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Pathways to Success: Medicare Shared Savings Program Overhaul and Changes to ACOs

Assumption of Risk, Benchmark Methodology, Expanded Telehealth Services, SNF Waivers

WEDNESDAY, MARCH 27, 2019

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"PATHWAYS TO SUCCESS": MEDICARE SHARED SAVINGS PROGRAM OVERHAUL AND CHANGES FOR ACOs

Webinar for Strafford
March 27, 2019

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New Final Rule

- Final Rule, Redesigning Medicare Shared Savings Program
- Entitled “Pathways to Success”
- Important Revisions
  - Redesigns participation options
  - Quicker transition to downside risk models (referred to as “performance based risk”)
  - Different options for Low-Revenue ACOs and High-Revenue ACOs and for Experienced and Inexperienced ACOs
  - 5-year agreement term
  - Benchmark revisions
  - Beneficiary Incentive Programs
  - Programmatic changes to add flexibility
  - New application timing

Presentation

- Background on MSSP
- Overview of Changes in Pathways to Success and Purposes for Change
- Impact on ACOs
- Revised Participation Options for ACOs
  - Basic Track (with 5 levels)
  - Enhanced Track

Presentation (cont'd)

- Term and Termination
- Benchmark Methodology Changes
- Beneficiary Incentives
- Repayment Mechanisms
- Programmatic Changes
  - Telehealth
  - Waiver of 3-Day Inpatient Stay for SNF Admission, including Swing Beds
- Seeking comments on Beneficiary assignment opt-in and pharmacy care coordination
- How will ACOs React to Changes? What Will/Should ACOs Do?
- Questions

MSSP Background

- First Enacted in 2012
- Largest Participation of Alternative Payment Programs
- In 2018, 561 ACOs Participating, affecting at least 10.5 Million Medicare FFS Beneficiaries
- 3-Year Terms
- 3 Tracks (Plus Track 1+)
  - Track 1 (2012): Upside only (82% of ACOs)
  - Track 2 (2012): Upside and downside risk (1.4% of ACOs (and declining))
  - Track 3 (2016): Upside and downside risk with larger sharing (6.7% of ACOs)
  - Track 1+ (2018): Lower risk, transitional model (9.8% of ACOs)
- ACOs Have Elected to Maximize Time in One-Sided Models

MSSP Background (cont'd)

- Those in Two-Sided Models have performed better
  - 2016: 68% of ACOs in two-sided model had shared savings vs. 29% in up-side only models;
  - 2017: 51% of those in 2-sided model vs. 33% of upside only
- Low-Revenue ACO (Physician-Led and Rural ACOs) have generally performed better than High-Revenue ACOs (with Hospital Leadership/Participation)
  - 2016: 41% of low-revenue ACOs shared saving vs. 23% of high-revenue ACOs
  - 2017: 94% of low-revenue vs. 28% of high-revenue
- Those in the MSSP longer better at Shared Savings

Principal Purposes and Themes for Pathways To Success

- Accelerate Movement to Two-Sided Risk
- Encourage Low-Revenue ACOs by Allowing More Flexibility for Them
- Allow Flexibility for ACOs to Engage Beneficiaries
- Reduce Opportunities to Game by Adopting Rules on Early Termination and Rejoining MSSP

MSSP Structure
Reminder of Structure

- Voluntary Program
- Not a Closed Network Program
- Beneficiary Choice of Providers Sacrosanct
- Measure All Medicare A & B Costs of Assigned Beneficiaries of an ACO against an Historic Cost Benchmark
- If Beat Cost Benchmark, Shared Savings after MSR, Subject to CAP
- In Two-Sided Models, if do not beat Cost Benchmark Pay Share of Losses After MLR, Subject to CAP
- Quality Performance affects Share of Savings

MSSP Structure
Aspects Not Changing

- General Payment Structure Not Changing (Benchmark Concept, Share Savings/Loss After MSR/MLR, CAP, Impact of Quality)
- Still Voluntary Program
- General Eligibility Not Changing
- ACO Management and Governance Not Changing
- Quality Performance Standards Not Changing
- Data Sharing Opportunities Not Changing
- Fraud and Abuse Waivers/Antitrust Safe Harbors Not Changing

Participation Options

- Change for all New and Renewing ACOs
- Tracks 1, 2, and 1+ Replaced With Basic Track
- Track 3 essentially becomes Enhanced Track
- Basic Track has Five Different Levels (A-E)
- New Definitions needed to understand where an ACO may start in Basic Track
  - "Low-Revenue ACO" – an ACO whose total Medicare A and B revenue for its ACO participants for most recent calendar year is less than 35% of total Medicare A and B revenue for ACO's assigned beneficiaries for most recent calendar year

Participation Options (cont'd)

- "High-Revenue ACO" – an ACO whose total Medicare A and B revenue for its ACO participants is at least 35% of the total Medicare A and B revenue for ACO's assigned beneficiaries
- "Experienced with performance-based risk Medicare ACO initiatives ("Experienced ACO") – means an ACO CMS determines either
  1. is the same ACO legal entity that is participating or previously participated in a performance-risk Medicare ACO initiative or that deferred its entry into a second SSP agreement period under a 2-sided model; or
  2. 40% or more of the ACO's ACO participants participated in a performance-based or risk Medicare ACO initiative or in an ACO that deferred its entry into a SSP agreement period with a 2-sided model in the prior 5 years

Participation Options (cont'd)

- "Inexperienced with performance-based risk Medicare ACO initiatives" ("Inexperienced ACO") – an ACO CMS determines meets all of:
  1. ACO legal entity that has not participated in any performance-based risk Medicare ACO initiative and has not deferred entry into a second SSP agreement period under a 2-sided model; and
  2. Less than 40% of the ACO's ACO participants participated in a performance-based risk initiative, Medicare ACO initiative or in an ACO that deferred a second SSP agreement period under a 2-sided model
- "Re-entering ACO" – same legal entity as an ACO that previously participated and applying after a break in participation because either its participation expired without renewal or was terminated, or a new legal entity and more than 50% of its ACO participants were included on the ACO participant list of the same ACO in any of the 5 most recent performance years

Options (cont'd)

- "Renewing ACO" – an ACO that continues its participation without a break in participation if its prior participation agreement expired or was terminated but ACO immediately entered a new agreement
- "Performance-based risk Medicare ACO initiative" – a 2-sided model under Basic, Enhanced or Track 2, Pioneer ACO, Next Generation ACO, Comprehensive ERSD model, Track 1+, other 2-sided risk models specified by CMS

Participation Options (cont'd)

- Basic Track – 5 Levels
  - Level A – shared savings only, may receive up to 40% of savings (based on quality performance) if meet or exceed the MSR, first dollar savings, cap of 10% of benchmark
  - Level B – shared savings only, may receive up to 40% (based on quality performance) of savings if meet the MSR, first dollar savings, cap of 10% of benchmark
  - Level C – upside and downside, may receive up to 50% of savings (based on quality performance) if meet or exceed MSR, cap of 10% of benchmark, for Losses 30% sharing of losses maximum of 2% of total Medicare A and B FFS revenue of ACO participants, but not more than 1% of the benchmark

Participation Options (cont'd)

- Level D – upside and downside, may receive up to 50% of savings (based on quality performance) if meet or exceed MSR, first dollar savings, cap of 10% of benchmark; Losses: 30% loss sharing rate, maximum of 4% of total Medicare A and B FFS revenue of ACO participants but never more than 2% of the benchmark
- Level E – upside and downside, may receive up to 50% of savings (based on quality performance) if meet or exceed the MSR, first dollar savings, cap of 10% of the benchmark; Losses: 30% loss sharing, may not exceed percentage of total Medicare A and B FFS revenue of ACO participants but never more than one (1) percentage point more than specified percentage of benchmark

Participation Options (cont'd)

- Glide Path
- General Rule: ACO is automatically advanced to the next level of the Basic Track's glide path at start of each performance year
  - Exceptions to automatic advancement:
  a) ACO may elect to advance more quickly
  b) ACO starting July 1, 2019 may remain at same level through Dec. 31, 2020
  c) Low-Revenue ACO that is not a Re-entering ACO may elect to remain in Basic Track Level B for 3rd performance years, but then advances to Level E at start of 4th performance year

Participation Options (cont'd)

- At what Basic Track Level may an ACO start in MSSP?
  - Unless ACO previously participated in Track 1 or a new ACO is a Re-entering ACO, may elect to start in any Level
  - If ACO previously participated in Track 1 or is a Re-entering ACO, may elect Levels B to E

Participation Options (cont'd)

- For agreement periods starting on or after July 1, 2019: CMS determines available participation options as follows:
  - High-Revenue ACO which is an Inexperienced ACO may enter at any Basic Level or Enhanced
  - High-Revenue ACO which is an Experienced ACO may enter at Enhanced but an ACO in first or second agreement period and in Track 1+ beginning in 2016 and 2017 may renew under Basic Level E or Enhanced

Participation Options (cont'd)

- Low-Revenue ACO that is an Inexperienced ACO may start at any Basic Level
- Low-Revenue ACO that is an Experienced ACO may enter at Basic Level E or Enhanced
- Low-Revenue ACOs may participate in Basic Track for maximum of two agreement periods
- Rules where in an agreement period Reentering ACO reentering is described in 42 CFR 425.600(f)

Term and Termination

- For 2017 and 2018, MSSP participation has a 3-year agreement period or term
  - Those starting Track 1 in 2014 or 2015 have options for another year under certain situations
  - For those starting July 1, 2019 the term is 5-years and 6-months (with 6 performance periods)
  - For those starting 2020 and thereafter term is 5 years
  - ACO may still voluntarily terminate participation agreement, now on 30 (as opposed to previous 60) days' notice

Term and Termination (cont'd)

- If ACO terminates or is terminated must still complete close-out procedures by a date specified by CMS, including
  - notice to ACO participants
  - record retention
  - data sharing
  - quality reporting
  - beneficiary continuity of care

Term and Termination (cont'd)

- Terminating ACO (but not an ACO that CMS terminated) may receive shared savings for performance year of termination, if CMS approves effective date as last day of performance year, close-out procedures completed, and shared savings criteria met
- For ACOs starting July 1, 2019 or later, ACOs in a 2-sided model liable for pro rata share of losses if termination prior to last day of performance year
  - If ACO terminates before June 30th of a 12-month PY, then pro rata loss for year

Term and Termination (cont'd)

- If CMS terminates ACO then ACO liable for pro-rated share of losses
- Pro-ration by month, with month of termination included as a full month
- If 6-month PY (those starting 7/1/19), if ACO terminates prior to end of first 6-months ACO not responsible for shared losses

Establishment Benchmark/ Adjustments, and Updates

- Now Uses Regional Medicare FFS Costs in the First Agreement Period with respect to Trending Historic Costs – more measurement against those in Region
- Method to Establish

Establishment Benchmark/ Adjustments, and Updates (cont'd)

- First Agreement Period
  - First agreement starting after July 1, 2019 benchmark established based on 3-year historic Part A and B costs based on ACO participants' TINs and beneficiary assignment method selected with certain adjustments (severity and case mix, dual eligibles, ESRD)
  - Weights benchmark years (1st - 10%, 2nd – 30%, 3rd – 60%)
  - Trends for each benchmark year using blend of national and regional growth rates – with caps on regional factors
  - Use of regional factors in first agreement period new and intended to strengthen incentives for ACOs

Establishment Benchmark/ Adjustments, and Updates (cont'd)

- Updating and Tending
  - Annual updates for each year of the agreement period using blend of national and regional factors
  - Using blend of regional and national factors in updating (as well as trending) with increased reliance on national factors as ACO has higher penetration in regional service area
  - This permits more favorable trend for ACOs with high penetration in regional area with lower national spending growth and less favorable trend for ACOs with higher penetration in regional area with higher spending growth
  - Regional is based on counties in ACO's regional service area based on assigned beneficiary population
  - Cap on impact of regional factors benefitting ACOs with higher cost in region

Establishment Benchmark/ Adjustments, and Updates (cont'd)

- **Re-setting Benchmark**
  - Benchmark re-set/re-based at start of each agreement period (every 5 years)
    - Use historic of three most recent years with each equally weighted
    - Use of regional and national factors
    - 5 years allows greater predictability in benchmark

Beneficiary Incentives

- General Rule: ACO, ACO Participants and ACO Providers/Suppliers or others Providing Services (ACO Entities) may not give Gifts or Remuneration to Beneficiaries as Inducements for Receiving Items or Services or Remaining in an ACO or with an ACO Provider/Supplier
- Exceptions:
  - In-Kind Incentives: ACO Entities may provide in-kind items or services to Medicare FFS beneficiaries if
    1) reasonable connection between item and service and medical care of the beneficiary
    2) items or services are preventive care items or services or advance a clinical goal if the beneficiary (e.g., adherence to treatment, a drug plan, a follow-up plan or management of a chronic disease)
    3) the item or service is not a Medicare-covered item or service

Beneficiary Incentives (cont'd)

- Monetary Incentives

  Beginning 7/1/19, ACOs in 2-sided model may establish a beneficiary incentive program ("BIP") with monetary incentives to beneficiaries who receive a "qualifying service"

  - Must file application for such a BIP; CMS must approve including material changes
  - Must begin on the start date of a performance year
  - Must operate for 18 months if a July 1, 2019 start or 12 months if a 1/1 start
  - ACO must certify it so operated the BIP and that program meets requirements

Beneficiary Incentives (cont'd)

- Beneficiaries eligible for incentive under a BIP must be assigned to ACO by Preliminary Prospective Assignment or Prospective Assignment
- Beneficiary must receive a "qualifying service" – a primary care service for which coinsurance applies under Part B from an ACO professional with a primary care designation, or by an ACO Professional who is a PA, NP, CNS, FQHC or RHC
- ACO must furnish an incentive payment for each qualifying service furnished to an eligible beneficiary
- Incentive payment must
  - Be in form of a check, debit card or traceable cash equivalent
  - Value may not exceed $20 (adjusted by CPI)
  - Must be provided no later than 30 days after qualifying service

Beneficiary Incentives (cont'd)

- Incentive payment must be in same amount to each eligible Medicare FFS beneficiary without regard to coverage under Med Supp, Medicaid or other health insurance policy or plan
- ACO must maintain records
  - Identifying beneficiary who received a payment, including name, HICN and Medicare beneficiary identifier
  - Type and amount of incentive payment to each
  - Date each beneficiary received a qualifying service, the HCPCS code for the service and the ACO provider/supplier of the service
  - Date of the incentive payment

Beneficiary Incentives (cont'd)

- May not use funds from entity outside of ACO to establish or operate a BIP
- ACO may not bill or shift cost of establishing or receiving a BIP to insurance or a Federal health care program
- ACO must notify beneficiaries of a BIP in manner specified
- Except for beneficiary notice, there can be no marketing of BIP
- BIP disregarded for ACO benchmarks, per capita expenditures and savings/losses

– Will BIPs be used?

ACO Elections During Agreement Period

- For Agreement Periods starting July 1, 2019 or later, ACOs must make elections before start of each Performance Year
  - Beneficiary assignment methodology
    - Preliminary prospective assignment with retrospective reconciliations
    - Prospective assignment
  - May elect a higher participation level of risk
  - Applying for or transitioning to a 2-sided model in Basic Track ACO must select its MSR/MLR, effective for rest of agreement period with following options:
    a) 0% MSR/MLR
    b) Symmetrical MSR/MLR between 0.5 and 2.0 percent
    c) Symmetrical MSR/MLR that varies by number of beneficiaries under Basic Track (table in 42 CFR 425.604); MSR of 3.9% for 5,000 Beneficiaries up; 2.0% for over 60,000 Beneficiaries

Repayment Mechanisms

- All ACOs in a 2-Sided Model need to assure CMS of ability to repay specified amount
- Repayment can be by
  - Escrow account with an insured institution
  - Surety bond from list
  - Letter of credit from insured institution
- Applies to Basic Track, Levels C, D and E and Enhanced Track prior to start of Agreement Period – If start at Level A or B, then before moving to 2-sided levels

Repayment Mechanisms (cont'd)

- Amount of Repayment Mechanism Varies
  - Track 2 ACO – 1% of total per capita Medicare A and B FFS expenditures used to calculate the benchmark of assigned beneficiaries
  - Basic or Enhanced Track ACOs: amount the lesser of
    - 1% of total per capita Medicare A and B FFS expenditures for assigned beneficiaries for most recent 12 months

      or
    - 2% of total per capita Medicare A and B FFS expenditures of ACO participants for most recent 12 months

Repayment Mechanisms (cont'd)

- Amount recalculated at start of each Performance Year – If recalculated amount exceeds existing by at least 50% or $1 Million, CMS sends notice and ACO has 90 Days to fix
- If renewing, an ACO for a new agreement period, amount must be greater of amount from last performance year

  or

  amount calculated by CMS in new approach
- Mechanism must be in effect for duration of ACO's participation plus 12 months

Payment Rule Waivers

- Telehealth Services:
  - Beginning on or after January 1, 2020 professional telehealth services billed by professionals under a TIN assigned to ACO in a 2-sided model are payable without regard to geographic requirements
    - ACO must elect prospective assignment
    - Beneficiary must be prospectively assigned to ACO for the performance year
    - Originating site must meet state licensing requirements
    - Beneficiary's home may be originating site and if so, telehealth services must be appropriate for home (no facility fee may be charged)

Payment Rule Waivers (cont'd)

- If telehealth services not billable solely because claim not covered because beneficiary not prospectively assigned, ACO participant may not charge beneficiary for expenses of such service and must return to beneficiary any monies collected
- CMS specifically monitors telehealth services

- CMS views Telehealth Services as efficient method to provide services if a downside protection against utilizing. Also a Carrot for APMs

Payment Rule Waivers (cont'd)

SNF 3-Day Rule

- CMS waives required 3-day acute care stay prior to SNF admission for
  - Eligible beneficiaries assigned to ACOs in a 2-sided model by an eligible SNF which has entered into a written agreement with ACO to partner for this waiver
  - ACO may elect 3-day rule waiver for performance years starting after 7/1/19
  - Eligible beneficiaries are
    - those prospectively assigned to ACO that selected prospective assignment for performance year (with 90-day grace from receipt of later exclusion list)
    - those on preliminary prospective assignment list at start of performance year or 1st, 2nd or 3rd quarter lists even if beneficiary subsequently removed from list

Payment Rule Waivers (cont'd)

- Eligible SNFs
  - Includes those entities with swing beds
  - If eligible for CMS 5-Star Quality rating, must have overall rating of 3 or higher
- Carrot of waiver available if 2-sided protection against utilization

Suggested Future Changes

- Policies to address impact of extreme and uncontrollable circumstances (e.g., disasters) in Performance Years and historical benchmark calculations
- CMS considering beneficiary assignment opt-in, allowing beneficiaries to be assigned to an ACO if beneficiary opts into that ACO
- CMS seeks comments on coordination between ACO and Part D sponsors– potential opportunities for data sharing to help on medication adherence and reductions of risk of adverse events

What Will or Should ACO Do?

- Historically, little risk in participating – Upside only Model Permitted Preparation and Testing without taking risk
- Few ACOs received Shared Savings
- Now, Downside Risk
- Will or Should ACOs Participate?
  - CMS projects modest (less than 10%) drop in ACO participation over 10 years and expects higher initial ACO participation

  Considerations
  - Is value-based reimbursement inevitable? How quickly?
  - What will CMS do if participation drops significantly?
  - What will the consequences to your organization be for not participating?

What Will or Should ACO Do? (cont'd)

- How will your entity perform in MSSP?
- Do you have necessary IT and infrastructure?
- Other factors:
  - Leadership/culture
  - Prior experience
  - Care management strategies
  - Alignment with other payers
- Where will savings come from?
  - Improvements in Care Delivery
  - Hospitals
  - Post-Acute

Questions?