Frequently Asked Questions on the Final Pathways to Success Rule

On December 21, CMS issued the final rule, *Accountable Care Organizations-Pathways to Success,* containing the most sweeping changes to the Medicare Shared Savings Program (MSSP) since the program's inception. The rule can be accessed here along with this CMS fact sheet. In this significant regulation, CMS makes a number of complex changes to overhaul the MSSP to create new Basic and Enhanced Tracks. This final rule comes after CMS issued a proposed rule following a comment period in the summer of 2018. NAACOS submitted comments in response to the proposals and engaged in a months-long advocacy campaign to urge CMS to make modifications to its proposals. This resource outlines the final policies CMS has adopted for the new program structure.

Members can learn more about the final Pathways to Success rule and resulting program changes by watching our on-demand webinar, An In Depth Review of the Final Pathways to Success Rule. For questions on the new Pathways to Success program structure, please email us at advocacy@naacos.com. NAACOS has also developed a separate in-depth analysis on the final Pathways to Success rule which incorporates many of the questions we are receiving from members on the new program structure and policies. NAACOS will continue to advocate for further changes to improve the program with both Congress and the Administration.

How does CMS determine what an ACO's participation options are under the new Basic and Enhanced Tracks?
CMS looks at two main things to determine the ACO's participation options in the Basic and Enhanced Tracks: the ACO's previous participation in models with performance-based risk and whether the ACO is determined to be high or low revenue. Tables 7 and 8 on pages 67911-67914 of the final rule provide a summary of the options for participation based on these criteria. Additionally, CMS defines whether the ACO is "re-entering", "renewing" or is a "new legal entity"; these definitions can further restrict the ACO's participation options. Please refer to our in-depth analysis for a detailed explanation of these definitions and the participation options under the Basic and Enhanced Track. Should you have specific questions about your ACO's unique situation, please contact us at advocacy@naacos.com and our staff would be happy to assist you in understanding your participation options.

If we are a Next Generation Model ACO, is our only option the Enhanced Track?
Next Generation ACOs are not prohibited from participating in the new MSSP program structure outlined in the Pathways to Success rule. Whether or not your ACO is eligible for other tracks depends on if your ACO is designated as low- or high-revenue and your previous experience with performance-based risk. Participation in the Next Generation ACO model makes the ACO designated as experienced with performance-based risk. However, if your participant list changes significantly, you may have additional options available to you. CMS defines an ACO as re-entering if the ACO is a new legal entity that has never participated in the shared Savings Program and more than 50 percent of its ACO participants were included on an ACO participant list of the same ACO in any of the five most recent performance years prior to the agreement start date.

Can ACOs elect to move to higher levels of risk after completing the 6-month performance period of July 1, 2019 to December 31, 2019? Or must they wait until January 1, 2021 to choose to voluntarily move to higher levels of risk than what are required by CMS?
In the final rule, CMS notes that ACOs can elect to move to higher levels of risk than are required by CMS after completing the 6-month performance period of July 1, 2019 to December 31, 2019. Therefore, they do not have to wait until January 1, 2021 to advance to higher levels of risk.

For ACOs who elect to participate for a six-month performance period in 2019, how will quality reporting be accomplished?
CMS notes that ACOs participating in either the January 1 to June 30, 2019 or July 1 to December 31, 2019 performance periods will be assessed on a full calendar year of quality data. Reporting will take place in early 2020 as is done typically. Therefore, ACOs participating in both six-month performance periods will not need to report quality data twice, but will report one time for the full 2019 calendar year. Please refer to our in-depth analysis of the Pathways to Success final rule for more information.

If we start in Basic Track Level E on July 1, 2019 can we advance to the Enhanced track at any time during our agreement period?
No. CMS prohibits ACOs from moving to from the Basic Track to the Enhanced Track within the same agreement period. ACOs do have the option to advance faster along the Basic Track's glidepath than what CMS stipulates within their current agreement. ACOs may advance more quickly along the glidepath but are prohibited from moving to lower levels of risk.

What options are available to Track 1+ ACOs given the track is being discontinued?
Participation in the Track 1+ program qualifies as experience with performance-based risk. High revenue ACOs experienced with performance-based risk would normally be advanced directly to the Enhanced Track. But CMS is granting a very limited, one-time exception to allow 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), which are considered high revenue ACOs, a one-time option to renew for a consecutive agreement period of at least 5 years under Level E of the BASIC track.

For a new legal entity wishing to join Basic Track A in July 2019, what data will be provided in advance of July 1, 2019 to help with planning, setup, etc.? Specifically, will any "preview" CCLF files get sent to a new ACO prior to July 2019?
Unfortunately, CMS does not anticipate it will provide CCLF preview files prior to the July 1, 2019 start date.

In the definition of "high revenue" and "low revenue", what is the difference between the numerator and denominator?
When calculating high/low revenue status, to find the numerator, look at all the TINs in your ACO and find the total A and B fee-for-service revenue of those affiliated TINs. This dollar amount includes spending for an ACO's assigned and unassigned beneficiaries. The denominator is the ACO's benchmark (the Parts A and B spending of assigned beneficiaries). These calculations are based on the most recent calendar year for which 12 months of data are available.

When will CMS tell me if my ACO is "high revenue" or "low revenue"?
CMS plans to make revenue determinations and tell ACOs of their high/low revenue status before they sign participation agreements. NAACOS asked for this determination to be made before an application is submitted, but CMS said since ACOs can still make changes to participant lists during the application process, it wouldn't be able to provide high-low status information to ACOs. The agency vowed to provide "timely feedback" to ACOs throughout an application cycle on whether it would likely be a low revenue or high revenue ACO. In the meantime, NAACOS will be providing members with high/low revenue reports, using 2016 data (the most recent data available at this time) as an estimate for ACOs.

What happens if during my agreement period, the composition of my ACO changes or without changes it suddenly becomes "high revenue"?
If, for example, an ACO enters the Basic Level E track because it's an experienced, low revenue ACO, and subsequently changes the makeup of its participant TINs and as a result crosses the high-revenue threshold during its agreement period, CMS would allow the ACO to finish the year in the Basic Track before being ineligible to continue in that track. As a result, the ACO in this example would then be required to participate in the Enhanced Track. CMS would however, allow an ACO to change its participant list to attempt to maintain low revenue status.

The same would be true if an ACO doesn't change its participant list and then crosses the threshold because spending levels inevitably change. CMS would allow ACOs the option to change participant lists to maintain their low-revenue status.

Will ACOs that enter in Basic Track Level E or the Enhanced Track in July 2019 be considered Advanced APMs under the Quality Payment Program in 2019? Will its participants be exempt from MIPS for 2019?
ACOs that move to Basic Level E or the Enhanced Track on July 1 will have one snapshot date (August 31) in which CMS will conduct calculations for Qualifying APM Participant threshold to determine if the ACO is eligible to receive the 5 percent Advanced APM bonus under the QPP. CMS clarified in the final rule it will still use the entire QP performance period (January 1, 2019, through August 31, 2019) rather than conducting QP determinations from July 1, 2019, through August 31, 2019. To qualify as an Advanced APM in 2019, 50 percent of Medicare payments must be made "through" or 35 percent patients must receive are under an Advanced APM.

If an ACO obtains Qualifying APM Participant (QP) status, it will be exempt from MIPS reporting for the entire calendar year 2019. As stated in the final 2019 Physician Fee Schedule rule, ACOs that reach QP status in under either snapshot in the first six months of the year (March 31, 2019 or June 30, 2019) will also receive a 5 percent MACRA bonus and be exempt from MIPS reporting. More information about the QPP how it applies to ACOs can be found in NAACOS's ACO Guide to MACRA. ACOs can check the status for their QPs via the CMS QP Lookup Tool.

Can you please explain why renormalizing is applied on the 3 percent of risk adjustment? Doesn't this negate the 3 percent cap? How is inflation is applied to the risk cap of 3 percent?
By allowing the 3 percent to include the market-wide increase in risk scores (i.e. inflation), the raw risk score can increase by more than 3 percent over the contract period. The 3 percent still serves as an upper bound to limit the increases in individual ACO renormalized risk scores but is fortunately indexed to the annual inflation in risk score. CMS has projected that approximately 30 percent of ACOs will reach the 3 percent risk cap in a given year.

Do you have to have repayment mechanisms in place at Basic Track Level A, or would it only need to be in place once you reach Level C?
Repayment mechanisms do not need to be in place for Basic Track Level A. The year prior to the transition to a downside risk track, e.g. Level C, will require that a repayment mechanism be in place.

When are the beneficiary incentive program and waivers available?
The new beneficiary incentive program is available to two-sided risk ACOs with preliminary prospective assignment with retrospective reconciliation or prospective assignment, including Track 3 ACOs effective July 1, 2019. Two-sided ACOs using prospective assignment are eligible to use the expanded telehealth provisions starting Jan. 1, 2020, making it available to Track 3 and Track 1+ ACOs using prospective assignment. The skilled nursing facility (SNF) three-day rule waiver is available to two-sided-risk ACOs using prospective or preliminary prospective assignment starting July 1, 2019. However, it's already available under Track 3 and Track 1+ ACOs that use prospective assignment. An ACO's choice between prospective assignment or preliminary prospective assignment with retrospective reconciliation is only available under new Pathways contracts.

What are considered "qualified services" for the beneficiary incentive program?
A qualifying service is a primary care service furnished through an ACO by a primary care physician, physician assistant, nurse practitioner, or certified nurse specialist, federally qualified health center or rural health clinic. Prior regulation of the MSSP defines primary care services in § 425.400(c) and ACO professionals in § 425.400. CMS will also be issuing sub-regulatory guidance to further define the program parameters and requirements.

Are ACOs given any sort of help in covering the initial costs of a beneficiary incentive program?
Despite calls for NAACOS for financial help establishing such incentive payments, ACOs must fully fund their beneficiary incentive programs and can't accept funds from outside entities like health plans or drug companies. They also can't bill Medicare for the costs. The payments must be the same amount for all patients and go to all patients who receive a qualifying service.

Does an ACO need to select prospective assignment to use telehealth services?
Only ACOs opting for prospective assignment are eligible for the expanded telehealth services provision of the Pathways to Success rule, so if an ACO opts for retrospective assignment, they could lose the right to bill for these expanded telehealth services. ACOs in the Enhanced Track and Basic Track Levels C, D and E are eligible to participate along with Track 3 and Track 1+ ACOs that use prospective assignment.

How do I know if a patient is eligible under a SNF waiver?
The SNF three-day wavier is available to two-sided ACOs using preliminary prospective assignment with retrospective reconciliation. The wavier can be used on beneficiaries for the whole year if they appear on an ACO's initial, first, second or third quarter preliminary prospective assignment lists unless they enroll in a Medicare group health plan or drop out of Medicare.