



NAACOS ANALYSIS OF THE FINAL MSSP PATHWAYS TO SUCCESS RULE

OVERVIEW

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 a comment period following a proposed [rule](#) issued 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.

In the rule, CMS offers a one-time only, start date of July 1, 2019, for ACOs interested in beginning under the new program rules in the Basic or Enhanced Tracks. Please note that CMS accepted applications from ACOs interested in this July 1, 2019 start option through February 19, 2019. CMS anticipates resuming the typical annual application cycle later this year for new agreement periods starting on January 1, 2020, and in subsequent years under the new program structure. Full application details are available on this CMS [website](#). Finally, please note that ACOs whose agreements did not expire on December 31, 2018, have the option to complete their current agreements under existing program rules.

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 Frequently Asked Question [resource](#) on the final Pathways to Success Rule that incorporates many of the questions we have received 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.

EXECUTIVE SUMMARY

The final Pathways to Success Rule includes the most significant changes to the MSSP since the program's initial launch in 2012. There are both opportunities and challenges presented by the changes. NAACOS' greatest concerns lie with the reduced amount of time provided to new ACOs in upside only models, which CMS has reduced from six years to two-to-three years. However, CMS did modify several concerning proposed provisions, such as increasing the shared savings rates available in the Basic Track, providing additional time in upside only models for certain ACOs, and raising the threshold to be considered a high revenue ACO. Some of the key changes included in the final rule include:

- Modifying the participation options by retiring Track 1 and Track 2 and creating a new Basic Track that includes a more gradual shift to risk with shared savings rates of 40–50 percent. The glide path to risk in the Basic Track includes five levels, with a one-sided model available only for the first two-to-three years to eligible ACOs;
- Retaining Track 3, which is renamed as the Enhanced Track, with a shared savings rate of up to 75 percent to encourage ACOs that are able to accept higher levels of potential risk and reward to drive the most significant systematic change in providers' and suppliers' behavior;
- Creating a distinction between high revenue and low revenues ACOs, with more limited participation options in some cases for certain high revenue ACOs;
- Modifying length of agreement periods from three years to five years to create more stability in agreement periods;
- Modifying methodologies related to benchmarking, including accelerating the use of factors based on regional fee-for-service (FFS) expenditures;
- Making changes to risk adjustment allowing for risk score growth of up to positive 3 percent over the length of an agreement period (with no negative 3 percent limit on risk score decreases);
- Allowing greater choice of beneficiary assignment methodologies by offering an annual election of prospective or retrospective assignment;
- Implementing provisions of the Bipartisan Budget Act (BBA) that allow for certain telehealth waivers and beneficiary incentive programs and broadening access to the current Skilled Nursing Facility (SNF) Three-Day Waiver for risk-bearing ACOs;
- Establishing policies to deter gaming by limiting more experienced ACOs to higher-risk participation options;
- More rigorously screening for good standing among ACOs seeking to renew their participation in the program or re-enter the program after termination or expiration of their previous agreement;
- Changing beneficiary notification requirements, requiring written notices regarding participation in the ACO, among other things; and
- Making changes to certain repayment mechanism requirements, reducing tail period coverage from 24 to 12 months, and increasing the threshold triggering a higher repayment mechanism from \$100,000 to \$1 million.

SUMMARY OF KEY PROVISIONS OF THE ACO FINAL RULE

Replacing Current Tracks with Basic and Enhanced Tracks

Among the sweeping program changes, CMS finalizes a policy that effective June 30, 2019, the agency will retire the current MSSP Tracks 1, 1+, 2 and 3. CMS would replace those existing MSSP Tracks with new Basic and Enhanced Tracks effective July 1, 2019, with the Basic Track containing Levels A through E. While there are a number of overall program changes, the new tracks and levels have overall similarities to most of the existing tracks, such that they are roughly equivalent as follows:

Current MSSP Track	Equivalent Under New MSSP Structure
Track 1	Basic Level A and B
Track 1+	Basic Level E
Track 2	No equivalent
Track 3	Enhanced Track

Please note that while CMS has created new Basic and Enhanced Tracks effective July 1, 2019, ACOs whose contracts did not expire on December 31, 2018 will have the opportunity to finish out their agreements under the existing program rules. Therefore, there will essentially be two sets of programs/rules running concurrently in 2019 and 2020. Beginning in 2021, all ACOs will be operating under the new program structure and rules (Basic and Enhanced Track options finalized in the Pathways to Success Rule).

Overview of New Tracks and Transition to Risk

Under the new program structure, ACOs will progress from shared savings only to risk-based models under CMS-mandated timeframes that apply to ACOs differently depending largely on previous program experience and high/low revenue distinction. ACOs will progress along the Levels of the Basic Track annually. Levels A and B of the Basic Track are the shared savings only models, while Levels C, D and E are risk-bearing models. Basic Level E and the Enhanced Track qualify as Advanced Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA), allowing clinicians in ACOs participating in those models to earn Advanced APM bonuses if they meet other specified criteria such as the Qualifying Participant (QP) thresholds.

While CMS will automatically advance ACOs over time along the levels, ACOs could elect annually to move up to higher risk levels in the Basic Track for a quicker transition than what is required. ACOs will not be permitted to switch from the Basic Track to the Enhanced Track during their five-year agreement period. As illustrated in Table A below, the new structure includes a more gradual glide path for assuming risk between Levels A and Level E; however, there remains a significant jump to the risk level required in moving from Basic Track Level E to the Enhanced Track.

Shared Savings and Losses

NAACOS is pleased that CMS has increased the shared savings rates available under the Basic Track from the proposed 25 to 50 percent to 40 to 50 percent, as shown in Table A. However, these amounts are still lower than the 50 percent shared savings rate available to Track 1 ACOs.

The shared loss rates remain constant at 30 percent across Levels C, D and E, but the amount of maximum losses, i.e., the loss sharing limit, gradually increases. CMS will determine the loss sharing limit (benchmark-based versus revenue-based) by evaluating the percent of the ACO participant Parts A and B fee-for-service revenue compared to ACO benchmarks, categorizing ACOs as “high revenue” or “low revenue.” These new terms are described in more detail in a later section of this document. CMS explains that the agency would determine the ACO’s loss sharing limit annually at the time of financial reconciliation, which the agency notes is consistent with its current process for Track 2 and 3 ACOs.

TABLE A: New MSSP Structure

Basic Track					Enhanced Track
Level A	Level B	Level C	Level D	Level E	
Up to 40% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 40% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 50% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 50% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 50% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 75% sharing rate based on quality performance, not to exceed 20% of updated benchmark
Upside only	Upside only	1 st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of benchmark	1 st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of benchmark	1 st dollar losses at 30%, not to exceed 8% of revenue capped at 4% of benchmark in 2019 and 2020*	1 st dollar losses at 40–75%, not to exceed 15% of benchmark
MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM

*Note: CMS ties this definition to revenue-based nominal amount standard under the Quality Payment Program (QPP).

High Revenue and Low Revenue ACO Designations

CMS finalizes a policy establishing a differentiation between high and low revenue ACOs. Despite NAACOS urging CMS to not finalize a high-low revenue distinction, CMS repeatedly cited data showing physician-led ACOs performed better than hospital-based ACOs, and that the latter had greater control over spending. CMS believes its high-low revenue distinction offers more flexibility for most doctor-based ACOs while realizing the agency's goal of increasing participation in risk-bearing ACOs. Citing concern over the potential impact on ACOs with small and rural hospitals, CMS increased the threshold for categorizing high revenue ACOs in this final rule. This new high-low revenue distinction determines program specifics such as the timing for when an ACO must move to risk. For example, new high revenue ACOs would be required to move to the Enhanced Track after one agreement period in the Basic Track. The finalized definitions of high and low revenue ACOs are as follows:

- High revenue ACO means an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is at least 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.
- Low revenue ACO means an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is less than 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.

The total ACO revenue of participants would be based on revenue for the most recent calendar year for which 12 months of data are available, as would the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries. In the proposed rule, CMS proposed a 25 percent threshold. In the final rule, CMS expressed concern that a 25 percent threshold would count ACOs with moderate revenue as high revenue ACOs because of, for example, the presence of multi-specialty physician practices or safety-net providers such as Federally Qualified Health Centers (FQHCs).

The new 35 percent threshold would increase the number of ACOs deemed “low revenue” by 13 percent, based on CMS modeling of 2018 performance data, CMS stated in the final rule. Under Track 1+, ACOs provide information about their participants, and CMS uses that to determine if the ACO falls under the revenue-based or benchmark-based risk standard. CMS’s new finalized method for determining high revenue or low revenue status removes the self-reporting requirement to provide a more accurate method for determining an ACO’s preparedness to take on additional risk.

CMS states it will notify ACOs if they are high or low revenue at some point in the application process and before they sign a participation agreement. The agency also intends to provide “timely feedback” to ACOs throughout an application cycle on whether it would likely be a low revenue or high revenue ACO. CMS states it anticipates providing information annually to ACOs within their agreement periods, particularly as part of the ACO participant list change request review cycles, about their ACO participants’ Medicare FFS revenue so they will have information about the composition of their ACO, and the Medicare FFS revenue of their ACO participants to support their ongoing participation in the program.

In the case that an ACO is initially identified as low revenue and subsequently becomes high revenue during the agreement period, CMS will allow the ACO to finish the performance year and to make participant list changes to attempt to retain low revenue status. If, for example, an experienced ACO enters Basic Track Level E because of its low revenue status and later meets the definition of high revenue during its agreement period, the ACO would be allowed to finish the performance year in the Basic Track before being ineligible to continue in the Basic Track. CMS notes it will take compliance action, up to and including termination of the participation agreement to ensure the ACO does not continue in the Basic Track for subsequent performance years of the agreement period.

2019 Applications and Eligibility for Future Participation

CMS is opening a new round of applications for 2019 with a shortened six-month performance period in 2019 due to the late nature of the regulation’s release. For ACO contracts that were scheduled to expire on December 31, 2018, ACOs had the one-time option to extend those agreements for an additional six months (January 1 to June 30, 2019). CMS has confirmed with NAACOS staff that ACOs within current agreement periods under Shared Savings Program participation options (Track 1, Track 2, or Track 3) and Track 1+ ACOs would be able to complete the remainder of their current agreement under the existing financial models and program rules.

CMS will offer a one-time only July 1, 2019 start date for new agreements for ACOs wishing to participate under the new program structure (Basic and Enhanced Tracks finalized in the Pathways to Success Rule). The July 1, 2019 start date will have a Spring 2019 application period. At the time of publication, CMS has released the Notice of Intent to Apply (NOIA) [guidance](#) document and deadline for submission of the NOIA of January 18, 2019, as well as the [application](#) deadline of February 19, 2019, by 12:00 pm Eastern. More details on the application and application deadline will be provided by CMS soon on the CMS applications [website](#). For ACOs electing the July 1, 2019 start, CMS will reconcile ACO performance for the first and second halves of 2019. More information on how the six-month performance periods will be evaluated is described in a later section of this document.

CMS plans to resume its typical annual application cycle in 2019 for Performance Year (PY) 2020 participation and thereafter. NAACOS will update this resource when more information and application deadlines are provided for ACOs electing a January 1, 2020 start date.

Typically, newly entering ACOs will begin in Level A of the Basic Track and they would stay in the shared savings only option (Level B in PY 2) for the first two consecutive performance years. Each year they would be required to automatically progress to the next level for the duration of the five-year agreement, ending in Level E. ACOs that enter in Level E of the Basic Track must stay in that level for the length of the five-year

agreement period. While ACOs in the Basic Track's glide path could annually elect to move more quickly to a higher level of risk/reward, they would not be permitted to return to lower levels of risk/reward. The one exception to this is ACOs starting in July 1, 2019, who will have two performance periods at the same initial level (July 1, 2019 to December 31, 2019, and January 1, 2020 to December 31, 2020). Finally, according to CMS, there will not be an option to move from the Basic Track to the Enhanced Track within an ACO's current agreement period. CMS states, "We continue to believe it is protective of the Trust funds to restrict ACOs from moving from the Basic Track to the Enhanced Track within the ACO's current agreement period."

Eligibility for Future Program Participation

CMS will determine program participation options based on two key factors: previous program participation and high/low revenue status. Participation options are determined in part based on whether CMS considers an ACO to be new, renewing or re-entering.

CMS defines "renewing ACOs" as those that continue in the program for a consecutive agreement period without a break in participation and are either:

1. ACOs whose participation agreements expired, and they immediately enter new agreement periods to continue participation in the program; or
2. ACOs that terminated their current participation agreements, and they immediately enter new agreement periods to continue participation in the program.

CMS defines "re-entering ACOs" as those that do not meet the definition of "renewing ACO" and are either:

1. The same legal entity that previously participated in the program and is applying to participation the program after a break in participation because either (a) an ACO's participation agreement expired without having been renewed; or (b) an ACO's participation agreement was terminated; or
2. A new legal entity (that has never participated in the Shared Savings Program) with more than 50 percent of its ACO participants included on the ACO Participant List of the same ACO in any of the five most recent performance years prior to the agreement start date.

CMS defines ACOs as "experienced with performance-based risk" if either of the following are met:

1. The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO initiative, or that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3; or
2. 40 percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative, or deferred entry into a second Shared Savings Program agreement period under Track 2 or Track 3, in any of the five most recent performance years prior to the agreement start date.

CMS defines "performance-based risk Medicare ACO initiative" as an initiative implemented by CMS that requires an ACO to participate under a two-sided model during its agreement period. This includes: Basic Track (including all levels), Enhanced Track, Track 2, Track 3, Track 1+, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive End-Stage Renal Disease (ESRD) Care Model two-sided risk tracks. ACOs identified as experienced with performance-based risk will have more limited participation options than those not experienced with performance-based risk, as displayed in Tables B and C on the next page.

Finally, CMS clarifies that the definition of renewing ACO, in combination with the policy to discontinue use of the "sit-out" period after termination, would create the flexibility for any ACO within an agreement period to voluntarily terminate its current participation agreement and (if eligible) enter a new agreement period under the Basic Track or Enhanced Track beginning at the start of the next performance year after the termination date of its previous agreement period, as early as July 1, 2019, thereby avoiding an interruption in participation. CMS states the agency would consider these ACOs to have effectively renewed

their participation early. Early renewal will be an option for all ACOs within a current agreement period within the Shared Savings Program.

High revenue ACOs will also have more limited participation options. Low revenue ACOs can participate in the Basic Track for up to two agreement periods. This participation option would mean the ACO remains at Basic Level E for the entire second, five-year agreement period. High revenue ACOs could have at most a single agreement period in the Basic Track.

Tables B and C (tables seven and eight in the final rule on pages 67911-67914) summarize participation options for high and low revenue ACOs based on applicant type and the ACO's experience with performance-based risk, and these tables also explain effective agreement periods for policies that phase-in over time (such as benchmarking and quality performance).

Table B: Participation Options for Low Revenue ACOs Based on Applicant Type and Experience with Risk

Applicant type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options ¹			Agreement period for policies that phase-in over time (benchmarking methodology and quality performance)
		Basic Track's glide path (option for incremental transition from one-sided to two-sided models during agreement period)	Basic Track's Level E (track's highest level of risk / reward applies to all performance years during agreement period)	Enhanced Track (program's highest level of risk / reward applies to all performance years during agreement period)	
New legal entity	Inexperienced	Yes – glide path Levels A through E; new legal entities (not re-entering ACOs) that are low revenue ACOs may elect to enter in Level A, transition to Level B and remain in Level B for an additional performance year prior to being automatically advanced to Level E for the remaining performance years of their agreement period	Yes	Yes	First agreement period
New legal entity	Experienced	No	Yes	Yes	First agreement period
Re-entering ACO	Inexperienced - former Track 1 ACOs or new ACOs identified as re-entering ACOs because more than 50 percent of their ACO participants have recent prior experience in a Track 1 ACO	Yes - glide path Levels B through E	Yes	Yes	Either: (1) the next consecutive agreement period if the ACO's prior agreement expired; (2) the same agreement period in which the ACO was participating at the time of termination; or (3) applicable agreement period for new ACO identified as re-entering because of ACO participants' experience in the same ACO

Re-entering ACO	Experienced - including former Track 1 ACOs that deferred renewal under a two-sided model	No	Yes	Yes	Either: (1) the next consecutive agreement period if the ACO's prior agreement expired; (2) the same agreement period in which the ACO was participating at the time of termination; or (3) applicable agreement period for new ACO identified as re-entering because of ACO participants' experience in the same ACO
Renewing ACO	Inexperienced - former Track 1 ACOs	Yes - glide path Levels B through E	Yes	Yes	Subsequent consecutive agreement period
Renewing ACO	Experienced - including former Track 1 ACOs that deferred renewal under a two-sided model	No	Yes	Yes	Subsequent consecutive agreement period

Note: ¹Low revenue ACOs may operate under the Basic Track for a maximum of two agreement periods.

Table C: Participation Options for High Revenue ACOs Based on Applicant Type and Experience with Risk

Applicant type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options ¹			Agreement period for policies that phase-in over time (benchmarking methodology and quality performance)
		Basic Track's glide path (option for incremental transition from one-sided to two-sided models during agreement period)	Basic Track's Level E (track's highest level of risk / reward applies to all performance years during agreement period)	Enhanced Track (program's highest level of risk / reward applies to all performance years during agreement period)	
New legal entity	Inexperienced	Yes – glide path Levels A through E	Yes	Yes	First agreement period
New legal entity	Experienced	No	No	Yes	First agreement period
Re-entering ACO	Inexperienced - former Track 1 ACOs or new ACOs identified as re-entering ACOs because more than 50 percent of their ACO participants have recent prior experience in a Track 1 ACO	Yes - glide path Levels B through E	Yes	Yes	Either: (1) the next consecutive agreement period if the ACO's prior agreement expired; (2) the same agreement period in which the ACO was participating at the time of termination; or (3) applicable agreement period for new ACO identified as re-entering because of ACO participants' experience in the same ACO

Re-entering ACO	Experienced - including former Track 1 ACOs that deferred renewal under a two-sided model	No	No	Yes	Either: (1) the next consecutive agreement period if the ACO's prior agreement expired; (2) the same agreement period in which the ACO was participating at the time of termination; or (3) applicable agreement period for new ACO identified as re-entering because of ACO participants' experience in the same ACO
Renewing ACO	Inexperienced - former Track 1 ACOs	Yes - glide path Levels B through E	Yes	Yes	Subsequent consecutive agreement period
Renewing ACO	Experienced - including former Track 1 ACOs that deferred renewal under a two-sided model	No	No (Except for a one-time renewal option for ACOs with a first or second agreement period beginning in 2016 or 2017 that participated in Track 1+)	Yes	Subsequent consecutive agreement period

Note: ¹High revenue ACOs that have participated in the Basic Track are considered experienced with performance-based risk Medicare ACO initiatives and are limited to participating under the Enhanced Track for subsequent agreement periods.

Moving to Five-Year Agreement Periods

CMS finalizes a policy to extend the length of agreement periods from three years to five years to allow for more program stability. Specifically, for agreement periods beginning on July 1, 2019, the length of the agreement would be five years and six months. For agreement periods beginning on January 1, 2020, and in subsequent years, the length of the agreement would be five years. CMS states that extended agreement periods allow ACOs a longer horizon on which to benefit from efficiency gains before benchmark rebasing. CMS also finalized a policy to modify current requirements that prevent an ACO from terminating its participation agreement and quickly re-entering the program to allow the flexibility for an ACO in a current three-year agreement period to terminate its participation agreement and immediately enter a new agreement period of not less than five years under one of the redesigned participation options finalized in this rule.

Minimum Savings Rate and Minimum Loss Rate

In order to qualify for a shared savings payment, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare Parts A and B FFS expenditures for its assigned beneficiary population for the performance year must be below or above the updated benchmark, respectively, by at least the minimum savings or loss rate (MSR/MLR). For ACOs under a one-sided model of the Basic Track's glide path, CMS will use the same sliding scale it currently uses for Track 1, which is based on the number of beneficiaries assigned to the ACO to establish the MSR (see Table 9 in the final rule on page 67927). ACOs in a two-sided model of the Basic Track will be able to choose among the MSR/MLR options that are available to ACOs participating in Track 2 or the Enhanced Track.

Prior to entering a two-sided model, 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

CMS will use a variable MSR/MLR when performing shared savings and shared losses calculations if an ACO's assigned beneficiary population falls below 5,000 for the performance year, regardless of whether the ACO selected a fixed or variable MSR/MLR. CMS will apply this approach to performance years beginning on or after July 1, 2019. The variable MSR/MLR will be determined based on the number of assigned beneficiaries that is currently used for two-sided model ACOs that have selected the variable option. CMS states the range of MSR values that will apply under the one-sided model of the Basic Track's glide path will also be used in determining the variable MSR/MLR for ACOs participating in two-sided models under the Basic Track and Enhanced Track.

Loss Sharing Limit

CMS will calculate the loss sharing limit using the following steps:

- Determine ACO participants' total Medicare FFS revenue, which includes total Parts A and B FFS revenue for all providers and suppliers that bill for items and services through the Tax Identification Number (TIN) or a CMS Certification Number (CCN) enrolled in Medicare under the TIN of each ACO participant in the ACO for the applicable performance year.
- Apply the applicable percentage from the specific Basic Level or Enhanced Track to this total Medicare Parts A and B FFS revenue for ACO participants to derive the revenue-based loss sharing limit.
- Use the applicable percentage of the ACO's updated benchmark detailed in the particular Basic Level or Enhanced Track instead of the revenue-based loss sharing limit, if the loss sharing limit as a percentage of total Medicare Parts A and B FFS revenue for ACO participants exceeds the amount that is the specified percentage of the ACO's updated historical benchmark. In that case, the loss sharing limit is capped and set at the applicable percentage of the ACO's updated historical benchmark for the applicable performance year. See Table E below (Table 5 on page 67856 of the final rule) for an example of this calculation.
- In this scenario, the ACO's loss sharing limit would be set at \$1,090,479 (8 percent of ACO participant revenue) because this amount is less than 4 percent of the ACO's updated historical benchmark expenditures. If in this scenario the ACO's revenue would have been greater, and the revenue-based loss sharing limit exceeded the benchmark-based loss sharing limit amount, the loss sharing limit would be capped and set at the benchmark-based loss sharing limit amount (in this example \$3,736,453).

Table E: Hypothetical Example of Loss Sharing Limit Amounts for ACO in Basic Track Level E

[A] ACO's Total Updated Benchmark Expenditures	[B] ACO Participants' Total Medicare Parts A and B FFS Revenue	[C] 8 percent of ACO Participants' Total Medicare Parts A and B FFS Revenue ([B] x .08)	[D] 4 percent of ACO's Updated Benchmark Expenditures ([A] x .04)
\$93,411,313	\$13,630,983	\$1,090,479	\$3,736,453

In the final rule, CMS explains that to accurately determine ACO participants' revenue for purposes of determining a revenue-based loss sharing limit, the agency will include total revenue uncapped by truncation and include IME, DSH and uncompensated care payments. This approach to calculating ACO participant Medicare FFS revenue is different from CMS' approach to calculating benchmark and performance year expenditures for assigned beneficiaries, which CMS truncates at the 99th percentile of

national Medicare FFS expenditures for assignable beneficiaries and excludes IME, DSH and uncompensated care payments. CMS will determine the loss sharing limit for Basic Track ACOs annually at the time of financial reconciliation for each performance year.

Risk Adjustment Changes

Under current policy, CMS uses an MSSP risk adjustment methodology that treats beneficiaries differently depending on whether they are considered newly or continuously assigned. Specifically, the current method of updating the benchmark for each performance year within an agreement period involves capping the risk ratio for continuously assigned beneficiaries to the demographic-only risk ratio. In response to confusion and concerns about the distinction between newly and continuously assigned beneficiaries, CMS finalizes a policy to eliminate the distinction between these two beneficiary types. The agency will instead use a positive 3 percent risk ratio cap between the performance year renormalized risk score and the most recent benchmark year for all assigned beneficiaries. Please note that CMS did not finalize a cap on negative risk score changes, citing concern for potential gaming issues. As an example, assuming that an ACO starts in July 2019, the most that the renormalized risk score used in the updated benchmark calculation can change in performance year six (2024) would be up to 103 percent of the 2018 renormalized risk score (based on 2018 Hierarchical Condition Categories [HCC] and coding practices for 2017 dates of service). NAACOS has repeatedly advocated for CMS to permit meaningful increases in beneficiary risk scores over time. It is important to note that 3 percent cap is across a five-year agreement period and is not a year-over-year increase. Risk ratios will be separately capped by 3 percent within each of the four beneficiary categories (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible), and CMS shows an example of this calculation in Table 12 on page 68009 of the final rule. Note that the final risk ratio for the disabled category is incorrect in this table. Instead of the 0.970 listed, the final risk ratio for the disabled category is 0.956 because the downside 3 percent cap was not finalized.

The agency will continue to use full CMS-HCC risk adjustment for all assigned beneficiaries between the benchmark period and the performance year, and the risk scores will continue to be renormalized within each of the four beneficiary enrollment categories. Similarly, CMS will continue to use full CMS-HCC risk scores when resetting or rebasing the historical benchmark prior to each new agreement period. Therefore, as under current policy, full CMS-HCC risk adjustment will apply to:

- Adjusting benchmark year expenditures for benchmark years one and two to benchmark year three risk score,
- Adjusting regional trend factors when trending benchmark years one and two to benchmark year three risk scores under regional benchmarking,
- Adjusting regional expenditures to the specific ACO risk score when calculating the regional adjustment, and
- Adjusting regional update factors during performance year benchmark updates.

The full CMS-HCC risk adjustment of regional expenditures and the regional update factor will be applicable during the first agreement period as a result of incorporating regional expenditures into the benchmark calculation in the initial agreement. These policies will be effective for agreement periods beginning on July 1, 2019, and in subsequent years.

Changes to the Benchmarking Methodology

CMS finalized changes to the benchmarking methodology in 2016, which are summarized in this [NAACOS resource](#) and remain in place as current policy. However, in this rule the agency finalizes new changes that will go into effect starting in an ACO's first agreement period for all ACOs entering the program for an agreement period beginning on July 1, 2019, and in subsequent years. CMS will maintain the overall approach to establishing and rebasing benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible). As finalized by the 2016 benchmarking rule, CMS incorporates a growing

component of regional expenditures into benchmarks as they are revised, i.e., “rebased,” for new agreement periods. In this rule CMS finalizes a policy to incorporate regional expenditures into benchmarks sooner, beginning with initial agreement periods for agreement periods beginning on July 1, 2019, and in subsequent years. This modifies the phase-in schedule for the regional expenditure adjustment weights as follows:

- ACOs have a regional adjustment weight of 15 or 35 percent during the first agreement period
- ACOs in their second agreement periods have a regional adjustment weight of 25 or 50 percent
- ACOs in their third agreement periods have a regional adjustment weight of 35 or 50 percent
- All ACOs in their fourth and subsequent agreement periods have a 50 percent regional adjustment weight

Please note that CMS finalizes a five-year agreement period under the new program structure, as described elsewhere in this document. The difference between the regional adjustment weights in the first three agreement periods depends on whether the ACO has spending higher or lower than that of its region. Consistent with the current approach, ACOs with spending higher than their region would receive the lower weight, and ACOs with spending lower than their region would receive the higher weight. The regional adjustment weight is capped at 50 percent, which is lower than the current policy that caps the maximum regional adjustment weight at 70 percent. Further, CMS introduces a symmetric +/- 5 percent cap on the dollar amount of the regional adjustment, implemented separately for each beneficiary enrollment category. The cap is based on +/- 5 percent of national assignable per capita expenditures; an example of applying the cap is shown in Table 13 on page 68019 of the final rule.

If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement. In the final rule, CMS clarified that for renewing or re-entering ACOs that previously received a rebased historical benchmark under the current benchmarking methodology, CMS will consider the agreement period the ACO is entering upon renewal or re-entry in combination with the weight previously applied to calculate the regional adjustment to the ACO’s benchmark in the ACO’s most recent prior agreement period to determine the weight that will apply in the new agreement period. For example, an ACO that was subject to a weight of 35 or 25 percent in its second agreement period in the Shared Savings Program (first agreement period subject to a regional adjustment) under the current benchmarking methodology that enters its third agreement period in the program (second agreement period subject to a regional adjustment) would be subject to a weight of 50 or 25 percent. By contrast, if the same ACO terminated during its second agreement period and subsequently re-enters the program, the ACO would face a weight of 35 or 15 percent until the start of its next agreement period. For a new ACO identified as a re-entering ACO because greater than 50 percent of its ACO participants have recent prior participation in the same ACO, CMS will consider the weight most recently applied to calculate the regional adjustment to the benchmark for the ACO in which the majority of the new ACO’s participants were participating previously. Table G on the next page (Table 6 in the final rule on page 67908) provides an example of the phase-in of modified regional adjustment weights based on agreement start dates and application type.

Table 6 – Examples of Phase-In of Modified Regional Adjustment Weights Based on Agreement Start Date and Applicant Type

Applicant Type	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 weight
<u>New entrant</u> with start date on July 1, 2019	Applicable to first agreement period starting on July 1, 2019	Applicable to second agreement period starting in 2025	Applicable to third agreement period starting in 2030	Applicable to fourth agreement period starting in 2035 and all subsequent agreement periods
<u>Renewing ACO</u> for agreement period starting on July 1, 2019, with initial start date in 2012, 2013 or 2016	Applicable to third (2012/2013) or second (2016) agreement period starting on July 1, 2019	Applicable to fourth (2012/2013) or third (2016) agreement period starting in 2025	Applicable to fifth (2012/2013) or fourth (2016) agreement period starting in 2030	Applicable to sixth (2012/2013) or fifth (2016) agreement period starting in 2035 and all subsequent agreement periods
<u>Early renewal</u> for agreement period starting on July 1, 2019, ACO with initial start date in 2014 that terminates effecting June 30, 2019	Currently applies to second agreement period starting in 2017 as follows: 35 percent or 25 percent (if spending above region)	Applicable to third agreement period starting on July 1, 2019	Applicable to fourth agreement period starting in 2025	Applicable to fifth agreement period starting in 2030 and all subsequent agreement periods
<u>Re-entering ACO</u> with initial start date in 2014 whose agreement expired December 31, 2016 (did not renew) and <u>re-enters</u> second agreement period starting on July 1, 2019	Applicable to second agreement period starting on July 1, 2019 (ACO considered to be re-entering a second agreement period)	Applicable to third agreement period starting in 2025	Applicable to fourth agreement period starting in 2030	Applicable to fifth agreement period starting in 2035 and all subsequent agreement periods
<u>Re-entering ACO</u> with second agreement period start date in 2017 terminated during performance year 2 (2018) and <u>re-enters</u> second agreement period starting on July 1, 2019	Applicable to second agreement period starting on July 1, 2019 (ACO considered to be re-entering a second agreement period)	Applicable to third agreement period starting in 2025	Applicable to fourth agreement period starting in 2030	Applicable to fifth agreement period starting in 2035 and all subsequent agreement periods

CMS also finalizes changes to the regional benchmarking update factor. In response to concerns raised by NAACOS and others, CMS will no longer use a pure regional update factor, which disadvantages ACOs that make up a large portion of the market share in their region. Instead, CMS will use a national-regional blended trend rate that would be based on the share of assignable beneficiary weighted national FFS and regional update factors. The national-regional blending factor would be determined by averaging the market penetration across all counties where the ACO has assigned beneficiaries. Specifically, CMS will use a blend of national and regional trend factors to trend forward Benchmark Year (BY)1 and BY2 to BY3 when determining the historical benchmark and a blend of national and regional update factors to update the historical benchmark to the performance year (or to Calendar Year [CY] 2019 in the context of determining the financial performance of ACOs for the six-month performance year from July 1, 2019, through December 31, 2019). The national component of the blended trend and update factors will receive a weight equal to the share of assignable beneficiaries in the regional service area that are assigned to the ACO, computed by taking a weighted average of county-level shares. The regional component of the blended trend and update factors will receive a weight equal to one minus the national weight. The blended trend and update factors will apply for all agreement periods starting on July 1, 2019, or in subsequent years, regardless of whether it is an ACO's first, second, or subsequent agreement period. An example of calculating the blending percentage is on page 68025 of the final rule.

Repayment Mechanisms

ACOs that incur losses beyond their MLR are required to pay CMS a portion of the losses, as detailed above. As with current risk-based ACO models, risk-based ACOs in the revised MSSP would be required to demonstrate their ability to repay losses by establishing a sufficient repayment mechanism. CMS finalizes a policy to retain the existing repayment mechanisms, including funds placed in escrow, a letter of credit, a surety bond, or a combination of those mechanisms. However, CMS does expand the acceptable institutions providing a repayment mechanism to include any insured institution, including credit unions, which provides more options than the current requirement to only utilize FDIC-insured institutions. Access to credit unions may provide cheaper alternatives and increase market competition, thereby lowering cost of access to repayment mechanisms. The agency also finalizes a policy to extend the duration of the repayment mechanism that would need to be in place for the number of risk-based years in the agreement period plus an additional 12 months of "tail coverage." The use of a 12-month tail period is a decrease from the current requirements (which require 24-months of tail coverage).

Under current policy, the repayment mechanism amount is based on benchmark period expenses. This amount is not updated during the performance year except for Track 1+ ACOs. For example, a Track 3 ACO that started in 2018 would use benchmark year two, (i.e., 2016 data) in determining the repayment mechanism amount. In an effort to make a more timely determination of the repayment mechanism amount, CMS finalizes a policy to instead use the most recent calendar year having 12 months of available data to establish the repayment mechanism amount. For example, the repayment mechanism amount for an Enhanced Track ACO starting in 2020 would be based on 2018 expenditures.

ACOs in the Basic Track would have a repayment mechanism amount equal to the lesser of 1 percent of total assigned beneficiary expenditures (benchmark-based standard) or 2 percent of ACO participant revenue (revenue-based standard) prior to entering risk-based Levels C, D or E. ACOs in the Enhanced Track would have a repayment amount equal to 1 percent of total assigned beneficiary expenditures (benchmark-based standard), which is equivalent to the requirements that were previously in place under Track 3. Repayment mechanism amounts would be recalculated prior to each performance year. Specifically, for agreement periods beginning on or after July 1, 2019, CMS will recalculate the ACO's repayment mechanism amount before the second and each subsequent performance year in the agreement period based on the certified ACO participant list for the relevant performance year. If the calculated amount is greater by the lesser of 50 percent of the existing repayment mechanism amount or \$1 million, then the required repayment mechanism amount would be increased by CMS. In other words, any increases over \$1

million would trigger a higher amount. However, repayment mechanism amounts cannot decrease within an agreement period, which is something NAACOS opposed in our comments to the agency. In an effort to minimize administrative burdens, CMS finalizes a policy that ACOs with a repayment mechanism would be permitted to extend its duration for the Basic or Enhanced Tracks. In the event that any of the following occur, the repayment mechanism may be terminated:

- Shared losses have been fully repaid for all performance years.
- CMS has exhausted the amount.
- CMS determines that shared losses are not owed.

According to CMS, for a renewing ACO that wishes to use its existing repayment mechanism to establish its ability to repay any shared losses incurred for performance years in the new agreement period, the existing repayment mechanism must be amended to meet one of the following criteria: (1) the duration of the existing repayment mechanism is extended by an amount of time that covers the duration of the new agreement period plus 12 months following the conclusion of the new agreement period; or (2) the duration of the existing repayment mechanism is extended, if necessary, to cover a term of at least the first two performance years of the new agreement period and provides for automatic, annual 12-month extensions of the repayment mechanism such that the repayment mechanism will eventually remain in effect through the duration of the new agreement period plus 12 months following the conclusion of the new agreement period.

Finally, if CMS notifies a renewing ACO that its repayment mechanism amount will be higher for the new agreement period, the ACO may either establish a second repayment mechanism arrangement in the higher amount under one of the qualifying options, or it may increase the amount of its existing repayment mechanism to the higher amount and amend the existing repayment mechanism arrangement under one of the qualifying options. On the other hand, if CMS notifies a renewing ACO that the repayment mechanism amount for its new agreement period is equal to or lower than its existing repayment mechanism amount, the ACO may choose to amend its existing repayment mechanism under one of the qualifying options instead of obtaining a second repayment mechanism for the new agreement period. In this case, the ACO would be required to maintain the repayment mechanism at the existing higher amount.

Beneficiary Notification Changes

CMS finalizes a policy to modify the current beneficiary notification requirements. Beginning July 1, 2019, and in subsequent years, CMS will require a standard written notification be provided annually to each Medicare FFS beneficiary either prior to or at their first primary care visit of the performance year in the form and manner specified by CMS. CMS states the agency will use a template for this purpose. Beginning July 1, 2019, the ACO will also be required, as part of the beneficiary notification process, to inform the patient about the beneficiary's ability to and the process by which he or she may identify or change identification of a primary care provider for purposes of voluntary alignment. CMS notes an ACO, directly or through its ACO participants, will be required to distribute these beneficiary notifications in writing through electronic transmission (such as email) or mail. CMS notes it will provide additional information regarding permissible methods of notification in further guidance, which will be issued prior to the July 1, 2019 effective date. The agency also invites ACO input through established modes of communication with CMS on any templates to be developed, and CMS will work with partners to conduct beneficiary focus groups to ensure the content of the template notice is written in plain language and is easy for beneficiaries to understand. NAACOS will alert members when additional guidance on this requirement has been provided by CMS.

Assignment Methodology Changes

Allowing Greater Choice for Prospective or Retrospective Assignment

As supported by NAACOS, CMS will provide Basic and Enhanced Track ACOs the choice between prospective assignment or preliminary prospective assignment with retrospective reconciliation for agreement periods beginning July 1, 2019, and thereafter, as required by the BBA. ACOs can switch their selection annually prior to the start of a new performance year. An ACO's historical benchmark would be adjusted to account for patients using the new assignment method since the populations used to determine benchmark and performance year assignment would vary based on the ACO's assignment selection. However, the benchmark calculations and calculations for determining savings and losses would be the same.

Voluntary Alignment

As also required by the BBA, CMS finalizes adjustments to the voluntary alignment process in the final 2019 Medicare Physician Fee Schedule (MPFS) Rule. Specifically, CMS is modifying its policies to assign a beneficiary to an ACO based upon his or her selection of any ACO professional, regardless of specialty, as his or her primary clinician. Previously, CMS required the designated ACO professional be a primary care physician, a physician with a specialty designation specified in §425.402(c), a nurse practitioner, physician assistant, or clinical nurse specialist. If a beneficiary selects a practitioner, he or she would be eligible for prospective assignment to the ACO in which the practitioner is an ACO professional, unless the beneficiary is excluded by the criteria set forth in 425.401(b). However, CMS will not voluntarily align a beneficiary to the ACO when the beneficiary is also eligible for assignment to an entity participating in a model tested or expanded under section 1115A of the Affordable Care Act under which claims-based assignment is based solely on claims other than primary care services and for which the HHS Secretary has determined a waiver is necessary to test the model. This policy applies to certain demonstrations and programs operated through the Center for Medicare & Medicaid Innovation (Innovation Center).

Definition of Primary Care Services Used in Beneficiary Assignment

CMS also finalized in the final 2019 MPFS Rule proposed revisions to the definition of primary care services included in the assignment methodology. Specifically, the revised list of primary care services used for beneficiary assignment will be modified, beginning with PY 2019, to include the following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes: (1) advance care planning service codes, CPT codes 99497 and 99498; (2) administration of health risk assessment service codes, CPT codes 96160 and 96161; (3) prolonged evaluation and management or psychotherapy service(s) beyond the typical service time of the primary procedure, CPT codes 99354 and 99355; (4) annual depression screening service code, HCPCS code G0444; (5) alcohol misuse screening service code, HCPCS code G0442; and (6) alcohol misuse counseling service code, HCPCS code G0443. The full list of primary care services for assignment is available [here](#).

CMS also finalized its proposal to revise its method for excluding services identified by CPT codes 99304 through 99318 when furnished in a SNF. Therefore, starting January 1, 2019, and in subsequent performance years, CMS will remove the exclusion of claims including the place of service (POS) code 31. Instead, CMS will exclude services billed under CPT codes 99304 through 99318 from use in the assignment methodology when such services are furnished in a SNF on the same date of service, using claims data, as determined based on whether there is a SNF facility claim with dates of service that overlap with the date of service for the professional service. As with previous assignment methodology changes, CMS will adjust ACOs' historical benchmarks for the performance year starting on January 1, 2019, to account for their changes to the assignment methodology.

Beneficiary-Based Opt-In Assignment

In response to criticism from NAACOS, CMS backed away from an idea to incorporate a new optional assignment method — a beneficiary opt-in methodology — into the MSSP. However, in the final rule, CMS notes it will work with CMMI to further develop a viable opt-in assignment methodology that it may consider adopting in future rulemaking.

Revised Early Program Termination Policies

CMS finalizes a policy to reduce the minimum notification period for early termination from 60 to 30 days. This would allow ACOs considering termination to have three quarters of feedback reports, instead of two. Effective for performance years beginning on or after July 1, 2019, CMS will require ACOs in two-sided models that voluntarily terminate after June 30 to share in losses. To calculate the pro-rated share of losses, CMS will multiply the amount of shared losses calculated for the performance year by the quotient equal to the number of months of participation in the program during the performance year, including the month in which the termination becomes effective, divided by 12. CMS will also pro-rate shared losses for ACOs in two-sided models that are involuntarily terminated by CMS for any portion of the performance year during which the termination becomes effective. Under this policy, ACOs giving at least 30 days advance notice for an effective termination date on or before June 30 of the performance year will not be subject to financial reconciliation and will not be accountable for shared losses for the performance year in which their termination becomes effective. Lastly, ACOs under a two-sided model that begin a six-month performance period on July 1, 2019, and that are involuntarily terminated by CMS would be required to repay a pro-rated amount of any shared losses determined. Lastly, CMS notes that for performance years beginning before July 1, 2019, an ACO under a two-sided model is not liable for any shared losses if its participation agreement is terminated effective before the last calendar day of a performance year.

Monitoring for Financial Performance

CMS states its belief that a financial performance requirement is necessary to ensure that the program promotes accountability for the cost of the care furnished to an ACO's assigned patient population. Specifically, beginning with the performance year commencing July 1, 2019 and subsequent performance years, CMS will monitor 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 one performance year, the agency may take pre-termination actions, including requiring a corrective action plan. If the ACO is negative outside corridor for another performance year of the ACO's agreement period, the agency may immediately or with advance notice terminate the ACO's participation agreement. However, CMS notes it anticipates taking into account certain relevant factors, such as an ACO's improvement over time, before imposing remedial action or termination for poor financial performance.

Expanding Access to Certain Payment Rule Waivers and Benefit Enhancements

SNF Waivers

CMS finalizes its proposal to expand use of the SNF Three-Day Waiver effective July 1, 2019, to ACOs participating in a two-sided model under either prospective assignment or preliminary prospective assignment with retrospective reconciliation. The waiver allows patients to enter a SNF without a three-day inpatient hospitalization. The SNF Waiver would be available for such ACOs with respect to all beneficiaries who have been identified as preliminarily prospectively assigned to the ACO on the initial performance year assignment list or on one or more assignment lists for quarters one, two, and three of the performance years for SNF services provided after the beneficiary first appeared on one of the assignment lists for the applicable performance year. Beneficiaries who are preliminarily prospectively assigned to a waiver-approved ACO will remain eligible to receive services furnished in accordance with the SNF Waiver for the remainder of that performance year unless they enroll in a Medicare group health plan or are otherwise no longer enrolled in Part A and Part B.

CMS also clarifies that, for purposes of determining eligibility to partner with an ACO for the SNF Waiver, SNFs include providers furnishing SNF services under swing bed arrangements. In these instances, the three-star quality rating requirement would be waived. This policy aims to address concerns of ACOs in rural areas that have fewer available SNFs. CMS notes that these new waiver modifications would continue to be inapplicable to Track 2 ACOs and would continue to be limited to those using prospective assignment in Track 1+. Table F below (Table 10 of the final rule on page 67977) summarizes each benefit enhancement and what ACOs are eligible for such enhancements, as well as the effective date of each benefit enhancement. More information is available in the CMS SNF Three-Day Waiver guidance [document](#).

Telehealth Services

CMS finalizes a policy to provide expanded access to telehealth services for qualifying ACOs. Specifically, as required by the BBA, Medicare will waive its typical geographic restrictions for telehealth originating sites and count patients' homes as originating sites for ACOs under two-sided models. Please note this provision is applicable only to ACOs who have elected prospective assignment. ACOs in the new Enhanced Track and Basic Track Levels C, D and E are eligible to participate along with Track 3 and Track 1+ ACOs that use prospective assignment. There is no application process for ACOs to submit before starting to bill for these expanded telehealth services. CMS finalizes a January 1, 2020 effective date for this provision, rejecting calls by NAACOS and others to have a July 1, 2019 effective date for this provision.

CMS also provides a 90-day grace period for beneficiaries who are prospectively assigned to an applicable ACO at the start of the performance year, but who are subsequently excluded from assignment. ACOs must not bill excluded beneficiaries for telehealth services outside of the 90-day window or when not assigned, and/or they must return any money paid by the beneficiary. ACOs could be subject to a corrective action plan and program termination if they do not comply with such requirements. Finally, ACOs who terminate from the program must notify beneficiaries in their termination notices that the ACO can no longer supply telehealth services. Table F below (Table 10 of the final rule on page 67977) summarizes each benefit enhancement and what ACOs are eligible for such enhancements, as well as the effective date of each benefit enhancement.

Table 10 – Availability of Payment and Program Policies to ACOs by Track

Policy	Policy Description	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)	BASIC Track (New Track)	ENHANCED Track (Current Track 3 Financial Model)
Telehealth Services furnished in accordance with section 1899(I) of the ACT	Removes geographic limitations and allows the beneficiary's home to serve as originating site for prospectively assigned beneficiaries.	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) ¹	For performance year 2020 and onward, applicable for performance years under a two-sided model (prospective assignment)	For performance year 2020 and onward (prospective assignment)

SNF 3-Day Rule Waiver ²	Waives the requirement for a 3-day inpatient stay prior to admission to a SNF affiliate	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)
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Notes: ¹An amendment to the Track 1+ Model Participation Agreement would be required to apply the proposed policies regarding the use of telehealth services under 1899(l) to Track 1+ Model ACOs as described in section II.F. of this final rule.

²As discussed in section II.A.7.c. and II.F. of this final rule, Track 3 ACOs and Track 1+ Model ACOs participating in a performance year beginning on January 1, 2019, may apply for a SNF 3-day waiver effective on July 1, 2019. We expect this application cycle would coincide with the application cycle for new agreement periods beginning on July 1, 2019.

Beneficiary Incentive Program

CMS finalizes a policy allowing certain ACOs to establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive “qualifying services”, which are primary care services as defined for purposes of the MSSP. Through this program, approved ACOs may provide limited “cash equivalent” incentive payments to certain patients who receive qualifying primary care services under this beneficiary incentive program established by the BBA. This allows ACOs to provide incentive payments to eligible beneficiaries who receive qualifying services of up to \$20 (adjusted annually for inflation). Payments cannot be in cash but rather must be provided as “cash equivalents,” such as debit cards or checks, and must be in the same amount for each eligible beneficiary. 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. Importantly, these incentive payments won’t count as ACO expenditures or figure into benchmarks or shared losses. To prevent “cherry picking” of healthier patients by ACOs with more resources, CMS is barring ACOs from advertising or marketing their incentive programs. However, ACOs must notify beneficiaries about their incentive program during the annual notification process, which will occur prior to or at the first primary care visit of the year. CMS will supply standardized language ACOs may use and will test that language to ensure it’s accurate, neutral and not misleading. More information is available in the CMS Beneficiary Incentive Program Guidance [document](#).

The beneficiary incentive program is available to two-sided risk ACOs with preliminary prospective assignment with retrospective reconciliation or prospective assignment (Tracks 2, 3, Basic Levels C, D, and E, and Enhanced). Incentives may be made available starting July 1, 2019, and must be offered for at least a full year. If an ACO begins an agreement on July 1, 2019, the ACO must offer the incentive for 18 months to sync annual renewal processes with those starting January 1, 2020. ACOs may apply to offer a program mid-cycle, for example, after the second or third year of a five-year agreement. ACOs are required to recertify each year and to notify CMS about material changes to their programs within 30 days. Additional information on what constitutes a “material change” will be provided in the future along with clarification on what happens if a patient denies payment.

CMS finalizes a requirement that ACOs identify and maintain records of who received such beneficiary incentive payments, the amounts, form of payment, date of service, who provided the service, as well as the HCPCS code for the qualifying service. ACOs must publicly report the number of patients receiving incentives, amounts of incentives, and other information. Despite calls from NAACOS for financial help establishing such incentive payments, ACOs must fully fund their programs and can't accept funds from outside entities like health plans or drug companies. They also can't bill Medicare for the costs of such a program. The payments must be the same amount for all patients and be provided to all patients who receive a qualifying service. CMS also reserves the right to terminate programs when the agency has fraud and abuse concerns.

CMS rejected NAACOS' request that the agency assists ACOs in funding the costs of a beneficiary incentive program, citing law that prohibits CMS from making any separate payment to ACOs for carrying out an incentive program. However, an ACO's shared savings payments may be used to fund the program. CMS notes the program is voluntary and if ACOs are concerned about up-front costs, they may still offer other in-kind items such as vouchers for transportation or wellness programs. In the rule CMS notes that ACOs already have the option to offer incentives directly related to a patients' medical care such as vouchers for transportation, wellness programs, or over-the-counter drugs.

Program Overlap Issues

CMS notes that entities may concurrently participate in the Bundled Payments for Care Improvement (BPCI) Advanced and the Shared Savings Program. The interactions between the Shared Savings Program assigned beneficiaries and episodes that are initiated under the BPCI Advanced model are governed by the model participation agreement. The current BPCI Advanced participation agreement addresses financial reconciliation and indicates that clinical episodes may not be initiated for beneficiaries assigned to a Shared Savings Program ACO in Track 3, but can be initiated for beneficiaries assigned to a Shared Savings Program ACO in Track 1, the Track 1+ Model or Track 2. In this regulation CMS notes it will continue to work with the Innovation Center to address interactions between models and Shared Savings Program ACOs, including the interaction between BPCI Advanced and the Basic Track and Enhanced Track, and the agency will provide this information in future guidance.

Quality Provisions

In the proposed Pathways to Success Rule, CMS discussed removing ACO Quality Measure 11, Use of Certified Electronic Health Record Technology (CEHRT). In the final 2019 MPFS [Rule](#), CMS finalized this change. In the absence of ACO-11, CMS will require ACOs to certify annually that the percentage of eligible clinicians (ECs), as defined in the QPP, who are participating in the ACO that use CEHRT to document and communicate clinical care to their patients or other health care providers meets or exceeds the applicable percentage during the performance year. ACOs will be required to submit this certification in the form and manner specified by CMS for performance years starting on January 1, 2019, and all subsequent performance years. For performance years starting on January 1, 2019, the annual certification will occur in the spring of 2019 for ACOs extending their participation agreement for six months, and in the fall of 2019 for ACOs that have a 12-month performance year during 2019. Further, ACOs participating in Advanced APMs would be required to demonstrate that the percentage of ECs in the ACO using CEHRT to document and communicate clinical care to their patients or other health care providers meets or exceeds the percentage specified in the CEHRT use criterion for Advanced APMs under QPP requirements (75 percent for 2019). ACOs in a track that is not designated as an Advanced APM must certify annually that at least 50 percent of the ECs participating in the ACO use CEHRT to document and communicate clinical care to their patients or other health care providers. This final policy does not affect the previously finalized requirements for Merit-Based Incentive Payment System (MIPS) ECs reporting on the Promoting Interoperability (PI) performance category under MIPS. Therefore, MIPS ECs, who are participating in ACOs under a payment track that is not an Advanced APM and/or who are not QPs, would continue to be required to report as usual on the PI performance category. Finally, the agency notes that it reserves the

right to monitor, assess, and/or audit an ACO's compliance with respect to its certification of CEHRT use among its participating ECs and to take compliance actions (including warning letters, corrective action plans, and termination) when ACOs fail to meet or exceed the required CEHRT use thresholds.

CMS made no further changes to the MSSP's quality performance standards. Therefore, ACOs will continue to be evaluated on quality measures that are pay-for-reporting for one performance year and pay-for-performance in subsequent years. For more information on the 2019 ACO quality measure standards, please refer to this NAACOS [resource](#) and the MSSP CMS Program Guidance and Specifications [webpage](#) (see Quality Measures and Reporting Specifications).

Assessing the Six-Month Performance Periods in 2019

SIX-MONTH PERFORMANCE PERIOD FOR ACOS EXTENDING CURRENT AGREEMENTS FROM JAN 1 THROUGH JUNE 30, 2019

As a result of the finalized policy in the 2019 MPFS Rule, ACOs with an agreement period ending on December 31, 2018 had the one-time option to voluntarily elect to extend current agreements in the Shared Savings Program for an additional six-month performance year, which begins January 1, 2019, and ends on June 30, 2019.

Beneficiary Assignment

For ACOs under preliminary prospective assignment with retrospective reconciliation, the assignment window for the six-month extension performance period is CY 2019. For ACOs under prospective assignment, Medicare FFS beneficiaries would be prospectively assigned to the ACO based on beneficiaries' use of primary care services in the most recent 12 months for which data are available.

Shared Savings/Losses

To determine shared savings and shared losses for the six-month extension performance period, CMS will calculate average per capita Medicare expenditures for Parts A and B services for CY 2019 for the ACO's performance year assigned beneficiary population and compare this amount to the updated historical benchmark. CMS will then pro-rate any shared savings or shared losses by multiplying the amounts by one-half, which represents the fraction of the calendar year covered by the six-month performance period. CMS will use the ACO participant list for the performance year beginning January 1, 2019, to determine beneficiary assignment.

Repayment Mechanisms

With regard to ACOs participating under Track 2 or Track 3, CMS clarifies that for the six-month performance period from January 1, 2019, through June 30, 2019, CMS will not require any ACO that elects to extend its participation agreement to modify the amount previously approved for the ACO's repayment mechanism arrangement, though ACOs must extend the terms of their repayment mechanisms until June 30, 2021. For Track 1+, CMS states the agency may require Track 1+ ACOs to update repayment mechanism amounts for the six-month extension. For example, if a Track 1+ ACO moves from the revenue-based standard to the benchmark-based standard, an updated repayment mechanism agreement may be required.

Quality

For the six-month extension performance period, CMS will use the ACO's quality performance for the 12-month CY 2019. CMS clarifies that the agency will apply the program's current sampling methodology to determine the beneficiaries eligible for the samples for claims-based measures (as calculated by CMS), CMS Web Interface reporting, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for

ACOs Survey using the ACO participant list effective on January 1, 2019. Reporting will take place in January through March of 2020.

Reports

CMS anticipates issuing performance reports and determining financial and quality performance for ACOs participating in the six-month performance period according to the typical annual projected timeline for making these determinations. ACO annual financial reconciliation reports, quality performance reports, and additional informational reports and files are typically made available in the summer following the conclusion of a 12-month performance year. CMS also plans to provide ACOs that participate in the six-month performance period with quarterly reports for the third and fourth quarter of CY 2019. Finally, CMS anticipates the agency will make an annual schedule for report delivery for 2019 available to ACOs electing the six-month extension, though CMS does not specify when such a schedule will be provided.

Interactions with Quality Payment Program

CMS clarifies that clinicians who obtain APM QP status based on the March 31, 2019, or June 30, 2019, snapshot through participation in an Advanced APM ACO with a six-month extension of its agreement period will maintain QP status, be exempt from the (MIPS), and receive the APM incentive payment, as long as the ACO completes its agreement period by remaining in the program through June 30, 2019.

If an ACO terminates or is involuntarily terminated any time after March 31, 2019, and before August 31, 2019, the ECs previously determined to have had QP status would lose their status as a result of the termination and would instead be scored under MIPS using the APM Scoring Standard. If an ACO terminates before March 31, 2019, the ECs will not be scored under the APM Scoring Standard and will be assessed under standard MIPS scoring rules.

ACO professionals that are MIPS ECs (not QPs based on their participation in an Advanced APM or otherwise excluded from MIPS) participating in an ACO that completes a six-month performance period from January 1, 2019, through June 30, 2019, would continue to be scored under MIPS using the APM Scoring Standard, based on quality data submitted for all of CY 2019 during the regular submission period that occurs in early 2020. Thus, for a Track 1 ACO in a six-month performance period from January 1, 2019, through June 30, 2019, whose agreement period expires and the ACO does not renew to continue program participation, the ACO would be scored under the MIPS APM scoring standard rules for quality reporting based on the entire CY 2019.

Data Sharing

CMS will continue to provide beneficiary-identifiable claims data (i.e., claim and claim line feed files) to ACOs only during their participation in the program, including during the six-month performance period from January 1, 2019, through June 30, 2019. ACOs would receive monthly Parts A, B, and D claims and claim line feed files during the six-month performance period based on the ACO participant list they certify before the start of the performance year.

Early Termination Policies

For ACOs participating in a performance year starting on January 1, 2019, CMS will continue to apply the program's current policies for payment consequences of early termination. CMS states that, "Under this approach, ACOs that terminate from a performance year starting on January 1, 2019, with an effective date of termination prior to the end of their performance year will not be eligible for shared savings or accountable for shared losses" (p. 1691-1692 of the final 2019 MPFS rule).

SIX-MONTH PERFORMANCE PERIOD FOR JULY 1 THROUGH DECEMBER 31, 2019

In the final rule, CMS offers a one-time only July 1 start in 2019. Below are the final policies for determining financial and quality performance for the six-month performance year from July 1, 2019, through December 31, 2019.

Beneficiary Assignment

For ACOs that select a prospective beneficiary assignment methodology for the six-month performance year from July 1, 2019, through December 31, 2019, CMS will use an assignment window from October 1, 2017, through September 30, 2018, to align with the assignment window used to determine prospective assignment for performance years beginning on January 1, 2019. This is a modification from CMS's earlier proposal to use an assignment window reflecting the most recent 12 months of data available as described in the August 2018 proposed rule. Therefore, the assignment window is the same as the assignment window that applies for ACOs under prospective assignment for the six-month performance year from January 1, 2019, through June 30, 2019. CMS will use the ACO participant list for the performance year beginning July 1, 2019, to determine beneficiary assignment.

Shared Savings/Losses

To determine shared savings and shared losses for the six-month extension performance period, CMS will calculate average per capita Medicare expenditures for Parts A and B services for CY 2019 for the ACO's performance year assigned beneficiary population and compare this amount to the updated historical benchmark. CMS will then pro-rate any shared savings or shared losses by multiplying the amounts by one-half, which represents the fraction of the calendar year covered by the six-month performance period. CMS will use the ACO participant list for the performance year beginning July 1, 2019, to determine beneficiary assignment. CMS will establish, adjust and update the ACO's historical benchmark according to the benchmarking policies finalized for agreement periods beginning on July 1, 2019, except that the benchmark will be adjusted for changes in severity and case mix based on growth in prospective HCC risk scores between BY3 and CY 2019, subject to a cap of positive 3 percent, and the benchmark will be updated to CY 2019. CMS will compare the ACO's updated historical benchmark to the expenditures during CY 2019 for the ACO's performance year assigned beneficiaries.

CMS also notes, if an ACO is reconciled for both the January 1, 2019, through June 30, 2019 performance year and the July 1, 2019, through December 31, 2019 performance year, CMS issues a separate notice of shared savings or shared losses for each performance year. If the ACO has shared savings for one performance year and shared losses for the other performance year, CMS reduces the amount of shared savings by the amount of shared losses. If any amount of shared savings remains after completely repaying the amount of shared losses owed, the ACO is eligible to receive payment for the remainder of the shared savings. If the amount of shared losses owed exceeds the amount of shared savings earned, the ACO is accountable for payment of the remaining balance of shared losses in full.

Repayment Mechanisms

A renewing ACO that is currently participating under a two-sided model and enters a new agreement period beginning on July 1, 2019, will also be permitted to use its existing repayment mechanism to establish its ability to repay shared losses incurred for performance years in its new agreement period. An ACO choosing this option would be required to either extend the term of the existing repayment mechanism such that it is in effect until 12 months following the end of the new agreement period or extend the term of the existing repayment mechanism, if necessary, such that it covers the first two performance years of the new agreement period and provides for automatic, annual 12-month extensions of the repayment mechanism, which will result in the repayment mechanism eventually remaining in effect for 12 months after the end of the new agreement period.

The ACO would also be required to increase the amount of its repayment mechanism to reflect the new repayment mechanism amount determined for its new agreement period, unless CMS notifies the

renewing ACO that the repayment mechanism amount for its new agreement period is equal to or lower than its existing repayment mechanism amount. If the repayment mechanism amount calculated for the new agreement period is lower than the existing repayment mechanism amount, the ACO would be required to maintain the repayment mechanism at the existing higher amount. Additionally, for agreement periods beginning on or after July 1, 2019, CMS notes it will recalculate the estimated amount of the ACO's repayment mechanism arrangement before the second and each subsequent performance year in which the ACO is under a two-sided model in the Basic Track or Enhanced Track.

Quality

To determine an ACO's quality performance during the six-month performance year from July 1, 2019, through December 31, 2019, CMS will use the ACO's quality performance for the 12-month CY 2019. CMS clarifies that the agency will apply the program's current sampling methodology to determine the beneficiaries eligible for the samples for claims-based measures (as calculated by CMS), CMS Web Interface reporting, and the CAHPS for ACOs Survey using the ACO participant list effective on July 1, 2019. Reporting will take place in January through March of 2020.

CMS notes the ACO participant list finalized for the first performance year of the ACO's agreement period beginning on July 1, 2019, is used to determine the quality reporting samples for the 2019 reporting year for the following ACOs: (1) an ACO that extends its participation agreement for a six-month performance year from January 1, 2019, through June 30, 2019, enters a new agreement period beginning on July 1, 2019; and (2) an ACO that participates in the program for the first six months of a 12-month performance year during 2019 but elects to voluntarily terminate its existing participation agreement effective June 30, 2019, enters a new agreement period starting on July 1, 2019.

Interactions with Quality Payment Program

Eligible clinicians in ACOs that elect to participate in Level E of the Basic Track or the Enhanced Track for the six-month performance year from July 1, 2019, through December 31, 2019, may earn the APM Incentive Payment and be excluded from the MIPS reporting requirements and payment adjustment for 2019 if they meet the QP payment thresholds (50 percent) or patient count (35 percent) thresholds on the third QP snapshot date of August 31, 2019, during the QP performance period. When conducting QP determinations for the third snapshot date (August 31, 2019) for ACOs that elect to participate in Level E of the Basic Track or the Enhanced Track for the six-month performance year from July 1, 2019, through December 31, 2019, CMS will continue to use the entire QP performance period (i.e., January 1, 2019, through August 31, 2019) rather than conducting QP determinations from July 1, 2019, through August 31, 2019.

If an eligible clinician is participating in an ACO that is in a track that meets the Advanced APM criteria for the six-month performance year from July 1, 2019, through December 31, 2019, and the ACO either voluntarily terminates or is involuntarily terminated on or before August 31, 2019: (1) If their ACO terminates or is involuntarily terminated on or before August 31, 2019, then ECs will lose the opportunity to attain QP status as a result of the termination. In addition, the ECs would not be scored under MIPS using the APM Scoring Standard because they would not be captured as participants in a MIPS APM on one of the four snapshots used to determine APM participation; (2) If the ACO is in an active agreement period on August 31, 2019, then ECs who are determined to be QPs based on the third QP snapshot date (August 31) will maintain their QP status and be considered MIPS APM participants, even if the ACO's agreement is terminated after that date.

Finally, ACO professionals that are MIPS ECs (not QPs based on their participation in an Advanced APM or otherwise excluded from MIPS) participating in an ACO that completes a six-month performance year from July 1, 2019, through December 31, 2019, would be scored under MIPS using the APM Scoring Standard for 2019, based on quality data submitted for all of 2019 during the regular submission period in early 2020.

Early Termination Policies

ACOs under a two-sided model that begin a six-month performance period on July 1, 2019, and that are involuntarily terminated by CMS would be required to repay a pro-rated amount of any shared losses determined.

Extreme and Uncontrollable Circumstances Policies for ACOs

CMS extends the current extreme and uncontrollable circumstances policy in effect for 2018 to 2019 and subsequent performance years. Extreme and uncontrollable circumstances policies were initially established in a December 2017 interim final rule to account for several devastating hurricanes and wildfires that year which compromised ACOs' ability to coordinate care. Despite NAACOS urging CMS to make modifications to this policy, CMS maintains the current approach with no changes. A summary of CMS's extreme and uncontrollable circumstances policy can be found [here](#). NAACOS will continue to collect data on how ACOs are affected by extreme and uncontrollable circumstances and advocate for policies that create a more equitable approach for ACOs affected by natural disasters. We encourage members to share their experiences with us by emailing advocacy@naacos.com.