
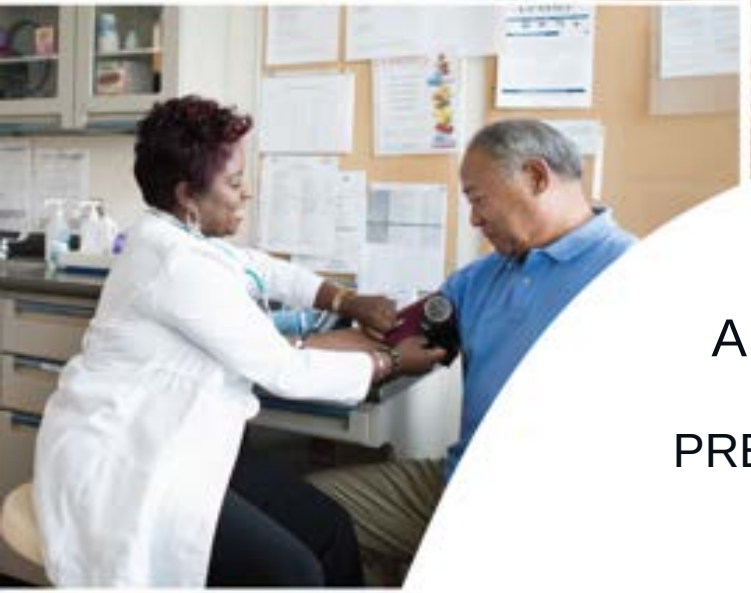


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

VALUE-BASED CARE: TRANSITIONING INTO RISK

AN OVERVIEW OF "PATHWAYS TO SUCCESS"

PRESENTATION TO AMERICAS PHYSICIAN GROUPS
SOUTHWEST REGIONAL MEETING

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Centers for Medicare & Medicaid Services

March 5, 2019

DISCLAIMER

- This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within this document for your reference.
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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

Agenda

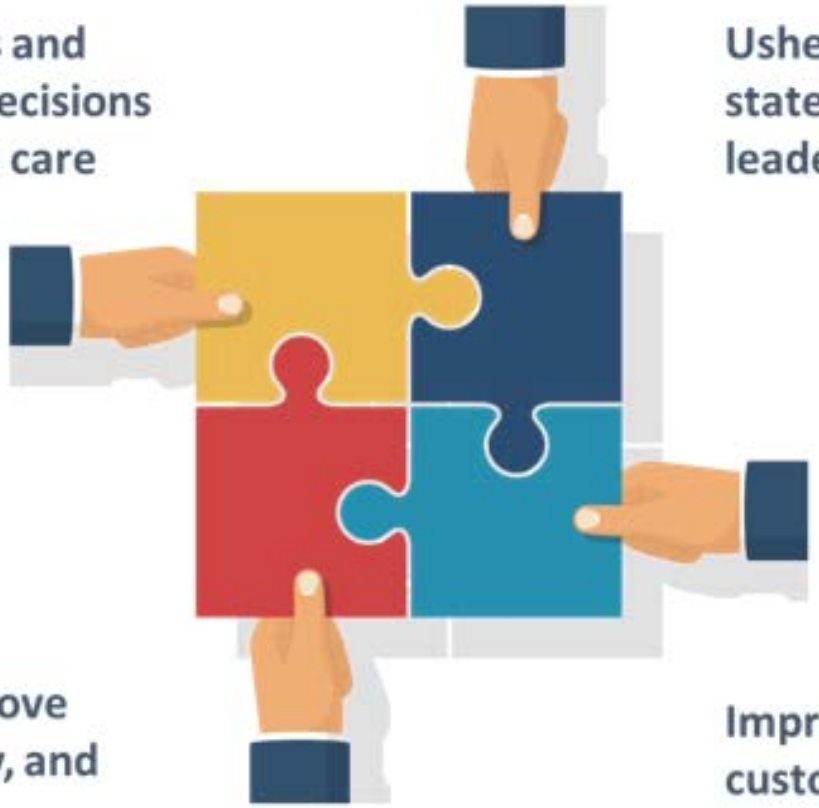
- Introduction
- Segment I. Accountability and Competition
- Segment II. Program Flexibilities
- Segment III. Tools to Strengthen Beneficiary Engagement
- Segment IV. Program Integrity
- Segment V. Changes Included in the November 2018 Final Rule
- Resources

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

A New Approach to Meaningful Outcomes

Empower patients and doctors to make decisions about their health care

Usher in a new era of state flexibility and local leadership



Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

CMS Strategic Goals

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

Section 3021 of Affordable Care Act

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Three scenarios for success

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

The Innovation Center portfolio aligns with broader CMS goals

Pay Providers

Test alternative payment models

- **Accountable Care**
  - ACO Investment Model
  - Pioneer ACO Model
  - Medicare Shared Savings Program (housed in Center for Medicare)
  - Comprehensive ESRD Care Initiative
  - Next Generation ACO
- **Primary Care Transformation**
  - Comprehensive Primary Care Initiative (CPC) & CPC+
  - Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
  - Independence at Home Demonstration
  - Graduate Nurse Education Demonstration
  - Home Health Value Based Purchasing
  - Medicare Care Choices
  - Frontier Community Health Integration Project
  - Medicare Diabetes Prevention Program Expanded Model
- **Bundled payment models**
  - Bundled Payment for Care Improvement Models 1-4
  - BPCI Advanced
  - Oncology Care Model
  - Comprehensive Care for Joint Replacement
- **Initiatives Focused on the Medicaid Population**
  - Medicaid Incentives for Prevention of Chronic Diseases
  - Strong Start Initiative
  - Medicaid Innovation Accelerator Program
- **Dual Eligible (Medicare-Medicaid Enrollees)**
  - Financial Alignment Initiative
  - Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- **Medicare Advantage (Part C) and Part D**
  - Medicare Advantage Value-Based Insurance Design Model
  - Part D Enhanced Medication Therapy Management

Deliver Care

Support providers and states to improve the delivery of care

- **Learning and Diffusion**
  - Partnership for Patients
  - Transforming Clinical Practice
- **Health Care Innovation Awards**
- **Accountable Health Communities**
- **State Innovation Models Initiative**
  - SIM Round 1 & SIM Round 2
  - Maryland All-Payer Model
  - Pennsylvania Rural Health Model
  - Vermont All-Payer ACO Model
- **Million Hearts Cardiovascular Risk Reduction Model**

Distribute Information

Increase information available for effective informed decision-making by consumers and providers

- **Information to providers in CMMI models**
- **Shared decision-making required by many models**

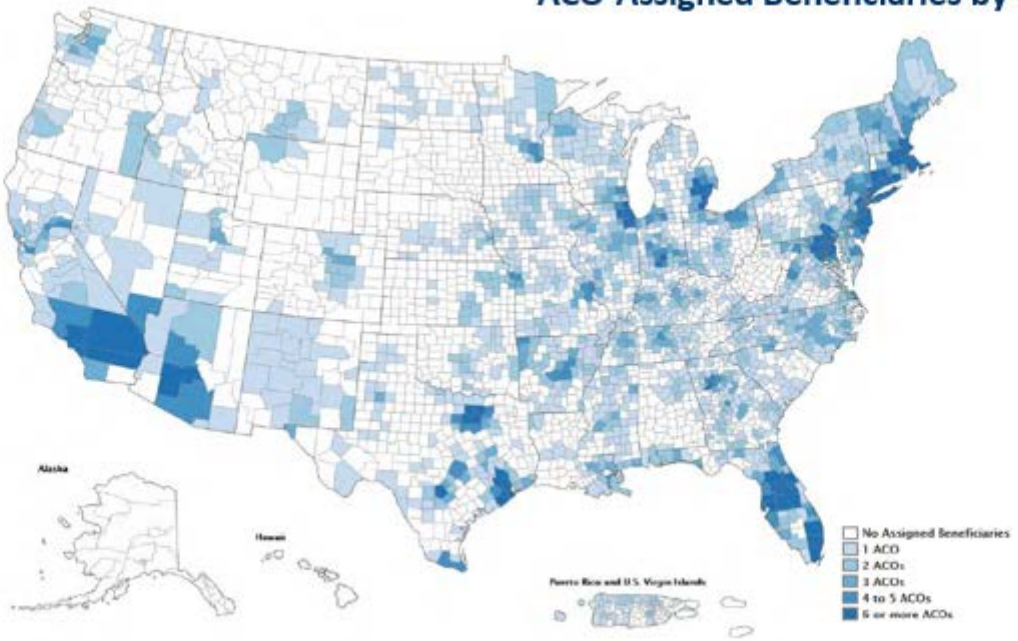
Medicare Shared Savings Program

Better
Care for
Individuals.

Better
Health for
Populations.

Lowering
Growth in
Expenditures.

ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

Report in Brief
August 2017
OEI-02-15-00450

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Review

Medicare spending is expected to grow to $1.4 trillion by 2027. To control this increase and promote quality and healthy populations, the Centers for Medicare & Medicaid Services (CMS) has implemented and is considering a number of alternative payment models that reward providers for the quality and value of services. The goal is to incentivize providers to keep patients healthy and thus lower costs.

The Medicare Shared Savings Program is one of the largest alternative payment models. As part of this program, health care providers form Accountable Care Organizations (ACOs) to coordinate care to reduce costs and improve quality of care. Information about the extent to which ACOs are able to reduce Medicare spending and improve quality is critical to inform future developments as ACOs and

Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality

What OIG Found

Over the first 3 years of the program, 428 participating Shared Savings Program ACOs served 9.7 million beneficiaries. During that time, most of these ACOs reduced Medicare spending compared to their benchmarks, achieving a net spending reduction of nearly $1 billion. One-third of ACOs reduced spending enough to receive a portion of the savings. ACOs participating in the program longer were more likely to reduce spending and by greater amounts than other ACOs. This suggests that more established ACOs are learning how to achieve greater cost savings over time.

Key Takeaway

Most Shared Savings Program ACOs were able to reduce Medicare spending and improve quality of care in the first 3 years of the program. A small subset of these ACOs showed substantial reductions in Medicare spending for key services.

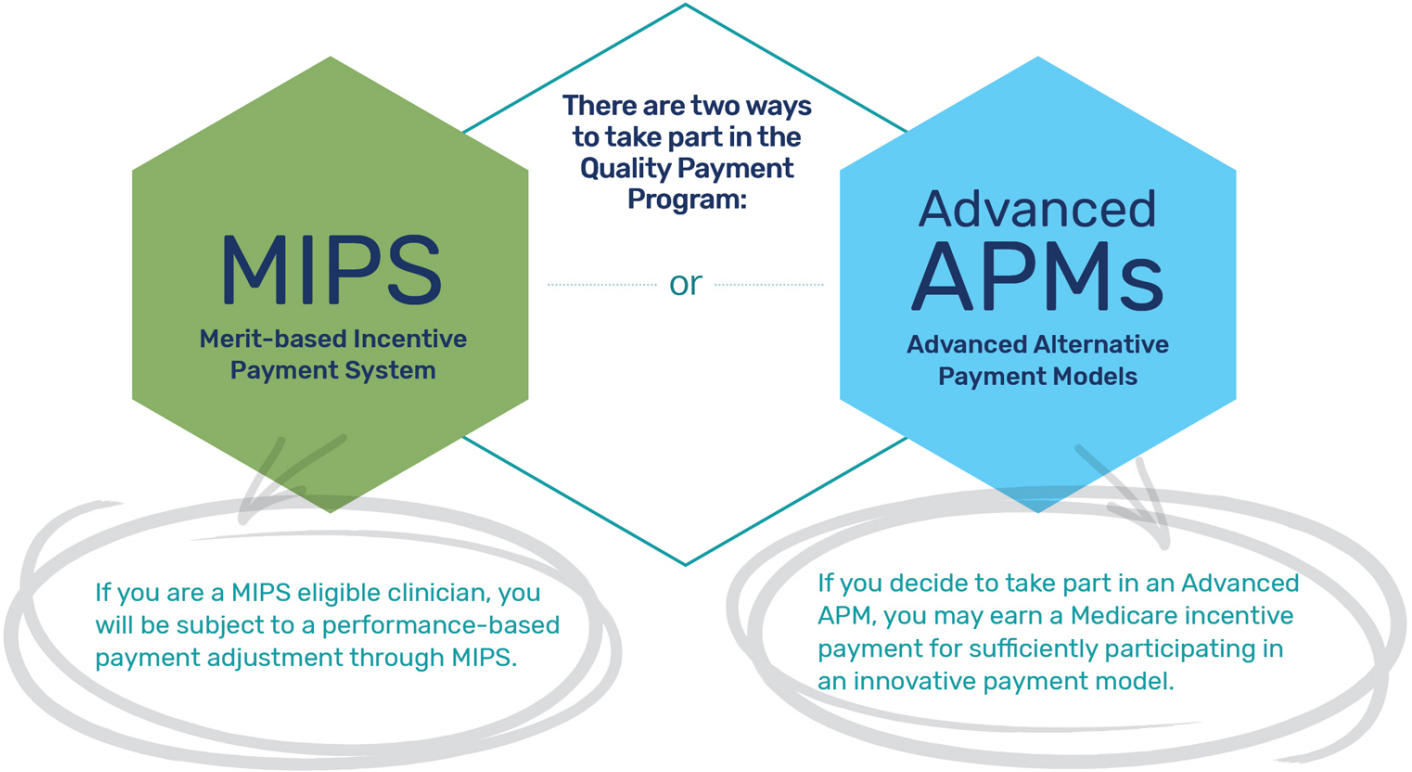
As alternative payment models further take shape, these high-performing ACOs are worth a close look to understand the strategies they are employing.

At the same time, ACOs generally improved the quality of care they provided, based on CMS's data on quality measures. In the first 3 years, ACOs improved their performance on most (82 percent) of the individual quality measures. These 33 measures track various aspects of care provided to beneficiaries, such as the percentage of beneficiaries screened for depression. ACOs also outperformed fee-for-service providers on most (81 percent) of the quality measures.

Full report can be found at
http://oig.hhs.gov/oei/reports/oei-02-15-00450.asp

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program:

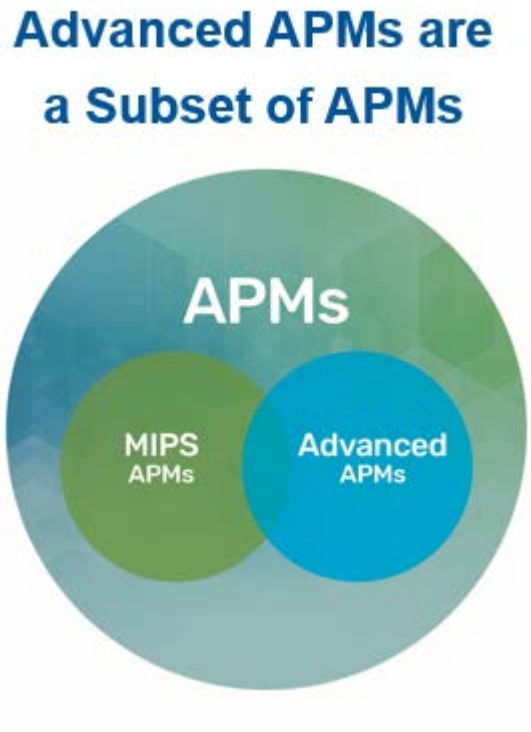


Alternative Payment Models (APMs)

A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care

Can apply to a specific condition, care episode or population

May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs



https://qpp.cms.gov/apms/overview

Advanced APMs

Current list of Advanced APMs for 2019

MEDICARE SHARED SAVINGS PROGRAM

- Bundled Payments for Care Improvement (BPCI) Advanced Model*
- Comprehensive Care for Joint Replacement Model
- Comprehensive ESRD Care Model (LDO Arrangement)
- Comprehensive ESRD Care Model (non-LDO Two-sided Risk Arrangement)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Maryland Total Cost of Care Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk Arrangement
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

*BPCI Advanced began in October 2018, and participants will have an opportunity to achieve QP status, or be scored under the APM scoring standard for MIPS, starting in performance year 2019.

The Medicare Shared Savings Program

- The Medicare Shared Savings Program (Shared Savings Program) was established in 2012 and is an important innovation for moving CMS' payment systems away from paying for volume and towards paying for value and outcomes.
- It is a voluntary national program that encourages groups of doctors, hospitals, and other health care providers to come together as an "Accountable Care Organization" (ACO) to lower growth in expenditures and improve quality.
  - An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.
  - ACOs that successfully meet quality and savings requirements share a percentage of the achieved savings with Medicare. ACOs under two-sided models are accountable for sharing in losses.
- Currently over 10.4 million beneficiaries in FFS Medicare (of the 38 million total FFS beneficiaries) receive care from providers participating in a Medicare ACO.

2018 Final Rules: Pathways to Success

- "Pathways to Success" refers to the combination of policy changes to redesign the Shared Savings Program, proposed in the August 2018 proposed rule and finalized in two final rules (December 2018 Final Rule and November 2018 Final Rule) after taking into consideration lessons learned from program experience to date as well as robust feedback we received during the comment solicitation process.
- Policy changes were informed by the following guiding principles:
  - Accountability and Competition
  - Quality
  - Beneficiary Engagement
  - Program Integrity

https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program

November 2018 Final Rule – Overview

83 FR 59452

- Makes timely updates to the program's voluntarily alignment approach and beneficiary assignment methodology.
- Streamlines the ACO core quality measure set, as part of the CY 2019 Physician Fee Schedule rulemaking cycle, to reduce burden and encourage better outcomes.
- Adds a new Certified EHR Technology (CEHRT) threshold criterion to determine ACOs' eligibility for program participation, to promote interoperability among ACO providers and suppliers.
- Provides relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances in 2018 and subsequent years, and finalized the disaster relief policies applicable in 2017.

December 2018 Final Rule – Overview

83 FR 67816

- Redesigns the participation options available under the program to encourage ACOs to transition to two-sided models (in which they may share in savings and are accountable for repaying shared losses) and to strengthen program integrity.
- Ensures rigorous benchmarking.
- Provides new tools to support coordination of care across settings and strengthen beneficiary engagement.

Segment I. Accountability and Competition

- BASIC Track and ENHANCED Track
- Determining Participation Options
- ACO Selections and Burden Reduction
- Participation Options for Agreement Periods Beginning in 2019
- Benchmarking Methodology Refinements

BASIC Track and ENHANCED Track

Streamlined Participation Options

BASIC track and ENHANCED track

- We redesigned the program's participation options to offer two tracks instead of three tracks and the Track 1+ Model, which eligible ACOs enter into for an agreement period of not less than 5 years, for agreement periods beginning on July 1, 2019, and in subsequent years:

  - **BASIC track:** Includes a "glide path" for eligible ACOs consisting of five levels (called Levels A through E) that begin under a one-sided model and incrementally phase-in higher levels of risk and reward. The highest level, Level E, qualifies as an Advanced Alternative Payment Model (APM) under the Quality Payment Program.

  - **ENHANCED track:** Based on the program's Track 3; provides greater risk in exchange for greater potential reward. This track is also an Advanced APM under the Quality Payment Program.

Streamlined Participation Options (cont.)

- We are discontinuing Track 1, Track 2, the deferred renewal option, and future application cycles for the Track 1+ Model for new agreement period start dates.
  - ACOs within existing 3-year agreement periods may complete the remainder of their current agreement period, and then renew under a new participation option.
  - ACOs may also choose to renew early to enter an agreement period of at least 5 years under either the BASIC track (if eligible) or ENHANCED track.

BASIC Track's Glide Path Design

Five Levels of Risk and Reward

Level	Risk Model	Shared Savings (once MSR** met or exceeded)	Shared Losses (once MLR* met or exceeded)	Advanced APM
Level A and Level B	One-sided	First dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	N/A	No
Level C	Two-sided	First dollar savings at a rate up to 50% based on quality performance; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%; not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	No
Level D	Two-sided	First dollar savings at a rate up to 50% based on quality performance; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%; not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	No
Level E	Two-sided	First dollar savings at a rate up to 50% based on quality performance; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%; for 2019 and 2020, not to exceed 8% of ACO participant revenue capped at 4% of updated benchmark (general policy, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program capped at 1 percentage point higher than the expenditure-based nominal amount standard)	Yes

* MSR is the "minimum savings rate"; MLR is the "minimum loss rate."

BASIC Track Progression to Risk

- ACOs in the BASIC track's glide path are automatically advanced at the start of each performance year along the progression of risk/reward levels or may elect to enter a higher level of risk/reward.
  - At the time of application, eligible ACOs may elect to enter their agreement at any level of risk/reward (Levels A–E).
  - ACOs entering an agreement period beginning on July 1, 2019, participate in a first performance year of 6 months (July 2019–December 2019), may stay in the same level for PY 2020, and will be automatically advanced for the first time for PY 2021.
  - In response to commenters' suggestions, we finalized an option for new, low revenue ACOs that are inexperienced with performance-based risk to elect to participate for 3 performance years under a one-sided model (4 performance years in the case of ACOs entering an agreement period beginning on July 1, 2019) of the BASIC track's glide path before transitioning to Level E.

BASIC Track Progression to Risk (cont.)

- The amount of time an ACO can participate under a one-sided model within the glide path will vary:
  - ACOs eligible for the glide path, without previous experience in the program may participate for two performance years (or three performance years, for July 1, 2019 starters) under a one-sided model (Level A and B).
  - ACOs with previous experience in the program's one-sided model, Track 1, may only participate for one performance year (or two performance years, for July 1, 2019 starters) under a one-sided model within the glide path (Level B) before entering performance-based risk.
  - New low revenue ACOs may participate for up to 3 performance years (or four performance years, for July 1, 2019 starters) under the one-sided models of the BASIC track's glide path before transitioning to Level E for the remaining two years of their agreement period.

BASIC Track Progression to Risk (cont.)

- ACOs can elect to move more quickly to a higher level of risk/reward within the glide path before the start of each performance year within their agreement period. ACOs cannot return to lower levels of risk/reward.

- ACOs eligible to enter the BASIC track but not the glide path participate in Level E for all performance years of the agreement period.

ENHANCED Track

- Highest level of risk/reward in the Shared Savings Program.
- References to the ENHANCED track apply to Track 3 ACOs, unless otherwise noted.

Shared Savings (once MSR met or exceeded)	Shared Losses (once MLR met or exceeded)	Advanced APM
No change. First dollar savings at a rate of up to 75% based on quality performance; not to exceed 20% of updated benchmark.	No change. First dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%; not to exceed 15% of updated benchmark.	Yes

Determining Participation Options

Track Option Determination – Overview

- We established eligibility criteria for the BASIC track that recognize differences in ACO participants' Medicare FFS revenue and the experience of the ACO and its ACO participants with performance-based risk Medicare ACO initiatives.

- Ultimately, all ACOs are expected to transition to the ENHANCED track under the redesigned program.

- Our final policies differentiate ACOs based on the degree of control they have over assigned beneficiaries' expenditures and their experience with performance-based risk when determining how quickly they must advance to the ENHANCED track.

Track Option Determination – Inexperienced vs. Experienced with Risk

MEDICARE SHARED SAVINGS PROGRAM

(1) We consider the experience of ACOs (legal entity) and ACO participants with performance-based risk Medicare ACO initiatives

- ACO is *inexperienced* with risk if **both:**
  - (1) The ACO legal entity has not participated in any performance-based risk Medicare ACO initiative; and
  - (2) Less than 40 percent of the ACO's participants participated in a performance-based risk Medicare ACO initiative in each of the 5 most recent performance years prior to the agreement start date.
- ACO is *experienced* with risk if **either** of the following criteria are met:
  - (1) The ACO is the same legal entity as a current or previous participant in a performance-based risk Medicare ACO initiative; or
  - (2) 40 percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative in any of the 5 most recent performance years prior to the agreement start date.
- Performance-based risk Medicare ACO initiatives include: BASIC track, ENHANCED track (Track 3), Track 2, Track 1+ Model, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model two-sided risk tracks.

Track Option Determination – Low Revenue vs. High Revenue

(2) We consider whether the ACO is low revenue or high revenue

- If total Medicare Parts A and B FFS revenue of ACO participants equals or exceeds 35% of total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries, the ACO is a high revenue ACO. While ACOs with a percentage less than 35% are low revenue ACOs.
- Based on commenters' suggestions, we increased the threshold from 25% to 35% so that additional ACOs with clinics or smaller institutional providers as ACO participants, including certain rural ACOs, may be identified as low revenue ACOs.

$$\frac{\textit{Medicare Parts A \& B FFS Revenue of ACO Participants}}{\textit{Medicare Parts A \& B FFS Expenditures for the ACO's Assigned Beneficiaries}}$$

Less than 35%
Low Revenue ACO

35% or more
High Revenue ACO

Limited Time in BASIC Track

- While all ACOs can elect to participate in the ENHANCED track, only ACOs that are inexperienced with performance-based risk (low revenue or high revenue) can elect to participate in the BASIC track's glide path.
  - An ACO that enters the BASIC track is considered experienced with risk, preventing ACOs from terminating and quickly re-entering the glide path.

- Low revenue ACOs can participate in the BASIC track for up to two agreement periods which are not required to be sequential. For example:
  - Low revenue ACOs that are *inexperienced* with performance-based risk that enter the BASIC track's glide path may renew for a subsequent agreement period under Level E of the BASIC track.
  - Low revenue ACOs *experienced* with performance-based risk may participate in Level E of the BASIC track for up to two agreement periods. For example, a low revenue ACO that transitions to the ENHANCED track after a single agreement period under the BASIC track may return to the BASIC track (Level E).

Limited Time in BASIC Track (cont.)

- High revenue ACOs could have at most a single agreement period in the BASIC track and are required to more quickly transition to participation in the ENHANCED track.

- In response to commenters' suggestions, we also finalized a limited exception that will allow ACOs that transitioned to the Track 1+ Model within their current agreement period** the option to renew for at least one agreement period under Level E of the BASIC track.

** that is, ACOs with a first or second agreement period start date in 2016 or 2017 that entered the Track 1+ Model in 2018

Defining Renewing ACO and Re-entering ACO

MEDICARE SHARED SAVINGS PROGRAM

- Definitions of “renewing ACO” and “re-entering ACO” include program safeguards to identify ACOs re-forming and re-entering under a different taxpayer identification number (TIN).

- Removal of the “sit-out” period after termination so ACOs can now renew early under the BASIC track or ENHANCED track or more quickly re-enter the program after termination.

- **Renewing ACO:** ACO that continues its participation in the program for a consecutive agreement period, without a break in participation, and is either:
  - (1) An ACO whose participation agreement expired and immediately enters a new agreement period to continue its participation in the program; or
  - (2) An ACO that voluntarily terminated its current ACO Participation Agreement and immediately enters a new agreement period to continue its participation in the program.

Defining Renewing ACO and Re-entering ACO (cont.)

- **Re-entering ACO:** ACO that does not meet the definition of a "renewing ACO" and is either:

  (1) The same legal entity as an ACO that previously participated in the program and is applying to participate in the program after a break in participation, because it is either (a) an ACO whose participation agreement expired without having been renewed; or (b) an ACO whose ACO Participation Agreement was terminated; or

  (2) A new legal entity that has never participated in the Shared Savings Program and is applying to participate in the program and more than 50 percent of its ACO participants were included on the ACO Participant List of the same ACO in any of the 5 most recent performance years prior to the agreement start date.

Eligibility Based on Past Participation

- We will use new evaluation criteria to determine eligibility of ACOs to renew or re-enter the program, including considering the ACO's per capita expenditures as well as failure to meet quality performance standards in multiple years of the previous agreement period.

- We will account for prior participation in determining the agreement period an ACO is entering for applying program requirements that phase in over time.
  - Weights used in calculating the regional adjustment to an ACO's historical benchmark, which phase in over multiple agreement periods.
  - Weights applied to benchmark year expenditures (equal weighting in second or subsequent agreement periods instead of weighting the 3 benchmark years (BYs) at 10 percent (BY1), 30 percent (BY2), and 60 percent (BY3)).
  - Quality performance standard, which phases in from complete and accurate reporting of all quality measures in the first performance year of an ACO's first agreement period to pay-for-performance in subsequent performance years.

Choice of Beneficiary Assignment Methodology

- Prior to the start of each agreement period, ACOs have the flexibility to elect prospective assignment or preliminary prospective assignment with retrospective reconciliation.

- ACOs may elect to change this selection before the start of each performance year during the agreement period.

Participation Options for Agreement Periods Beginning in 2019

July 1, 2019, Agreement Start Date

- To facilitate ACOs' transition to the new BASIC track or ENHANCED track, there will be a **special one-time July 1, 2019, agreement period start date** to allow for participation by:
  - Renewing ACOs
  - Early renewal
  - ACOs new to the program (initial entrants)
  - Re-entering ACOs

- Annual application cycle in advance of a January 1 agreement start date will resume for the January 1, 2020 start date and subsequent years.

6-Month Performance Years (or performance period) in 2019

- We will reconcile ACOs' performance for the first half of 2019 (January 1–June 30) and second half of 2019 (July 1–December 31) separately.
  - Financial and quality performance determined on a calendar year basis based on program rules applicable to each 6-month period.
  - Savings and losses pro-rated for each of the 6-month periods.
  - These policies only apply to ACOs with a 6-month performance year (or performance period) in 2019, and do not apply to ACOs with a 12-month performance year.

July 1, 2019, Application Cycle Key Dates

MEDICARE SHARED SAVINGS PROGRAM

Step 1: Submit a NOIA

January 2, 2019 - January 18, 2019
12:00 p.m. (noon) Eastern Time (ET)

- ❑ Review NOIA Guidance for requirements
- ❑ Complete NOIA in ACO-MS
- ❑ Submit sample agreements
- ❑ Submit draft repayment mechanism documentation

Step 2: Complete & submit the application[1]

January 22, 2019 – February 19, 2019
12:00 p.m. (noon) ET

- ❑ Review the Application Reference Manual for instructions
- ❑ Review sample applications
- ❑ Refer to the application checklists to complete the application in the ACO Management System (ACO-MS)
- ❑ Mail CMS Form-588 to CMS

Step 3: Respond to RFIs

Refer to RFI Response Actions and Deadlines for details

- ❑ Respond to RFIs by specified deadlines
- ❑ Work with your application reviewer to resolve questions

Step 4: Sign the participation agreement

- ❑ Review and certify final materials
- ❑ Sign the ACO Participation Agreement

[1] Visit the Application Types & Timeline webpage for up-to-date information on submission deadlines.

Segment II. Program Flexibilities

- Expanded Skilled Nursing Facility (SNF) 3-Day Rule Waiver Eligibility
- Expanded Use of Telehealth Services

Expanded SNF 3-Day Rule Waiver Eligibility

MEDICARE SHARED SAVINGS PROGRAM

- Allow eligible ACOs, in performance-based risk within the BASIC track's glide path and the ENHANCED track, use of the SNF 3-Day Rule Waiver, regardless of their choice of prospective assignment or preliminary prospective assignment with retrospective reconciliation.
- Amended the existing SNF 3-Day Rule Waiver to allow Critical Access Hospitals and other small, rural hospitals operating under a swing bed agreement to be eligible to partner with eligible ACOs as SNF affiliates for purposes of the SNF 3-Day Rule Waiver.

Track 1 (One-sided model; Discontinued for Future Agreement Periods)	Track 2 (Two-sided model; Discontinued for Future Agreement Periods)	Track 1+ Model (Two-sided model; Discontinued for Future agreement Periods)	BASIC track (New track)	ENHANCED track (Track 3 financial model)
N/A (unavailable under current policy)	N/A (unavailable under current policy)	Current policy (prospective assignment)	For performance years beginning on July 1, 2019, and subsequent years, eligible for performance years under a two-sided model (prospective or preliminary prospective assignment)	For performance years beginning on July 1, 2019, and subsequent years (prospective or preliminary prospective assignment)

Expanded Use of Telehealth Services

- Beginning on January 1, 2020, eligible physicians and practitioners in ACOs under performance-based risk and prospective assignment may receive payment for telehealth services furnished to prospectively assigned beneficiaries even if the otherwise applicable geographic limitations are not met, including when the beneficiary's home is the originating site.
  - **Note:** the beneficiary's home may only be used as the originating site if the service is appropriate to provide in the home setting; a service that is typically furnished in an inpatient setting will not be covered where the beneficiary's home is the originating site.

Track 1 (One-sided model; Discontinued for Future Agreement Periods)	Track 2 (Two-sided model; Discontinued for Future Agreement Periods)	Track 1+ Model (Two-sided model; Discontinued for Future Agreement Periods)	BASIC track (New track)	ENHANCED track (Track 3 financial model)
N/A (because this is a one-sided model)	N/A (because this track uses preliminary prospective assignment)	For performance year 2020 and onward (prospective assignment)	For Performance Year 2020 and onward, applicable for performance years under a two-sided model (ACO selects prospective assignment)	For Performance Year 2020 and onward (ACO selects prospective assignment)

Segment III. Tools to Strengthen Beneficiary Engagement

- Beneficiary Incentive Program
- Beneficiary Incentive Program – ACO Eligibility
- Clarification – In-kind Incentives
- Modifications to Beneficiary Notification Requirements

Beneficiary Incentive Program

- Allow eligible ACOs in certain two-sided models the opportunity to apply to establish a beneficiary incentive program.

- An eligible ACO that is approved to operate a beneficiary incentive program would provide incentive payments of up to $20 to its assigned beneficiaries for each qualifying primary care service that a beneficiary receives from certain ACO professionals, or from a Federally Qualified Health Center or Rural Health Clinic.

Beneficiary Incentive Program – ACO Eligibility

MEDICARE SHARED SAVINGS PROGRAM

- An ACO would be **required to operate its CMS-approved beneficiary incentive program for an initial period of 18 months** (for ACOs approved to operate a beneficiary incentive program beginning on July 1, 2019), or 12 months (for ACOs approved to operate a beneficiary incentive program beginning on January 1 of a performance year).
- An ACO completing an agreement period on December 31, 2019, is not eligible to establish a beneficiary incentive program on July 1, 2019, but may establish a program beginning when entering a renewed agreement period.

Track 1 (One-sided model; Discontinued for Future Agreement Periods)	Track 2 (Two-sided model; Discontinued for Future Agreement Periods)	Track 1+ Model (Two-sided model; Discontinued for Future Agreement Periods)	BASIC track (New track)	ENHANCED track (Track 3 financial model)
N/A	Beginning July 1, 2019, and for subsequent performance years (preliminary prospective assignment)	N/A	Beginning July 1, 2019, and for subsequent performance years for ACOs in Levels C, D, or E (prospective or preliminary prospective assignment)	Beginning July 1, 2019, and for subsequent performance years (prospective or preliminary prospective assignment)

Clarification – In-kind Incentives

- We clarify that, under the program's existing regulations, **we consider vouchers**, which can be used only for particular goods or services (including certain gift cards in the nature of a voucher), **to be "in-kind items or services" that may be provided** to beneficiaries so long as the applicable requirements at § 425.304 are met.

Modifications to Beneficiary Notification Requirements

- We finalized requirements for ACOs to ensure that beneficiaries are notified each performance year about their participation in the program and what it means for their care, the opportunity to decline data sharing, the ability to, and process by which, a beneficiary may voluntarily align to a primary clinician that he or she designates, and the availability of a beneficiary incentive program (if applicable).

- Notifications can be provided by mail, email or via a patient portal, at or prior to a beneficiary's first primary care service visit of the performance year; and ACO participants must post signs in their facilities and make certain notifications available upon request in settings in which beneficiaries receive primary care services.

- To mitigate the burden of these requirements, CMS is developing template notices for ACOs and ACO participants to use.

- Applicable to all ACOs beginning on July 1, 2019, including ACOs in 3-year agreement periods and ACOs in agreement periods of at least 5 years.

Segment IV. Program Integrity

- Monitoring and Termination for Poor Financial Performance
- Notice for and Payment Consequences of Early Termination

Monitoring and Termination for Poor Financial Performance

- For performance years beginning on July 1, 2019, and subsequent performance years, we will monitor for whether the expenditures for the ACO's assigned beneficiary population are "negative outside corridor," meaning that the expenditures for assigned beneficiaries exceed the ACO's updated benchmark by an amount equal to or exceeding either the ACO's negative MSR under a one-sided model, or the ACO's MLR under a two-sided model.

- If the ACO is negative outside corridor for a performance year, we may take any of the pre-termination actions set forth in 42 CFR § 425.216 (such as issuing a warning notice, requesting a corrective action plan, or placing the ACO on a special monitoring plan).

- If the ACO is negative outside corridor for another performance year of the ACO's agreement period, we may immediately or with advance notice terminate the ACO's Participation Agreement under 42 CFR § 425.218.

- Based on commenters' suggestions we will also consider improvement in performance in deciding whether to terminate an ACO for 2 years of poor financial performance.

Notice for and Payment Consequences of Early Termination

- Reduces the minimum notification period for voluntary termination from 60 to 30 days.

- Holds terminated ACOs in two-sided models accountable for pro-rated shared losses, for performance years beginning on July 1, 2019, and subsequent performance years.

  - ACOs that voluntarily terminate their participation after June 30 of a 12-month performance year will be ineligible for shared savings and accountable for pro-rated shared losses.

  - ACOs that voluntarily terminate early from 6-month performance years during 2019 will be ineligible for shared savings and not accountable for losses.

  - Involuntarily terminated ACOs will be ineligible for shared savings and accountable for pro-rated shared losses.

Segment V. Changes Included in the November 2018 Final Rule

- Updates to ACO Quality Measure Set
- Policies for Disaster Impacted ACOs
- Updates to Voluntary Alignment Process and Beneficiary Assignment

Updates to ACO Quality Measure Set

- As part of the CY 2019 Physician Fee Schedule Final Rule, we reduced the ACO core quality measure set from 31 to 23 measures, to reduce burden and encourage better outcomes.

- To promote interoperability among ACO providers and suppliers we added a new CEHRT threshold criterion to determine ACOs' eligibility for program participation.
  - ACOs must annually certify that the percentage of eligible clinicians participating in the ACO that use 2015 Edition CEHRT to document and communicate clinical care to their patients or other health care providers meets or exceeds a specified percentage:
    - 50% for ACOs in a track that does not meet the financial risk standard to be an Advanced APM.
    - 75% for ACOs in a track that meets the financial risk standard to be an Advanced APM.
  - We retired the Shared Savings Program quality measure on the percentage of eligible clinicians using CEHRT.

Policies for Disaster-Impacted ACOs

- We are continuing policies to provide relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances in 2018 and subsequent years.

https://www.fema.gov/disasters

- If 20% or more of the ACO's assigned beneficiaries are impacted by an extreme and uncontrollable circumstance or the ACO's legal entity is located in such an area, we will use the higher of the ACO's quality performance score (if the ACO completely and accurately reports all quality measures) or the mean quality performance score for all Shared Savings Program ACOs.

- For ACOs under performance-based risk, losses determined to be owed will be reduced by an amount determined using the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.

- CMS will use determinations under the Quality Payment Program with respect to whether an extreme and uncontrollable circumstance has occurred and to identify the affected geographic areas and the applicable time periods.

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/304/2018%20MIPS%20Extreme%20and%20Uncontrollable%20Circumstances%20Fact%20Sheet.pdf

Updates to Voluntary Alignment Process and Beneficiary Assignment

- We finalized refinements to the voluntary alignment process to allow beneficiaries who voluntarily align to a nurse practitioner, physician assistant, certified nurse specialist, or a physician with a specialty not used in assignment to be prospectively assigned to an ACO if the clinician they align with is participating in an ACO, even if they have not received a primary care service from a physician in the ACO.

- We finalized revisions to expand the definition of primary care services used in beneficiary assignment:
  - **Added new codes**: advance care planning codes, administration of health risk assessment service codes, and codes for annual depression screening, alcohol misuse screening, and alcohol misuse counseling.
  - Revised how we determine whether evaluation and management services were furnished in a SNF.

Resources

Contact Information

Contact Information	Type of Inquiry
aco@cms.hhs.gov	General public
SharedSavingsProgram@cms.hhs.gov	Shared Savings Program ACOs
SSPACO_Applications@cms.hhs.gov	Notice of Intent to Apply (NOIA) and applications

Resources

Resource	Description
Shared Savings Program webpage	Overview of the Shared Savings Program including helpful information and resources
Shared Savings Program Regulations: 42 CFR part 425	Regulatory authority for the administration of the Shared Savings Program
Pathways to Success Final Rules	Final rules released in November 2018 (refer to CY 2019 Physician Fee Schedule Final Rule) and December 2018 finalizing changes to the Shared Savings Program
Applications Types & Timeline webpage	Key deadlines and resources to help complete the application including sample applications
Application Toolkit	Quick access to guidance and other materials relevant to all application types
ACO Management System (ACO-MS)	NOIA and application submission system
ACO-MS Videos	Video tutorials on how to complete actions in ACO-MS including how to complete the application(s)

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APPENDIX

- ACO Selections and Burden Reduction
- Benchmarking Methodology

ACO Selections and Burden Reduction

Selection of MSR/MLR

- ACOs in a one-sided model of the BASIC track's glide path will have a variable MSR based on the ACO's number of assigned beneficiaries.
- Two-sided model ACOs choose the MSR/MLR to be applied, and the MSR/MLR selection applies for the duration of their agreement period under risk:
  - Zero percent MSR/MLR.
  - Symmetrical MSR/MLR in a 0.5 percent increment between 0.5-2.0 percent.
  - Symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO. The MSR is the same as the MSR that would apply in a one-sided model. The MLR is equal to the negative MSR.
- ACOs entering the BASIC track's glide path under a one-sided model (Level A or B) will choose the MSR/MLR to be applied before the start of their first performance year in a two-sided model (Level C, D, or E).

Addressing Small Populations

- For performance years starting on July 1, 2019, and in subsequent years, ACOs under two-sided models that elected a fixed MSR/MLR, and have fewer than 5,000 assigned beneficiaries for the performance year, are reconciled using a variable MSR/MLR consistent with their number of assigned beneficiaries.

Repayment Mechanism Requirements

- Repayment mechanism arrangements provide CMS with assurance that an ACO in a two-sided model can repay losses for which it may be liable.
- The December 2018 Final Rule included final policies to reduce the burden of these arrangements:
  - Aligned BASIC track and ENHANCED track ACOs repayment mechanism amounts, making both the lesser of 1% of total per capita Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries, or 2% of total Medicare Parts A and B FFS revenue of its ACO participants.
  - Reduced the period of time after the end of the agreement period that the repayment mechanism must be in effect from 24 months to 12 months.
  - Permitted ACOs to use auto-renewal clauses in establishing and maintaining their repayment mechanism.

Repayment Mechanism Requirements (cont.)

- Renewing ACOs may maintain a single, existing repayment mechanism arrangement to support their ability to repay shared losses in the new agreement period, so long as it is sufficient to cover any increase to the repayment mechanism amount during the new agreement period.
- Policies related to timing for demonstrating the adequacy of a repayment mechanism arrangement for ACOs in the BASIC track's glide path. ACOs must establish the adequacy of their repayment mechanism prior to the start of any performance year in which the ACO elects to participate in, or is automatically transitioned to a two-sided model (Levels C, D, or E).
- The threshold to determine if a repayment mechanism amount will need to be increased based on ACO Participant List changes prior to the start of the next performance year is 50% or $1,000,000, whichever is the lesser value.

Benchmarking Methodology Refinements

Use of Regional Factors when Establishing and Resetting ACO Benchmarks

MEDICARE SHARED SAVINGS PROGRAM

For agreement periods beginning on July 1, 2019, and in subsequent years

- Incorporate factors based on regional FFS expenditures in establishing, adjusting and updating the ACO's historical benchmark beginning with the ACO's first agreement period, rather than starting in the ACO's second or subsequent agreement period.
- Changes to the regional adjustment calculation mitigate the effects of excessive positive or negative regional adjustments used to establish and reset the benchmark by:
  - Reducing the maximum weight used in calculating the regional adjustment from 70 percent to 50 percent; and
  - Capping the regional adjustment amount using a flat dollar amount equal to 5 percent of national Medicare FFS per capita expenditures.

Changes to Regional Adjustment Weights

For agreement periods beginning on July 1, 2019, and in subsequent years

- In response to commenters' feedback, we also finalized modifications to reduce the initial weight applied to the regional adjustment for ACOs with historical expenditures above their regional service area to 15 percent and to provide a longer phase-in of a higher weight for such ACOs:
  - First time regional adjustment used: 35 percent or 15 percent (if spending above region)
  - Second time regional adjustment used: 50 percent or 25 percent (if spending above region)
  - Third time regional adjustment used: 50 percent or 35 percent (if spending above region)
  - Fourth and subsequent time regional adjustment used: 50 percent for all ACOs

Annual Update and Risk Adjustment Methodology

For agreement periods beginning on July 1, 2019, and in subsequent years

- In calculating the regional trend and update factors, we finalized our proposal to use a blend of regional and national growth rates based on Medicare FFS expenditures with increasing weight placed on the national component of the blend as the ACO's penetration in its regional service area increases.
- We replaced the current methodology for annually risk adjusting the benchmark for newly assigned and continuously assigned populations of beneficiaries with an approach that allows for adjustments to reflect changes in health status of up to positive three percent over the length of the agreement period.
- In response to some commenters' suggestions, we did not finalize the proposed negative three percent limit on risk score changes.