2017 MSSP Policy Changes and Implications for ACOs

There are a number of policy changes effective in 2017 for ACOs. This resource highlights some of the key regulatory changes to be aware of. Although this year will bring a number of other developments impacting the healthcare industry, including a new Congress and Administration, this resource focuses on detailed Medicare Shared Savings Program (MSSP) changes taking place this year.

New ACO Benchmarking Policies Go Into Effect

New benchmarking methodologies take effect in 2017, as finalized in the June 2016 Benchmarking rule. The new rebased benchmarking methodology gradually phases in the use of regional expenditure data over the course of multiple three-year ACO agreement periods. The transition to the new methodology varies for ACOs based on the year they began MSSP participation and on whether the ACO's spending is higher or lower than that of its region. CMS continues to establish the benchmark for an ACO's first agreement period based on the historical expenditures for beneficiaries assigned to the ACO with no adjustment for expenditures in the ACO's region. More details are available in the NAACOS Summary of the Final MSSP Benchmarking Rule.

Modification to Assignment Algorithm Related to SNF Place of Service

As explained in this NAACOS summary of the 2016 final Medicare Physician Fee Schedule, CMS finalized a modification of the MSSP assignment algorithm which is effective January 1, 2017. This revision applies beginning with performance year 2017 and excludes certain Current Procedural Terminology (CPT) codes for physician claims with a SNF place of service (POS) 31. Specifically, starting in 2017 the assignment algorithm is modified by excluding CPT codes 99304 through 99318 when the claim contains POS 31; these are no longer considered primary care services for the purposes of beneficiary assignment. Primary care services delivered to nursing home (POS 32) residents will continue to count. CMS will adjust all benchmarks at the start of the 2017 performance year so that the benchmark for an ACO reflects the use of the same assignment rules that apply in the performance year.

Quality Reporting Changes for ACOs

The 2017 Medicare Physician Fee Schedule rule finalized a number of changes to the quality measure set ACOs will report in 2017 and going forward. CMS removed and/or retired a number of quality measures to better align with the Core Quality Measures Collaborative measure set. CMS also added one new measure on use of imaging studies for low back pain, and reintroduced a measure used previously (ACO-12) relating to medication reconciliation. Lastly, CMS added a composite measure ACO-43 (Ambulatory Sensitive Condition Acute Composite) to the Care Coordination/Patient Safety domain. This measure is AHRQ Prevention Quality Indicator 91.

Table 42 of the Fee Schedule (p. 80488) outlines the MSSP quality measure set that will be used to assess quality performance starting with the 2017 performance year including the new measures adopted in the final rule. Each measure that is indicated as a new measure will be assessed as a pay-

for-reporting measure for the 2017 and 2018 performance years. After that, the measure will be assessed based on the phase-in schedule noted in Table 42. For more details regarding these changes, refer to our 2017 Fee Schedule summary (pages 1-3).

CMS also made changes to the quality audit process which take effect in 2017. CMS will now audit enough medical records to achieve a 90 percent confidence interval; conduct the audit in a single phase; and calculate an overall audit performance rate. Implementation of the new streamlined audit process will begin in spring 2017 to validate data received from ACOs for the 2016 performance year. See the 2017 Fee Schedule summary (pages 2-3) for more details.

Finally, CMS also made changes to measure ACO-11 which evaluates ACOs' use of EHRs, which take effect for 2017 reporting. Beginning in 2017, this measure evaluates all eligible clinicians' (ECs) use of EHRs. ACOs will also now be required to follow reporting instructions for this measure as detailed in the new Advancing Care Information (ACI) criteria under The Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP). Read more about these new requirements in NAACOS's resource: *The ACO Guide to MACRA* (pages 31-33) as well as our 2017 Fee Schedule summary (pages 3-4).

First Performance Year Under MACRA

2017 marks the first performance year under the MACRA QPP. Medicare physician fee schedule payments in 2019 are based on performance in 2017, for both those participating in the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). ACOs have unique performance requirements and evaluations under MACRA. Track 1 ACOs will be evaluated under MIPS using the MIPS APM Scoring Standard, and the Next Generation ACO model, as well as MSSP Track 2 and 3, qualify as Advanced APMs. Therefore, the ECs in ACOs that meet Qualifying APM Participant (QP) thresholds in these Advanced APM Entities will receive a 5 percent bonus in 2019 based on their 2018 Medicare payments. Learn more about this complex new law and how it impacts ACOs by reviewing NAACOS's resource: *The ACO Guide to MACRA.*

SNF 3-Day Rule Waiver Changes

The Social Security Act requires that Medicare beneficiaries have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient Skilled Nursing Facility (SNF) care. The Next Generation ACO model has a waiver that allows beneficiaries to receive SNF care without having the required inpatient stay, and this waiver of the 3-day SNF rule will be available to MSSP Track 3 ACOs starting in 2017. Specifically, Track 3 ACOs may apply to CMS for a waiver of the 3-day SNF rule beginning with performance year 2017. If approved, this waives the requirement for a 3-day inpatient hospital stay prior to a Medicare covered post-hospital extended care service for eligible beneficiaries prospectively assigned to the ACO that receive otherwise covered post-hospital extended care services. This pertains to services furnished by an eligible SNF that has entered into a written agreement to partner with the ACO for purposes of this waiver, and the SNF must maintain a quality rating of 3 stars or greater. The waiver is only for prospectively assigned Track 3 beneficiaries.

The 2017 Medicare Physician Fee Schedule rule modified the MSSP Track 3 SNF 3-day rule waiver to include a 90-day grace period that permits payment for SNF services provided to beneficiaries who were initially on the ACO's prospective assignment list for a performance year, but were subsequently excluded and are therefore not eligible for the waiver as a beneficiary protection. In such instances where SNF services are not covered but would have been covered under the SNF 3-day rule waiver, CMS will make payments for these SNF services, provided certain conditions are met. The Next

Generation model has a similar 90-day grace period. For more information, access our Medicare Physician Fee Schedule summary (pages 6-7).

New Bundled Payment Models Take Effect

A new mandatory Cardiac Episode Payment model (EPM) is scheduled to begin July 1, 2017 in 98 geographic areas across the United States. Additionally, the Comprehensive Care for Joint Replacement (CJR) model will be expanded in July 2017. The overlap of mandatory and voluntary bundled payment models will continue to create complexities for ACOs in 2017.

Unfortunately, in the EPM rule finalized in late 2016, CMS has created a policy which will exclude only beneficiaries aligned to Track 3 MSSP and Next Generation ACOs from EPMs. CMS will also exclude beneficiaries from EPMs who are aligned to End Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) in the Comprehensive ESRD Care initiative in tracks with downside risk for financial losses. This overlap policy is limited to AMI, CABG, SHFFT and CJR payment models. Shared savings payments to ACOs and losses repaid by ACOs to CMS have the potential to overlap with EPM reconciliation payments. As with CJR, CMS will attribute savings achieved during an EPM episode to the EPM participant, and include EPM reconciliation payments for ACO-assigned beneficiaries as ACO expenditures. Additionally, for EPMs CMS will make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the MSSP or any other ACO model, but only when an EPM hospital also participates in the ACO and the beneficiary in the EPM episode is also assigned to that ACO. In these cases, CMS will reclaim from the EPM participant any discount percentage paid out as shared savings for ACOs when the hospital is an ACO participant and the beneficiary is aligned with that ACO.

NAACOS will continue its advocacy efforts to establish policies which would exclude ACO patients from these initiatives to allow ACOs to continue to provide population focused care for its beneficiaries. Learn more about episode payment models and their overlap with ACO efforts in this resource.

Value-Based Payment Modifier (VM) Application

The 2017 VM is applied to ACOs based on 2015 performance. Providers and groups outside of ACOs are evaluated on quality and cost, however Tax Identification Numbers (TINs) that participated in a MSSP ACO in 2015 are automatically classified as "average" for the VM Cost Composite and thus will only be evaluated on quality. This is due to the fact that the agency already evaluates ACO cost through the MSSP. The 2017 VM Quality Composite score was calculated based on the quality data submitted by the ACO via the 2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Web Interface and the ACO's performance on the claims-based 30-day All-Cause Hospital Readmission Measure calculated by CMS using claims data. ACO participants may receive an upward, neutral or downward payment adjustment based on their Quality Composite performance and TIN size.

The 2017 VM is waived for groups and solo practitioners, as identified by their Medicare-enrolled TIN, if at least one eligible professional who billed for Medicare physician fee schedule items and services under the TIN during 2015 participated in the Pioneer ACO Model. For more information, access our NAACOS resource giving an overview of the 2015 Quality Resource Use Reports (QRURs) and 2017 VM or the CMS ACO FAQs on 2017 Value Modifier. Payment adjustments resulting from the VM are applied at the TIN level.

Application of Meaningful Use Penalties
In 2017, Meaningful Use penalties are applied to those eligible professionals (EPs) who did not meet reporting criteria in 2015. The payment adjustment is a -2 percent reduction to covered professional services billed under the Medicare Physician Fee Schedule for 2017 and will be applied on each claim as it is processed for the affected clinicians. According to CMS, EPs that are subject to the EHR Incentive Program (Meaningful Use) Medicare payment adjustment for 2017 received separate notification from CMS via a United States Postal Service (USPS) letter in December 2016. The PQRS, EHR Incentive Program, and Value Modifier currently use claim adjustment reason code (CARC) 237 – Legislated/Regulatory Penalty, to designate when a negative or downward payment adjustment will be applied. Learn more about the 2015 Meaningful Use requirements here. More details on the 2017 penalty can be found here. The deadline for EPs to submit Reconsideration forms for the 2017 payment adjustment, based on the 2015 EHR reporting period is February 28th, 2017. For inquiries about the Reconsideration Application, CMS advises to email pareconsideration@provider-resources.com.

Penalties will also be applied in fiscal year 2017, beginning Oct. 1, 2016, to those eligible hospitals and critical access hospitals (CAHs) who did not meet 2015 reporting requirements. In 2015, eligible hospitals and CAHs were required to report for any continuous 90-day period from October 1, 2014 to December 31, 2015. Eligible hospitals that are not meaningful EHR users are subject to a payment adjustment that is applied as a reduction to the applicable percentage increase to the Inpatient Prospective Payment System (IPPS) payment rate, thus reducing the update to the IPPS standardized amount for these hospitals. Eligible hospitals receive the payment adjustment amount that is tied to a specific fiscal year, therefore eligible hospitals that did not successfully demonstrate meaningful use for the reporting period in 2015 are receiving a reduction to the IPPS applicable percentage increase in FY 2017. If a CAH does not demonstrate meaningful use for the 2015 EHR Reporting Period, its Medicare payment will be reduced from 101 percent of its reasonable costs to 100.66 percent of reasonable costs. For more information on the hospital reporting requirements for Meaningful Use, visit the CMS website.

Application of PQRS Penalties
In 2017, Physician Quality Reporting System (PQRS) penalties are applied to those EPs who did not meet reporting criteria in 2015. The payment adjustment is a -2 percent reduction to covered professional services billed under the Medicare Physician Fee Schedule for 2017 and will be applied on each claim as it is processed for the affected clinicians. If the ACO Primary Tax Identification Number (TIN) satisfactorily reports quality data through its ACO Group Practice Reporting Option (GPRO) Web Interface reporting, the Participant TINs avoid the 2017 PQRS negative adjustment. More information on PQRS is available on the CMS website.

Hospital Value-Based Programs Continues
The Hospital Value-Based Purchasing (VBP) Program is a Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries. CMS bases hospital performance on an approved set of measures and dimensions grouped into specific quality domains. These domains vary depending on the fiscal year. For FY 2017, hospitals with sufficient data in at least three out of the four domain scores receive a TPS. The Hospital VBP Program is funded by a percentage withheld from participating hospitals' Diagnosis-Related Group (DRG) payments. For FY 2017 that amount is 2 percent of DRG payments. More information is available in this CMS fact sheet. Additionally, the CMS Readmissions Reduction Program and Hospital Acquired Condition (HAC) Reduction Program continue in FY 2017. Section 3025 of the Affordable Care Act established the Hospital Readmissions Reduction Program, which requires

CMS to reduce payments to IPPS hospitals with excess readmissions. The HAC Reduction Program adjusts payments to applicable hospitals that rank in the worst-performing quartile of all subsection (d) hospitals with respect to risk-adjusted HAC quality measures. These hospitals will have their payments reduced to 99 percent of what would otherwise have been paid for such discharges. In the FY 2017 HAC Reduction Program, hospitals with a Total HAC Score greater than 6.5700 are subject to a payment reduction.

Should you have feedback on this resource or further questions, please contact us at advocacy@naacos.com.