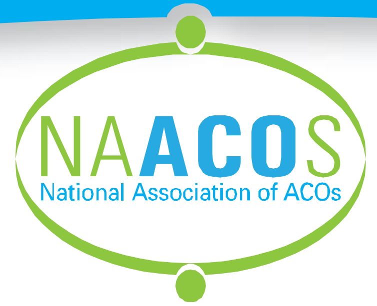

Overview

The Medicare Shared Savings Program (MSSP) is the primary Medicare ACO program. MSSP was permanently authorized by the Affordable Care Act following the accountable care concept's testing during the George W. Bush administration as the Physician Group Demonstration Project. The model officially launched in 2012. There have been numerous updates and modifications since then. Additional tracks were added in 2016 and 2018. The Centers for Medicare & Medicaid Services (CMS) revamped the program in 2018 and 2022.

This resource is meant to summarize the program's major pieces and serve as a guide for current and future ACOs. NAACOS offers resources to assist ACOs in pieces of MSSP not mentioned here, including guides on quality reporting requirements and the ACO Guide to MACRA. This resource only covers MSSP and is based on federal regulations governing MSSP. Information on other Medicare ACO initiatives and models tested under the CMS Innovation Center can be found elsewhere on the NAACOS website. Questions about this MSSP resource or any other ACO model or NAACOS resource can be directed to advocacy@naacos.com.

Key MSSP Terms

CMS determines what policies ACOs are eligible for on a few key factors discussed below. These include the level of risk ACOs must accept in a given year, eligibility for advance investment payments, and other financial incentives.

New, Renewing, and Re-entering
Participation options are determined in part based on whether CMS considers an ACO to be new, renewing or re-entering.

Renewing ACOs: Those that continue in the program for a consecutive agreement period without a break in participation and are either:
1. ACOs whose participation agreements expired, and they immediately enter new agreement periods to continue participation in the program; or
2. ACOs that terminated their current participation agreements, and they immediately enter new agreement periods to continue participation in the program.

Re-entering ACOs: Those that do not meet the definition of renewing ACO and are either:
1. The same legal entity that previously participated in the program and is applying to participate in the program after a break in participation because either (a) an ACO's participation agreement expired without having been renewed; or (b) an ACO's participation agreement was terminated; or
2. A new legal entity (that has never participated in the Shared Savings Program) with more than 50 percent of its ACO participants included on the ACO Participant List of the same ACO in any of the five most recent performance years prior to the agreement start date

New ACOs: Those that have never participated in the Shared Savings Program and are not identified as a re-entering ACO or a renewing ACO.

Experienced and Inexperienced
Participation options are also determined in part based on an ACO's experience with risk.

Experienced with Risk
1. The same legal entity as the current or previous ACO that is participating in, or has participated 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.

Inexperienced with Risk
1. A legal entity that has <u>not</u> participated in any performance-based risk Medicare ACO initiative; or
2. Less than 40 percent of the ACO's participants participated in a performance-based risk Medicare ACO initiative under a two-sided model in each of the 5 most recent performance years.

CMS defines performance-based risk in §425.20 as MSSP's Basic track (Levels A through E) prior to 2023, Levels C through E of the Basic track in 2023 or after, the Enhanced track, Track 2, Track 3, Track 1+, the Pioneer ACO Model, Next Generation ACO Model, Comprehensive ESRD Care Model two-sided risk tracks, or other initiatives involving two-sided risk that CMS specifies.

High Revenue and Low Revenue ACO Designations
In 2018 rulemaking, CMS established a policy the creates separate categories for "high revenue" and "low revenue" ACOs. This high-low revenue distinction determines program specifics such as who is eligible for advance investment payments. The high-low revenue distinction intends to give more favorable policies to low revenue ACOs, who are intended to be providers with less control over patient spending, with fewer financial resources, and more likely to be "physician-led" ACOs.

- **High revenue ACO** means an ACO whose total Medicare Parts A and B fee-for-service (FFS) revenue of its ACO participants is <u>at least 35 percent</u> 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 <u>less than 35 percent</u> of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.

The total ACO revenue of participants would be based on revenue for the most recent calendar year for which 12 months of data are available, as would the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries. CMS notifies ACOs if they are high or low revenue during the application process and before they sign a participation agreement. CMS states it anticipates providing information annually to ACOs within their agreement periods, particularly as part of the ACO participant list change request review cycles, about their ACO participants' Medicare FFS revenue so they will have information about the composition of their ACO. In the case that an ACO is initially identified as low revenue and subsequently becomes high revenue during the agreement period, CMS will allow the ACO to finish the performance year and to make participant list changes to attempt to retain low revenue status.

NAACOS has strongly advocated for CMS to revoke the high-low revenue distinction, which we feel is an arbitrary and unnecessary way to classify ACOs. Furthermore, a number of physician practices, particularly those with higher specialty participation, and a high proportion of safety-net providers like Federally Qualified Health

Centers, Rural Health Clinics, and Critical Access Hospitals are classified as "high revenue," signaling the distinction is not an accurate characterization of ability to control patient spending. All providers should have a level playing field to enter value-based payment models, and the high-low revenue distinction places a barrier to entry into MSSP.

"Sit-Out" Period
CMS in 2018 did away with the so-called "sit-out" period that had existed in the early days of MSSP. The removal of the sit-out period allows an ACO to voluntarily terminate its current participation agreement and (if eligible) enter a new agreement period beginning at the start of the next performance year, thereby avoiding an interruption in participation. CMS states the agency would consider these ACOs to have effectively renewed their participation early. Early renewal will be an option for all ACOs within a current agreement period within the MSSP.

Glide Path to Risk

In 2022, CMS made several changes to participation options for all ACOs. These include:
- Providing up to seven years in upside-only tracks for ACOs inexperienced with performance-based risk before being required to take on risk in the eighth year
- Allowing ACOs currently in upside-only tracks (Tracks A and B) to remain in upside-only for the duration of their agreement
- Making the Enhanced Track optional for all ACOs

CMS also extends this participation option to re-entering former Track 1 ACOs because these ACOs have not previously participated in the Basic Track glide path and CMS would like to encourage these ACOs to participate in the program again. ACOs continuing to meet the definition of inexperienced with performance-based risk may enter a second agreement period in the Basic Track's glide path if the following criteria are met:
- The ACO is the same legal entity as a current or previous ACO that previously entered into a participation agreement for the Basic Track's glide path only once; or
- For a new ACO identified as a re-entering ACO, the previous ACO (the ACO in which the majority of the re-entering ACO's participants were previously participating) entered into a participation agreement for the Basic Track's glide path only once.

Beginning in 2024, CMS will monitor ACOs identified as inexperienced with performance-based risk using a five-year rolling lookback period. CMS will monitor the ACO participant list to determine if the ACO could now be considered experienced with performance-based risk Medicare ACO initiatives, and thus ineligible for participation in a one-sided model. If an ACO is determined to meet the definition of having experience with performance-based risk, the ACO would be permitted to remain in its current track for the remainder of the performance year. The ACO would be required to advance to Basic Level E at the start of the next performance period.

TABLE A: Glide Path Options for Renewing ACOs

ACO type	ACO experienced or inexperienced with risk	Participation Options		
		First Agreement Period (or Subsequent for Period Periods Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
Renewing ACO	Inexperienced	A,B,C,D,E	E,E,E,E,E	Remain in Level E indefinitely, or move to ENHANCED track
Renewing ACO	Experienced - participated under Track 2, 3, BASIC Level C, D, or E, or ENHANCED track, the Track 1+ ACO Model, or another performance-based risk ACO initiative	E,E,E,E,E	E,E,E,E,E	Remain in Level E indefinitely, or move to ENHANCED track

TABLE B: Glide Path Options for Re-entering ACOs

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Period Periods Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
Re-entering ACO	Inexperienced- former BASIC track Level A or B	A,B,C,D,E	E,E,E,E,E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Inexperienced - former Track 1	A, A, A, A, A via one-time election prior to the start of the second performance yea	A,B,C,D,E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Experienced - participated under Track 2, 3, BASIC track Level C, D, or E, ENHANCED track, the Track 1+ ACO Model, or another performance-based risk ACO initiative	E,E,E,E,E	E,E,E,E,E	Remain in Level E indefinitely, or move to ENHANCED track

TABLE C: Glide Path Options for New ACOs

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Period Periods Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
New legal entity	Inexperienced	A, A, A, A, A	A,B,C,D,E via one-time election prior to the start of the second performance year	Remain in Level E indefinitely, or move to ENHANCED track
New legal entity	Experienced	E,E,E,E,E	E,E,E,E,E	Remain in Level E indefinitely, or move to ENHANCED track

TABLE D: Glide Path Options for Current ACOs

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Period Periods Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
Currently participating ACO in Level A or B for PY 2022	Inexperienced - BASIC track Level A or B	Current level (remain at A B for remainder of current agreement period)	A,B,C,D,E	Remain in Level E indefinitely, or move to ENHANCED track
ACOs in Level A or B with agreement periods beginning on January 1, 2023	Inexperienced - BASIC track Level A or B	Current level (remain at A B for remainder of current agreement period)	A,B,C,D,E	Remain in Level E indefinitely, or move to ENHANCED track

Shared Savings and Losses

MSSP allows ACOs to potentially earn shared savings or losses if they fall below or exceed their established financial benchmark. CMS altered the shared savings and loss rates for MSSP in 2018 rulemaking.

TABLE E: Shared Savings and Loss Rates for Basic Track ACOs

	Basic Track					Enhanced Track
	Level A	Level B	Level C	Level D	Level E	
Shared Savings Rates	Up to 40% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 40% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 50% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 50% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 50% sharing rate based on quality performance, not to exceed 10% of updated benchmark	Up to 75% sharing rate based on quality performance, not to exceed 20% of updated benchmark
Shared Loss Rates	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 in 2019 and 2020*	1st dollar losses at 40– 75%, not to exceed 15% of benchmark
	MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM

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

Quality Scores' Impact on Savings and Loss Rates

ACOs are evaluated on a number of quality measures, which allows CMS to assess the quality of care being provided to patients served by ACOs. These quality evaluations also determine whether an ACO is eligible to keep a portion of any financial savings it may generate, which is shared with CMS. Conversely, if shared losses are owed to CMS, the quality score determines the portion of losses the ACO must pay to CMS. MSSP ACOs are not required to report additional quality measures for MIPS beyond those included in the APM Performance Pathway (APP) set that are scored for both MSSP and MIPS quality assessments (when applicable). ACOs in the first year of their contracts are provided with full credit so long as the ACO completely and accurately reports all quality measures to CMS (pay-for-reporting). Each subsequent year, the ACO will be assessed on quality measure performance for each prescribed measure in the measure set (pay-for-performance). More information on quality reporting and scoring requirements are outlined in this resource.

Minimum Savings Rate and Minimum Loss Rate

In order to qualify for a shared savings payment, or to be responsible for sharing losses, an ACO's Medicare Parts A and B expenditures for its assigned beneficiaries in a given year must be below or above the updated benchmark, respectively, by at least the minimum savings rate (MSR) or minimum loss rate (MLR).

Under rule changes created in 2018, one-sided ACOs in the Basic Track have a variable MSR ranging from 3.9 percent for ACOs with 5,000 assigned beneficiaries to 2.0 percent for ACOs with 60,000 or more assigned beneficiaries. The variable MSR for those one-sided ACOs in the Basic Track is laid out in Table F below.

Table F: Determination of MSR by Number of Assigned Beneficiaries

Number of Beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
1-499	≥12.2	
500-999	12.2	8.7
1,000-2,999	8.7	5.0
3,000-4,999	5.0	3.9
5,000-5,999	3.9	3.6
6,000-6,999	3.6	3.4
7,000-7,999	3.4	3.2
8,000-8,999	3.2	3.1
9,000-9,999	3.1	3.0
10,000-14,999	3.0	2.7
15,000-19,999	2.7	2.5
20,000-49,999	2.5	2.2
50,000-59,999	2.2	2.0
60,000+	2.0	2.0

ACOs in a two-sided model will be able to select among three MSR/MLR options. An ACO will make this selection as part of the application cycle prior to entering a two-sided model, and this will be in effect for the duration of the agreement period that the ACO is under two-sided risk. The ACO must choose from the following options:

- 0 percent MSR/MLR
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0 percent
- Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO

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

Additional Shared Savings Opportunities for Low Revenue ACOs Below MSR

CMS will allow low revenue ACOs in the Basic Track the opportunity to earn some shared savings even if the ACO fails to meet or exceed its MSR. According to NAACOS analysis, a large number of ACOs generate savings for CMS but not enough to earned shared savings. This included 16 percent of MSSP ACOs in 2020, 22 percent in 2019, and 29 percent in 2018. Qualifying ACOs are eligible for half of their maximum shared savings rate as follows:

TABLE G: Shared Savings Rates for ACOs Failing to Meet their MSR

Risk Level	Maximum Shared Savings Rate if the MSR is Exceeded	Maximum Shared Savings Rate if the MSR is NOT Exceeded
Basic Levels A and B	40%	20%
Basic Levels C, D, and E	50%	25%

This option is not available for high revenue ACOs in the Basic Track nor any ACO in the Enhanced Track. This takes effect for ACOs beginning new agreement periods in 2024. To qualify, ACOs must still meet the quality performance standard or the proposed alternative quality performance standards. Similar to the approach used for ACOs that exceed MSR, the final savings rate would be multiplied by an ACO's health equity adjusted quality performance score.

Advance Investment Payments

As part of its efforts to grow participation in accountable care models and advance equity, CMS finalized new policies to provide certain MSSP ACOs advance shared savings payments, termed advance investment payments (AIPs) beginning in the 2024 performance year. NAACOS has called for such investments as a strategy to enable ACOs to effectively operate in under-resourced communities, close gaps in health equity, and address social drivers of health (SDOH). Largely modeled after the successes of the ACO Investment Model (AIM), AIPs will provide funding over the first two years of an ACO's agreement period, which will be recouped by CMS through any shared savings earned by the ACO.

Eligibility and Application
In order to be eligible to receive AIPs, an ACO must be:

- New and not identified as renewing or re-entering,
- Designated as low revenue,
- Identified as inexperienced with performance-based risk Medicare ACO initiatives, and
- Must have applied and be eligible to participate in Level A or B of the Basic Track.

ACOs will be required to apply for AIPs in conjunction with the annual MSSP application cycle, with the initial application cycle taking place in 2023 for a January 1, 2024, start date. CMS will provide preliminary information to applicant ACOs about eligibility to receive AIPs during the MSSP Phase 1 application cycle requests for information. As part of the application, ACOs will be required to submit supplemental information including a spend plan for the AIPs. CMS will provide guidance on required AIP application materials and there will be a feedback process to allow ACO applicants to revise or clarify applications if needed.

Duration and use of AIPs
AIPs will be paid over the first two years of an ACO's agreement period, and all AIPs must be spent within the five-year agreement period. Any unspent AIPs must be repaid to CMS at the end of the agreement period. ACOs that receive AIPs will be required to publicly report the spend plan and other details on the use of AIPs during each performance year.

CMS will limit the use of AIPs to investments in three specified categories: increased staffing, health care provider infrastructure, and the provision of accountable care for underserved beneficiaries, including SDOH strategies. ACOs will be prohibited from using AIPs for any non-permitted expenses, including management/parent company profits, salary augmentation or bonuses, the provision of medical services covered by Medicare, or to pay back shared losses. More details on the permitted uses of AIPs can be found in this CMS guidance.

Payment Methodology
AIPs will be comprised of two types of payments: a one-time upfront payment of $250,000 and eight quarterly payments calculated per-beneficiary for up to 10,000 assigned beneficiaries. CMS will calculate quarterly AIP

amounts prior to the start of each quarter using the latest available assignment list and to disburse quarterly AIPs at the beginning of each of the first eight quarters of the ACO's participation agreement.

The per beneficiary amounts will vary based on a risk factors-based score calculated by CMS, which is informed by dual eligibility status (DES), enrollment in the Medicare Part D low-income subsidy (LIS), and the Area Deprivation Index (ADI) national percentile ranking of the census block group of the beneficiary's primary address. CMS will calculate an ACO's quarterly payment amounts using the following steps:

1. Determine the ACO's assigned beneficiary population using the latest available assignment list
2. Assign each beneficiary a risk factors-based score:
    a. Beneficiaries with DES = score of 100 (out of 100)
    b. Beneficiaries with at least one month of Part D LIS enrollment = score of 100
    c. All other beneficiaries will be assigned a score (1–100) based on ADI
    d. For beneficiaries with insufficient data to assign a score, impute a score of 50
3. Determine each beneficiaries' payment amount based on the risk factors-based score:

Risk factors-based score	1-24	25-34	35-44	45-54	55-64	65-74	75-84	85-100
Payment amount	$0	$20	$24	$28	$32	$36	$40	$45

Source: Table 53 in the 2023 Medicare Physician Fee Schedule Final Rule

4. Sum per beneficiary payment amounts for each assigned beneficiary, capped at 10,000. ACOs with more than 10,000 beneficiaries will have their total quarterly payment amounts based on the 10,000 assigned beneficiaries with the highest risk factors-based scores.

Compliance, Monitoring, Termination, and Recoupment

CMS will monitor the spending of AIPs by comparing the ACO's spend plan against actual spending. If CMS determines that an ACO has used AIPs for a prohibited expense, CMS may immediately terminate the receipt of AIPs and take compliance action. CMS will monitor for changes in AIP ACOs' revenue and experience designations during the agreement period. If an AIP recipient becomes experienced and/or high revenue due to changes in the ACO participant list, CMS will cease paying AIPs. The ACO will have an opportunity to modify its participant list prior to the start of the next performance year to remain eligible for AIPs. If the ACO continues to be experienced and/or high revenue after a deadline specified by CMS, the ACO would be obligated to repay all spent and unspent AIPs.

CMS will recoup AIPs from any shared savings earned in any performance year until CMS has recouped all AIPs. This includes performance years in subsequent agreement periods. If an ACO does not earn shared savings in any agreement period, CMS will not recoup any AIPs. However, CMS will recoup any outstanding balance from a renewing or re-entering ACO that received AIPs in a previous agreement period. If an ACO terminates its participation agreement during the agreement period in which it received an AIP, the ACO must repay all AIPs received.

Financial Methodology

Financial benchmarks are a cornerstone of ACOs. They are the spending targets ACOs must hit in order to achieve shared savings or avoid shared losses. Its importance is equaled by its complexity. MSSP's financial methodology has evolved with the program. Below provides a summary, but not exhaustive explanation, of several of MSSP's benchmarking policies. Additional information on MSSP's financial methodology and assignment is available in this CMS guidance.

Setting benchmarks

CMS bases MSSP benchmarks on per capita Parts A and B FFS expenditures for beneficiaries that would have been assigned to the ACO in any of the three most recent years prior to the start of the agreement period. These

calculations include a three-month run out with completion factor and excludes indirect medical education, disproportionate share hospital payments, and the supplemental payment for Indian Health Service/Tribal hospitals and Puerto Rico hospitals. ACOs' benchmarks are trended forwarded each performance year to account for annual increases in Medicare spending.

CMS makes calculations for four beneficiary populations: those with end-stage renal disease (ESRD), disabled, those dually eligible for Medicare and Medicaid, and those who have simply aged into Medicare. Spending is truncated at the 99th percentile to minimize variation from catastrophically large claims. For ACOs in their first agreement period, benchmark years 1, 2, and 3 are weighed at 10 percent, 30 percent, and 60 percent respectively. For ACOs in their second or subsequent agreement period, the three benchmark years are weighted equally.

Regional adjustments

CMS incorporates a component of regional expenditures into benchmarks beginning with an ACO's first agreement period. An ACO's region is defined as counties from which an ACO has assigned beneficiaries for that year. The regional adjustment weights as follows:

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

The difference between the regional adjustment weights in the first three agreement periods depends on whether the ACO has spending higher or lower than that of its region. ACOs with spending higher than their region would receive the lower weight, and ACOs with spending lower than their region would receive the higher weight. The regional adjustment weight is capped at 50 percent. Further, CMS introduces a symmetric +/- 5 percent cap on the dollar amount of the regional adjustment, implemented separately for each beneficiary enrollment category. The cap is based on +/- 5 percent of national assignable per capita expenditures.

For ACOs that previously received a rebased historical benchmark, CMS will consider the agreement period the ACO is entering upon renewal or re-entry in combination with the weight previously applied to calculate the regional adjustment to the ACO's benchmark.

In 2022 rulemaking, CMS finalized a reduction in the cap on negative regional adjustments from -5 percent of national per capita FFS spending to -1.5 percent for agreement periods beginning in 2024 and after. This helps ACOs that have spending higher than their region and would receive a higher benchmark after the regional adjustment. CMS will keep the upward cap of +5 percent for ACOs that have lower spending than their region.

Accountable Care Prospective Trend

For agreement periods starting in 2024, CMS will add a prospective administrative growth factor called the "Accountable Care Prospective Trend" (ACPT) to update an ACO's benchmark for each performance year in an agreement period. This creates a new three-way blend, along with national and regional growth rates. The new three-way blend would be calculated as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for updating an ACO's historical benchmark between Benchmark Year 3 and the performance year. The new update factor would look as follows:

Two-way blend = (National Update Factor X National Weight) + (Regional Update Factor X [1 – National Weight])

Three-way blend = [PY1 ACPT X (1/3)] + [PY1 Two-Way Blend X (2/3)]

CMS will base the ACPT on the United States Per Capita Cost, which is already calculated by the CMS Actuary and used to base annual rate updates in Medicare Advantage. CMS would calculate ACPT projections at the start of an ACO's five-year agreement period. These projections are expected to be published in the spring of the first performance year. If projections are not uniform over the five-year period, the ACPT could be two or more numbers.

If an ACO generates losses under the three-way blend, CMS will recalculate an updated benchmark using the two-way national-regional blend. CMS will then use the lesser shared loss amount for an ACO's repayment responsibility and resulting financial performance monitoring policy. If the ACO generates losses under the three-way blend but savings under the two-way blend, the ACO will not be responsible for shared losses nor eligible for shared savings even if the ACOs minimum savings rate (MSR) was exceeded.

While ACPT projections would not change during an agreement, CMS will retain discretion to adjust the weight of the ACPT in the three-way blend if actual spending significantly deviated from projections. This could happen for unforeseen circumstances such as an economic recession, pandemic, or other factors. If CMS determines a need to protect against either excessive ACO shared savings or losses, CMS could reduce the weight of the ACPT from a third of an updated benchmark to as low as zero.

Accounting for an ACO's Prior Savings
Beginning in agreements that start in 2024, CMS will account for prior savings when establishing benchmarks for renewing and re-entering ACOs. CMS will calculate the simple average per capita savings or losses generated by an ACO during the three years that immediately precede the start of the performance period, the same three years that constitute its baseline. For these calculations, CMS will use all savings generated, not just savings that meet or exceed an ACO's MSR for that performance year. If an ACO is not eligible to receive a prior savings adjustment, the ACO will receive the regional adjustment to its benchmark. For re-entering ACOs, CMS will calculate prior savings on the performance of the ACO in which 50 percent or more of the ACO participants previously participated.

CMS will adjust prior savings amount depending on whether an ACO has higher or lower spending than its region.

- For ACOs with spending lower than the region. CMS will apply the higher of either (1) an ACO's positive regional adjustment or (2) a prior savings adjustment equal to the lesser of – (i) 50 percent of its prorated positive average per capita prior savings and (ii) 5 percent of national per capita FFS expenditures for assignable beneficiaries. Halving the prior savings adjustment accounts for ACOs' shared savings rates.
- For ACOs with spending higher than its region. CMS will add the prior savings adjustment (which will be a positive number) and the regional adjustment (which will be a negative number). If sum is positive, the ACO will receive half the prior savings adjustment capped at 5 percent of national FFS spending. If the sum is negative, ACOs receive the negative regional adjustment.

Risk Adjustment
CMS adjusts MSSP ACOs' benchmarks each performance year to account for the relative sickness of its assigned patients. CMS uses patients scores from the CMS Hierarchical Condition Category (CMS-HCC) prospective risk adjustment model. CMS caps risk score increases at +3 percent between the performance year renormalized risk score and the most recent benchmark year for all assigned beneficiaries. Please note that CMS does not employ a cap on negative risk score changes, citing concern for potential gaming issues. NAACOS has repeatedly advocated for CMS to permit meaningful increases in beneficiary risk scores over time. It is important to note

that 3 percent cap is across a five-year agreement period and is not a year-over-year increase. Risk ratios will be separately capped by 3 percent within each of the four beneficiary categories (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible).

Beginning in agreements that start in 2024, CMS will account for changes in demographic risk scores for an ACO's assigned population between Benchmark Year 3 and the applicable performance year before applying the 3 percent cap on positive HCC scores. Under the policy, the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) after CMS accounts for changes in demographic risk scores, which do not change and are not subject to coding intensity. While CMS will calculate a single cap level based on demographic risk scores for the four enrollment types, it will only apply the risk score cap for a particular enrollment type if the aggregate growth in HCC risk scores exceeds the value of the cap. This makes it less likely that risk scores for Medicare enrollment types with smaller populations (typically ESRD, disabled, and dual eligible beneficiaries) would be subject to the cap.

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 MSSP would be required to demonstrate their ability to repay losses by establishing a sufficient repayment mechanism. Repayment funds include money placed in escrow, a letter of credit, a surety bond, or a combination of those mechanisms.

The repayment mechanism amount must be equal to the lesser of the following:

- One-half (0.5) percent of the total per capita Medicare Parts A and B FFS expenditures for its assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available; or
- One percent of the 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.

An ACO may be required to adjust its repayment mechanism arrangement during its agreement period if the recalculated repayment mechanism amount exceeds the existing repayment mechanism amount by $1 million. An ACO's shared losses may be more or less than the repayment mechanism amount. If so, the ACO will be required to repay any remaining balance using alternative funding sources. CMS will annually recalculate the repayment mechanism amount estimates. Additional information is found in this CMS guidance.

Early termination
Effective January 1, 2020, CMS reduced the minimum notification period for early termination from 60 to 30 days. This allows ACOs considering termination to have three quarters of feedback reports, instead of two. CMS requires ACOs in two-sided models that voluntarily terminate after June 30 to share in losses. To calculate the pro-rated share of losses, CMS will multiply the amount of shared losses calculated for the performance year by the 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 will also pro-rate shared losses for ACOs in two-sided models that are involuntarily terminated by CMS for any portion of the performance year during which the termination becomes effective.

Monitoring
CMS monitors whether the expenditures for the ACO's assigned beneficiary population are "negative outside corridor," meaning that the expenditures for assigned beneficiaries exceed the ACO's updated benchmark by an amount equal to or exceeding either the ACO's negative MSR under a one-sided model or the ACO's MLR under a two-sided model. If the ACO is negative outside corridor for one performance year, the agency may take pre-termination actions, including requiring a corrective action plan. If the ACO is negative outside corridor for

another performance year of the ACO's agreement period, the agency may immediately or with advance notice terminate the ACO's participation agreement. However, CMS notes it anticipates taking into account certain relevant factors, such as an ACO's improvement over time, before imposing remedial action or termination for poor financial performance.

Beneficiary Assignment

Attribution is a foundational aspect of ACO models and identifies individual patients for whom ACOs take accountability for. Attribution also determines which beneficiaries are eligible for benefit enhancements such as telehealth visits and waivers of the requirement that patients have three-day inpatient hospital stay before a skilled nursing facility stay.

Medicare beneficiaries must have had at least one primary care service with a physician who is an ACO professional in the ACO and who is a primary care physician as defined under § 425.20 or who has one of the primary specialty designations included in paragraph (c) of this section. Patients are assigned to the ACO from which they receive the plurality of their care as based on allowed charges.

Codes used for assignment
Claims-based assignment is driven by analysis of utilization of primary care services. Primary care services are further defined as a specific set of qualified treatment codes, many of which are Evaluation and Management (E&M) codes. CMS uses more than 60 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for MSSP assignment and lists them in §425.400(c)(1). CMS regularly updates and adds to this list.

ACOs can choose between retrospective or prospective attribution and can annually change this choice prior to the start of each performance period. An ACO's historical benchmark would change based on attribution selection since the populations used to determine benchmark and performance year assignment would vary based on the ACO's choice. More information on the difference between retrospective or prospective attribution can be found in this NAACOS resource.

Retrospective Attribution
Preliminary prospective assignment with retrospective reconciliation, as it is more formally called, will attribute patients an ACO if allowed charges for primary care services from their ACO professionals are greater than allowed charges for primary care services furnished by ACO professionals in any other ACO or who are unaffiliated with an ACO. Patients must have at least one visit with a physician with specialty designations in §425.402(c) to be assigned to that ACO.

CMS preliminarily assigns beneficiaries at the beginning of a performance year based on most recent data available, and ACOs will receive an assignment list naming these preliminarily assigned beneficiaries. Assignment will be updated quarterly based on the most recent 12 months of data, and newly generated lists will be distributed to ACOs. For final assignment, the assignment window is the relevant 12-month calendar year.

Prospective Attribution
For these ACOs, CMS uses a process similar to that of retrospective assignment, which is based on where a beneficiary receives the plurality of primary care services. However, the timing of the assignment window is different. Prospective assignment is determined at the beginning of each benchmark and performance year based on the beneficiary's use of primary care services in the most recent 12 months for which data are available. The window ends up running roughly from October of the prior year to September just before the performance year.

This process results in a list of prospectively attributed beneficiaries that is provided to the ACO close to the start of each performance year and cannot be increased. Once a beneficiary is prospectively assigned to an ACO, the beneficiary is not eligible for assignment to a different ACO, even if they receive the plurality of their primary care in a different ACO during the relevant benchmark or performance year.

NAACOS offers different resources to help ACOs better understand the assignment process, including this one that better explains the pros and cons of retrospective versus prospective assignment and this resource that evaluates the potential bias in performance based on the two methods.

Voluntary Alignment
CMS also incorporates voluntary alignment into ACOs' attribution. Through voluntary alignment, beneficiaries can identify their "primary clinician," and, provided other criteria are met, such as receiving at least one primary care service during the assignment window from a physician in that ACO, then the beneficiary will be attributed to that provider's ACO, superseding any claims-based attribution. Designation is optional and done through MyMedicare.gov. Voluntary alignment first became an option for Performance Year 2018. More information on voluntary alignment is provided in this NAACOS resource.

The purpose of voluntary alignment is to encourage ACOs to work on establishing or confirming care relationships between ACO providers and beneficiaries. This allows ACOs to focus efforts and resources on segments of their beneficiary population that may not be aligned based on claims data but would benefit from a relationship with the ACO. It is important to note that voluntary beneficiary alignment does not obligate a beneficiary to receive care from a particular ACO, and the beneficiary still retains freedom to receive services from the Medicare provider of his/her choice.

Beneficiary Notification Requirements

CMS requires ACO participants post signs and provide an annual written notice to beneficiaries that its providers are participating in the MSSP. ACOs that selected retrospective assignment must furnish the written notice to all FFS beneficiaries and ACOs that have selected prospective assignment must furnish the notice to each prospectively assigned beneficiary. In 2022, CMS finalized several changes to the beneficiary notification requirements, including:

- Clarifying that beneficiary notification signs must be posted in all ACO participant facilities, regardless of whether primary care services are provided in each facility.
- Reducing the frequency of the annual standardized written notices from once per performance year to once per five-year agreement period. The standardized written notice must be furnished prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant.
- Establishing a new follow-up communication requirement in conjunction with the standard beneficiary notice. The communication may be written or verbal communication and must occur no later than the beneficiary's next primary care service visit or 180 days after the standardized written notice was provided. CMS clarified that the follow-up may be furnished via email or patient portal. ACOs will be required to track and document how the follow-up communication is implemented and make this documentation to CMS upon request. The requirement provides flexibility in how the follow-up is implemented so long as it includes a meaningful opportunity for beneficiaries to ask questions and engage with a representative of the ACO or ACO participant.

Waivers

SNF 3-Day Rule

All MSSP ACOs participating in a two-sided risk model may apply to CMS for a waiver that allows them to admit their patients into a skilled nursing facility (SNF) without a three-day inpatient hospitalization. ACOs must apply for the waiver during the annual application cycle. Partnering SNFs must have a rating of three stars or higher and must sign a SNF affiliate agreement with the ACO that includes certain elements outlined by CMS. Eligible SNFs include providers furnishing SNF services under swing bed arrangements. In these instances, the three-star quality rating requirement would be waived.

The SNF Waiver would be available 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 quarterly updates during the year for which SNF services are provided. Beneficiaries who are preliminarily prospectively assigned a to waiver-approved ACO will remain eligible to receive services furnished in accordance with the SNF Waiver for the remainder of that performance year unless they enroll in a Medicare group health plan or are otherwise no longer enrolled in Part A and Part B.

Telehealth

CMS allows certain ACOs to provide expanded access to telehealth services. Specifically, as required by the Bipartisan Budget Act of 2018, Medicare will waive its typical geographic restrictions for telehealth originating sites and count patients' homes as originating sites for ACOs under two-sided models who use prospective assignment and only on those ACOs' prospectively assigned patients.

There is no application process for ACOs to submit before starting to bill for these expanded telehealth services. CMS also provides a 90-day grace period for beneficiaries who are prospectively assigned to an applicable ACO at the start of the year, but who are subsequently excluded from assignment. ACOs must not bill excluded beneficiaries for telehealth services outside of the 90-day window or when not assigned, and/or they must return any money paid by the beneficiary. ACOs could be subject to a corrective action plan and program termination if they do not comply with such requirements. Finally, ACOs who terminate from the program must notify beneficiaries in their termination notices that the ACO can no longer supply telehealth services.

Beneficiary Incentive Program

CMS allows ACOs to establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying services. Through this program, ACOs may provide limited "cash equivalent" incentive payments to certain patients who receive qualifying primary care services under this beneficiary incentive program. This allows ACOs to provide incentive payments to eligible beneficiaries who receive qualifying services of up to $20 (adjusted annually for inflation). Payments cannot be in cash but rather must be provided as "cash equivalents," such as debit cards or checks. Payments must be provided within 30 days of a qualifying service and must be furnished by the ACO directly, not by its participants. Importantly, these incentive payments won't count as ACO expenditures or figure into benchmarks or shared losses.

To prevent "cherry picking" of healthier patients by ACOs with more resources, CMS is barring ACOs from advertising or marketing their incentive programs. However, ACOs must notify beneficiaries about their incentive program during the annual notification process, which will occur prior to or at the first primary care visit of the year. The beneficiary incentive program is available to all two-sided risk ACOs.