Session 125, Pathways to Success: How the MSSP Final Rule has Re-vamped the Program

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Pathways to Success
How the MSSP final rule has re-vamped the program

Noah Champagne, FSA, MAAA - Milliman
Annie Man, FSA, MAAA, Ph. D – Milliman
Rick Lassow, FSA, MAAA - Deloitte

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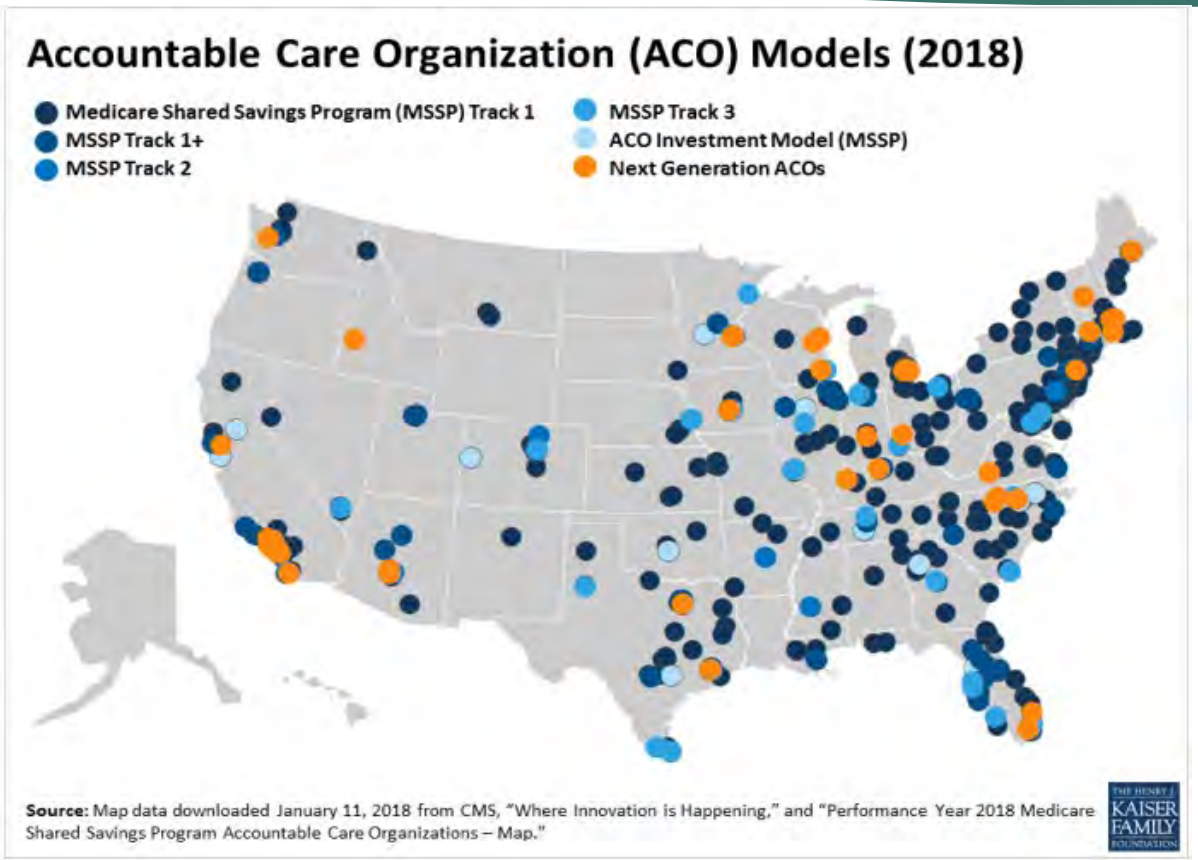
What is an ACO?

- A group of providers (TINs, NPIs, CCNs) working together to provide high quality managed care to Medicare Fee-for-service (FFS) beneficiaries
- ACOs that meet cost and quality benchmarks can share in the savings (or losses) that they generate for the Medicare program

Current ACO Landscape



Track	Risk	Number of ACOs
Track 1	One Sided	460
Track 1+	Two Sided	55
Track 2	Two Sided	8
Track 3	Two Sided	38

Pathways to Success

- December 31, 2018 – CMS Published “Pathways to Success” MSSP Final Rule

- Goal: “…create a pathway for success that facilitates ACO’s transition to performance-based risk more quickly and makes the transition smooth by phasing-in risk more gradually.”

- Creates a structured timetable for inexperienced ACOs to transition to downside risk
  - Gradually increasing the minimum risk exposure as ACOs gain more experience with the MSSP

Changes to Track Options

Current ACO Tracks	Proposed ACO Tracks	
Track 1	BASIC	5 year transition from risk similar to the current Track 1 to risk similar to the current Track 1+
Track 1+		
Track 2	N/A	
Track 3	ENHANCED	Financial parameters in the ENHANCED track are the same as Track 3

BASIC Track Glide Path

Risk level	One-sided/two-sided risk	Advanced APM status under QPP?
Level A	One-sided	No
Level B	One-sided	No
Level C	Two-sided	No
Level D	Two-sided	No
Level E	Two-sided	Yes

Track Details by Risk Level

Risk Level	MSR / MLR	Shared Savings Rate	Shared Loss Rate	Loss Sharing Limit (lesser of…)	
				% of Parts A + B Revenue	% of Updated Benchmark
BASIC - Level A	Based on ACO size	40% x Quality Score	N/A	N/A	
BASIC - Level B	Based on ACO size	40% x Quality Score	N/A	N/A	
BASIC - Level C	Choice of MSR / MLR	50% x Quality Score	30%	2%	1%
BASIC - Level D	Choice of MSR / MLR	50% x Quality Score	30%	4%	2%
BASIC - Level E	Choice of MSR / MLR	50% x Quality Score	30%	8%	4%
ENHANCED	Choice of MSR / MLR	75% x Quality Score	1 – sharing rate (40% - 75%)	N/A	15%

Revenue vs Benchmark Based Cap

Benchmark-Based Approach		Revenue-Based Approach	
ACO's total updated benchmark expenditures	$100M	ACO participants' total Medicare Part A and Part B FFS revenue	$20M
Nominal standard percentage	4.00%	Nominal standard percentage	8.00%
Benchmark-based cap	$4M	Revenue-based Cap	$1.6M

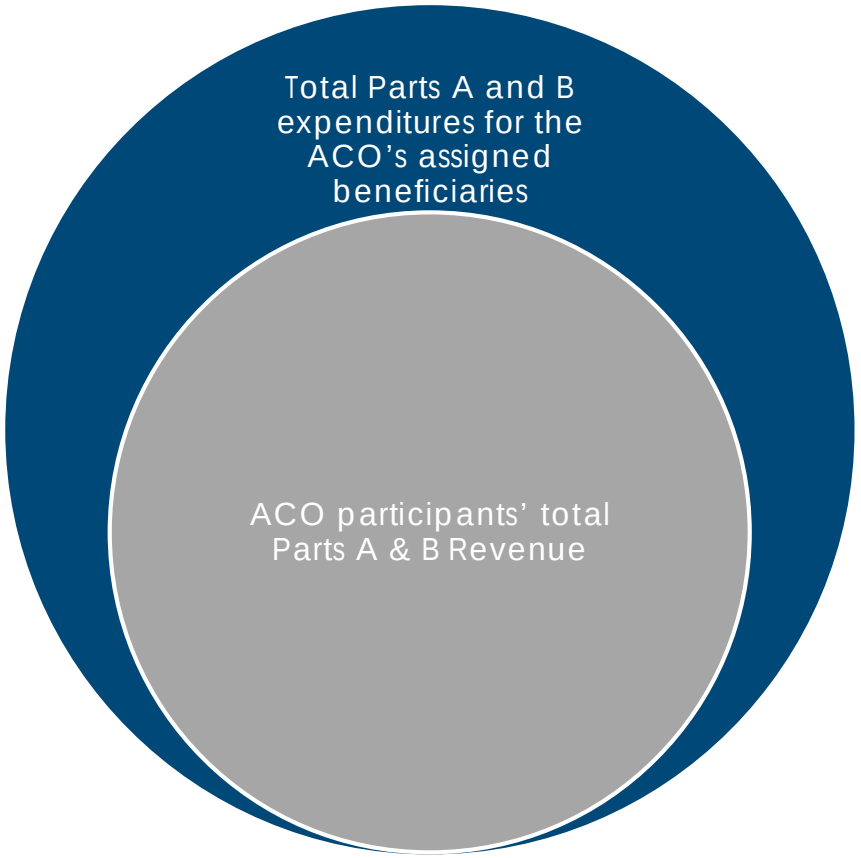
ACO Entry Options

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 Re-entering 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

What makes an “Inexperienced” vs. an “Experienced” ACO?

- An ACO is determined to be experienced if *either* of the following conditions apply:
  - An ACO previously participated in a performance-based Medicare ACO initiative or deferred entry into a second MSSP agreement period under Track 2 or Track 3.
    - Track 1+ participants are considered experienced. However, high-revenue ACOs from Track 1+ will have a one-time option to renew into BASIC, Level E for their next agreement period
  - ACOs that remained in Track 1 for their second agreement periods are considered “experienced.”
  - If 40% or more of an ACO’s providers participated in a performance-based risk initiative or were part of a deferred renewal arrangement in any of the five most recent years

High vs. Low Revenue ACO



Conceptually, CMS is trying to separate ACOs with low total revenue where shared losses that are a percentage of ***total*** beneficiary expenditures could bankrupt the ACO.

Low revenue ACO

Essentially, an ACO is "low-revenue" if ACO ***total*** Medicare revenue is less than 25% of total FFS expenditures for Parts A and B beneficiaries.

Otherwise, an ACO is considered "high revenue".

Assignment Methodology Changes

- Addition of new codes used for assignment
- Changes to how primary care services are considered when a patient is in a SNF
- CMS will offer the choice of retrospective or prospective beneficiary assignment under both the BASIC and ENHANCED tracks

Additional Key Changes

- Agreement period extended to 5 years
- Update to regional adjustment formula
- Adjustment to risk adjustment formula
  - True risk adjustment capped at a +3% adjustment from BY3
- Update to trend being utilized