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Top 5 Takeaways: CMS's Proposed Overhaul of the MSSP ACOs

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On August 17, 2018, the Centers for Medicare & Medicaid Services (CMS) released proposed rule that would make sweeping changes to the Medicare Shared Savings Program (MSSP), a federal program that incentivizes integrated health provider networks to form Accountable Care Organizations.

Comments are due October 16, 2018.

- *The proposed regulations are available here.*
- *The CMS press release is available here.*
- *Bipartisan Budget Act of 2018 information.*

Our top 5 takeaways for the MSSP proposed rule follow.

For more information please contact Mara McDermott or Peter Rich.

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule on August 17, 2018, that would make sweeping changes to the Medicare Shared Savings Program (MSSP), a federal program that incentivizes integrated health provider networks to form Accountable Care Organizations (ACOs). According to CMS, the proposed rule aims to create new "pathways for success" for participating organizations to move more swiftly into performance-based risk arrangements.

Created under the Affordable Care Act (ACA), the MSSP currently consists of 561 organizations serving more than 10.5 million Medicare beneficiaries. The existing program comprises three tracks:

- Track 1 – An upside-only track where organizations may share in savings they achieve as compared to a historical benchmark, but are not liable to repay losses if they overspend pre-determined targets.
- Tracks 2 and 3 – Two-sided models where organizations share in savings but also are accountable for repaying losses if they overspend targets. These two tracks differ in specific design elements.

The MSSP began in 2012 and since that time has seen steady growth in participation. However, the majority of ACOs remain in Track 1.

To help facilitate the transition to performance based risk, CMS previously created Track 1+, an Innovation Center Model that is two-sided (organizations share in savings and repay losses) but has lower upside potential and downside risk than MSSP Tracks 2 and 3.

Track	Number of Participating ACOs
Track 1	460 participants
Track 1+	55 participants
Track 2	8 participants
Track 3	38 participants

With the new proposed rule, the administration is seeking to encourage more ACOs to move into higher-risk-bearing models. The administration states that ACOs in two-sided models have shown significant savings to Medicare while advancing quality, but most ACOs have yet to assume performance-based risk. CMS also states that it is concerned that upside-only arrangements may be encouraging consolidation and reducing competition and choice. To address these concerns, CMS proposes to create two new MSSP tracks that encourage movement to performance-based risk over a shorter period of time.

Under this proposed rule, (1) the new **BASIC** track will incorporate Tracks 1 and 1+, (2) Track 2 will be removed, and (3) Track 3 will be renamed the **ENHANCED** track.

Organizations entering the BASIC track in 2019 will participate in contracts that are five years and six months in duration (compared to current contracts that are generally three years in length, subject to some exceptions) beginning July 1, 2019. Under the BASIC track, there will be five levels labeled A through E. Each level would represent a progression along a glide path to

risk. The first two levels, A and B, will continue to be upside only; levels C, D and E would progressively increase the amount of risk, with level E having roughly the same amount of risk and reward as Track 1+. In general, organizations in the BASIC Track would be automatically advanced from level to level at the start of each new performance year, although organizations could choose to start at higher levels or skip levels, as long as they are moving along the glide path toward level E.

Under the proposed rule, participating organizations would have less time and a lower shared savings rate in upside-only arrangements. However, the proposed rule also contains additional flexibility and incentives for organizations that choose to move to performance-based risk arrangements.

In addition to defining the new MSSP options, the proposed rule implements a number of changes included in the Bipartisan Budget Act of 2018 (BBA), including additional flexibilities for ACOs and expanded telehealth services.

Below are our top five takeaways from the proposed rule. Comments are due October 16, 2018.

1. The Trump Administration recommits to the MSSP, including upside-only arrangements, but the program would be smaller.

In the lead-up to release of the proposed rule, several administration officials voiced criticisms of the MSSP, including Alex Azar, Secretary of the US Department of Health and Human Services, who labeled the program's results "lackluster." At the same time, a number of ACOs had participated in upside-only arrangements for the maximum amount of time allowed under current regulations (six years, i.e., two three-year agreements) and were not choosing to participate in more risk-bearing tracks. In addition, the administration was delayed in releasing the 2019 MSSP application. Taken together, the MSSP's future seemed uncertain.

In the proposed rule, CMS redefines the MSSP options but commits to a future for the program. In general, ACOs currently in Track 1 will have the option to remain in upside-only arrangements for another two years (2019 and 2020) before they enter the glide path's downside risk levels. New participants in the program will have two years in upside-only arrangements before they must begin advancing along the downside options in the glide path (reduced from the six years available under current regulations). ACOs thus will continue to have the opportunity to gain experience in upside-only arrangements prior to moving to downside risk. In addition, the glide path introduces lower levels of downside risk than were previously available and could be more palatable to some program participants.

The effect of the proposed changes, however, is that some ACOs would be expected drop out, and fewer new organizations would choose to start. CMS estimates that requiring organizations to move to downside risk over a shorter period of time will result in some organizations dropping out; and that only 20 to 50 new ACOs would join the

MSSP each year, compared to historical program growth of about 100 new ACOs each year. This lower rate of uptake is due to both the transition to downside risk and the lower sharing rate available in upside only track (down from 50 percent in Track 1 to 25 percent in the new BASIC levels A and B).

Taken together, these changes would likely result in a smaller MSSP in the future.

2. MSSP ACO participants would have enhanced flexibility and additional tools for care coordination, particularly in performance-based risk arrangements.

The proposed rule contains new flexibilities and opportunities for organizations to incentivize the move to performance-based risk. Organizations would be eligible for increasing percentages of shared savings as they progress along the glide path to risk. For example, while an upside-only ACO in BASIC level A is eligible to share in only 25 percent of the realized savings, a BASIC level E ACO could be eligible to share in up to 50 percent of its realized savings. In both cases, the total amount of the bonus is subject to a benchmark-based cap.

CMS proposes a number of additional flexibilities for organizations in performance-based risk. For example, beginning in 2020, ACOs in performance-based risk could receive payment for telehealth services furnished to prospectively assigned beneficiaries, even when geographic requirements are not met, including when the beneficiary's home is the originating site. CMS also proposes to expand the use of the Skilled Nursing Facility (SNF) three-day rule waiver for organizations in two-sided risk. Furthermore, the agency would allow eligible ACOs in two-sided models to establish a beneficiary incentive program, which would permit a payment of up to $20 to an assigned beneficiary for each qualifying primary care service the beneficiary receives from certain ACO professionals.

For organizations in upside-only levels of the BASIC track, CMS includes additional flexibility sought by the ACO community, including an annual choice of beneficiary assignment methodology (prospective or preliminary prospective with retrospective reconciliation), and the flexibility to enter higher levels of risk throughout an agreement period.

For ACOs that remain in or enter the program, there will be greater flexibility intended to improve ACOs' ability to coordinate and improve care for beneficiaries, with additional tools for organizations taking on performance-based risk.

3. CMS is exploring additional ways to encourage beneficiary engagement, including opt-in enrollment.

Consistent with the agency's priorities, CMS states in the proposed rule that it is interested in exploring additional ways to encourage beneficiaries' engagement in their health care decisions. One potential way to do so in the MSSP is to add a beneficiary opt-in to the ACO assignment methodology. In the proposed rule, CMS indicates that it is considering developing an opt-in-based assignment methodology that would

encourage and empower beneficiaries. It may also allow ACOs to better target their efforts to manage and coordinate care for beneficiaries.

Under the BBA, CMS has begun testing a voluntary alignment process, which allows beneficiaries to electronically designate a primary clinician as responsible for coordinating their care. If a beneficiary designates an ACO professional as responsible for his or her overall care and other requirements are met, the beneficiary would be assigned to that ACO. For 2018, 4,314 beneficiaries voluntarily aligned to 339 ACOs. Of those beneficiaries who voluntarily aligned, 92 percent were already assigned to the same ACO.

CMS distinguishes opt-in assignment from the current voluntary alignment, noting that while voluntary alignment is based on a relationship between the beneficiary and a clinician, opt-in assignment would be based on an election of the ACO itself. CMS states that such an opt-in could be similar to a beneficiary enrolling in a Medicare Advantage plan. The agency seeks comments on a number of process and implementation issues related to an opt-in for MSSP beneficiaries.

4. CMS will differentiate between ACO types based on whether they are high or low revenue to determine their future glide-path options.

In the proposed rule, CMS cites evidence that low-revenue ACOs, which are typically physician led, perform better than high-revenue ACOs, which often include hospitals. CMS also states its belief that high-revenue ACOs—which are typically larger and better capitalized, and have a greater opportunity to control assigned beneficiaries' total Part A and B expenditures as they coordinate a larger portion of care across settings—should be required to move to higher levels of risk more quickly. For this reason, CMS would require high-revenue ACOs to move from the BASIC to the ENHANCED track after a single agreement period. Low-revenue ACOs will have at most two agreement periods under the BASIC track.

CMS proposes to define high-revenue ACOs as those whose total Parts A and B fee-for-service revenue for ACO participants is at least 25 percent of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries. However, the agency also seeks comments on alternative approaches to defining low versus high revenue.

The idea of differentiating ACO types began with the Track 1+ program and provides some insights into the agency's thinking about organizations' readiness to pursue risk contracting.

5. MACRA's options for Advanced APM status will remain roughly the same.

The Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP) includes a 5 percent incentive payment for qualifying participants in certain Advanced Alternative Payment Models (APMs). Under existing law and regulation, the ACO models that qualify as Advanced APMs include MSSP Tracks 1+, 2 and 3, as well as Next Gen ACOs.

Under the new proposed rule, the ENHANCED Track and BASIC level E will qualify as Advanced APMs. Given that ENHANCED replaces Track 3 and BASIC level E mirrors Track 1+, clinicians Advanced APM options remain roughly the same. A small number of organizations participating in Track 2 will need to identify new participation options. Overall, clinicians' MACRA Advanced APM options, at least as far as the ACO programs are concerned, remain roughly the same.

Conclusion

The MSSP proposed rule is the most recent in a series of proposals that indicate where this administration is headed with its push toward innovation and value initiatives. The emphasis of the proposed new regulation is on moving to ACO models that shift financial risk and clinical accountability to providers. We expect that these efforts will ultimately be paired with the administration's simultaneous efforts to reduce regulatory burdens for Advanced APM formation by modifying the Physician Self-Referral (Stark) Law and the Anti-Kickback Statute. Requests for Information have been issued on both topics. In addition, we expect additional details to emerge about new models out of the Innovation Center in the near future.

For more information about the MSSP proposed rule or Advanced APMs, please contact Mara McDermott or Peter Rich.