CMS issues Pathways to Success ACO proposed rule:

A discussion of proposed policy changes that would significantly alter the Medicare ACO program

On August 9, 2018, the Centers for Medicare & Medicaid Services (CMS) published the long-awaited Pathways to Success proposed rule. On the same day, CMS Administrator Seema Verma published a related article on the *Health Affairs Blog*. If finalized, the policies in the proposed rule would usher in significant changes for Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP), beginning with performance years that start on January 1, 2019.

Accountable care organizations

As a result of the Affordable Care Act, groups of providers, such as doctors and hospitals, may join together to form an ACO and be held accountable for the quality and cost of care provided to a group of assigned beneficiaries. Providers in an ACO continue to be reimbursed on a fee for service basis under Medicare Parts A and B. If the ACO meets certain quality and savings thresholds, the ACO is eligible to share a portion of the savings with CMS. Since 2012, there have been several ACO initiatives :

- Pioneer ACO model
- MSSP Track 1, 2, and 3
- Track 1+ model
- Next generation ACO model
- Comprehensive end-stage renal disease care model

Additional information about these ACO programs may be found here. In the fact sheet released with the proposed rule, CMS states that ACOs in Track 1 that have been generating losses while having access to certain fraud and abuse waivers as a result of their participation, “may be encouraging consolidation in the market place, reducing competition and choice for Medicare FFS beneficiaries.” In January, CMS announced that 561 ACOs were participating in MSSP, covering 10.5 million Medicare fee-for-service beneficiaries. Physicians, hospitals and other facilities made up 58% of ACOs, 30% were physician only, and 12% were federally qualified health centers or rural health clinics. Presently, 82% (460 of 561) of MSSP ACOs participate as upside-only Track 1 ACOs. Additionally, 55 were in Track 1+, 8 were in Track 2, and 38 were in Track 3. CMS states that in 2018, there are over 20,000 ACO Participant Taxpayer Identification Numbers that include 377,515 clinicians.

CMS results have shown that two-sided model ACOs have performed better over time than one-sided model ACOs. In a one-sided model, the ACO may receive a share of any savings below their benchmark. An ACO participating in a one-sided model will not be responsible for repayment of any losses if their spending exceeds the benchmark. On the other hand, an ACO participating in a two-sided model may be eligible to share in a larger portion of savings but is also required to share in losses where their spending exceeds the benchmark. MSSP results have also shown that ACOs perform better the longer they participate in the program.

The proposed rule is intended to encourage ACOs to take on greater risk and demonstrates CMS' willingness to grant additional flexibility in how care is provided when the ACO takes on greater risk.

In this whitepaper we discuss several proposed policy changes that would significantly alter the Medicare ACO programs.

Restructuring of the MSSP tracks

CMS proposes to discontinue Track 1, Track 2, and Track 1+ and replace them with two exclusive tracks that an ACO would participate in for no less than five years: BASIC and ENHANCED. ACOs currently participating in Track 1, Track 2, or Track 1+ may finish their current agreement or terminate and apply to immediately participate in a BASIC or ENHANCED track. ACOs would be required to enter the BASIC or ENHANCED tracks beginning on July 1, 2019. A comparison of BASIC and ENHANCED track characteristics can be found in Appendix A of the CMS fact sheet.

BASIC track

The BASIC track would use a "glide path" to permit ACOs to begin in a one-sided model that incrementally phases into higher levels of risk sharing. An ACO would have two years (Levels A and B) of upside-only risk and then gradually move to increased shared risk (Levels C, D, and E). The ACO would automatically advance to the next level each year. Once the ACO is at the highest level of risk (Level E), they would qualify as an Advanced Alternative Payment Model under the Quality Payment Program (QPP). CMS believes the BASIC track "would provide an additional opportunity for organizations to enter a risk-sharing arrangement and accept greater responsibility for beneficiary care."

As ACOs enter the performance-based risk portion of the glide path (Levels C, D, E), they would be required to select a Minimum Savings Rate and a Minimum Loss Rate, as well as establish an adequate repayment mechanism (discussed infra). An ACO's participation options in the BASIC track would depend on an ACO's prior experience with MSSP. If an ACO is new to the program, they may enter the glide path at any level. ACOs previously participating in Track 1, or a reentering ACO, are limited to one year of upside-only risk under Level B. CMS believes that ACOs with experience need less time prior to transitioning to performance-based risk. Notably, ACOs would be permitted to annually elect to take on higher risk. However, once a higher level of risk has been chosen, the ACO may not return to a lower level of risk.

The maximum upside reward is equal to the upside found in the Track 1 and the Track 1+ model.

Sharing rates in the proposed BASIC track:

	Levels A&B	Level C	Level D	Level E
Shared savings	Up to 25% (dependent on quality performance) not to exceed 10% of updated benchmark	Up to 30% (dependent on quality performance) not to exceed 10% of updated benchmark	Up to 40% (dependent on quality performance) not to exceed 10% of updated benchmark	Up to 50% (dependent on quality performance) not to exceed 10% of updated benchmark
Shared losses	N/A	30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the QPP, capped at a percentage of updated benchmark that is 1% higher than the expenditure-based nominal amount standard in 42 C.F.R. §414.1415(c)(3)(i)(B) (in order to qualify for Advanced APM)

ENHANCED track
CMS proposes to rename current Track 3 as the ENHANCED Track. Presently, Track 3 ACOs have the greatest opportunity for upside and downside risk. Track 3 ACOs have prospectively assigned beneficiaries, a symmetrical Minimum Savings Rate and Minimum Loss Rate that varies based on the number of assigned beneficiaries. The shared savings rate limit is 20% of the ACO's benchmark and the shared loss limit is 15% of the ACO's benchmark.

Sharing rates in the proposed ENHANCED track:

	ENHANCED track
Shared savings	Up to 75% (dependent on quality performance) not to exceed 20% of updated benchmark
Shared losses	1 minus the final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

Participation options
CMS proposes placing limits on participation based on an ACO's experience and revenue. An ACO would be designated as "low revenue" or "high revenue." CMS proposes the following definitions:

Low revenue ACO: An ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants based on revenue for the most recent calendar year for which 12 months of data are available, is less than 25 percent of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries based on expenditures for the most recent calendar year for which 12 months of data are available.

Low-revenue ACOs have less control over beneficiary expenditures, such as physician practices.

High revenue ACO: An ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants based on revenue for the most recent calendar year for which 12 months of data are available is at least 25 percent of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries based on expenditures for the most recent calendar year for which 12 years of data are available.

High revenue ACOs typically include a hospital, and are able to coordinate a greater portion of beneficiary care and expenditures across settings.

Despite high revenue ACOs being "able to exert more influence, direction, and coordination over the full continuum of care", low revenue ACOs have tended to perform better. In 2016, "41 percent of low revenue ACOs shared savings compared to 23 percent of high revenue ACOs." CMS wishes to drive more meaningful change in high revenue ACOs, while continuing to encourage participation by low revenue ACOs that may need additional time and support before moving to performance-based risk. Therefore, CMS proposes to move ACOs with higher revenue to a higher loss sharing limit while continuing to offer a lower loss sharing limit to low revenue ACOs.

To date, ACOs have been able to participate in MSSP Track 1 with upside-only risk for two agreement periods (six years). ACOs with experience would be limited to participation in the performance-based risk options. An ACO would be considered "experienced" with performance-based risk Medicare ACO (two-sided) initiatives if:

(1) the ACO is the same legal entity as a current or previous participant in a performance-based risk Medicare ACO initiative, or

(2) CMS determines that 40% or more of the ACO's participants participated in a performance based risk Medicare ACO initiative in any of the five most recent performance years.

CMS also proposes limitations on participation options for "re-entering ACOs." The proposed rule would define re-entering ACOs as those having more than 50% of their ACO participants with recent prior experience in a Track 1 ACO. For "experienced" ACOs or re-entering ACOs, there would be a limit of one performance year under the one-sided model in Level B of the BASIC track.

Thus, CMS proposes the following participation options based on an ACO's revenue and experience with performance-based risk:

- **High-revenue/inexperienced** – May participate in the BASIC or ENHANCED tracks. If the ACO has previously participated in Track 1 or is a re-entering ACO, than it may only participate in BASIC track levels B, C, D, or E.
- **High-revenue/experienced** – Only permitted to participate in the ENHANCED TRACK.
- **Low-revenue/inexperienced** – May participate in the BASIC or ENHANCED tracks. If the ACO previously participated in Track 1 or is a re-entering ACO, than it may only participate in BASIC track levels B, C, D, or E.
- **Low-revenue/experienced** – May participate in BASIC track E or the ENHANCED track.
- Low-revenue ACOs may participate in a second agreement under the BASIC track, but must participate at Level E (the highest shared-risk level in the BASIC track) during the second agreement period.

Qualifying as an advanced alternative payment model (Advanced APMs)
Under the Quality Payment Program (QPP), eligible clinicians that significantly participate in Advanced APMs receive incentive payments between 2019 – 2024 and will receive larger fee schedule updates beginning in 2026. Currently, Tracks 2 and 3 of the MSSP and the Track 1+ Model are Advanced APMs. CMS proposes that once an ACO reaches the highest level of risk (Level E) in the BASIC track, they would qualify as an Advanced APM. The ENHANCED track would immediately qualify as an Advanced APM.

Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)
Under the BASIC track, CMS proposes that ACOs would continue to use the same MSR/MLR options available under the MSSP. Specifically, in a one-sided model of the BASIC track, ACOs would have a variable MSR dependent on their number of assigned beneficiaries. The two-sided risk models under the BASIC track and the ENHANCED track would have symmetrical MSR/MLR options.

ACOs in a performance-based risk model are required to have a repayment mechanism. CMS proposes to keep the same repayment mechanisms presently available to ACOs.: (1) funds placed in escrow; (2) a line of credit evidenced by a letter of credit that Medicare could draw upon; or (3) a surety bond.

Length of agreement period
CMS proposes to require agreement periods of no less than five years instead of the current three year agreement periods. Section 1899(b)(2)(B) of the Social Security Act requires participating ACOs to enter into agreements that are no less than three years. CMS believes that five year agreement terms may provide greater certainty regarding benchmarks and offer ACOs "a greater chance to succeed in the program by allowing them more time to understand their performance, gain experience and implement redesigned care processes before rebasing of the ACO's historical benchmark." For agreements that begin on July 1, 2019, the initial length of the agreement would be five years and six months. Agreements beginning on January 1, 2020 and later would have a five year agreement period. CMS proposes to end the deferred renewal option for Track 1 ACOs under 42 CFR § 425.200(e). The deferred renewal option permits a Track 1 ACO to defer for one year a renewal for a second agreement period that would be in a two-sided risk model.

Choice of beneficiary assignment methodology
ACOs would be permitted to annually choose their assignment methodology. Presently, ACOs in Tracks 1 and 2 are assigned beneficiaries under preliminary prospective assignment with retrospective reconciliation. ACOs in Track 3 are prospectively assigned beneficiaries. The BASIC and ENHANCED tracks would permit an ACO to select prospective assignment or preliminary prospective assignment with retrospective reconciliation prior to the start of each agreement period. An ACO would be able to change their selection for each subsequent performance year.

Fee-for-service benefit enhancements

CMS proposes to allow ACOs with performance-based risk under either prospective assignment or preliminary prospective assignment with retrospective reconciliation to use the existing skilled nursing facility (SNF) three-day rule waiver. The waiver permits coverage of certain SNF services for beneficiaries that are not preceded by a three-day inpatient hospital stay. The SNF three-day rule waiver has been available to ACOs participating in Track 3 of the MSSP and the Track 1+ model. The proposed rule also seeks to implement the Bipartisan Budget Act of 2018 by permitting eligible physicians and practitioners in ACOs in a performance-based risk track to receive payment for telehealth benefits beginning January 1, 2020, even where geographic limitations have not been met. Additionally, the home of a beneficiary may be treated as an originating site.

Tools to strengthen beneficiary engagement

In order to implement the Bipartisan Budget Act of 2018, CMS proposes to permit ACOs in levels C, D, or E of the BASIC track or the ENHANCED track to establish a beneficiary incentive program. The incentive payment could be up to $20 for assigned beneficiaries that receive qualifying services. The incentive payment would need to be provided no later than 30 days after the qualifying service has been provided. Due to program integrity concerns, the incentive payments may not be provided in cash. Instead, the incentive payment must be in the form of a cash equivalent, such as checks, debit cards, and vouchers. The voucher can be used towards preventive care items or services or to advance a health goal for the beneficiary.

The proposed rule also seeks to improve transparency between ACOs and beneficiaries. CMS proposes to require that a written notice be provided to beneficiaries at their first primary care visit during a performance year, beginning July 1, 2019. The notice would inform beneficiaries that their provider is participating in the MSSP, about voluntary alignment, and the ability to decline sharing of their claims data. CMS proposes to require ACO participants to use a template notice. The proposed rule also requests comment on a beneficiary "opt-in" methodology whereby the beneficiary could choose to be attributed to an ACO.

Voluntary alignment

To implement the Bipartisan Act of 2018, CMS proposes to permit beneficiaries to choose their "primary clinician" from a broader range of ACO professionals, regardless of specialty. A beneficiary that selects a primary clinician, but who doesn't receive any services from an ACO participant during the assignment window, will still remain eligible for assignment to the ACO.

Use of certified electronic health record technology

CMS proposes to require a certain threshold of an ACO's eligible clinicians to use Certified Electronic Health Record Technology (CEHRT). ACOs that are considered an Advanced APM under the QPP would attest to the level of CEHRT required for the QPP. ACOs that do not meet the Advanced APM designation would be required to attest that at least 50% of eligible clinicians use CEHRT.

Financial performance

CMS proposes to hold ACOs participating in the two-sided model accountable for partial year losses if they leave the program more than mid-way through a performance year. The proposed rule proposes to terminate ACOs with a record of poor financial performance. More specifically, CMS proposes a financial performance review where if the ACO generates losses that were negative outside corridor for two performance years they may be subject to corrective action or termination of the ACO agreement. "Negative outside corridor" would be defined to mean that expenditures for assigned beneficiaries exceed the ACO's updated benchmark by an amount equal to or exceeding the ACO's negative MSR under a one-sided model, or the ACO's MLR under a two-sided model. CMS states that ACOs in two-sided models tend to terminate participation following a single year of losses.

Benchmarks

The proposed rule would also modify the calculation of benchmarks by including regional and national spending growth rates. A historical benchmark is calculated using beneficiary expenditures that would have been assigned to the ACO in the three years before the agreement period. Presently, a national trend factor is used in the first agreement period, and is replaced by a phased approach that uses regional trend factors in rebasing the benchmark for the second or subsequent agreement period. At reconciliation, the benchmark is risk adjusted to account for health and demographic factors of the ACO's beneficiary population.

CMS proposes to incorporate regional FFS expenditures to establish the ACO's historical benchmark in the first agreement period beginning on July 1, 2019. CMS would continue to weigh the three benchmark years with weights of 10%, 30%, and 60%. CMS proposes to blend national and regional expenditure growth weights, with a larger weight on the national component as the ACO's regional penetration increases.

CMS would also apply a regional adjustment to the ACO's first benchmark calculation. CMS proposes that a regional adjustment weight of 35% would apply to the benchmark for the first agreement period if the ACO's historical spending was lower than its region, and a weight of 25% if the historical spending was higher. For the second performance agreement, the regional weights would increase to 50% and 35%. The third or subsequent benchmark calculation would apply a weight of 50% in all cases. CMS believes that a five year agreement period will provide greater certainty to benchmark amounts. CMS proposes to use full CMS-HCC risk adjustment for all assigned beneficiaries between the benchmark period and the performance year, subject to a symmetrical cap of positive or negative 3% for the agreement year.

Start date
CMS is proposing a mid-year start date of July 1, 2019 for the first agreement period under the BASIC and ENHANCED tracks. ACOs participating in this initial agreement period would have an agreement period of five years and six months. ACOs that have a participation agreement ending December 31, 2018 would be allowed to extend their agreement through June 30, 2019. The ACO could then apply for a new agreement under the BASIC or ENHANCED tracks. ACOs that currently participate in Track 1, Track 2, Track 3, or the Track 1+ Model may choose whether to finish their current agreement, or to immediately enter a new agreement under the BASIC or ENHANCED tracks.

The agency projects savings from the proposed changes would save Medicare $2.24 billion over the next decade. They also predict a decrease in participation of 109 ACOs in 2028.

Next steps
ACOs, ACO Participants, and other stakeholders should examine the provisions of this proposed rule and consider the potential ramifications on their business operations. Stakeholders and interested parties should consider submitting comments to CMS. Norton Rose Fulbright can assist clients with the drafting and submission of comments and advise on the proposed rule's possible implications. Comments must be submitted to CMS by October 18, 2018 and may be submitted here.

For additional information regarding this proposed rule, please contact the Norton Rose Fulbright professional(s) listed below.

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