After 'banner year,' Shared Savings pushes ahead with bold changes, good numbers

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Medicare Shared Savings Program

The change of quality reporting method for accountable care organizations (ACO) in the Medicare Shared Savings Program (MSSP) from APP to APP Plus is significant, and will grow even more important with the proposed full switch-over to electronic clinical quality measures (eCQM) in five years (*see the Quality Payment Program article*). But other bold strokes, like the new prepaid model and the Health Equity Benchmark Adjustment (HEBA), are expected to have a more immediate effect.

"The [MSSP] policies in the CY 2025 PFS final rule are expected to further drive growth in participation, particularly in rural and underserved areas, promote equity, and advance alignment across accountable care initiatives, and are central to achieving CMS' goal of having 100% of people with traditional Medicare in a care relationship with accountability for quality and total cost of care by 2030," CMS says.

As the rule points out, 19 MSSP ACOs are already getting advance investment payments (AIP) for "caring for underserved communities" in the health-equity-conscious Primary Flex model under CMS' Center for Medicare and Medicaid Innovation (CMMI) (*PBN 4/1/24*). The new prepaid option, which authorizes upfront payment to certain MSSP participants on the condition that they devote 50% of the payment to the provision of "direct beneficiary services... not otherwise payable in traditional Medicare," has been finalized without significant changes from the proposed rule.

Notably, the mention of specific direct beneficiary services that was made in the proposed rule, e.g. meals, dental, vision or hearing coverage, was not repeated in the final.

"CMS certainly received a lot of feedback that the 50% requirement to use pre-paid shared savings for certain things ['non-Medicare covered services'] is a major departure from how the program operates today," says Ashley Ridlon, vice president of health policy with Evolent Health. "Having more flexibility is generally preferred. I think it's reasonable to assume there will have to be more guidance there."

The Health Equity adjustment, in which an MSSP ACO's benchmark is upwardly adjusted if at least 15% of assigned beneficiaries are enrolled in Medicare Part D low-income subsidy (LIS) or are dually eligible for Medicare and Medicaid, is "critical," says Dave Halpert, chief of client team, Roji Health Intelligence in Chicago.

"In order to ensure that all traditional Medicare beneficiaries are in an accountable care relationship, support for ACOs in rural and underserved areas is critical," Halpert says. With this adjustment, "to entice providers in these areas, an ACO will be able to spend more on patient care before crossing from shared savings into shared losses. The HEBA will also offset the CBO's finding that ACOs launching in rural and underserved communities have higher start-up costs than their peers. Furthermore, this will help to mitigate the historically — and unfortunately — low health care spending trends in rural and underserved communities."

Ridlon and Halpert believe these investments are promising for the program, which CMS reports now stands at "480 ACOs with over 634,000 health care providers and organizations providing care to over 10.8 million assigned beneficiaries," and which the Biden administration recently reported had yielded $2.1 billion in savings for the Medicare fund in 2023 alone.

"It's been a banner year for the Medicare Shared Savings Program," Ridlon says. "All of the changes in this rule are mainly at the margins, tweaks to improve the program. Regardless of politics and changes in administration, the work will continue to make this program better."

Note other changes

Along with technical changes in benchmarking and other metrics, CMS made a number of other program changes including:

A break for sub-5,000 ACOs. When an MSSP ACO's assigned population fall below 5,000 beneficiaries during their agreement period, they're supposed to submit a corrective action plan (CAP), whereupon CMS adjusts their Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR) so "both CMS and the ACO from inappropriate over or underpayments" until such time as the ACO either gets back to 5,000 beneficiaries or is cut from the program. CMS proposes no longer cutting such ACOs, although they must have 5,000 at the outset of any reporting period or they cannot join or re-up.

Sharing with the feds. New entrants must agree that CMS may share their application information with "the Antitrust Agencies" — that is, the U.S. Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ).

New non-primary beneficiary assignment codes, standard. Attribution of beneficiaries to an ACO has traditionally been based on their utilization of primary care services as indicated by selected CPT and HCPCS codes billed by an ACO-affiliated primary care physician. CMS will now add 14 new primary care codes as well, including the post-discharge telephonic follow-up contacts intervention code **G0544**; advanced primary care management services codes **G0556, G0557** and **G0558**; and the direct care caregiver training services codes **G0541, G0542** and **G0543**. (The interprofessional consultation codes that had been proposed were not finalized for attribution.)

Also, CMS will allow ACOs in certain circumstances to assign MSSP beneficiaries to entities participating in certain disease- or condition-specific CMS Innovation Center ACO models, such as the Comprehensive ESRD Care (CEC) model.

Significant, anomalous, and highly suspect (SAHS) billing activity. As proposed, CMS "will exclude payment amounts from expenditure and revenue calculations for the relevant calendar year for which the SAHS billing activity is identified, as well as from historical benchmarks used to reconcile the ACO for a [relevant] performance year."

Beneficiary notification requirement modifications. ACOs already have to provide notification to beneficiaries when they have been assigned; now they must also send a follow-up notice no later than 180 days after the first one

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