NAACOS ANALYSIS OF THE 2018 PROPOSED MSSP "PATHWAYS TO SUCCESS" RULE

OVERVIEW

On August 9, CMS released a Notice of Proposed Rulemaking (NPRM), titled *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success*, containing significant proposed changes to the MSSP. The rule can be accessed here, along with a CMS factsheet on the proposed regulation. Importantly, the 2019 MSSP application process has been delayed as a result of this NPRM. CMS will forego a January 1, 2019 start date for new and renewing ACOs, and instead proposes a July 1, 2019 start date for ACOs. NAACOS is disappointed that CMS acknowledges that its proposals would limit the number of ACOs in the program, resulting in fewer providers in the leading Medicare Alternative Payment Model (APM), thus undermining bipartisan payment reforms and the broader shift to value-based care. As we move forward with advocacy efforts surrounding this NPRM, ACOs must actively communicate feedback about the rule to the administration and Congress. It is important to note that these proposals are not final, and we are working to affect significant changes in the final rule. We encourage members to share reactions and feedback on these proposals by emailing advocacy@naacos.com.

EXECUTIVE SUMMARY

The NPRM introduces significant changes to the MSSP. There are both opportunities and challenges presented by the changes; NAACOS greatest concerns lie with the low sharing rates proposed for ACOs choosing upside only and low-risk models, as well as the reduced amount of time provided to new ACOs in upside only models. NAACOS will continue to analyze the rule, seek member feedback, and advocate for changes that will make the new structure a valid option for both existing ACOs as well as those seeking to enter the program. Highlights of the NPRM are listed below.

Proposed Program Updates:

- Modify the participation options by retiring Track 1 and Track 2 and introducing a new Basic Track that includes a gradual shift to risk with progression through five levels
- Retain equivalents of Tracks 1+ and 3 with Track 3 renamed as the Enhanced Track
- The new MSSP options are detailed in Table 2 from the rule
- Modify the duration of agreement periods from three years to five years
- Update the benchmarking methodology to incorporate regional expenditures into benchmarks sooner but dampen the overall effect of regional benchmarking by changing other elements of the methodology

Opportunities presented by the proposals:

- More gradual increases in risk than currently available and permanent inclusion of a Track 1+ equivalent (renamed Basic Level E)
- 82 ACOs facing a January 1 deadline for moving to risk have more time in a shared savings only model than they would have had under current program rules
- Efforts to promote program stability and predictability through longer agreement periods
- Expands opportunities to use the skilled nursing facility (SNF) three-day rule waiver for ACOs using retrospective assignment and ACOs in rural areas

- Implementation of Bipartisan Budget Act (BBA) provisions for risk-based ACOs, providing expanded use of telehealth waivers and introduction of a beneficiary incentive program
- Flexibility with choosing assignment methodology regardless of risk model and more opportunity to voluntarily move up risk levels annually
- Removes ACO quality measure 11 and instead uses an annual certification for all ACOs to attest to their Certified Electronic Health Record Technology (CEHRT) use, while also asking for feedback on further quality measure changes that would reduce administrative burdens and focus on meaningful measurement

Challenges presented by the proposals:

- Moving ACOs more quickly to mandatory risk and requiring annual risk increases
- Introducing restrictions on ACOs reforming and applying as new ACOs if more than 50 percent of participants were already in a Track 1 ACO
- Reducing shared savings rates for shared savings only and low risk models (e.g., the new shared savings only model would have a shared savings rate of 25 percent)
- Introducing new early termination policies based on spending increases outside a certain corridor
- Continued policy to require more risk and earlier risk from hospital-based ACOs
- Proposed application of a +/- 3 percent risk ratio cap across the five-year agreement period, which would reduce benchmark accuracy in later performance years

SUMMARY OF KEY PROVISIONS OF THE ACO NPRM

Replacing Current Tracks with an Enhanced and Basic Track

Among the sweeping program changes, CMS proposes that effective June 30, 2019 the agency would 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 Proposed MSSP Structure
Track 1	Basic Level A and B
Track 1+	Basic Level E
Track 2	No equivalent
Track 3	Enhanced Track

Overview of New Tracks and Transition to Risk

Under the proposed structure, ACOs would 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 ACO type. Levels A and B of the Basic Track would be shared savings only models, and after up to two years, ACOs would gradually assume more risk over time. Basic Level E and the Enhanced Track would qualify as Advanced 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 MACRA criteria.

While CMS would automatically advance ACOs over time across the levels, ACOs could elect annually to move up to higher risk levels in the Basic Track more quickly than what is required. ACOs would not be permitted to switch from the Basic to the Enhanced Track during their five-year agreement period. However, since CMS proposes to eliminate the current restriction that prevents ACOs that terminate during an agreement from re-entering the program before the contract they terminated would have ended, an ACO could terminate its contract and quickly move to the Enhanced Track under a new agreement. As

illustrated in Table A below, the new proposed 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 the Enhanced Track.

Shared Savings and Losses

As shown in Table A, some of the most notable changes in this proposed rule are the amount of shared savings and losses for ACOs in Levels A through D of the Basic Track. NAACOS has significant concerns about the proposed major reductions in shared savings rates. The current shared savings rate for Track 1 is 50 percent, which would be reduced to 25 percent under the proposed Basic Track Levels A and B. The shared savings rates and shared loss rates gradually increase across the levels until they reach those in Level E, which has the same shared savings and loss rates as Track 1+. 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 (FFS) revenue compared to ACO benchmarks, categorizing ACOs as "high revenue" or "low revenue." These new proposed 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 Proposed MSSP Structure

Basic					Enhanced
Level A	**Level B**	**Level C**	**Level D**	**Level E**	
25% sharing rate	25% sharing rate	30% sharing rate	40% sharing rate	50% sharing rate	75% sharing rate
Upside only	Upside only	1st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of benchmark	1st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of benchmark	1st dollar losses at 30%, not to exceed 8% of revenue capped at 4% of benchmark	1st dollar losses not to exceed 15% of benchmark
MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM

High Revenue and Low Revenue ACO Designations

CMS proposes a new distinction that evaluates the percent of the ACO participant Parts A and B FFS revenue compared to ACO benchmarks in order to categorize ACOs as "high revenue" or "low revenue" ACOs. This distinction determines program specifics such as the timing for when an ACO must move to risk and what its loss sharing limit would be. Under current Track 1+ program requirements, ACOs provide information to CMS about their participants, and CMS uses that information to determine if the ACO falls under the revenue-based or benchmark-based risk standard. The proposed method for determining high revenue or low revenue ACOs removes the ACO self-reporting requirement, and CMS would instead use Medicare claims data to make this determination. The new approach would no longer directly consider ownership or operational interests but would focus on participant revenue compared to benchmarks. The definitions of high revenue 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 25 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 25 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 and B FFS expenditures for the ACO's assigned beneficiaries. CMS notes that that low revenue ACOs tend to be smaller, physician-led, and rural ACOs, which the agency explains are less likely to have access to capital to assume risk. Therefore, CMS considers but does not propose benefits to low revenue ACOs, such as providing them with a lower Minimum Savings Rate (MSR) in Levels A and B (1 or 2 percent) or using a higher shared savings rates such as 50 percent for Levels A through D. Hospital ACOs will typically be considered high revenue ACOs, but hospital-based ACOs with relatively low ACO participant FFS revenue compared to their benchmark would be low revenue ACOs. In the rule, CMS states its belief that ACOs whose participants have greater total Medicare Parts A and B FFS revenue relative to their benchmarks have more ability to control costs and may be better financially prepared to move to greater levels of risk. Accordingly, the agency notes that its comparison of revenue to benchmark would provide a more accurate method for determining an ACO's preparedness to take on additional risk rather than an ACO's self-reported information regarding the composition of its ACO participants and any ownership and operational interests in those ACO participants.

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 expire at the end of 2018, ACOs will have the option to extend current agreements for six months while offering a special, one-time July 1, 2019 start date for new agreements. At the time of publication, CMS has not yet provided further details on how current ACOs will elect the voluntary extension of current agreements to June 30, 2019. The July 1, 2019 start will have a Spring 2019 application period, should these proposals be finalized. CMS states in its fact sheet that it plans to resume its annual application cycle in 2019 for Performance Year 2020. CMS also proposes to 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 has confirmed with NAACOS staff that as proposed, ACOs within current agreement periods under Shared Savings Program participation options (Track 1, Track 2, or Track 3) would be able to complete the remainder of their current agreement under the existing financial models.

Eligibility for Future Program Participation

Participation options are determined in part based on whether CMS considers an ACO to be new, renewing or re-entering. CMS proposes to allow new ACOs to 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.

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 voluntarily 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 as (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 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.

Re-entering ACOs are ineligible for Level A and must begin at Level B of the Basic Track.
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 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 five most recent performance years prior to the agreement start date.

CMS defines "performance-based risk Medicare ACO initiative" as: 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 Model two-sided risk tracks. All ACOs can elect to participate in the Enhanced Track. Only ACOs that are inexperienced with performance-based risk can elect to participate in the Basic Track's glide path. Low revenue ACOs could participate in the Basic Track for up to two agreement periods. Low revenue ACOs experienced with performance-based risk would be ineligible for the glide path but would be eligible to enter a second agreement in the Basic Track at Level E. High revenue ACOs could have at most a single agreement period in the Basic Track.

Tables B and C (tables six and seven in the proposed rule on pages 41833-41834) summarize participation options for low and high revenue ACOs based on applicant type and the ACO's experience with risk.

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	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: [1]Low 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	Yes	Subsequent consecutive agreement period

Note: [1]High 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.

Table D below summarizes examples of current Track 1 ACO options for future participation by the ACO's initial start date. This table assumes that an ACO had prior participation in Track 1 only and does not meet the definition of an ACO experienced with performance-based risk. As discussed above, ACOs that are "experienced" may enter only at Basic Level E or Enhanced. CMS also considers Track 1 ACOs, who deferred renewal, as "experienced." Deferred renewal ACOs are those ACOs, who upon entering their second, three-year agreement, elected to add a fourth performance year in Track 1 before moving into a risk-based track for the remaining two years of the agreement period. This was a unique opportunity made available to only a small number of ACOs (i.e., ACOs seeking to enter their second agreement period beginning in 2017 and in subsequent years).

Table D: Example of Track 1 ACO Options by Start Date under Proposed New MSSP Policies

Year Started	Basic Level A	Basic Level B	Basic Level C (First risk-based)	Basic Level D	Basic Level E	Basic Level E	Year Enhanced Allowed/ Required
2012/2013	N/A	2019/2020	2021	2022	2023	2024	2019/2025
2014	N/A	2020	2021	2022	2023	2024	2020/2025
2015	N/A	2021	2022	2023	2024	2025	2021/2026
2016	N/A	2019/2020	2021	2022	2023	2024	2019/2025
2017	N/A	2020	2021	2022	2023	2024	2020/2025
2018	N/A	2021	2022	2023	2024	2025	2021/2026
2019 and on (New legal entity, not re-entering/ renewing)	2019/2020	2021	2022	2023	2024	N/A	2025

As discussed above, Track 1 ACOs scheduled to end in 2018 may voluntarily renew for a 4th period from January 1, 2019 – June 30, 2019. Any ACO starting in 2019 will have two performance years at the same initial Level (July 1, 2019 – December 31, 2019 and January 1, 2020 – December 31, 2020). Table B lists dates on which the ACO is required to start a new performance period; alternatively, Track 1 ACOs can voluntarily elect to terminate participation in June 2019 and transition to Basic Level B as of July 1, 2019. Alternatively, ACOs can elect to finish out their participation in the remainder of their current three-year agreement period. An ACO that enters the Basic Track at Level B and is automatically transitioned through the levels of the glide path would participate in Level E for the final two performance years of its agreement period.

Moving to Five-Year Agreement Periods

CMS proposes to extend the length of agreement periods from three years to five years to allow for more program stability. Specifically, CMS proposes that 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 proposes 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 proposed 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 would 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.

Prior to entering a two-sided model, the ACO must select the MSR/MLR. For an ACO making this selection during an agreement period, as part of the application cycle prior to entering a two-sided model of the Basic Track, the selection applies for the remaining duration of the applicable agreement period under the Basic Track. 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 also proposes to 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 would use this approach beginning with performance year 2019. The variable MSR/MLR would be determined based on the number of assigned beneficiaries that is currently used for two-sided model ACOs that have selected the variable option.

Loss Sharing Limit

Under these proposals, CMS would 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 4 in the proposed rule found on page 41809) for an example of this calculation.

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

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 proposes to eliminate the distinction between these two beneficiary types. The agency also proposes to use a symmetric +/-3 percent risk ratio cap between the performance year renormalized risk score and the most recent benchmark year for all assigned beneficiaries. For example, assuming that an ACO starts in July 2019, the most that the risk score used in the updated benchmark calculation can change in performance year six (2024) would be between 97 to 103 percent of the 2018 risk score (based on 2017 Hierarchal Condition Category [HCC] coding practices). NAACOS has repeatedly advocated for CMS to permit meaningful increases in beneficiary risk scores over time. While the proposal would permit an increase of up to 3 percent, it is important to note that 3 percent is across a five-year agreement period and is not a year-over-year increase. NAACOS will comment that while we appreciate the agency allowing risk score increases, the selection of 3 percent is arbitrary and insufficient when applied across a five-year agreement. Risk ratios would be separately capped by +/-3 percent within each of the four beneficiary enrollment types (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible), and CMS shows an example of this calculation in Table 11 on page 41885 of the proposed rule.

The agency would continue to use full CMS-HCC risk adjustment for all assigned beneficiaries between the benchmark period and the performance year, and the risk scores would continue to be renormalized within each of the four beneficiary enrollment types. Similarly, CMS would 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 would 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.

Note that if the proposed benchmarking methodology changes are finalized, the full CMS-HCC risk adjustment of regional expenditures and the regional update factor would be applicable during the first agreement period as a result of incorporating regional expenditures into the benchmark calculation in the initial agreement.

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 proposes some new changes that, if finalized, would go into effect along with the revised MSSP structure. CMS would 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. CMS proposes to incorporate regional expenditures into benchmarks sooner, beginning with initial agreement periods. This would modify the phase-in schedule for the regional expenditure adjustment as follows:

- ACOs would have a regional expenditure adjustment of 25 or 35 percent during the first agreement period.
- ACOs in their second agreement periods would have regional expenditure adjustments of 35 or 50 percent.
- All ACOs in their third and subsequent agreement periods would have a 50 percent regional expenditure adjustment.

The difference with the regional expenditure adjustment in the first two 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 adjustment, and ACOs with spending lower than their region would receive the higher adjustment. A notable difference with what CMS proposes in this rule is that the regional adjustment would be capped at 50 percent, which is lower than the current policy that caps the maximum regional adjustment at 70 percent. Further, CMS proposes to introduce a symmetric +/- 5 percent cap, implemented separately for each beneficiary category. The cap would be based on +/- 5 percent of national per capita expenditures and an example of applying the cap is shown in Table 12 on page 41890 of the proposed rule. If an ACO is considered a re-entering ACO, CMS proposes to apply the regional adjustment percentage that was used in the most recent agreement.

Another regional benchmarking proposal focuses on the update factor. In response to concerns raised by NAACOS and others, CMS proposes to 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 proposes to 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. This proposal is a step in the right direction to address some of our concerns; however, it needs to be verified that the new methodology would not over-emphasize the national trend component. NAACOS is disappointed that CMS does not propose to remove ACO beneficiaries from the population that determines the regional expenditures, a recommendation for which NAACOS has repeatedly advocated.

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 proposes 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 proposes to 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 lowering cost of access to repayment mechanisms. The agency also proposes to extend the duration of the repayment mechanism, which would need to be in place for the number of risk-based years in the agreement period plus an additional 24 months of "tail coverage." The use of a 24-month tail period is consistent with current requirements, but the duration of the repayment mechanism would be extended due to the extended agreements and more time in risk-based models.

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 proposes to 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. It is proposed that repayment mechanism amounts *would be* recalculated prior to each performance year. Under the proposed rule, if the calculated amount is greater by the lesser of 10 percent or $100,000, then the repayment mechanism amount would be increased by CMS. In other words, any increases over $100,000 would trigger a higher amount. While CMS proposes details related to increasing the amount of the repayment mechanism, it is proposed that repayment mechanism amounts cannot decrease within an agreement period, which is something NAACOS will contest in our comments to the agency. In an effort to minimize administrative burdens, CMS proposed 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, CMS proposes that 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.

Beneficiary Notification Changes

CMS proposals would modify the current beneficiary notification requirements and instead would require a standard written notification be provided annually to each Medicare FFS beneficiary at their first primary care visit of the performance year in the form and manner specified by CMS. CMS states they 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. Under this proposal, an ACO participant would be required to provide this notice during a beneficiary's first primary care visit in the six-month performance year from July 1, 2019 through December 31, 2019, as well as the first primary care visit in the 12-month performance year that begins on January 1, 2020 (and in all subsequent performance years). This notice would be in addition to the existing requirement that an ACO participant must post signs in its facilities and make standardized written notices available upon request.

Assignment Methodology Changes

Revisions to the Definition of Primary Care Services used in Beneficiary Assignment

CMS proposes to revise the definition of primary care services 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.

In addition, if finalized as proposed in the 2019 Medicare Physician Fee Schedule (MPFS) proposed rule, CMS would add these three new HCPCS codes to the MSSP assignment methodology: (1) GPC1X add-on code, for the visit complexity inherent to evaluation and management associated with certain primary care services, (2) GCG0X add-on code, for visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care, and (3) GPRO1, an additional add-on code for prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure.

Finally, starting with January 1, 2019 and subsequent performance years, CMS proposes to remove the exclusion of claims including the POS code 31 and, in its place, indicate more generally that CMS would exclude services billed under CPT codes 99304 through 99318 when such services are furnished in a SNF on the same date of service, using claims data to make that determination.

Beneficiary Opt-In Based Assignment Methodology

CMS proposes to allow ACOs to elect a new "opt-in" methodology that would be supplemented by a modified claims-based assignment. An opt-in assignment methodology would be based on an affirmative recognition of the relationship between the beneficiary and the ACO itself. A beneficiary would be assigned to an ACO if the beneficiary opted into assignment to the ACO. The "opt-in" approach would be supplemented with a modified claims-based assignment approach that focuses on the most complex patients by assigning beneficiaries to the ACO who have seven or more primary care service visits from ACO clinicians. Additionally, beneficiaries who choose voluntary alignment would be considered in this new assignment methodology.

CMS would allow, but not require, ACOs to elect an opt-in-based assignment methodology. At the time of application to enter or renew participation in the MSSP, an ACO could make this election which would apply for the length of the agreement period. If an ACO chooses not to elect the opt-in-based assignment methodology during the application or renewal process, then beneficiaries would continue to be assigned

to the ACO based on the existing assignment methodology (i.e., claims-based assignment with voluntary alignment). CMS is considering but not formally proposing to discontinue the existing assignment methodology and applying the opt-in-based assignment methodology program-wide. CMS also clarifies that this proposal would have no effect on the voluntary alignment process that exists currently.

Allowing Greater Choice for Prospective or Retrospective Assignment
CMS proposes to provide more flexibility in choosing prospective or retrospective assignment for Basic and Enhanced ACOs, as required by the BBA. Specifically, for ACOs entering agreement periods beginning on July 1, 2019 and in subsequent years, CMS proposes to allow ACOs annually to elect the beneficiary assignment methodology (i.e., preliminary prospective assignment with retrospective reconciliation or prospective assignment) to apply for each remaining performance year within their agreement period. CMS also proposes to provide an opportunity for ACOs to switch their selection of beneficiary assignment methodology on an annual basis, which would be done prior to the start of a new performance year.

Voluntary Alignment Changes
As required by the BBA of 2018 for Performance Year 2018 and each subsequent performance year, CMS will permit a Medicare FFS beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, if a system is available for electronic designation. A voluntary identification by a Medicare FFS beneficiary under this provision supersedes any claims-based assignment. Therefore, CMS proposes to establish a process under which a Medicare FFS beneficiary is notified of his or her ability to designate a primary care provider or subsequently to change this designation.

CMS proposes to modify the current voluntary alignment 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. Under this proposal, a beneficiary may select a practitioner with any specialty designation, for example, a specialty of allergy/immunology or surgery, as his or her primary care provider and be eligible for voluntary alignment assignment to the ACO in which the practitioner is an ACO professional. Currently the ACO professional designated by the beneficiary must be a primary care physician as defined at §425.20, a physician with a specialty designation included at §425.402(c), or a nurse practitioner, physician assistant, or clinical nurse specialist. CMS proposes to use a beneficiary's designation to align the beneficiary to the ACO in which his or her primary clinician participates even if the beneficiary does not receive primary care services from an ACO professional in that ACO. Finally, CMS proposes that the agency will not assign 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 Act under which claims-based assignment is based solely on claims for services other than primary care services and for which there has been a determination by Secretary that a waiver is necessary solely for purposes of testing the model.

Revised Early Program Termination Policies
CMS proposes to reduce the minimum notification period from 60 to 30 days for early termination. This would allow ACOs considering a year-end termination to have three quarters of feedback reports, instead of two. CMS would require ACOs in two-sided models that voluntarily terminate after June 30 to share in losses using the full 12 months of performance year expenditure data in performing reconciliation for terminated ACOs with partial year participation. 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 was effective, divided by 12. CMS also proposes to 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.

CMS outlines special rules for ACOs that participate for a portion of a six-month performance year during 2019 (January 1, 2019 –June 30, 2019 or July 1, 2019 - December 31, 2019):

1. If the ACO terminates its participation agreement effective before the end of the performance year, CMS would not reconcile the ACO for shared savings or shared losses (if a two-sided model ACO).
2. If CMS terminates a two-sided model ACO's participation agreement effective before the end of the performance year, the ACO would not be eligible for shared savings and CMS would reconcile the ACO for shared losses and pro-rate the amount reflecting the number of months during the performance year that the ACO was in the program.

Finally, CMS clarifies that ACOs starting a 12-month performance year in 2019 would have the option to participate for the first six months of the year prior to terminating their current agreement and entering a new agreement period beginning July 1, 2019. These ACOs would be eligible for prorated shared savings or losses for the six-month period from January 1, 2019 – June 30, 2019.

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 on January 1, 2019 and beyond, CMS proposes to 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, CMS proposes that 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, CMS proposes that the agency may immediately or with advance notice terminate the ACO's participation agreement. One-sided model monitoring would apply to ACOs in Track 1 or the first 2 years of the Basic Track's glide path, and the two-sided model monitoring would apply to ACOs under performance-based risk in the Basic Track (including the glide path) and the Enhanced Track, as well as Track 2. CMS also seeks comment on whether ACOs should be permitted to obtain reinsurance.

Expanding Access to Certain Payment Rule Waivers

SNF Three-Day Rule

Beginning July 1, 2019, CMS proposes to expand eligibility for the SNF three-day rule waiver to include ACOs participating in a two-sided model under preliminary prospective assignment. The SNF three-day rule 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 1, 2, and 3 of the performance year 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 a to waiver-approved ACO will remain eligible to receive services furnished in accordance with the SNF three-day rule 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 three-day rule waiver, SNFs include providers furnishing SNF services under swing bed arrangements. In these instances, the three-star quality rating requirement would be waived. This proposal aims to address concerns of ACOs in rural areas that have fewer available SNFs. CMS notes that these new waiver modifications would not apply to ACOs still participating in Track 2.

Telehealth

As required by the BBA, CMS proposes beginning with Performance Years 2020 and beyond, the agency would treat the beneficiary's home as an originating site and not apply the originating site geographic restrictions for telehealth services furnished by a physician or practitioner participating in an applicable ACO. Medicare would not pay a facility fee when the originating site is the beneficiary's home. CMS proposes to apply these policies to ACOs under a two-sided model that participate under the prospective assignment method, not a *preliminary* prospective assignment method. As such, Track 2 ACOs would not be eligible. Only Track 1+, Basic Track Levels C, D, E, and Enhanced (including Track 3 starting in 2018 or January 1, 2019) ACOs would be eligible. This proposal would provide a 90-day grace period for beneficiaries who are who are prospectively assigned to an applicable ACO at the start of the year, but 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 must return any money paid by the beneficiary, and ACOs could be subject to a corrective action plan and program termination if they do not comply.

Addition of a Beneficiary Incentive Program

As required by the BBA, CMS proposes to allow any ACO in Track 2, Levels C, D, or E of the Basic Track, or the Enhanced Track to establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying services. CMS outlines certain certification and application procedures. Consistent with the BBA, CMS proposes a $20 payment limit, updated annually consistent with the consumer price index and rounded to the nearest dollar, and made no later than 30 days after the service. A beneficiary would be eligible to receive an incentive payment if the beneficiary is assigned to an ACO through either preliminary prospective assignment with retrospective reconciliation or prospective assignment.

Any service furnished by an ACO professional who is a physician but does not have a specialty designation included in the definition of primary care physician would not be considered a qualifying service for which an incentive payment may be furnished. The ACO legal entity, not any participant providers or suppliers, must furnish the incentive directly to the beneficiary. Incentives must not be cash but may be cash equivalent (e.g., check or debit card). Incentives must be non-Medicare covered items and services. ACOs must keep records of all incentive payments. ACOs must fully fund the costs of operating the beneficiary incentive program, including the cost of any incentive payments. ACOs are prohibited from accepting or using funds furnished by an outside entity, including, but not limited to, an insurance company, pharmaceutical company, or any other entity outside of the ACO, to finance its beneficiary incentive program. However, shared savings may be used, per the BBA.

CMS proposes that incentive payments made by an ACO shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings. CMS also proposes to disregard incentive payments made by an ACO for purposes of calculating shared losses. CMS would require ACOs to publicly report, for each performance year, the total number of beneficiaries who receive an incentive payment, the total number of incentive payments furnished, HCPCS codes associated with any qualifying payment for which an incentive payment was furnished, the total value of all incentive payments furnished, and the total type of each incentive payment (e.g., check or debit card) furnished.

Quality Provisions

CMS proposes to discontinue use of the quality measure 11 that assesses an ACO's eligible clinicians' level of adoption of CEHRT. Instead, CMS proposes that for performance years starting on January 1, 2019 and subsequent performance years, ACOs in a track or a payment model within a track, which does not meet the financial risk standard to be an Advanced APM, must attest and certify upon application to participate in the MSSP and subsequently as part of the annual certification process that at least 50 percent of the eligible clinicians participating in the ACO use CEHRT to document and communicate clinical care to their

patients or other health care providers. ACOs would be required to submit this certification in the form and manner specified by CMS. NAACOS is seeking clarification on whether ACOs in models not considered Advanced APMs would still be required to report Promoting Interoperability for purposes of the Merit-Based Incentive Payment System (MIPS) requirements. CMS also seeks feedback on ways to reduce burden and focus on meaningful quality measures as part of their "Meaningful Measures" initiative. Under this initiative, CMS states it is working towards assessing performance on only those core issues that are most vital to providing high-quality care and improving patient outcomes with an emphasis on outcome-based measures, reducing unnecessary burden on providers, and putting patients first.

Finally, CMS is also considering the addition of one or more measures specific to opioid use to the ACO quality measures set. The potential benefits of such policies would be to focus ACOs on the appropriate use of opioids for their assigned beneficiaries and support their opioid misuse prevention efforts. Specifically, CMS is considering the following relevant National Quality Forum (NQF)-endorsed measures with emphasis on Medicare individuals with Part D coverage who are 18 years or older without cancer or enrolled in hospice: NQF 2940, Use of Opioids at High Dosage in Persons Without Cancer; NQF 2950, Use of Opioids from Multiple Providers in Persons Without Cancer; NQF 2951, Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer.

Assessing the Six-month Performance Periods in 2019

At the end of Calendar Year 2019, CMS proposes to reconcile the financial and quality performance of ACOs that participated in the MSSP in 2019. Given the varying participation options in 2019, CMS proposes to treat each six-month period separately for purposes of calculating financial and quality performance. These calculations would be reconciled based on the ACO's performance during the entire 12-month calendar year, but CMS would pro-rate the calendar year shared savings or losses based on the ACO's performance during the applicable six-month period.

Financial and Quality Performance Policies for Six-Month Performance Year from January 1, 2019 to June 30, 2019

If adopted as proposed, these policies would apply to ACOs that extended their current agreement for a fourth six-month performance year as well as ACOs that begin a 12-month performance year on Jan. 1, 2019 but elect to terminate their participation agreement with an effective termination date of June 30, 2019 in order to enter a new agreement period on July 1, 2019.

Assignment Window

For ACOs under preliminary prospective assignment with retrospective reconciliation, the assignment window would be Calendar Year 2019. For ACOs under prospective assignment, the assignment window would be October 1, 2017 through September 30, 2018, with beneficiaries remaining prospectively assigned to the ACO at the end of Calendar Year 2019 unless the beneficiary meets certain exclusion criteria. Lastly, beneficiary assignment would be based on the ACO's certified ACO participant list for the agreement period beginning January 1, 2019.

Benchmark

CMS would calculate the ACO's benchmark and assigned beneficiary expenditures as though the six-month performance year were the entire calendar year. The ACO's benchmark would be determined according to the applicable methodology of the ACO's track and agreement with CMS, except that data from the entire Calendar Year 2019 would be used in place of data for the six-month performance year for the benchmarking approaches CMS currently uses to update and adjust historical benchmarks. Thus, the existing methodology would be used to determine the benchmark for the January 1 – June 30, 2019 performance year by performing the following calculations:

- Benchmarks would be adjusted for changes in severity and case mix between benchmark year three and Calendar Year 2019 using the current HCC risk score and demographic factors methodology; and
- Benchmarks would be updated to Calendar Year 2019 according to the methodology for using growth in either national or regional Medicare FFS expenditures, depending on whether the ACO is in its first or second agreement period and whether the second agreement period began in 2016 or 2017–2019.

Financial Performance

CMS would apply the methodology for determining shared savings and losses according to the track the ACO is participating in on January 1, 2019, with the following exceptions to the applicable methodology implemented to calculate the expenditures for assigned beneficiaries over the full calendar year for purposes of determining the shared savings and losses for the six-month performance year:

- Average per capita Medicare Parts A and B services expenditures for Calendar Year 2019 would be calculated for the ACO's performance year assigned beneficiary population;
- CMS would compare the expenditures to the ACO's updated benchmark, determined for Calendar Year 2019 as listed above;
- CMS would apply the MSR or MLR, if applicable; and
- CMS would pro-rate any amounts of shared savings or losses by multiplying those amounts by 50 percent, which represents the portion of the calendar year covered by the six-month performance year.

Quality Performance

For ACOs participating in tracks where shared savings or losses are affected by the ACO's quality performance, CMS would multiply the difference between the updated benchmark expenditures by the applicable MSR or MLR based on the ACO's quality performance.

Financial and Quality Performance Policies for 6-Month Performance Year from July 1, 2019 to December 31, 2019

If adopted as proposed, these policies would apply to all ACOs that start a new agreement period on July 1, 2019. In general, CMS would apply the same general methodological steps for calculating pro-rated shared savings and losses as described above for the six-month performance year from January 1 – June 30, 2019, except where the ACO's agreement and track stipulates a different methodology — for example, the benchmarking methodology or financial calculations specific to the track in which the ACO participates.

Assignment Window

For ACOs under preliminary prospective assignment with retrospective reconciliation, the assignment window would be Calendar Year 2019. For ACOs under prospective assignment, the assignment window would be April 30, 2018 through March 31, 2019, with beneficiaries remaining prospectively assigned to the ACO at the end of Calendar Year 2019 unless the beneficiary meets certain exclusion criteria. Lastly, beneficiary assignment would be based on the ACO's certified ACO participant list for the agreement period beginning July 1, 2019.

Benchmark

CMS would calculate the ACO's benchmark and assigned beneficiary expenditures as though the six-month performance year were the entire calendar year. The ACO's benchmark would be determined according to the applicable methodology of the ACO's track and agreement with CMS, except that data from Calendar Year 2019 would be used in place of data for the six-month performance year for the benchmarking

approaches CMS has proposed to use in 42 CFR 425.601 to update and adjust historical benchmarks. Thus, the proposed methodology would be used to determine the benchmark for the July 1 – December 31, 2019 performance year by performing the following calculations:

- Benchmarks would be adjusted for changes in severity and case mix between benchmark year three and Calendar Year 2019 based on growth in prospective HCC risk scores, subject to a symmetrical cap or +/- 3 percent; and
- Benchmarks would be updated to Calendar Year 2019 according to proposed methodology in 42 CFR 425.601(b) using a blend of national and regional growth rates.

Financial Performance

CMS would apply the methodology for determining shared savings and losses according to whether the ACO is in the Basic or Enhanced Track on July 1, 2019, with the following exceptions to the proposed methodologies of those tracks implemented to calculate the expenditures for assigned beneficiaries over the full calendar year for purposes of determining the shared savings and losses for the six-month performance year:

- Average per capita Medicare Parts A and B services expenditures for Calendar Year 2019 would be calculated for the ACO's performance year assigned beneficiary population;
- Except for prospectively assigned beneficiaries, Calendar Year 2019 expenditures would be calculated to include all assigned beneficiaries that are alive as of January 1, 2019, including those with a date of death before July 1, 2019;
- CMS would compare the expenditures to the ACO's updated benchmark determined for Calendar Year 2019 as listed above;
- CMS would apply the MSR or MLR, if applicable; and
- CMS would pro-rate any shared savings or losses by multiplying those amounts by 50 percent, which represents the portion of the calendar year covered by the 6-month performance year.

Quality Performance

For ACOs participating in tracks where its shared savings or losses is affected by the ACO's quality performance, CMS would multiply the difference between the updated benchmark expenditures a by the applicable MSR or MLR based on the ACO's quality performance.

Request for Feedback on Ways ACOs Can Collaborate with Part D Sponsors

CMS solicits comment on how Medicare ACOs and Medicare Part D sponsors could collaborate to improve the coordination of pharmacy care for Medicare FFS beneficiaries. CMS acknowledges that ACOs have called for better ways to handle pharmacy benefits to improve medication adherence and reduce adverse events. Specifically, CMS seeks comment in a number of areas including:

- How ACOs and Part D plans can better work together to coordinate care.
- What new tools and support would help stand up "new, innovative business arrangements to promote pharmacy care coordination."
- How to financially reward Part D plans for hitting ACO program goals.
- If ACOs are currently partnering with Part D plans and what barriers they faced and how those challenges can be overcome.

Extreme and Uncontrollable Circumstances Policies for ACOs

Starting with Performance Year 2017 and every year that follows, CMS will use an alternative approach to calculate ACOs' quality scores if deemed affected by an "extreme and uncontrollable circumstance." Extreme and uncontrollable circumstance is granted if:

1. At least 20 percent of an ACO's patients identified under MACRA's Quality Payment Program are affected by an extreme and uncontrollable circumstance. For 2017, CMS will use the list of beneficiaries assigned to the ACO. In 2018 and following years, CMS will use the list of assigned beneficiaries generated by the Web Interface quality reporting sample; or
2. The ACO's legal entity, determined by the address in an application to CMS, is in an area identified under the Quality Payment Program (QPP) as being affected by an extreme and uncontrollable circumstance.

Note that these policies were finalized previously, and in this rule, CMS proposes to apply these policies for each performance year going forward.