ACOs & CMS's Proposed "Pathways to Success" Rule

The Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs) is a significant national program driving our health care system from fee-for-service volume to value-based care. With 561 ACOs covering 10.5 million Medicare beneficiaries, the MSSP is the largest value-based payment model in the country, and research shows savings and quality benefits. For example, a 2018 peer-reviewed paper by Harvard researchers published in the New England Journal of Medicine found that in 2015 the MSSP generated gross savings of $704 million and reduced Medicare spending by $145 million after accounting for shared-savings payments earned by ACOs. A new study by Dobson Davanzo & Associates using similar scientific methods found that MSSP ACOs saved $1.84 billion from 2013 through 2015 and reduced Medicare spending by $542 million during that time after accounting for shared savings payments earned by ACOs. Finally, recent CMS MSSP results for performance year 2017 show ACOs generated $1.1 billion in savings with $314 million in net savings.

CMS proposed Pathways to Success Rule

On August 9, 2018, CMS released a proposal that would set a new direction for the MSSP, referred to as the "Pathways to Success" proposed rule. This would improve the MSSP in a number of ways, including through proposals to extend agreement periods to five years, to provide a more gradual ramp up of risk, to permanently include a Track 1+ equivalent (renamed Basic Level E), and to reduce reporting burdens, among others. CMS's proposed rule also includes some provisions that are of significant concern, including the following.

Cutting shared savings from 50 to 25 percent, which will deter new entrants. The proposed rule cuts shared savings in half for shared savings-only ACOs, severely undermining the business case to join the MSSP and begin the transition to value-based payment for new ACOs. ACOs are investing millions of dollars of their own capital to improve care; CMS's proposed reduction of the shared savings rate will preclude ACOs from generating a return on investment. Closing off the pipeline of new ACOs will significantly hamper the overall shift to value-based payment. We request CMS maintain or increase the existing shared savings rates.

Shortening the time ACOs have to take on downside financial risk, which will deter new entrants and drive existing ACOs to leave the program. The proposal reduces the onramp to assuming downside financial risk for new ACOs from six to only two years. Research, including the HHS Inspector General's, shows that it typically takes more than two years for ACOs to make the clinical and operational changes to prepare successfully for financial risk. Of the 142 ACOs that earned shared savings payments in 2017 and had prior program experience, 36 percent had losses (i.e., expenditures higher than benchmarks) in one of their first two years of the program, illustrating the need to provide ACOs with time to develop before assuming risk. We urge more time for ACOs in a shared savings-only model, with additional time for high performing ACOs.

Introducing distinctions between high and low revenue ACOs and requiring more risk sooner from high revenue ACOs. The proposed calculation for high and low revenue ACOs is arbitrary and would unfairly push high revenue ACOs into higher levels of risk sooner. We oppose this distinction and requirements that high revenue ACOs – or any ACOs – be forced into higher levels of risk. Specifically, we request that CMS not require any ACOs to participate in the Enhanced Track but to keep that a voluntary model for ACOs prepared for higher levels of risk and reward.

Modifying the risk adjustment methodology to allow risk score changes of +/- 3 percent across an extended five-year agreement period. We appreciate CMS's recognition of the need to allow risk score changes over time, and we support the proposal to modify MSSP risk adjustment by eliminating the distinction between newly and continuously assigned beneficiaries. However, CMS's proposal to allow risk score changes of +/- 3 percent is insufficient when applied across an extended five-year agreement period. We request the agency use a more appropriate range such as +/- 5 percent and to cap the risk ratios in aggregate across the four beneficiary enrollment types.