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

OVERVIEW

On December 21st, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that redesigns participation options for the Medicare Shared Savings Program (MSSP) under a new model referred to as "Pathways to Success." The final rule will discontinue or replace all MSSP Tracks (1, 1+, 2, and 3) and implement two new tracks, BASIC and ENHANCED, beginning in 2019.

Current ACOs may elect to continue under their current agreement until the end of their performance period, or terminate early to join the Pathways to Success model. Entities interested in applying for the earliest start date of July 1, 2019 must submit a non-binding Notice of Interest to Apply (NOIA) between January 2, 2019 and January 18, 2019.

The final rule is available here and application information, including NOIA guidance, is posted here.

TRACK CHANGES

The final rule will 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 will 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 start date will begin on January 1st of each year and the agreement period will be five years.

Existing ACOs may terminate their current participating agreement to enter into a new agreement under one of the new tracks as early as July 1, 2019. Existing ACOs with a participation agreement ended on December 31, 2018 have been 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 will 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 will be required to take on higher levels of risk: levels A and B will be one-sided models, while levels C through E will require two-sided, performance-based risk. Level E will have risk requirements that are equivalent to those of the existing Track 1+ model.

ACOs may elect to skip levels to take on more risk, but may not return to a lower level of risk and all ACOs will be required to reach Level E by no later than their final performance year. BASIC Track ACOs with a July 1, 2019 start date will not be required to advance to a higher Level until 2021, as their first performance year is only six months long.

ACOs will select or be assigned a Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR), depending on the ACO's Track and beneficiary volume, that will have to be met to trigger shared

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savings or losses. 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 will have an MSR that increases from 2% as the number of beneficiaries decrease	• ACOs with at least 5,000 beneficiaries may choose symmetrical fixed MSR & MLR equal to: 0%, 0.5%, 1%, 1.5%, or 2%; or a symmetrical MSR & MLR that varies based on the number of assigned beneficiaries • ACOs with fewer than 5,000 beneficiaries will have variable MSR & MLR that increases from 3.6% as the number of beneficiaries decrease		
Shared Savings (once MSR met or exceeded)	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	1st dollar savings at a rate of up to **50%** 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 **30%**, 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 for an Advanced APM, capped at a percentage of updated benchmark that is **1 percentage point** higher than the expenditure-based nominal amount standard (in 2019 these limits are 8% and 4%, respectively)

ENHANCED Track

Under the ENHANCED Track, ACOs with at least 5,000 beneficiaries may choose symmetrical fixed MSR & MLR equal to: 0%, 0.5%, 1%, 1.5%, or 2%; or a symmetrical MSR & MLR that varies based on the number of assigned beneficiaries. ACOs with fewer than 5,000 beneficiaries will have variable MSR & MLR of at least 2% based on the number of beneficiaries.

The ENHANCED Track is based on 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

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- Shared losses of 40-75%, based on quality performance, not to exceed 15% of the benchmark.

ELIGIBILITY REQUIREMENTS

CMS will 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 will 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.
- Past quality performance will be assessed by determining if the ACO was terminated for failing to meet quality performance standards or failed to the meet quality performance standard in certain performance years.

The level at which an ACO is required to enter the BASIC or ENHANCED Track will be based on the ACO's revenue and prior Medicare ACO experience (with a five-year look back period). The final rule defines "high revenue" ACOs as those whose total annual Part A and B FFS revenue of its participants is at least 35% of total annual Part A and B FFS expenditures for assigned beneficiaries. "Low revenue" ACOs will be defined as those whose total annual Part A and B FFS revenue of its participants is less than 35% of total Part A and B FFS expenditures for assigned beneficiaries. CMS anticipates that high revenue ACOs will include most hospital-led ACOs, while low-revenue ACOs will include small, physician-only, and rural ACOs.

The rule finalized the following track entry requirements for ACOs:

- All ACOs that have not previously participated in MSSP, or any performance-based risk Medicare ACO, will have the flexibility to enter at any of the five BASIC levels or the ENHANCED Track. However, high revenue ACOs without performance-based risk experience will be limited to one performance period in the BASIC Track before they have to advance to 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, will have to enter at Level B or higher and will 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).
- Most high revenue ACOs that have experience in a performance-based risk Medicare ACO will be required to enter the ENHANCED Track. There is one exception: high revenue ACOs that transitioned to the Track 1+ Model within their current agreement period will be allowed to participate in Level E of the BASIC Track for one performance period. 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.
- 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 will be limited to two agreement periods under the BASIC Track.
- Low revenue ACOs that do not have experience in a performance-based risk Medicare ACO will be allowed to participate in a one-sided model of the BASIC Track for three performance years, as opposed to two, before they have to transition to Level E's two-sided risk model. Specifically, the ACO could enter the BASIC Track at Level A, advance to Level B after one performance year, continue at Level B for its third performance year (as opposed to Level C), and then automatically advance to Level E for the last two performance years of its agreement period.

PARTICIPATION REQUIREMENTS

Financial Performance

The rule also finalized 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.

ACOs in two-sided models that are terminated will be held accountable for pro-rated shared losses:

- ACOs that voluntarily terminate after June 30th of a 12-month performance year will be accountable for pro-rated shared losses.
- ACOs that involuntarily terminate will be accountable for pro-rated shared losses that were incurred during the portion of the performance year prior to termination

Assigned Beneficiaries

Shared Savings Program ACOs must have at least 5,000 beneficiaries to be eligible to participate. CMS will consider an ACO to have initially satisfied this requirement if 5,000 or more beneficiaries are historically assigned to the ACO in each of the three benchmark years.

If at any time during the performance year, an ACO's assigned population fell below 5,000, the ACO would be subject to pre-termination actions such as requiring a remediation plan. In addition, an ACO with fewer than 5,000 beneficiaries would no longer be able to maintain a fixed MSR/MLR benchmark, but would be subject to a variable threshold before savings or losses are triggered that increases as the assigned population decreases (to avoid savings/losses due to random variation).

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Quality Performance

In order for an ACO to qualify for shared savings, it must also meet quality performance standards. ACOs that demonstrate quality improvement will be eligible for bonus points. CMS may terminate ACOs that fail to meet the quality performance standards.

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 (including either an escrow account, letter of credit or a surety bond). The final rule will implement a lower repayment mechanism amount for ACOs in the BASIC track compared to ACOs in the ENHANCED track to reflect lower levels of loss liability. The final rule will also specify that the data used to determine the repayment mechanism amount will 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 final rule will 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 mechanism increased significantly, CMS will require the ACO to submit documentation that the funding for its repayment mechanism had increased to reflect the new amount. This determination will 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 final rule, the estimated repayment mechanism amount for an ACO was not revised during the ACO's agreement period.

Beneficiary Notification

ACOs must ensure that beneficiaries are notified about their involvement in the ACO. Specifically, the ACO most notify beneficiaries that:

- Its ACO providers and suppliers are participating in the Shared Savings Program;
- The beneficiary has the opportunity to decline claims data sharing;
- The beneficiary has the ability to choose their designated primary clinician for purposes of voluntary alignment;

ACOs operating a Beneficiary Incentive Program (see more below) are also required to notify its beneficiaries of the availability of the Program.

BENCHMARKING

The final rule aims to redesign benchmarking methodology to improved accuracy. CMS will gradually increase the weight of regional adjustments. For the first agreement period that an ACO is subject to a regional adjustment, CMS will apply a weight of 15% if the ACO's historical spending is higher than the region. This weight will increase to 25% for the second agreement period, 35% for the third, and

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50% to the fourth an all subsequent agreement periods. The rule will also cap the adjustment amount to 5% of national Medicare FFS per capita expenditures

The revised benchmarking methodology will 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 benchmarks based on Hierarchical Condition Category (HCC) scores will also be adapted to cap upward changes in health status at 3% over the length of a five-year performance period (previously, HCC adjustments were not allowed once the benchmark had been set).

BENEFICIARY ASSIGNMENT METHODOLOGY

The Bipartisan Budget Act of 2018 requires that ACOs that lie 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 final 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. ACOs will also be able to change their beneficiary assignment methodology each performance year.

BENEFIT ENHANCEMENTS

Under the final rule, ACOs that participate in performance-based risk (BASIC Levels C-E and ENHANCED) will 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 final rule will 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 will include circumstances where the beneficiary's home is the originating site.

Skilled Nursing Facility (SNF) Three-Day Rule Waiver

Under the final 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 will be eligible. The rule will 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.

Beneficiary Incentive Program

The rule will also allow two-sided ACOs to engage beneficiaries through an incentive program that allows the ACO to offer vouchers of up to $20 per service to beneficiaries who receive qualifying primary care services from certain ACO providers, Federally Qualified Health Centers, or Rural Health

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Clinics. The payment must be the same for each of the ACO's beneficiaries and must be applied towards "in-kind items or services." 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.

ADVANCED ALTERNATIVE PAYMENT MODEL (APM)

Level E BASIC Track ACOs and ENHANCED Track ACOs will 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 final rule will implement a requirement for ACOs to demonstrate use of CEHRT in order to be eligible to participate. ACOs that participate in a track or payment model that is not an Advanced APM will 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 will need to attest to CMS that they meet the higher of the 50% threshold. As a result, the final rule will retire the ACO-11 EHR quality measure in an effort to reduce reporting burden on ACOs.