

CMS ISSUES A NEW MEDICARE SHARED SAVINGS PROGRAM PROPOSED RULE AND AIMS TO ENCOURAGE EXISTING ACCOUNTABLE CARE ORGANIZATIONS TO RENEW THEIR PARTICIPATION IN THE PROGRAM

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Health Care Alert

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On February 3, 2016, the Centers for Medicare and Medicaid Services ("CMS") issued a new proposed rule that makes a number of revisions to the Medicare Shared Savings Program ("MSSP").^[1] Several of the proposed changes create incentives for existing Accountable Care Organizations ("ACOs") to renew their MSSP participation agreements with CMS at the end of their initial three year agreement period. These incentives include: (i) introducing new adjustments to an ACO's historical cost benchmark that will take into account average expenses and patient risk factors from the ACO's local region; and (ii) providing ACOs with flexibility to transition to a risk-based MSSP shared savings track more gradually. The proposed rule also introduces a new methodology for updating an ACO's benchmark based on participant providers joining or departing the ACO, and finally includes a mechanism for CMS to re-open shared saving and shared loss claims in instances of fraud or for other good cause. Comments from interested parties about the proposed rule changes are due no later than April 3, 2016.

CHANGES TO HOW CMS CALCULATES AN ACO COST BENCHMARK

Under the current rules, when an ACO reaches the end of its initial three-year agreement period with CMS, and renews for a second agreement period, the ACO's target expense benchmark is reset based on historical expenses from the most recent three years -- during which the ACO was operating.^[2] Thus, if an ACO is highly successful in reducing expenses during one agreement period, it will lower the benchmark and make future shared savings more difficult to achieve (and future shared losses more likely). To address this concern, CMS is proposing to take into account regional Medicare expenditures and regional beneficiary health status factors when resetting an ACO's benchmark for the second or subsequent three-year agreement periods.^[3] In addition, CMS is proposing an adjustment process to account for changes in the participating providers in the ACO.

Adjustments Based on Regional Medicare Expenditures - Starting when an ACO enters its second agreement period, CMS proposes to incorporate the regional expenditures of other providers in the local area when establishing the ACO's cost target. CMS proposes to develop a county-by-county average expenditure by looking at the total cost of services for all beneficiaries in each county that are eligible to be assigned to an ACO. The

county averages are then weighted proportionately to the ACO based on the home counties of the ACO's assigned beneficiaries.

For an ACO's second agreement period, 30% of the ACO's total benchmark will be based on this regional average (with the ACO's historical performance making up the remainder). For third and subsequent agreement periods, 70% of the benchmark will be based off of the regional average. In choosing these 30%/70% figures, CMS stated that it is trying to encourage and reward long-term ACO participation, while at the same time being cognizant of the concern that low-cost providers (compared to their regional average) may be able to beat regional benchmark targets and earn shared savings without having to make any improvements to current practices.

Regional Risk Adjustments - CMS is also proposing to perform risk adjustments to account for the health of an ACO's assigned population relative to fee-for-service beneficiaries in the ACO's regional service area, and to make adjustments to the ACO benchmark accordingly.^[4] CMS stated that it intends to remain vigilant in monitoring this risk adjustment, however, as it is concerned about creating incentives for ACOs to generate high benchmarks merely through "systematic coding practices." Accordingly, CMS noted that, if needed, it will undertake additional rulemaking to limit such practices.^[5]

Adjustments for Participants Joining or Leaving an ACO - CMS also proposes to modify the methodology for making adjustments to an ACO's benchmark based on changes in the composition of an ACO's participating providers. Currently, when new participants join an ACO, CMS updates the benchmark for the next performance year by going back and recalculating the ACO participants' expenses for the original three benchmark years based on the new composition of the ACO. CMS is experiencing operational burdens under this methodology, where historical expenses must be recalculated for a number of years each time a change occurs. CMS proposes to use a new two-part methodology to update the benchmark based on existing participant "stayers" and new participant "joiners."^[6] Under this proposed methodology, CMS would use a single reference year (for example, the third benchmark year), and adjust the benchmark based on weighted expenditures for both "stayers" and "joiners" during the reference year.

FLEXIBILITY WHEN TRANSITIONING TO A RISK-BASED MSSP TRACK

Another carrot offered by CMS to retain ACOs is that it will offer flexibility to ACOs starting their second agreement period in 2017 or later to enter into a risk-based Track 2 or Track 3 model with a one-year delay before shifting to the risk-model.^[7] Effectively, the ACO would remain in Track 1 for one additional year in the new agreement period, and then automatically transition to Track 2 or Track 3. CMS has proposed this option to assist ACOs that desire to shift to a risk-based model but need a little more time in order to be prepared for the shift. However, consistent with current rules for risk-based ACOs, ACOs will still need to demonstrate access to an adequate repayment mechanism required under the risk-based models at the time it applies for renewal.

REVISED POLICIES FOR REOPENING AND CORRECTING INITIAL PAYMENT DETERMINATIONS

Finally, CMS is proposing new discretionary authority to re-open claims after shared savings and shared losses

have been initially determined.^[8] Specifically, CMS is proposing that when it determines there is "good cause" to re-open a decision, it may do so up to four years after the initial determination. In addition, CMS proposes that it can re-open a decision going back any number of years if it determines there has been fraud or "similar fault."^[9] Under the proposed rule, it will be the sole discretion of CMS to determine whether good cause exists. CMS does not intend to provide an exhaustive list of actions that constitute good cause, but proposes defining the term as occurring when:

1. there is new and material evidence that was not available or known at the time of the payment determination and may result in a different conclusion; or
2. the evidence that was considered in making the payment determination clearly shows on its face that an obvious error was made at the time of the payment determination.^[10]

CMS further suggests that it may assess whether an error is material based on a threshold of whether it accounted for 3 percent or more of the total amount of net shared savings and losses across all ACOs in the MSSP for an applicable performance year.

CMS states that it understands this re-opening provision will create some uncertainty, as an ACO may be called upon to return shared savings payments or make additional shared loss payments four years or more after the initial determination. Particularly for risk-based ACOs, CMS recognizes this could create impediments to an ACO obtaining clean opinions from financial auditors and acquiring a surety bond, line of credit, or other repayment mechanism required by CMS to demonstrate an ACO's ability to repay the Medicare program. However, CMS stated that it needed to balance these concerns with Medicare program integrity concerns, including the ability to correct material errors. The re-opening provision of the proposed rule is scheduled to take effect 60 days after publication of the final rule.

Notes:

^[1] CMS, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, 81 Fed. Reg. 5,824 (Feb. 3, 2016) (proposed rule).

^[2] 42 C.F.R. § 425.602(c).

^[3] In addition, CMS proposes that for ACOs in renewal agreement periods, the benchmark will be annually updated based on regional fee-for-service expenditure growth, instead national fee-for-service growth, as is currently done. 81 Fed. Reg. at 5,838.

^[4] 81 Fed. Reg. at 5,846.

^[5] 81 Fed. Reg. at 5,847.

^[6] 81 Fed. Reg. at 5,850.

^[7] 81 Fed. Reg. at 5,851.

^[8] 81 Fed. Reg. at 5,853.

^[9] "Similar fault" means to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. 42 C.F.R. § 405.902.

^[10] Proposed 42 C.F.R. § 425.314(e).

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