American Hospital Association™
Advancing Health in America

Regulatory Advisory

January 16, 2019

Medicare Shared Savings Program Final Rule: Accountable Care Organizations-Pathways to Success

At A Glance

At Issue:
On Dec. 21, the Centers for Medicare & Medicaid Services (CMS) issued its final rule on the Medicare Shared Savings program (MSSP). The rule, called "Pathways to Success," finalizes changes to the MSSP, including to the structure of payments made to accountable care organizations (ACOs) and other aspects of participation in the MSSP. The final rule was published in the Dec. 31 Federal Register. The changes in the rule build upon the MSSP policies that CMS finalized in November of last year in the calendar year 2019 physician fee schedule final rule.

Our Take:
While we appreciate CMS's efforts to expand participants' ability to care for beneficiaries, such as through expanded access to telehealth waivers and longer agreement periods, we are disappointed CMS drastically shortened the length of time in which ACOs can participate in an upside-only model. And, although CMS slightly improved its shared savings rate policies from the proposed rule, they still are not adequate to reward ACOs appropriately for improving quality and reducing costs. Thus, the AHA is concerned that the policies in the final rule will hamper the ability of MSSP ACOs to provide high-value, coordinated care to their patients and will result in decreased participation in the MSSP, undercutting ACOs' contribution to the transition to value-based care. We are particularly concerned about the impact of these policies on high-revenue ACOs.

Key Takeaways

The final rule will:

- **Participation Options:** Redesign the MSSP to include only two Tracks – BASIC and ENHANCED.
- **Agreement Period:** Increase the length of agreement periods to at least five years.
- **Risk and Reward:** Reduce shared savings rates for upside-only models from 50 to 40 percent.
- **Upside-only Risk:** Allow a maximum of two to three years in upside-only risk.
- **Low- and High-revenue ACOs:** Differentiate between "low-" and "high-revenue" ACOs and require high-revenue ACOs to take on more risk more quickly.
- **Assignment Methodology:** Permit ACOs to annually elect their beneficiary assignment methodology.
- **Benchmarking Methodology:** Expand the use of regional factors in the benchmarking methodology.
- **Risk Adjustment:** Cap risk score growth at 3 percent, but allow ACOs' risk scores to decrease by an unlimited amount.
- **Waivers:** Increase access to waivers of telehealth and other Medicare payment requirements.
- **Beneficiary Incentives:** Enable ACOs to establish beneficiary incentive programs.

What You Can Do:

- ✓ **Review the AHA members-only webinar on the final rule that was held on Friday, Jan. 11.**
- ✓ Submit a notice of intent to apply by Jan. 18 if you intend to participate in the redesigned MSSP on July 1, 2019.
- ✓ Share this advisory with your chief medical officer, chief financial officer and other members of your senior management team, as well as your ACO leadership team and others involved in shared savings arrangements.
- ✓ Assess the potential impact of the changes on your Medicare ACO participation.

Further Questions:
For additional questions, please contact Shira Hollander, senior associate director for policy development, at (202) 626-2329 or shollander@aha.org.

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Background

On Dec. 21, the Centers for Medicare & Medicaid Services (CMS) issued its final rule on the Medicare Shared Savings program (MSSP). The rule – called "Pathways to Success" – finalizes changes to the MSSP, including to the structure of payments made to accountable care organizations (ACOs) and other aspects of participation in the MSSP. The final rule was published in the Dec. 31 Federal Register and builds upon the MSSP policies that CMS finalized in November of last year in the calendar year (CY) 2019 physician fee schedule (PFS) final rule. The provisions of the rule are generally effective July 1, 2019. CMS estimates the changes to the MSSP will result in $2.9 billion in savings to the federal government and 36 fewer ACOs over 10 years.

Redesigned MSSP Participation Options

Modified Participation Options under Five-year Agreement Periods

CMS finalizes as proposed five-year agreement periods for ACOs that participate in the MSSP, beginning July 1, 2019. For agreement periods beginning on July 1, 2019, the length of the agreement will be five years and six months. In subsequent years, the length of the agreement period will be five years.

CMS also finalizes its redesign of the MSSP's participation options. Specifically, CMS will discontinue Tracks 1 and 2 of the MSSP and the deferred renewal option, which allowed ACOs in Track 1 in their first agreement period to defer renewal for a second agreement period in a two-sided risk model by one year. CMS also will cease to offer additional application cycles for the Center for Medicare & Medicaid Innovation (CMMI) Track 1+ Model.

To replace these existing participation options, CMS created two new MSSP participation tracks – BASIC and ENHANCED – that eligible ACOs can enter for an agreement period of not less than five years. Under the BASIC Track, eligible ACOs will begin participation in a one-sided model and incrementally phase-in risk and potential reward over the course of a single agreement period. This "pathway" to risk comprises five levels, A through E, the first two of which (Levels A and B) offer only shared savings. Levels C through E are two-sided models that carry the potential for shared savings and shared losses. Level E is similar to the existing Track 1+ model.

The ENHANCED Track, which is based on the MSSP's existing Track 3, will offer ACOs the highest level of risk and potential reward. All ACOs will be required to eventually transition to the ENHANCED Track. Although several commenters requested CMS create a pathway from Level E to the ENHANCED Track so that ACOs can more smoothly adapt to the high degree of risk and reward in the ENHANCED Track, CMS declined to create such a pathway. It stated it believes that other program elements would ease this transition and that additional participation options would complicate the program.

Creating a BASIC Track with Glide Path to Performance-based Risk

In this rule, CMS finalizes the creation of a pathway to risk in the BASIC Track of the redesigned MSSP. The pathway comprises five levels: an upside-only model available only for one to three years (Levels A and B), depending on ACOs' participation options, and three levels of progressively higher risk and potential reward (Levels C, D and E). CMS will automatically advance ACOs at the start of each participation year along the glide path until they reach the maximum Level E. However, ACOs that wish to do so will be allowed to skip a level or levels during the agreement period, except for ACOs at Level D, which will automatically transition to Level E at the start of the next performance year. ACOs will not be permitted, at any point, to transition to a lower level of risk. ACOs with agreement periods beginning July 1, 2019 will be permitted to remain at the level of the BASIC Track at which they entered through the 2020 performance year.

Phase-in of Performance-based Risk in the BASIC and ENHANCED Tracks. CMS proposed to significantly reduce the amounts of shared savings that upside-only ACOs could earn from 50 percent down to 25 percent. In response to the numerous comments it received opposing this proposal, **CMS finalizes a shared savings rate of 40 percent for upside-only ACOs in Levels A and B of the BASIC Track. It finalizes a 50 percent shared savings rate for ACOs in Levels C, D and E and a 75 percent rate for ENHANCED Track ACOs.** The following shared savings and shared loss rates will be available to ACOs in the new program, once the minimum savings rate (MSR) or minimum loss ratio (MLR), respectively, is met or exceeded:

	BASIC Track				
Levels	**Levels A and B**	**Level C**	**Level D**	**Level E**	**ENHANCED Track (Current Track 3)**
Shared Savings (once MSR is met or exceeded)	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	1st dollar savings at a rate of up to 50% 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 (same as current Track 1 and Track 1+)	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 is 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 percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (QPP) (8% of ACO participant revenue in 2019 – 2020), capped at a	1st dollar losses at a rate of 1 minus final sharing rate (between 40% -75%), not to exceed 15% of updated benchmark

				percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard (4% of updated benchmark in 2019-2020)	
Alternative Payment Model (APM) under QPP	Merit-based Incentive Payment System (MIPS) APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM

As demonstrated in the table above, the shared loss rates to which ACOs will be subject remain constant at 30 percent across levels C, D and E, but the loss sharing limit – the amount at which losses are capped – gradually increases. CMS will calculate the loss sharing limit on an annual basis using a claims-based approach and the following steps:

1) Determine the total Medicare fee-for-service (FFS) revenue for each participant in the ACO for the applicable performance year. Total revenue includes hospital-add on payments such as Indirect Medical Education, Disproportionate Share Hospital and uncompensated care payments.
2) Apply the applicable percentage under the phase-in schedule described above to the total revenue for all ACO participants to derive the revenue-based loss sharing limit.
3) To derive benchmark-based loss sharing limit, apply the applicable percentage listed in the table above to the ACO's updated benchmark.
4) The loss sharing limit will be set at the lower of the resulting numbers in steps 2 and 3.

CMS includes the following hypothetical as Table 5 in the rule to illustrate this calculation. In this hypothetical, 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:

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

Participation Options Based on Medicare FFS Revenue and Prior Participation

In an effort to improve the accountability of ACOs, CMS proposed several distinctions among ACOs and restricted participation options for certain ACOs depending on these

distinctions. As described below, CMS finalizes these policies with some modifications. The policies distinguish between "low-revenue" and "high-revenue;" "new," "renewing" and "reentering" ACOs; and "experienced" and "inexperienced" ACOs.

Defining Low- and High-revenue ACOs. To differentiate between low- and high-revenue ACOs, CMS will evaluate an ACO's degree of control over the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries. Despite numerous comments, including from the AHA and the Medicare Payment Advisory Commission, opposing this policy, CMS believes that the distinction is necessary and appropriate, and will allow it to transition high-revenue ACOs more quickly to higher levels of risk. CMS will assess control by comparing the total Medicare Part A and Part B FFS revenue of an ACO's participants (or providers and suppliers) with the total Medicare Part A and Part B FFS expenditures of its assigned beneficiaries. CMS had proposed to designate an ACO as "high-revenue" if the ACO's Medicare Parts A and B FFS revenue equaled at least 25 percent or more of the Medicare Parts A and B FFS expenditures for its assigned beneficiaries. **However, due to several comments expressing concern about ACOs with small, rural hospitals that would be considered "high-revenue" under the proposed definition, CMS finalizes a 35 percent threshold instead of the proposed 25 percent.**

For ACOs with a July 1, 2019 agreement start date, CMS finalizes its proposal to determine whether an ACO is low- or high-revenue using expenditure data from the most recent calendar year for which 12 months of data are available. CMS indicates it will inform ACOs as to whether they qualify as high- or low-revenue after they have submitted an application but before they would be required to execute a participation agreement.

Defining Renewing and Re-Entering ACOs. CMS finalizes its proposed definitions of renewing ACOs and re-entering ACOs. A renewing ACO is one that continues its participation in the MSSP for a consecutive agreement period, without a break in participation, because it is either: (1) an ACO whose participation agreement expired and that immediately enters a new agreement period; or (2) an ACO that terminated its current participation agreement and immediately enters a new agreement period.

A re-entering ACO is one that does not meet the definition of a renewing ACO and meets either of the following conditions:

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

2) Is a new legal entity that has never participated in the Shared Savings Program, but more than 50 percent of its ACO participants were 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.

All other ACOs will be considered new entities.

Eligibility Requirements and Application Procedures for Renewing and Re-entering ACOs. CMS finalizes its proposals to clarify the eligibility requirements and application procedures for renewing and re-entering ACOs. Specifically, CMS is removing the required "sit-out" period for terminated ACOs so as to enable ACOs in current agreement periods to quickly transition to the redesigned MSSP participation options under new agreements. **CMS also finalizes as proposed several policies for evaluating ACOs' prior quality and financial performance, timeliness of repayment of shared losses, and correction of deficiencies that caused poor financial or quality performance or failure to timely repay shared losses.** CMS will utilize the evaluation policies to prevent ACOs with a history of poor performance from participating in the MSSP. Specifically, CMS will utilize a financial performance review criterion through which it will evaluate whether an ACO generated losses that were "negative outside corridor" for two performance years of the ACO's previous agreement period. "Negative outside corridor" describes the situation in which an ACO's benchmark minus performance year expenditures are less than or equal to the negative MSR for ACOs in a one-sided model, or the MLR for ACOs in a two-sided model.

Defining Experienced vs. Inexperienced ACOs. As a factor in determining participation options, CMS finalizes its proposed differentiation between ACOs with prior experience in the program and those without. The distinction will be governed by prior participation in a performance-based risk Medicare ACO initiative, which is one that requires two-sided risk. These initiatives include the existing MSSP Tracks 2 and 3, the redesigned MSSP BASIC and ENHANCED Tracks, and several CMMI ACO Models involving two-sided risk including, among others, the Track 1+ Model and the Next Generation ACO Model.

- Experienced with performance-based risk Medicare ACO initiatives: Defined as an ACO that meets *either* of the following criteria:
    1) The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO initiative, or that deferred its entry into a second MSSP agreement period under a two-sided model[1]; or
    2) Forty percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second MSSP agreement period under a two-sided model, in any of the five most recent performance years prior to the agreement start date.

- Inexperienced with performance-based risk Medicare ACO initiatives: Defined as an ACO that meets *all* of the following criteria:
    1) The ACO is a legal entity that has not participated in any performance-based risk Medicare ACO initiative, and has not deferred its entry into a second MSSP agreement period under a two-sided model; and

[1] The deferred renewal option allowed ACOs in Track 1 in their first agreement period to defer renewal for a second agreement period in a two-sided risk model by one year.

2) Less than 40 percent of the ACO's participants participated in any performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second MSSP agreement period under a two-sided model, in each of the five most recent performance years prior to the agreement start date.

CMS received comments on these definitions that explained that experience is not transferable across population and geography and that experience of ACO participants does not necessarily equate to the ACO as a whole being experienced. However, CMS believes there is sufficiently similarity in the fundamental goals of Medicare ACO initiatives for there to be a sufficient degree of transferability of experience across these initiatives.

CMS also received comments from ACOs that would have been considered "experienced" under these definitions despite having only one year of experience with performance-based risk in the Track 1+ model. These ACOs began their three-year agreements in Track 1 and voluntarily elected to transition to Track 1+ in the third year of their current agreement periods. As detailed in the participation options below, if these ACOs are high-revenue, they would be required to enter the new program in the ENHANCED Track with only one year of experience with two-sided risk. **In recognition of the unreasonable result for these ACOs that elected to take on two-sided risk, CMS finalizes a limited exception to allow ACOs that transitioned to the Track 1+ Model within their current agreement period a one-time option to renew for a consecutive agreement period of at least five years under Level E of the BASIC Track.** This policy is most relevant for high-revenue ACOs, as experienced, low-revenue ACOs are already permitted to participate in Level E of the BASIC Track.

Determining Participation Options. Using the above definitions of low- and high-revenue, new, re-entering and renewing ACOs, and experienced and inexperienced ACOs, CMS outlines the participation options available to each type of ACO. CMS largely finalizes these options as proposed with one modification, as described below. The options are summarized in the tables below and described in more detail in the text that follows. CMS's summary of the options are included in the rule as Tables 7 and 8 and appear in Appendix A at the end of this document.

Participation Options for Low-revenue ACOs Based on Applicant Type and Experience with Risk:

Applicant Type	Inexperienced or Experienced	BASIC Track Glide Path	BASIC Track Level E	ENHANCED Track
New legal entity	Inexperienced	Yes, Levels A – E	Yes	Yes
New legal entity	Experienced	No	Yes	Yes
Re-entering ACO	Inexperienced	Yes, Levels B – E	Yes	Yes
Re-entering ACO	Experienced	No	Yes	Yes
Renewing ACO	Inexperienced	Yes, Levels B – E	Yes	Yes
Renewing ACO	Experienced	No	Yes	Yes

Participation Options for High-revenue ACOs Based on Applicant Type and Experience with Risk:

Applicant Type	Inexperienced or Experienced	BASIC Track Glide Path	BASIC Track Level E	ENHANCED Track
New legal entity	Inexperienced	Yes, Levels A – E	Yes	Yes
New legal entity	Experienced	No	NO	Yes
Re-entering ACO	Inexperienced	Yes, Levels B – E	Yes	Yes
Re-entering ACO	Experienced	No	NO	Yes
Renewing ACO	Inexperienced	Yes, Levels B – E	Yes	Yes
Renewing ACO	Experienced	No	NO	Yes

Participation Options for Low- and High-Revenue ACOs. **CMS finalizes its proposal to limit high-revenue ACOs to a single agreement under the BASIC Track, before requiring them to transition to the ENHANCED Track.** Conversely, low-revenue ACOs will be permitted to participate in two agreement periods in the BASIC Track before they will be required to transition to the ENHANCED Track. The two BASIC Track agreement period do not have to be sequential, but after completing one agreement period in the BASIC Track's pathway to risk, low-revenue ACOs will be restricted to Level E of the BASIC Track for their second or subsequent agreement period. CMS received several comments suggesting the agency make the ENHANCED Track voluntary for all ACOs, allow high-revenue ACOs a second agreement period in the BASIC Track, and/or create more level participation options for low- and high-revenue ACOs. CMS declined to adopt any of these recommendations.

Participation Options for Experienced and Inexperienced ACOs. As depicted in the table above, CMS will allow *only* inexperienced ACOs that are new legal entities – regardless of whether they are low-or high-revenue – to enter the BASIC Track's glide path at Level A. Inexperienced re-entering or renewing ACOs, which include ACOs that previously participated in Track 1 or for which the majority of their ACO participants participated in the same Track 1 ACO, would be permitted to enter the BASIC Track's glide path at Level B.

These participation options provide new, high-revenue ACOs a maximum of two years in upside-only risk (or 2.5 years if they participate in the six-month agreement period from July 1, 2019 – Dec. 31, 2019). Inexperienced re-entering or renewing ACOs can spend a maximum of one year (or 18 months) in the BASIC Track's one-sided risk levels.

CMS received many comments on the two year maximum in upside-only risk, with most commenters expressing their belief that two years is too short a time period for ACOs to prepare for two-sided risk. CMS agrees with commenters that some ACOs may need additional time under a one-sided model to gain experience with program participation and to prepare for the transition to performance-based risk. **Therefore, CMS finalizes a modified participation option for *low-revenue* ACOs only. New, inexperienced, low-revenue ACOs will be permitted to spend an additional year in Level B of the BASIC Track for a total of three (or 3.5) years in upside-only risk. However, in exchange for the additional year in one-sided risk, the low-revenue ACOs that elect this option will be required to advance straight to Level E for the remaining performance years of their agreement periods.**

CMS finalizes as proposed the participation options for experienced ACOs. Specifically, experienced, low-revenue ACOs – whether new, re-entering, or renewing – will be permitted to participate only in Level E of the BASIC Track or in the ENHANCED Track. **Experienced, high-revenue ACOs – whether new, re-entering, or renewing – will be permitted to participate *only* in the ENHANCED Track.**

Applicability of Policies that Phase-In. CMS finalizes as proposed policies for determining which agreement period an ACO will be considered to be entering for purposes of applying policies that phase-in over the course of the ACO's first and subsequent agreement periods. These policies include: the weights applied to benchmark year expenditures; the weights used in calculating the regional adjustment to ACOs' historical benchmark; and the quality performance standard. An ACO entering an initial agreement period will be considered to be entering a first agreement period in the MSSP. Renewing ACOs will be considered to be entering the next consecutive agreement period.

A re-entering ACO whose participation agreement expired without having been renewed will re-enter the MSSP under the next consecutive agreement period. A re-entering ACO whose participation agreement was terminated will re-enter the program at the start of the same agreement period in which it was participating at the time of termination. The agreement period for ACOs determined to be re-entering due to the prior participation of the majority of the new ACO's participants in a prior ACO will be determined based on the prior participation of the ACO participants. Specifically, if the participation agreement of the other ACO was terminated or expired, the rules described in this paragraph will apply. However, if the other ACO is currently participating in the MSSP, the new ACO would be considered to be entering into the same agreement period in which this other ACO is currently participating, beginning with the first performance year of that agreement period.

Monitoring for Financial Performance. **To better address recurrent poor financial performance, CMS finalizes policies to qualify an ACO's failure to lower growth in Medicare FFS expenditures as grounds for pre-termination actions and potentially termination, similarly to how poor quality performance can subject an ACO to remedial action or termination.** Despite receiving opposition to this proposal, CMS will monitor for whether expenditures for an ACO's assigned beneficiaries are "negative outside corridor," meaning, as described above, that the expenditures for assigned beneficiaries exceed the ACO's updated benchmark by an amount equal to or greater than the ACO's negative MSR under a one-sided model or the ACO's MLR under a two-sided model.[2]

[2] For purposes of this final rule, an ACO is considered to have shared savings when its benchmark minus performance year expenditures are greater than or equal to the MSR. An ACO is "positive within corridor" when its benchmark minus performance year expenditures are greater than zero, but less than the MSR. An ACO is "negative within corridor" when its benchmark minus performance year expenditures are less than zero, but greater than the negative MSR for ACOs in a one-sided model or the MLR for ACOs in a two-sided model. An ACO is "negative outside corridor" when its benchmark minus performance year expenditures are less than or equal to the negative MSR for ACOs in a one-sided model or the MLR for ACOs in a two-sided model.

If an ACO is negative outside corridor for a single performance year, CMS may take a variety of pre-termination actions. If the ACO is negative outside corridor for an additional performance year of the same agreement period, CMS may immediately or with advance notice terminate the ACO's participation. CMS had proposed to apply this to performance years beginning Jan. 1, 2019 but instead will not apply it until performance years beginning July 1, 2019 and subsequent years. In response to the negative comments about this policy, CMS will take into consideration certain relevant factors, such as an ACO's improved performance over time, before imposing remedial action or termination for poor financial performance.

ACOs' Election of MSR/MLR

CMS finalizes as proposed requirements related to the election of the MSR/MLR for ACOs in the BASIC Track's pathway to risk. The MSR and MLR are intended to ensure ACOs earn shared savings or pay shared losses only when changes in expenditures represent actual change in performance, not normal or random variation. Similarly to current program requirements, CMS finalizes the following MSR/MLR requirements and options:

- ACOs in the upside-only levels of the BASIC Track (Levels A and B) will be assigned a variable MSR based on the number of their assigned beneficiaries.
- ACOs in the two-sided levels of the BASIC Track (Levels C, D and E) and in the ENHANCED track will be able to choose from the following options: (1) zero percent MSR/MLR; (2) symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0 percent; or (3) symmetrical MSR/MLR that varies based on the number of assigned beneficiaries.

ACOs that transition from one- to two-sided risk during a single agreement in the BASIC Track will select their updated MSR/MLR before beginning participation in two-sided risk. No other changes to MSR/MLR will be permitted during an agreement period.

CMS also finalizes as proposed policies to modify the MSR/MLR if an ACO's performance year assigned beneficiary population falls below 5,000. In that case, 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, regardless of whether the ACO selected a fixed or variable MSR/MLR. This policy is a change from current regulations where ACOs in two-sided models that selected a fixed MSR/MLR remain with that fixed MSR/MLR even if their assigned beneficiary populations fall below 5,000.

Annual Participation Elections

Election of Differing Levels of Risk within the BASIC Track's Glide Path. CMS finalizes as proposed policies to permit ACOs in the BASIC Track's pathway to risk to annually elect to accept higher levels of performance-based risk than required. ACOs must elect to change their participation options before the start of the performance year and must meet all applicable requirements for the newly selected level of risk. Any such election will not alter the timing of benchmark rebasing. Rather, CMS will continue to assess ACOs' financial performance using the historical benchmark established at the start of the ACO's current agreement period, as adjusted and updated consistent with its benchmarking methodology.

Election of Beneficiary Assignment Methodology. Section 1899(c)(1) of the Social Security Act (the Act), as amended by the Bipartisan Budget Act of 2018 (BiBA), requires CMS to determine an appropriate assignment methodology that is based on utilization of primary care services furnished by physicians in the ACO and, beginning on or after Jan. 1, 2019, services provided by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). The current MSSP offers two claims-based beneficiary assignment methodologies, including prospective assignment and preliminary prospective assignment with retrospective reconciliation. CMS also offers a non-claims based process for voluntary alignment, discussed below. There is no pure retrospective assignment methodology.

In accordance with the BiBA's mandate that ACOs be allowed to choose prospective assignment for agreement periods beginning on or after Jan. 1, 2020, **CMS finalizes its proposal to allow ACOs to choose prospective assignment for agreement periods beginning July 1, 2019 and in subsequent years.** Thus, all ACOs that enter the redesigned MSSP on or after July 1, 2019 will have the option to choose either prospective assignment or preliminary prospective assignment with retrospective reconciliation prior to the start of their agreement periods. ACOs will be permitted to switch their beneficiary assignment selection on an annual basis. ACOs will select their preferred beneficiary assignment methodology at the time of application and that methodology will remain effective unless the ACO chooses to change its selection. This process will not impact the voluntary alignment process, but CMS will adjust ACOs' historical benchmarks to reflect their election of a different assignment methodology.

Advance Notice for and Payment Consequences of Termination

CMS finalizes as proposed a reduction in the minimum notification period from 60 days to 30 days for ACOs that wish to voluntarily terminate their participation agreements. Due to the timing of data availability, this change will allow ACOs to base their decision to terminate on three quarters of feedback data instead of two.

CMS also finalizes its proposal to conduct financial reconciliation for all ACOs in two-sided models that voluntarily terminate after June 30. ACOs that terminate on or before that date will not be liable for any portion of shared losses. If an ACO terminates after June 30, CMS will use the full 12 months of performance year expenditure for reconciliation purposes, and then will pro-rate any shared losses by the number of months during the year in which the ACO participated in the MSSP. The policy of pro-rating shared losses will also be applied to ACOs that are involuntarily terminated by CMS for any portion of the year during which the termination becomes effective. CMS had proposed to apply these policies to performance years beginning in Jan. 2019 but will instead delay their implementation until performance years beginning July 1, 2019 and subsequent years.

ACOs may still share in savings if they voluntarily terminate with an effective date of Dec. 31 of a given performance year, if they meet all other requirements. ACOs that voluntarily terminate with an effective date prior to Dec. 31 of a performance year or that are involuntarily terminated are not eligible to share in savings for that year.

Participation Options for Agreement Periods Beginning in 2019

CMS finalizes as proposed July 1, 2019 as the start date for the redesigned MSSP program and a return to calendar year application cycles and start dates beginning in 2020.

In the CY 2019 PFS final rule, CMS finalizes the option for existing ACOs with agreement periods expiring on Dec. 31, 2019 to extend their agreements for an additional six months from Jan. 1, 2019 through June 30, 2019. Ninety percent of ACOs eligible to participate in this six-month performance period elected to do so. In this rule, CMS finalizes the second six-month performance period from July 1, 2019 through Dec. 31, 2019. Additionally, CMS finalizes an "early renewal" option for ACOs that began a 12-month performance period on Jan. 1, 2019. Under the early renewal option, these ACOs may voluntarily terminate their agreements, effective June 30, 2019, and immediately enter a new participation agreement in the new MSSP beginning on July 1, 2019. **It is important to note that the two six-month performance periods (Jan. 1, 2019 – June 30, 2019 and July 1, 2019 – Dec. 31, 2019) are complete performance "years" and carry financial and quality reporting requirements as well as the potential for shared savings and losses.**

CMS also finalizes the methodology for calculating savings and losses for the July 1, 2019 through Dec. 31, 2019 six-month performance year. Specifically, CMS will use data from the full 12-month 2019 calendar year to perform financial and quality reconciliation and then will pro-rate shared savings and losses for the six-month performance year. This approach mirrors the policies CMS finalized in the CY 2019 PFS final rule for calculating shared savings and losses for the first six-month performance year. CMS believes this calendar year approach best aligns the financial reconciliation for the two six-month performance years with the other policies in the MSSP that are based on 12 months of data, including those that relate to the calculation of benchmark expenditures and risk adjustment. In addition, CMS finalizes several policies to address issues unique to the six-month performance years, including issues related to ACOs' participant lists, beneficiary assignment, the quality reporting period and the benchmark methodology, among others.

Waivers

Shared Savings Program Skilled Nursing Facility (SNF) 3-Day Waiver

CMS finalizes as proposed an expansion of the applicability of the SNF 3-Day rule waiver. Under pre-existing regulations, ACOs in two-sided models that elected prospective beneficiary assignment qualified for use of the SNF 3-Day rule waiver. **In this rule, CMS expands eligibility to use the waiver to ACOs in two-sided risk models that elect preliminary prospective beneficiary assignment.** CMS also extends the waiver to SNF services furnished under swing bed arrangements between critical access hospitals and certain small, rural hospitals, if those services fall under a written agreement between the swing bed operator and a waiver-eligible ACO. These changes will apply to waivers approved for performance years beginning on July 1, 2019 and subsequent years.

Billing and Payment for Telehealth Services

To execute certain provisions of the BiBA, CMS finalizes as proposed regulatory changes for the coverage of approved telehealth services furnished during performance years 2020 and beyond by risk-bearing ACOs with prospectively assigned beneficiaries. Specifically, CMS will waive restrictions on the originating site and geographic location for telehealth services provided by these ACOs, which will allow payment for telehealth services originating in a beneficiary's home and from geographic locations that would otherwise be prohibited. However, no facility fee will be paid to the originating site when services originate from the beneficiary's home, and no payment will be made for a service delivered in the home if it was not appropriate to do so. In addition to offering this expanded telehealth policies to two-sided risk ACOs under the redesigned MSSP (assuming they elect prospective beneficiary assignment), CMS will also offer the expanded telehealth policy to current Track 3 and Track 1+ Model ACOs that elect prospective assignment.

In addition, CMS finalizes various protections for beneficiaries that might be charged by ACOs or their participants for telehealth services that would have otherwise been covered if the beneficiary were prospectively assigned. CMS anticipates this situation could arise if an ACO and/or clinician fails to verify whether or not a beneficiary was prospectively assigned to their ACO prior to furnishing services or due to other intentional or unintentional billing errors. In the event that the situation leads to claim rejection, CMS will: (1) prohibit ACOs from charging the beneficiary for expenses incurred in delivering the telehealth services; (2) require ACOs to return to the beneficiary any monies collected for such services; and (3) subject certain ACOs to compliance actions. CMS also finalizes a 90-day grace period after any change in a beneficiary's telehealth eligibility, during which payment will be made for expanded telehealth services.

Beneficiary Engagement

Beneficiary Incentives

As directed by the BiBA, CMS finalizes policies to enable ACOs that bear two-sided risk to establish beneficiary incentive programs. **Specifically, beginning July 1, 2019, eligible ACOs that establish an approved beneficiary incentive program will be permitted to provide incentive payments directly to assigned beneficiaries upon their receipt of qualifying primary care services[3] from an ACO professional with a primary care designation or an FQHC or RHC.** ACOs that establish such programs must operate them throughout their first agreement cycle (12 or 18 months, depending on their start dates). In accordance with the BiBA, CMS will require that these incentive programs be available to all eligible FFS beneficiaries, regardless of assignment methodology. Incentive payments can be

[3] Qualifying primary care services include office, nursing facility, home, domiciliary, transitional and chronic care management, the Welcome to Medicare and annual wellness visits, and FQHC and RHC services, furnished through the ACO by a primary care physician (MD/DO), physician assistant, nurse practitioner, or clinical nurse specialist.

up to $20, updated annually, but must be identical for each FFS beneficiary and made within 30 days of the delivery of each qualifying service.

ACOs must make incentive payments to beneficiaries for each and every qualifying primary care service that they receive. ACOs may vary the incentive payment type (e.g., gift cards or checks but no cash for reasons of program integrity) and the payment must distributed to beneficiaries by the ACO legal entity, not by providers or suppliers. ACOs must maintain records of each incentive payment and fully fund all of the operational costs of their incentive programs, without funds from external entities. CMS will not consider the incentive payments when calculating ACOs' benchmarks and shared savings and losses. CMS finalizes its proposal to ban advertising of incentive payment programs, but will require ACOs to notify beneficiaries about such programs and publicly report specified information about their programs on their public reporting web pages. Finally, CMS finalizes as proposed several policies related to program integrity requirements for the incentive payment program.

Beneficiary Notifications

Under existing regulations, MSSP ACOs are required to display posters in their facilities and make a written notice – the Beneficiary Information Notice (the Notice) – available on request in areas where primary care services are delivered. CMS provides templates for these notices. However, CMS included several policies in the proposed rule to make the Notice a more comprehensive resource. **In light of several comments CMS received about the proposals increasing administrative burden for ACOs, CMS finalizes these proposals with modification.**

In particular, CMS finalizes two, separate required notifications – a general notification and a notification specific to incentive programs. CMS will provide subregulatory guidance about both notifications as well as templates for both. Instead of requiring ACO participants to notify a beneficiary during his or her first primary care visit of each performance year, CMS finalizes requirements to allow an ACO legal entity *or* their participants to deliver both notices to beneficiaries at their first primary care visits *or* at some earlier point in the performance year. CMS will also allow both notices to be disseminated by electronic transmission or mailed hard copy.

ACOs must begin disseminating the notices on July 1, 2019. The general notice must inform beneficiaries that the ACO providers/suppliers are participating in the MSSP, that they have the opportunity to decline claims data sharing and that they may identify (and change the identification) a primary care provider for purposes of voluntary alignment. The incentive notice will be specific to the incentive program described above. ACOs still will be required to display posters and provide standardized written notifications upon request.

Opt-in Assignment Methodology

In the proposed rule, CMS explored the possibility of implementing an "opt-in" methodology through which beneficiaries would directly opt into an ACO. CMS invited comments on several topics related to this methodology but did not make any proposals to execute it. Many commenters opposed the opt-in assignment concept, though CMS did receive some support for it. CMS does not finalize an opt-in methodology in this rule but indicates it will collaborate

with CMMI to test opt-in assignment for MSSP ACOs through a model that may be proposed in future rulemaking.

Benchmarking Methodology Refinements

Risk-adjustment Methodology for Adjusting Historical Benchmark Each Performance Year

In this rule, CMS finalizes its proposal to switch to using full CMS Hierarchical Condition Category (HCC) prospective risk adjustment to adjust an ACO's historical benchmark for changes in severity and case mix. CMS will apply this methodology to all assigned beneficiaries' risk scores between the benchmark period and the performance year. This change will eliminate the distinction between newly and continuously assigned beneficiaries that arises from CMS's current risk adjustment methodology.

The resulting risk score will be subject to a positive 3 percent cap over the length of the agreement period, for agreement periods beginning on July 1, 2019 and in subsequent years. In other words, CMS will permit ACOs' risk scores to rise by a maximum of three percent. CMS had proposed to also implement a negative three percent cap on risk scores, which would have prevented risk scores form dropping by more than 3 percent. However, CMS does not finalize the negative cap, due to concerns that it could incentivize ACOs to seek out low-cost beneficiaries or avoid high-cost beneficiaries.

Use of Regional Factors When Establishing and Resetting ACOs' Benchmarks

Applying Regional Expenditures in Determining the Benchmark for an ACO's First Agreement Period. **CMS finalizes as proposed the incorporation of regional expenditures into the historical benchmarking methodology starting with the first agreement period for all ACOs entering the redesigned program beginning on July 1, 2019.** This is a change from current regulations under which CMS applies a regional adjustment to ACOs' historical benchmarks to rebase them for ACOs entering a second or subsequent agreement period. Despite the change, CMS will continue to apply different weights to the benchmark years for the first agreement period compared with the second or subsequent agreement period. Specifically, when calculating the historical benchmark for an ACO in its first agreement period, CMS will weight the three benchmark years – the three calendar years prior to the start of the agreement period – at 10 percent, 30 percent, and 60 percent, respectively. This differs from the equal weights that are used in resetting the benchmark for ACOs entering a second or subsequent agreement period.

Modifying the Regional Adjustment. To mitigate the potential that the regional adjustment to the benchmark could make achieving savings in the MSSP too easy for ACOs with historical spending lower than their regions and too difficult for ACOs with historical spending higher than their regions, CMS finalizes its proposal, with modifications, to amend the schedule of weights use to phase in the regional adjustment. Despite opposition from most commenters, CMS finalizes the reduction of the maximum weight of the regional adjustment to the

benchmark from 70 percent to 50 percent. For ACOs with historical spending lower than their regions, the weight of the adjustment will range from 35 percent to 50 percent, as CMS had originally proposed. **For ACOs with historical spending higher than their regions, CMS modifies its original proposal such that the weight will now range from 15 percent to 50 percent and will be phased in more gradually.**

The schedule for the level of regional adjustment, as finalized, is as follows:

Schedule for Level of Regional Adjustment		
Timing when regional adjustment is applied	**ACO's historical spending is lower than its region**	**ACO's historical spending is higher than its region**
First agreement period in which new weights would apply to regional adjustment	35% weight	15% weight
Second agreement period in which new weights would apply to regional adjustment	50% weight	25% weight
Third or agreement period in which new weights would apply to regional adjustment	50% weight	35% weight
Fourth or subsequent agreement period in which new weights would apply to regional adjustment	50% weight	50% weight

The "timing" of when a regional adjustment will be applied depends on ACOs' agreement start dates and whether they are new, renewing or re-entering ACOs. For example, a new ACO entering the redesigned MSSP on July 1, 2019 will first be subject to a regional adjustment to its historical benchmark for its first agreement period beginning July 1, 2019. Because CMS rebases ACOs' historical benchmarks for each agreement period, the "second time" the ACO will be subject to a regional adjustment will be when CMS calculates its rebased benchmark for its second agreement period and the "third time" will be when CMS calculates the rebased benchmark for its third agreement period, and so forth. See Appendix B of this Advisory for examples from CMS of the phase-in of the regional adjustment weights based on agreement start date and applicant type.

CMS also finalizes its proposal to cap the regional adjustment amount at a flat dollar amount equal to five percent of national per capita Medicare FFS expenditures for assignable beneficiaries, calculated separately for each Medicare enrollment population (disabled, aged/dual eligible, aged/non-dual eligible, and end stage renal disease). CMS believes this approach will provide meaningful reward for ACOs that are efficient relative to their regions, while reducing potential windfall gains for ACOs with lower relative costs.

Modifying the Methodology for Calculating Benchmark Trend and Update Factors. **CMS finalizes as proposed the implementation of a national-regional blended "trend factor" to trend forward expenditures in the first two years on which ACOs' benchmarks are based to the third benchmark year.** CMS uses this trend factor to establish and reset ACOS's historical benchmarks. **CMS also finalizes the use of this blend of national and**

regional growth rates to update ACOs' benchmarks from the third benchmark year to the relevant performance year. The blended trend and update factors will apply to 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.

To calculate the national-regional blend, CMS will calculate a weighted average of national FFS and regional trend factors, where the weight assigned to the national component will represent the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO. The weight assigned to the regional component will be equal to one minus the national weight. As an ACO's penetration in its region increases, this approach will result in a higher weight being placed on the national component of the blend and a lower weight on the regional component, reducing the extent to which the trend factors reflect the ACO's own expenditure history. However, CMS notes that most ACOs do not currently have significant penetration in their regional services areas and therefore will see a higher weight on the regional component of the trend factor. Thus, CMS anticipates that the overall impact of this policy on benchmarks would be small.

Updates to Program Policies

Extreme and Uncontrollable Circumstances Policy

In December 2017, CMS issued an interim final rule with comment period (IFC) in which it adopted policies to address quality performance scoring and shared loss determinations for MSSP ACOs experiencing extreme and uncontrollable circumstances in 2017. CMS published the final version of the IFC in the Dec. 31 Federal Register, completing the regulatory process by responding to comments received on the IFC and finalizing the extreme and uncontrollable circumstances policies for MSSP performance year 2017. CMS finalizes the extreme and uncontrollable circumstances policies for MSSP performance year 2018 and subsequent years in the CY 2019 PFS Final Rule.

Coordination of Pharmacy Care for ACO Beneficiaries

In the proposed rule, CMS solicited comments on how to foster collaboration between MSSP ACOs and independent Part D plan sponsors to better coordinate pharmacy care for Medicare FFS beneficiaries. CMS included this request for comments due to its belief that there are possible synergies between ACOs and Part D stand-alone prescription drug plan sponsors such as improved formulary compliance by clinicians, enhanced delivery of pharmacist counseling services to patients and more widespread implementation of medication therapy management. CMS received several comments in support of its proposal to encourage collaboration between ACOs and Part D plan sponsors, including specific recommendations such as the creation of a demonstration in which MSSP ACOs are held accountable for some or all Part D costs. Some commenters raised concerns about the proposal and requested more information from CMS. The agency indicated that the feedback will be incorporated into future planning.

Applicability of Proposed Policies to Existing Track 1+ Model ACOs

Given that CMS finalizes the redesigned MSSP tracks, it will no longer offer application cycles for the Track 1+ model. Existing Track 1+ ACOs will be permitted to complete their agreement periods under the Track 1+ model, or they may terminate their Track 1+ agreements and apply to enter new agreements under the BASIC Track Level E or ENHANCED Track. Thus, the Track 1+ model will end with performance year 2020. CMS discusses in this rule and in the CY 2019 PFS Final Rule how it will apply specific policy changes to Track 1+ Model ACOs.

Next Steps

The AHA held a members-only webinar on Jan. 11 to discuss the provisions of the final rule. To view the recorded version of this webinar, visit here.

If you intend to participate in the redesigned MSSP on July 1, 2019, you must submit a notice of intent to apply by Jan. 18 at 12 p.m. ET. Notices of intent are required to apply for the program's new tracks, the SNF 3-Day rule waiver, and beneficiary incentive programs, among other programmatic elements. Submitting a notice of intent does not bind an organization to submit an application, and ACOs can make changes to their participation options during the Jan. 22 to Feb. 19 application submission period.

Further Questions

For further questions, please contact Shira Hollander, senior associate director for policy development, at (202) 626-2329 or shollander@aha.org.

Appendix A

Table 7: Participation Options for Low-Revenue ACOs Based on Applicant Type and Experience with Risk

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

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

Table 8: Participation Options for Low-Revenue ACOs Based on Applicant Type and Experience with Risk

		Participation Options			
Applicant type	**ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives**	**BASIC track's glide path** (option for incremental transition from one-sided to two-sided models during agreement period)	**BASIC track's Level E** (track's highest level of risk / reward applies to all performance years during agreement period)	**ENHANCED track** (program's highest level of risk / reward applies to all performance years during agreement period)	**Agreement period for policies that phase-in over time** (benchmarking methodology and quality performance)
New legal entity	Inexperienced	Yes - glide path Levels A through E	Yes	Yes	First agreement period
New legal entity	Experienced	No	No	Yes	First agreement period
Re-entering ACO	Inexperienced - former Track 1 ACOs or new ACOs identified as re-entering ACOs because more than 50 percent of their ACO participants	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)

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

Appendix B

Table 6: 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 15 percent (if spending above region)	Second time regional adjustment used: 50 percent or 25 percent (if spending above region)	Third time regional adjustment used: 50 percent or 35 percent (if spending above region)	Fourth and subsequent time regional adjustment used: 50 percent weight
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	Applicable to fourth agreement period starting in 2035 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	Applicable to sixth (2012/2013) or fifth (2016) agreement period starting in 2035 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 as follows: 35 percent or 25 percent (if spending above region)	Applicable to third agreement period starting on July 1, 2019	Applicable to fourth agreement period starting in 2025	Applicable to fifth agreement period starting in 2030 and all subsequent agreement periods
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 reentering a second agreement period)	Applicable to third agreement period starting in 2025	Applicable to fourth agreement period starting in 2030	Applicable to fifth agreement period starting in 2035 and all subsequent agreement periods

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 reentering a second agreement period)	Applicable to third agreement period starting in 2025	Applicable to fourth agreement period starting in 2030	Applicable to fifth agreement period starting in 2035 and all subsequent agreement periods