

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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FACT SHEET

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Contact: CMS Media Relations
(202) 690-6145 or press@cms.hhs.gov

Proposed Changes to the Medicare Shared Savings Program Regulations

OVERVIEW

On December 1, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update and improve policies governing the Medicare Shared Savings Program (Shared Savings Program). The proposed 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 proposed rule 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 CY2015 Medicare Physician Fee Schedule on October 31, 2014.

This fact sheet summarizes the major proposed changes and topics on which CMS seeks comments that are associated with implementation of the Shared Savings Program. There will be a 60-day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as it develops final regulations on the program. Comments can be submitted at:

<http://www.regulations.gov/>

BACKGROUND

Section 3022 of the Affordable Care Act added a new section 1899 to the Social Security Act that establishes the Shared Savings Program. This program encourages providers of services and suppliers (e.g., physicians, hospitals and others involved in patient care) to create a new type of health care entity, an Accountable Care Organization (ACO). ACOs agree to be held accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending. If they are successful, they receive a share of the savings achieved. Studies have shown that better care often costs less, because coordinated care helps to ensure that the patient receives the right care at the right time, with the goal of avoiding unnecessary duplication of

services and preventing medical errors. In November 2011, CMS published a final rule under the Affordable Care Act to implement the Medicare Shared Savings program. The Shared Savings Program has an annual application period.

The Shared Savings Program now includes more than 330 ACOs and more than 125,000 Medicare enrolled practitioners. They function in 47 states, in addition to DC and Puerto Rico. Roughly 4.9 million beneficiaries are assigned to these ACOs (while assigned, such beneficiaries are free to seek services from non-ACO providers under traditional Fee-For-Service Medicare).

On November 7, 2014, CMS released the first financial reconciliation and quality performance results for the 220 Shared Savings Program ACOs with start dates in 2012 and 2013. Details can be found at:
<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-10.html>

CMS is encouraged by the first year results and is proposing some adjustments and improvements to the program to support its continued success.

Participation Agreement Renewal and Continued Participation in Track 1

Background: Current regulations require that ACOs participating in Track 1 (sharing savings, but not losses) may continue in the program after their initial 3-year agreement period only if they enter a performance risk-based (two-sided) track.

Proposal: We propose rules for the review and approval of participation agreement renewal requests, taking into account such things as the ACO's history of compliance with the requirements of the Shared Savings Program and the ACO's history of meeting the quality performance standard during the first 2 years of program participation. Additionally, we propose to permit ACOs to participate in one additional agreement period under Track 1, but at a lower sharing rate than the previous agreement period to encourage progression along the performance risk continuum. This policy would be available to ACOs that have met the quality performance standard in at least one of the first two years and have not generated losses that exceed the negative minimum savings rate (MSR) in both of the first two years of the previous agreement period.

Beneficiary Assignment

Background: The existing methodology assigns beneficiaries to ACOs in two steps (after satisfying the statutory requirement by identifying beneficiaries who have received a primary care service from a physician in the ACO) based on the plurality of primary care services furnished by 1) primary care physicians, and 2) by specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists.

Proposal: We propose to revise Step 2 of the assignment methodology to remove certain specialty types whose services are not likely to be indicative of primary care services. Additionally, we propose to

include nurse practitioner, physician assistant, and clinical nurse specialist primary care services in Step 1 in order to recognize the primary care delivered by these professionals.

Data Sharing

Background: Current policy permits CMS to share claims data with ACOs that is necessary for health care operations, but only after ACOs have notified beneficiaries and provided them an opportunity to decline to have their data shared with the ACO among other requirements. ACOs can either mail notices to beneficiaries, wait 30 days before requesting data, and then follow up with the beneficiary at the next primary care office visit, or they may notify beneficiaries at the point of care and request data immediately. This process has created beneficiary confusion, delays in data sharing, and administrative complexity.

Proposal: We propose to streamline the process for ACOs to access beneficiary claims data necessary for health care operations while retaining the opportunity for beneficiaries to decline to have their claims data shared with the ACO. Specifically, we propose that ACO participants would 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. Under this proposal, beneficiaries would 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.

Establishing, updating, and resetting ACO financial benchmarks:

Background: Pursuant to section 1899(d)(1)(B)(ii) of the Act, in the November 2011 final rule, we adopted a methodology for establishing ACO financial benchmarks used for determining shared savings and losses. Under 1899(i) we have flexibility to implement alternative benchmarking approaches; however, these must not result in additional program expenditures.

Proposal: We seek comment on a number of alternative methodologies for establishing, updating, and resetting ACO financial benchmarks. For example, we are interested in hearing reactions to potentially:

- using regional FFS expenditures instead of national FFS expenditures in establishing and updating the benchmark,
- transitioning to using regional FFS cost data to make ACO benchmarks gradually more independent of the ACO's past performance and gradually more dependent on the ACO's success in being more cost efficient relative to its local market, resetting the ACO's benchmark in subsequent agreement periods such as equally weighting the three benchmark years and/or accounting for shared savings payments received by an ACO in its prior agreement period.

In addition, we seek comment on related changes to calculations related to the benchmark that would support these options, including changes to risk adjustment normalization and coding intensity adjustments, comparison group definitions, adjustments for ACO composition changes, the timeline for transition to regional FFS costs, and other adjustments.

Encouraging ACOs to take on greater performance based risk

Background: We seek to encourage ACOs to progress along the performance risk continuum. Based on comments from stakeholders, we believe certain aspects of the Shared Savings Program could be improved to increase interest in performance risk-based options.

Proposal: We seek comment and propose a number of modifications including:

- Proposing to implement an additional performance risk-based model (Track 3) for ACOs to participate in the Shared Savings Program. Track 3 would offer a higher sharing rate than Tracks 1 and 2 and would prospectively assign beneficiaries to the ACO rather than preliminarily assigning beneficiaries to ACOs and then doing a retrospective reconciliation.
- Proposing to modify Track 2 to increase its attractiveness by making the minimum savings and loss rates variable rather than the current flat 2 percent.
- Seeking comment on what other design elements would be necessary for organizations to consider taking on greater financial risk, including options to:
 - Augment the current assignment methodology by including beneficiaries on the assignment list when the beneficiary attests that a practitioner participating in the ACO is responsible for his or her care coordination.
 - Waive certain FFS payment and regulations related to qualifying hospital stays for SNF admission, telehealth, qualifications for home health services, and qualifications for post-acute referrals.

Eligibility Requirements

We propose several minor modifications to the eligibility requirements for ACO participation including:

- requirements related to the agreements the ACOs have with Medicare enrolled entities (that is, ACO participants as defined in the program rules)
- governing body and leadership requirements - for example, currently, the ACO's medical director is required to be an ACO provider/supplier. We propose to remove this requirement to permit more flexibility.
- the process the ACO has for coordinating care, requiring ACOs to articulate how they will encourage and promote the use of enabling technologies for improving care coordination, and
- a more streamlined process to allow prior Pioneer ACOs to apply for program participation.

The 60-day comment period closes on **January XX, 2015**, and we encourage all interested members of the public to submit comments.

SHARED SAVINGS FINANCIAL MODEL OVERVIEW

Issue	Track 1; One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
	Current	Proposed	Current Track 2	Proposed Track 2	Proposed Track 3
Transition to Two-Sided Model	First agreement period under one-sided model. Subsequent agreement periods under two-sided model	Remove requirement to transition to two-sided model in a second agreement period.	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.	No change	Same as Track 2
Assignment	Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change	Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change	Prospective assignment for reports and financial reconciliation
Benchmark	Reset at the start of each agreement period	Seeking comment on alternative methodology	Same as Track 1	Seeking comment on alternative methodology	Same as Tracks 1 and 2 and seeking comment on alternative methodology

Issue	Track 1; One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
	Current	Proposed	Current Track 2	Proposed Track 2	Proposed Track 3
Adjustments for health status and demographic changes	Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of 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.	No change	Same as Tracks 1 and 2.
Adjustments for IME and DSH	IME and DSH excluded from benchmark and performance year expenditures.	No change	Same as Track 1	No change	Same as Tracks 1 and 2
Other payment adjustments	Include other payment adjustments included in Part A and B claims such as, geographic payment adjustments and HVBP payments, in benchmark and performance year expenditures	Seeking comment on other technical adjustments	Same as Track 1	Seeking comment on other technical adjustments	Same as Tracks 1 and 2

Issue	Track 1; One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
	Current	Proposed	Current Track 2	Proposed Track 2	Proposed Track 3
Quality Sharing Rate	Up to 50 percent based on quality performance	Up to 50 percent based on quality performance for first agreement period, reduced by 10 percentage points for each subsequent agreement period under the one-sided model	Up to 60 percent based on quality performance	No change	Up to 75 percent based on quality performance
Minimum Savings Rate	2.0 percent to 3.9 percent depending on number of assigned beneficiaries.	No change	Fixed 2.0 percent	2.0 percent to 3.9 percent depending on number of assigned beneficiaries	Fixed 2.0 percent
Minimum Loss Rate	Not applicable	No change	Fixed 2.0 percent	2.0 percent to 3.9 percent depending on number of assigned beneficiaries	Fixed 2.0 percent
Performance Payment Limit	10 percent	No change	15 percent	No change	20 percent
Shared Savings	First dollar sharing once MSR is met or exceeded.	No change	Same as Track 1.	No change	Same as Tracks 1 and 2.

Issue	Track 1; One-Sided Risk Model		Tracks 2 and 3: Two-Sided Risk Models		
	Current	Proposed	Current Track 2	Proposed Track 2	Proposed Track 3
Shared Loss Rate	Not applicable	No change	One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate not to exceed 60 percent	No change	One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate may not be less than 40 percent or exceed 75 percent
Loss Sharing Limit	Not applicable	No change	Limit on the amount of losses to be shared in phases in over 3-years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3 and any subsequent year. Losses in excess of the annual limit would not be shared.	No change	15 percent. Losses in excess of the annual limit would not be shared.