January 7, 2019

CMS Finalizes Overhaul of Medicare Shared Savings Program

On December 21, 2018, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule (the "Final Rule") (available here) establishing the "Pathways to Success" program, which overhauls the Medicare Shared Savings Program ("MSSP") for Accountable Care Organizations ("ACOs"). The changes primarily involve provisions for new beneficiary incentives, coverage of telehealth services, and choice of beneficiary assignment methodology. The principal changes from the proposed rule announced in August (the "Proposed Rule"), are adjustments to the proposed Shared Savings Cap for a participation option and the proposed definition of low- and high-revenue ACOs.

In addition to the changes contained in the Final Rule, in November CMS finalized certain changes to the MSSP as part of its Calendar Year 2019 Physician Fee Schedule final rule (available here). Those changes originally had been introduced in the Proposed Rule and include: (i) a new Certified EHR Technology (CEHRT) threshold criterion to determine an ACO's eligibility for program participation to promote interoperability among ACO providers and suppliers, (ii) refinements to the voluntary alignment process, allowing beneficiaries to select an ACO professional, regardless of specialty, as a primary care clinician, (iii) policies intended to address extreme and uncontrollable circumstances experienced by ACOs (*e.g.*, natural disasters) for performance year 2018 and subsequent years, and (iv) revisions to the primary care services definition used in beneficiary assignment.

The Original ACO Program

CMS launched the MSSP, created by the Affordable Care Act, in 2012. Currently, 561 ACOs participate in the program, serving over 10.5 million Medicare beneficiaries. The MSSP is designed to hold ACOs accountable for the total cost of care and quality outcomes. ACOs that reduce Medicare expenditures below a set benchmark while meeting quality requirements are eligible to receive additional reimbursement in the form of a percentage of the cost savings achieved.

Prior to the new changes, the MSSP had three participation tracks. Track 1, a one-sided shared savings track, allowed ACOs to receive additional reimbursement of up to 50% of savings under the benchmark, with no requirement to share in the costs should spending exceed the benchmark. The vast majority of MSSP ACOs (82%) participated in Track 1. ACOs participating in Tracks 2 and 3, the two-sided shared savings/shared losses tracks, were eligible to receive a greater percentage of program savings, but also had to bear downside risk, sharing losses with CMS if their spending was above the benchmark.

Though their results are disputed, some studies indicated that the previous MSSP failed to reduce federal government spending and in fact led to increased spending of over $380 million. However, the two-sided models (Tracks 2 and 3) did reduce federal spending by $60 million over five years—though those savings were overshadowed by program losses generated in the more popular Track 1. Through the redesigned program, CMS seeks to increase savings for the Medicare program by increasing the number of ACOs participating in two-sided risk tracks.

Redesign of the Program

Changes to the Risk Model

The Final Rule implements the proposed revisions to the MSSP's participation tracks and mandatory advancement to greater levels of two-sided risk. Under the Final Rule, Tracks 1, 2 and 3 will be replaced with two "glide paths." The table at the end of this Alert summarizes the key characteristics of the paths.

BASIC Path

Under the Final Rule, the BASIC glide path will replace Tracks 1 and 2 and limit the amount of time ACOs may participate in a one-sided risk model. On the BASIC path, eligible ACOs will initially participate in a one-sided model, with a maximum amount of potential shared savings ("Shared Savings Cap") of 40%, a reduction from Track 1's Shared

Savings Cap of 50% but an increase from the proposed 25% cap, and would incrementally assume downside risk, which would increase over time.

The BASIC glide path, like the ENHANCED glide path described below, achieves this incremental phase-in through the use of four levels. Under the levels, ACOs become eligible for both increased Shared Savings Caps and amounts of shared downside risk.

ACOs new to the program would be permitted two years in a one-sided risk level (one year at Level A and one year at Level B). Programs identified as low-revenue ACOs and inexperienced with performance-based risk Medicare ACO initiatives may stay in a one-sided risk level for an additional program year. ACOs that previously participated in Track 1 would be ineligible to enter the program at Level A, thereby limiting them to just one year of participation in a one-sided risk level (Level B). Levels A and B will be similar and will be the only two levels without any downside risk. Regardless of the level in which an ACO begins, ACOs advance through further levels, climbing one level each year (or more, if they wish), and assume additional risk with each level.

ACOs would begin to bear two-sided risk and thereby to share in losses at Level C, assuming risk for 30% of higher-than-benchmark costs, not to exceed 2% of ACO participant revenue, and capped at 1% of the updated benchmark. By Level E, ACOs' Shared Savings Cap would reach 50%, and shared losses would reach 30% of higher-than-benchmark costs, subject to a calculated cap. Participation at Level E qualifies as participation in an Advanced Alternative Payment Model under the Quality Payment Program. Providers participating in an Advanced Alternative Payment Model are eligible to receive additional incentive payments from CMS and are exempt from participation in Merit-based Incentive Payment System (MIPS) reporting requirements and potential downward payment adjustments.

ENHANCED Path

Under the Final Rule, the ENHANCED glide path will replace the current MSSP ACO Track 3, which it largely mirrors. As with Track 3, ACOs participating in the ENHANCED path will have a Shared Savings Cap of 75% and will shoulder responsibility for between 40% and 75% of higher-than-benchmark costs.

The Final Rule indicates that CMS also will offer ACOs participating in the BASIC Path under two-sided risk (Levels C, D, and E) and ENHANCED path additional tools and regulatory flexibility, including, among others, broadened use of telehealth and waiver of the 3-day Skilled Nursing Facility admission rule, as described below.

Eligibility

Eligibility to participate in each path varies, and depends on an ACO's prior participation and level of experience, and whether the ACO is classified as a high-revenue or low-revenue ACO.

Under the Final Rule, ACOs less experienced with performance-based Medicare initiatives are eligible to enter an agreement period under the BASIC path.

Experienced ACOs, including those identified as previously participating in Track 2 or Track 3, will be eligible to participate in only the ENHANCED path, or the BASIC path's Level E if the ACO qualifies as a low-revenue ACO.

Low-revenue ACOs, defined as ACOs that receive less than 35% (increased from 25% in the Proposed Rule) of their total Medicare FFS expenditures from the ACO's assigned beneficiaries, may participate in the BASIC path for up to two agreement periods. These low-revenue ACOs are typically smaller physician practices, rural providers or other providers working in underserved markets.

High-revenue ACOs, those with total Medicare FFS revenue for assigned beneficiaries greater than 35%, would be required to transition to the ENHANCED path more quickly and would be permitted, at most, a single agreement period on the BASIC path.

When considering the level in which to participate (or whether to participate at all), both current and prospective ACOs will want to consider carefully their financial and operational readiness for the various percentages of downside and upside risk for each level, summarized in the chart below—in addition to more general factors, including the strategy that they intend to employ to avoid downward adjustments under MACRA (*e.g.*, through participation in an Advanced APM such as a BASIC path Level E or ENHANCED path ACO), and the relative benefits of participation in the revised MSSP versus a more targeted focus, such as the Bundled Payments for Care Improvement Advanced (BPCI-A) Initiative.

The Final Rule also includes modifications to the repayment mechanism requirements, to reduce the burden on ACOs in performance-based risk tracks. Under the current MSSP, ACOs accepting performance-based risk must establish a repayment mechanism to assure CMS that they can repay losses for which they may be liable. Under Pathways to Success, certain ACOs participating in the BASIC path in Levels C, D, or E would have a lower required repayment mechanism amount, to reflect the BASIC path's potentially lower levels of loss liability. Additionally, the Final Rule permits ACOs renewing their participation in the MSSP to maintain a single, existing repayment arrangement, to streamline the repayment of shared losses during the transition period to the new glide paths.

Updates to the Benchmarking Methodology

The Final Rule also refines certain parts of the MSSP benchmarking methodology, a complex calculation incorporating each ACO's risk-adjusted historical expenses along with national or regional spending trends.

First, the Final Rule accelerates inclusion of regional factors into the benchmarking methodology within the first agreement period, allowing for an earlier and more accurate comparison of an ACO's expenses to others in its service area. Second, the extension of the agreement period from three years to five years reduces the frequency of benchmark rebasing and provides greater predictability for both ACOs and CMS. Lastly, so as not to punish or reward an ACO excessively based on its geographic location, CMS will reduce the maximum weight given to the regional adjustment from 70% to 50% and will cap the total regional adjustment at 5% of national Medicare FFS per capita expenditures.

As part of its updated benchmark methodology, CMS will use a blended regional and national growth rate, with the weight placed on the national component of the blend increasing as an ACO's penetration in its regional services area increases. It is CMS' expectation that this revised methodology will lead to more favorable treatment for ACOs with high penetration in their regional service area and with lower spending growth compared to the nation, and less favorable treatment for ACOs with high penetration in their regional service area with higher spending growth compared to the nation. The intent behind this policy is to encourage overall cost savings for Medicare by rewarding increased market penetration coupled with lower spending growth. CMS intends for the change in treatment of ACOs with moderate to low regional penetration to be negligible.

Greater Flexibility for ACOs

The Final Rule's Pathways to Success encourages ACOs to become more innovative in their coordination of care and beneficiary engagement by offering regulatory flexibility. The Final Rule contains three changes that have a primary focus of increasing ACO flexibility to achieve these goals.

First, physicians in ACOs participating in the ENHANCED path, or Levels C, D, or E of the BASIC path, will be permitted to receive payment for telehealth services, even if otherwise applicable Medicare geographic requirements for telehealth are not met.

Second, for providers participating in ACOs in the ENHANCED path, or Levels C, D, or E of the BASIC path, CMS will waive the rule requiring a three-day stay in an inpatient hospital, acute-care hospital, or critical access hospital prior to admission to a skilled nursing facility.

Finally, the Final Rule will provide ACOs with greater choice of beneficiary assignment methodology. Enrolled ACOs, regardless of track, will be permitted to select prospective assignment or preliminary prospective assignment with retrospective reconciliation prior to the start of each agreement period, and will be able to change their selection for each

subsequent performance year. This will provide ACOs with more flexibility to test and choose the beneficiary assignment methodology that works best with their needs, irrespective of their track or level of risk they take on.

Enhanced Beneficiary Engagement

The Final Rule contains several provisions aimed at improving quality and lowering costs by promoting beneficiary engagement. ACOs participating in certain two-sided risk models (the ENHANCED path or the BASIC paths Levels C, D, or E) will be allowed to operate a beneficiary incentive program, so long as it is approved by CMS, and to provide incentive payments of up to $20 per qualifying service to beneficiaries for receiving primary care services from certain ACO professionals or from a Federally Qualified Health Center or Rural Health Clinic. The final rule also clarifies that under the program's existing regulations, vouchers, including vouchers redeemable for over-the-counter medication, transportation services, or access to meal programs, are considered to be "in-kind items or services" that may be provided to beneficiaries if all other program requirements are met.

The Final Rule, however, requires ACOs to provide additional beneficiary notifications. ACOs must ensure that FFS beneficiaries are notified: (1) that ACO providers/suppliers are participating in the MSSP; (2) about their opportunity to decline claims data sharing; and (3) about their ability to, and the process by which they may, identify or change their primary clinician for purposes of voluntary alignment (an assignment methodology under which a beneficiary would be assigned to an ACO if the beneficiary "opted-in," which the Proposed Rule sought comment on, was not included in the Final Rule).

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The final rule offers a one-time new agreement period start date of July 1, 2019, in order to avoid an interruption in participation by ACOs with a participation agreement ending on December 31, 2018. It is CMS' hope that this timing provides ACOs time to review and assess the impact of the final Rule, and to determine their future participation in the MSSP, if any.

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Should you have any questions regarding this alert or matters involving the MSSP or ACOs generally, please contact your usual Ropes & Gray advisor.