Bloomberg BNA

BNA's Health Law Reporter™

VOL. 24, NO. 4 JANUARY 29, 2015

MSSP ACO Version 2.0: CMS Proposes to Remove 34 Physician Specialties From the Beneficiary Assignment Process

By Stanford L. Moore

I. Introduction

Beneficiary assignment is the mechanism used to assign patients to an accountable care organization (ACO) engaged in the Medicare Shared Savings Program (MSSP or MSSP ACO). Whether Medicare assigns one of its fee-for-service (FFS) beneficiaries to an MSSP ACO controls not only whether it has a sufficient number of beneficiaries to qualify for the MSSP but also eligibility and amount of any shared savings payments.[1] The Centers for Medicare & Medicaid Services (CMS) recently proposed to narrow its current beneficiary assignment methodology for MSSP ACOs by excluding claims from 34 physicians' specialties.[2]

[1] "The first step in calculating ACO shared savings or losses is to assign beneficiaries to the ACO." CMS, *Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology*, Version 3, p. 11 (December 2014).

[2] 42 C.F.R. § 425.402 (noting current "Basic Assignment Methodology"); 79 Fed. Reg. 72796 (Dec. 8, 2014) (the "proposed rule"); *see also* Press Release; Fact Sheet.

Stanford L. Moore is a Healthcare Fellow at Squire Patton Boggs, Columbus, Ohio, and member of the Georgia Bar. *He would like to thank Peter Pavarini for his guidance and helpful input during the writing process.*

II. Background

A. The MSSP [3]

The Patient Protection and Affordable Care Act (ACA) established the MSSP as the cornerstone of the ACO program, arguably one of the more innovative provisions of the 2010 law. The goal of the MSSP is to improve the quality of care and reduce unnecessary costs. Medicare currently offers the MSSP to participating entities consisting of providers, hospitals, and suppliers.[4] The MSSP provides qualified performance payments to ACOs in the form of "shared savings" as an incentive for reducing costs without sacrificing quality.[5] Fifty-eight MSSP ACOs earned performance payments totaling $315 million in their first year.[6]

B. The Current Assignment Methodology

Providers choose to *participate* in MSSP ACOs; beneficiaries are *assigned*. Beneficiary assignment is important because it controls the dimensions of the ACO's population. The ACO is responsible for the quality, cost, and overall care of their assignees. Accordingly, the population controls the eligibility and amount of potential shared savings to the MSSP ACO.[7] The ACA tasked CMS with synthesizing a beneficiary assignment methodology based on the utilization of "primary care services" by an "ACO Professional."[8] CMS promulgated the current regulations in late 2011.[9]

1. 'Primary Care Services'

One of the goals of the ACA is to increase patient access to prevention and primary care. Accordingly, primary care is heavily weighted in the MSSP ACO. In order to be eligible for assignment to an MSSP ACO, "[a]

[3] 42 U.S.C. § 1395jjj *et seq*.

[4] 79 Fed. Reg. 72795.

[5] 42 C.F.R. § 425.604(e).

[6] CMS, *Fact Sheets: Medicare ACOs Continue To Succeed In Improving Care, Lowering Cost Growth* (Nov. 10, 2014).

[7] 42 C.F.R. § 425.400(b); 42 U.S.C. § 1395jjj(b)(2)(A).

[8] 42 U.S.C. § 1395jjj(c).

[9] 76 Fed. Reg. 67802 (Nov. 2, 2011); 42 C.F.R. § § 425.400, 425.402.

 ISSN 1064-2137

beneficiary must have had at least one 'primary care service' furnished by a[n ACO MSSP] physician. . .''[10]

The ACA did not define primary care services, leaving CMS to define it. CMS defined ''primary care services'' by selected Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.[11] CPT and HCPCS codes are uniform identifiers of providers' services.

The definition of primary care services is multidimensional. '''Primary care services' can generally be defined based on the type of service provided, the type of provider specialty that provides the service, or both.''[12] Any definition of ''primary care services'' that omits the type of provider rendering the primary care is incomplete.[13] Nonetheless, CMS omitted the type of provider that rendered the service from the definition. It chose to define primary care services by only the type of service provided. Thus, the definition is incomplete.

The issue is that ''most of the CPT and other HCPCS codes that are included in the definition of primary care services . . . are actually more general purpose codes used for a wide variety of clinical practices that are not specific to primary care, such as CPT office visit codes.''[14] For example, an ophthalmologist bills for some of the office visit codes that are included in the definition of ''primary care,'' but in actual practice, these doctors do not perform primary care when they report these codes.[15]

2. 'ACO Professional'

The ACA defines an ''ACO professional'' as a ''physician'' or ''non-physician provider'' (physician assistant (PA) or nurse practitioner (NP)).[16] The ACA has a broad statutory definition of ''physician.'' ''Physician'' means ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action.''[17] Moreover, the definition includes dentists, podiatrists, optometrists, and chiropractors.[18]

3. The Two Step Methodology

CMS adopted a two-step assignment methodology ''that simultaneously maintains the primary care-centric approach . . . to beneficiary assignment, *while recognizing the necessary and appropriate role of specialists in providing primary care services*.''[19] Under the two-step approach, ''beneficiaries are first assigned to ACOs on the basis of utilization of primary care services provided by primary care physicians. Those beneficiaries who are not seeing any primary care physician may be assigned to an ACO on the basis of primary care services provided by other physicians [i.e. specialist]'' in step two.[20]

a. Step One: Primary Care Services Provided by a Primary Care Physician

A beneficiary is eligible for assignment to an MSSP ACO in Step One if the beneficiary has had at least one primary care service by a primary care physician. In other words, in order for a beneficiary to be assigned to an MSSP ACO in Step One, the physician providing primary care must be a general practitioner, family medicine, internal medicine, or geriatric medicine physician.

b. Step Two: Primary Care Services From an 'ACO Professional'

A beneficiary is eligible for assignment to an MSSP ACO at Step Two if an ''ACO Professional'' (i.e. physician—regardless of specialty—NP, PA, etc.) provided the beneficiary with at least one primary care service.[21] For example, if a MSSP ACO's surgeon provides primary care services to a Medicare beneficiary, that beneficiary is eligible for Medicare to assign that beneficiary to the MSSP ACO.

Accordingly, the current regulation ''allows for consideration of *all physician specialties* in the assignment process.''[22] ''Application [of the current two-step assignment methodology] for the first 220 ACOs participating in the program [revealed] that, on average, about 92 percent (3,381,243) of the beneficiaries assigned to ACOs [were] assigned in step 1, with only about [eight] percent (294,021) of the beneficiaries being assigned in step 2.''[23]

The upshot of CMS's proposal is a one-step method with primary care physicians and non-physician providers providing primary care services. The proposed rule repositions non-physician providers at Step One and virtually cuts non-primary care physician specialists out of Step Two. If finalized as proposed, the rule would virtually do away with the current two-step methodology

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[10] CMS, *Assignment Methodology*, p. 12(F) (noting a beneficiary must have a primary care service with a physician at the ACO).

[11] 42 C.F.R. § 425.400(c); ''Primary care services'' mean the set of services identified by the following HCPCS codes: (1) 99201 through 99215 and (2) 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits). 42 C.F.R. § 425.20.

[12] 76 Fed. Reg. 67853.

[13] *See* American Academy of Family Physicians, *Primary care*, http://www.aafp.org/about/policies/all/primary-care.html, last visited Jan. 12, 2015.

[14] 79 Fed. Reg. 72796.

[15] *Id.*

[16] 42 U.S.C. § 1395jjj(h)(1) (defining ACO Professional; 42 U.S.C. § 1395x(r)(1) (defining physician); 42 U.S.C. § 1395u(b)(18)(C)(i) (defining practitioner).

[17] *See* 42 U.S.C. § 1395x(r)(1).

[18] *See* 42 U.S.C. § 1395x(r)(2-5).

[19] 76 Fed. Reg. 67855 (emphasis added).

[20] 76 Fed. Reg. 67855.

[21] 42 C.F.R. § 425.402(a). The proposed rule moves non-physician providers to Step One. 79 Fed. Reg. 72795,

[22] 76 Fed. Reg. 67855-56 (emphasis added).

[23] 79 Fed. Reg. 72794; *see also data* (noting 3,675,263 beneficiaries were assigned). There is not any research available regarding how many were assigned in Step Two from receiving primary care services from NP, PA, or CNS.

by removing and/or repositioning the guts of the second step into the first.

III. The Proposed Rule Removes More Than 30 Physician Specialties from the Assignment Process

This proposed rule comes on the heels of promising data[24] that MSSP ACOs have successfully improved care and reduced cost, $383 million in 2013. Moreover, the MSSP remains attractive under the current regulations. After 89 new organizations enroll in the MSSP this year, a total of 405 ACOs are expected to serve 7.2 million beneficiaries in 2015.[25]

CMS now attempts to narrow the definition of 'primary care services' by excluding over 30 physician specialties. In order ''to identify primary care services more accurately, the CPT codes for primary care services should be paired with the specialties of the practitioners that render those services . . . .''[26]

During the rulemaking and comment process of the current regulations, CMS received ''many requests and comments from specialists and specialty societies asking to have their services included in the assignment methodology.''[27] CMS accepted this policy. CMS stated that because of ''the delivery of primary care services by specialists,'' the current regulations ''recognize[ed] the necessary and appropriate role of specialists in providing primary care services.''[28]

However, despite the marked success of the MSSP ACOs and the passage of less than four years since CMS published the current regulations, CMS is reversing its position in the proposed rule. The proposed rule removes 34 specialties: general surgery, otolaryngology, anesthesiology, dermatology, interventional pain management, osteopathic manipulative therapy, neurosurgery, ophthalmology, orthopedic surgery, cardiac electrophysiology, pathology, plastic and reconstructive surgery, psychiatry, geriatric psychiatry, colorectal surgery, diagnostic radiology, thoracic surgery, urology, nuclear medicine, hand surgery, pain management, peripheral vascular disease, vascular surgery, cardiac surgery, addiction medicine, critical care (intensivists), maxillofacial surgery, neuro-psychiatry, surgical oncology, radiation oncology, emergency medicine, interventional radiology, unknown physician specialty, and sleep medicine. [29] Accordingly, if the rule is implemented as proposed, receiving primary care services from one of these 34 specialties may no longer make a beneficiary eligible for assignment to an MSSP ACO.

Although CMS seeks to simplify the process of assigning beneficiaries to ACOs that participate in MSSP, the proposed rule cuts with too broad of a swath. For example, CMS has recognized, ''in some areas with shortages of primary care physicians, . . . specialists necessarily deliver the bulk of primary care services.''[30] Accordingly, the proposed rule is ''unduly restrictive.''[31]

Several of these participating specialists may not be interested in providing primary care services or being assigned beneficiaries in an MSSP ACO. On the other hand, a significant number of the excluded physician specialties are capable of providing and in fact do provide primary care services. Specifically, it is foreseeable that the following specialties provide primary care services, and thus could be included in the assignment process: general surgery, otolaryngology, dermatology, interventional pain management, ophthalmology, orthopedic surgery, cardiac electrophysiology, plastic and reconstructive surgery, psychiatry, geriatric psychiatry, urology, hand surgery, pain management, vascular surgery, addiction medicine, emergency medicine, interventional radiology, and sleep medicine.

The ACA's broad definition of physician may be the linchpin of the proposed rule's broad exclusion of physician specialties. The ACA definition does not limit the term ''physician'' in any way, not even by specialty.[32] However, the proposed rule does. This conflict may be the most persuasive argument against the narrowing of the beneficiary assignment methodology.

A physician's choice to participate in multiple ACOs is also an issue. ''[W]henever primary care service claims submitted by the ACO participant are considered in the beneficiary assignment process,'' current regulations ''require[] that an ACO participant['s tax identification number, or TIN,] must be exclusive to a single ACO. . . .''[33] The ''exclusivity requirement applies only to the ACO participant [the entity] and not to individual practitioners. Some may argue that removing specialists from the assignment process will allow more physicians to participate in multiple ACOs.[34] This argument is not persuasive. ''Individual practitioners are free to participate in multiple ACOs, provided they are billing under a different Medicare-enrolled TIN [taxpayer identification number] for each ACO in which they participate.''[35]

In the past, CMS was ''concerned that it could undermine our goal of ensuring competition among ACOs by reducing the number of specialists that can participate in more than one ACO, since the TINs of specialists to whom beneficiaries are assigned would be required to be exclusive to one ACO.''[36] Nonetheless, CMS allowed, without incident, assignment of beneficiaries who received primary care services from all physician specialists. There is a middle ground, which is more desirable than the option CMS used.

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[24] *See summary of data*.
[25] CMS, *ACOs Moving Ahead* (Dec. 22, 2014).
[26] 79 Fed. Reg. 72796.
[27] 79 Fed. Reg. 72796.
[28] 76 Fed. Reg. 67855.
[29] 79 Fed. Reg. 72797, Table 3.
[30] 76 Fed. Reg. 67855.
[31] CMS stated, in 2011, removing specialists who provide primary care services from the assignment process ''would be unduly restrictive in areas with shortages of primary care physicians.'' 76 Fed. Reg. 67855.
[32] *See* 42 U.S.C. § 1395x(r).
[33] 79 Fed. Reg. 7295; 42 C.F.R. § 425.306(b) (''Each ACO participant TIN upon which beneficiary assignment is dependent must be exclusive to one [MSSP] ACO for purposes of Medicare beneficiary assignment. ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive to one Medicare Shared Savings Program ACO.'')
[34] McDonald Hopkins, *Proposed Rule Would Allow More Physicians To Participate In Multiple ACOs* (Dec. 11, 2014).
[35] 79 Fed. Reg. 7295.
[36] 76 Fed. Reg. 67855 (noting ''the TINs upon which assignment is based must be exclusive to one ACO for purposes of participation in the Medicare Shared Savings Program. However, exclusivity of an ACO participant to one ACO is not necessarily the same as exclusivity of individual practitioners to one ACO''); *see also* 76 Fed. Reg. 67808.

IV. It's a Subterfuge

The Proposed Rule may allow ACOs to share larger parts of the whole, but this provision of the Proposed Rule reduces the whole, thus reducing or maintaining net gain sharing potential to providers. It is no coincidence that the specialists removed from the beneficiary assignment process provide the most expensive care. Thus, under the Proposed Rule, less potential savings can be accumulated into the gain sharing arrangements because this limitation not only reduces the number of potential assigned beneficiaries to an ACO but also reduces the size of the pie.

V. The Proposed Rule Revitalizes a Gatekeeper Medicine Model

Under current regulations, an MSSP ACO may consist of the excluded specialties as long as they provide primary care services. From the beginning, CMS stated that assignment ''in no way implies any limits, restrictions, or diminishment of the rights of Medicare FFS beneficiaries to exercise complete freedom of choice . . . .''[37] The proposed rule would require that a MSSP ACO have a ''primary care physician'' or certain specialist providing primary care services. Accordingly, this provision indirectly limits FFS beneficiaries' choices on which provider they may see in order to be assigned to an ACO.

The proposed rule may not place direct limitations on Medicare beneficiaries. This provision of the proposed rule indirectly limits beneficiaries' choices through forcing a gatekeeper medicine model. For example, a patient with a skin lesion who goes directly to a dermatologist for management is removed from assignment consideration of the ACO. Even a patient with appendicitis who goes to directly to a general surgeon for management is excluded from assignment consideration.

Gatekeeper medicine has a history. Hoping to reduce health care, it arrived on the scene in the 1980s with the advent of the closed-panel HMO. Several demonstration projects were conducted that projected savings of up to 15 percent.[38] However, the gatekeeper model fell out of favor with patients and providers because of free access to providers. More recently, it was found that ''[d]irect patient access to specialists in [open-panel model] plans does not necessarily result in higher medical care expenditures.'' [39] The study found, because of administrative cost, that ''[t]otal expenditures for medical care ranged from equal in both plans to [7] percent higher in the [closed-panel] gatekeeper'' model.[40]

CMS did not propose this change because of a fault in current MSSP ACO regulations but to fix a definitional issue regarding ''primary care services.'' ''Some stakeholders have argued that certain specialties that bill for some of the evaluation and management services designated as primary care services under § 425.20 do not actually perform primary care services.''[41]

VI. Conclusion

In light of the attraction to the program and its success, the proposed rule should be scaled back to exclude fewer specialty physicians.

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[37] 76 Fed. Reg. 67851.

[38] *See e.g.*,Moore, S., *Cost Containment Through Risk-Sharing by Primary Care Physicians*, New England Journal of Medicine, 300 (24): 1359-62 (1979).

[39] Escarce JJ, et al., *Medical care expenditures under gatekeeper and point-of-service arrangements*, Health Services Research 2001; 36 (6 Pt 1):1037 (2001).

[40] *Id.*

[41] 79 Fed. Reg. 72796.

  HLR ISSN 1064-2137