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"Pathways to Success"
An Overhaul of Medicare's ACO Program: What Does It Entail?

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Introduction

This article attempts to answer the most pressing changes to the ACO rules as published in the December 31, 2018, Federal Register. A majority of the entries will have corresponding page numbers located in the footer. A table has been created from the Table of Contents, for the reader with corresponding page location to quickly identify areas that maybe of interest for further reading.

A Table of Tables identifies the Tables within the Federal Register Vol. 83, No. 249 /Monday, December 31, 2018 /Rules and Regulations.

Background

ACO's were envisioned as a method by which the Centers for Medicare and Medicaid Services (CMS) could control spending while gaining quality and improved outcomes for their Fee For Service (FFS) beneficiaries.

Several years into this experiment it has become abundantly clear that of the 561 ACO's, some are doing much better than others.[1]

CMS will decrease the initial six-year risk free ACO track 1 and 2 to no more than three years for "New" Low Revenue (Rural) or Physician led ACO's and two years for all others.

Executive Summary

The reasoning for this change going forward as of July 1, 2019 is:

- The rule is projected to achieve $2.9 billion in savings over ten years.
- Incentives to bring healthcare providers into the ACO program, while ensuring the transition to value, protects taxpayers and includes patients taking charge of their healthcare and choices.
- A reduction in the amount of time that an ACO can remain in the program without taking accountability for healthcare spending risk.
- Increases flexibility for certain performance-based risk ACOs to encourage innovation and expand access to high-quality services that are convenient for patients, including Telehealth services provided at a patient's place of residence.
- Driving innovation and efficiency and to ensure regulations are not hindering the development of new ways of delivering care
- Patient involvement that includes incentives that can be derived from the ACO's shared savings as long as it is allowed by CMS (Anti-Kickback).
- Patient portals and electronic communications from the ACO's that allow patients to better control their healthcare options and how participating in ACO's can shape their healthcare.
- To ensure rigorous financial benchmarking for ACOs, by incorporating regional spending factors in establishing an ACO's target spending during the entire agreement periods,
- Also providing accurate point of comparison for evaluating ACO performance.

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[1] "Smaller, physician-led or "low revenue" ACOs – many of which are in rural areas – have shown greater success in controlling costs than hospital-led ACOs, which is an example of why CMS is focused on promoting competition in healthcare marketplaces and ensuring that patients have choices of where to obtain care".(CMS Blog: "Pathways to Success," an Overhaul of Medicare's ACO Program)
https://www.cms.gov/blog/pathways-success-overhaul-medicares-aco-program)

- Changes to the benchmarking process for ACOs also promote greater alignment between the ACO program and Medicare Advantage secondary Insurance products.
  How CMS intends to achieve these improvements are expressed in the five following areas. The five areas of Improvement are[2]:
  1. Accountability - Accelerated risk-sharing tracks 2-3 years vs. 5 years.
  2. Competition – Physician lead and rural ACO's independence encourages beneficiary choice.
  3. Engagement – Beneficiaries are in control of their healthcare while incentives can be offered by the ACO's for their participation
  4. Integrity – Opportunity for gamming the system is decreased.
  5. Quality – Sharing of quality data among providers for improved outcomes while addressing and combating the opioid addiction.

The majority of ACO's will be in a higher risk pool by 2020.

Major Changes:

1. New ACO's, risk free time frame is decreased from six years to two years.
2. Contracts will be for three years rather than five.
3. As of July 1, 2019, 83 ACO contracts are due for renewal. These new contracts will be initiated under a higher shared risk arrangement. A six-month transition period will be included, considered a six-month first performance year.
4. Track 1 and 2 are replaced with Track 1+, Basic A-E and Track 3 now referred to as "Enhanced" is retained.
5. Termination (contractual or otherwise) and reinstatements will not erase shared risk payments due.[3]
6. Reinstatement with greater than 50% participants of a terminated ACO will be subject to a complicated calculation methodology of risk assignment. An ACO terminating in the second or third year and reinstating thereafter will not assure a lower risk assignment. Thereby, avoiding "gamming" of the system. [4]
7. Caps on regional adjustment relief for 'Extreme and Uncontrollable" circumstances hurricanes Harvey, Ivan, Maria California wildfires.[5]
8. ACOs affected by a disaster in any month of 2019, CMS would use the alternative scoring methodology specified in §425.502(f) to determine the quality performance score or the 2019 quality reporting period.[6]
9. ACOs participating in the 6- month performance year from July 1, 2019, through December 31, 2019, are required to contract with a CMS-approved vendor to administer the CAHPS for ACOs survey for the 2019 reporting period.[7]
10. Proposed greater access to the SNF 3 day rule exclusion was not available on Track 2. Changes allow for participants in ACO to receive SNF services so long as the ACO standing is 3 stars or above. Waivers for the 3 day rule are available under strict rules over the entire ACO spectrum.[8]

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[2] Page 67820
[3] Page 67852
[4] Page 68024
[5] Page 67824
[6] Page 67961
[7] Page 67961
[8] Page 67822

11. Beneficiaries will have ability to control their healthcare and those who chose proactive measures can benefit from incentive's provided by the ACO's. The new rules take into account the revenue streams of stronger ACO's and these will be tracked and audited to prevent "cherry picking" by both the ACO and beneficiaries.[9]
12. New incentive programs should be shared with the Secretary of HHS for approval.[10]
Approval of the program does not negate future removal of the program by the secretary.[9]
13. Telehealth services are acceptable methods for delivery of services when applicable. However, CPTs associated with "Inpatient" codes G0406, G0407, G0408, G0425, G0426, and G0427 cannot be used for patients when services provided in their homes. These codes are now for reporting inpatient hospital visits and are included on the 2018 approved Telehealth list.[11][10]
14. Methodology for Benchmarking will continue to evolve, with a greater emphasis on Quality and savings, used as the metric. Moving away from ACO's historical costs to benchmarking within the ACO's region. The benchmark maximum weight will be lowered from 70% to 50%.[12]
15. While still utilizing CMS Hierarchical Condition Category (HCC capped at 3%) latest edition located here: §§ 425.602(a)(3) and (8), 425.603(c)(3) and (8); see also Medicare Shared Savings Program, Shared Savings and Losses and Assignment Methodology Specifications (May 2018, version 6) available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-andspecifications.html.[13]
16. Of note, the Benchmarking will be reviewed annually with the exception of the first year July 1, 2019 – December 31-2019, time frame. ACO's with a 6 months term will use the new benchmark established during that period. Also adjustments for percentage FFS spending nationally will be capped.
17. Modifying the MSR/MLR to address small population sizes. Performance year beginning on July 1, 2019, and subsequent years.[14]
MSR
    - Under both the one-sided and two-sided models of the Shared Savings Program, ACOs must meet or exceed a Minimum Savings Rate (MSR) to get a shared savings payment.
    - MLR
    - Minimum Loss Rate (MLR) is applied to protect against losses resulting from random variation.
18. Benchmarking changes include elimination of the "Sit Out Period". That identifies a year period where ACO's can transition out of their current contracts and begin a new agreement under the new rules. However, these have not been finalized as of this publication of Federal Register Vol. 83, No. 249 /Monday, December 31, 2018 /Rules and Regulations.
19. The domains at the present remain unchanged.

[9] Page 67986
[10] Page 67975, 67980
[11] Page 67824
[12] Page 68007
[13] Page 68000

Resources:
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QualityMetrics / Domains:

The following Quality Metrics have not been changed for July 1, 2019 reporting period.
CMS Blog: “Pathways to Success,” an Overhaul of Medicare’s ACO Program
https://www.cms.gov/blog/pathways-success-overhaul-medicares-aco-program

DOMAIN	NUMBER OF INDIVIDUAL MEASURES	TOTAL MEASURES FOR SCORING PURPOSES	TOTAL POSSIBLE POINTS	DOMAIN WEIGHT
Patient/Caregiver Experience	8	8 individual survey module measures	16	25%
Care Coordination/ Patient Safety	10	10 measures, including the EHR measure, which is double-weighted (4 points)	22	25%
Preventive Health	8	8 measures	16	25%
At-Risk Population	5	4 measures: three individual measures and a two-component diabetes composite measure that is scored as one measure	8	25%
Total in all Domains	31	30	62	100%