ACO 'PATHWAYS TO SUCCESS' POLICIES FINALIZED IN THE 2019 MEDICARE PHYSICIAN FEE SCHEDULE RULE

On November 7, 2018, CMS released the final 2019 Medicare Physician Fee Schedule (MPFS) rule. In addition to payment policies for physician fees, this regulation also includes a number of final policies previously included in the 'Pathways to Success' rule, which made significant proposed changes to the Medicare Shared Savings Program (MSSP). This resource outlines key MSSP Pathways to Success policies finalized in the MPFS rule including details regarding the six-month agreement extension option, changes to certain patient attribution methodologies, clarifications on policies pertaining to Track 1+, and updates to the extreme and uncontrollable circumstances policies for ACOs.

It is anticipated that CMS will issue a final 'Pathways to Success' rule in late 2018 or early 2019 that will address the remaining policies included in the proposed regulation. NAACOS has provided members with webinars, analyses, and various in-person educational sessions reviewing this significant regulation and its potential impact on ACOs. To learn more about this rule, please visit our website. The NAACOS comment letter in response to the agency's proposals is available here.

SIX-MONTH PERFORMANCE PERIOD FOR ACOs EXTENDING CURRENT AGREEMENTS THROUGH JUNE 30, 2019

As a result of the finalized policy in the Medicare Physician Fee Schedule rule, ACOs with an agreement period ending on December 31, 2018, will have the one-time option to voluntarily elect to extend their current agreement period in the Shared Savings Program for an additional six-month performance year, which begins January 1, 2019, and ends on June 30, 2019. CMS recently communicated additional details regarding how ACOs can make this election in the ACO Spotlight Newsletter (more information below). Unfortunately, it is unlikely that CMS will offer the option for a 12-month extension, despite NAACOS' requests for this option. Specifically, CMS cites concerns regarding selective participation bias that could adversely affect the Trust Fund and therefore has finalized a six-month extension option only.

Electing the Six-Month Agreement Extension Option

ACOs electing to extend their participation agreement with CMS must update their ACO participant agreements and Skilled Nursing Facility (SNF) Affiliate Agreements before the beginning of the 2019 performance year to reflect the extension of their current agreement period. As part of the annual certification process in advance of 2019, ACOs electing the six-month extension will be required to certify: (1) that they have notified their ACO participants and SNF affiliates of their continued participation in the Shared Savings Program in 2019 and (2) that their ACO Participant Agreements and SNF Affiliate Agreements have been updated (CMS notes these do not need to be submitted to CMS for approval). Further, ACOs will need to execute ACO Participant Agreements with any new ACO participants to be added to its ACO participant list effective January 1, 2019.

In the ACO Spotlight Newsletter, CMS instructed ACOs to log into the ACO-MS and complete the ACO Extension Tasks no later than November 13, 2018, at 12:00 p.m. (noon) Eastern Time**.** ACOs must have indicated if they were electing the voluntary six-month extension or voluntarily terminating their participation in the program on December 31, 2018. According to CMS, ACOs that elected to voluntarily extend must have:

1. Selected "Yes" in ACO-MS for the ACO Extension Task(s) to indicate that they will extend their Participation Agreement.
2. Updated the terms of the ACO Participant and SNF Affiliate Agreements, as applicable, before the beginning of the next performance year to reflect the extension; and certify that the ACO has notified their ACO participants and SNF affiliates, as applicable, of their continuation in the program in 2019 and that the ACO Participant and SNF Affiliate Agreements have been updated. However, ACOs do not need to submit updated ACO Participant or SNF Affiliate Agreements to CMS for review to reflect the extension.
3. ACOs participating in a performance-based risk track also needed to update the terms of their repayment mechanism to reflect the extension. ACOs should submit their draft updated repayment mechanism documentation to CMS via the Shared Savings Program mailbox. Upon conditional approval, ACOs should submit final repayment mechanism documentation to CMS via tracked mail by **December 14, 2018.**
4. Complete Annual Certification beginning **November 19, 2018, through December 6, 2018.**

ACOs that did not elect to voluntarily extend must have:

1. Selected "No" in ACO-MS for the ACO Extension Task(s) to indicate that they will not extend their Participation Agreement.
2. ACOs that did not elect to extend their agreement period will end participation in the Shared Savings Program on December 31, 2018**,** and must complete close-out procedures by the deadline specified by CMS. These ACOs will need to monitor email for additional information regarding close-out procedures.

CMS asks ACOs to email the Shared Savings Program mailbox with any questions and include your ACO ID, indicate either "Repayment Mechanism" or "Extension" in the email subject line and copy your CMS coordinator.

Beneficiary Assignment

For ACOs under preliminary prospective assignment with retrospective reconciliation, the assignment window for the six-month extension performance period would be calendar year (CY) 2019. For ACOs under prospective assignment, Medicare fee for service (FFS) beneficiaries would be prospectively assigned to the ACO based on beneficiaries' use of primary care services in the most recent 12 months for which data are available.

Shared Savings/Losses

To determine shared savings and shared losses for the six-month extension performance period, CMS will calculate average per capita Medicare expenditures for Parts A and B services for CY 2019 for the ACO's performance year assigned beneficiary population and compare this amount to the updated historical benchmark. CMS will then pro-rate any shared savings or shared losses by multiplying the amounts by one-half, which represents the fraction of the calendar year covered by the six-month performance period.

Repayment Mechanisms

With regard to ACOs participating under Track 2 or Track 3, CMS clarifies that for the six-month performance period from January 1, 2019, through June 30, 2019, CMS will not require any ACO that elects to extend its participation agreement to modify the amount previously approved for the ACO's repayment mechanism arrangement, though ACOs must extend the terms of their repayment mechanisms until June

30, 2021. For Track 1+, CMS states the agency may require T1+ ACOs to update repayment mechanism amounts for the six-month extension. For example, if a T1+ ACO moves from the revenue-based standard to the benchmark-based standard, an updated repayment mechanism agreement may be required.

Quality
For the six-month extension performance period, CMS will use the ACO's quality performance for the 12-month CY 2019. CMS clarifies that the agency will apply the program's current sampling methodology to determine the beneficiaries eligible for the samples for claims-based measures (as calculated by CMS), CMS Web Interface reporting, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey using the ACO participant list effective on January 1, 2019. Reporting will take place in January through March of 2020.

Reports
CMS anticipates issuing performance reports and determining financial and quality performance for ACOs participating in the six-month performance period according to the typical annual projected timeline for making these determinations. ACO annual financial reconciliation reports, quality performance reports, and additional informational reports and files are typically made available in the summer following the conclusion of a 12-month performance year. CMS also plans to provide ACOs that participate in the six-month performance period with quarterly reports for the third and fourth quarter of CY 2019. Finally, CMS anticipates the agency will make an annual schedule for report delivery for 2019 available to ACOs electing the six-month extension, though CMS does not specify when such a schedule will be provided.

Interactions with Quality Payment Program
CMS clarifies that clinicians who obtain Qualifying APM Participant (QP) status based on the March 31, 2019, or June 30, 2019, snapshot through participation in an Advanced APM ACO with a six-month extension of its agreement period will maintain QP status, be exempt from the Merit-Based Incentive Payment System (MIPS), and receive the Alternative Payment Model (APM) incentive payment, as long as the ACO completes its agreement period by remaining in the program through June 30, 2019.

If an ACO terminates or is involuntarily terminated any time after March 31, 2019, and before August 31, 2019, the eligible clinicians (ECs) previously determined to have had QP status would lose their status as a result of the termination and would instead be scored under MIPS using the APM Scoring Standard. If an ACO terminates before March 31, 2019, the ECs will not be scored under the APM Scoring Standard and will be assessed under standard MIPS scoring rules.

ACO professionals that are MIPS ECs (not QPs based on their participation in an Advanced APM or otherwise excluded from MIPS) participating in an ACO that completes a six-month performance period from January 1, 2019, through June 30, 2019, would continue to be scored under MIPS using the APM Scoring Standard, based on quality data submitted for all of CY 2019 during the regular submission period that occurs in early 2020. Thus, for a Track 1 ACO in a six-month performance period from January 1, 2019, through June 30, 2019, whose agreement period expires and the ACO does not renew to continue program participation, the ACO would be scored under the MIPS APM scoring standard rules for quality reporting based on the entire CY 2019.

Data Sharing
CMS will continue to provide beneficiary-identifiable claims data (i.e., claim and claim line feed files) to ACOs only during their participation in the program, including during the six-month performance period from January 1, 2019, through June 30, 2019. ACOs would receive monthly Parts A, B, and D claim and claim line feed files during the six-month performance period based on the ACO participant list they certify before the start of the performance year.

Early Termination
For ACOs participating in a performance year starting on January 1, 2019, CMS will continue to apply the program's current policies for payment consequences of early termination. CMS states that, "under this approach, ACOs that terminate from a performance year starting on January 1, 2019, with an effective date of termination prior to the end of their performance year will not be eligible for shared savings or accountable for shared losses" (p. 1691-1692).

ASSIGNMENT CHANGES

Definition of Primary Care Services Used in Beneficiary Assignment

CMS finalized a number of proposed revisions to the definition of primary care services included in the assignment methodology. Specifically, the revised list of primary care services used for beneficiary assignment will be modified, effective beginning with PY 2019, to include the following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes: (1) advance care planning service codes, CPT codes 99497 and 99498; (2) administration of health risk assessment service codes, CPT codes 96160 and 96161; (3) prolonged evaluation and management or psychotherapy service(s) beyond the typical service time of the primary procedure, CPT codes 99354 and 99355; (4) annual depression screening service code, HCPCS code G0444; (5) alcohol misuse screening service code, HCPCS code G0442; and (6) alcohol misuse counseling service code, HCPCS code G0443. The full list of primary care services for assignment is available here.

CMS also finalized its proposal to revise its method for excluding services identified by CPT codes 99304 through 99318 when furnished in a skilled nursing facility (SNF). Therefore, starting January 1, 2019, and in subsequent performance years CMS will remove the exclusion of claims including the place of service (POS) code 31. Instead, CMS will exclude services billed under CPT codes 99304 through 99318 from use in the assignment methodology when such services are furnished in a SNF on the same date of service, using claims data, as determined based on whether there is a SNF facility claim with dates of service that overlap with the date of service for the professional service. As with previous assignment methodology changes, CMS will adjust ACOs' historical benchmarks for the performance year starting on January 1, 2019, to account for their changes to the assignment methodology.

Voluntary Alignment

As required by the Balanced Budget Act of 2018, CMS finalized adjustments to the voluntary alignment process. Specifically, CMS is modifying its policies to assign a beneficiary to an ACO based upon his or her selection of any ACO professional, regardless of specialty, as his or her primary clinician. Under this revised policy, a beneficiary may select a practitioner with any specialty designation as his or her primary care provider and be eligible for voluntary alignment assignment to the ACO in which the practitioner is an ACO professional. (Note: the previous policy required that the ACO professional designated by the beneficiary had to be a primary care physician as defined at §425.20, a physician with a specialty designation included at §425.402(c), or a nurse practitioner, physician assistant, or clinical nurse specialist.) Despite NAACOS objections, CMS finalized a policy to use a beneficiary's designation to align the beneficiary to the ACO in which his or her primary clinician participates even if the beneficiary does not receive primary care services from an ACO professional in that ACO within a 12-month window.

CMS also finalized a policy in which the agency will not voluntarily align a beneficiary to the ACO when the beneficiary is also eligible for assignment to an entity participating in a model tested or expanded under section 1115A of the Act under which claims-based assignment is based solely on claims for services other than primary care services and for which there has been a determination by the HHS Secretary that a

waiver is necessary solely for purposes of testing the model. This policy applies to certain demonstrations and programs operated through the Center for Medicare & Medicaid Innovation.

APPLICATION OF PATHWAYS TO SUCCESS POLICIES TO TRACK 1+ ACOs

2018 is the first year for participation in Track 1+ with 55 ACOs joining the model either under existing agreements with CMS or through new agreements. While CMS had intended to offer opportunities to join the model in 2019 and 2020, given the proposed Pathways to Success rule, the agency will not do so, and ACOs could instead join the Basic Level E Model, which largely matches Track 1+. In the final 2019 Medicare PFS, CMS clarifies which policies, including those finalized in that rule and those that will be included in the final Pathways to Success rule, would apply to Track 1+ ACOs through revisions to regulations governing the MSSP and through revisions to the Track 1+ Model Participation Agreement. For example, CMS will apply final policies to Track 1+ Model ACOs including revisions to voluntary alignment policies and the definition of primary care services used in assignment. Additionally, Track 1+ ACOs are subject to the discontinuation of ACO quality measure 11, related to use of CEHRT, and introduction of an annual certification of the percentage of ECs participating in the ACO that use CEHRT.

CMS also confirms that Track 1+ ACOs that began an agreement in 2016 and entered Track 1+ in 2018 may elect to extend their participation agreement for the six-month performance period of January 1, 2019, through June 30, 2019. Track 1+ ACOs doing so must extend their repayment mechanism so that it remains in effect for 24 months after the end of the extended agreement period (June 30, 2021). CMS notes that, unlike with Track 2 or 3 ACOs, the agency may require Track 1+ ACOs to update the amount of their repayment mechanism for the six-month extension, which would largely be a result of ACO participant changes that would evaluate a Track 1+ ACO under the benchmark-based loss sharing limit as opposed to the revenue-based loss sharing limit. CMS will notify affected ACOs if the amount of their repayment mechanism needs to be updated.

CMS also clarifies that Track 1+ ACOs extending their agreements in the first six months of 2019 are eligible for shared savings if the ACO completes the six-month performance year and completes all close-out procedures specified in §425.221(a) by the deadline specified by CMS as long as the ACO has satisfied the criteria for sharing in savings for the performance year. As with other ACOs extending their existing agreements, CMS will determine performance from January 1, 2019, through June 30, 2019 according to the approach specified in a new section of the regulations at §425.609(b). The agency will apply the financial methodology for calculating shared savings or losses specified in the ACO's Track 1+ Model Participation Agreement. CMS also notes that it will continue to share aggregate report data with Track 1+ ACOs for the duration of calendar year 2019 and will apply revised extreme and uncontrollable circumstances policies for PY 2018 and subsequent years to Track 1+ ACOs.

EXTREME AND UNCONTROLLABLE CIRCUMSTANCES POLICY FOR ACOs

CMS finalized proposals to account for ACOs affected natural disasters and public health emergencies in 2018 and future program years. Extreme and uncontrollable circumstances policies were initially established during a December 2017 interim final rule to account for several devastating hurricanes and wildfires that year which compromised ACOs' ability to coordinate care or forced assigned beneficiaries into higher-cost sites like emergency departments. In this regulation, CMS adopts permanent policies to provide this relief to affected ACOs. Specifically, CMS finalized a policy establishing that if at least 20 percent of an ACO's assigned beneficiaries are in counties designated as a major disaster or public health emergency area, or the ACO's legal entity is in such an area, CMS's extreme and uncontrollable circumstances policies apply. For ACOs participating using a six-month performance period in 2019 (January 1 through June 30,

2019), if the ACO is affected by a disaster in any month of 2019 CMS will use the extreme and uncontrollable circumstances alternative scoring methodologies described here.

Quality

CMS finalizes an extreme and uncontrollable circumstances policy which specifies the ACO's quality score will be set to the mean quality performance score for all MSSP ACOs for the applicable performance year. However, if the ACO is able to completely and accurately report all quality measures, CMS will use the higher of the ACO's quality performance score or the mean quality performance score for all MSSP ACOs. If the ACO's own quality score is used, the ACO will also be eligible for improvement points. If an ACO receives the mean MSSP quality score, they will not be eligible for improvement points but in the next performance year, CMS will measure quality improvement based on a comparison of the ACO's performance in that year and in the most recently available prior performance year in which the ACO was able to report quality.

In relation to MIPS, CMS clarifies that the MIPS quality performance category will be reweighted to zero if a disaster-affected ACO receives the mean quality score under the MSSP extreme and uncontrollable circumstances policy. This would result in the ACO's MIPS score being comprised of PI performance at 75 percent and IA performance at 25 percent of the ACO's overall MIPS score. If the PI performance category score is also reweighted to zero due to the effects of the natural disaster, there would be only one performance category score for the ACO triggering the MIPS policy which would award the ACO entity and its ECs with a neutral MIPS payment adjustment.

Mitigating Shared Losses

CMS will also continue its policy to mitigate the amount of shared losses an ACO must pay back to CMS should it be affected by an extreme and uncontrollable circumstance. CMS will reduce the amount of shared losses calculated for the performance year by an amount determined by multiplying (1) the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance; and (2) the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance. For ACOs in a six-month performance period CMS will first determine shared losses for the ACO over the full calendar year, reduce the ACO's shared losses for the calendar year for extreme and uncontrollable circumstances, and then determine the portion of shared losses for the six-month performance period.

Finally, CMS notes they continue to believe the use of regional factors in establishing and updating the benchmark will provide an inherent and sufficient adjustment for regional variations in expenditures related to extreme and uncontrollable circumstances; therefore, CMS does not make any changes to how benchmarks are established and/or updated to account for extreme and uncontrollable circumstances.

NAACOS will continue to collect data on how ACOs are impacted by extreme and uncontrollable circumstances and advocate for policies that create a more equitable approach for ACOs affected by natural disasters.