NATIONAL ASSOCIATION OF Community Health Centers

Final Rule on the "Pathways to Success" Medicare ACO Program

ISSUES AFFECTING HEALTH CENTERS IN "PATHWAYS TO SUCCESS" FINAL RULE

In December 2018, the Center for Medicare and Medicaid Services (CMS) released the "Pathways to Success" Final Rule, which outlines significant changes to the Medicare Shared Savings Program (MSSP). In effect, it will require Accountable Care Organizations (ACOs) participating in the MSSP to take greater financial risks.

NACHC submitted comments on the CMS proposed rule, which was issued in August 2018. The comments addressed the proposed rule's potential impact on health centers across the country. NACHC also requested clarification from CMS in several areas of the proposed rule. A brief summary of NACHC'S comments, as well as an overview of CMS' responses in the final rule are outlined below.

- **ACOs must enter into either a "BASIC" or "ENHANCED" track. The "BASIC" track allows low-revenue ACOs three years in an upside-only agreement prior to taking financial risk on the "ENHANCED" track.**
  - NACHC Comment: NACHC requested that CMS introduce a more gradual pathway for provider-led ACOs to adopt the two-sided financial risk that the program would require. Specifically, NACHC requested that CMS allow provider-led ACOs at least three years in the "BASIC" track under an upside-only arrangement before taking further financial risk.
  - Final Rule: The Final Rule allows low-revenue ACOs *without prior ACO experience* three years on the "BASIC" track under an upside-only agreement. Through incremental financial risk taking, low-revenue ACOs with prior ACO experience will remain on the BASIC track, while ultimately working to qualify as an Advanced APM.

- **Increase in Shared Savings Rates for ACOs in order to maintain financial security.**
  - NACHC comment: NACHC highlighted that health centers serve some of the most vulnerable communities in the country and requested that CMS increase the shared savings rates during the upside-only years of the "BASIC" track to at least 35 percent in order for ACOs to be equipped for a two-sided risk agreement thereafter.
  - Final Rule: As requested, CMS stated in their Final Rule that ACOs under one-sided agreements will be eligible for up to 40 percent shared savings rates, and those under a two-sided risk agreement will be eligible for up to 50 percent.

- **ACOs following two-sided risk arrangements will receive reimbursement for telehealth services in 2020.**
  - NACHC comment: NACHC requested further clarification on whether ACOs will be able to receive reimbursement for telehealth services, despite the fact that only certain rural health centers can serve as 'originating sites' for such services in Medicare.
  - Final Rule: CMS noted that as per the Bipartisan Budget Act of 2018, beginning in 2020, for those providers participating in a Medicare ACO, a patient's home can serve as an originating site, that the rural restrictions on originating sites will be removed and that eligible providers will receive reimbursement for telehealth services. Note: the final rule did not address the issue of health centers serving as distant sites in Medicare (see NACHC fact sheet for more information on this issue).

- **CMS is revising the benchmarking process, "ensuring rigorous benchmarking by using regional benchmarks for all agreement periods."**
    - NACHC Comment: NACHC requested revisions to the benchmarking process that would more appropriately support health centers in delivering the best care for the vulnerable populations that they serve.
    - Final Rule: CMS did not specifically address NACHC's concerns regarding benchmarking and health centers. In the Final Rule, CMS establishes 4 revisions to the benchmarking process.
        - *Regional Adjustment* – CMS will incorporate regional FFS expenditures into an ACO's benchmark in year one.
        - *Risk Adjustment* – CMS will use a risk score ratio, eliminating the "newly assigned" and "continuously assigned" categories previously used.
        - *Trends* – CMS will use a "national-regional blend" throughout the agreement periods.
        - *Agreement Periods and Rebasing* – CMS is changing the agreement periods to 5 years and rebasing the benchmark at the beginning of each new period.

- **CMS will allow ACOs to apply to develop beneficiary incentive programs. They will be able to offer up to $20 for every qualifying primary care service received from an ACO professional, FQHC, or Rural Health Clinic.**
    - NACHC Comment: NACHC requested that CMS exercise caution in allowing ACOs to offer beneficiary incentives. Beneficiary Incentives may draw healthier patients to higher-revenue ACOs, leaving sicker patients with fewer, lower-quality options. NACHC requested that CMS implement safety nets to avoid these issues, and to also ensure that there are no anti-kickback or physician self-referral laws violated in the process.
    - Final Rule: CMS did not fully address NACHC's concerns regarding beneficiary incentives. CMS did not address the fact that offering incentives may put sicker patients at a disadvantage. However, CMS did clarify that any voucher or gift card that is offered must contribute to the medical well-being or advancement of the beneficiary in some way, and that the ACO will be responsible for notifying every beneficiary of the incentive program.

For more information on the final rule, see the following:

- CMS Fact Sheet on "Pathways to Success" Final Rule
- Accountable Care Learning Collaborative Summary of Final Rule
- Health Affairs Article "*Risk Adjustment In Medicare ACO Program Deters Coding Increases But May Lead ACOs To Drop High-Risk Beneficiaries*"
- NACHC Blog "A New Medicare Shared Savings Proposed Rule Could Affect Health Centers"