MILLIMAN WHITE PAPER

"Pathways to Success" MSSP proposed rule: Beneficiary incentive program

The proposed rule offers new flexibilities for accountable care organizations to offer monetary beneficiary incentives—presenting the opportunities, risks, and responsibilities for ACOs

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On August 8, 2018, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that will significantly change the Medicare Shared Savings Program (MSSP) if enacted.[1] This paper is the fifth in a series of Milliman white papers on the proposed rule and focuses on the beneficiary incentive program.

Proposed changes to the MSSP include allowing accountable care organizations (ACOs) taking on two-sided risk (i.e., upside and downside risk) the flexibility to establish beneficiary incentive programs. Beginning as early as July 2019, CMS proposes to allow certain MSSP ACOs to provide general monetary incentive payments to beneficiaries who receive primary care services in order to foster greater patient engagement.

Overview

Under the proposed rule, ACOs under two-sided risk arrangements, regardless of their elected assignment methodologies, will have the option of offering incentive payments of up to $20 per service for all primary care services. To participate in the program, ACOs must agree to a minimum of 12 months of participation (18 months for ACOs that start on July 1, 2019) and must provide incentives of equal value to *all* beneficiaries assigned to the ACO and who seek primary care with an ACO provider, regardless of the value of that primary care service to advancing the ACO's goals. In this paper, we explore the details of the current and proposed policies for beneficiary incentives.

[1] CMS (August 17, 2018). Proposed Rule: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success. HHS. Federal Register. Vol. 83, No. 160.

Background: Current policies

ACO-SPECIFIC BENEFICIARY INCENTIVE POLICIES

ACOs currently have some flexibility to offer beneficiary incentives to encourage patient engagement, promote care coordination, and achieve the objectives of the MSSP to improve quality and reduce costs. ACOs, along with ACO participants, ACO providers and suppliers, and other individuals or entities performing functions or services related to ACO activities may provide in-kind items and services (not including those that are Medicare-covered) to beneficiaries if the following criteria are met:

- There is a reasonable connection between the items or services and the medical care of the beneficiary.
- The items or services are preventive care items or services or advance a clinical goal of the beneficiary, including adherence to a treatment regime; adherence to a drug regime; adherence to a follow-up care plan; or management of a chronic disease or condition.

Incentives may currently be offered on a targeted basis to beneficiaries based on patient-specific clinical goals. While the permissibility of incentives must be assessed against the applicable law and regulations on a case-by-case basis, the proposed rule presents a variety of acceptable examples under existing policies that illustrate the flexibilities available at present to ACOs:

- Vouchers for over-the-counter medications recommended by a healthcare provider; prepaid, nontransferable vouchers that are redeemable for transportation services solely to and from an appointment with a healthcare provider
- Items and services to support management of a chronic disease or condition, such as home air-filtering systems or bedroom air-conditioning for asthmatic patients, and home improvements such as railing installation or other home modifications to prevent reinjury
- Wellness program memberships, seminars, and classes; electronic systems that alert family caregivers when a family member with dementia wanders away from home

- Vouchers for those with chronic diseases to access chronic disease self-management, pain management, and fall prevention programs
- Vouchers for those with malnutrition to access meals programs
- Phone applications, calendars, or other methods for reminding patients to take their medications and promoting patient adherence to treatment regimes

BENEFICIARY INCENTIVES UNDER EXISTING FRAUD AND ABUSE LAWS

In addition to the flexibility that allows MSSP ACOs to provide certain types of incentives, ACOs, ACO participants, and ACO providers and suppliers may offer a beneficiary an incentive to promote the beneficiary's clinical care if the incentive does not violate the federal AntiKickback Statute (AKS, section 1128B[b]), the Civil Monetary Penalties (CMP) law provision relating to beneficiary inducements (section 1128A[a][5]), or other applicable law.

Recently, the Office of the Inspector General (OIG) identified the broad reach of the AKS and beneficiary inducements CMP as a potential obstacle to beneficial arrangements that would advance coordinated care. Because care coordination is a key aspect of value-based delivery systems, removing unnecessary government obstacles to care coordination for all individuals and entities involved in the delivery of healthcare is a key priority for the U.S. Department of Health and Human Services (HHS). On August 27, 2018, the OIG released a request for information (RFI) seeking input from the public on how to address any current regulatory provisions that may act as barriers to coordinated care or value-based care.[2] The RFI specifically requests public information about ways the OIG might modify or add new safe harbors to the AKS and exceptions to the beneficiary inducements CMP definition of ''remuneration'' to foster arrangements that would promote care coordination and advance the delivery of value-based care. As a supplement to ACO-specific beneficiary incentive flexibilities described in this paper, any future additional OIG safe harbors to the AKS or exceptions to the beneficiary inducements CMP may offer ACOs further opportunities to encourage patient engagement.

Despite what is permitted under current law, the additional flexibilities afforded by the current MSSP policies, and the federal interest in the potential for offering greater flexibilities broadly in the future to individuals and entities providing healthcare services and coordinating care, ACO beneficiaries cannot currently receive general monetary incentives in order to increase patient engagement.

[2] OIG (August 27, 2018). Request for Information Regarding the Anti- Kickback Statute and Beneficiary Inducements CMP. HHS. Federal Register. Vol. 83, No. 166.

Proposals for the MSSP beneficiary incentive program

CMS will continue to allow ACOs to provide in-kind items and services under the existing criteria described above (reasonable connection to the medical care of the beneficiary and a preventive care service or a service that advances a clinical goal of the beneficiary). They also clarify that the provision of in-kind items and services is available to all Medicare fee-for-service (FFS) beneficiaries and is not limited solely to beneficiaries assigned to an ACO.

We present key elements of the proposals including implications for ACOs in the following sections.

ACOS UNDER TWO-SIDED RISK ARRANGEMENTS ARE ELIGIBLE REGARDLESS OF ASSIGNMENT METHOD

An ACO in a two-sided risk model (Track 2; Levels C, D, or E of the BASIC track; or the ENAHNCED track), regardless of the ACO's election of prospective or preliminary prospective assignment, can apply to offer a beneficiary incentive program.

APPLICATION FOR THE PROGRAM IS REQUIRED, BEGINNING AS EARLY AS THE JULY 1, 2019, CYCLE

An eligible ACO can apply to offer a beneficiary incentive program beginning during the July 1, 2019 MSSP application cycle or during a future annual application cycle for the MSSP. Moreover, an ACO that is already in an agreement can apply during the application cycle prior to the performance year in which the ACO chooses to begin implementing its beneficiary incentive program.

MINIMUM 12-MONTH PROGRAM PERIOD

An ACO's beneficiary incentive program is required to operate for a minimum of 12 months. For those ACOs starting an incentive program on July 1, 2019, the minimum period would be 18 months. Implications for ACOs include:

- The minimum 12-month commitment would place the ACO at risk for these payments regardless of changes in the number of qualifying services for which payments must be made throughout the year, whether in response to the incentive payments or other factors.
- The initial period of 18 months requires a longer commitment than usual for ACOs that are considering offering incentive payments at the first possible date, especially as CMS does not propose to allow an ACO itself to terminate its operation of a beneficiary incentive program.

INCENTIVE PAYMENTS FOR ALL PRIMARY CARE SERVICES

Qualifying services eligible for incentive payments must meet three requirements. First, they must be primary care services as previously defined for the MSSP—mainly evaluation and management (E/M) visits. Second, coinsurance must apply to the services under Medicare Part B. Third, the services must be provided by an ACO professional who is a primary care physician (general practice, family practice, internal medicine, geriatric medicine), physician assistant, nurse practitioner, or clinical nurse specialist, or a federally qualified health center (FQHC) or rural health clinic (RHC) to an ACO-assigned beneficiary. Implications for ACOs include:

- A service provided by an ACO professional who is a physician but who does not have a specialty designation included in the definition of primary care physician (regardless of whether the beneficiary has voluntarily designated that physician as the beneficiary's primary care provider for purposes of assignment to the ACO) would not be considered a qualifying service for which an incentive payment could be made. For example, an ACO could not provide incentive payments to a beneficiary with a chronic medical condition for office visits to the specialist the beneficiary has designated as a primary care provider, even if the specialist is managing the beneficiary's overall care.
- Given other proposals in the MSSP proposed rule to waive the geographic limitations on telehealth services and allow beneficiaries to receive these services at home, telehealth services (which include primary care services) may increase beginning in 2020. This could place an ACO at risk for increases in incentive payments that may be unrelated to a positive effect of the incentive payments on increasing primary care services but are, instead, related to additional telehealth flexibilities.

ALL INCENTIVE PAYMENTS ARE OF EQUAL VALUE

Incentive payments are required to be of equal monetary value and distributed as a cash equivalent, which includes instruments convertible to cash or widely accepted on the same basis, such as checks and debit cards. Implications for ACOs include:

- Unlike beneficiary incentives under existing rules, which may be targeted to specific beneficiaries based on their needs, an ACO could not offer higher-valued incentive payments for particular qualifying services or to particular beneficiaries. This would place the ACO at risk for incentive payments for some primary care services that may not help meet the ACO's objectives to reduce cost and improve quality. For example, beneficiaries who are already fully engaged and receiving regular primary care services resulting in well-managed clinical conditions would receive the same incentive payment as beneficiaries with a history of insufficient visits who are experiencing the negative health effects of poorly managed conditions.

MAXIMUM PER-SERVICE INCENTIVE PAYMENT OF $20

The maximum amount per qualifying service payment is $20 in the first year, updated annually by the consumer price index for all urban consumers (U.S. city average). Implications for ACOs include:

- Given that the coinsurance amount for Medicare Part B services is 20% and CMS proposed a $92 payment for office visits under the Physician Fee Schedule (PFS) for 2019, an ACO would have the flexibility to provide an incentive payment that would cover the coinsurance amount for typical primary care office visits.[3] This could remove a potential barrier to primary care for beneficiaries without secondary insurance if the ACO chooses to provide an incentive payment of $20 per qualifying service. However, the large majority of Medicare FFS beneficiaries have additional health insurance coverage.[4] Therefore, in most cases, the beneficiary incentive payment would be an additional payment to the beneficiary who receives the service.

PAYMENT BY ACO ENTITY WITHIN 30 DAYS OF SERVICE

The incentive payment must be made no later than 30 days after a qualifying service is provided to the beneficiary. Only the ACO legal entity, and not ACO participants or ACO providers or suppliers, can make the incentive payments directly to beneficiaries. Implications for ACOs include:

- Claims processing timelines are too long for ACOs to identify qualifying services using this method. An ACO with a robust electronic health record (EHR) with alerts would be able to flag qualifying primary care services when they are provided to trigger an incentive payment to the beneficiary. Otherwise, ACOs may need to instruct primary care providers to notify the ACO when qualifying services were provided, which would place a new operational burden on both primary care providers and the ACO.
- The ACO would be at risk for making an impermissible incentive payment if the claim for a service ultimately does not reflect a qualifying service or for failing to make a required incentive payment if there is a lapse in communication from the primary care provider.

3 CMS (July 27, 2018). Proposed Rule 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; and Medicaid Promoting Interoperability Program. HHS. Federal Register. Vol. 83, No. 145.

4 Medicare Payment Advisory Commission (June 2017).3: Medicare Beneficiary and Other Payer Financial Liability. A Data Book: Healthcare Spending and the Medicare Program Retrieved September 16, 2018, from http://www.medpac.gov/docs/default-source/data-book/jun17_databooksec3_sec.pdf?sfvrsn=0.

PROGRAM FULLY FUNDED BY ACO

An ACO is required to fully fund the costs associated with operating a beneficiary incentive program, including the cost of any incentive payments. The ACO is prohibited from accepting or using funds for the program provided by an outside entity, such as an insurance company or pharmaceutical company. The ACO is also not permitted to bill the cost of an incentive payment to any plan or program that provides health benefits, whether directly, through insurance, or otherwise, and that is funded directly, in whole or in part, by the U.S. government. The ACO is permitted to use Medicare shared savings to carry out the program.

DETAILED RECORDS MAINTAINED

An ACO is required to maintain records that include the following information: identification of each beneficiary who received a payment; the type and amount of each payment; the date of the qualifying service and the Healthcare Common Procedure Coding System (HCPCS) code; the identification of the ACO provider and/or supplier that provided the service; and the date the ACO provided each payment.

PUBLIC REPORTING OF AGGREGATE INFORMATION

An ACO is required to publicly report each year the number of beneficiaries who received an incentive payment, the number of incentive payments, HCPCS codes associated with the incentive payments, the total value of all incentive payments, and the total type of each incentive payment. Implications for ACOs include:

- The public reporting requirement would pose an administrative burden on an ACO. However, this information would allow members of the public, including ACO participants, ACO providers and suppliers, and other ACOs to identify an ACO's investments in incentive payments.

ADVERTISEMENT NOT PERMITTED

An ACO is prohibited from advertising a beneficiary incentive program. However, CMS is considering whether ACOs should be required to make beneficiaries aware of the incentive payments via approved outreach material from CMS.

INCENTIVE PAYMENTS EXCLUDED FROM ACO FINANCIAL CALCULATIONS

Incentive payments made by an ACO are disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings as well as for purposes of calculating shared losses.

ONLY CMS CAN TERMINATE AN ACO'S INCENTIVE PROGRAM

An ACO's incentive payment program can be terminated by CMS for failure to comply with the program requirements, as well as for the same reasons for which CMS can terminate an ACO's participation agreement. Termination can be without administrative or judicial review. CMS does not propose to allow an ACO to terminate its incentive program early. Implications for ACOs include:

- These provisions are general and pose some risk that CMS could terminate an ACO's program for lack of compliance with a minor requirement of the program.
- An ACO cannot terminate its incentive program early (before 12 months or 18 months, as applicable). Therefore, the ACO would have no way to mitigate its financial risk based on its ongoing assessment of financial performance or other factors once it establishes a beneficiary incentive program for the year.

PROGRAM EVALUATION

By October 1, 2023, a report to Congress is due that analyzes the impact of implementing beneficiary incentive programs on health expenditures and outcomes. While CMS makes no proposals for additional ACO reporting requirements for this evaluation, it seeks comments on whether there might be information that it should require ACOs to maintain (in addition to the information that would be maintained as part of record retention requirements) to support the evaluation. Implications for ACOs include:

- CMS notes that it does not want to discourage participation in the beneficiary incentive program by overly burdensome data management requirements, so there would likely be no additional burden on ACOs due to the evaluation alone.
- The timing of the evaluation makes it unlikely that ACOs would have meaningful information on the impact of beneficiary incentive programs on expenditures and outcomes to use in their decision-making about offering such a program for several years.

Conclusion

CMS's implementation proposals follow the requirements of the statutory provisions for the MSSP beneficiary incentive program. The program is a step toward providing ACOs with the ability to use incentive payments as an additional strategy to increase beneficiary engagement that promotes improved quality and reduced cost of care. However, both the statutory requirements for the program and CMS's proposed additional conditions, particularly the requirements that the ACO legal entity make all incentive payments and maintain detailed records, may pose an administrative burden on an ACO entity considering offering a program.

ACOs would be well advised to ensure they fully understand and evaluate the payment requirements for the program as they consider offering incentive payments. The operational burden could result in some ACO entities not applying to offer incentive payments due to the total cost of the program and its uncertain financial benefit. This could ultimately hurt the assignment of beneficiaries to ACOs that choose not to offer incentive payments because the required public reporting on the program may lead beneficiaries to ultimately choose which ACO they want to be a part of based on the incentive payments offered. Because the large majority of Medicare FFS beneficiaries have additional health insurance coverage**,** the beneficiary incentive payment would typically be an additional payment to the beneficiary who receives the service.

While beneficiary engagement is important to the overall MSSP objective of improved quality and reduced cost, the beneficiary incentive program does not provide ACOs with a flexible approach to engaging beneficiaries because the incentive payments cannot be targeted to individuals or specific primary care services. However, directed incentives that are not general monetary incentives can continue to be provided to beneficiaries under existing MSSP rules by both ACOs and other parties carrying out ACO activities. These other types of beneficiary incentives may have previously been underutilized by ACOs due to concerns over compliance with their legal requirements. CMS's specifics in the proposed rule detailing acceptable incentives may be helpful to ACOs thinking broadly about the types of beneficiary incentives they may want to offer to increase beneficiary engagement, whether it is through the new beneficiary incentive program or under existing regulations.

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