MILLIMAN ISSUE BRIEF

“Pathways to Success” MSSP final rule: Key revisions to the proposed rule

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On December 31, 2018, the Centers for Medicare and Medicaid Services (CMS) published the final rule for the 2019 Medicare Shared Savings Program (MSSP).

This rule finalizes many of the “Pathways to Success” provisions detailed in the proposed rule published on August 8, 2018, with some modifications that may have a significant impact on a number of accountable care organizations (ACOs). At its core, the final rule creates a structured timetable for inexperienced ACOs to transition to downside risk, gradually increasing the maximum risk exposure as those ACOs gain more experience with the MSSP. This paper summarizes the key provisions of this final rule and highlights differences from CMS’s August proposal.

Key revisions to the proposed rule

While most of the final regulation is consistent with the proposed rule, certain key details were revised from the original proposal based on industry feedback and a refinement of CMS’s policy goals. The key changes to the proposed rule are listed in Figure 1.

FIGURE 1: KEY REVISIONS TO THE PROPOSED RULE

CHANGE	DESCRIPTION	IMPLICATIONS
Increase to shared savings rate under the BASIC track	Levels A and B maximum shared savings percentage increased from 25% to 40% while Levels C and D increased from 30% and 40%, respectively, to 50%.	This makes the BASIC track more enticing to ACOs and more in line with the current Track 1 maximum shared savings rate of 50%.
Less strict definition of low-revenue ACO	ACOs are considered “low revenue" if their historical Medicare Part A and B fee-for-service (FFS) revenues are less than 35% of the total historical expenditures for their assigned Medicare beneficiaries. Under the proposed rule, the low-revenue threshold was 25% of expenditures for the ACOs’ assigned Medicare beneficiaries.	This expands the definition of low-revenue ACOs to include entities with slightly higher revenue. In particular, CMS noted a desire to allow ACOs that include small hospitals or clinics, including small rural hospitals, to have access to the more gradual assumption of downside risk while retaining the quicker transition to risk for ACOs with large institutional providers who can have more impact on beneficiary spending.
Current Track 1+ ACOs can enter BASIC track, Level E	High-revenue ACOs currently participating in MSSP Track 1+ will be allowed an exception to renew for one agreement period in Level E of the BASIC track.	ACOs participating in Track 1+ are still considered experienced with performance-based risk. However, CMS is providing all Track 1+ ACOs the opportunity to renew with a similar level of downside risk rather than limiting high-revenue Track 1+ ACOs to the ENHANCED track—which has significantly greater downside risk than Level E of the BASIC track.
New, low-revenue ACOs can spend up to three years in an upside-only arrangement	New, low-revenue ACOs, not experienced with performance-based Medicare ACO initiatives, will be allowed to remain in Level B (one-sided risk) for an additional performance year. If an ACO elects this option, it will transition directly to Level E for the remaining two performance years of the agreement period.	This allows inexperienced low-revenue ACOs to have an additional year of one-sided risk (if desired) in exchange for a more rapid transition to downside risk afterwards, paralleling the ability under the previous rules to defer renewal into a second agreement period with risk to gain an additional year in Track 1.
Removal of cap on risk score reductions to performance benchmarks	The final rule retains the proposed 3% cap on benchmark increases for risk scores. However, ACOs’ benchmarks will be fully adjusted for changes in the relative risk score when there is a decrease from the baseline year to the performance year instead of applying a 3% reduction cap as originally proposed.	This limits the potential impact of coding practice improvements while fully adjusting the benchmark for decreases in an ACO’s relative risk score in order to limit incentives for ACOs to target only healthy members.
Slower schedule for regional cost adjustment reductions	The final rule still uses a maximum regional cost blending percentage of 50%, but finalizes a more gradual phase-in of the maximum blending percentage from the proposed rule for ACOs with historical expenditures above their regional service areas.	This change helps protect ACOs with higher costs than their regions, including those serving special-needs/high-cost populations, by more gradually phasing in benchmark reductions through the incorporation of the regional costs.
Prospective assignment for the July to December 2019 performance period	ACOs participating in the July to December 2019 performance period and selecting prospective assignment will be assigned beneficiaries based on October 2017 to September 2018 experience data.	This helps ACOs participating in two 2019 performance periods (e.g., January to June and July to December 2019) maintain a consistent set of assigned beneficiaries. Note that there are many other factors that can lead to changes in an ACO’s assigned beneficiaries between performance years, including changes in the assignment methodology and ACO participant list.

Taken together, these changes from the proposed rule offer some opportunities to ACOs that may have been hesitant to enter or continue in the MSSP while maintaining a clear focus on fiscal responsibility and payment for value.

This paper is focused on changes to the MSSP financial benchmark and settlement parameters from the proposed rule published on August 8, 2018, and the final rule published on December 31, 2018. We do not address all of the changes from the proposed rule nor do we address all of the changes made to the MSSP as a result of this final rule. Some of the changes that we do not discuss include changes to the guidelines around quality reporting and scoring, repayment rules, the application and termination process, benefit enhancements, data sharing, and the specific mechanics of the six-month performance periods (January to June 2019 and July to December 2019).

While each of these changes is significant and may have a notable effect on certain ACOs, most of the provisions of the proposed rule have been preserved in the final rule. The lack of significant changes suggests CMS remains committed to transitioning more ACOs from upside-only risk arrangements to upside and downside arrangements, even if this leads to a reduction in the number of ACOs participating in the MSSP. We refer readers to Milliman's series of white papers[1] addressing key topics of the "Pathways to Success" rule.

Key financial elements of the 2019 MSSP final rule are described below.

What is in the 2019 MSSP final rule?

The final rule outlines sweeping changes to the MSSP that will affect the 500+ organizations that currently participate in the program. The changes are largely in response to three primary factors: (1) the limited number of ACOs participating in downside risk (18% of ACOs in 2018), (2) perception of poor performance among ACOs in upside-only risk arrangements (e.g., the settlements paid to Track 1 ACOs exceed the overall savings relative to the benchmark achieved in 2017),[2] and (3) various financial concerns about the benchmarking methodology.

The 2019 Medicare Physician Fee Schedule final rule[3] also finalized parts of the Pathways to Success proposed rule, most notably the scope of services used for beneficiary assignment. These changes are not covered in this paper.

BASIC and ENHANCED Tracks

One of the main changes to the MSSP as a result of the final rule is the complete restructuring of the Track system. Previously, ACOs could elect to participate in Tracks 1, 1+, 2, or 3, with each track representing varying degrees of ACO risk. Beginning on July 1, 2019, any ACOs entering a new agreement period will be able to select either the BASIC track (which roughly replaces Tracks 1 and 1+) or the ENHANCED track (which largely mirrors Track 3). ACOs will be allowed to elect (annually) either prospective or retrospective beneficiary assignment regardless of their track selections.

The BASIC track includes a "glide path" with five levels to align with the new five-year agreement period, each with increasing potential for downside risk. Level A and Level B are upside only arrangements similar to Track 1, while Level E is a two-sided arrangement similar to Track 1+. Figure 2 summarizes the details of each of these levels, including the minimum savings rate (MSR) and minimum loss rate (MLR):

[1] The final rule maintains many of the general provisions of the proposed rule, and so we refer readers interested in more information/detail on "Pathways to Success" to previous Milliman white papers addressing various aspects of the proposed rule. These white papers, covering topics ranging from high-level summaries to the specifics of various components of the rule such as the beneficiary incentive program, can be found at http://www.milliman.com/MSSP/.

[2] CMS typically evaluates savings produced by the MSSP for the Medicare Trust Funds against program benchmarks. Several researchers dispute the reasonability of this approach given that program benchmarks might reflect savings already achieved. Some studies using alternative savings measurement methodologies have found that ACOs have produced significant savings for Medicare even with limited downside risk. See, for example, McWilliams et al. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. *N Engl J* Med 379:12, 1139-1149.

[3] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, 83 FR 59452, pages 59452-60303, 11/23/2018.

FIGURE 2: SAVINGS AND LOSS-SHARING PARAMETERS BY BASIC TRACK RISK LEVEL

				LOSS SHARING LIMIT (LESSER OF…)	
Risk Level	**MSR / MLR**	**Shared Savings Rate****	**Shared Loss Rate**	**% of Parts A + B Revenue**	**% of Updated Benchmark**
Level A	Based on ACO size*	40% x Quality Score	N/A	N/A	
Level B	Based on ACO size*	40% x Quality Score	N/A	N/A	
Level C	Choice of MSR/MLR**	50% x Quality Score	30%	2%	1%
Level D	Choice of MSR/MLR**	50% x Quality Score	30%	4%	2%
Level E***	Choice of MSR/MLR**	50% x Quality Score	30%	8%	4%

*There are no changes to the existing methodology for settings the MSR/MLR based on ACO size.

**ACOs can choose between a MSR/MLR based on ACO size or from 0% up to 2% in 0.5% increments. If an ACO's assigned beneficiaries fall below 5,000 during a performance year, then the ACO's MSR/MLR are automatically set using the ACO size method for that performance year.

An ACO participating at Level A in the first year of the agreement period will be required to move up a level in the second year of its agreement period to either Levels B, C, D, or E. While an ACO can opt to advance toward higher risk more quickly (e.g., from Level A directly to Level D), it will not be permitted to move down a level (e.g., from Level B to Level A) or stay at the same risk level (e.g., from Level C to Level C) until it reaches Level E. Once an ACO reaches Level E, it will stay in Level E for the duration of its agreement period. The only exceptions to this transition pattern are:

- ACOs that renew effective July 1, 2019, will have a special six-month performance period from July 1, 2019, to December 31, 2019, and will not be required to progress to the next level of the BASIC track on January 1, 2020.
- New, low-revenue ACOs that are not experienced in Medicare ACO initiatives have the option to remain in Level B (one-sided risk) for two performance years. ACOs that elect to remain in Level B for an additional year are required to transition to Level E for the duration of the agreement period.

Figure 3 below demonstrates the yearly level advancement options for an ACO in the BASIC track.

FIGURE 3: BASIC TRACK ADVANCEMENT OPTIONS

STARTING LEVEL	DEFAULT ADVANCEMENT LEVEL	OTHER ADVANCEMENT OPTIONS
Level A	Level B	Any ACO can elect to advance to Levels C, D, or E
Level B	Level C	Any ACO can elect to advance to Levels D or E *or* A new low-revenue ACO can elect an additional year at Level B, and after that it must advance directly to level E
Level C	Level D	Any ACO can elect to advance to Level E
Level D	Level E	None
Level E	Level E	None

REVENUE-BASED LOSS-SHARING LIMITS

As outlined in Figure 2 above, one feature of the new BASIC track is the use of revenue-based loss-sharing limits. Revenue-based loss-sharing limits were introduced into the MSSP with the inception of Track 1+. They served to limit the financial exposure of physician-led ACOs that typically provide a smaller overall portion of Medicare beneficiaries' total services.[4] In the Pathways to Success final rule, all ACOs electing the BASIC track with Medicare revenues under 50% of their aggregate benchmarks will receive the benefit of a revenue-based loss-sharing limit. Figure 4 compares the revenue-based and benchmark-based loss limits for a low revenue ACO (where revenue is 15% of the benchmark expenditures) under the BASIC track Levels C, D, and E and under the ENHANCED track.

[4] As compared to ACOs whose participant list includes organizations like hospitals that expand the ACO revenue to include facility services.

FIGURE 4: COMPARISON OF LOSS-SHARING LIMITS FOR A LOW-REVENUE ACO UNDER THE MSSP TRACKS WITH DOWNSIDE RISK

METRIC	BASIC: LEVEL C	BASIC: LEVEL D	BASIC: LEVEL E	ENHANCED
Total Part A and B Medicare FFS revenue for ACO participants	$15M	$15M	$15M	$15M
Percent of revenue limit	2%	4%	8%	n/a
Revenue-based loss-sharing limit	$0.3M	$0.6M	$1.2M	n/a
Benchmark expenditures for ACO assigned beneficiaries	$100M	$100M	$100M	$100M
Percent of benchmark limit	1%	2%	4%	15%
Benchmark-based loss-sharing limit	$1M	$2M	$4M	$15M
Loss-sharing limit (lesser of the revenue- and benchmark-based limits)	$0.3M	$0.6M	$1.2M	$15M

As shown above, the revenue-based limits increase as ACOs move to higher levels in the BASIC glide path, transitioning the ACOs into greater downside risk. However, the revenue-based loss-sharing limits are significantly lower than the benchmark-based loss-sharing limit of the ENHANCED track and the prior Track 2 and 3 models. Many of the low-revenue ACOs argued that their risk exposures were so high under the two-sided risk arrangements that an unfavorable performance year could bankrupt their organization before they would be able to implement effective cost-control measures. These revenue-based caps limit the exposure for lower-revenue ACOs and allow them more time to implement effective cost and care management structures before exposure to higher levels of risk. However, low-revenue ACOs still face a significant jump in downside risk when they transition from BASIC Level E to ENHANCED.

WHAT TRACK IS MY ACO ELIGIBLE FOR?

The track (and BASIC track level) an ACO will be able to enter at the start of an agreement period is dictated by past participation in performance-based ACO initiatives as well as its revenue levels (low or high revenue). The details of these requirements are outlined in Figure 5.

FIGURE 5: ACO ENTRY OPTIONS

APPLICANT TYPE	EXPERIENCED/ INEXPERIENCED	LOW REVENUE/ HIGH REVENUE	BASIC, GLIDE PATH	BASIC, LEVEL E	ENHANCED
New legal entity	Inexperienced	Low	Yes (A through E)	Yes	Yes
		High	Yes (A through E)	Yes	Yes
	Experienced	Low	No	Yes	Yes
		High	No	No	Yes
Renewing or reentering ACOs	Inexperienced	Low	Yes (B through E)	Yes	Yes
		High	Yes (B through E)	Yes	Yes
	Experienced	Low	No	Yes*	Yes
		High	No	No**	Yes

* Low-revenue ACOs are limited to two agreement periods of participation under the BASIC track with the second agreement period entirely in Level E.
** High-revenue ACOs with an agreement period beginning in 2016 or 2017 that are currently participating in the MSSP Track 1+ can renew into BASIC, Level E for the ACO's next (consecutive) agreement period.

A **renewing ACO** is an existing MSSP ACO that renews for a consecutive agreement period under the same taxpayer identification number without a break in participation. A **reentering ACO** is one that is not a renewing ACO, but previously participated in the MSSP or is made up of participants (at least 50%) who participated in the same MSSP ACO in the five years prior to the agreement period start date. A **new legal entity ACO** is all other ACOs.

Low-revenue ACOs are defined as having historical Medicare FFS Part A and B revenue that is less than 35% of the historical expenditures for the ACO's assigned beneficiaries. All other ACOs are considered high revenue. CMS will calculate an ACO's status as low or high revenue based on the most recent full calendar year available prior to the next agreement period (e.g.,

calendar year 2018 for a start date of January 1, 2020). Additionally, CMS has indicated it will monitor an ACO's status as low-revenue and take action if the ACO shifts from low revenue to high revenue during an agreement period.

Experienced ACOs have either participated in a performance-based Medicare ACO initiative or 40% or more of the ACO's providers have participated in a performance-based Medicare ACO initiative[5] (including deferred entry into the MSSP Tracks 2 or 3[6]) in any of the five most recent performance years prior to the agreement start date. All other ACOs are considered inexperienced with the following considerations:

- Performance-based Medicare ACO initiatives are programs with downside risk. Track 1 is not considered a performance-based Medicare ACO.
- MSSP Track 1+ participants are considered experienced. However, high-revenue ACOs participating in the MSSP Track 1+ will have a one-time option to renew into BASIC, Level E for their next consecutive agreement periods.

Changes to the benchmark calculation

CMS has implemented four changes to the MSSP benchmark calculation, which will affect all of the MSSP ACOs in their next agreement periods:

1. **Regional cost adjustment**: An ACO's historical experience is blended with its region's experience to come up with an aggregate base benchmark, which is then trended to the performance year. Previously, the regional cost adjustment started in an ACO's second agreement period as shown in Figure 6. The 2019 final rule implements this adjustment for all agreement periods beginning on or after July 1, 2019, and caps the impact of the regional adjustment at 5% of the national Medicare FFS per capita expenditures.
2. **Risk adjustment**: The final rule allows the benchmark to be adjusted using the full relative Hierarchical Condition Categories (HCC) risk score change up to a 3% increase. This would provide some mild protection to ACOs that see a less healthy population in the performance year while allowing Medicare to retain savings if an ACO enrolls a healthier population. The final rule does not limit benchmark reductions for risk score changes—not adopting the proposed 3% floor on risk adjustment reductions, which would have effectively allowed ACOs to keep costs associated with a significantly healthier population.
3. **Trend**: All agreement periods will use a trend based on a mix of the regional trend and the national trend as determined by the ACO's share of assignment-eligible beneficiaries in the ACO's region. For example, if an ACO's average market share is 30% of assignment-eligible beneficiaries, then the ACO's trend will be calculated as a blend of 70% of the regional trend and 30% of the national trend.
4. **Agreement period duration (and rebasing frequency)**: All agreement periods will now be five years instead of the previous three years. This additional time enhances the stability of the benchmark.

FIGURE 6: REGIONAL COST ADJUSTMENT BLENDING PERCENTAGES BY AGREEMENT PERIOD

	CURRENT METHODOLOGY		UPDATED METHODOLOGY*	
AGREEMENT PERIOD*	LOWER SPENDING RELATIVE TO REGION	HIGHER SPENDING RELATIVE TO REGION	LOWER SPENDING RELATIVE TO REGION	HIGHER SPENDING RELATIVE TO REGION
1	0%	0%	35%	15%
2	35%	25%	50%	25%
3	70%	50%	50%	35%
4+	70%	70%	50%	50%

*The regional benchmark weights apply in progression to when an ACO is first subject to the regional adjustment. For example, an ACO currently participating in the MSSP and not subject to a regional cost adjustment will be subject to the agreement period 1 weights in its next agreement period.

[5] The final rule defines a "performance-based risk Medicare ACO initiative" as an "initiative implemented by CMS that requires an ACO to participate under a two-sided model during its agreement period" and specifies that this includes:

- MSSP Tracks 2, 3, ENHANCED, and BASIC (Levels A to E). Track 1+ is also included per below.
- Innovation Center ACO Models involving two-sided risk: the Pioneer ACO Model, Next Generation ACO Model, the performance-based risk tracks of the CEC Model (including the two-sided risk tracks for LDO ESCOs and non-LDO ESCOs), and the Track 1+ Model.

[6] Experienced ACOs are those for which 40% or more of the participants were in an ACO that deferred entry into the MSSP Tracks 2 or 3 by extending an agreement period to an optional fourth year under Track 1 within the five years prior to the agreement period start date.

Conclusion

CMS introduced the MSSP with the goal of transitioning ACOs to becoming risk-bearing entities and improving the quality of care provided to Medicare FFS beneficiaries. With the MSSP final rule, CMS has reaffirmed its commitment to these goals while offering greater shared savings potential to ACOs participating in the BASIC track and making the BASIC track available to a broader set of ACOs. The effect of these rule changes on specific ACOs will vary significantly depending on an ACO's size, region, cost and quality performance, and structure. It is critical that ACOs fully consider all of the implications of these new rules in order to identify both the risks and the opportunities specific to their organizations.

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