOs will have a choice of a symmetrical MSR/MLR: (i) no MSR/MLR; (ii) symmetrical MSR/MLR in 0.5% increments between 0.5% - 2.0%; (iii) symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)	Same as Track 2

Overview of Shared Savings Program Financial Model Final Policy Changes (cont'd.)

Issue	Track 1: One-Sided Model (shared savings only)	Two-sided Models (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Performance Payment Limit	No change. 10%	No change. 15%	20%
Shared Savings	No change. First dollar sharing once MSR is met or exceeded.	No change. Same as Track 1.	Same as Tracks 1 and 2
Shared Loss Rate	No change. Not applicable.	No change. One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 60%	One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 75%
Loss Sharing Limit	No change. Not applicable	No change. Limit on the amount of losses to be shared in phases in over 3-years starting at 5% in year 1; 7.5% in year 2; and 10% in year 3 and any subsequent year. Losses in excess of the annual limit would not be shared.	15%. Losses in excess of the annual limit would not be shared.
Payment and Program Rule Waivers and Part 425	Not applicable	Not applicable	Beginning in 2017, ACOs may elect to apply for a waiver of the SNF 3-Day Rule

Specialty Codes Included in Assignment Step 1

Code	Specialty Name
01	General Practice
08	Family Practice
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine

Reference: 80 FR 32753

CMS Non-Physician Specialty Codes Included in Assignment Step 1

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

Reference: 80 FR 32753

Physician Specialty Codes Included in Assignment Step 2

Code	Specialty Name
06	Cardiology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonary disease
39	Nephrology
46	Endocrinology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventive medicine
86	Neuro-psychiatry
90	Medical oncology
98	Gynecology/oncology

Reference: 80 FR 32753

Physician Specialty Codes Excluded in Assignment Step 2

Code	Specialty Name
02	General surgery
03	Allergy/immunology
04	Otolaryngology
05	Anesthesiology
07	Dermatology
09	Interventional pain management
10	Gastroenterology
14	Neurosurgery
17	Hospice and Palliative Care
18	Ophthalmology
20	Orthopedic surgery
21	Cardiac electrophysiology
22	Pathology
24	Plastic and reconstructive surgery
28	Colorectal surgery
30	Diagnostic radiology
33	Thoracic surgery
34	Urology
36	Nuclear medicine

Code	Specialty Name
40	Hand surgery
44	Infectious disease
66	Rheumatology
72	Pain management
76	Peripheral vascular disease
77	Vascular surgery
78	Cardiac surgery
81	Critical care (intensivists)
85	Maxillofacial surgery
91	Surgical oncology
92	Radiation oncology
93	Emergency medicine
94	Interventional radiology
99	Unknown physician specialty
C0	Sleep medicine
C3	Interventional Cardiology

Reference: 80 FR 32753-32754