NCHA Financial Feature

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CMS Issues Proposed ACO Rule; Would Extensively Restructure the Program

The Centers for Medicare and Medicaid Services (CMS) has published a proposed rule that would overhaul the Medicare Shared Savings Program, which is the program established by the ***Affordable Care Act*** (ACA) and launched in 2012 under which the vast majority of Medicare's Accountable Care Organizations (ACOs) operate. The redesigned program would be called "Pathways to Success."

The 607-page document, which was released on Aug. 9, 2018, can be found on the NCHA website at https://www.ncha.org/wp-content/uploads/2018/08/2018-ACO-PROPOSED3.pdf. This publication did not contain a table of contents, so we developed one with page numbers to assist you in navigating this publication: https://www.ncha.org/wp-content/uploads/2018/08/ACO-Proposed-Rule-TOC3.pdf.

The proposed rule was published in the ***Federal Register*** on Aug. 17, 2018 and can be found at https://bit.ly/2wc2wcN. A 60-day comment period is provided.

Comment

CMS notes the program began in 2012, and as of January 2018, there are 561 ACOs participating and serving over 10.5 million Medicare FFS beneficiaries. A major goal of the ACO restructuring is to improve Medicare's savings; i.e., reduce program outlays. CMS notes that it is looking/ projecting savings of $2.2 billion over 10-years.

The Shared Savings Program currently includes three financial models. The vast majority of ACOs, 82 percent in 2018, have chosen to enter under the one-sided, shared savings-only model (Track 1), under which eligible ACOs receive a share of any savings under their benchmark, but are not required to pay back a share of spending over their benchmark.

CMS says that its results to date have shown that ACOs in two-sided models perform better over time than one-sided model ACOs. Further, low revenue ACOs, which are typically physician-led, perform better than high revenue ACOs, which often include hospitals, and the longer ACOs are in the program the better they do at achieving the program goals of lowering growth in expenditures and improving quality.

Summary of the Major Provisions

This proposed rule would restructure the participation options by discontinuing Track 1 (the one-sided shared savings-only model) and Track 2 the (two-sided shared savings and shared losses model) while maintaining Track 3 (renamed the ENHANCED track) and offering a new BASIC track.

Under the proposed approach, the program's two tracks would be: (i) a BASIC track, offering a path from a one-sided model to progressively higher increments of risk and potential reward within a single agreement period, and (ii) an ENHANCED track based on the existing Track 3 (two-sided model), for ACOs that take on the highest level of risk and potential reward.

To provide ACOs time to consider the new participation options and prepare for program changes, make investments and other business decisions about participation, obtain buy-in from their governing bodies and executives, and complete and submit a Shared Savings Program application for a performance year beginning in 2019, CMS intends to forgo the application cycle in 2018 for an agreement start date of Jan. 1, 2019, and instead proposes to offer a July 1, 2019 start date. This midyear would also allow both new applicants and ACOs currently participating in the program an opportunity to make any changes to the structure and composition of their ACO as may be necessary to comply with the new program requirements for the ACO's, if changes to the participation options are finalized as proposed.

Additionally, ACOs with a participation agreement ending on Dec. 31, 2018, would have an opportunity to extend their current agreement period for an additional 6-month performance year and to apply for a new agreement period under the BASIC track or ENHANCED track beginning on July 1, 2019.

ACOs entering a new agreement period on July 1, 2019, would have the opportunity to participate in the program under an agreement period spanning 5 years and 6 months, where the first performance year is the 6-month period between July 1, 2019, and Dec. 31, 2019. This proposed rule includes the proposed methodology for determining ACO financial performance for these two, 6-month performance years during CY 2019.

Further, the proposal would make other updates to the program's regulations, for consistency with other changes in program policies or Medicare policies more generally, such as: (1) modifying the definition of primary care services used in beneficiary assignment to add new codes and revising how CMS determines whether evaluation and management services were furnished in a Skilled Nursing Facility (SNF); (2) extending policies previously adopted for performance year 2017 to performance year 2018 and subsequent years to address quality performance scoring and the determination of shared losses (under two-sided models) in the event of extreme or uncontrollable circumstances; and (3) promoting interoperability in Medicare by establishing a new Shared Savings Program eligibility requirement related to adoption of CEHRT by an ACO's eligible clinicians, while discontinuing use of the existing quality measure on use of CEHRT.

Below are several tables from the proposed rule that reflect some major changes:

ACOs by Track and Number of Assigned Beneficiaries for Performance Year 2018

Track	Number of ACOs	Number of Assigned Beneficiaries
Track 1	460	8,147,234
Track 1+ Model	55	1,212,417
Track 2	8	122,995
Track 3	38	993,533
Total	**561**	**10,476,179**

Note that few ACOs are currently in risk sharing models.

Comparison of Risk and Reward Under Basic Track and Enhanced Track

	BASIC Track's Glide Path				ENHANCED Track (Current Track 3)
	Level A & Level B (one-sided model)	**Level C (risk/reward)**	**Level D (risk/reward)**	**Level E (risk/reward)**	
Shared Savings (once Minimum Savings Rate (MSR) met or exceeded)	1st dollar savings at a rate of up to 25% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 30% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 40% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (once Minimum Loss Rate (MLR) met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (for example, 8% of ACO participant revenue in 2019 – 2020), capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard (for example, 4% of updated benchmark in 2019 – 2020)	No change. 1st dollar losses at a rate of 1 minus final sharing rate (between 40% - 75%), not to exceed 15% of updated benchmark
Annual choice of beneficiary assignment methodology? (see section II.A.4.c)	Yes	Yes	Yes	Yes	Yes
Annual election to enter higher risk? (see section II.A.4.b)	Yes	Yes	No; ACO will automatically transition to Level E at the start of the next performance year	No; maximum level of risk / reward under the BASIC track	No; highest level of risk under Shared Savings Program
Advanced APM status under the Quality Payment Program? [1, 2]	No	No	No	Yes	Yes

Notes:

1 To be an Advanced APM, an APM must meet the following three criteria: 1. CEHRT criterion: requires participants to use certified electronic health record technology (CEHRT); 2. Quality Measures criterion: provides payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and 3. Financial Risk criterion: either (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses. See, for example Alternative Payment Models in the Quality Payment Program as of February 2018, available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf.

2 As proposed, BASIC track Levels A, B, C and D would not meet the Financial Risk criterion and therefore would not be Advanced APMs. BASIC track Level E and the ENHANCED track would meet all three Advanced APM criteria and thus would qualify as Advanced APMs. These preliminary assessments reflect the policies discussed in this proposed rule. CMS will make a final determination based on the policies adopted in the final rule.

PY 2016 Results by Shared Savings Program Track

Track	Two-sided Risk?	Number of ACOs Reconciled	Parts A and B Spending Above Benchmark [A]	Parts A and B Spending Below Benchmark [B]	Shared Savings Payments from CMS to ACOs [C]	Shared Loss Payments from ACOs to CMS [D]	Net Effect in Aggregate [A minus B plus C minus D]	Net Effect per Beneficiary per year
Track 1	No	410	$1.021 billion	$1.562 billion	$590 million	$0	$49 million	$7
Track 2	Yes	6	$0	$42 million	$24 million	$0	– $18 million	– $308
Track 3	Yes	16	$25 million	$95 million	$64 million	$9 million	– $14 million	– $39

Final Thoughts

This is a detailed and complex proposal. It is apparent that CMS is not satisfied with the current ACO program because it is not producing expected Medicare results.

The proposal is intended to save Medicare in excess of $2 billion over 10-years. To do so, it will place ACOs at financial risk. Considering the limited number of ACOs currently participating in the risk models, the question will be how many will reapply. Already, some in the Washington trade circles are predicting less than 100 will participate.

Our Washington liaison, Larry Goldberg of Larry Goldberg Consulting, has provided us with this summary and comments. For questions, please contact Jeff Weegar, NCHA at 919-677-4231, jweegar@ncha.org or Ronnie Cook, NCHA, at 919-677-4225, rcook@ncha.org.