June 23, 2016

New ACO Rule: Continued CMS Efforts to Promote Program Participation

On June 6, 2016, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule (the "Final Rule") for accountable care organizations ("ACOs") participating in the Medicare Shared Savings Program ("MSSP"). The Final Rule makes three key changes.

- First, it revises the benchmark to reflect regional trend factors (rather than national trend factors and an ACO's past performance).
- Second, it permits ACOs participating under Track 1 to defer, by one year, advancement to a two-sided risk track.
- Third, it establishes procedural rules for appeals and reopenings.

According to CMS, the changes adopted in the Final Rule are designed to promote broad-based participation in the MSSP (by establishing balanced measures of success, and allowing some ACOs to continue to be insulated from downside risk) and to improve transparency.

The Final Rule modifies the regulations implementing the Medicare Shared Savings Program promulgated in November 2011 and June 2015 as codified at 42 C.F.R. Part 425. Concurrently with the Final Rule, CMS issued a related fact sheet.

The Benchmark Methodology

An ACO that reduces Medicare expenditures by a set percentage below the ACO's benchmark and meets quality requirements is eligible to receive a percentage of the savings achieved. The benchmark operates to establish the ACO's cost target.

Rebasing the Historical Benchmark

Before adoption of the Final Rule, an ACO's benchmark was reset (or rebased) at the start of each three-year agreement period, according to a formula that compared the ACO's historical spending and past performance against national spending growth trends.

Under the Final Rule, CMS revised the benchmark formula for purposes of rebasing an ACO's historical benchmark for the second and subsequent agreement periods, beginning on or after January 1, 2017, such that each ACO's benchmark will be based on regional, and not national, spending growth trends. Specifically, when establishing the ACO's rebased historical benchmark, the Final Rule (1) replaces the national trend factor with regional trend factors; (2) removes the adjustment that accounted for savings generated under the ACO's prior agreement period, such that ACOs no longer will be required to exceed their savings from the previous period; and (3) adds a new adjustment to reflect a percentage of the difference between the regional fee-for-service expenditures in the ACO's regional service area and the ACO's historical expenditures.

ACOs should note that, under the Final Rule, their regional service area is defined to include each county in which at least one ACO-assigned beneficiary resides.

For purposes of calculating the regional adjustment (item (3), above), the Final Rule adopts a phased approach under which a lower weight will apply initially and be replaced by increasingly higher weights over the course of multiple agreement periods. Specifically, in the first agreement period in which the regional adjustment is applied, higher-spending ACOs will have the regional adjustment weighted at 25% and lower-spending ACOs will have the regional adjustment weighted at 35%. In the second agreement period, higher-spending ACOs will have the regional adjustment weighted at 50% and lower-spending ACOs will have the regional adjustment weighted at 70%. Ultimately, beginning no later than the third agreement period in which the ACO's benchmark is rebased using the revised methodology, a weight of 70% will be applied in calculating the regional adjustment for all ACOs. According to CMS, the purpose of this phased approach is to balance CMS's preferences for a quick transition to the new rebasing methodology with its concerns over the potential for ACOs to alter their healthcare provider and beneficiary compositions to achieve more favorable performance relative to their region without actually changing their efficiency.

Updating and Adjusting the Benchmark

The Final Rule further revises the benchmark formula so that regional factors are reflected in annual updates and adjustments. Under the Final Rule, an ACO's rebased historical benchmark must be updated annually, to account for changes in regional fee-for-service spending rather than the absolute amount of projected growth in national fee-for-service spending. In addition, the benchmark must be adjusted annually to account for changes in the ACO's certified "ACO Participant List" during the agreement period. According to CMS, use of regional trend factors to update benchmarks annually is expected to result in relatively higher benchmarks for ACOs that are low-growth in their regions compared to benchmarks for ACOs that are relatively high-growth.

In general, the goal of incorporating regional expenditures is to make an ACO's cost target more independent of its historical expenditures and more reflective of fee-for-service spending in the ACO's region. CMS anticipates that incorporation of such factors will have mixed effects on ACOs overall by increasing or decreasing benchmarks for ACOs depending on the circumstances.

Deferred Risk

Under the Medicare Shared Savings Program, an ACO enters a three-year agreement period for participation in one of three tracks—the one-sided shared savings track (Track 1) or one of two two-sided shared savings/shared losses tracks (Track 2 and Track 3)—and continues operating under that track for the duration of the agreement period. For its first agreement period, an ACO may participate under any one of these three tracks. An eligible ACO that participates under Track 1 for its first agreement period may, for its second agreement period, apply either to continue under Track 1 or to participate under Track 2 or Track 3.

In response to stakeholder concerns and to provide flexibility for ACOs that are willing to accept performance-based risk arrangements but need more time to develop necessary infrastructure, under the Final Rule, an ACO participating under Track 1 may apply to renew for a second agreement period under Track 2 or 3 and, if the application is approved, the ACO may extend its first agreement period under Track 1 for a fourth performance year, and thereby delay entry into a two-sided risk track for one year. If entry into a two-sided risk track is so deferred, the ACO's benchmark rebasing will also be deferred for one year.

This option will become available beginning with the 2017 application cycle.

Finality of Reconciliation Calculations

In the Final Rule, CMS defined time frames and other criteria for reopening a determination of ACO shared savings or shared losses to correct financial reconciliation calculations. CMS is limited to reopening a determination for good cause for no more than four years after the date of the notification of the initial determination. "Good cause" is not defined, but may be established where there is new, previously unavailable evidence indicating an error was made, or where evidence CMS previously used in its decision is found to have been relied upon in error. CMS can reopen a

payment determination at any time in the case of fraud or similar fault. These time frames and criteria echo those that have been long-established for Medicare's fee-for-service payments.

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Should you have any questions regarding this alert or matters involving ACOs generally, please contact your usual Ropes & Gray advisor.