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Lead

Medicare Shared Savings Program "Pathways to Success" Final Rule

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Association of
American Medical Colleges

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Agenda

- Redesigning Participation Options to Facilitate Performance-Based Risk
  - Two Tracks: BASIC and ENHANCED
  - Options Based on FFS Revenue & Prior Participation
  - Annual Elections
  - Requirements for Participation in Two-Sided Risk
  - Payment Consequences of Termination
- Benchmarking Methodology Refinements
  - Annual Risk Adjustment
  - Regional Adjustment Blends & Growth Factor
- Benefit Enhancements & Tools to Strengthen Beneficiary Engagement
  - SNF 3-Day Rule Waiver & Telehealth Services
  - Incentive Payment Programs & Notifications

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Key Highlights of the Rule

- Five year agreement periods
- BASIC and ENHANCED Tracks replace Tracks 1, 1+, 2, and 3
- Reduces amount of time an ACO may participate without taking on downside risk (generally 1-2 years, with a limited exception)
- Differentiates between ACOs on basis of revenue and prior experience in terms of options for participation
- Accelerates use of regional adjustments to historical benchmarks & reduces maximum weight of regional adjustment
- Caps positive risk adjustment to benchmark for growth in risk scores to 3%, but *no cap* on negative adjustment for decrease in risk scores
- Greater flexibility to use telehealth and the SNF 3-Day Rule Waiver for ACOs in downside risk; flexibility to create a beneficiary incentive program (BIP)

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Rulemaking Process

The “Pathways to Success” Proposed Rule was published in the *Federal Register* on August 17, 2018 (83 Fed. Reg. 41786)

Finalized policies split between **CY19 Physician Fee Schedule Final Rule** and **“Pathways” Final Rule**, which were published in the *Federal Register* on November 23, 2018 (83 Fed. Reg. 59940) and December 31, 2018 (83 Fed. Reg. 67816) respectively

Finalized policies will take effect in 2019, unless otherwise noted.

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Redesigning Participation Options

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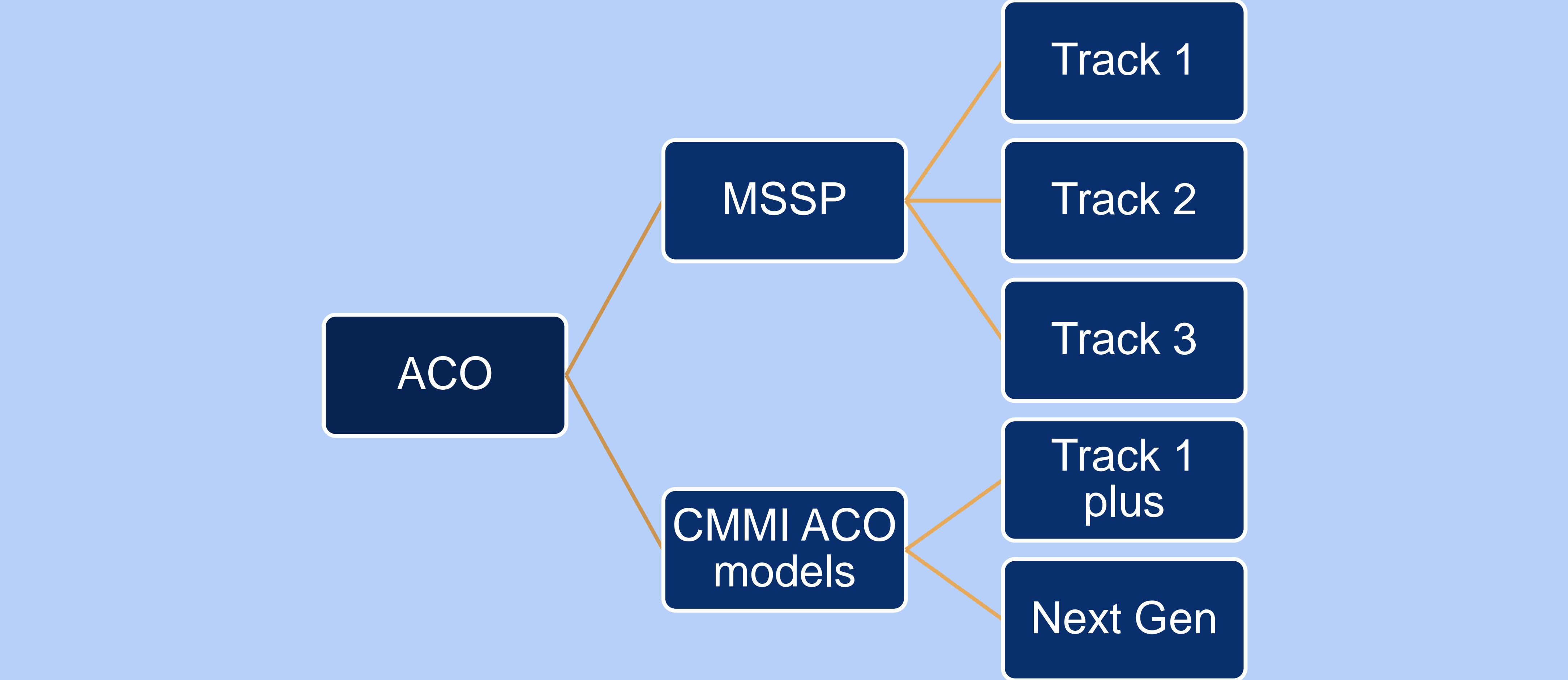
Past ACO Participation Options



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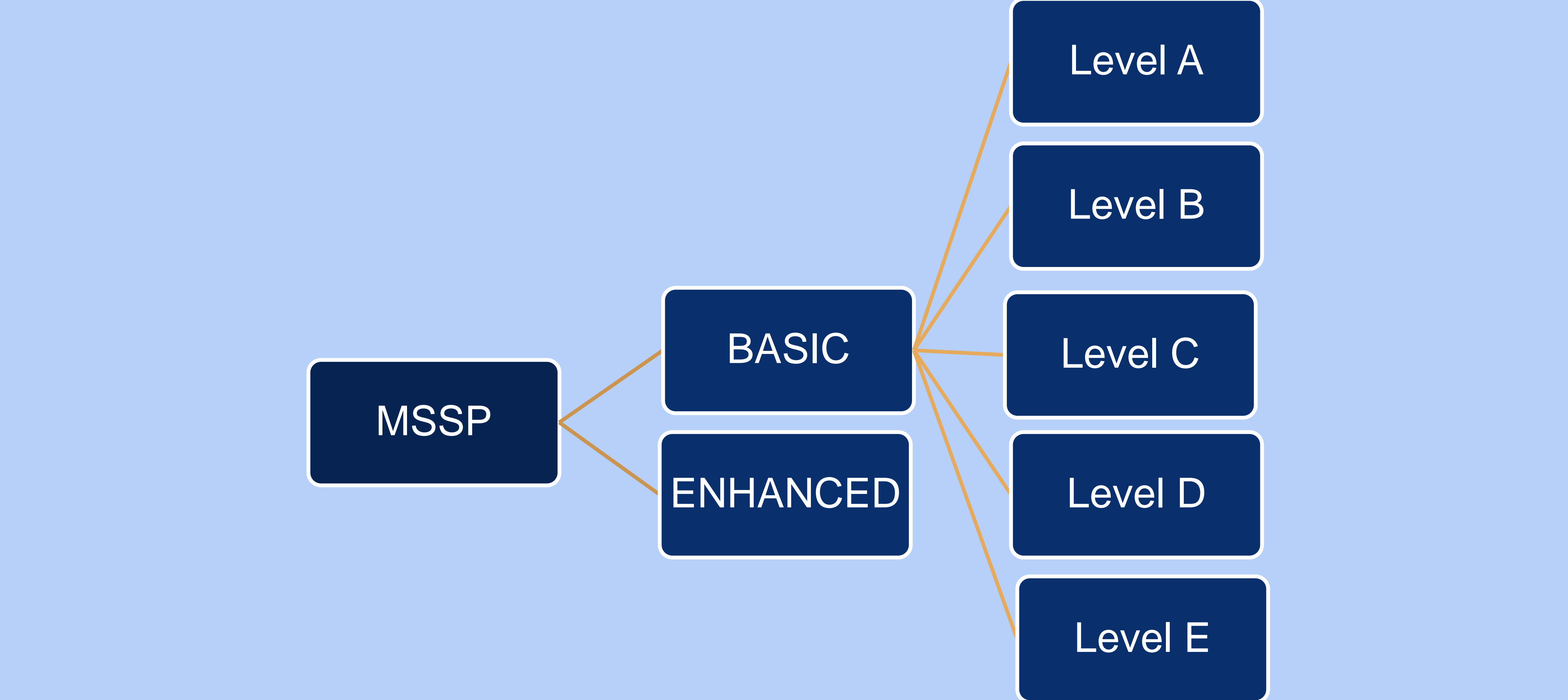
Pathways to Success Options (5 year terms)



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Two Tracks: Risk

	BASIC (Glide Path to Taking on Downside Risk)				ENHANCED
Basic Levels	A and B	C	D	E	
Shared Savings (once MSR met or exceeded)	1st dollar savings at a rate of up to 40% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change to Track 3. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (once MLR met or exceeded)	n/a	1st dollar losses at a rate of up to 30%, not to exceed 2% of ACO Participant revenue capped at 1% updated benchmark	1st dollar losses at a rate of up to 30%, not to exceed 4% of ACO Participant revenue capped at 2% updated benchmark	1st dollar losses at a rate of up to 30%, not to exceed percentage of revenue specified in the revenue-based nominal amount standard under QPP (for example, for 2019-20 it's 8% of ACO Participant revenue), capped at a percentage of updated benchmark that is 1 percentage point high than the expenditure-based nominal amount standard (for example, for 2019-20 it's 4% of updated benchmark) – it's set by the QPP rulemaking	No change to Track 3. 1st dollar losses at a rate of inverse of final sharing rate but no lower than 40% (between 40%-75%), not to exceed 15% of benchmark.
Qualify as an AAPM (note – still must meet QP thresholds to receive bonus)	No	No	No	Yes	Yes

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Example of Loss Sharing Limit Under BASIC Level E
(2019, 2020)

ACO's Total Updated Benchmark Expenditures:

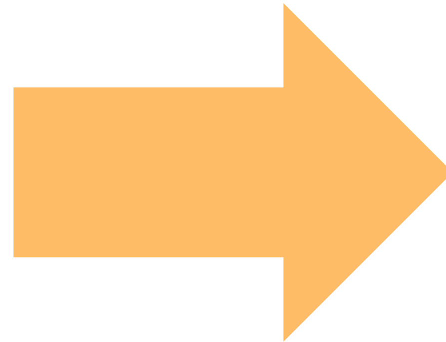
$93,411,313

ACO's Participant's Total Parts A and B FFS Revenue:

$13,630,983

4 percent of Benchmark:

$3,736,453



8 percent of Revenue:

$1,090,479

An ACO's Loss Sharing Limit will be revenue-based, *unless* that figure exceeds the benchmark-based limit.

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Participation Options

An ACO applying for a July 1, 2019 start (or a future January 1, 2020 start) will be assessed on the following:

- Low FFS Revenue vs. High FFS Revenue; and
- Inexperienced vs. Experienced (with performance-based risk); and
- New ACO vs. Re-Entering ACO vs. Renewing ACO

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Participation Options: Revenue Standard

Compares the following figures from the most recent CY for which 12 months of data are available:

Total Medicare Parts A and B FFS revenue* of the ACO's Participants (TINs)

to

Total Medicare Parts A and B FFS expenditures of ACO's assigned beneficiaries

- **High Revenue**: FFS revenue is at least 35% of expenditures
- **Low Revenue**: FFS is less than 35% of expenditures

*Calculation of FFS revenue differs from calculations for benchmarking:

- INCLUDES hospital add-on payments (IME, DSH, uncompensated care payments); and
- NOT TRUNCATED at 99th percentile of national Medicare FFS expenditures

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Participation Options: Experience Standard

An ACO is Experienced with Performance-Based Risk if either:

1. ACO is same legal entity as current or previous ACO that is participating in, or has participated in a performance based risk Medicare ACO initiative; OR
2. 40 percent or more of the ACO's Participants participated in a performance-based risk Medicare ACO initiative in any of the 5 most recent performance years prior to the agreement start.

Track 1+

Track 2

Track 3

Next Gen Model

CEC (ESRD) Model

BASIC

ENHANCED

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Participation Options: Entity Standard

Renewing ACO: ACO that continues its participation in the program for a consecutive agreement period (without a break in participation). This includes ACOs that terminated current agreements and immediately enter a new agreement to continue participation in the program.

Re-Entering ACO: Either the same legal entity as an ACO (ACO-level TIN) that previously participated in the program and is applying to participate after a break in participation OR a new legal entity applying to participate in the program where more than 50% of its ACO Participants previously participated in the program in the same ACO in any of the 5 most recent performance years prior to the agreement start date.

New ACO: An ACO who has never participated in the program and does not meet the definition of a re-entering ACO based on prior participation by its ACO Participants.

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Low Revenue ACO Participation Options

Entity Type	Experience	Participation Options
New ACO	Inexperienced	BASIC Levels A-E or ENHANCED*
New ACO	Experienced	BASIC Level E or ENHANCED
Re-Entering ACO	Inexperienced	BASIC Levels B-E or ENHANCED
Re-Entering ACO	Experienced	BASIC Level E or ENHANCED
Renewing ACO	Inexperienced	BASIC Levels B-E or ENHANCED
Renewing ACO	Experienced	BASIC Level E or ENHANCED

*Exception for inexperienced, new, low revenue ACOs – can elect to enter BASIC Level A and remain in Level B for a third PY if the ACO agrees to jump to Level E for the remainder of the agreement period.

5 year agreement period would look like: A – B – B – E – E (instead of A – B – C – D – E)

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High Revenue ACO Participation Options

Entity Type	Experience	Participation Options
New ACO	Inexperienced	BASIC Levels A-E or ENHANCED*
New ACO	Experienced	ENHANCED
Re-Entering ACO	Inexperienced	BASIC Levels B-E or ENHANCED
Re-Entering ACO	Experienced	ENHANCED
Renewing ACO	Inexperienced	BASIC Levels B-E or ENHANCED
Renewing ACO	Experienced	ENHANCED*

*ONE-TIME Exception for experienced, renewing, high revenue ACOs – if currently in Track 1+, ACO can elect to terminate current agreement and renew for a 5-year agreement under BASIC Level E (essentially 5 years at the same level of risk as Track 1+)

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Permitting Annual Elections

- Beneficiary Assignment (regardless of Track):
  - Preliminary prospective assignment with retrospective reconciliation, or
  - Prospective assignment
- If in BASIC Track Glide Path – can elect to skip next Level of risk for higher Level risk in path:
  - Normal Glide Path: A – B – C – D – E
  - Example of Accelerated Risk: A – B – D – E - E
  - *Cannot* elect to go back a Level

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Requirements under Two-Sided Risk

- Selection of Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)
  - BASIC A-B: Variable MSR (no MLR) based on # of beneficiaries
  - BASIC C-E: ACO must select MSR/MLR before start of PY in two-sided risk (selection will last remainder of agreement period)
    - 0 percent MSR/MLR (i.e., 1st dollar savings/losses)
    - Symmetrical MSR/MLR in 0.5 percent increments between 0.5 and 2.0 percent
    - Symmetrical MSR/MLR varied upon # of assigned beneficiaries
  - ENHANCED: ACO must select MSR/MLR before start of agreement; same choices as under BASIC C-E.

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Variable MSR/MLR by # of Assigned Beneficiaries

# of Beneficiaries	MSR (low end of assigned beneficiaries)	MSR (high end of assigned beneficiaries)
1-499	≥ 12.2%	
500-999	12.2%	8.7%
1,000-2,999	8.7%	5.0%
3,000-4,999	5.0%	3.9%
5,000-5,999	3.9%	3.6%
6,000-6,999	3.6%	3.4%
7,000-7,999	3.4%	3.2%
8,000-8,999	3.2%	3.1%
9,000-9,999	3.1%	3.0%
10,000-14,999	3.0%	2.7%
15,000-19,999	2.7%	2.5%
20,000-49,999	2.5%	2.2%
50,000-59,000	2.2%	2.0%
60,000+	2.0%	2.0%

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Requirements Under Two-Sided Risk

- Establishment of Repayment Mechanism
  - Amount must be equal to the lesser of:
    - 1 percent of expenditures for assigned beneficiaries, or
    - 2 percent of revenue for ACO Participants
  - Trigger for new required repayment mechanism is the lesser of 50% or $1,000,000
  - 12 months tail period past the end of the agreement

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Payment Consequences of Termination

- Minimum advance notice of termination: 30 days
- June 30th is the last effective date of termination to withdraw without financial risk in a two-sided arrangement
- ACOs that voluntarily terminate effective July 1st or later will be liable for pro-rated shared losses
  - Ex. An ACO that terminates any time in July will be liable for 7/12 of any shared losses demand
- If ACO is *involuntarily* terminated by CMS, it will be liable for pro-rated shared losses regardless of timing of termination

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Benchmarking Methodology Refinements

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Benchmarking Methodology (Factors)

- Attribution
- Historical/Regional Costs
- Risk Adjustment
- Update Factors (Trends)

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What’s Staying the Same?

- Use of 3 historical benchmark years (BYs)
- Initial agreement weighting of BYs:
  - BY1 – 10%
  - BY2 – 30%
  - BY3 – 60%
- Second (and any subsequent agreements) will weight BYs equally (33.3%)
- Uncapped risk adjustment during initial establishment of historical benchmark and resetting the historical benchmark between agreement periods.
- Uncapped risk adjustment of the regional adjustment and regional update factor relative to the county-level assignable population.

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What's Changing?

- Benchmarks will be rebased every 5 years, instead of every 3 years
- Annual risk adjustment to the benchmark
- Phase-in and amount of regional adjustment to the benchmark
- Regional update factor (growth rate)

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Annual Risk Adjustment

- Gets rid of policy distinguishing between newly assigned and continuously assigned beneficiaries
- Instead: will use full Hierarchical Condition Category (HCCs) for all assigned beneficiaries to risk adjust historical benchmark
  - Comparing risk of beneficiaries assigned to BY3 to risk of beneficiaries assigned to PY
- Uses renormalized risk scores based upon national assignable population
- Adjustment to benchmark capped at +3%
  - Applied separately by enrollment type: ESRD, disabled, aged/dual eligible, aged/non-dual eligible
- Negative adjustment NOT capped

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Expedited Phase-In of Regional Adjustment

Timing when subject to regional adjustment	If ACO's historical spending is lower than its region	If ACO's historical spending is higher than its region
1st agreement period	35% Regional/ 65% Historical	15% Regional/ 85% Historical
2nd agreement period	50% Regional/ 50% Historical	25% Regional/ 75% Historical
3rd agreement period	50% Regional/ 50% Historical	35% Regional/ 65% Historical
4th agreement period and beyond	50% Regional/ 50% Historical	50% Regional/ 50% Historical

Flat dollar cap to regional adjustment equal to 5 percent of national per capita expenditures in BY3 (calculated and applied by enrollment type)

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Example of Cap on Regional Adjustment

Enrollment Type	Uncapped Adjustment	National Assignable FFS Expenditure	5 percent of National Assignable FFS Expenditure	ACO’s Final Adjustment
ESRD	$4,214	$81,384	$4,069	**$4,069**
Disabled	-$600	$11,128	$556	**-$556**
Aged/Dual-eligible	$788	$16,571	$829	$788
Aged/non-dual	-$367	$9,942	$497	-$367

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Example of the Phase-In of Regional Adjustment Weights

Applicant Type	1st Regional Adjustment (35% or 15% weight)	2nd Regional Adjustment (50% or 25% weight)	3rd Regional Adjustment (50% or 35% weight)	4th & Subsequent Regional Adjustment (50% weight)
New ACO with start date 7/1/2019	Applicable to 1st agreement 7/1/2019	Applicable to 2nd agreement starting in 2025	Applicable to 3rd agreement starting in 2030	Applicable to 4th agreement starting in 2035
Renewing ACO with agreement starting 7/1/2019, with initial start in 2012/2013, or 2016	Applicable to 3rd agreement or 2nd agreement starting 7/1/2019	Applicable to 4th agreement or 3rd agreement starting 2025	Applicable to 5th agreement or 4th agreement starting 2030	Applicable to 6th agreement or 5th agreement starting 2035
Early Renewal for agreement starting 7/1/2019, ACO with initial start date in 2014 that terminates 6/30/2019	Currently applies to 2nd agreement period starting 2017 *(either 35% or 25% under 2016 rule)*	Applicable to 3rd agreement period starting 7/1/2019	Applicable to 4th agreement starting in 2025	Applicable to 5th agreement starting in 2030
Re-Entering ACO with initial start in 2014 (completed) and re-entering 2nd agreement 7/1/2019	Applicable to 2nd agreement starting 7/1/2019	Applicable to 3rd agreement period starting in 2025	Applicable to 4th agreement starting in 2030	Applicable to 5th agreement starting in 2035
Re-Entering ACO with 2nd agreement start in 2017 and re-enters 2nd agreement 7/1/2019	Applicable to 2nd agreement starting 7/1/2019	Applicable to 3rd agreement period starting in 2025	Applicable to 4th agreement starting in 2030	Applicable to 5th agreement starting in 2035

Modifying the National/Regional Growth Rate

- Growth rates used to trend forward BY1 and BY2 to BY3 when establishing/resetting an ACO’s historical benchmark
- National-regional blended growth rate:
  - Weighted average of national FFS and regional trend factors
  - Weight assigned to the national component represents the share of assignable beneficiaries in the ACO’s regional service area that are assigned to the ACO
  - Weight to the regional component will be 1 minus the national weight
  - As ACO’s market penetration in a region increases, a higher weight will be placed on the national component

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Illustrative Example of Blended Trend Factor

ACO:
11,000 assigned Aged/Non-dual beneficiaries across two counties

County A:
10,000 assignable Aged/Non-dual beneficiaries; 9,000 assigned to ACO

County B:
12,000 assignable Aged/Non-dual beneficiaries; 2,000 assigned to ACO

National component of blended trend factor=

[(Assigned Beneficiaries in County A/Assignable Beneficiaries in County A) x (Assigned Beneficiaries in County A/Total Assigned Beneficiaries)] + [(Assigned Beneficiaries in County B/Assignable Beneficiaries in County B) x (Assigned Beneficiaries in County B/Total Assigned Beneficiaries)] , or

[(9,000/10,000) x (9,000/11,000)] + [(2,000/12,000) x (2,000/11,000)] = 0.767 or 76.7 percent

Regional component of blended trend factor=

(1 – National Component), or

1-0.767= 0.233 or 23.3 percent

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Benefit Enhancements & Tools to Strengthen Beneficiary Engagement

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FFS Benefit Enhancements

	BASIC A, B, Track 1 (One-Sided)	**BASIC C, D, E, or ENHANCED** (Two-Sided)
3-Day SNF Rule Waiver Waives requirement for a 3-day inpatient stay prior to admission to a SNF affiliate for assigned ACO beneficiaries	N/A	Eligible for PY beginning July 1, 2019 [must apply!]; either prospective assignment or preliminary prospective assignment of beneficiaries
Billing & Payment for Telehealth Removes geographic limitations and allows the beneficiary's home to serve as an originating site for certain telehealth services for *prospectively* assigned ACO beneficiaries	N/A	Eligible for PY2020 and onward so long as ACO elects prospective assignment of beneficiaries

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SNF 3-Day Rule Waiver Details

- Waiver applicable only for beneficiaries identified as preliminarily prospectively assigned or prospectively assigned to the ACO during a PY in which the beneficiary appears on the ACO's lists
- Beneficiary remains eligible for remainder of PY, unless no longer enrolled in both Part A and B services or has enrolled in MA
- SNF affiliates must have an overall rating of 3 stars or greater (not applicable to SNF swing bed operators, CAHs or small rural hospitals, which are not included in the rating system for SNFs)
- An ACO physician must evaluate and approve each beneficiary for SNF admission within 3 days prior to the admission

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Telehealth Billing Rule Waiver Details

- Waiver applicable only for beneficiaries identified *prospectively* assigned to the ACO during a PY in which the beneficiary appears on the ACO's lists
- 90 day grace period for prospectively assigned beneficiary if subsequently removed from assignment during PY
- Protection from beneficiary liability if telehealth services are furnished to a beneficiary not prospectively assigned to the ACO and the associated claims are denied. No originating site facility fee paid if services originate from beneficiary's home
- Beneficiary's home cannot be used as originating site for services designated as in-patient only (e.g., HCPCS codes G0406-G0408 and G0425-G0427)

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Beneficiary Incentive Payment Programs

- ACOs may apply to create a PY program that pays incentives for assigned beneficiaries to receive qualifying services
  - Payment maximum: up to $20 per service (must be identical amount for all beneficiaries/services included under incentive program)
  - Payment type: traceable cash equivalents (e.g., prepaid debit cards, checks, etc.)
  - Payment timing: must be made within 30 days of service delivery
  - Payment Distribution: only by ACO legal entity
- Qualifying Service:
  - A primary care service to which coinsurance applies under Part B; and
  - A service furnished through an ACO by an ACO professional with a primary care designation; or an ACO professional who is a PA, NP, or certified nurse specialist; or an FQHC or RHC.

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Beneficiary Incentive Payment Programs (cont'd)

- ACOs must fully fund the incentive programs (cannot accept or utilize funds from an outside entity)
- Prohibition on advertising/marketing beneficiary incentive programs *BUT* **mandatory beneficiary notification** about programs
- Public Reporting Requirements:
  - # of beneficiaries who received an incentive payment;
  - # of incentive payment furnished;
  - HCPCS codes associated with any qualifying payment;
  - Total value of all incentive payments furnished; and
  - Total of each type of incentive payment furnished (e.g., check or debit card)

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Beneficiary Incentive Payment Programs (cont'd)

- Incentive payments will not be included in calculation of:
  - ACO benchmarks,
  - Estimated average per capita Medicare expenditures, and
  - Shared savings and losses.
- Incentive payments to beneficiaries exempt for purposes of income tax laws or laws governing qualification for Federal or State assistance programs
- Reminder! In-kind items or services provided by an ACO to a beneficiary **must not** include Medicare-covered items or services

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Beneficiary Information Notice Requirements

- General and Incentive Program Notifications
  - Forthcoming: separate guidance for each type of notification and templates for each
  - ACOs cannot develop own templates
- Notices may be provided by ACOs or by their participants
- May be provided at the first primary care service visit of a PY or at some point earlier in the PY
- May be disseminated electronically or mailed hard copy
- Notifications **in addition to** requirements to display posters and provide standardized written notifications upon request!

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Deadlines for July 1, 2019 Start Date

Notice of Intent to Apply (non-binding) due

Jan. 18, 2019

Application (non-binding) Submission Period

Jan. 22 - Feb. 19, 2019

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Questions?

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