



ADVANCING EMERGENCY CARE 

## Summary of the Medicare Shared Savings Program (MSSP) Final Rule

### Overview

On December 21, 2018, the Centers for Medicare & Medicaid Services (CMS) released a [rule](#) finalizing changes to the Medicare Shared Savings Program (MSSP). CMS had issued a [proposed rule](#) in August 2018, which ACEP responded to with a set of comments. ACEP's response to the proposed rule is found [here](#).

The MSSP, established by the Affordable Care Act, is the nation's largest accountable care organization (ACO) program. There are currently 561 Medicare ACOs in the program, serving more than 10.5 million Medicare fee-for-service (FFS) beneficiaries. The MSSP has three Tracks: Track 1 only includes the opportunity for shared saving and Tracks 2 and 3 require ACOs to take on progressively more downside financial risk, with a greater opportunity for reward. The majority of ACOs are in Track 1 and the remaining ACOs are mostly in Track 3 (there are hardly any ACOs in Track 2). CMS believes that some of the Track 1 ACOs are generating losses to the Medicare program while at the same time encouraging consolidation in the market place, reducing competition and choice for Medicare beneficiaries. Track 2 and Track 3 ACOs however have shown savings to the Medicare program and are improving quality.

The 957-page final rule massively redesigns the program. A more detailed summary of the rule is found below, but the major changes to the program include:

- **Faster Transition to Financial Risk:** CMS is eliminating the three Tracks and replacing them with two Tracks: the BASIC and ENHANCED Tracks. Under this new construct, ACOs must transition to downside risk over a two to three-year period, a much quicker progression than current rules allow (currently ACOs can stay in Track 1 for up to six years).
- **Regional Benchmarks:** Under current program rules, CMS uses an ACO's historical spending to set its benchmark. The benchmark is the expenditure target set for each ACO that is used to determine whether or not an ACO generates any savings or losses for the Medicare program and is therefore eligible for shared savings or liable for shared losses. CMS will now blend in costs from an ACO's region when establishing the benchmark initially.
- **Assignment of Beneficiaries:** All ACOs will now be allowed to use "prospective" assignment to align beneficiaries, meaning that they will know which beneficiaries they are financially responsible for prior to the start of the year. Also, as required by the Balanced Budget Act (BBA) of 2019, ACOs will also be able to use "voluntary" alignment as a mechanism to assign beneficiaries. Voluntary alignment allows beneficiaries to pick their own ACO by choosing the physician that is their primary doctor responsible for coordinating their overall care.
- **Expanding the Use of Payment Waivers and Incentives:** CMS is increasing the number of ACOs that can apply for waivers to current Medicare payment rules that restrict the use of telehealth and skilled nursing facility (SNF) services. CMS is also implementing a Beneficiary Incentive Program that gives ACOs the option of providing an incentive payment of up to \$20 to a Medicare beneficiary for each primary care service that the beneficiary receives from an ACO provider.
- **Impact of Rule:** The CMS actuaries estimate that the changes included in the rule will save Medicare approximately \$2.9 billion over 10 years but will cause 36 ACOs to drop out of the program.

## **Detailed Summary of the Final Rule**

- **Transitioning to Downside Risk:** CMS is phasing out Tracks 1, 2, and 3 of the MSSP. Starting with agreement periods **beginning on July 1, 2019** and in subsequent years, ACOs will now have the option to enter into TWO tracks for contractual agreement periods of not less than **5 years** (currently agreement periods are three years):
  - BASIC Track: This Track will allow eligible ACOs to begin under a shared savings-only model and incrementally phase-in higher levels of risk that, at the highest level, will qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program.
  - ENHANCED Track: This Track is based on the program's existing Track 3, providing additional tools and flexibility for ACOs that take on a high level of risk and potential reward.
  
- **BASIC Track:** To phase in downside risk over time, the BASIC track will include five levels:
  - Level A: A shared savings-only model available only for the first two years to most ACOs (ACOs identified as having previously participated in the program under Track 1 will be restricted to a single year under a one-sided model. In addition, new, "low revenue" ACOs that are not identified as re-entering ACOs will be allowed up to three years under a shared savings-only model). ACOs can share up to 40% of the total Medicare savings based on quality performance. However, savings will be capped at 10 percent of the ACO's benchmark. The shared savings rate of 40% is an increase over the 25% shared savings rate that CMS had proposed in the proposed rule. Commenters had stated that a 25% shared savings rate was too low and would discourage participation.
  - Level B: Same as Level B above.
  - Level C: A downside financial risk model with a shared savings rate of up to 50% based on quality performance and a shared losses rate of 30%. To protect ACOs from large losses, total losses cannot exceed 2% of an ACO's revenue or 1% of an ACO's expenditure benchmark.
  - Level D: A downside financial risk model with a shared savings rate of up to 50% based on quality performance and a shared losses rate of 30%. Total losses cannot exceed 4% of an ACO's revenue or 2% of an ACO's expenditure benchmark.
  - Level E: A downside financial risk model with a shared savings rate of up to 50% based on quality performance and a shared losses rate of 30%. Total losses cannot exceed 8% of an ACO's revenue or 4% of an ACO's expenditure benchmark. These downside risk requirements align with the nominal financial risk standards so that this level of the program will count as an Advanced APM.
  
- **ENHANCED Track:** This Track is very similar to the current Track 3. It will include a shared savings rate of up to 75% based on quality performance, capped at 20% of the expenditure benchmark. The shared loss rate will be a minimum of 40% and a maximum of 75%, not to exceed 15% of the ACO's benchmark.
  
- **Eligibility and Transition to ENHANCED Track:**
  - ACOs in the BASIC track will automatically advance at the start of each performance year along the progression of risk/reward levels or could elect to move more quickly to a higher level of risk/reward over the course of their 5-year agreement period.
  - CMS creates different rules for physician-based ACOs that have "low revenue" versus larger ACOs that have "high revenue." A low revenue ACO is an ACO that has total Medicare Parts A and B Fee-for-Service (FFS) revenues that represent 35 percent or less of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries. In other words, to qualify as a low-revenue ACO, the total spending of an ACO will have to represent roughly a third or less of its beneficiaries' total expenditures.

- Low revenue ACOs determined to be inexperienced with risk-based Medicare ACO initiatives may enter an agreement period under the BASIC track’s glide path. Low revenue ACOs that have experience with risk are restricted to participating in either the BASIC track’s highest level of risk and reward or the ENHANCED track.
- High revenue ACOs that are inexperienced with risk will be limited to no more than a single agreement period under the BASIC track. High revenue ACOs that do have experience with risk will be restricted to participating in the ENHANCED track.
- **Regional Benchmarks and Risk Adjustment**
  - Under the current benchmarking methodology, CMS includes regional costs in addition to the historical costs of the ACO when re-basing the expenditure benchmark after the conclusion of the ACO’s 3-year agreement period. When the benchmark is originally established, CMS only uses historical costs to set the benchmark.
  - CMS will now blend in regional costs into the benchmark starting in the first agreement period. CMS will slowly phase in the regional adjustment over time, from 15 percent to a maximum of 50 percent.
  - CMS will replace the current methodology for annually risk adjusting the benchmark with an approach that will allow for modest risk score growth of up to 3 percent over the length of the agreement period.
- **Assignment of Beneficiaries**
  - Currently in Tracks 1 and 2, Medicare beneficiaries are preliminarily prospectively assigned to ACOs with a retroactive adjustment at the end of the year. Thus, while ACOs have a sense of who is in their ACO throughout the year, they do not receive a final list until the end of the year. In Track 3, beneficiaries are prospectively assigned to the ACOs. Many ACOs prefer prospective assignment over preliminary prospective assignment with retrospective reconciliation. Therefore, CMS will allow BASIC track and ENHANCED track ACOs to have the flexibility to elect prospective assignment or preliminary prospective assignment with retrospective reconciliation prior to the start of each agreement period, and to change that selection for each subsequent performance year.
  - As required by the Balanced Budget Act (BBA) of 2019, ACOs will also be able to use “voluntary” alignment as a mechanism to assign beneficiaries. Voluntary alignment allows beneficiaries to pick their own ACO by choosing the physician that is their primary doctor responsible for coordinating their overall care. Beneficiaries can designate a physician regardless of specialty or a nurse practitioner, physician assistant, or clinical nurse specialist as their primary clinician. CMS is requiring that each ACO provide a standardized notice to each of its Medicare FFS beneficiaries that informs them of their ability to identify or change identification of a primary care provider for purposes of voluntary alignment.
- **Expand the Use of the Telehealth Waiver:** CMS is implementing requirements imposed by the BBA of 2018 related to telehealth services. For all ACOs that have downside risk and choose prospective assignment, CMS will waive the originating site requirement and pay for telehealth services regardless of where the beneficiary is located (i.e. even if the beneficiary is at home.)
- **Expand Skilled Nursing Facility (SNF) 3-day Rule Waiver Eligibility:** Under the previous program rules, only ACOs that used prospective assignment were allowed to apply for a waiver to the SNF 3-day rule. The SNF 3-day rule requires a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital, extended SNF care service. CMS will now allow ACOs that take on downside risk to use the existing SNF 3-day waiver regardless of their choice of prospective assignment or preliminary prospective assignment with retrospective reconciliation. CMS will also allow critical access hospitals

and other small, rural hospitals operating under a swing bed agreement to be eligible to partner with eligible ACOs as SNF affiliates for purposes of the SNF 3-day rule waiver.

- **Beneficiary Incentive Programs:** The BBA of 2018 created a Beneficiary Incentive Program to encourage patient engagement. Under this program, ACOs that take on downside risk will have the option of providing an incentive payment of up to \$20 to a Medicare beneficiary for each primary care service that the beneficiary receives from a primary care physician, physician assistant, nurse practitioner, or clinical nurse specialist in the ACO or from a Federally Qualified Health Center or Rural Health Clinic.
- **Program Integrity:** CMS is finalizing a number of policies that will strengthen the integrity of the program, including: using past participation in ACO initiatives to determine an ACO's participation options; terminating ACOs that have multiple years of poor financial performance from the program; and holding terminated ACOs in downside-risk models accountable for pro-rated shared losses.
- **Impact Analysis**
  - The CMS actuaries project that the impact of the final program changes will be approximately \$2.9 billion in lower federal spending over 10 years (from 2019 through 2028.) This is comprised of about -\$950 million in lower Medicare spending, \$2.43 billion in reduced shared savings payments, and approximately \$490 million in additional incentive payments made under the Quality Payment Program to additional ACOs expected to become Qualifying APM Participants (Qualifying APM Participants receive a 5% payment bonus for participating in Advanced APMs).
  - The actuaries also estimate that 36 ACOs will drop out of the program because they will be forced to take on downside-risk. However, because of the policy modifications CMS made in the final rule (such as increasing the minimum shared savings rate to 40%), this estimate has significantly decreased from the 109 ACOs that the actuaries projected would drop out of the program in the proposed rule.