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The Path Forward – Big Decisions Ahead for ACOs under MSSP Final Rule

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The December 21, 2018 "Pathways to Success" final rule governing Accountable Care Organizations participating in the Medicare Shared Savings Program (MSSP) will require expedited migration to financial risk arrangements. The final rule will likely trigger a close analysis and create headwinds for the participation strategy of many organizations.

For ACOs currently participating in the MSSP, the rule further complicates ongoing assessment of current performance, improvement opportunities and the financial and operational details associated with continued participation under the rule's new "glide path." Provider communities that are just now considering whether to engage in the MSSP must make a realistic assessment of whether current resources and capabilities align with the new rule's shortened timeframe to bear performance-based financial risk.

Overall, the final rule's numerous highly technical changes represent an improvement over the original proposal which included drastic cuts to the shared savings rate for upside-only ACOs and a more aggressive move to risk for low revenue ACOs than was finalized. Yet the strategic implications of the final rule are sufficiently challenging to lead to a hard study and decision-making by health care providers in crafting future strategies.

Some of the more significant changes in the final rule and their potential implications are described below.

CMS Policy Objectives

The substantial changes in the final rule were intended by CMS to promote certain core policy objectives:

- Accountability – increasing savings for the Medicare Trust funds
- Competition – encouraging physician-only ACOs to provide pathways for physicians to remain independent and preserve beneficiary choice
- Engagement – providing regulatory flexibility to permit ACO innovation and choices on care coordination, quality and beneficiary engagement
- Integrity – reducing opportunities for "gaming" in the program
- Quality – improving care quality for patients through data sharing, interoperability, meaningful quality measures and combatting opioid addiction

In addition to these policy goals, CMS took into account other observations from its experience, including that Track 2 and 3 ACOs have yielded savings and are improving quality, and "Low Revenue" ACOs which typically are physician-owned, have outperformed "High Revenue" ACOs involving hospitals and health systems. These policy objectives and observations led to the final rule's "Pathway to Success" strategy which included a gradual, step-wise "glide path" to migrate to risk.

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Revised Participation Tracks

CMS finalized sweeping changes to the MSSP participation options for ACOs. Under the new structure, all ACOs will eventually be required to assume "downside" risk. And while certain ACOs will still have an ability to participate in "upside-only" models, the rule shortens the permitted time period in which ACO entities can avoid assuming financial risk for repayments to CMS from six years to two or three years depending on the ACO.

Under the new structure, ACOs will participate in one of two new tracks: Basic and Enhanced under a participation agreement with CMS with a five (rather than three) year term.
The Basic track is divided into five levels (A-E) that create the new glide path involving various levels of reward opportunities and/or downside risk. Each level has different financial requirements for the applicable minimum savings rate (MSR), minimum loss rate (MLR), maximum savings rates, loss sharing rates and limits and other financial variables. With certain exceptions discussed below, Basic track ACOs will automatically advance to a higher level annually.

ACOs that progress through the glide path to the Enhanced track will be subject to standard financial and other terms. Only Basic track level E and Enhanced track ACOs qualify as "Advanced APMs" for the Quality Payment Program.

A high-level summary of the new tracks and levels is below:

Track/Level	Minimum Savings Rate / Minimum Loss Rate	Maximum Sharing Rate	Loss Sharing Rate
Basic Track Levels A and B	MSR assigned by CMS based on ACO size	Up to 40% (based on quality), capped at 10% of benchmark	N/A
Basic Track Level C	Choice of fixed MSR/MLR	Up to 50% (based on quality), capped at 10% of benchmark	30% of losses, not to exceed 2% of ACO Participants' revenue, capped at 1% of benchmark
Basic Track Level D	Choice of fixed MSR/MLR	Up to 50% (based on quality), capped at 10% of benchmark	30% of losses, not to exceed 4% of ACO Participants' revenue, capped at 1% of benchmark
Basic Track Level E	Choice of fixed MSR/MLR	Up to 50% (based on quality), capped at 10% of benchmark	30% of losses, not to exceed 8% of ACO Participants' revenue, capped at 4% of benchmark. (Note: values may change annually to ensure qualification as an Advanced APM.)
Enhanced Track	Choice of MSR/MLR	Up to 75% (based on quality), not to exceed 20% of benchmark	Rate of one minus the final sharing rate; minimum 40% & maximum 75%, not to exceed 15% of benchmark.

Implications of Past Participation

Under the final rule the prior history of the ACO legal entity and its various "ACO participant" TINs will affect available participation options. These and other factors will determine whether the applicant entity is classified as a "Re-entering," "Initial Entrant" or "Experienced" ACO.

"Re-entering" ACOs are defined as those involving an ACO legal entity that is re-entering the MSSP after a break in participation following termination or expiration of a prior participation agreement. They also include entirely new ACO legal entities in which 50% or more of the ACO participant TINs participated together in an ACO during the last five performance years.

A Re-entering ACO that previously participated in Track 1 of the MSSP must start at Basic level B and will be restricted to one year of upside-only participation. In the future, ACOs that have terminated their participation in the Basic track but subsequently seek to reenter the program will be required to rejoin at the next higher participation level (e.g., if it terminated at level C, the ACO may only rejoin at Basic track level D or higher).

"Initial Entrant" ACOs are those ACO legal entities that have not previously participated in the MSSP, and those that do not qualify as a Re-entering ACO because less than 50% of the ACO entity's ACO participant TINs had a prior participation experience. All Initial Entrant ACOs are permitted to begin at Basic track level A, permitting at least two years of participation in an upside-only/shared savings model.

"Experienced" ACOs are defined as those ACO legal entities that previously participated in a downside risk model (Tracks 1+, 2, 3, Basic track level C-E, Enhanced track or the Pioneer or Next Generation models), or ACOs in which 40% or more of the ACO entity's ACO participant TINs previously participated in a downside risk model. In general, Experienced ACOs must participate in the Enhanced track, with the notable exception being ACOs classified as Experienced Low Revenue ACOs, as described below.

Low and High Revenue ACO Distinctions

"Low Revenue" and **"High Revenue" ACOs** are distinguished from each other based on the portion of the total Medicare Part A & B expenditures for the ACO's assigned beneficiaries derived from the services of its ACO participant TINs. In Low Revenue ACOs, the ACO participant TINs' combined Part A & B revenues must comprise less than 35% of the total Medicare Part A & B expenditures for the ACO's assigned beneficiaries. High Revenue ACOs are those in which the percentage is 35% or greater.

Low Revenue ACOs are more likely to be physician-led and/or rural and less likely to involve a major hospital as an ACO participant. CMS intentionally provides Low Revenue ACOs with significant flexibility regarding their participation options, including an ability to remain in upside-only ACO models for one additional year, and to remain in the Basic track level E downside risk model for a longer period. This greater flexibility results in the following options for Low-Revenue ACOs:

- Initial Entrant Low Revenue ACOs may participate in upside-only models under the Basic track for up to three years
- Re-Entering Low-Revenue ACOs that previously participated in Track 1 can have two years of upside-only participation
- Experienced Low-Revenue ACOs can participate in Basic level E rather than the Enhanced track
- Low Revenue ACOs may renew into a second 5-year participation period in Basic track level E, rather than being required to move to the Enhanced track

Taken together, the various categories of ACOs enjoy the following participation options (assuming the Low Revenue ACO uses its flexibility to choose an added year of upside-only participation and each ACO starts at the lowest level of risk):

Category	Revenue	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Initial Entrant ACO	High	Basic Level A	Basic Level B	Basic Level C	Basic Level D	Basic Level E	Enhanced
Initial Entrant ACO	Low	Basic Level A	Basic Level B	Basic Level B	Basic Level E	Basic Level E	Enhanced OR Second 5-year period in Basic Level E
Re-Entering ACO with prior participation in Track 1	High	Basic Level B	Basic Level C	Basic Level D	Basic Level E	Basic Level E	Enhanced
Re-Entering ACO with prior participation (other than Track 1)	Low	Basic Level B	Basic Level B	Basic Level E	Basic Level E	Basic Level E	Enhanced
Experienced ACO	High	Enhanced	Enhanced	Enhanced	Enhanced	Enhanced	Enhanced
Experienced ACO	Low	Basic Level E	Basic Level E	Basic Level E	Basic Level E	Basic Level E	Enhanced OR Second 5-year period in Basic Level E

2019 Stub Year:

CMS will operate a special half-year model in 2019, therefore permitting ACOs to apply to participate in 2019 beginning on July 1, 2019. This 6-month "stub" period in 2019 will be treated as an extension of the 2020 participation year, so a Basic track ACO starting a MSSP participation agreement in 2019 will operate under the same rules for the first 18 months of its participation. This will permit these ACOs to have an agreement term of five years and six months, and by doing so, provide an extended period of access to the CMS claims data, fraud and abuse waivers and other resources associated with program participation that can benefit an ACO's prospects for success in the long-term.

Although the term of participation technically starts in July 1, shared savings and quality scores for participating ACOs in 2019 will be calculated based on the ACO's performance over

the full 2019 calendar year. CMS recently announced the Notice of Intent to Apply for 2019 must be completed no later than January 18, 2019.

The Path Forward

ACOs currently participating in the MSSP can complete their existing participation agreement term or switch to the Basic or Enhanced track. This means an ACO that participated in MSSP Track 1 in 2018 could potentially continue to participate in an upside-only model through 2021 (e.g., ACO Track 1 through 2020, then Basic Level B).

A currently participating ACO can also choose to terminate its existing participation agreement with CMS early and immediately transition into the Basic or Enhanced track. In that case, the ACO would be evaluated under the rules for a Re-Entering or Experienced ACOs. Certain special rules apply to ACOs currently in their first year of participation under Track 1+.

CMS also finalized changes to an ACO's ability to terminate and re-enter the program or change its participation terms. Basic track ACOs will automatically move to the next level annually, but they can also elect to skip to a higher level if desired (e.g., moving from Level B to Level E).

Under the new rule, ACOs will not be permitted to move from the Basic to Enhanced track under the same CMS participation agreement, but they will be allowed to terminate their Basic track participation to reapply to the Enhanced track. ACOs involved in downside risk arrangements that terminate after June 30th of a participation year will be responsible for a pro-rata repayment of any shared losses.

ACOs that terminate their participation but use the same legal entity TIN to apply for future participation will be treated as Re-Entering ACOs or, if the prior participation was in a downside risk arrangement, as an Experienced ACO.

Overall, the provisions of the final rule's glide path and classifications related to Initial, Re-Entering, Experienced, Low and High Revenue ACOs are designed to migrate provider communities to financial risk and prevent "gaming" of the participation structure.

Financial Benchmarks and Use of Regional Data

CMS sets financial benchmarks for each ACO that are used to determine whether an ACO has achieved savings (or losses) in its MSSP program participation. CMS finalized changes proposed to the benchmarking methodology with slight revisions related to the use of regional FFS expenditures in calculating the initial and annual updates to the benchmarks.

Under the new program, regional data will be considered during each ACO's first agreement period, rather than in subsequent years under the historical program. Regional data will also be used in the annual update of benchmarks, with the consideration of regional data to be adjusted from a proposed 70%, downward impact in the proposed rule to a 50% downward impact in the final rule, subject to a cap equal to five percent of the Medicare national per capita expenditures.

The final rule also includes other refinements related to the weighting of regional adjustments in setting the benchmark for some ACOs, and it incorporates modest risk adjustments (up to three percent during the five year participation agreement term) based on changes in HCC risk scores associated with ACO assigned beneficiaries.

The changes involving the use of regional data and others in the calculation of benchmarks are designed to provide financial benchmarks that are more representative of local market conditions. The changes are also intended to promote predictability, create incentives for ACOs to migrate to risk, and reduce the reoccurrence of past experience in which ACOs in high cost areas were able to garner "easy wins" in their early years of MSSP participation due to the historical use of national benchmarks.

Program Operations

Within the rule's refined glide path to risk, only modest changes were made to current operational requirements. CMS acknowledges that the rule represents an amalgamation of policy changes and lessons learned from the initial years of the MSSP and related programs, including the CMS Innovation Center's Next Generation and MSSP Track 1+ models. In contrast to the "one size fits all" approach used in the MSSP's early days, under the final rule organizations participating in the MSSP will have flexibility to make choices regarding the operational details of their participation strategy.

In the rule, CMS finalized its proposal to permit ACOs to make an annual choice regarding the methodology for assigning Medicare beneficiaries to the ACO. During the initial and each subsequent year of their participation agreement with CMS, participating ACOs in any track and level will be able to select between "prospective assignment" of beneficiaries (historically used in downside risk models), and "preliminary prospective assignment with retrospective reconciliation" (historically used in Track 1).

Notably, CMS declined to implement proposals to permit Medicare beneficiary "opt-in" arrangements akin to those available with Medicare Advantage plans. However, current rules allowing beneficiaries to "voluntarily align" with primary care providers will remain in place. In the final rule CMS does, however, provide greater clarity regarding notices required to be provided to Medicare beneficiaries regarding MSSP-related operational details, while increasing the number of issues which are subject to beneficiary disclosure. CMS will continue to provide standard language for disclosures that must be posted

in offices and made available to patients prior to or in connection with their first primary care visit of the year but expressed intent to consult with stakeholders to promote understanding and utility in the disclosure materials.

Regulatory Flexibility and Other Changes

The final rule furthers the administration's efforts to enhance regulatory flexibility and reduce burden. In the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS set forth new threshold criterion applicable to Certified EHR Technology (CEHRT) used to determine an ACO's eligibility for program participation and to promote interoperability among ACO providers and suppliers. The MPFS also implemented changes mandated by the Bipartisan Budget Act of 2018 (BBA) designed to provide greater beneficiary flexibility in selecting their primary care clinician, including nurse practitioners, physician assistants and clinical nurse specialists. The MPFS made other changes including refining and expanding the list of "primary care services" that are used in the MSSP to attribute beneficiaries to ACOs and finalizing changes to address ACOs that are impacted by "extreme and uncontrollable circumstances" such as recent hurricanes, fires and other natural disasters.

Among the positive features of the rule's revised glide path is the availability of waivers of Medicare payment policies, coupled with additional options and clarifications regarding incentives that the ACO can provide to Medicare beneficiaries.

On the payment front, CMS approved an expanded waiver of payment rules requiring a three-day inpatient hospital stay before a beneficiary can be discharged to a skilled nursing facility. This "three-day SNF waiver" is available for Basic track C and higher ACOs beginning in 2019. The three-day SNF waiver was also modified to permit critical access hospitals and other small rural hospitals operating under swing bed agreements to partner with ACOs as SNF affiliates.

As mandated by the BBA, beginning in 2020, certain payment policies governing telehealth services are waived for Basic track C and higher level ACOs selecting the prospective assignment methodology during a performance year. The telehealth waiver enhances care coordination and transitions by providing payment for telehealth services even when the "originating site" requirements of existing Medicare reimbursement payment rules are not met, permitting reimbursable telehealth services to be furnished from various settings, including homes of Medicare beneficiaries.

The final rule also implements changes approved in the BBA permitting certain ACOs taking downside risk to operate beneficiary incentive programs that provide limited incentives – including monetary incentives up to $20 – to an ACO assigned Medicare beneficiary for qualifying primary care services received from certain ACO professionals, Federally Qualified Health Centers or Rural Health Clinics. The rule also provides useful clarification regarding beneficiary incentives involving the use of "vouchers" – defined as certificates that can be used only for particular goods or services, including certain gift cards in the nature of a voucher. CMS clarified that such vouchers qualify as "in kind items or services" that may be provided to Medicare beneficiaries under defined circumstances (i.e., when there is a "reasonable connection" to the beneficiary's medical care, the items/services involve preventive care, or otherwise advance beneficiary-specific clinical goals like adherence to drug regimes, follow-up care plans, or management of a chronic disease or condition).

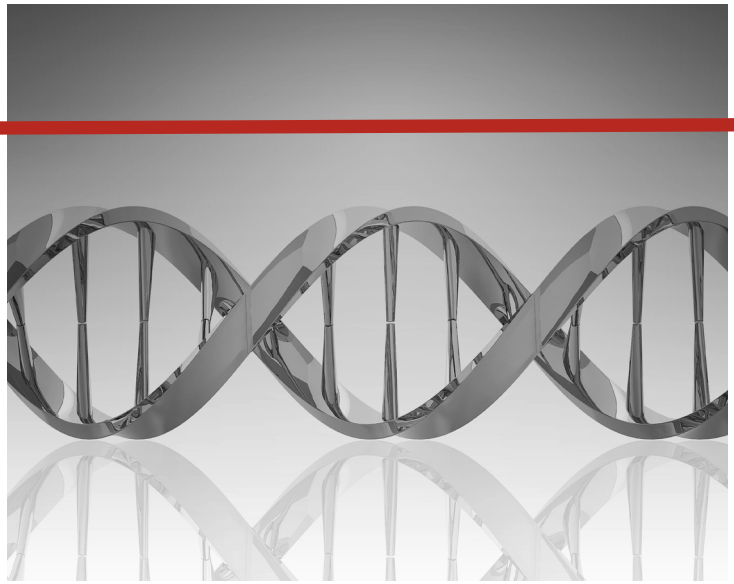
Implications and Conclusion

Time will tell whether and how the changes in the final rule will impact participation in the MSSP. The final rule will most certainly trigger a close analysis by current participating ACOs regarding continued participation options, and where an ACO or provider community stands on their view of the rule changes will likely hinge on their current position in relation to the program.

The 2019 stub period will permit entirely new entrants an opportunity to participate in a Basic track upside-only model for two years and six months. The slightly longer initial participation period under an upside-only model can provide additional time in the near term to implement effective data analysis and other systems that will be important to future success.

Re-entering ACOs that previously participated in Track 1 of the MSSP must start at Basic level B, and they will be restricted to one year of upside-only participation under the new program. However, since ACOs currently participating in the MSSP can complete their existing participation agreement term or switch to the Basic or Enhanced track, a Track 1 ACO that began participation in 2018 could continue to participate in an upside-only model through 2021 (e.g., ACO Track 1 through 2020, then Basic level B). The considerable flexibility provided to Low Revenue ACOs under the final rule will likely be welcomed by qualifying organizations. Conversely, the changes and limitations that the will apply to High Revenue ACOs is likely to trigger hospitals and health systems to seriously assess whether to continue participating in the program.

Overall, the final rule includes many changes that are improvements over the proposed rule by not adopting proposals to drastically cut shared savings rates for upside-only ACOs and in other areas. Yet the final rule's strategic implications are sufficiently challenging that health care provider communities will need to engage in a close study and analysis as they settle on future strategies.



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