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Medicare Shared Savings Program 2019 Final Rule
HFMA Executive Summary
December 21, 2018

On December 21, 2018, CMS issued a widely anticipated final rule for the Medicare Shared Savings Program (MSSP). Referred to by CMS as "Pathways to Success," the rule finalizes wide-ranging modifications to the program. Among the most significant, CMS consolidates the various MSSP Tracks into two participation options – BASIC (incorporates current Track 1, Track 1+, and Track 2) and ENHANCED (formerly Track 3) that are available for new and renewing contracts starting in 2019. The final rule expands the contract period from three to five years. In the BASIC model, participants start out in an upside only risk track but are required to progressively assume increased risk over the course of the contract term. Additionally, in a significant change from the proposed rule, the shared savings rate in the BASIC Model is reduced to 40 percent (down from 50 percent currently in Track 1, but significantly increased from the proposed 25 percent in BASIC Levels A&B) in the initial two years and gradually increases to 50 percent in the third year when the ACO enters a two sided risk level (BASIC Levels C – E). ACOs that qualify for the BASIC track would have limited contract period(s) in the model before being required to renew into the EHANCED model. CMS finalizes that ACOs defined as "Low Revenue" are granted more time in lower risk models. The rule also makes significant improvements to the benchmarking methodology. CMS also delays the start date of the new and renewing ACOs until July 1, 2019.

The goal of these changes is to encourage ACOs to accelerate the transition to two-sided risk models faster. Below is an executive summary of the final "Pathways to Success" rule. A detailed summary of the final rule is available here.

Summary of CMS Costs and Benefits: CMS projects the finalized changes to the regional adjustment and risk adjustment factors to the benchmark coupled with an accelerated transition to two-sided risk models will result in $2.29 billion (B) in federal savings over 10 years (down from $2.4B in the proposed rule). Based on analysis included in the final rule, CMS estimates that because of the changes in the final rule the number of ACOs participating in the MSSP will increase by 58 in 2023 before starting to decrease. By 2028 CMS projects there will be 39 fewer ACOs, largely due to fewer new applications as a result of the shorter upside only period (two years vs. six years). However, these losses are significantly lower than the 109 projected in the proposed rule.

Restructuring of the Participation Options: The rule significantly restructures the MSSP's participation options. MSSP Tracks 1, 1+ and Track 2 are consolidated into the "BASIC" option (described in detail below). Track 3 has been renamed the "ENHANCED" option. These new participation options will be available for start dates beginning on 7/1/19. New contracts will be for a period of at least five years, increased from three years. ACOs that are participating in the current tracks will be allowed to finish out their contract term before transitioning into the applicable new model.

1. Program timing: CMS finalizes a 6-month delay for new entrants (2019 enrollees) enabling a 7/1/19

off cycle start, followed by annual start dates beginning on January 1, 2020 for subsequent years. For ACOs who are ending their 3-year agreement on 12/31/18, CMS is offering a 6-month extension. New ACOs that enter into the BASIC Track (described below) on 7/1/19 will have 30 months in an upside only track (Levels A – B). ACOs that delay entry to 1/1/20 will only have 24 months in an upside only track. New and existing ACOs interested in applying to the new BASIC or ENHANCED track must complete the non-binding Notice of Intent to Apply (NOIA), which will be available from January 2, 2019, through January 18, 2019. The application submission due date will be posted on the Shared Savings Program website in the coming days.

2. BASIC Track: Over the five-year contact period, the participants in the BASIC option will face increasing risk (ACOs that start on 7/1/19 will remain in their chosen BASIC level for their first and second PY unless they elect to advance more quickly). Each year of the five-year contract period is assigned a Level A-E which denotes the risk level the ACO assumes. Please note that BASIC Levels A and B have a reduced maximum shared savings rate (40 percent vs. 50 percent currently available to upside only and Track 1 + participants). The table below illustrates the BASIC Track Levels, their associated sharing/loss rates, and caps on gains and losses.

Table 1: Overview of BASIC Track Options

Year/Level	Y1 Level A	Y2 Level B	Y3 Level C	Y4 Level D	Y5 Level E[1]
Max Sharing Rate	Up to 40%	Up to 40%	Up to 50%	Up to 50%	Up to 50%
Cap on Gains	10% of Benchmark	10% of Benchmark	10% of Benchmark	10% of Benchmark	10% of Benchmark
Max Loss Rate	N/A	N/A	30% Fixed	30% Fixed	30% Fixed
Cap on Losses	N/A	N/A	Not to exceed 2% of ACO Participant revenue capped 1% of benchmark.	Not to exceed 4% of ACO Participant revenue capped at 2% of benchmark.	Not to exceed 8% of ACO Participant revenue capped at 4% of benchmark (2019 – 2020).
Quality Payment Program	MIPS APM	MIPS APM	MIPS APM	MIPS APM	AAPM

Note: Level E (year five) is analogous to the current Track 1+ MSSP model

Similar to the current program, gain/loss sharing occurs at the first dollar once the Minimum Savings/Minimum Loss Rates are exceeded.

For each performance year (PY) starting after January 1, 2020, the default option in the BASIC track is for an Accountable Care Organization's (ACO's) risk level to increase annually. However, an ACO may select a higher risk track for any PY as long as it can meet the repayment mechanism requirements. If an

ACO elected to skip a level, the normal annual progression would continue as scheduled. For example, if it skipped Level A and started participating in Level C in year one, in year two it would advance to Level D. Accelerating risk track progression will not change an ACO's benchmark rebasing timeframe.

ACOs that previously participated in Track 1, or a new ACO identified as a re-entering ACO because more than 50 percent of its ACO participants have recent prior experience in a Track 1 ACO, would be ineligible to enter the glide path at Level A, thereby limiting their opportunity to participate in a one-sided model of the glide path to one year by starting at Level B. Tables seven and eight from the final rule (Appendix I) map the Tracks and Levels an ACO is eligible to participate in under the final rule, based on the ACO's revenue and experience with the MSSP program.

An ACO within the BASIC track's glide path could not elect to return to lower levels of risk/reward or the one-sided model within an agreement period under the glide path. If an ACO enters the BASIC track's glide path in a one-sided, model, and is unable to meet the requirements (e.g. establish a repayment mechanism) to participate under performance-based risk prior to being automatically transitioned to a PY under risk, CMS would terminate the ACO's agreement.

3. Low Revenue and Inexperienced ACOs: The rule provides additional flexibility and greatly improved terms to "Low Revenue" and "Inexperienced" ACOs. The rule affords ACOs that meet the low revenue criteria two five-year contract periods in the BASIC Model. The first contract term would progress through risk Levels A – E. The second contract period would occur under Level E (similar to the current MSSP Track 1+). Additionally, CMS modified the final rule to allow new legal entities that are low revenue ACOs and inexperienced with performance-based risk Medicare ACO initiatives the option to forgo automatic advancement to Level C to remain in Level B for an additional PY, and then be automatically advanced to Level E.

   The final rule defines a "Low Revenue" ACO as an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants based on revenue for the most recent calendar year for which 12 months of data are available, is less than 35 percent (up from 25 percent in the proposed rule) of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries based on expenditures for the most recent calendar year for which 12 months of data are available.

   The final rule defines "high revenue ACO" to mean an ACO whose total Medicare Parts A and B fee-for-service (FFS) revenue of its ACO participants based on revenue for the most recent calendar year for which 12 months of data are available, is at least 35 percent (up from 25 percent in the proposed rule) of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries based on expenditures for the most recent calendar year for which 12 months of data are available.

   CMS will continually monitor low revenue ACOs that have experience with Medicare performance-based risk participating in the BASIC track, to determine if they continue to meet the definition of low revenue ACO. If, during the agreement period, the ACO meets the definition of a high revenue ACO, the ACO will be permitted to complete the remainder of its current PY under the BASIC track, but will be ineligible to continue participation in the BASIC track after the end of that PY unless it takes corrective action, for example by changing its ACO participant list.

   An inexperienced ACO is one that is a new ACO entity and less than 40 percent of the ACO participants participated in a performance-based risk Medicare ACO initiative in each of the five

most recent PYs prior to the start date. CMS defines "performance-based risk Medicare ACO initiative" to mean an initiative implemented by CMS that requires an ACO to participate under a two-sided model during its agreement period.

CMS differentiates between low revenue ACOs and high revenue ACOs with respect to the continued availability of the BASIC track as a participation option. This approach would allow low revenue ACOs, new to performance-based risk arrangements, additional time under the BASIC track's revenue-based loss sharing limits, while requiring high revenue ACOs to more rapidly transition to the ENHANCED track under which they would assume relatively higher, benchmark- based risk. The final rule limits "high revenue" ACOs to at most, a single agreement period under the BASIC track prior to transitioning to participation under the ENHANCED track. By contrast Low Revenue ACOs would be allowed at most, two agreement periods under the BASIC track. These agreement periods would not be required to be sequential, which would allow low revenue ACOs that transition to the ENHANCED track after a single agreement period under the BASIC track the opportunity to return to the BASIC track if the ENHANCED track initially proves too high of risk.

If an ACO is identified as "high revenue," the following participation options apply:

- If the ACO is "inexperienced" with performance-based risk, the ACO may enter the BASIC track's glide path or the ENHANCED track. As long as the ACO has not previously participated in Track 1 (or is a new ACO identified as re-entering because of participants' prior participation in Track 1), the ACO may enter into any of the BASIC track's five levels (A through E).

- An ACO that previously participated in Track 1, or a new ACO identified as a re-entering ACO because more than 50 percent of its ACO participants have recent prior experience in the same Track 1 ACO may enter the glide path under either Level B, C, D, or E. It may also enter into the ENHANCED Track.

- An experienced ACO may only enter the ENAHCED Track. However, ACOs that entered the Track 1+ Model within their current agreement period have the opportunity to renew for a subsequent agreement period under Level E of the BASIC track for a consecutive agreement period beginning on July 1, 2019, or January 1, 2020.

If an ACO is identified as "low revenue" the following options would apply:

- If the ACO is "inexperienced" it may enter the BASIC's glide path at any level (A through E) or the ENHANCED track. ACOs that previously participated in Track 1 (or a new ACO identified as re-entering because more than 50 percent of its ACO participants have prior experience in Track 1) may enter the BASIC glide path in levels B through E.

4. BASIC Loss Sharing Limits: The rule finalizes revenue-based loss sharing limit as the default for ACOs in the BASIC track, and to phase-in the percentage of ACO participants' total Medicare Parts A and B FFS revenue. However, if the amount that is the applicable percentage of ACO participants' total Medicare Parts A and B FFS revenue exceeds the amount that is the applicable percentage of the ACO's updated benchmark based on the phase-in schedule, then the ACO's loss sharing limit would be capped and set at a percentage of the ACO's updated historical benchmark as described in Table 1 above.

For the BASIC track, the percentage of ACO participants' FFS revenue used to determine the revenue-based loss sharing limit for the highest level of risk (Level E) would be set for each PY consistent with the generally applicable nominal amount standard under the Advanced Alternative Payment Model (APM). In calculating the revenue-based standard, an ACO participant's Medicare FFS revenue would not be limited to claims associated with the ACO's assigned beneficiaries, and would instead be based on the claims for all Medicare FFS beneficiaries furnished services by the ACO participant. The revenue used to calculate the loss sharing limit would not be subject to CMS standardization process (e.g. remove add on payments, truncate extreme outliers) that is used when calculating benchmarks and actual performance.

5. ENHANCED Track: Under the final rule, the existing MSSP Track 3 model will be renamed the ENHANCED Track. If the ACO meets the "High Revenue" criteria, it will transition into the ENHANCED Track at the end of its first five-year contract period. If an ACO meets the "Low Revenue" criteria discussed above, it will have the option of transitioning into the ENHANCED Track after its second five-year contract period. The ENHANCED Track qualifies as an Advanced APM. Participating physicians who meet the criteria to be considered a Qualifying Professional will receive a 5 percent bonus payment on their FFS revenue for the services they provide.

6. Discontinues Deferred Renewal Option: The final rule discontinues the deferred renewal option, so that it is available to only those Track 1 ACOs that began a first agreement period in 2014 and 2015 and have already renewed their participation agreement under the deferred renewal option (in either 2017 or 2018). Therefore, this option is not be available to Track 1 ACOs seeking to renew for a second agreement period beginning on July 1, 2019, or in subsequent years.

Defining Renewing and Re-Entering ACOs: The rule finalizes definitions of renewing and re-entering ACOs, and discusses their participation options. CMS defines a renewing ACO to mean an ACO that continues its participation in the program for a consecutive agreement period, without a break in participation, because it is either:

1. An ACO whose participation agreement expired and immediately enters a new agreement period to continue its participation in the program; or

2. An ACO that terminated its current participation agreement, and immediately enters a new agreement period to continue its participation in the program.

The final rule defines "re-entering ACO" to mean an ACO that does not meet the definition of a "renewing ACO" and meets either of the following conditions:

1. Is the same legal entity as an ACO, identified by taxpayer identification number that previously participated in the program, and is applying to participate in the program after a break in participation, because it is either:
   - an ACO whose participation agreement expired without having been renewed; or
   - an ACO whose participation agreement was terminated

2. Is a new legal entity that has never participated in the Shared Savings Program and is applying to participate in the program and more than 50 percent of its ACO participants were included on the ACO participant list of the same ACO in any of the 5 most recent PYs prior to the agreement

start date.

CMS clarifies that the 50 percent threshold for prior participation by ACO participants is not cumulative when determining whether an ACO is a re-entering ACO.

The final rule divides re-entering ACOs into three categories in order to determine which agreement period an ACO will be considered to be entering for purposes of applying program requirements that phase-in over time.

1. For an ACO whose participation agreement expired without having been renewed, the ACO would re-enter the program under the next consecutive agreement period. For example, if an ACO completed its first agreement period and did not renew, upon re- entering the program, the ACO would participate in its second agreement period.

2. For an ACO whose participation agreement was terminated, the ACO re-entering the program would be treated as if it is starting over in the same agreement period in which it was participating at the time of termination, beginning with the first PY of the new agreement period.

3. 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 would consider the prior participation of the ACO in which the majority of the ACO participants in the new ACO were participating in order to determine the agreement period in which the new ACO would be considered to be entering the program. However, if the other ACO is currently participating in the program, the new ACO would be considered to be entering into the same agreement period in which the other ACO is currently participating, beginning with the first PY of that agreement period.

Finally, an ACO that terminates its current participation agreement and immediately enters a new agreement period to continue its participation in the program would also be considered to be entering the next consecutive agreement period.

Table 6 in the final rule (not included in this summary) illustrates the impact of this policy by providing examples of the phase-in of the modified regional adjustment weights based on agreement start date and applicant type (initial entrant, renewing ACO, or reentering ACO).

Participation Options for ACOs Participating in a Six-Month Performance Year in 2019: For ACOs whose current agreement period ends on 12/31/18, and those who start a new agreement period (both new and continuing ACOs) on 7/1/19, CMS will use an approach that would maintain financial reconciliation and quality performance determinations based on a 12-month calendar year period, but would prorate shared savings or shared losses for each potential 6-month period of participation during 2019. ACOs whose agreement period ends on 12/31/18 that elect to extend that contract period until 6/30/19 and then renew on 7/1/19 will have two separate reconciliations. The benchmark and results under this scenario will change based on differences in the ACO's participation lists and Medicare policies (e.g. benchmarking) related to the MSSP between the two performance periods. Attribution will be based on a full year using the assignment windows for the methodology associated with the risk track. Reconciliation for both periods will occur after the second performance period. If an ACO participated in both performance periods, CMS will net the results.

Beneficiary Assignment Changes: Starting on 7/1/19, participants have the choice of either prospective or retrospective assignment. If an ACO wishes to change assignment methodologies, it will have the opportunity to make an election that will follow the annual application and waiver election cycle. When an ACO elects to change its attribution methodology, CMS will recalculate its benchmark based on the beneficiaries attributed to it. While ACOs can select their attribution methodology, a beneficiary's voluntary election will continue to over-ride claims based attribution.

ACO Incentives/Enhancements: As required by the Balanced Budget Act of 2018, and the 21st Century Cures Act, CMS finalizes provisions for a number of participation incentives or enhancements. These include:

1. *SNF 3-Day Rule*: ACOs in two-sided risk models (Basic Tracks C – E and ENHANCED Track) are eligible for the SNF-3 Day waiver regardless of which attribution model they have selected. These revisions would be applicable for SNF 3-day rule waivers approved for PYs beginning on July 1, 2019, and in subsequent years.

2. *Telehealth Waiver*: For PY 2020 and subsequent years, ACOs in two-sided risk models (Basic Tracks C – E and ENHANCED Track) that select prospective assignment are eligible for a waiver of Medicare's originating site (including provision of telehealth services at home) and geographic telehealth requirements. In the case of a beneficiary that is no longer eligible to be attributed to an ACO, CMS is proposing to provide a 90-day grace period for payment of otherwise covered telehealth services, to allow sufficient time for it to notify an applicable ACO of any beneficiary exclusions, and for the ACO then to inform its ACO participants and ACO providers/suppliers of those exclusions.

3. *Beneficiary Incentive Waiver*: For PYs starting 7/1/19 and thereafter, ACOs in two- sided risk models (BASIC Tracks C – E and ENHANCED Track), regardless of attribution methodology, are eligible for a waiver to provide beneficiary incentives. The incentives may not exceed $20 adjusted annually for inflation. The incentive payment must be for receiving a "qualifying primary care service" from an ACO professional who has a primary care specialty designation included in the definition of primary care physician. The ACO legal entity, and not ACO participants or ACO providers/suppliers, must furnish the incentive payments directly to beneficiaries.

   The incentive payment must be "in the same amount for each Medicare fee-for-service beneficiary" without regard to enrollment of such a beneficiary in a Medicare supplemental policy, in a State Medicaid plan, or a waiver of such a plan, or in any other health insurance policy or health plan.

MSR/MLR: Similar to the currently available MSSP models, upside only ACOs (BASIC Level A and B) are subject to a population based variable MSR. ACOs with at least 5,000 assigned beneficiaries will have an Minimum Savings Rate (MSR) that varies between 2 percent and 3.9 percent based on the size of the ACO's assigned beneficiary population.

Risk bearing ACOs (BASIC Level C-E and ENHANCED ACOS) may choose a symmetrical MSR/MLR. Prior to entering a risk track, an ACO will have the opportunity to select its MSR/MLR from the following options:

- Zero percent MSR/MLR
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5–2.0 percent
- Symmetrical MSR/MLR that varies based on the ACO's number of assigned

However, once an ACO makes an election the MSR/MLR is set for the remainder of the contract period.

MSSP Benchmarking Changes: Among other changes, CMS will factor in changes in health status for the continuously assigned population, accelerate the use of regional factors in the benchmark, and modifies the methodology for calculating expenditure growth rates. Below each of these changes are described in more detail.

1. *Hierarchical Condition Category (HCC) Score Adjustment*: For agreement periods beginning on July 1, 2019 and in subsequent years CMS eliminates the distinction between newly and continuously assigned beneficiaries and allows an ACO's HCC risk score to increase annually for all beneficiary categories. There is a +3 percent risk adjustment cap from the benchmark year through all PYs. CMS proposed, but did not finalize a symmetrical -3 percent cap on decreases to risk scores. For ACOs participating in a 5 year and 6-month agreement period beginning on July 1, 2019, the cap would represent the maximum change in risk scores for the agreement period between benchmark year (BY) 3 and calendar year 2019 in the context of determining financial performance for the 6-month PY from July 1, 2019 through December 31, 2019, as well as the maximum change in risk scores between BY3 and any of the subsequent five PYs of the agreement period. The cap will be applied separately for each of the four enrollment types used for benchmarking.

2. *Regional Benchmark Adjustment*: Instead of waiting until the second contract period, the final rule incorporates regional adjustments to the benchmark in the first contract period for all ACOs entering the program on July 1, 2019, and in subsequent years. Similar to the current model used in subsequent contact periods, the percentage of the regional adjustment blended into the benchmark will depend on how efficient the ACO is relative to its region as detailed in the table below.

Table 2: Regional Adjustment Factor Weighting by Contract Period

ACO Relative to Market	First Contract Period	Second Contract Period	Third Contract Period	Subsequent Contract Periods
More Efficient (lower spending than region)	35% of Regional Benchmark	50% of Regional Benchmark	50% of Regional Benchmark	50% of Regional Benchmark
Less Efficient (higher spending than region)	15% of Regional Benchmark	25% of Regional Benchmark	35% of Regional Benchmark	50% of Regional Benchmark

For renewing or re-entering ACOs that previously received a rebased historical benchmark under the current benchmarking methodology adopted in the June 2016 final rule, CMS would 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 would 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, under the policies CMS adopts in the final rule, 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.

CMS finalizes a symmetrical cap on the regional adjustment amount using a flat dollar amount equal to +/-5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program by enrollment type. The cap would be applied to both positive and negative adjustments.

3. *Benchmark Weighting*: Under the final rule CMS would continue to use weights of 10 percent, 30 percent, and 60 percent to weight the three BYs during the first contract period. In subsequent contract years, the benchmark years will be equally weighted.

4. *Trend Factors*: The final rule incorporates a national trend factor that is more independent of an ACO's own performance. CMS believes the national-regional blend would reduce the influence of the ACO's assigned beneficiaries on the ultimate trend factor applied. It would also lead to greater symmetry between the Shared Savings Program and Medicare Advantage which, among other adjustments, applies a national projected trend to update county-level expenditures.

   CMS will use a blend of national and regional trend factors (that is, the national-regional blend) to trend forward BY1 and BY2 to BY3 when determining the historical benchmark. The blended trend and update factors would apply to determine the historical benchmark 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. 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 1 minus the national weight.

MIPS/MACRA Impact: For 7/1/19 starters, participating in BASIC Levels A – D will still count as a Merit-Based Incentive Payment System (MIPS) APM while participating in BASIC Level E and the ENANCED Model will count as an Advanced Alternative Payment Model for purposes of qualifying for the 5 percent AAPM participation bonus.

Preventing "Gaming" of the System: In response to CMS's long held belief that some ACOs were "gaming" the system by taking advantage of the waivers without engaging in meaningful efforts to redesign care the final rule takes a number of steps to "protect the program." As discussed above, these include preventing ACOs that reform under new legal entities and new ACOs that contain 50 percent of its participants from the same ACO from starting over in the program in a low risk Track. Additional steps include:

1. *Financial Performance Review*: CMS adds a financial performance review criterion to evaluate whether the ACO generated losses that were negative outside of the Minimum Loss Rate (MLR) corridor for two PYs of the ACO's previous agreement period. CMS will use this criterion to evaluate the eligibility of ACOs to continue participating in the program starting with PYs beginning on July 1, 2019, and in subsequent years. For purposes of this provision, an ACO is negative outside its

corridor when its benchmark minus PY expenditures are less than or equal to the negative MSR for ACOs in a one-sided model, or the MLR for ACOs in a two-sided model.

Further, for ACOS that are in an agreement period starting in 2019, CMS will monitor performance on an ongoing basis. If the ACO is negative outside of the MLR corridor for a PY, CMS may take any of the pre-termination actions at its disposal. If the ACO is negative outside of the MLR corridor for another PY of the ACO's agreement period, CMS may immediately or with advance notice terminate the ACO's participation agreement.

2. Failure to Meet Quality Standards: ACOs with two consecutive years of failure to meet the program's quality performance standard will be terminated.

3. Early Termination: For PYs beginning on or after July 1, 2019, CMS will hold ACOs in two-sided models accountable for prorated losses if it terminates after June 30th. CMS will use the full 12 months of PY expenditure data in performing reconciliation for terminated ACOs with partial year participation. For those ACOs that generate shared losses, the shared loss amount will be pro- rated by the number of months during the year in which the ACO was in the program. Terminated ACOs would continue to receive aggregate data reports following termination, but, as under current policy, would lose access to beneficiary-level claims data and any payment rule waivers. For ACOs that are involuntarily terminated early, CMS will pro-rate shared losses for ACOs in two-sided models for any portion of the PY during which the termination becomes effective.

Beneficiary Notifications: Beginning on July 1, 2019, the final rule expands requirements related to beneficiary notification. Under this rule, an ACO participant would be required to provide this notice during a beneficiary's first primary care visit in the 6-month PY from July 1, 2019, through December 31, 2019, as well as the first primary care visit in the 12-month PY that begins on January 1, 2020 (and in all subsequent PYs). Additionally, MSSP participants would be required to notify beneficiaries of their right to decline claims data sharing.

Repayment Mechanism: The final rule modifies the regulations related to repayment mechanisms to reduce the administrative burden and ensure it does not pose a barrier to the continued participation of ACOs that have relatively little experience with risk.

For a Track 2 ACO, the repayment mechanism amount must be equal to at least one percent of the total per capita Medicare Parts A and B fee-for-service expenditures used to calculate the benchmark for the applicable agreement period, as estimated by CMS at the time of application.

For a BASIC track or ENHANCED track ACO, the repayment mechanism amount must be equal to the lesser of the following:

- one percent of the total per capita Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available; or

- two percent of the total Medicare Parts A and B fee-for service revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available.

For agreement periods beginning on or after July 1, 2019, CMS will recalculate the estimated amount of

the ACO's repayment mechanism arrangement before the second and each subsequent PY in the agreement period, as based on the certified participant list for the relevant PY.

If the recalculated repayment mechanism amount exceeds the existing repayment mechanism amount by at least 50 percent or $1,000,000, whichever is the lesser value, CMS notifies the ACO in writing that the amount of its repayment mechanism must be increased to the recalculated repayment mechanism amount. Within 90 days after receipt of such written notice from CMS, the ACO must submit, for CMS approval, documentation that the amount of its repayment mechanism has been increased to the amount specified by CMS.

Appendix I

TABLE 7—PARTICIPATION OPTIONS FOR LOW REVENUE ACOs BASED ON APPLICANT TYPE AND EXPERIENCE WITH RISK

		Participation Options[1]			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**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)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
New legal entity	Inexperienced	Yes - glide path Levels A through E; new legal entities (not reentering 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

		Participation Options[1]			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**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)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
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[2] 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[2] for new ACO identified as re-entering because of ACO participants' experience in the same ACO

		Participation Options[1]			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**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)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
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

Notes: [1] Low revenue ACOs may operate under the BASIC track for a maximum of two agreement periods.

[2] We consider the participation of the ACO in which a majority of the new ACO's participants were participating: (1) If the participation agreement of the other ACO was terminated, then the new ACO reenters the program at the start of the same agreement period in which the other ACO was participating at the time of termination from the Shared Savings Program, beginning with the first performance year of that agreement period. (2) If the participation agreement of the other ACO expired without having been renewed, then the new ACO re-enters the program under the other ACO's next consecutive agreement period in the Shared Savings Program. (3) If the other ACO is currently participating in the program, the new ACO would be considered to be entering into the same agreement period in which this other ACO is currently participating, beginning with the first performance year of that agreement period.

Appendix I – Continued

TABLE 8—PARTICIPATION OPTIONS FOR HIGH REVENUE ACOs BASED ON APPLICANT TYPE AND EXPERIENCE WITH RISK

		Participation Options[1]			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**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)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
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[2] for new ACO identified as re-entering because of ACO participants' experience in the same ACO

		Participation Options[1]			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**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)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
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[2] for new ACO identified as re-entering because of ACO participants' experience in the same ACO

		Participation Options[1]			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**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)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
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+ Model)	Yes	Subsequent consecutive agreement period

Notes: [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.

[2]We consider the participation of the ACO in which a majority of the new ACO's participants were participating: (1) If the participation agreement of the other ACO was terminated, then the new ACO reenters the program at the start of the same agreement period in which the other ACO was participating at the time of termination from the Shared Savings Program, beginning with the first performance year of that agreement period. (2) If the participation agreement of the other ACO expired without having been renewed, then the new ACO re-enters the program under the other ACO's next consecutive agreement period in the Shared Savings Program. (3) If the other ACO is currently participating in the program, the new ACO would be considered to be entering into the same agreement period in which this other ACO is currently participating, beginning with the first performance year of that agreement period.