MSSP FINAL RULE:
ACOs-PATHWAYS TO SUCCESS

January 11, 2019
Presentation

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Today’s presentation will be available at:
https://www.aha.org/accountable-care-organizations-acos
MSSP ACOs-Pathways to Success

Final Rule Timeline

- Proposed rule published in Aug. 17 Federal Register
- Some provisions finalized in CY 2019 Physician Fee Schedule final rule
- MSSP final rule issued Dec. 21
- Final rule published in Dec. 31 Federal Register
- Most provisions effective on July 1, 2019
- Notice of intent to apply due Jan. 18
Agenda

- Redesigned MSSP participation options
- Waivers
- Beneficiary engagement
- Refinements to benchmarking methodology
- Updates to program policies
- Applicability of proposed policies to existing Track 1+ Model ACOs
Redesigned MSSP
Participation Options
New Participation Options Under 5-Year Agreements

- Discontinue Tracks 1 and 2 and deferred renewal option
- Instead, offer BASIC and ENHANCED tracks
  - **BASIC**: pathway to risk
  - **ENHANCED**: based on existing Track 3
- New program start date: July 1, 2019
- Extend agreement period from 3 years to 5 years
  - 5 years, 6 months for July 1, 2019 starters
BASIC Track’s Glide Path

Levels A & B  Level C  Level D  Level E
# Levels of Risk and Reward: Shared Savings

<table>
<thead>
<tr>
<th>Levels</th>
<th>Levels A and B</th>
<th>Level C</th>
<th>Level D</th>
<th>Level E</th>
<th>ENHANCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Savings once MSR is met or exceeded</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; dollar savings at a rate of up to 40% based on quality performance not to exceed 10% of updated benchmark</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; dollar savings at a rate of up to 50% based on quality performance not to exceed 10% of updated benchmark</td>
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<td>1&lt;sup&gt;st&lt;/sup&gt; dollar savings at a rate of up to 75% based on quality performance not to exceed 20% of updated benchmark</td>
</tr>
</tbody>
</table>
# Levels of Risk and Reward: Shared Losses

<table>
<thead>
<tr>
<th>Levels</th>
<th>Levels A and B</th>
<th>Level C</th>
<th>Level D</th>
<th>Level E</th>
<th>ENHANCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Losses once MLR is met or exceeded</td>
<td>N/A</td>
<td>1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark</td>
<td>1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark</td>
<td>1st dollar losses at a rate of 30%, not to exceed % of revenue specified in revenue-based nominal amount standard under QPP, capped at % of updated benchmark that is 1 percentage point higher than expenditure-based nominal amount</td>
<td>1st dollar losses at a rate of 1 minus final sharing rate (40-75%), not to exceed 15% of updated benchmark</td>
</tr>
</tbody>
</table>
### Calculation of Loss Sharing Limit

Hypothetical example of loss sharing limit amounts for ACOs in Basic Track Level E

<table>
<thead>
<tr>
<th>[A] ACO’s Total Updated Benchmark Expenditures</th>
<th>[B] ACO Participants’ Total Medicare Parts A and B FFS Revenue</th>
<th>[C] 8% of ACO Participants’ Total Medicare Parts A and B FFS Revenue ([B] x .08)</th>
<th>[D] 4% of ACO’s Updated Benchmark Expenditures ([A] x .04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$93,411,313</td>
<td>$13,630,983</td>
<td>$1,090,479</td>
<td>$3,736,453</td>
</tr>
</tbody>
</table>
Differentiated Participation Options

- **Low-revenue vs. High-revenue**
  - High: ACO whose Medicare A/B FFS revenue is 35% or more of Medicare Part A/B FFS expenditures for assigned beneficiaries

- **Renewing vs. Re-entering**
  - Renewing: ACO that continues participation for a consecutive agreement period without a break
  - Re-entering: Same legal entity that previously participated and applying again after break in participation or new legal entity with > 50% of its participants previously part of same ACO

- **Inexperienced vs. Experienced**
  - Governed by prior participation in performance-based risk Medicare ACO
  - Experienced: Same legal entity that previously participated in performance-based risk or new entity with > 40% participants experienced
Low- vs. High-Revenue Participation Options
## Participation Options: Low-Revenue ACOs

<table>
<thead>
<tr>
<th>Applicant Type</th>
<th>Inexperienced or Experienced</th>
<th>BASIC Track Glide Path</th>
<th>BASIC Track Level E</th>
<th>ENHANCED Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>New legal entity</td>
<td>Inexperienced</td>
<td>Yes, Levels A – E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Experienced</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Re-entering ACO</td>
<td>Inexperienced</td>
<td>Yes, Levels B – E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Experienced</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Renewing ACO</td>
<td>Inexperienced</td>
<td>Yes, Levels B – E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Experienced</td>
<td>No</td>
<td>Yes</td>
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<td>Inexperienced or Experienced</td>
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<td>Yes, Levels A – E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>New legal entity</td>
<td>Experienced</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Re-entering ACO</td>
<td>Inexperienced</td>
<td>Yes, Levels B – E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Re-entering ACO</td>
<td>Experienced</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Renewing ACO</td>
<td>Inexperienced</td>
<td>Yes, Levels B – E</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Renewing ACO</td>
<td>Experienced</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Monitoring for Financial Performance

- CMS will qualify ACO’s failure to lower growth in FFS expenditures as grounds for pre-termination/termination

- How?
  - Monitor for expenditures that are “negative outside corridor”
  - Meaning: expenditures for assigned beneficiaries > ACO’s updated benchmark by amount ≥ ACO’s negative MSR under a one-sided model or MLR under a two-sided model

- ACOs negative outside corridor for one year: subject to pre-termination actions

- ACOs negative outside corridor for additional year in same agreement period: subject to termination
Election of MSR/MLR

- **Purpose:** ensure ACOs earn shared savings or pay shared losses only when changes in expenditures represent actual change in performance, not normal or random variation

- **BASIC Levels A & B:** CMS will assign variable MSR based on the number of assigned beneficiaries

- **BASIC Levels C, D, E and Enhanced:** Select from options:
  - Zero percent MSR/MLR
  - Symmetrical MSR/MLR in 0.5 percent increments between 0.5 and 2.0 percent
  - Symmetrical MSR/MLR that varies based on the number of assigned beneficiaries
Election of Beneficiary Assignment Methodology

- **Current program:** Two claims-based assignment methodologies based on utilization of primary care services
  - Prospective assignment
  - Preliminary prospective assignment with retrospective reconciliation

- **Bipartisan Budget Act of 2018:** Allow all ACOs to choose prospective assignment

- **Policy finalized as proposed:** Allow BASIC and ENHANCED ACOs to choose prospective or preliminary prospective assignment
  - ACOs can also switch beneficiary assignment methodology each year
Payment Consequences of Termination

- CMS will conduct financial reconciliation for **all ACOs in two-sided models** that voluntarily terminate **after June 30th**
  - Terminate on or before June 30: Not liable for shared loses
  - Terminate after June 30: Liable for pro-rated shared loses
- ACOs involuntarily terminated by CMS also liable for pro-rated losses
Proposals Related to July 1, 2019 Start Date

- Agreement period will be **5 years, 6 months**
  - ACOs would be permitted to spend first 18 months at BASIC Track level at which they enter

- CMS finalized policies for ACOs that would have had a gap in participation in PFS final rule:
  - Voluntary extension for fourth performance year from Jan. 1, 2019 – June 30, 2019; or
  - ACOs may choose to voluntary terminate and enter new program
Waivers
Expansion of Access to Waivers

- **SNF 3-Day Waiver** (July 1, 2019 performance year)
  - Expand access to risk-bearing ACOs electing preliminary prospective assignment
  - Allow application to SNF services furnished under swing bed arrangements

- **Telehealth** (2020 performance year)
  - Risk-bearing ACOs with prospectively assigned beneficiaries: no originating site and geographic restrictions
  - Protections for beneficiaries improperly charged for telehealth services
Beneficiary Engagement
Beneficiary Incentive Program

- Up to $20 from ACO directly to beneficiary for receiving “qualifying primary care service”
  - Payment must be identical for all beneficiaries
  - Can be gift cards or checks but no cash
- Available only to ACOs bearing two-sided risk
  - Payment must be from ACO directly to beneficiary
- ACOs would be required to fully fund program themselves
  - Also required to report certain information to CMS
  - May not advertise program, but must notify beneficiaries of program
Beneficiary Notifications

- **Changes to notice requirements:**
  - Two required notifications – general and incentive program
  - May be submitted electronically or via snail mail
  - ACOs or their participants can notify beneficiaries at first primary care visit or earlier point during performance year

- **Content of notices**
  - **General:** ACO providers/suppliers are participating in MSSP, beneficiaries have option to decline claims data sharing, beneficiaries may identify (and change the identification) of a primary care provider for voluntary alignment.

- **Posters and standard written notifications still required**
Refinements to Benchmarking Methodology
Risk Adjustment of Historical Benchmark

- CMS finalizes switch to full CMS-HCC prospective risk adjustment
  - Used to adjust ACOs’ historical benchmarks for changes in severity and case mix between benchmark period and performance year
  - Eliminates distinction between new and continuously assigned beneficiaries

- CMS will cap risk score at +3% over 5 year agreement
  - CMS did not finalize negative 3% cap
Use of Regional Factors in Benchmarking Methodology

- Use of regional expenditures in establishing and resetting ACO’s benchmark
  - Current program: first used to rebase benchmarks for ACOs entering second or subsequent agreement period
  - Modification: incorporate into historical benchmarking methodology starting with first agreement period
- Modifying regional adjustment
  - Alter schedule of weights used to phase in regional adjustment to benchmark
  - Reduction of maximum weight form 70% to 50%
  - Cap: flat dollar amount = 5% of national per capita Medicare FFS expenditures for assignable beneficiaries
<table>
<thead>
<tr>
<th>Timing when regional adjustment is applied</th>
<th>ACO’s historical spending is lower than its region</th>
<th>ACO’s historical spending is higher than its region</th>
</tr>
</thead>
<tbody>
<tr>
<td>First agreement period in which new weights would apply</td>
<td>35% weight</td>
<td>15% weight</td>
</tr>
<tr>
<td>Second agreement period in which new weights would apply</td>
<td>50% weight</td>
<td>25% weight</td>
</tr>
<tr>
<td>Third agreement period in which new weights would apply</td>
<td>50% weight</td>
<td>35% weight</td>
</tr>
<tr>
<td>Fourth or subsequent agreement period in which new weights would apply</td>
<td>50% weight</td>
<td>50% weight</td>
</tr>
</tbody>
</table>
Modifying Methodology for Calculating Benchmark Trend and Update Factors

- **Trend factor**: trend forward expenditures in first two years on which benchmark is based to third benchmark year

- **Update factor**: update ACO benchmark from third benchmark year to relevant performance year

- **Modification**: Use national-regional blend to trend forward and update benchmark

- **How?** Weighted average of national FFS and regional trend factors
Updates to MSSP Program Policies
Program Policies Already Finalized

- Updates to program policies finalized in CY 2019 PFS Final Rule:
  - Voluntary alignment
  - Definition of primary care used for beneficiary assignment
  - Extreme and uncontrollable circumstances policies for performance years 2018 and subsequent years
  - Promoting healthcare system interoperability through ACOs’ use of certified EHR technology
- Extreme and uncontrollable circumstances policy – response to comments from Dec. 2017 IFC
RFI on Coordination of Pharmacy Care for ACO Beneficiaries

- RFI in proposed rule: How can CMS foster collaboration between MSSP ACOs and independent Part D plan sponsors to better coordinate pharmacy care for Medicare FFS beneficiaries?

- Possible benefits of working together:
  - Improved formulary compliance by clinicians
  - Enhanced delivery of pharmacist counseling services to patients
  - More widespread implementation of medication therapy management

- Several commenters made recommendations in response to RFI, such as creation of demonstration; some expressed concern

- No action at this time
Applicability of Proposed Policies to Existing Track 1+ Model ACOs
Applicability of Proposals to Track 1+ ACOs

- No future Track 1+ applications
- BASIC Track Level E designed to replicate many elements of Track 1+ Model
- Existing Track 1+ ACOS may complete agreements and then transition to new program or terminate and immediately enter new program
- Track 1+ model will end in 2020
Questions?

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