Partners In Care ACO
POWERED BY CONTINUUM HEALTH

2018 ACO Proposed Rule Outline

Medicare Shared Savings Program;

Accountable Care Organizations--Pathways to Success

Centers for Medicare & Medicaid Services 42 CFR Parts 414 and 425

[CMS-1701-P] RIN 0938-AT45

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Date: 8/22/18

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1. Program Design/Structure

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i. Transition

1. Restructure (Page 222)
   a. Discontinuing current Program Structure
   b. Forgoing the application cycle that otherwise would take place during calendar year 2018 for a 1/1/2019 Agreement start in lieu of new structure to begin on 1/1/2019.
   c. The Application cycle for the July 1, 2019 start date would begin in early 2019.
   d. The only exception are the several ACOs that entered initial agreements beginning in 2015 deferred renewal into a second agreement period by 1 year and will begin participating in a new 3-year agreement period beginning January 1, 2019 under a performance-based risk track.
2. Continuing ACOs (PY1/PY2)
   a. Track 1, Track 2, Track 3, or the Track 1+ Model, can choose whether to finish their current agreement or to terminate and apply to immediately enter a new Agreement Period through an "early renewal". (Page 146).
   b. Limitation - Track 1 & 2 ACOs may be involuntarily terminated based on Performance. See Outside Negative Corridor (Section 6G below).
3. New Entrant ACOs - Deferred start until July 1, 2019 with full Application; 6-month initial PY and total of 5.5 Years Agreement Period.
4. Anticipated Lapsers (ACOs with an Agreement Period start date of 1/1/2016 may elect to extend their agreement period for an optional fourth performance year (defined as the 6-month period from January 1, 2019 through June 30, 2019). Note, CMS would maintain financial reconciliation and quality performance determinations based on a 12-month calendar year period, but would pro-rate shared savings / shared losses for each potential 6-month period of participation during 2019.

ii. Deferred Renewal - discontinue some deferred renewal options (Page 53)

1. Track 1 – Deferral still available for Track 1 ACOs (Class of 2014/2015)
2. Track 2 - Discontinue ability to defer renewal for a 2nd Agreement Period in a two-sided model by 1 year (previously enabling 4th year of period and deferring rebasing)

iii. New Program Structure (Pages 51-52 and 61-65)
1. Replaces 3 Year Agreement Periods with 5 year Agreement Periods (5.5 for new entrants on 7/1/19)
2. Replaces ALL legacy Tracks with 2 Options;
   a. BASIC track - begin participation under one-sided model and incrementally phase-in risk. Can elect to enter at the highest risk level desired each performance year.
   b. ENHANCED track – Nearly same as current Track 3 structure; highest level of risk / reward
3. Glide Path - (Page 157) ACOs that previously participated in Track 1 of the Shared Savings Program or new ACOs, for which the majority of their ACO participants previously participated in the same Track 1 ACO, that are eligible to enter the BASIC track's glide path, may enter a new Agreement Period under either Level B, C, D or E.

iv. Variation from in-force rules – Proposal models original rules: (Page 61-62)
1. Subparts B-F and H and I
2. Add section for Benchmarking Methodology
3. Reopen determinations of Shared Savings/Losses to correct financial reconciliation calculations
4. Retain two-sided model rules for MSR/MLR and notification of losses and timing of repayment

2. Entry Determination Considerations

A. Program Participants will be assessed for Entry based on the following attributes (Page 102 -124 and Pages 162-165)
i. Low versus High Revenue
ii. Experienced versus Inexperienced with Performance-Based Risk (Page 150)
iii. Previous Agreement Period status
iv. Termination and Re-entry criterion

B. Definitions (Pages 170 – 173 and 151-154)
   i. "Low Revenue" – when total Medicare Parts A and B FFS revenue compared to total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries is less than 25%; for the same 12 month period. Limited to, at most, two Agreement Periods under the BASIC track.
   ii. "High Revenue" – when total Medicare Parts A and B FFS revenue compared to total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries is 25% or greater; for the same 12 month period
   iii. Performance-Based Risk Medicare ACO initiative – program implemented by CMS that requires an ACO to participate under a two-sided model during its Agreement Period (Track 2, Track 3 or the ENHANCED track, and the proposed BASIC track [including Level A through Level E], as well as Innovation Center Models [Pioneer, Next Gen and the performance based risk tracks of CEC; ESCOs and Track 1+] –specifically not Track 1 SSPs).
   iv. "Experienced with Risk Performance" (Pages 152-154)
      1. An ACO under the same legal entity as a current or previous ACO under in a performance-based risk Medicare ACO as defined under§ 425.20, or that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3 in accordance with § 425.200(e).
      2. An ACO with 40 percent or more of the ACO's Participant TINs in a Performance-Based Risk Medicare ACO initiative that deferred its entry into a second SSP Agreement Period under Track 2 or Track 3 in any of the 5 most recent performance years prior to the agreement start date. This includes circumstances for example where 20% of the Participants were from a Track 2 ACO and another 20% are from a Next Gen ACO.
   v. "Inexperienced with Risk Performance" (Pages 154-156)
      1. An ACO that has not participated in any Performance-Based Risk Medicare ACO initiative (specifically a Track 1 ACO) that has not deferred its entry into a second SSP Agreement Period in Track 2 or Track 3.
      2. An ACO with less than 40 percent of the ACO's TINs participating in a Performance-Based Risk Medicare ACO initiative or in an ACO that deferred its entry into a second SSP Agreement Period under Track 2 or Track 3 in each/any of the 5 most recent performance years prior to the agreement start date.

C. BASIC Track Determinations (Pages 112 – 117; 159)
   i. High Revenue & Inexperienced must enter BASIC Level E (Page 117)
   ii. Low/High Revenue & Inexperienced can enter anywhere in BASIC (or ENHANCED)
   iii. Track 1 Renewal/Re-entry not eligibility for Level A and must start in Level B (Page 159)

D. ENHANCED Track Determinations (Pages 112 – 117)
   i. High Revenue & Experienced must enter ENHANCED
   ii. Low/High Revenue & Inexperienced can enter into ENHANCED (or BASIC at any level)

E. Other Considerations
   i. ACOs moving from BASIC to ENHANCED could drop back to BASIC if they had not used their 2nd Agreement Period in BASIC (Page 115)

3. Participation/Entry Types (Page 125; Pages 131 – 140)

A. New ACOs – a new entity that has less than 50% of its Providers not having previously participating in the Shared Savings Program.
B. Renewing ACOs - an existing ACO that continues its participation in the program for a consecutive Agreement Period, without a break in participation, because either:
   i. The current participation agreement expires or after 12/31/2018 and the ACO immediately enters a new Agreement Period for 2020 to continue its participation in the program; or
   ii. The ACO terminates its current participation agreement and immediately enters a new Agreement Period without interruption to continue its participation in the program – starting 7/1/19 (aka "early entry").
C. Re-entering ACO – an Entity that has any previous experience in the SSP who does not meet the definition of "renewing"

4. Requirements for Performance Based Risk

A. General Minimum Savings Rate (MSR) / Minimum Loss Ratio (MLR) provisions;
   i. Applies to both one and two-sided models
   ii. ACOs may elect MSR/MLR levels annually; lower MSR/MLR provides less risk protection, but enables benefit from a corresponding lower threshold for eligibility for Shared Savings.
   iii. MSR / MLR Levels (Pages 187 and 576)
      1. Zero Percent
      2. Symmetrical – based on .5% increments between 0.5%–2.0%.
      3. Symmetrical – based on the number benes. Same as single-sided model (Minimum Loss Ratio MLR is equal to the negative MSR)
   iv. Timing - ACOs under the BASIC track's glide path in Level A or Level B to choose the MSR/MLR to be applied before the start of their first performance year in a two-sided model. This selection would occur before the ACO enters Level C, D or E of the BASIC track's glide path, depending on whether the ACO is automatically transitioned to a two-sided model (Level C) or elects to more quickly transition to a two-sided model within the glide path (Level C, D, or E).

5. Coordination of Pharmacy Care (Pages 455-456)

A. Seeking comments on collaboration to improve Part D (pharmacy care and opioid use)

6. Program Governance

A. Levels of Risk/Reward (Pages 66-69)
   i. Basic Track (max level same as Track 1+)
   ii. Levels A/B – one-sided model for first 2 consecutive performance years
   iii. Levels C-E – progressive risk

B. Automatic advancement policy (doesn't apply for New entrants until 2022) (Page 70)
   i. Track 1 (or a new ACO identified as a re-entering) 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.
   ii. Level E is required no later than Year 5 of the Agreement Period for new entrants, renewed entrants by Year 4

C. Discontinue the "sit-out" period for previously deferred or terminated/re-entry (Page 56)

D. Annual Elections
   i. Assignment Methodology (Page 62)– annual election of either Prospective or Retrospective with Reconciliation - with no effect on Voluntary Alignment
   ii. Risk Level (BASIC track) – option to participate in a higher levels of risk more rapidly than automatic advancement
      1. Establish and select a MSR/MLR (two-sided model only)

E. Repayment Provisions (Page 75 and Page 193)
   i. Revise the criterion governing the evaluation of whether an ACO under a two-sided model repaid shared losses owed to the program that were generated during the first 2 years of the previous Agreement Period (§ 425.224(b)(1)(v)), to instead consider whether the ACO failed to repay shared losses in full within 90 days in accordance with subpart G of the regulations for any performance year of the ACO's previous Agreement Period.
   ii. Extends use of current method into next Agreement Period
   iii. BASIC track - equal to the lesser of
      1. One 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
      2. Two 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.
   iv. Track 2 or Enhanced - Equal to at least 1 percent of the total per capita 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.
   v. Must be declared as part of the Annual Certification Process
   vi. ACOs entering an Agreement Period in Levels C, D, or E of the BASIC track's glide path must demonstrate the adequacy of its repayment mechanism prior to the start of its Agreement Period and at such other times as requested by CMS.

vii. ACOs entering an Agreement Period in Level A or Level B of the BASIC track's glide path must demonstrate the adequacy of its repayment mechanism prior to the start of any two-sided Level or Track. (Page 203)

viii. Repayment mechanism must be in effect for the duration of the ACO's participation in a two-sided model plus 24 months after the conclusion of the Agreement Period.

ix. CMS may require extensions

x. A Second repayment mechanism is available when an ACO has overlapping periods

xi. Must demonstrate ability by placing funds in escrow with an insured institution, obtaining a surety bond (Certified company) or establishing a line of credit that Medicare can draw on.

F. Condensed Application (Page 172)

i. Discontinue for certain applicants but seeking comments

G. Monitoring Financial Performance (Page 175)

ii. Add financial performance criterion to evaluate whether the ACO generated losses that were negative outside corridor period - under a one-sided model, or the ACO's MLR under a two-sided model..

1. Negative Outside Corridor (Page 177) when an ACOs expenditures exceed its Benchmark by an amount equal or greater than the MSR amount (known as the negative MSR - Page 144). For example, an ACO with a $100M Benchmark and an MSR of $4M has expenditures of $105M. The negative MSR is $4M and the expenditures are $1 greater than threshold.

H. Pre-Termination/Termination - Applicable in PY 2019 - If the ACO is negative outside corridor for a performance year, CMS may take any of the pre-termination actions set forth in § 425.216. Negative outside corridor for another performance year may immediately or with advance notice terminate the ACO's participation.

i. Pre-Termination / Deficiency Review (Page 144)

1. Add criterion to consider whether the ACO has demonstrated in its application that it has corrected the deficiencies that caused it to fail to meet the quality performance standard for 2 or more years, fail to timely repay shared losses, or to generate losses outside its negative corridor for 2 years, or any other factors that may have caused the ACO to be terminated from the Shared Savings Program.

2. Require processes to be put in place to ensure that it will remain in compliance with the terms of the new participation agreement. This replaces the need to identify in the application (causes for net losses) – will discontinue this policy.

I. Extreme and Uncontrollable Circumstances (Pages 412-436)
   i. Provisions for ACOs affected by natural disasters; extend policies to PY 2018 and subsequent years (Page 428)
   ii. Risk Adjustment and Performance would be measured differently if 20% or more of beneficiaries reside in an affected area, based on the GPRO Sample.

7. Program Integrity

A. Participation Options for 2019 (Page 220-269)
B. Anti-Gaming (Page 54)
   i. Determining eligibility for BASIC versus ADVANCED and determining Participation options and Glidepath progress - See Table 2 below (Page 77),
   ii. Must elect MSR/MLR in advance of the beginning of the Performance Year. (Page 185).
   iii. ACOs who Voluntarily Terminate after June 30th of a PY are subject to financial reconciliation.
   iv. Revise evaluation criteria for assessing prior participation of at least 5 Years (among other factors).
   v. New Entrants - Starting July 2019 – ACOs can enter BASIC glidepath for first 6 months and remain in PY 2 (through 2020), but must advance in 2021
   vi. Serial Re-Entry – to avoid ACOs from taking advantage of the higher weights used in calculating the regional adjustment, ACOs' benchmarks would be rebased, thereby mitigating this concern.
   vii. Limit high revenue ACOs toa single agreement period under the BASIC track.
   viii. Migration to High Revenue ACO - permitted to complete the PY under the BASIC track, ineligible to continue unless taking corrective action (for example by changing its ACO participant list).
      a. CMS could take compliance action (Page 111).
         ⇒ May issue a warning notice or request a corrective action plan (CAP)
         ⇒ May terminate the participation agreement for the next PY
   ix. ACOs with providers of 50% or greater who have participated in another ACO will be held accountable for past experience and will not be considered New ACOs, but rather Re-entry ACOs.
      1. Participant Splitting - If the ACO remains in the program under its current agreement past June 30, 2019, these ACO participants would not be eligible to be included on the ACO participant list of another ACO applying to enter a new Agreement Period under the program beginning on July 1, 2019. Annual Certification (Page 251)
      2. ACOs who shift from Prospective Assignment to Preliminary Prospective with Reconciliation will not be able to take advantage of the following;

C. Fee Enhancements (SNF Waiver and Telehealth Provisions)
   i. Regional Factors - changes in Participant List or Assignment Methodology will apply weighting of PY1 instead of the ACO's current PY.

D. Advanced Notice of Payment consequences (Pages 212 – 217)
   i. Reduced Notification from 60 days to 30 days

E. Pre-Termination / Termination
   i. Consequences – ACOs unable to meet requirements for accepting performance-based risk can be terminated.
   ii. Failure to meet 5K Benes (Page 187) –4% of ACOs are expected to fall below
      1. Subject to the pre-termination actions - CMS may require the ACO to submit a corrective action plan (CAP)
      2. While under a CAP an ACO remains eligible for shared savings and losses unless not exceeding 5K benes by the end of the PY whereby CMS terminates the ACO's participation agreement eliminating shared savings.

8. Risk and Loss Profiles

A. General rules on differing Levels of Risk (Page 90)
   i. Cannot move between BASIC and ENHANCED in the same Agreement Period
   ii. Remove sit-out period for re-entry after termination (Page 92)
   iii. Can annually elect

B. Shared Savings Proportions (Pages 69-73)
   i. Level A/B – 25% above MSR - not to exceed 10 percent of the ACO's updated benchmark
   ii. Level C – 30% - losses capped and set at 1 percent of the ACO's updated historical benchmark for the applicable performance year
   iii. Level D - 40% savings– 30% - losses capped and set at 2 percent of the ACO's updated historical benchmark for the applicable performance year
   iv. Level E - 50% savings– 30% - losses capped at 1 percentage point higher than the expenditure-based nominal amount (which is calculated as a percentage of the ACO's updated historical benchmark).
      1. Earns APM incentive payments and higher fee schedule updates starting in 2026;
      2. Regarding capping and the 8%; Example on Page 74; loss limit phase in begins at 5% of the ACO's Benchmark)

C. Loss Sharing Limit (Pages 78-83); See Table 3 (Page 82) for detailed breakdown
   i. Shift to Revenue-to-Benchmark Comparison (from Self-Reported Information) - The comparison of revenue to benchmark provides a more accurate method for determining ACO preparedness for additional risk than an ACO's self-reported information regarding the composition of its ACO participants and any ownership and operational interests in those ACO participants.
   ii. BASIC - percentage of ACO participants' total Medicare Parts A and B FFS revenue that is capped at a percentage of the ACO's updated historical benchmark expenditures when the amount that is a certain percentage of ACO participant FFS revenue (depending on the BASIC track risk/reward level) exceeds the specified percentage of the ACO's updated historical benchmark expenditures for the relevant BASIC track risk/reward level.
   iii. ENHANCED – calculated same as Track 1+ (see Table 4 Example - Page 86)
      1. 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 TIN, or a CCN enrolled in Medicare under the TIN, of each ACO participant in the ACO for the applicable performance year.
      2. Apply the applicable percentage under the proposed phase-in schedule (described in section II.A.3.b.2. of this proposed rule) to this total Medicare Parts A and B FFS revenue for ACO participants to derive the revenue-based loss sharing limit.

3. Use the applicable percentage of the ACO's updated benchmark, 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, based on the phase-in schedule. 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

9. Fee Enhancements (Page 62 and detail Pages 270-296)

A. SNF Waiver
   i. SNF Waiver (Page 62)- allow eligible ACOs under performance-based risk under either prospective assignment or preliminary prospective assignment with retrospective reconciliation to use the program's existing SNF 3-day rule waiver
   ii. Allows critical access hospitals (ACHs) to become eligible partner (swing bed arrangement)

B. Modifications to the existing SNF 3-day rule waiver (275)

B. Tele-health (Page 62 AND 282 - 296)
   i. General
      1. Telehealth Payment support (Page 62) - telehealth services furnished on or after January 1, 2020, by physicians and other practitioners participating in an ACO.
      2. Requires performance-based (Double-sided) risk and has selected prospective assignment only starting in 2020 (Page 287)
      3. Establishes regulations to govern telehealth services to prospectively assigned beneficiaries.
      4. Does not extend beyond the term of the Agreement period or if involuntarily terminated. ACOs must confirm this if providing Voluntary Term notice.
      5. Waive the requirements as necessary to provide for a 90-day grace period to allow for payment for telehealth services furnished to a beneficiary who was prospectively assigned to an applicable ACO, but was subsequently excluded from assignment to the ACO.
      6. CMS is NOT proposing a waiver for services delivered through asynchronous technologies (Page 295)

C. Operations Restrictions
   i. Cannot charge beneficiary if CMS makes "no payment" for the services
   ii. ACO participants must hold beneficiaries financially harmless for telehealth services that are not provided in compliance or during the 90-day grace period.
   iii. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service, when these conditions are met:
      1. Via an interactive telecommunications system, asynchronous (that is, store and forward) technologies,
      2. By Physician or other practitioner specified at § 410.78(b)(2) who is licensed to furnish the service under State law as specified at § 410.78(b)(1).
      3. Bene located at an originating site at the time the service being furnished via a telecommunications system occurs. The eligible originating sites are specified in section 1834(m)(4)(C)(ii) of the Act and § 410.78(b)(3) and, for telehealth services furnished during 2018, include the following: the office of a physician or practitioner, a CAH, RHC, FQHC, hospital, hospital-based or CAH-based renal dialysis center (including satellites), SNF, and community mental health center.

4. The originating site must be in a location specified in section 1834(m)(4)(C)(i) of the Act and § 410.78(b)(4). The site must be located in a health professional shortage area that is either outside of a MSA or within a rural census tract of an MSA.
5. Provision to treat the beneficiary's home as an originating site and not to apply the originating site geographic restrictions, making payment to a physician or practitioner billing though the TIN of an ACO participant (288).
6. ACO participants must not submit claims for services inappropriate to be furnished in the home (Example inpatient only; CPT codes G0406, G0407, G0408, G0425, G0426, and G0427 used for reporting inpatient hospital visits) though they may be included on the 2018 approved telehealth list.

10. Beneficiary Incentive Program (Page 296 - 322)

A. Structural
   i. Established to encourage patient engagement, promote care coordination and achieve objectives of the SSP. (Page 299)
   ii. Requires promulgation by the Secretary (Page 301)

B. General Requirements
   i. Requires application and can be terminated at any time by the CMS
   ii. Dual-side model only; either prospective or preliminary prospective (Page 302)
   iii. Benes to be notified at first primary care visit each year and posters in office for ability to opt-in to the ACO.
   iv. Designated for beneficiaries who receive qualifying primary-care services in order to encourage Medicare FFS beneficiaries to obtain medically necessary primary care services. Qualifying service defined as primary care service with respect to coinsurance applies under Part B. Acceptable services include:
      1. Vouchers for over the counter meds
      2. Transportation
      3. Access to meal programs for those with malnutrition
      4. Wellness programs
      5. Vouchers for chronic disease
      6. Phone apps, calendars and other reminder systems to promote adherence
      7. Others

C. Incentive Payment restrictions and guidelines (Pages 311-314);
   i. Payments shall not exceed the cost of the service or a $20 max (updated annually based on CPI). Not applicable to calculating benchmarks, expenditures or savings. Can be furnished each time the bene receives a qualifying service.
   ii. Incentive payment be made no later than 30 days after qualifying service is incurred.
   iii. Incentive payments must be an equal amount, not higher-valued for particular services. (Page 310)
   iv. Maintain records with minimum MBI, Amount, Date, HCPCS code, TIN of service provider and Date of Payment.
   v. Payment Sourcing must consider the following;
      a. ACO TIN to make payment, not Participants
      b. Cannot source funding from outside entities
      c. Cannot shift costs to any plan or program that provides health benefits.

D. Reporting and Disclosures
   i. Revise the program's public reporting requirements in §425.308 to require any ACO that has been approved to implement an Incentive Payment Program.
   ii. Activity is reportable to the Secretary, including the amount and frequency of incentive payments made and the number of Medicare fee-for-service beneficiaries receiving such payments.

11. Beneficiary Choice (Page 323)

A. CMS considering various alternatives for Opt-In Methodology of Assignment (Pages 330-351)

B. Voluntary Alignment Provisions (Page 95 and 392 - 398)

i. Permits a Medicare FFS beneficiary to voluntarily identify an ACO professional as their primary care provider for purposes of assignment to an ACO when meeting the eligibility criteria established at § 425.401(a) and is not excluded from assignment by the criteria in § 425.401(b),

ii. Supersedes claims based assignments and remain in place, regardless of whether the PCP has any services during the PY;

iii. May only be changed by the beneficiary via Medicare.com and are effective in the subsequent Performance Year. (Pages 394 and 398)

iv. Assignments remain in place during the ACO's entire agreement period and any subsequent agreement periods even if the beneficiary no longer seeks care from any ACO. (Page 397)

v. Removes the requirement for having at least one primary care service during the assignment window with an ACO professional in the ACO who is a primary care physician or a physician with one of the primary specialty designations included in § 425.402(c). (Page 396)

vi. Removes the restriction on designated primary care specialties, allowing assignment regardless of specialty. (Page 395)

vii. Assignment is suppressed from ACO in the current PY when bene is also participating in a CEC Model (Innovation Center Model). Such beneficiaries will be added prospectively to the ACO's list of assigned beneficiaries for the subsequent performance year.

viii. Expand to a broader range of professionals as PCP (find this Page 396-398)

ix. Beneficiary designations of clinicians outside the ACO as their primary clinician suppress the bene in the next PY. §425.402(e)(2)(iv).

C. Notification (Pages 326)

i. Provider Responsibility

1. Must notify benes about providers' participation in SSP, Voluntary Alignment and ability to decline data sharing.
2. Must be at first primary care visit of each PY starting 2020 (unless early renewal)
3. Participants must use a CMS-developed template notice that encourages beneficiaries to check their designation regularly and to update their designation when they change care providers or move to a new area.
4. Notification must be to all FFS benes, not just SSP (Page 326)

ii. CMS Responsibility

1. CMS to provide mandatory templates
2. Comprehensive Resources - secretary to establish a process to notify of benes ability to identify their PCP and informed of how to do so and a comprehensive resource on program info and how participation is beneficial

12. Benchmarking Methodology (Page 352 - 390)

A. Risk adjustment methodology (Page 359) - better accounting for certain health status changes by using full CMS-Hierarchical Condition Category (HCC) risk scores to adjust the benchmark each performance year, although restricting the upward and downward effects of these adjustments to positive or negative 3 percent over the new Agreement Period.
   i. CMS-HCC prospective risk scores for both Demographic and Conditions will be used to adjust the historical benchmark for all assigned beneficiaries (including both newly and continuously enrolled beneficiaries, as opposed to the current method whereby only newly enrolled beneficiaries apply both Demographic and Conditions while continuously enrolled are limited to the Demographic portion only.
   ii. Subject to a symmetrical cap of positive or negative 3 percent. The cap would reflect the maximum change in risk scores allowed in an Agreement Period between BY3 and any performance year in the Agreement Period.
   iii. Applies to ACOs participating in either a 5 or 5.5 year Agreement Period.

B. Regional Factors (Page 363)
   i. Current State - CMS applies a regional adjustment to the rebased historical benchmark for ACOs entering a second or subsequent Agreement Period in 2017 or later years. This adjustment reflects a percentage of the difference between the regional FFS expenditures in the ACO's regional service area and the ACO's historical expenditures. The percentage used in calculating the adjustment is phased-in over time, ultimately reaching 70 percent.
   ii. CMS Position - CMS proposes to reduce the Maximum Regional adjustment but states that because the availability of the adjustment has longevity over several Agreement Periods ACOs will still experience a benefit. (Page 374)
   iii. Redesign (Pages 373 – 376) - includes application of factors based on regional FFS expenditures to establish, adjust, and update the ACO's benchmark beginning in an ACO's first Agreement Period, to move benchmarks away from being based solely on the ACO's historical costs and allow them to better reflect costs in the ACO's region. This mitigates the effects of excessive positive or negative regional adjustment used to establish and reset the benchmark by;
      1. Reducing the maximum weight used in calculating the regional adjustment from 70 percent to 50 percent (within the existing phase-in schedule for applying increased weights in calculating the regional adjustment);

C. Regional Adjustment Phase-Ins (162- 168)
   i. New Entrants
      1. Historical benchmark would be weighted BY1-3 (10/30/60)
      2. Regional adjustment 25% or 35% (based on whether it is higher or lower spending compared to its regional service area) – more detail below
   ii. Re-entry
      1. Expired Non-renewals – treated as if it was continuously renewing
      2. Terminated – treated as if starting over in the same Agreement Period
      3. Re-entering due to 50% ACO Participants – treated as if starting over in the same Agreement Period as previous ACO
   iii. Renewal – treated as if entering next consecutive Agreement Period

iv. Phase-in for Regional Adjustment (Page 372)
    1. First time - weight of 35% if spending lower than region; 25% percent if higher
    2. Second time - weight of 50% if spending lower than region; 35% percent if higher
    3. Third Time - weight of 50% if spending lower than region; 50% percent if higher
v. Instituting a 5% cap, of national per capita FFS (Part A and Part B) for BY3 (assignable benes) based on Enrollment Type. See Table 12 below. (Page 376).
    1. Restrictions
        a. If changes in Participant List or Assignment Methodology, same weights as PY 1
        b. Renewing or Re-entering ACOs will use weighting previously applied

D. Growth Rate Calculation (Page 360 and 378 – 391) – trends expenditures to establish the benchmark and in updating the benchmark each performance year as a blend of regional and national expenditure growth rates with increasing weight placed on the national component of the blend as the ACO's penetration in its region increases.
i. Blend of national and regional trend factors to trend forward BY1 and BY2 to BY3 when determining the historical benchmark.
ii. Blend of national and regional update factors to update the historical benchmark to the performance year.
iii. 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.
iv. Upon changes to Participant List or Assignment Methodology the weight that is applied to the national and regional components of the blended trend and update factors would be recomputed to reflect changes in the composition of the ACO's assigned beneficiary population.

E. Expand Definition of Primary Care Services Pages (402-404)
i. Addition of HCPCS/CPT Codes; includes the following services;
    1. Care provided in Nursing Facilities, patient domiciliary, rest home or custodial care
    2. AWV, TCM and CCM
    3. Behavioral health integration
    4. Advance care planning
    5. Health risk assessment
    6. Prolonged E&M psychotherapy
    7. Annual depression screening
    8. Alcohol misuse and counseling
    9. 3 new HCPCS codes
        a. Visit complexity primary care
        b. Visit complexity endo, rheum, hemonc, urology, neurology, OB/Gyn, etc.
        c. Prolonged E&M psychotherapy
ii. Better determination of E&M services furnished in a SNF

13. Program Data and Quality Measures

A. Promoting Interoperability (Page 448-454)
   i. For PYs starting on January 1, 2019, and subsequent performance years APMs (not Advanced APMs) must certify upon application as part of the annual certification process that at least 50 percent of the eligible clinicians (ECs) participating in the ACO use CEHRT.
   ii. Advanced APMs must meet the CEHRT criterion of QPP
   iii. This new requirement should replace the current ACO quality measure that assesses the Use of Certified EHR Technology (ACO-11) and discontinues use of double-weighting quality measure for Promoting Interoperability PIC (ACO-11).
   iv. CMS finalized a separate Advanced APM CEHRT use criterion that applies for the Shared Savings Program at § 414.1415(a)(1)(ii). To meet the Advanced APM CEHRT use criterion under the Shared Savings Program, a penalty or reward must be applied to an APM Entity based upon the degree of CEHRT use among its eligible clinicians. (Page 454).

B. Quality Measure Changes (Separate Proposed Rule)

14. Extra Content referenced

Pre-Participation Waivers – see link
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/2019-Pre-Participation-Waiver-Guidance.pdf

15. Collection of Information Requirements (Title III) (Page 469) –

A. Placeholder

16. Regulatory Impact Analysis (Title IV) – (Page 469-510)

A. Statement of Need
B. Overall Impact
C. Anticipated Effects

17. Response to Comments & Document Administration

(Pages 510-607 - the end)

18. Document management logistics – (no content)

V. Tables

1. TABLE 1—ACOS BY TRACK AND NUMBER OF ASSIGNED BENEFICIARIES FOR PERFORMANCE YEAR 2018

Track	Number of ACOs	Number of Assigned
Track 1	460	8,147,234
Track 1+ Model	55	1,212,417
Track 2	8	122,995
Track 3	38	993,533
Total	**561**	**10,476,179**

2. TABLE 2—COMPARISON OF RISK AND REWARD UNDER BASIC TRACK AND ENHANCED TRACK

	BASIC Track's Glide Path				ENHANCED Track (Current Track 3)
	Levels A & B (one-sided model)	**Level C (risk/reward)**	**Level D (risk/reward)**	**Level E (risk/reward)**	
Shared Savings (once MSR met or exceeded)	1st dollar savings at a rate of up to 25% based on quality performance; not to exceed 10% of	1st dollar savings at a rate of up to 30% based on quality performance, not to exceed 10% of updated	1st dollar savings at a rate of up to 40% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (once MLR met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (for example, 8% of ACO participant revenue in 2019 – 2020), capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard (for example, 4% of updated benchmark in 2019 – 2020	No change. 1st dollar losses at a rate of 1 minus final sharing rate (between 40% - 75%), not to exceed 15% of updated benchmark

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3. (CONTINUED) TABLE 2—COMPARISON OF RISK AND REWARD UNDER BASIC TRACK AND ENHANCED TRACK

	BASIC Track's Glide Path				
	Levels A & B (one-sided model)	**Level C (risk/reward)**	**Level D (risk/reward)**	**Level E (risk/reward)**	**ENHANCED Track (Current Track 3)**
Annual choice of beneficiary assignment methodology? (see section II.A.4.c)	Yes	Yes	Yes	Yes	Yes
Annual election to enter higher risk? (see section II.A.4.b)	Yes	Yes	No; ACO will automatically transition to Level E at the start of the next performance	No; maximum level of risk / reward under the BASIC track	No; highest level of risk under Shared Savings Program
Advanced APM status under the Quality Payment Program? [1, 2]	No	No	No	Yes	Yes

Notes:

[1] To be an Advanced APM, an APM must meet the following three criteria: 1. CEHRT criterion: requires participants to use certified electronic health record technology (CEHRT); 2. Quality Measures criterion: provides payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and 3. Financial Risk criterion: either (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses. See, for example Alternative Payment Models in the Quality Payment Program as of February 2018, available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource- Library/Comprehensive-List-of-APMs.pdf. [2] As proposed, BASIC track Levels A, B, C and D would not meet the Financial Risk criterion and therefore would not be Advanced APMs. BASIC track Level E and the ENHANCED track would meet all three Advanced APM criteria and thus would qualify as Advanced APMs. These preliminary assessments reflect the policies discussed in this proposed rule. CMS will make a final determination based on the policies adopted in the final rule.

4. TABLE 3—DETERMINATION OF LOSS SHARING LIMIT BY SELF-REPORTED COMPOSITION VERSUS CLAIMS-BASED APPROACH FOR TRACK 1+ MODEL APPLICANTS

Approach to determining loss liability	Revenue-based loss sharing limit	Benchmark-based loss sharing limit
Use of applicants' self-reported composition (Track 1+ Model approach)	34%	66%
Use of claims: percentage of ACO participant revenue compared to percentage of ACO benchmark	38%	62%

In this scenario, the ACO's loss sharing limit would be set at $1,090,479 (8 percent of ACO participant revenue) because this amount is less than 4 percent of the ACO's updated historical benchmark expenditures.

5. TABLE 4—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

6. TABLE 5—EXAMPLES OF PHASE-IN OF PROPOSED REGIONAL ADJUSTMENT WEIGHTS BASED ON AGREEMENT START DATE AND APPLICANT TYPE

Applicant Type	First time regional adjustment used: 35 percent or 25 percent (if spending above region)	Second time regional adjustment used: 50 percent or 35 percent (if spending above region)	Third and subsequent time regional adjustment used: 50 percent weight
New entrant with start date on July 1, 2019	Applicable to first Agreement Period starting on July 1, 2019	Applicable to second Agreement Period starting in 2025	Applicable to third Agreement Period starting in 2030 and all subsequent Agreement Periods
Renewing ACO for Agreement Period starting on July 1, 2019, with initial start date in 2012, 2013, or 2016	Applicable to third (2012/2013) or second (2016) Agreement Period starting on July 1, 2019	Applicable to fourth (2012/2013) or third (2016) agreement period starting in 2025	Applicable to fifth (2012/2013) or fourth (2016) agreement period starting in 2030 and all subsequent Agreement Periods
Early renewal for Agreement Period starting on July 1, 2019, ACO with initial start date in 2014 that terminates effective June 30, 2019	Currently applies to second Agreement Period starting in 2017	Applicable to third Agreement Period starting on July 1, 2019	Applicable to fourth Agreement Period starting in 2025 and all subsequent Agreement Periods

7. (CONTINUED) TABLE 5—EXAMPLES OF PHASE-IN OF PROPOSED REGIONAL ADJUSTMENT WEIGHTS BASED ON AGREEMENT START DATE AND APPLICANT TYPE

Applicant Type	First time regional adjustment used: 35 percent or 25 percent (if spending above region)	Second time regional adjustment used: 50 percent or 35 percent (if spending above region)	Third and subsequent time regional adjustment used: 50 percent weight
Re-entering ACO with initial start date in 2014 whose agreement expired December 31, 2016 (did not renew) and re-enters second Agreement Period starting on July 1, 2019	Applicable to second Agreement Period starting on July 1, 2019 (ACO considered to be re-entering a second Agreement Period)	Applicable to third Agreement Period starting in 2025	Applicable to fourth Agreement Period starting in 2030 and all subsequent Agreement Periods
Re-entering ACO with second Agreement Period start date in 2017 terminated during performance year 2 (2018) and re-enters second Agreement Period starting on July 1, 2019	Applicable to second Agreement Period starting on July 1, 2019 (ACO considered to be re-entering a second Agreement Period)	Applicable to third Agreement Period starting in 2025	Applicable to fourth Agreement Period starting in 2030 and all subsequent Agreement Periods

8. TABLE 6—PARTICIPATION OPTIONS FOR LOW REVENUE ACOs BASED ON APPLICANT TYPE AND EXPERIENCE WITH RISK

Applicant Type	**ACO experienced or inexperienced with performance- based risk**	**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	**BASIC track's Level E** (track's highest level of risk / reward applies to all performance years during Agreement	**ENHANCED track** (program's highest level of risk / reward applies to all performance years during	
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

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9. (CONTINUED) TABLE 6—PARTICIPATION OPTIONS FOR LOW REVENUE ACOs BASED ON APPLICANT TYPE AND EXPERIENCE WITH RISK

Applicant Type	**ACO experienced or inexperienced with performance-based risk**	**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)	
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
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.

10. TABLE 7—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	**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

11. (CONTINUED) TABLE 7—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 AP)	**BASIC track's Level E** (track's highest level of risk / reward applies to all performance years during AP)	**ENHANCED track** (program's highest level of risk / reward applies to all performance years during AP)	
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

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 the ENHANCED track for subsequent Agreement Periods.

12. TABLE 8—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

13. TABLE 9—AVAILABILITY OF PROPOSED PAYMENT AND PROGRAM POLICIES TO ACOs BY TRACK

Policy	Policy Description	Track 1 (One-sided model; Propose to discontinue)	Track 2 (Two-sided model; Propose to discontinue)	Track 1+ Model (Two-sided model)	BASIC track (Proposed new track)	ENHANCED track (Proposed; current track 3 financial model)
Telehealth Services furnished §1899(l) of the Act	Removes geographic limitations and allows the beneficiary's home to serve as originating site for prospectively assigned beneficiaries	N/A (because this is a one-sided model under preliminary prospective assignment)	N/A (because under preliminary prospective assignment)	Proposed requirements for performance year 2020 and onward (prospective assignment) [1]	Proposed requirements for performance year 2020 and onward, applicable for performance years under a two-sided model (prospective assignment)	Proposed requirements for performance year 2020 and onward (prospective assignment)
SNF 3-Day Rule Waiver [2]	Waives the requirement for a 3-day inpatient stay prior to admission to a SNF affiliate	N/A (unavailable under current policy)	N/A (unavailable under current policy)	Current policy (prospective assignment)	Proposed for performance years beginning on July 1, 2019 and subsequent years, eligible for performance years under a two-sided model (prospective or preliminary prospective assignment)	Proposed for performance years beginning on July 1, 2019 and subsequent years (prospective or preliminary prospective assignment)

Notes:

[1] An amendment to the Track 1+ Model Participation Agreement would be required to apply the proposed policies regarding the use of telehealth services under §1899(l) to Track 1+ Model ACOs as described in section II.F of this proposed rule.

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

14. TABLE 10—ABILITY OF ACOs TO ESTABLISH A PROPOSED BENEFICIARY INCENTIVE PROGRAM BY TRACK

Policy	Policy Description	Track 1 (One-sided model; Propose to discontinue)	Track 2 (Two-sided model; Propose to discontinue)	Track 1+ Model (Two-sided model)	BASIC track (Proposed new track)	ENHANCED track (Proposed; current track 3 financial model)
Beneficiary Incentive Program	Requires ACOs that establish a beneficiary incentive program to provide an incentive payment to each assigned beneficiary (prospective or preliminary prospective) for each qualifying service received	N/A	Proposed beginning July 1, 2019 and for subsequent performance years (preliminary prospective assignment)	N/A	Proposed beginning July 1, 2019 and for subsequent performance years for ACOs in Levels C, D or E (prospective or preliminary prospective assignment)	Proposed beginning July 1, 2019 and for subsequent performance years (prospective or preliminary prospective assignment)

15. TABLE 11—HYPOTHETICAL DATA ON APPLICATION OF AGREEMENT PERIOD CAP ON PY TO BY3 RISK RATIO

Medicare Enrollment Type	BY3 Renormalized CMS-HCC	PY Renormalized CMS-HCC	Risk Ratio before Applying Cap	Final Risk Ratio
ESRD	1.031	1.054	1.022	1.022
Disabled	1.123	1.074	0.956	0.970
Aged/dual eligible	0.987	1.046	1.060	1.030
Aged/non-dual	1.025	1.001	0.977	0.977

In the example, the decrease in the disabled risk score and the increase in the aged/dual risk score would both be subject to the positive or negative 3 percent cap. Changes in the ESRD and aged/non-dual risk scores would not be affected by the cap; the ACO would receive full upward and downward adjustment, respectively, for these enrollment types.

16. TABLE 12—HYPOTHETICAL DATA ON APPLICATION OF CAP TO REGIONAL ADJUSTMENT AMOUNT

Medicare Enrollment Type	Uncapped Adjustment	National Assignable FFS Expenditure	5 percent of National Assignable FFS Expenditure	Final Adjustment
ESRD	$4,214	$81,384	$4,069	$4,069
Disabled	-$600	$11,128	$556	-$556
Aged/dual eligible	$788	$16,571	$829	$788
Aged/non-dual	-$367	$9,942	$497	-$367