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.

PARTICIPATION OPTIONS AND APPLICATION QUESTIONS

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.

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.

How will an ACO select their Minimum Savings Rate and Minimum Loss Rate (MSR/MLR) under the new program structure?
If applying to Basic Track Level A or B, the MSR/MLR will be selected for the ACO based on the number of assigned beneficiaries. Prior to entering a two-sided model such as Basic Track Levels C-E or Enhanced Track, the ACO must select the MSR/MLR (whether automatically being advanced to a two-sided model or voluntarily electing to move to a two-sided model more quickly than is required). An ACO will make this selection as part of the application cycle prior to entering a two-sided model and this will be in effect for the duration of the agreement period that the ACO is under two-sided risk. The ACO must choose from the following options, which are consistent with current policy:

- 0 percent MSR/MLR
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0 percent
- Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO

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.

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.

QUALITY REPORTING AND QUALITY PAYMENT PROGRAM (QPP) QUESTIONS

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 an ACO begins participating under the new program structure starting on July 1, 2019, when do quality measures move from pay-for-reporting to pay-for-performance?
For July 1, 2019 starters, performance year one is the six-month performance year from July 1, 2019, through December 31, 2019. ACOs in a first agreement period will be under pay-for-reporting during this time. In performance year 2020 (starting on Jan. 1, 2020), the phase-in to pay-for-performance begins. See more information on the phase-in schedule in the CMS 2019 Quality Measurement Methodology resource.

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 Qualifying APM Participant (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 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 bonus and be exempt from Merit-Based Incentive Payment System (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.

If our ACO enters Levels C, D, or E of the Basic Track or the Enhanced Track for an agreement period beginning on July 1, 2019, and chooses to leave the Shared Savings Program before the end of the first performance year (e.g., an effective date of termination on or before December 30, 2019), would we be required to pay shared losses and would our providers and suppliers be able to qualify as Alternative Payment Model Participants (QPs) under the Pathways to Success Final Rule?
An ACO under a two-sided model that terminates its participation agreement during the 6-month performance year beginning July 1, 2019, with an effective date of termination prior to the last calendar day of the performance year, is not liable for shared losses incurred during the performance year. However, ACOs under a two-sided model that begin a six-month performance year on July 1, 2019, whose participation agreement is terminated by CMS, are liable for a pro-rated share of any shared losses determined for the performance year during which the termination becomes effective. If an ACO does not complete its performance year because it chooses an effective date of termination before the last calendar day of the performance year, or if the ACO's participation agreement is terminated at any time by CMS, the ACO is ineligible to receive shared savings for the performance year during which the termination becomes effective.

If an ACO participates in the Level E of the Basic Track or the Enhanced Track beginning July 1, 2019, and does not terminate before the August 31st snapshot, then its eligible clinicians will be eligible for the QP determination. If the ACO exceeds the QP payment amount or patient count thresholds, then all eligible clinicians who have reassigned their billing rights to ACO participant TINs and are captured on the August 31st snapshot will be QPs. As a QP, eligible clinicians will be exempt from MIPS for the 2019 performance year/2021 payment year and will receive the 5 percent APM bonus in the 2021 payment year. If the ACO

does not exceed the QP threshold, then eligible clinicians will be subject to MIPS and scored under the APM scoring standard.

If an ACO in Basic Track Level E or the Enhanced Track terminates before the August 31st snapshot, then eligible clinicians will not be included in the QP determinations, because the ACO terminated before the end of the QP performance period (January 1st to August 31st). In this scenario, the eligible clinicians will not be scored under MIPS using the APM scoring standard as a result of participating in the terminated ACO, because they would not be captured as participants in a MIPS APM on any of the four snapshots (March 31st, June 30th, August 31st, and December 31st) used to determine APM participation for MIPS, due to the ACO's participation in the Shared Savings Program starting July 1st and ending before August 31st.

HIGH/LOW REVENUE DETERMINATION

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 Tax Identification Numbers (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.

BENEFICIARY NOTIFICATION REQUIREMENTS

When will the new beneficiary notification requirements go into effect? Are those applicable to all ACOs, or only ACOs choosing to enter the new program structure created by the Pathways to Success rule?
All ACOs that are currently participating in the Shared Savings Program, as well those entering the new Basic Track and Enhanced Track, will need to comply with the new beneficiary notification requirements beginning July 1, 2019. CMS states more guidance on these new requirements is forthcoming.

RISK ADJUSTMENT

Can you please explain why renormalizing is applied on the three percent of risk adjustment? Doesn't this negate the three percent cap? How is inflation is applied to the risk cap of three percent?
By allowing the three percent to include the market-wide increase in risk scores (i.e. inflation), the raw risk score can increase by more than three percent over the contract period. The three 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 three percent risk cap in a given year.

REPAYMENT MECHANISMS

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.

BENIFICIARY INCENTIVE PROGRAM AND WAIVERS

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 risk ACOs using prospective assignment are eligible to use the expanded telehealth provisions starting Jan. 1, 2020. The skilled nursing facility (SNF) three-day rule waiver is available to two-sided risk ACOs using prospective assignment or preliminary prospective assignment with retrospective reconciliation starting July 1, 2019. However, please note the SNF three-day rule waiver is already available to Track 3 and Track 1+ ACOs that use prospective assignment. Table 10 in the final rule outlines these options and is found on page 67977.

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. For more information, refer to the CMS beneficiary incentive program guidance document.

When must beneficiary incentive payments be offered?
Per the Bipartisan Budget Act of 2018, incentive payments must be made for each qualifying primary care service eligible beneficiaries receive in the performance year in which an ACO offers the incentive program. Payments may be up to $20 (adjusted annually for inflation) for each visit and cannot be in cash but rather must be provided as "cash equivalents," such as debit cards or checks. Payments must be provided within 30 days of a qualifying service and must be furnished by the ACO directly, not by its participants. The payments must be the same amount for all patients and go to all patients who receive a qualifying service. For more information, refer to the CMS beneficiary incentive program guidance document.

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. The payments must be the same amount for

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Does an ACO need to select prospective assignment to use telehealth services?
Only ACOs who elect prospective assignment are eligible for the expanded telehealth services provision of the Pathways to Success rule. If an ACO elects 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, E and Track 3 and Track 1+ ACOs that use prospective assignment are eligible to participate.

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. For more information, refer to the CMS SNF three day waiver guidance document.

EARLY TERMINATION QUESTIONS

If our ACO enters Levels C, D, or E of the Basic Track or the Enhanced Track for an agreement period beginning on July 1, 2019, and chooses to leave the Shared Savings Program before the end of the first performance year (e.g., an effective date of termination on or before December 30, 2019), would we be required to pay shared losses and would our providers and suppliers be able to qualify as Alternative Payment Model Participants (QPs) under the Pathways to Success Final Rule?
An ACO under a two-sided model that terminates its participation agreement during the 6-month performance year beginning July 1, 2019, with an effective date of termination prior to the last calendar day of the performance year, is not liable for shared losses incurred during the performance year. However, ACOs under a two-sided model that begin a six-month performance year on July 1, 2019, whose participation agreement is terminated by CMS are liable for a pro-rated share of any shared losses determined for the performance year during which the termination becomes effective. If an ACO does not complete its performance year because it chooses an effective date of termination before the last calendar day of the performance year, or if the ACO's participation agreement is terminated at any time by CMS, the ACO is ineligible to receive shared savings for the performance year during which the termination becomes effective.

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If an ACO in Basic Track Level E or the Enhanced Track terminates before the August 31st snapshot, then eligible clinicians will not be included in the QP determinations, because the ACO terminated before the end of the QP performance period (January 1st to August 31st). In this scenario, the eligible clinicians will not be scored under MIPS using the APM scoring standard as a result of participating in the terminated ACO, because they would not be captured as participants in a MIPS APM on any of the four snapshots (March 31st, June 30th, August 31st, and December 31st) used to determine APM participation for MIPS, due to the ACO's participation in the Shared Savings Program starting July 1st and ending before August 31st.