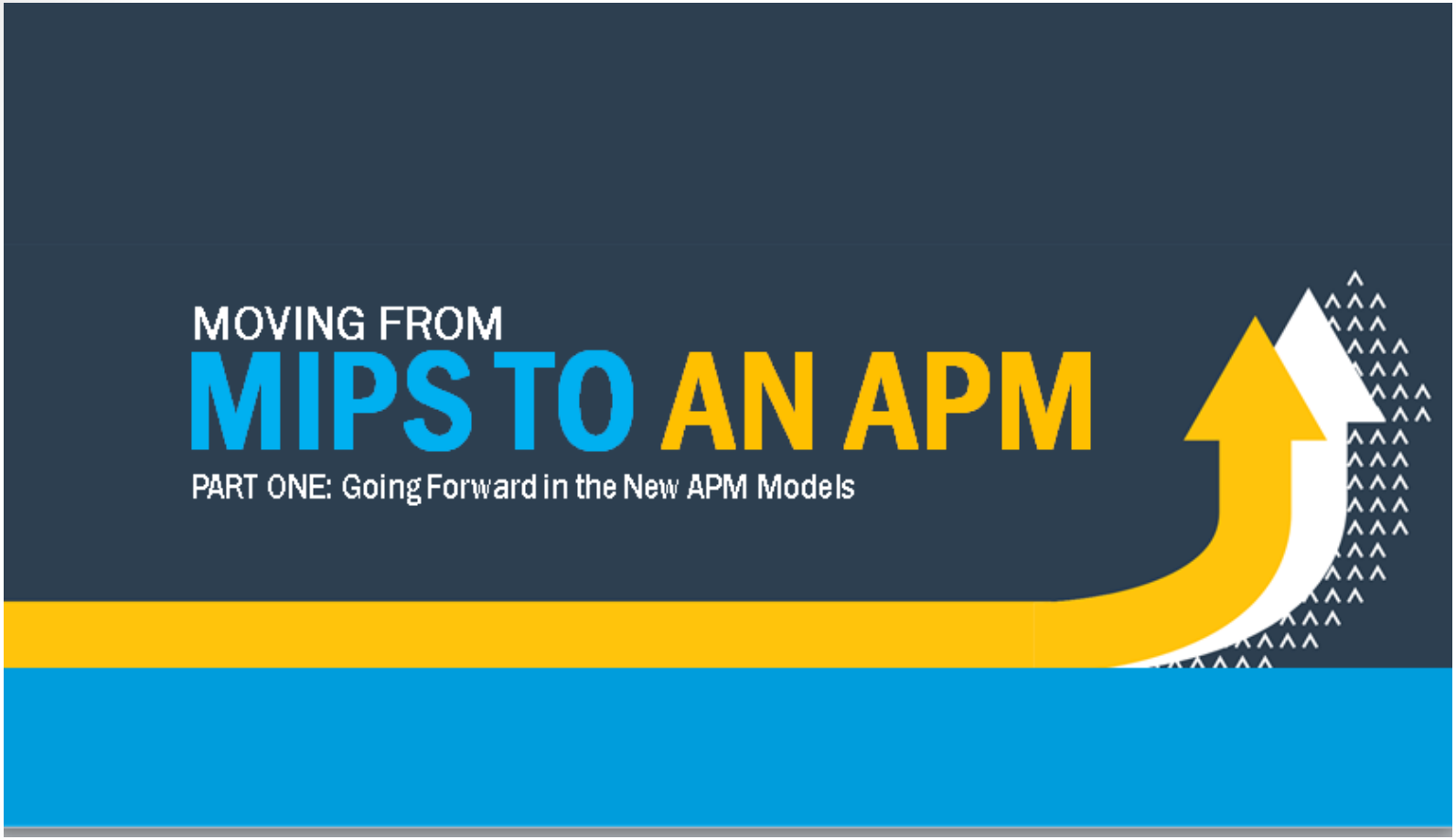

Sandy Swallow and Donald Klitgaard, MD

Tuesday, February 19, 2019

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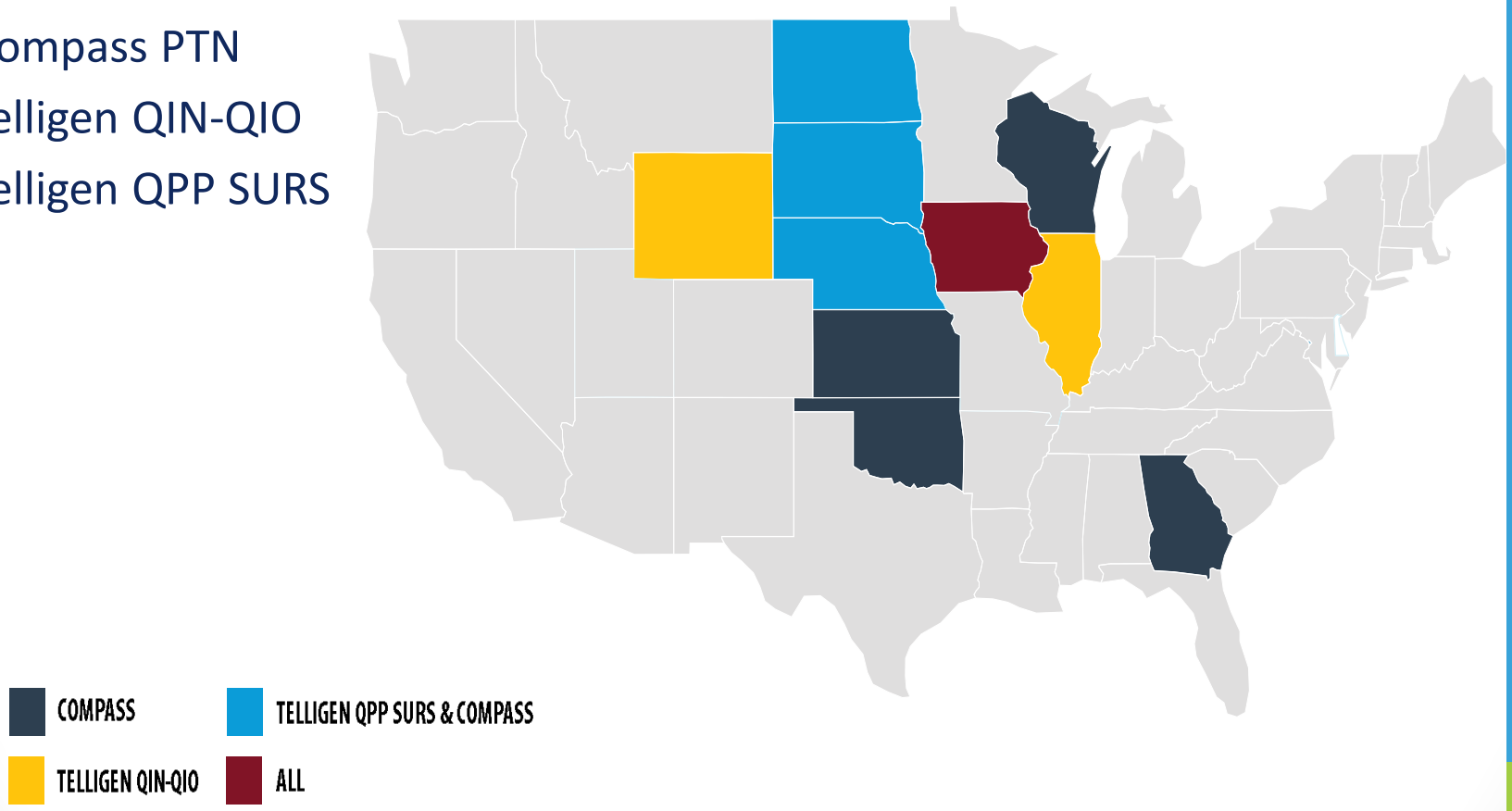


Guest Speaker

Don Klitgaard, MD, FAAFP

- *Founding CEO of MedLink Advantage (MLA)*
- *Serves on AAFP Commission on Quality and Practice*
- *Past physician champion in the AAFP's TransforMED National Demonstration Project*
- *Educator and consultant on PCMH and ACO transformation*

Going Forward in the New APM Models

An In-Depth Analysis of the CMS "Pathways to Success" Final Rule

APM 201 Series
2/19/2019

Don Klitgaard, MD, FAAFP
CEO, MedLink Advantage

Final Pathways Rule

- On December 21, 2018, CMS released the final MSSP ACO rule, dubbed the Pathways to Success, making sweeping and significant changes to the Medicare Shared Savings ACO Program
  - The rule can be accessed here and CMS also released a related factsheet
- The rule's release follows months of advocacy efforts led by a wide variety of healthcare stakeholders since CMS issued their proposed rule in August 2018
- CMS also addressed several final ACO policies for 2019 in the 2019 Medicare Physician Fee Schedule rule
  - The rule can be accessed here along with the CMS factsheet
  - MedLink also provided a summary of the ACO provisions in this resource

Opportunities

- More gradual ramp up of risk in new Basic Track
- Efforts to promote program stability and predictability through use of 5-year agreements
- Makes T1+ equivalent permanent part of MSSP
- Implementation of expanded waivers and beneficiary incentives at lower levels of risk
- Allows ACOs to choose assignment methodology annually regardless of risk
- Removes ACO measure 11 (CEHRT use), replacing with an attestation
- Benchmarking changes (benefits many ACOs)

Challenges

- Shortens shared savings only timeframe for many new ACOs (from the current 6 years permitted to 2-3 years)
- Requires the move to downside risk
- New termination policies based on spending above a certain threshold (related to MSR/MLR) for 2 or more years
- CMS establishes a distinction between high/low revenue ACOs and requires more risk sooner from high revenue ACOs, though CMS did raise the threshold to be considered a high revenue ACO
- While risk scores can now rise, CMS sets a risk adjustment cap of 3% across 5 years and removes the cap on downward adjustments

New Program Structure

BASIC Track Level A	Level B	Level C	Level D	Level E	ENHANCED Track
40% sharing rate	40% sharing rate	50% sharing rate	50% sharing rate	50% sharing rate	75% sharing rate
Upside only	Upside only	1st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of BM	1st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of BM	1st dollar losses at 30%, not to exceed 8% of FFS revenue capped at 4% of BM	1st dollar losses 40-75% and not to exceed 15% of BM
MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM

* Agreement Period 5 years (increase from current 3 years)

Options Going Forward

- Certain existing ACOs with contracts expiring on 12/31/18 were offered the opportunity to extend that current contract through 6/30/19
- ACOs with existing contracts not expiring on 12/31/18 have the option to finish out the remainder of their current agreements
- ACOs have the option to start under the new program structure starting 7/1/19. Any ACO starting in July 2019 will have two performance years at the same initial Level (7/1/19 – 12/31/19 & 1/1/20 – 12/31/20)

Options Going Forward

- CMS is offering slightly different participation options for ACOs based on several different distinctions of the applying ACO:
  - high vs. low revenue status
  - new vs. renewing vs. reentering ACO
  - previous participation in 'performance-based risk' models

- Let's take a look at how CMS defines each one of these…

Definitions

High Revenue ACO = an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is at least 35% of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries

Low Revenue ACO = an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is less than 35% of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries

- Total ACO revenue of participants is based on revenue for the most recent calendar year for which 12 months of data are available
- Low revenue ACOs may participate under the BASIC track for a maximum of two agreement periods; High revenue ACOs limited to one agreement
- High revenue ACOs have more limited participation options

Definitions

Renewing ACO = an ACO that continues its participation in the program for a consecutive agreement period, without a break in participation, because it is either:

- An ACO whose participation agreement expired and that immediately enters a new agreement period to continue its participation in the program; or
- An ACO that terminated its current participation agreement under §425.220 and immediately enters a new agreement period to continue its participation in the program

Definitions

Reentering ACO = meets **either** of the following:

- Is the same legal entity as an ACO, identified by TIN according to the definition of ACO in §425.20, that previously participated in the program and is applying to participate in the program after a break in participation, because it is either:
  - (a) an ACO whose participation agreement expired without having been renewed; or
  - (b) an ACO whose participation agreement was terminated under §425.218 or §425.220; **OR**
- Is a **new legal entity that has never participated in the Shared Savings Program AND** is applying to participate in the program and **more than 50 percent of its ACO participants were included on the ACO participant list under §425.118, of the same ACO in any of the 5 most recent performance years** prior to the agreement start date

Definitions

Experienced with performance-based risk = an ACO that CMS determines meets either of the following criteria:

- The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO initiative, or that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3; **OR**

- 40 percent or more of the ACO's ACO participants participated in a **performance-based risk Medicare ACO initiative**, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3 (in accordance with §425.200(e)), in any of the 5 most recent performance years prior to the agreement start date

Definitions

Performance-based risk initiative = performance-based risk Medicare ACO initiative means an initiative implemented by CMS that requires an ACO to participate under a two-sided model during its agreement period. This includes Track 2, Track 3 or the ENHANCED track, and the BASIC track (including Level A through Level E)

- This also includes the following 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.
- This definition also includes such other Medicare ACO initiatives involving two-sided risk as may be specified by CMS

Participation Options

Low Revenue ACOs		
Applicant Type	**ACO experienced or inexperienced with performance based risk**	**Participation Options**
New legal entity	**Inexperienced**	Basic Track Levels A through E or Enhanced Track *one exception
New legal entity	Experienced	Basic Track Level E or Enhanced Track
Reentering ACO	**Inexperienced**	Basic Track Levels B through E or Enhanced Track
Reentering ACO	Experienced	Basic Track Level E or Enhanced Track
Renewing ACO	**Inexperienced**	Basic Track Levels B through E or Enhanced Track
Renewing ACO	Experienced	Basic Track Level E or Enhanced Track

From table 7 in the final rule on page 67911-67912

Participation Options

High Revenue ACOs		
Applicant Type	**ACO experienced or inexperienced with performance based risk**	**Participation Options**
New legal entity	**Inexperienced**	Basic Track Levels A through E or Enhanced Track
New legal entity	Experienced	Enhanced Track
Reentering ACO	**Inexperienced**	Basic Track Levels B through E or Enhanced Track
Reentering ACO	Experienced	Enhanced Track
Renewing ACO	**Inexperienced (includes former Track 1)**	Basic Track Levels B through E or Enhanced Track
Renewing ACO	Experienced	Enhanced Track **one exception

From table 8 in the final rule on page 67913-67914

Participation Options

- *Exception #1- Low Revenue ACOs that are new legal entities (not reentering) that are low revenue ACOs may elect to enter in Level A, transition to Level B and remain in Level B for an additional performance year prior to being automatically advanced to Level E for the remaining performance years of the agreement period (thus, skipping level C and D)
  - Example, exception: Level A, Level B, Level B, Level E, Level E
  - Example, no exception: Level A, Level B, Level C, Level D, Level E
- **Exception #2- High Revenue ACOs have a one-time renewal option for ACOs with first or second agreement period beginning in 2016 or 2017 that participated in Track 1+ Model to elect Basic Track Level E
  - Otherwise, renewing High Revenue ACOs with experience with performance based risk must participate in the Enhanced Track

2019 Applications

- **Notice of Intent to Apply was due by Jan. 18**
- **Application is due by February 19**

Application Timeline for a July 1, 2019, Start Date*

Step 1: Complete the Notice of Intent to Apply (NOIA)	January 2, 2019 - January 18, 2019	• NOIA Guidance (Updated 1/2/2019)
Step 2: Submit the application(s)	January 22, 2019 - February 19, 2019 at 12:00 p.m. (noon) Eastern Time (ET)	• Application Toolkit
Step 3: Respond to requests for information (RFIs)	Spring 2019	• RFI Response Actions and Deadlines
Step 4: Sign the agreement	June 2019	• Prior year Shared Savings Program ACO Participation Agreement for reference • Data Use Agreement

*Dates are subject to change

2020 Applications

- A similar timeline will be released for a January 2020 start
- Notice of Intent to Apply will be due by end on May
- Applications will be due by early August

- **Therefore, practices interested in joining an MSSP ACO will have two opportunities to do so:**
  - **Now for a July 1, 2019 start date. ACOs can add participants through**
  - **May – July 2019 for a January 1, 2020 start date.**
- **If you don't join then, the next opportunity to join an MSSP would be in Summer 2020 for a January 1, 2021 start date.**

Key Policy Changes

Assignment Changes

- For agreement periods beginning on July 1, 2019 and in subsequent years, an ACO may select the assignment methodology.
  - (1) Preliminary prospective assignment with retrospective reconciliation
  - (2) Prospective assignment
    - This selection is made prior to the start of each agreement period, and may be modified prior to the start of each performance year
- Revisions to the definition of Primary Care Services used in assignment finalized in MPFS rule
- CMS did not move forward with the 'beneficiary opt-in' assignment option

Assignment Changes

- **Voluntary alignment** –CMS is modifying its policies to assign a beneficiary to an ACO based upon his or her selection of any ACO professional, regardless of specialty, as his or her primary clinician.
  - Beneficiary may select a practitioner with any specialty designation as his or her primary care provider and be eligible for voluntary alignment assignment to the ACO in which the practitioner is an ACO professional (Previous policy required that the ACO professional designated by the beneficiary was a primary care physician as defined at §425.20, a physician with a specialty designation included at §425.402(c), or a nurse practitioner, physician assistant, or clinical nurse specialist)
- CMS also finalized a policy in which the agency will not voluntarily align a beneficiary to the ACO when the beneficiary is also eligible for assignment to an entity participating in a model tested or expanded under section 1115A of the Act under which claims-based assignment is based solely on claims for services other than primary care services

Waivers & Incentives

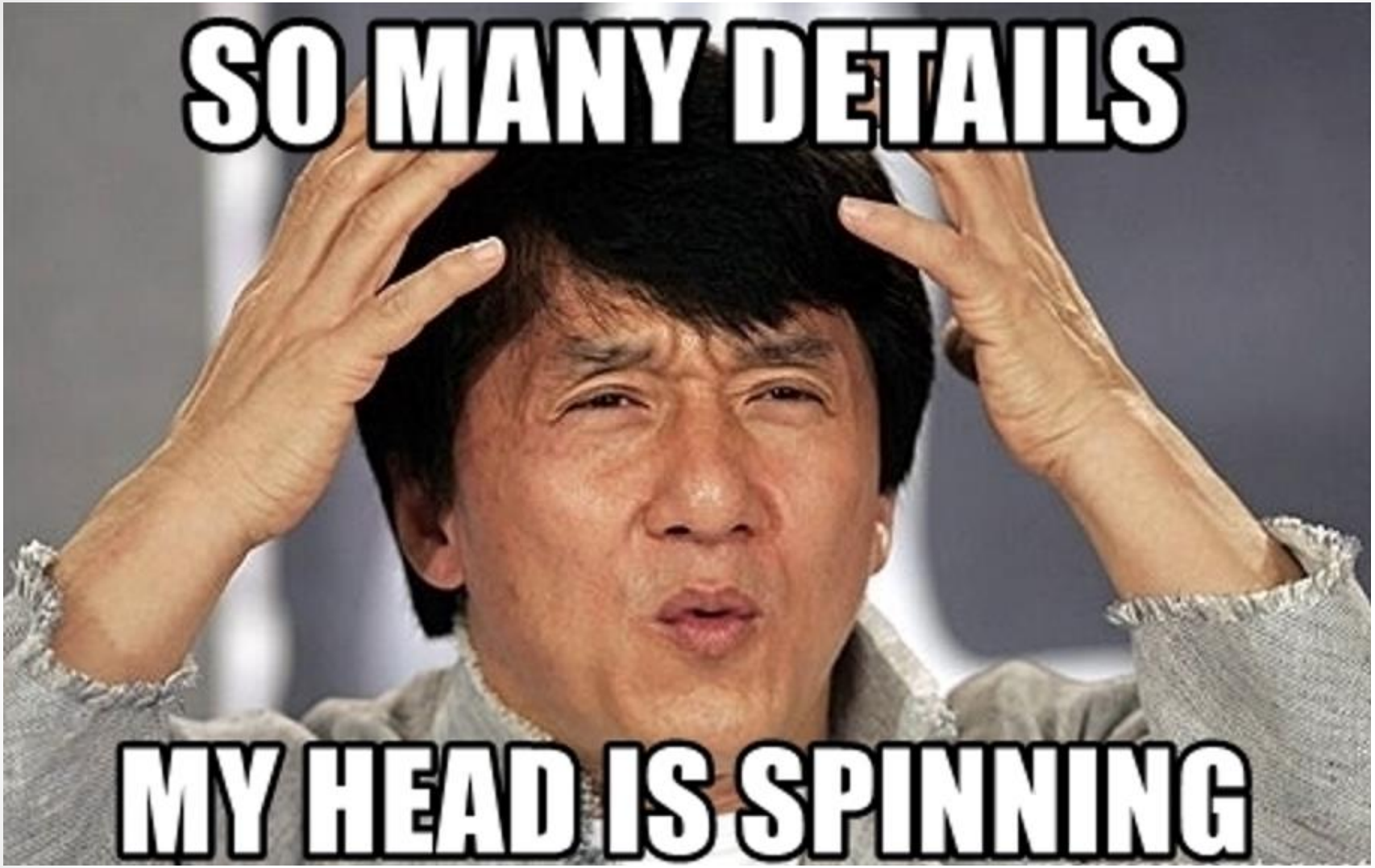
- **SNF waiver-** expands use of this waiver to all ACOs in downside risk models, regardless of attribution method and provides more opportunity for use of waiver by rural ACOs
- **Telehealth**- removes originating site geographic restrictions and treats the beneficiary's home as an originating site for all ACOs in downside risk models
- **Beneficiary Incentive Program–** for ACOs in downside risk models, CMS will allow use of a CMS-approved beneficiary incentive program to provide incentive payments up to $20 to eligible beneficiaries who receive qualifying (primary care) services. Incentives are not counted as expenditures

Beneficiary Notification

- Beginning July 1, 2019 and each subsequent performance year, an ACO or ACO participant must provide each beneficiary with a standardized written notice
  - ***prior to or at the first primary care visit of the performance year***
  - in the form and manner specified by CMS (and ACO participant must post signs in its facilities and in settings in which beneficiaries receive primary care services)
  - must include the following in the notice:
    - (1) that each ACO participant and its ACO providers/suppliers are participating in the Shared Savings Program;
    - (2) the beneficiary's opportunity to decline claims data sharing; and
    - (3) beginning July 1, 2019, the beneficiary's ability to, and the process by which, he/she may identify or change identification of the individual designated for purposes of voluntary alignment
  - Notice permitted via patient portal, email or written notice- more guidance to be shared prior to July 1, 2019

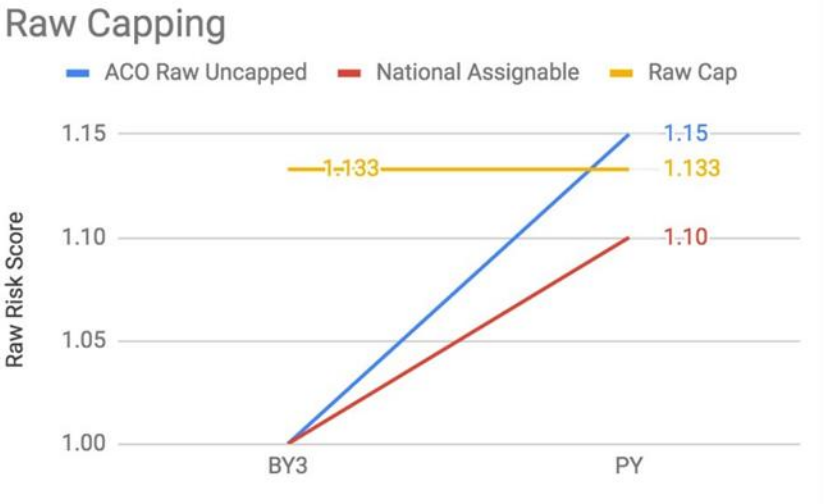
Benchmarking Changes

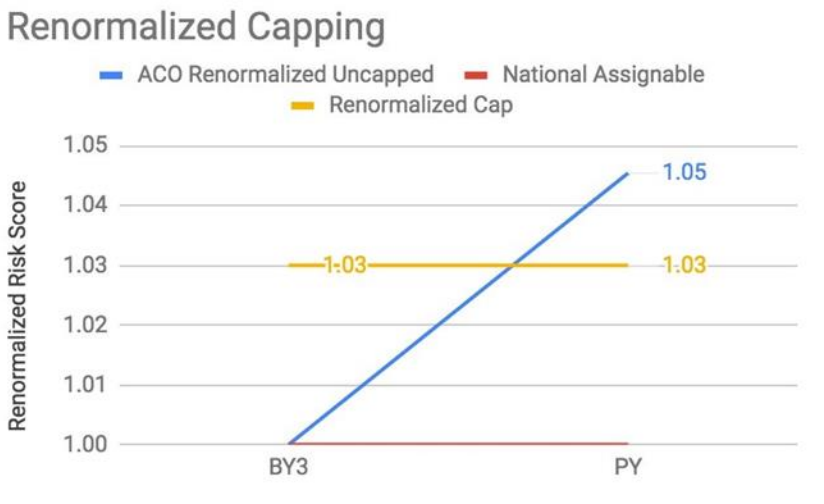
- Benchmark rebased every 5 years instead of every 3 years
- Significant changes related to annual risk adjustment to the historical benchmark, regional adjustment and regional update factor (growth rate)
- The following remain the same:
  - Use of 3 historical benchmark years
  - Initial historical benchmark year weighting of 10%, 30%, 60%
  - Reset historical benchmark weightings of 33%, 33%, 33%
  - Uncapped risk adjustment during initial establishment of the 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


SO MANY DETAILS
MY HEAD IS SPINNING

Risk Adjustment

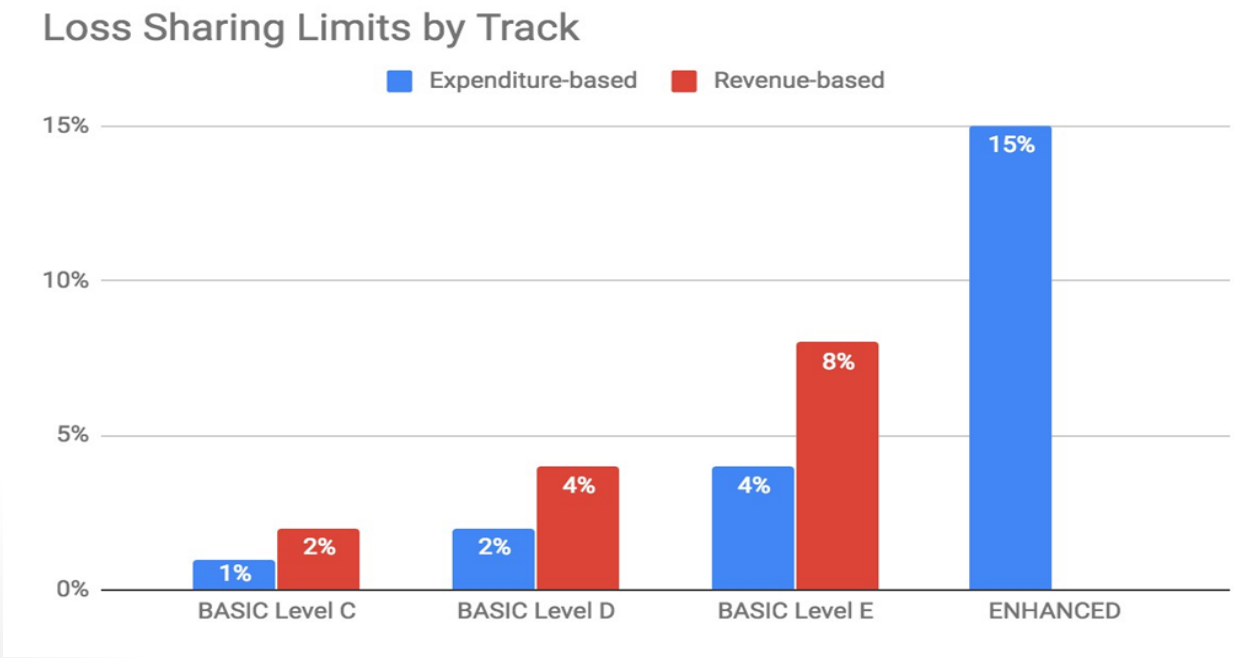
- No demographic-only capping of the continuously assigned risk score
- Upside-only cap of 3% on the BY3 to PY renormalized risk score
- 3% cap is applied prior to renormalization. Raw cap is 103% x inflation where inflation is the change in BY3 to PY national assignable risk score.
- Cap is applied separately by enrollment type
- Model version can still vary between benchmark and performance years
- Downside cap of -3% was not finalized





Loss Sharing Limits

- Adoption of a claims-based definition instead of self-reported ACO composition or ownership-based definitions
- Basic Level E loss sharing limit is the lesser of the revenue-based standard nominal amount and 1% expenditure-based standard nominal amount



Repayment Mechanisms

- Repayment mechanism amount is the lesser of 2% of revenue and 1% of expenditure for both BASIC and ENHANCED downside risk tracks
- Minimum threshold to trigger new required repayment mechanism amount is the lesser of 50% or $1,000,000 (versus lesser of 10% or $100,000 under proposed)
- Reduction of the 24-month tail period to a 12-month tail period
- Renewing ACOs can extend an existing repayment mechanism to the next agreement period
- Credit unions may now offer escrow accounts and letters of credit as repayment mechanisms
- ACOs may obtain reinsurance but reinsurance is not recognized as a repayment mechanism

Termination Policies

- For performance years beginning on July 1, 2019 and subsequent performance years, CMS determines whether the Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for the performance year exceed the ACO's updated benchmark by an amount equal to or exceeding either the ACO's negative MSR under a one-sided model, or the ACO's MLR under a two-sided model
  - If the Medicare Parts A and B FFS **expenditures** for the ACO's assigned beneficiaries for the performance year **exceed** the ACO's updated **benchmark by an amount equal to or exceeding its negative MSR or MLR**, CMS may take any of the established pre-termination actions (ex: **corrective action plan**)
  - If the Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for the performance year **exceed** the ACO's **updated benchmark by an amount equal to or exceeding its negative MSR or MLR for another performance year** of the agreement period, **CMS may immediately or with advance notice terminate** the ACO's participation agreement

Termination Policies

- **ACOs voluntarily terminating**: reduces minimum notification period for voluntary termination from 60 days to 30 days
- **Payment consequences of termination**: for performance years beginning on or after July 1, 2019, ACOs in two-sided models with an effective termination date before the last calendar day of the performance year that voluntarily terminate with an effective date of termination after June 30 or that are terminated by CMS at any time during the performance year will be liable for
  - a pro-rated amount of any shared losses determined, with the pro-rated amount reflecting the number of months during the performance year that the ACO was in the program
- ACOs under a two-sided model that begin a 6-month performance year on July 1, 2019, and that are involuntarily terminated by CMS would be required to repay
  - a pro-rated amount of any shared losses determined


MY BRAIN HURTS
IT'LL HAVE TO COME OUT

Six Month PYs in 2019

- CMS finalized policies for the 1/1/19–6/30/19 performance period in the final MPFS rule.
- The 6-month performance period 7/1/19–12/31/19 will use the same approach for financial reconciliation and quality reporting
- **Calculating shared savings/losses –** To determine shared savings and shared losses for the six-month extension performance period, CMS will:
  - calculate average per capita Medicare expenditures for Parts A and B services for CY 2019 for the ACO's performance year assigned beneficiary population, and
  - compare this amount to the updated historical benchmark.
  - CMS will then pro-rate any shared savings or shared losses by multiplying the amounts by one-half, which represents the fraction of the calendar year covered by the six-month performance period

Six Month PYs in 2019

- **Quality -** Uses ACO's quality performance for 12-month CY 2019; agency will apply the program's current sampling methodology to determine the beneficiaries eligible for the samples for
  - claims-based measures (as calculated by CMS)
  - CMS Web Interface reporting, and
  - the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey
  - Will use the ACO participant list effective on January 1, 2019 (or July 1, 2019)
  - Reporting will take place in January through March of 2020

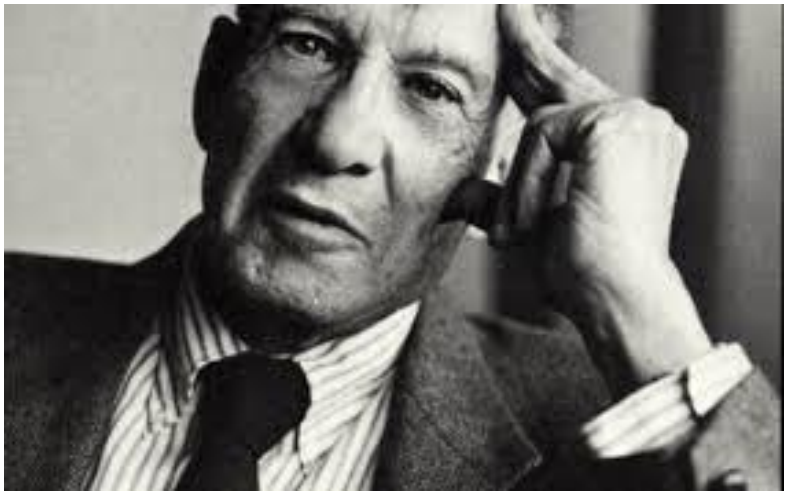
- **Assignment -** For ACOs that select a prospective beneficiary assignment methodology for the 6-month performance year from July 1, 2019, through December 31, 2019,
  - CMS will use an assignment window from October 1, 2017, through September 30, 2018, to align with the assignment window used to determine prospective assignment for performance years beginning on January 1, 2019.
  - This is a modification to the proposal to use an assignment window reflecting the most recent 12 months of data available

Six Month PYs in 2019

- If an ACO is reconciled for both the January 1, 2019, through June 30, 2019 performance year and the July 1, 2019, through December 31, 2019 performance year,
  - CMS issues a separate notice of shared savings or shared losses for each performance year, and
  - if the ACO has shared savings for one performance year and shared losses for the other performance year, CMS reduces the amount of shared savings by the amount of shared losses
- If any amount of shared savings remains after completely repaying the amount of shared losses owed, the ACO is eligible to receive payment for the remainder of the shared savings
- If the amount of shared losses owed exceeds the amount of shared savings earned, the ACO is accountable for payment of the remaining balance of shared losses in full

The best way to predict your future is to create it

— Peter Drucker



Two Excellent Educational Opportunities

- Heartland Annual Conference
  - Educational sessions on topics including preparing for ACOs and other alternative payment models, use of Community Health Workers in practice, surviving in Fee for Service while transitioning to Value-based payment, working with employers in VBP, better understand risk
  - For physicians, advanced providers, nurses, administrators, quality staff, etc.
  - March 14 from 8am - 4pm at the Stoney Creek Conference Center in Johnston
  - 6 hours CME/CEU available for the $79 registration fee
  - http://events.r20.constantcontact.com/register/event?oeidk=a07eg0swlq9ed2d0367&llr=f8jrrzdab to register
- Ascent Physician Leadership program
  - To prepare physician leaders to lead through the opportunities and challenges presented by today's healthcare world
  - Beginning in June 28-29, 2019 in Denver
  - www.ascentphysicianleadership.org for more information

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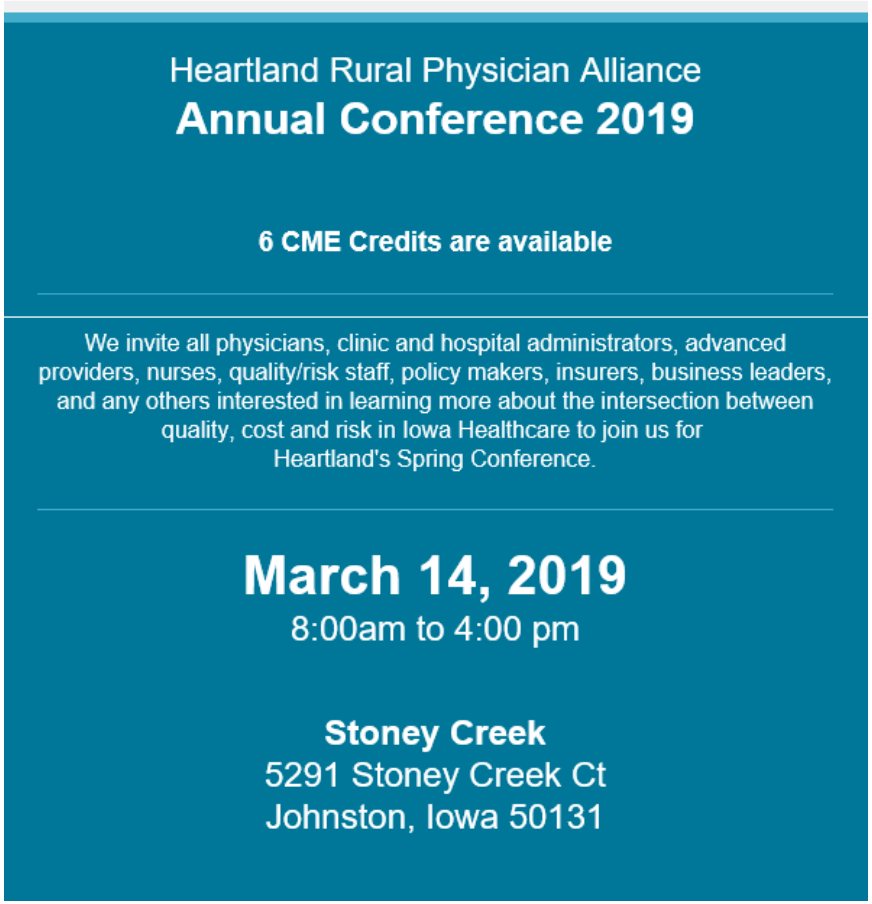

- Registration link: http://events.r20.constantcontact.com/register/event?oeidk=a07eg0swlq9ed2d0367&llr=f8jrrzdab

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Thank you for joining us!

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