Deep Dive: 2019 MSSP Final Rule
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America’s Physician Groups (APG)

• Purpose of our Organization

• **Resources**
  – Advocacy
    • Representation on Capitol Hill
    • Washington Weekly Update
    • Federal comment letters
  – Education
    • Standards of Excellence
    • Risk Evolution Task Force
    • Regional meetings

**Mission Statement**
The mission of America’s Physician Groups is to assist accountable physician groups to improve the quality and value of healthcare provided to patients. America’s Physician Groups represents and supports physician groups that assume responsibility for clinically integrated, comprehensive, and coordinated healthcare on behalf of our patients. *Simply, we are taking responsibility for America’s health.*

**Strategic Vision**
America’s Physician Groups and its member groups will continue to drive the evolution and transformation of healthcare delivery throughout the nation.
CMS Observations

ACOs with two sided risk lead to greater savings to trust fund and improved quality

Low Revenue ACOs generally outperform high Revenue ACOs

Participation in down sided risk contracts remain modest

Low Revenue ACOs need assistance with a pathway to transition to risk based contracts

[Logos and graphics related to CMS and physician groups]
Pathways to Success Goals

- Increase Savings for Trust Fund
- Mitigate Losses
- Reduce Gaming
- Promote Regulatory flexibility and free market principles
Goal of CMS

“We believe all ACOs should transition to the level of risk and reward under the Enhanced Track.”
Major Changes in Final Rule

- Higher Sharing Rates in the Basic Track
- Increased threshold percentage for definition of low/high revenue ACOs
- More flexibility for low revenue ACOs and Track 1 plus
- Repayment mechanism has been lessened
**Former ACO Options**

- **ACO**
  - MSSP
    - Track 1*
    - Track 2
    - Track 3
    - Track 1 plus**
    - Next Gen**

- **CMMI ACO Models**

- **MSSP Contract terms are 3 years**
  - No downside risk, can renew for total of 6 years
  - **Sunsets in 2020**

**Pathways to Success Options**

- **MSSP**
  - Basic
  - Enhanced
    - **Level A**
    - **Level B**
    - **Level C**
    - **Level D**
    - **Level E**

- **Contract terms are 5 years except for the July 1, 2019 start dates**
MSSP Participation Definitions

New/Reentering/Renewing ACOs

If greater than 50% of same participants in past 5 performance years, ACO will viewed as re-entering versus new

Will assess past quality and financial performance in order to renew or reenter.

Will be monitoring for negative financial performance outside MSL corridor for possible termination

Will be held to partial year end losses if exit early

Low/High Revenue ACOs

Total FFS revenue of ACO is at or greater than 35% Part A and B assigned beneficiaries for High Revenue

Low revenue (MD only or rural hospitals) can stay in basic for 2 agreement (non sequential) periods while high revenue (hospital partners) has to quickly move to enhanced after a single period (5 years)

Experienced/Inexperienced ACOs

Experienced is greater than 40% participants had prior participation under two-sided risk (participated in Track 2,3, Next Gen, Pioneer, or 1 plus)

Use 5 year lookback timeframe.
*Depends on agreement period status. Details are on Table 7 and 8 of Final Rule.
Track 1 Plus Options

Existing Track 1+ Model ACOs can complete the remainder of their current agreement period in the Track 1 plus model.

High Revenue Track 1 Plus ACOs with a first or second agreement period starting in 2016 or 2017 can terminate their current participation agreements and apply to enter a new Shared Savings Program agreement period under the BASIC track (Level E).

Low Revenue Track 1 Plus ACO can terminate their agreement and apply to Level E.
Low Revenue ACOs Options

They may elect an additional year in no downside risk if they agree to move to Level E in 4th year.
## Risk Comparison

<table>
<thead>
<tr>
<th></th>
<th>Basic</th>
<th>Enhanced track</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level A and B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Saving* based upon quality</td>
<td>up to 40%, not to exceed 10% of benchmark</td>
<td>up to 50%, not to exceed 10% of benchmark</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>up to 50%, not to exceed 10% of benchmark</td>
</tr>
<tr>
<td>Shared Losses*</td>
<td>N/A</td>
<td>30%, capped at 1% of benchmark**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30%, capped at 2% of benchmark</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30%, capped at 4% of benchmark</td>
</tr>
</tbody>
</table>

*Once MSR/MLR is met

| **Level C**               |       |                |
| Shared Saving* based upon quality | up to 50%, not to exceed 10% of benchmark |
|                         |       | up to 50%, not to exceed 10% of benchmark |
| Shared Losses*         | N/A   | 30%, capped at 1% of benchmark** |

**| $10,000 benchmark for 7800 beneficiaries is $780,000 total max risk at Level C

| **Level D**               |       |                |
|                         |       | up to 50%, not to exceed 10% of benchmark |
|                         |       | up to 50%, not to exceed 10% of benchmark |
|                         |       | up to 50%, not to exceed 10% of benchmark |

| **Level E**               |       |                |
|                         |       | up to 50%, not to exceed 10% of benchmark |
|                         |       | up to 50%, not to exceed 10% of benchmark |
|                         |       | up to 50%, not to exceed 10% of benchmark |
|                         |       | up to 75%, not to exceed 20% of benchmark |

Each year, the ACO is advanced up one level with ability to skip levels as requested. The Contract term is for 5 years so, if they start at Level B then they will spend the last 2 years at Level E. Low Revenue can stay in 2 non sequential contract terms which means they can return to basic for their 2 contract if enhanced track is too much of a risk.
## Other Key Differences

<table>
<thead>
<tr>
<th></th>
<th>Level A &amp;B</th>
<th>Level C</th>
<th>Level D</th>
<th>Level E</th>
<th>Enhanced</th>
</tr>
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<tbody>
<tr>
<td>MACRA</td>
<td>MIPS APM</td>
<td>MIPS APM</td>
<td>MIPS APM</td>
<td>Advanced APM</td>
<td>Advanced APM</td>
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<tr>
<td>Beneficiary Incentive</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>yes</td>
</tr>
<tr>
<td>Telehealth</td>
<td>No</td>
<td>Yes if Prospective</td>
<td>Yes if Prospective</td>
<td>Yes if Prospective</td>
<td>Yes if prospective</td>
</tr>
<tr>
<td>3 Day SNF</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
New Benchmarking Methodology

- Annual Attribution Selection
- Regional
- Risk Adjustment
- Trend factors
Attribution Options

Claims

Annual selection option
• Preliminary prospective with retrospective reconciliation
• Prospective

Non Claims

Voluntary PCP selection by beneficiary
# Regional Adjustments

<table>
<thead>
<tr>
<th></th>
<th>1st Agreement Period</th>
<th>2nd Agreement Period</th>
<th>3rd Agreement Period</th>
<th>4th Agreement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regionally Efficient</td>
<td>35% Regional/65% Historical</td>
<td>50% Regional/50% Historical</td>
<td>50% Regional/50% Historical</td>
<td>50% Regional/50% Historical</td>
</tr>
<tr>
<td>Regionally Inefficient</td>
<td>15% Regional/85% Historical</td>
<td>25% Regional/75% Historical</td>
<td>35% Regional/65% Historical</td>
<td>50% Regional/50% Historical</td>
</tr>
</tbody>
</table>

First Agreement Period Benchmark year weights: 10/30/60%
Second (and any subsequent) Agreement Benchmark Year weights: equally weighted
Risk Adjustment

Both Newly and Continuously Assigned beneficiaries of all 4 types (ESRD, Disabled, Duals, and Aged non Duals)

Asymmetrical cap - 3% upside cap but no cap on downside

Third Benchmark (BY3) year to Performance year (PY)
Trend Factors

- Blend of regional and national cost growth
- Weights are based upon percent of ACO in regional expenditures
- Majority of ACOs will have a heavier weight on regional
Repayment Mechanism

- 1% of expenditures or 2% of revenue. Can wait until entering performance year Level C and above
- 3 types (Not Reinsurance)
  - Escrow
  - Surety bond
  - Line of credit
- Length of time is agreement period plus 12 months
- CMS will recalculate repayment amount before each year and if change is greater than 50% or 1 million (whichever is lesser) then an increase in repayment must be submitted to CMS.
Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)

MSR for Level A and B will be based upon number of beneficiaries.

MSR/MLR will be selected at start of performance year in two sided risk (Level C, D, or E) or at application in Enhanced. Selection is binding and can’t be changed.

Options for MSR/MSL
- Fixed Zero percent
- Fixed Symmetrical MSR/MLR in .5 percent ranging from .5-2.0 percent
- Variable Symmetrical based upon number of assigned beneficiaries
Beneficiary Notification

Must be notified in writing by ACO or provider prior to or at first PCP visit

Template is being developed by CMS prior to July 1, 2019

Beneficiaries must be informed of incentive payment program prior to or at first PCP visit
Waivers

3 Day SNF for two sided risk Tracks (C-E and Enhanced)  
July 1, 2019

Telehealth for two-sided risk levels (C-E and Enhanced) with prospective assignment.  
Jan 1, 2020

Beneficiary Incentives:  
In-kind services like vouchers for transportation or Payment Program for up to 20 dollars per primary care service. Must be furnished by ACO and records maintained  
July 1, 2019
Application Deadlines

**July 1, 2019 start date** for both BASIC and ENHANCED. Their agreement will be 5 years and 6 months. Next Start Date will be Jan 1, 2020.

**Non-binding Notice of Intent must be completed by January 18, 2019**

**Application Deadline**

The application submission period for a July 1, 2019, start date will be open from January 22nd to February 19th

**3 Day SNF**

Application for C, D, E, ENHANCED, Track 3, or Track 1 Plus

**Beneficiary Incentive**

Waiver application for Levels C, D, E, ENHANCED, Track 2, or 3.
What Infrastructure/Competencies do you need to implement each of these?

- Assuming More Risk
- Benchmarking Changes from Historical to Regional
- Beneficiary Incentives
- Waivers (Telehealth and 3 Day SNF)
- Beneficiary Active Enrollment
5 Takeaways for Practices

1. Complete NOIA by January 18 and Application by February 19
2. Assess Infrastructure Needs
4. Model options including MACRA impact
5. Benchmark Cost Savings Opportunities using both FFS and MA data
Questions?

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Save the Date

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