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Final rules for the Medicare Shared Savings Program

On Nov. 2, 2011, the Centers for Medicare and Medicaid Services (CMS) published the Final Rules for the Medicare Shared Savings Program (MSSP). These Final Rules establish the framework for health care providers to join together to form Accountable Care Organizations (ACO) to provide coordinated, high quality, cost effective care to Medicare fee-for-service beneficiaries. The Final Rules include financial incentives for health care providers to join ACOs by allowing providers to share in savings achieved in Medicare expenditures resulting from improved, coordinated care. The Proposed MSSP Rules, issued in April 2011, were widely criticized because of concerns that they posed significant financial risk and operational challenges to providers. In response to these comments, and to encourage greater provider participation, CMS relaxed the operational requirements and increased the corresponding financial incentives.

In May of 2011, HPIO published a Health Policy Brief entitled "Understanding the Medicare ACO and its Potential Impact on Ohio and the Nation: Considerations of the CMS Draft Rules," which outlined the Proposed MSSP Rules and reactions from Ohio-based health systems implementing the accountable care model. This policy brief is an update to that original and outlines some of the significant changes included in the Final Rules and impact they may have on participation in the program.

The important changes made by CMS to the MSSP as contained in the Final Rules are as follows:

- **Rural Health Centers (RHCs) and Federally Quality Health Centers (FQHCs) may now independently form ACOs.**
  The Proposed Rules did not allow RHCS or FQHCs to form ACOs because of technical issues related to how RHCs and FQHCs collect and report Medicare patient claims and encounter data. Recognizing that RHCs and FQHCs are critically important to our health care system because they serve underserved populations, CMS adjusted the rules to allow RHCs and FQHCs to form independent ACOs. This change should encourage the development of ACOs in rural and underserved communities.

- **Program governance and operational requirements now provide greater flexibility to ACOs.**
  The Final Rules provide more flexibility to ACOs in the following areas: (1) ACOs do not need to have each and every participant represented on the governing board as long as participants have input in board decisions, (2) ACOs need not have a separate quality improvement committee as long as they have a quality improvement program, (3) ACOs may add participants during the three year agreement with notice to CMS, (4) ACOs may adopt patient processes best suited to their own practices and patient populations, and (5) ACOs need not have electronic medical records so long as they meet care coordination requirements in other ways.

- **The time for complying with the first year requirements of the MSSP is now extended for ACOs that join in 2012.**
  Due to concerns that ACOs would not be able to meet the first year requirements because of time constraints, the time for compliance with first year measures was extended until December 31, 2103 for ACOs that join the MSSP in 2012.

How is the Medicare Shared Savings Program relevant to Ohio policymakers?

Although Medicare, unlike Medicaid, is a federally funded program, 1.3 million Ohioans receive coverage through Medicare and may benefit from the Shared Savings Program. In addition, throughout its history, Medicare has been a forerunner for new health care reimbursement strategies. Typically, when Medicare adopts a change to its payment policies, private health plans and state Medicaid programs follow. Federal authorities have also given guidance that ACOs formed under the Shared Savings Program will be in compliance with federal anti-trust, self-referral and anti-kickback laws even if they also serve Medicaid and commercially insured patients. This would suggest that the outcomes-based pay and shared savings mechanisms that are part of the proposed Medicare Shared Savings Program could be adopted by other insurers as well.

In addition, some experts believe that ACOs have the potential to improve quality of care while controlling costs and improving population health. The system reform concepts in the Shared Savings Program may provide Ohio policymakers with valuable insight into quality-improvement and cost-containment strategies that have the potential to improve the health of Ohioans.

- **Beneficiaries will be assigned to ACOs based on the use of primary care services rendered by primary care providers and, in some cases, by specialists that participate in the ACO.**
  Recognizing that some patients with chronic conditions receive primary care services through specialists, the Final Rules changed the way beneficiaries are assigned to ACOs to reflect this common practice. Under the Final Rules, patients will be assigned to an ACO based, first, on whether they received a plurality of primary care services from primary care providers. If a beneficiary receives no primary care from primary care physicians, assignment will then be based on a plurality of primary care from non-primary care providers within the ACO.

- **CMS will provide to ACOs an advanced list of beneficiaries likely to be assigned to the ACO.**
  The Proposed Rules provided for retrospective beneficiary assignment to an ACO based on actual primary care utilization during a year. This approach came under criticism because neither providers nor patients would know whether the patient was assigned to an ACO until after care was rendered. The Final Rules address this by requiring CMS to notify the ACO, and the ACO in turn to notify the patient, that the patient would likely be assigned to the ACO. This prior notice allows the provider and patient to work together to make sure the patient receives the appropriate care from the ACO.

- **The ACO quality measurements were reduced from 65 measures to 33 measures.**
  The Proposed Rules were criticized because the 65 quality measures could pose significant administrative challenges and cost to ACOs. Critics noted that only 11 of the 65 measures could be met through the use of claims data, and the other measures could be tracked only through resource intensive data collection. The Final Rules reduced the number of quality measures to 33 across 4 domains. The 4 domains are (1) care coordination and patient safety, (2) preventive care, (3) patient experience and (4) care for at risk populations. The Final Rules require the ACO to report on these quality measures in the first year of the program, and both report and meet minimum attainment levels for the second and third years. A list of the 33 quality measures can be found on pages 3 and 4.

- **ACOs may choose to share in savings but not in losses during the entire duration of the three year agreement.**
  Under the Proposed Rules, ACOs could choose between one of two tracks in terms of sharing in savings and losses. Under Track 1, an ACO would share in savings but not in losses during the first two years of the three year agreement but, in the third year, the ACO would be required to share in losses. Under Track 2, an ACO would share in savings and in losses during all three years. Under the Final Rules, Track 1 ACOs will share in savings, but not in losses, during all three years. This change was made out of concern that many providers would not participate if they were at risk for increased Medicare expenditures.

- **Shared saving calculations were changed to make it more financially advantageous for ACOs to participate.**
  The Final Rules change the shared savings formula in the following ways to make participation more attractive:
  - Indirect medical education (IME) and disproportionate share hospital payments (DSH) will no longer reduce the amount of shared savings an ACO may receive.
  - High cost populations will be taken into account when calculating savings.
  - The calculation of "savings" to be shared is more favorable to ACOs.
  - The limits on savings payments are higher.
  - Shared savings payments will be paid on an annual basis, with no portion of the savings withheld until the end of the three year agreement as previously required.

- **ACOs will not be required to undergo a mandatory antitrust review to participate in the MSSP program.**
  Concurrent with the issuance of the Proposed Rule, Federal agencies responsible for antitrust enforcement issued a "Statement of Antitrust Enforcement Policy" with guidance to ACOs to avoid antitrust violations. The Statement required that ACOs undergo a mandatory antitrust review process before participating in the MSSP. This requirement was viewed as unnecessary and, as a result, the Final Rules eliminates the requirement. However, ACOs must still follow the guidelines contained in the final Statement of Antitrust Enforcement Policy.

Author

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Measures for use in establishing quality performance standards that ACOs must meet for shared savings

Patient/caregiver experience

	measure title	NQF measure number/ measure steward	method of data submission	Pay for performance phase in R=Reporting P=Performance Year 1	Year 2	Year 3
1	CAHPS: Getting Timely Care, Appointments, and Information	NQF #5, AHRQ	Survey	R	P	P
2	CAHPS: How Well Your Doctors Communicate	NQF #5, AHRQ	Survey	R	P	P
3	CAHPS: Patients' Rating of Doctor	NQF #5, AHRQ	Survey	R	P	P
4	CAHPS: Access to Specialists	NQF #5, AHRQ	Survey	R	P	P
5	CAHPS: Health Promotion and Education	NQF #5, AHRQ	Survey	R	P	P
6	CAHPS: Shared Decision Making	NQF #5, AHRQ	Survey	R	P	P
7	CAHPS: Health Status/ Functional Status	NQF #6, AHRQ	Survey	R	R	R

Care coordination/patient safety

	measure title	NQF measure number/ measure steward	method of data submission	Pay for performance phase in R=Reporting P=Performance Year 1	Year 2	Year 3
8	Risk-Standardized, All Condition Readmission*	NQF #TBD CMS	Claims	R	P	P
9	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator (PQI) #5).	NQF #275 AHRQ	Claims	R	P	P
10	Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	NQF #277 AHRQ	Claims	R	P	P
11	Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment	CMS	EHR Incentive Program Reporting	R	P	P
12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #97 AMA–PCPI/ NCQA	GPRO Web Interface	R	P	P
13	Falls: Screening for Fall Risk	NQF #101 NCQA	GPRO Web Interface	R	P	P

Preventive health

	measure title	NQF measure number/ measure steward	method of data submission	Pay for performance phase in R=Reporting P=Performance Year 1	Year 2	Year 3
14	Influenza Immunization	NQF #41 AMA–PCPI	GPRO Web Interface	R	P	P
15	Pneumococcal Vaccination	NQF #43 NCQA	GPRO Web Interface	R	P	P
16	Adult Weight Screening and Follow-up	NQF #421 CMS	GPRO Web Interface	R	P	P

*HHS noted in the Federal Register that measure 8 "has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012."

Preventive health (cont.)

	measure title	NQF measure number/ measure steward	method of data submission	Pay for performance phase in R=Reporting P=Performance Year 1	Year 2	Year 3
17	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #28 AMA–PCPI	GPRO Web Interface	R	P	P
18	Depression Screening	NQF #418 CMS	GPRO Web Interface	R	R	P
19	Colorectal Cancer Screening	NQF #34 NCQA	GPRO Web Interface	R	R	P
20	Mammography Screening	NQF #31 NCQA	GPRO Web Interface	R	R	P
21	Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years	CMS	GPRO Web Interface	R	P	P

At-risk population: Diabetes

	measure title	NQF measure number/ measure steward	method of data submission	Pay for performance phase in R=Reporting P=Performance Year 1	Year 2	Year 3
22	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (< 8 percent)	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
23	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (< 100)	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
24	Diabetes Composite (All or Nothing Scoring): Blood Pressure < 140/90	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
25	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
26	Diabetes Composite (All or Nothing Scoring): Aspirin Use	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P
27	Diabetes Mellitus: Hemoglobin A1c Poor Control (> 9 percent)	NQF #0729 MN Community Measurement	GPRO Web Interface	R	P	P

At-risk population: Hypertension

28	Hypertension (HTN): Blood Pressure Control	NQF #18 NCQA	GPRO Web Interface	R	P	P

At-risk population: Ischemic vascular disease

29	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100 mg/dl	NQF #75 NCQA	GPRO Web Interface	R	P	P
30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #68 NCQA	GPRO Web Interface	R	P	P

At-risk population: Heart failure

31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #83 AMA–PCPI	GPRO Web Interface	R	R	P

At-risk population: Coronary artery disease

32	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol	NQF #74 CMS (composite)/ AMA–PCPI (individual component)	GPRO Web Interface	R	R	P
33	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD).	NQF #66 CMS (composite)/ AMA–PCPI (individual component).	GPRO Web Interface	R	R	P