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Proposed Rule to Redesign the Medicare Shared Savings Program (MSSP)

OVERVIEW

On August 8th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would redesign participation options for the Medicare Shared Savings Program (MSSP) under a new model referred to as "Pathways to Success." The proposed rule would discontinue or replace all MSSP Tracks (1, 1+, 2, and 3) and implement two new tracks, BASIC and ENHANCED, beginning in 2019.

CMS will accept comments on the proposed rule until October 16th. The proposed rule is available here.

TRACK CHANGES

The proposed rule would re-organize participation options for ACOs by combining elements of Track 1, 1+, and 2 into the new BASIC Track and renaming Track 3 the ENHANCED Track.

CMS is proposing to open the first BASIC and ENHANCED Track application cycle in early 2019 with July 1, 2019 as an initial start date to enter a five and a half year agreement period. For all subsequent application cycles, the agreement start date would begin on January 1st of each year and the period would be five years.

Existing ACOs may complete their current agreement period or terminate their contract to enter into a new agreement under one of the new tracks as early as July 1, 2019. Existing ACOs with a participation agreement currently scheduled to end on December 31, 2018 would be offered a six-month extension period so that they may enter a new BASIC or ENHANCED Track agreement period on July 1, 2019.

BASIC Track

The BASIC track would consist of five levels (A, B, C, D, and E) that provide an incremental approach to higher levels of risk and potential reward. Each year, the ACO would be required to take on higher levels of risk: levels A and B would be one-sided models, while levels C through E would require two-sided, performance-based risk. Level E would have risk requirements that are equivalent to those of the existing Track 1+ model.

ACOs could elect to skip levels to take on more risk, but could not return to a lower level of risk and all ACOs would be required to reach Level E by their final performance year. New ACOs in the BASIC Track with a July 1, 2019 start date would not be required to advance to a higher Level until 2021 as their first performance year is only six months long. BASIC track ACOs that transitioned from existing ACOs would be required to advance to Level E earlier.

In order to advance to performance-based risk (Levels C-E), ACOs would be required to select a symmetrical Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR), which would have to be met to trigger shared savings or losses, and establish a sufficient repayment mechanism (see more below). The MSR and MLR would be calculated as a percentage of the ACO's updated historical benchmark.

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The chart below outlines MSR, MLR, Shared Savings, and Shared Losses thresholds for BASIC Levels A-E.

Provision	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)
MSR & MLR	• ACOs with at least 5,000 beneficiaries would have MSR that varies 2-3.9%, based on # of beneficiaries • ACOs with fewer than 5,000 beneficiaries would have an MSR that increases as beneficiaries decrease	• ACOs with at least 5,000 beneficiaries may choose fixed MSR & MLR equal to: 0%, 0.5%, 1%, 1.5%, or 2%. • ACOs with fewer than 5,000 beneficiaries will have symmetrical but variable MSR & MLR of at least 2% based on the # of beneficiaries		
Shared Savings (once MSR met or exceeded)	1st dollar savings at a rate of up to **25%** based on quality performance; not to exceed **10%** of updated benchmark	1st dollar savings at a rate of up to **30%** based on quality performance, not to exceed **10%** of updated benchmark	1st dollar savings at a rate of up to **40%** based on quality performance, not to exceed **10%** of updated benchmark	1st dollar savings at a rate of up to **50%** based on quality performance, not to exceed **10%** of updated benchmark
Shared Losses (once MLR met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 40%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program, capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard

ENHANCED Track

The proposed ENHANCED track continues the existing Track 3's model of shared savings and losses:

- Shared savings of up to 75% based on quality performance, not to exceed 20% of the benchmark; and
- Shared losses of 40-75%, not to exceed 15% of the benchmark.

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ELIGIBILITY REQUIREMENTS

BASIC and ENHANCED Track ACOs would be required to have at least 5,000 fee-for-service (FFS) beneficiaries. If an ACO's enrollment falls below 5,000 during a performance year, its MSR/MLR would be adjusted (see chart above). CMS would also evaluate ACOs applying to participate in the BASIC or ENHANCED Tracks based on their prior Medicare ACO financial and quality performance.

- Past financial performance would be assessed by determining if an ACO's benchmark minus performance year expenditures were less than or equal to the negative MSR for ACOs in a one-sided model or MLR for ACOs in a two-sided model for two performance years of the ACO's previous agreement. CMS may consider ACOs with poor financial performance to be eligible to participate in a Pathways to Success track if the ACO can demonstrate that it has corrected its financial performance deficiencies.
- Past quality performance would be assessed by determining if the ACO was terminated for failing to meet quality performance standards or failed to meet quality performance standard for at least two years, regardless of whether the years were consecutive or not. CMS may consider ACOs with poor quality performance to be eligible to participate in a Pathways to Success Track if the ACO can demonstrate that it has corrected its quality performance deficiencies.

The level at which an ACO is required to enter the BASIC or ENHANCED Track would be based on the ACO's revenue and prior Medicare ACO experience (with a five-year look back period). The proposed rule defines "high revenue" ACOs as those whose total annual Part A and B FFS revenue of its participants is at least 25% of total annual Part A and B FFS expenditures for assigned beneficiaries. "Low revenue" ACOs would be defined as those whose total annual Part A and B FFS revenue of its participants is less than 25% of total Part A and B FFS expenditures for assigned beneficiaries. CMS anticipates that high revenue ACOs would include hospital ACOs, while low-revenue ACOs would include small, physician-only, and rural ACOs.

The rule proposes the following track entry requirements for ACOs:

- All ACOs that have not previously participated in MSSP, or any performance-based risk Medicare ACO, would have the flexibility to enter at any of the five BASIC levels or the ENHANCED Track.
- All ACOs that have previously participated in Track 1, or are considered a re-entering ACO because more than 50% of its participants have participated in Track 1, would have to enter at Level B or higher and would be required to enter Level E by their fourth performance year (fifth performance year for an ACO with an agreement period starting July 1, 2019).
- High revenue ACOs that have experience in a performance-based risk Medicare ACO would be required to enter the ENHANCED Track. ACOs that are considered to have experience in performance-based risk include:
    - Track 1+, Track 2, Track 3, Next Generation, Pioneer, and Track 1 ACOs that are in their fourth and final year of their first agreement period under Track 1 because they were deferred entry into a second agreement period under Track 2 or Track 3; and

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  - ACO's with 40% or more of its participants in one of the performance-based risk Medicare ACO initiatives listed above.
- High revenue ACOs are limited to one agreement period under the BASIC Track.
- Low revenue ACOs that have experience in a performance-based risk Medicare ACO may enter the BASIC Track Level E or the ENHANCED Track, but they would be limited to two agreement periods under the BASIC Track.

PARTICIPATION REQUIREMENTS

Financial Performance

The rule also proposes safeguards to ensure that ACOs with poor financial performance are not allowed to continue their participation in the program or re-enter after being terminated. If CMS finds that an ACO's expenditures for assigned beneficiaries exceed the ACO's benchmark by an amount equal to or exceeding either the ACO's negative MSR (for one-sided models) or the ACO's MLR (for two-sided models), CMS may implement a pre-termination process. If the ACO's financial performance does not improve in the next performance year, CMS may immediately terminate the ACO's participation agreement.

Quality Performance

In order for an ACO to qualify for shared savings, it must also meet quality performance standards. CMS may terminate ACOs that fail to meet the quality performance standard for two consecutive years.

Repayment Mechanism Requirements

In order for an ACO to participate in a two-sided model, it must submit documentation to CMS that supports its ability to repay shared losses. The proposed rule would implement a lower repayment mechanism amount for ACOs in the BASIC track compared to ACOs in the ENHANCED track to reflect lower levels of potential loss liability. The proposed rule would also specify that the data used to determine the repayment mechanism amount would come from the most recent calendar year for which 12 months of data were available rather than the most recent prior year for which 12 months of data were available.

When evaluating the repayment mechanism, the proposed rule would allow CMS to recalculate the estimated amount of the repayment mechanism arrangement before the second and each subsequent performance year on or after July 1, 2019 while the ACO is under a two-sided model in the BASIC or ENHANCED track. If the ACO's repayment potential liability increased, CMS would require the ACO to submit documentation that the funding for its repayment mechanism had increased to reflect the new amount. This determination would be part of the ACO's annual certification process before the start of each performance year where the ACO finalizes their participant list. Prior to this proposed rule, the estimated repayment mechanism amount for an ACO was not revised during the ACO's agreement period.

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BENCHMARKING

The proposed rule aims to redesign benchmarking methodology to reduce "windfall" savings for historically low-spending ACOs and increase the potential savings for ACOs whose participants have historically higher spending rates than their regions. The following changes are proposed:

- Reduce the maximum weight used in calculating the regional adjustment from 70% to 50%; and
- Cap the adjustment amount to 5% of national Medicare FFS per capita expenditures

The revised benchmarking methodology would also use regional FFS expenditures to establish an ACO's historical benchmark beginning with the ACO's first agreement period instead of subsequent agreement periods. The methodology to annually risk adjust would also be adapted to reflect changes in health status of up to 3% (positive or negative) over the length of an agreement period.

BENEFICIARY ASSIGNMENT METHODOLOGY

The Bipartisan Budget Act of 2018 requires that ACOs in a track that retrospectively assigns beneficiaries will have the chance to pursue a prospective methodology for agreement periods entered into or renewed on or after January 1, 2020. As such, the proposed rule gives ACOs in the BASIC and ENHANCED tracks the choice of operating under a prospective assignment or a preliminary prospective assignment with retrospective reconciliation before the start of the agreement period beginning July 1, 2019. ACOs would also be able to switch their beneficiary assignment methodology on an annual basis.

BENEFIT ENHANCEMENTS

Under the proposed rule, ACOs that participate in performance-based risk (BASIC Levels C-E and ENHANCED) would be eligible to waive certain Medicare payment requirements and offer the benefit enhancements outlined below

Telehealth

In accordance with the Bipartisan Act of 2018, the proposed rule would allow practitioners in an ACO under performance-based risk to bill for telehealth services in non-rural areas to prospectively assigned beneficiaries, beginning in January 2020. This would include circumstances where the beneficiary's home is the originating site. CMS is seeking comment on whether ACOs that participate in preliminary prospective assignment with retrospective reconciliation should be eligible to receive payments for telehealth services.

Skilled Nursing Facility (SNF) Three-Day Rule Waiver

Under the proposed rule, eligible ACOs may elect to waive the three-day inpatient stay requirement prior to admission to a SNF or post-acute care hospital. ACOs that that use prospective assignment or preliminary prospective assignment with retrospective reconciliation would be eligible. The rule would also allow critical access hospitals and other small, rural hospitals operating under a swing bed agreement to partner with eligible ACOs for purposes of the SNF three-day rule waiver.

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Beneficiary Incentive Program

The proposed rule also clarifies an ACO's ability to engage beneficiaries through an incentive program with vouchers, as long as the voucher applies towards "in-kind items or services" and the voucher meets all other program requirements. The items and services that are a result of the voucher must have a reasonable connection to the beneficiary's medical care and must be preventative care items or services or must advance a clinical goal of the beneficiary. In accordance with the Bipartisan Budget Act, an ACO is able to offer an inventive of up to $20, with the incentive payment being the same amount for each Medicare FFS beneficiary. As such, the proposed rule would allow eligible ACOs to apply to provide incentive payments to eligible beneficiaries for qualifying services.

ADVANCED ALTERNATIVE PAYMENT MODEL (APM)

Level E BASIC Track ACOs and ENHANCED Track ACOs would qualify as Advanced APMs under the Quality Payment Program. Providers participating in Advanced APMs are excluded from the Merit-based Incentive Payment System reporting requirements and are eligible to receive incentive payments.

CERTIFIED EHR TECHNOLOGY (CEHRT)

The proposed rule would implement a requirement for ACOs to demonstrate use of CEHRT in order to be eligible to participate, which better aligns the MSSP with the CEHRT requirements in the Quality Payment Program. ACOs that participate in a track or payment model that is not an Advanced APM would need to attest to CMS that at least 50% of eligible clinicians use CEHRT. ACOs that participate in a track deemed to meet the financial risk standard of an Advanced APM would need to attest to CMS that they meet the higher Advanced APM threshold, proposed in the Physician Fee Schedule rule as 75% for 2019.

As a result of these changes, the proposed rule would retire the ACO-11 EHR quality measure in an effort to reduce reporting burden on ACOs.