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"Pathways to Success:" CMS Publishes Final Rule Modifying the Medicare Shared Savings Program

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The Centers for Medicare and Medicaid Services (CMS) issued a final rule (the Rule) on December 21, 2018, which reshapes the Medicare Shared Savings Program (MSSP). Termed "Pathways to Success," the Rule, among other things,

- Redesigns the options for participation in the MSSP,
- Requires accelerated movement to downside risk,
- Is designed to increase savings for the Medicare program

The Rule also allows greater flexibility for accountable care organizations (ACOs) in the areas of new beneficiary incentives, telehealth services, and choice of beneficiary assignment methodology, all as established in the Bipartisan Budget Act of 2018.

The Rule follows the proposed rule issued in August of 2018 and reflects CMS' responses to comments received by CMS on such proposal.

In announcing the Rule, CMS indicated there will be a one-time start date of July 1, 2019 for new applicants. That start date allows continuation by ACOs who had elected to continue their current agreements and provides an opportunity for new and currently participating ACOs to apply for the reshaped MSSP. Such applicants must file a non-binding Notice of Intent to Apply between January 2, 2019 and January 18, 2019, with application submission dates thereafter still to be determined. There will also be opportunities to commence participation on January 1, 2020 and annually thereafter.

The MSSP has been the most utilized alternative payment program with some 560 ACOs and more than 10.5 million beneficiaries involved. CMS believes the provisions of the Rule will be a Pathway to Success by promoting accountability, flexibility and beneficiary engagement in the MSSP. Given that few ACOs have been willing to commit to downside risk models, it will be interesting to observe how participation in the MSSP is affected by the Rule. If participation drops significantly, CMS will need to consider use of more mandatory downside risk models if it is serious about moving the health care payment and delivery systems to full accountable, value-based care.

The More Significant Changes to the MSSP in the Rule Include:

- **Establishment of two tracks for participation by ACOs – Basic and Enhanced**. The current MSSP has three tracks, as well as a Track 1+. Under the Rule, ACOs are eligible for participation in one of two tracks, Basic and Enhanced, for an agreement period of five years. All ACOs are expected to transition over time to the Enhanced track. Those characterized as "low revenue ACOs" or "high revenue ACOs inexperienced in performance-based risk initiatives" may enter under the Basic track's glide path, that starts with up-side only but moves to downside risk. Eligible high revenue ACOs must transition more quickly to downside risk. Low revenue ACOs with prior experience in performance-based risk initiatives also are required to transition to risk more quickly.
    - The Basic track begins as an up-side model but has a glide path to higher levels of risk, with only the highest level of risk qualifying as an Advanced Alternative Payment Model under MACRA. The Basic track allows eligible ACOs a one-sided model for only two years (though ACOs which previously participated in Track 1 would be restricted to one year and low revenue ACOs not identified as re-entering ACOs would be eligible for up to three years). There is progressively higher risk in years three through five. In the upside only levels of the Basic track, ACOs could receive 40% of shared savings based on meeting quality targets, after achieving a minimum savings rate. With downside risk in the higher levels, ACOs could share up to 50% of the shared savings. The transition to higher risk levels would be automatic, but ACOs could elect to move up to higher levels of risk more quickly.
    - The Enhanced track is based on the current Track 3, which offers more flexibility and higher potential rewards for ACOs that agree to take on higher levels of risk.
- **July 1, 2019 Start Date**. As noted above, the Rule includes a one-time start date of July 1, 2019 to facilitate transitions to the re-designed MSSP. For those starting on July 1, 2019 the six-month period from July 1, 2019 through December 31, 2019 will have a methodology for financial and quality performance during that period. Also, CMS is removing the required "sit-out" period after termination, which allows ACOs currently in a three-year agreement to voluntarily terminate their participation agreement effective June 30, 2019 and enter a new agreement as of July 1, 2019 under the Basic track (if eligible) or the Enhanced track, in either case without a required period of non-participation in the MSSP.
- **Modification to Repayment Mechanism for Two-Sided Model ACOs**. CMS seeks to reduce the burden of the repayment mechanism in the Rule. Those taking downside risk in the Basic track or participating in the Enhanced track may have a lower repayment mechanism set based on a percentage of the ACO's participants' Medicare Part A and B revenue, with annual recalculations of the amount that must be guaranteed. The Rule also sets a higher threshold that must be met before CMS will require an ACO to increase the repayment mechanism amount. The Rule also reduces the time the repayment mechanism must be in effect from 24 to 12 months after termination.
- **Changes to Benchmarking, Incorporating Regional Benchmarks for all Agreement Periods**. The Rule includes revised benchmarking utilizing regional Medicare Fee-for-Service expenditures in establishing the ACOs historical cost benchmarks, rather than waiting until the start of the second (and subsequent) years. The Rule also uses a blend of regional and national growth rates based on Medicare FFS expenditures, with increased weight on the national component, in setting cost benchmark trends and updates.
- **Reduced Opportunities for Gaming**. The Rule includes a number of provisions that help ensure program integrity by reducing opportunities for gaming. Among such revisions are: using past participation in performance-based risk Medicare initiatives by the ACO legal entity as well as by its ACO participants to determine MSSP participation options; monitoring

financial performance and permitting termination of ACOs with years of poor financial performance; modifying application criteria to allow consideration of the ACOs financial and quality performance standards in prior agreement periods; and holding ACOs responsible for pro-rated shared losses in voluntarily terminated arrangements.

- **Regulatory Flexibility in Annual Choice of Beneficiary Assignment Method**. Following the Bipartisan Budget Act of 2018, ACOs participating in Basic or Enhanced tracks are afforded the flexibility to elect prospective or preliminary prospective alignment with retrospective reconciliation of beneficiaries to the ACO. Such election may be changed for each subsequent performance year.
- **Expanded use of Telehealth in Downside Risk Arrangements**. Beginning January 1, 2020, eligible physicians and practitioners in certain ACOs participating in downside risk tracks or levels will be entitled to payment for telehealth services furnished to prospectively assigned beneficiaries, irrespective of whether geographic limitations are met.
- **Expanded Use of SNF 3-Day Acute Stay Waiver Eligibility**. ACOs in the Basic or Enhanced tracks will be eligible to apply for a SNF 3-day rule waiver, irrespective of their choice of prospective assignment or preliminary prospective assignment with retrospective reconciliation. In addition, critical access hospitals and other small rural hospitals operating under a swing-bed agreement are eligible to partner with certain ACOs as SNF affiliates for purposes of the SNF 3-day rule waiver.
- **Beneficiary Incentive Programs**. ACOs under certain downside models will have the opportunity to operate a beneficiary incentive program. As permitted under the Bipartisan Budget Act of 2018, an ACO approved to operate a beneficiary incentive program may provide up to a $20 incentive payment to assigned beneficiaries for each qualifying primary care service the beneficiary receives from certain ACO professionals, or from a FQHC or Rural Health Clinic. Also certain vouchers are considered to be in-kind or services that may be provided to beneficiaries under certain circumstances.
- **Beneficiary Notification**. The Rule strengthens beneficiary notification. It requires an ACO to ensure beneficiaries receive notices of: ACO providers/supplies that are participating in the MSSP, a beneficiary's opportunity to decline claims data sharing, and a beneficiary's ability to identify and change identification of the primary care professional of the beneficiary for purposes of voluntary alignment.

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