The Interim ACO Rule Explained: A Pause, Not a Reprieve

written by Dave Halpert | May 7, 2020

As the coronavirus pandemic continues to upend health care in the U.S., pressure has mounted on CMS to adjust its efforts to drive providers to adopt risk. In response, at the end of last week CMS announced a carve-out of COVID-19 patient expenses from certain reporting requirements. In this round, ACOs were on the receiving end, being largely excused from remaining 2019 reporting and 2020 enrollment obligations.

True to our predictions, this will slow, but not reverse CMS's ultimate agenda to push providers to manage under risk. Those who interpret the Interim Rule as a reprieve will do so at their organization's peril. Here's what you need to know about the reporting adjustments and planning ahead.

How ACO Reporting and Cost Calculations Are Being Modified for the Pandemic

For several weeks, ACOs and stakeholders had become increasingly concerned that a sudden influx of high and unexpected costs throughout the country could upset scoring and payment methodologies for ACOs. In a letter dated April 17, 2020, the Medicare Payment Advisory

Committee (MedPAC) urged CMS to take steps proactively to ensure that ACOs were not harmed by the global pandemic.

In the face of mounting concern, and given the opportunity to be held harmless for failing to report data for MIPS, it was inevitable that Medicare Shared Savings Program ACOs—the largest Alternate Payment Model on the other side of the QPP reporting track—would receive similar treatment. The primary provisions addressed the following concerns:

> Shared Losses Calculations: CMS has updated its methodology when calculating expenditures against its target to account for COVID-19. This will apply to all ACOs regardless of the extent to which an ACO's patients are affected. An update to the Extreme and Uncontrollable Circumstances policy will factor the duration of the Public Health Emergency (PHE, the term specified in the policy), and will prorate losses accordingly. In other words, should the PHE continue through June, shared losses would be reduced by half to account for the six PHE months.
> Quality Reporting: Although the reporting deadline was extended to April 30, ACOs who do not complete quality reporting requirements will be held harmless, and assigned the mean quality score. Those who do report will be assigned either the mean quality score or their own score, depending on which is higher. This is similar to the policy CMS adopted for the 2019 MIPS program year.
> Participation: The 2020 application cycle for the 2021 performance year is being deferred. An ACO with an agreement term ending on December 31, 2020, will have the opportunity to extend their existing agreement by one year. Those in the BASIC track will be able to defer their previously required transition to an increased level of risk for one year, resuming advancement in 2022.
> Financial Methodology: CMS is also attempting to avoid penalizing (or rewarding) ACOs based on the prevalence of COVID-19 in the assigned population. All Part A and Part B spending related to COVID-19 treatment will be removed from benchmark calculation and performance year expenditures, in addition to other payment methodologies designed to "level the playing field" amongst ACOs.
> Beneficiary Assignment: Because of the enhanced use of telehealth services to treat patients (either because they are exhibiting COVID-19 symptoms or in order to provide ongoing care while sheltered safely in place), CMS will use telehealth services in its beneficiary assignment methodology.

Plan Ahead for Managing Risk or Risk Falling Behind

Although these provisions provide a temporary reprieve from an immediate and crushing blow, ACOs must recognize that this will not be a long-term pass from responsibility or risk. CMS has long expressed its desire to move providers into Alternate Payment Models, and as we all work

our way through an unprecedented disruption to the health care system (and life in general), it behooves ACOs to begin planning for what comes next:

> Proactively reach out to patients with underlying conditions. Patients with poorly managed conditions, particularly diabetes, hypertension, and obesity, appear to be at the greatest risk of experiencing the most severe complications of COVID-19. Ensuring that these patients are well managed now will be essential to preventing catastrophe down the road. Furthermore, some patients will be more receptive to treatment options and care than last year.
> Investigate strategic partnerships with entities that can facilitate alternate methods of contact and care, and for measuring the efficacy of your efforts. We do not know if the next wave of COVID-19 will be better or worse, or to what degree. However, we can anticipate the return of social distancing guidelines, shelter-at-home orders, and the fact that patients will still need care.
> Continue striving for improvement and excellence. The Interim Rule provides relief for ACOs, but the provisions are decidedly targeted at COVID-19-related issues. In other words, expenditures will continue to be weighed against benchmarks, and the result will be shared savings—or losses.

ACOs should continue to maintain their goals of delivering efficient, high-quality care. The Interim Rule gives ACOs the freedom they need now to ensure that patients receive the right care at the right time. The rule does not give ACOs a free pass, and those who make that mistake will fall behind their peers.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Annie Spratt