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NAVVIS INSIGHTS AND ANALYSIS

December 31, 2018 CMS MSSP Final Rule

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On December 21, 2018, the Centers for Medicare & Medicaid Services (CMS) issued the final rule and direction for the Medicare Shared Savings Program (MSSP). This new direction, referred to as "Pathways to Success," proposes significant modifications to the program.

The goal of these changes is to encourage ACOs to accelerate the transition to two-sided risk models. Below is Navvis' analysis based on our analysis of the rule.

The final rule increases the shared savings from the proposed rule and significantly restructures the MSSP's participation options into BASIC and ENHANCED Tracks. ACOs who want to participate in 2019 will need to act quickly filing a Notice of Intent to Apply (NOIA) between January 2-18, 2019.

Summary of CMS Costs and ACO Benefits

1. Estimated Net Savings to the Program: CMS projects the changes to the regional adjustment and risk adjustment factors to the benchmark, coupled with an accelerated transition to two-sided risk models, will result in $2.9 billion in federal savings over 10 years.
2. Improvements to the Benchmark: CMS will use regional adjustment factors to the benchmark in the first year of an ACO's first contract period. It also allows the HCC risk score for selected continuously attributed beneficiaries to change each year based on health status, as well as a national-regional trend factor.
3. Increased Program Flexibility: CMS expands access to waivers for telehealth, SNF 3-day stay, beneficiary incentives for ACOs that meet certain criteria, and offers an annual choice of either prospective or retrospective beneficiary alignment.
4. Impact on Program Participation: Due to the changes in the final rule, CMS estimates only 36 ACOs will drop out of the program, which is significantly reduced from the original 109 ACOs forecasted to drop under the proposed rule.

Restructuring of Participation Options

The final rule significantly restructures the MSSP's participation options. For ACOs the current tracks 1, 1+, and Track 2 are consolidated into the "BASIC" option (described in detail below). Track 3 has been renamed the "ENHANCED" option. These new participation options will be available for start dates beginning on 7/1/19. New contracts are for a period of at least five years, increased from three years. ACOs that are participating in the current tracks are allowed to finish out their contract term before transitioning into the applicable new model.

Detailed Analysis

1. ***Program Timing***: CMS provides 2019 enrollees with a 7/1/19 off cycle start (18-month initial year) followed by annual start dates beginning on January 1, 2020 for subsequent years. For ACOs who are ending their first or second three-year agreement on 12/31/18, CMS offered a six month extension. (90% of eligible ACOs renewed their agreements through 6/30/19.)

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2. ***BASIC Track***: Over the five-year contract period, the participants in the BASIC option will face increasing risk. Each year of the five-year contract periods is assigned a Level A-E, which denotes the risk level the ACO assumes. The default option is for an ACO's risk level to increase annually. However, an ACO may select a higher risk track for any performance year, as long as it can meet the repayment mechanism requirements. CMS finalized the rule with a higher shared savings rate than initially proposed. BASIC Levels A–B incorporate a shared savings rate of up to 40%, a reduction from the current 50% shared savings rate available to current upside only and Track 1+ participants. Levels C-E will be eligible to receive up to 50%.

   Similar to the current program, gain/loss sharing occurs at the first dollar once the Minimum Savings/Minimum Loss Rates are exceeded. Level E (year five) is analogous to the current Track 1+ MSSP model. Below is a summary of the Levels and related risk.

3. ***ENHANCED Track***: Under the Final Rule, the *existing* MSSP Track 3 model will be renamed the ENHANCED Track. If an ACO meets the "Low Revenue" criteria discussed below, it will transition into the ENHANCED Track after its second five-year contract period. If the ACO meets the "High Revenue" criteria, it will transition into the ENHANCED Track at the end of its first five-year contract period. Below is a summary of the Levels and related risk.

BASIC and ENHANCED Track Comparison

Year/Level	**BASIC TRACK**					**ENHANCED TRACK**
	Y1= Level A	**Y2= Level B**	**Y3= Level C**	**Y4=Level D**	**Y5= Level E**	
Max Sharing Rate	40%	40%	50%	50%	50%	Up to 75%
Cap on Gains	10% of Benchmark	10% of Benchmark %	10% of Benchmark	10% of Benchmark	10% of Benchmark	20% of Benchmark
Max Loss Rate	N/A	N/A	30%	30%	30%	1 minus the final sharing rate, not less than 40% and maximum of 75%
Cap on Losses	N/A	N/A	Not to exceed 2% of ACO Participant revenue or 1% of benchmark.	Not to exceed 4% of ACO Participant revenue or 2% of benchmark.	Not to exceed 8% of ACO Participant revenue or 4% of benchmark (2019 – 2020).	Not to exceed 15% of benchmark
Quality Payment Program	MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM (AAPM)	Advanced APM (AAPM)

New "low revenue" ACOs that start on 7/1/19 may participate in upside only Levels for the first two and a half years of the program. New ACOs that wait to start until 1/1/20 will have only two risk free years (Levels A–B).

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4. ***Low Revenue and Inexperienced ACOs***: The final rule provides additional flexibility and greatly improved terms to "Low Revenue" and "Inexperienced" ACOs compared to the Proposed Rule. CMS defines a "Low Revenue" ACO as an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available, is less than 35% of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries. An inexperienced ACO is one that is a new ACO entity and has less than 50% of the ACO participants that have participated in the same performance-based risk Medicare ACO initiative in each of the five most recent performance years prior to the start date.

   The final rule affords ACOs that meet the low revenue criteria two five-year contract periods in the BASIC Model. The first contract term would progress through risk Levels A–E. The second contract period would occur under Level E (similar to the current MSSP Track 1+).

   CMS finalized the rule with a change permitting inexperienced, low revenue ACOs to stay in a one-sided model of the BASIC track's glide path for an additional performance year. Under this approach, eligible ACOs will have the opportunity to participate for up to three performance years (or three and a half performance years in the case of ACOs entering an agreement period beginning on July 1, 2019) in a one-sided model of the BASIC track's glide path before automatically advancing to Level E of the BASIC track for the remaining performance years of their agreement period (this allows an ACO to have the equivalent of three years as a Track 1 and then move to Track 1+ for the final two years). CMS will make this option available to inexperienced, low-revenue ACOs during their second performance year enabling the ACO sufficient time in the program before making its decision.

5. ***Beneficiary Assignment Changes***: Participants have the choice of either prospective or retrospective assignment. If an ACO wishes to change assignment methodologies it will have the opportunity to make an annual election.

   Further, CMS is expanding the provider types that drive beneficiary attribution to include mid-levels as well as expanded E&M codes. Finally, CMS finalized requiring ACOs to notify beneficiaries, through a CMS designed poster, sign or through electronic notification, during their first or subsequent primary care visit of the year of their right to align with an ACO by identifying their primary care physician to encourage elective assignment and to decline claims sharing.

6. ***ACO Incentives/Enhancements***: As required by the Balanced Budget Act of 2018 and the 21st Century Cures Act, CMS finalized a number of participation incentives or enhancements including options that were only available to Next Gen or two-sided risk ACOs. These include:

   Telehealth Waiver: ACOs in two-sided risk models (BASIC Tracks C–E and ENHANCED Track) that select prospective assignment are eligible for a waiver of Medicare's originating site and geographic telehealth requirements. The waiver only covers services on Medicare's Telehealth list. Services provided in the home are not eligible for an originating site fee.

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SNF 3-Day Rule: ACOs in two-sided risk models (BASIC Tracks C–E and ENHANCED Track) are eligible for the SNF-3 Day waiver regardless of which attribution model that have selected.

Beneficiary Incentive Waiver: ACOs in two-sided risk models (BASIC Tracks C–E and ENHANCED Track) are eligible for a waiver to provide beneficiary incentives. The incentives may not exceed $20. The incentive payment must be for receiving a "qualifying primary care service" from an ACO professional who has a primary care specialty designation included in the definition of primary care physician and must be paid to the beneficiary by the ACO and not the provider. The beneficiary incentive cannot be funded by a health plan or a pharmaceutical company.

7. ***MSR/MLR***: Similar to the currently available MSSP models, upside only ACOs (BASIC Level A and B ACOs) are subject to a population based variable MSR. Risk-bearing ACOs (BASIC Level C-E and ENHANCED ACOs) may choose a symmetrical MSR/MLR. Prior to entering a risk track, an ACO will have the opportunity to select its risk track. However, once the ACO makes an election, the MSR/MLR is set for the remainder of the contract period.

8. ***Changes to MSSP Benchmarking***: CMS finalized factoring in changes in health status for the continuously assigned population and accelerate the use of regional factors in the benchmark. Below both changes are described in more detail.

   CMS finalized eliminating the distinction between newly and continuously assigned beneficiaries and allow an ACO's HCC risk score to increase annually for all beneficiary categories beneficiaries. The increase is capped at +3% upward increase over the five-year agreement and was finalized removing the downward risk adjustment cap. CMS reported that based on analysis of 239 ACOs that received demographic risk adjustment for their continuously assigned population under the current policy in PY 2016 (55% of the 432 ACOs reconciled), 86% would have received a larger positive adjustment to their benchmark had this policy been in place.

   Instead of waiting until the second contract period, CMS will incorporate regional adjustments to the benchmark in the first contract period. Similar to the current model used in subsequent contract periods, the percentage of the regional adjustment blended into the benchmark will depend on how efficient the ACO is relative to its region as detailed in the table below.

   CMS caped the regional adjustment amount using a flat dollar amount equal to 5% of national per capita expenditures for Parts A and B services under the original Medicare FFS program by enrollment type. Finally, CMS finalized the rule continuing to use the 10%, 30%, and 60% weight to the three benchmark years in the initial contract period.

ACO Relative to Market	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4 (and Thereafter)
More Efficient	35% of Regional Benchmark	50% of Regional Benchmark	50% of Regional Benchmark	50% of Regional Benchmark
Less Efficient	15% of Regional Benchmark	25% of Regional Benchmark	35% of Regional Benchmark	50% of Regional Benchmark

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9. ***MIPS/MACRA Impact***: For 7/1/19 starters participating in BASIC Levels A–D, participation will still count as a MIPS-APM. Participating in BASIC Level E and the ENANCED Model will qualify as an Advanced Alternative Payment Model (APM) for purposes of qualifying for the 5% Advanced APM participation bonus.

10. ***Preventing "Gaming" of the System***: In response to CMS's long-held belief that some ACOs were "gaming" the system by taking advantage of the waivers without engaging in material efforts to redesign care the final rule takes a number of steps to "protect the program." These include preventing ACOs that reform under new legal entities and new ACOs that contain 50% of its participants from the same ACO from starting over in the program in a low risk Track. The final rule also prevents ACOs from terminating and quickly reforming to game the benchmark by requiring the reformed ACO to enter into the program under a second contract period.

    CMS will hold ACOs in two-sided risk models accountable for prorated losses if the ACO terminates after June 30th during any performance year (an ACO in a one-sided, upside only risk model in the BASIC track can terminate at any time during the year without the risk of prorated loss). Finally, CMS outlined a number of scenarios where it will terminate an ACO if it does not meet quality or financial performance standards.

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