NCHA Financial Feature

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CMS Finalizes ACO Rule; Will Extensively Restructure the Program; Transferring More Risk to Participants

The Centers for Medicare and Medicaid Services (CMS) has issued a final rule that will 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.

CMS says the new direction of the program is to encourage ACOs to transition to performance based risk more quickly.

However, the rule's overall average projection is to save the program approximately $2.9 billion over 10 years relative to a baseline that assumes the prior program regulations remained in effect through this ten-year period. The proposed rule, issued in August 2018, assumed savings of $2.2 billion over 10-years.

The final rule was published in the Dec. 31, 2018 ***Federal Register*** and can be found at: https://bit.ly/2F6G63q.

Comment

Much of the following is from a CMS fact sheet summarizing the rule's major changes. For those either participating or considering participation, a complete review of the rule is paramount. As noted above, CMS is moving to place more ACOs at risk and is intending to save considerable monies. The concept of moving to more value and better quality appears diminished by the risk/money issues.

Unlike the proposed rule, this rule does contain a table of contents, but there is still no page numbering.

CMS notes there are 561 ACOs participating during 2018 and serving over 10.5 million Medicare FFS beneficiaries. These numbers are unchanged from those cited in the August 2018 proposed rule.

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 notes that from 2012 through 2016, the one-sided model actually increased Medicare spending relative to their benchmarks under the program's financial methodology.

Summary of the Major Provisions

New Basic and Enhanced Tracks and Five Year Agreement Periods

The rule will 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.

(1) BASIC track will allow eligible ACOs to begin under a one-sided model and incrementally phase-into higher levels of risk that, at the highest level, would qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program, and

(2) ENHANCED track based on the program's existing Track 3, which provides additional tools and flexibility for ACOs that take on the highest level of risk and potential reward.

The BASIC track has a "glide path" that offers an incremental approach to transitioning eligible ACOs to higher levels of risk and potential reward. The glide path includes 5 levels: a one-sided model available only for the first two years to most eligible ACOs (ACOs identified as having previously participated in the program under Track 1 would be restricted to a single year under the one-sided model, but new, and low revenue ACOs that are not identified as re-entering ACOs would be allowed up to three years under the one-sided model); and three levels of progressively higher risk in years 3 through 5 of the agreement period.

Under Levels A and B of the glide path, an ACO's maximum shared savings rate under a one-sided model will be 40 percent based on quality performance, applicable to first dollar shared savings after the ACO meets the minimum savings rate (MSR). Under Levels C, D, and E of the glide path, an ACO can earn up to a maximum 50 percent sharing rate under a two-sided model, based on quality performance.

ACOs in the BASIC track glide path generally will be automatically advanced at the start of each performance year along the progression of risk/reward levels or could elect to move more quickly to a higher level of risk/reward, over the course of their agreement period. While the typical agreement period will be 5 years in duration, with 12-month performance years based on calendar years, ACOs entering an agreement period beginning on July 1, 2019, would participate in a first performance year for 6 months for the period from July 2019 – December 2019 plus 5 additional years in their first agreement period.

For ACOs entering the BASIC track's glide path for an agreement period beginning on July 1, 2019, the first automatic advancement occur at the start of performance year 2021. Additionally, a new, low revenue ACO in the glide path that is not identified as a re-entering ACO will be permitted to choose to remain at Level B for an additional year, in exchange for agreeing to progress immediately to Level E at the start of the fourth performance year (or fifth, in the case of an agreement period starting on July 1, 2019).

CMS says it will determine whether an ACO is a low revenue ACO versus a high revenue ACO, and whether an ACO is experienced or inexperienced with performance-based risk Medicare ACO initiatives.

CMS notes it has increased the threshold for low revenue ACOs to include ACOs with ACO participants' total Medicare Parts A and B FFS revenue of less than 35 percent of the total Medicare Parts A and B FFS expenditures to capture additional ACOs, especially those that include clinics or smaller institutional providers, including rural ACOs. Ultimately, all ACOs are expected to transition to the ENHANCED track under the redesigned program.

CMS is finalizing an option for new low revenue ACOs not identified as re-entering ACOs (and therefore inexperienced with performance-based risk Medicare ACO initiatives) to participate for up to 3 years (or 3.5 years in the case of ACOs entering an agreement period beginning on July 1, 2019) under a one-sided model of the BASIC track's glide path before transitioning to Level E (the highest level of risk and potential reward under the BASIC track). Under this participation option, the ACO would enter the glide path at Level A and automatically advance to Level B. Prior to the automatic advancement of the ACO to Level C, an eligible ACO may elect to remain in Level B for another performance year, and then be automatically advanced to Level E for the remaining two years of its agreement period.

CMS is also finalizing a limited exception that will allow high revenue ACOs that transitioned to the Track 1+ Model within their current agreement period (therefore ACOs with a first or second agreement period start date in 2016 or 2017 that entered the Track 1+ Model in 2018), the option to renew for one agreement period under Level E of the BASIC track, beginning on July 1, 2019 or January 1, 2020, respectively, even though such ACOs will qualify as experienced with performance-based risk Medicare ACO initiatives based on their participation in the Track 1+ Model.

July 1, 2019 Start Date

CMS finalized certain changes to the Shared Savings Program as part of the Calendar Year 2019 Physician Fee Schedule final rule in order to ensure continuity of participation, finalize time-sensitive program policy changes for currently participating ACOs, and streamline the ACO core quality measure set to reduce burden and encourage better outcomes.

These final policies included (1) the availability of the optional 6-month extension for ACOs whose agreement periods would otherwise expire on December 31, 2018; (2) the methodology for determining financial and quality performance for this 6-month performance year from January 1, 2019, through June 30, 2019; (3) a reduction in the Shared Savings Program core quality measure set by eight measures and a new Certified EHR Technology (CEHRT) threshold criterion to determine ACOs' eligibility for program participation in order to promote interoperability among ACO providers/suppliers; (4) refinements to the voluntary alignment process, to allow beneficiaries greater flexibility as authorized under the ***Bipartisan Budget Act of 2018***, in selecting their primary care clinician, nurse practitioner, physician assistant, clinical nurse specialist and in the use of that selection for purposes of assigning the beneficiary to an ACO if the clinician they align with is participating in an ACO; (5) policies to address the impact of extreme and uncontrollable circumstances on ACOs for performance year 2018 and subsequent years; and (6) revisions to the definition of primary care services used in beneficiary assignment to incorporate advance care planning codes, administration of

health risk assessment service codes, and codes for annual depression screening, alcohol misuse screening and alcohol misuse screening and alcohol misuse counseling.

CMS notes that 90 percent of eligible ACOs with participation agreements that would otherwise end on Dec. 31, 2018, have elected to extend their agreement period by a 6-month performance year from Jan. 1, 2019, to June 30, 2019.

CMS is finalizing the methodology for determining financial and quality performance for the 6-month performance year from July 1, 2019, through December 31, 2019. CMS is also finalizing changes to the program's regulations to remove the "sit out" period after termination, which includes the flexibility for ACOs currently in a 3-year agreement period to voluntarily terminate their existing participation agreement, effective June 30, 2019, and enter a new agreement period starting on July 1, 2019, under either the BASIC track (if eligible) or the ENHANCED track. CMS will reconcile these ACOs' performance for the first half of 2019 (if applicable), and second half of 2019 for ACOs entering agreements beginning on July 1, 2019, separately by considering financial and quality performance on a calendar year basis, and then pro-rating savings and losses to reflect participation for one-half of the year.

CMS will offer an application cycle for a one-time new agreement period start date of July 1, 2019.

New and existing ACOs interested in applying to the new BASIC or ENHANCED track must complete a non-binding Notice of Intent to Apply (NOIA), which will be available from Jan. 2, 2019, through Jan. 18, 2019. See the Application Types and Process webpage at https://go.cms.gov/2R708Bb for eligibility requirements, key timelines, and detailed instructions on the submission process. CMS will resume the usual annual application cycle for agreement periods starting on Jan. 1, 2020, and in subsequent years.

Updates to Repayment Mechanism Requirements for Two-sided Model ACOs

The final rule includes modifications to the proposed repayment mechanism arrangement requirements for ACOs in performance-based risk tracks to reduce burden. CMS is finalizing its proposal to annually recalculate the amount that must be guaranteed by the repayment mechanism based on ACO participant list changes, but CMS is increasing the threshold that must be satisfied before CMS will require the ACO to increase its repayment mechanism amount. Under the final rule, an ACO will not have to increase the amount of its repayment mechanism unless the difference between the recalculated repayment mechanism amounts exceeds the existing repayment mechanism amount by at least 50 percent or $1,000,000. CMS is reducing the period of time after the end of the agreement period that the repayment mechanism must be in effect from 24 months to 12 months, and CMS is permitting all ACOs to establish repayment mechanisms for a shorter duration as long as the arrangement provides for automatic annual renewal. CMS is finalizing its proposal to permit renewing ACOs to maintain a single, existing repayment mechanism arrangement to support its ability to repay shared losses in the new agreement period.

Ensuring rigorous benchmarking by using regional benchmarks for all agreement periods

For each performance year, an ACO's spending is compared to its benchmark to determine if the ACO receives shared savings from CMS or owes shared losses to CMS. CMS is finalizing revisions to the program's benchmarking methodology, which incorporates differing amounts of ACO historical experience and regional performance depending on the ACO's agreement period.

CMS says these benchmarks will protect the Trust Funds by ensuring that ACOs do not unduly benefit from any one aspect of the benchmark calculations, while also helping to ensure the program continues to remain attractive to ACOs, especially those caring for the most complex and highest risk patients who could benefit from high-quality, coordinated care from an ACO.

The revised benchmarking methodology incorporates factors based on regional FFS expenditures in establishing the ACO's historical benchmark beginning with the ACO's first agreement period, rather than applying this approach starting in the ACO's second or subsequent agreement period.

More generally, the revised methodology will mitigate the effects of excessive positive or negative regional adjustments used to establish and reset the benchmark by: (1) reducing the maximum weight used in calculating the regional adjustment from 70 percent to 50 percent, and (2) capping the regional adjustment amount using a flat dollar amount equal to 5 percent of national Medicare FFS per capita expenditures.

CMS is finalizing modifications to reduce the initial weight applied to the regional adjustment for ACOs with historical expenditures above their regional service area to 15 percent and to slow the phase-in of a higher weight for such ACOs. The finalized approach also allows for modest risk score growth of up to positive 3 percent over the length of the agreement period, replacing the methodology for annually risk adjusting the benchmark for newly assigned and continuously assigned populations of beneficiaries. However, CMS is not finalizing the proposed negative 3 percent limit on risk score decreases.

In calculating the regional trend and update factors, CMS will use a blend of regional and national growth rates based on Medicare FFS expenditures with increasing weight placed on the national component of the blend as the ACO's penetration in its regional service area increases. This approach is expected to result in more favorable trend factors for ACOs with high penetration in a regional service
area with lower spending growth compared to the nation and less favorable trend factors for ACOs with high penetration in a regional service area with higher spending growth compared to the nation. CMS says this approach is expected to have little impact on ACOs with low to medium penetration in their regional service area.

Ensure program integrity by reducing opportunities for gaming

CMS is finalizing a combination of policies to strengthen the integrity of the program: using past participation in performance-based risk Medicare ACO initiatives by the ACO legal entity and by its ACO participants to determine available participation options; monitoring for financial performance and permitting termination of ACOs with multiple years of poor financial

performance; modifying application review criteria to permit CMS to consider the ACO's financial performance and failure to meet quality performance standards in multiple years of the previous agreement period; and holding terminated ACOs in two-sided models accountable for pro-rated shared losses. ACOs that voluntarily terminate their participation would be accountable for pro-rated shared losses if they terminate after June 30 of a 12-month performance year.

CMS would hold involuntarily terminated ACOs accountable for pro-rated shared losses incurred during the portion of the performance year prior to their termination.

Promote regulatory flexibility to allow ACOs to innovate

Expand Use of Telehealth for Practitioners in ACOs in Performance-Based Risk Arrangements

To support ACOs' coordination of care across settings, CMS finalized regulations which govern the use of telehealth services by physicians and practitioners in certain ACOs under performance-based risk, consistent with the requirements of the ***BBA of 2018***. Under this approach, beginning Jan. 1, 2020, eligible physicians and practitioners in applicable ACOs in performance-based risk tracks will receive payment for telehealth services furnished to prospectively assigned beneficiaries even if the otherwise applicable geographic limitations are not met, including when the beneficiary's home is the originating site. This policy applies to ACOs participating in the BASIC track (under a two-sided model) and ENHANCED track (including current Track 3 ACOs), when the ACO elects prospective assignment, as well as ACOs in the Track 1+ Model.

Expand Skilled Nursing Facility (SNF) 3-Day Rule Waiver Eligibility

ACOs in performance-based risk within the BASIC track's glide path or under the ENHANCED track will be eligible to apply for a SNF 3-day rule waiver, regardless of their choice of prospective assignment or preliminary prospective assignment with retrospective reconciliation, to support ACO efforts to increase quality and decrease costs. CMS also amended the existing SNF 3-day rule waiver to allow critical access hospitals and other small, rural hospitals operating under a swing bed agreement to be eligible to partner with eligible ACOs as SNF affiliates for purposes of the SNF 3-day rule waiver.

Promoting beneficiary engagement by incentivizing beneficiaries to achieve and maintain good health

Beneficiary Incentive Programs

To encourage patient engagement, ACOs, under certain two-sided models, will have the opportunity to apply to operate a beneficiary incentive program. Consistent with the ***BBA of 2018***, an ACO approved to operate a beneficiary incentive program will provide an incentive payment of up to $20 to an assigned beneficiary for each qualifying primary care service that the beneficiary receives from certain ACO professionals, or from a Federally Qualified Health Center or Rural Health Clinic. Further, CMS clarifies that under the program's existing regulations, it considers vouchers (certificates that can be used only for particular goods or services, including certain gift cards that are in the nature of a

voucher), to be "in-kind items or services" that may be provided to beneficiaries so long as the voucher meets all other program requirements. For example, the items and services accessible through use of the voucher must have a reasonable connection to the beneficiary's medical care and be preventive care items or services or advance a clinical goal for the beneficiary, including adherence to a treatment or drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition.

Beneficiary Notification

To further empower beneficiary choice, CMS is finalizing requirements to strengthen beneficiary notifications. An ACO must ensure that Medicare FFS beneficiaries are notified about all of the following: (1) its ACO providers/suppliers are participating in the Shared Savings Program; (2) the beneficiary's opportunity to decline claims data sharing; and (3) the beneficiary's ability to, and the process by which, he or she may identify or change identification of the individual he or she designated as their primary clinician for purposes of voluntary alignment. In addition, an ACO that operates a beneficiary incentive program must ensure that its assigned FFS beneficiaries are notified of the availability of the beneficiary incentive program. ACOs or their ACO participants must provide such notifications prior to or at a beneficiary's first primary care service visit of each performance year. To mitigate the burden of these additional notifications, CMS says it is developing template notices for ACOs and ACO participants to use.

APPENDIX A: COMPARISON OF BASIC TRACK AND ENHANCED TRACK CHARACTERISTICS

	BASIC Track's Glide Path				**ENHANCED Track (Track 3) (risk/ reward)**
	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 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	1st dollar savings at a rate of up to 50% 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 capped at 1 percentage point higher than the benchmark nominal risk amount (e.g., 8% of ACO participant revenue in 2019 – 2020, capped at 4% of updated benchmark)	No change. 1st dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark
Annual choice of beneficiary assignment methodology?	Yes	Yes	Yes	Yes	Yes

	BASIC Track's Glide Path				ENHANCED Track (Track 3) (risk/ reward)
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Annual election to enter higher risk?	Yes, but new low revenue ACOs may elect an additional year under Level B if they commit to completing the remainder of their agreement under Level E.	Yes	No; ACO will automatically transition to Level E at the start of the next performance year, except for July 1, 2019 starters that elect to enter at Level D	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?	No	No	No	Yes	Yes
Beneficiary Incentive Program	No	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years
Expanded Telehealth Services	N/A	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years
3-Day SNF Rule Waiver	N/A	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years

[Appendix A is ***NOT*** part of the final rule. It appears in a CMS fact sheet. The items are in the final rule, but in narrative form.]

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**

Final Thoughts

This is a detailed and complex proposal. As we noted in the proposed rule, it is apparent that CMS is not satisfied with the current ACO program because it is not producing expected Medicare saving results. Perhaps one issue is the limited benefits a provider may gain from exhaustive compliance. CMS is fearful it will spend too much in trying to reward those willing to assume 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 ACOs will participate in the future. CMS keeps arguing for value over volume. A worthwhile and honest endeavor. However, one has to question whether or not such is obtainable on the track CMS is taking.

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 919-644-4231, jweegar@ncha.org or Ronnie Cook, NCHA, at 919-677-4225, rcook@ncha.org.