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Medicare Shared Savings Program Final Rule

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Medicare Shared Savings Program Final Rule

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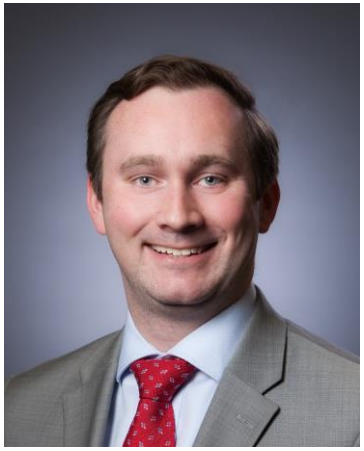

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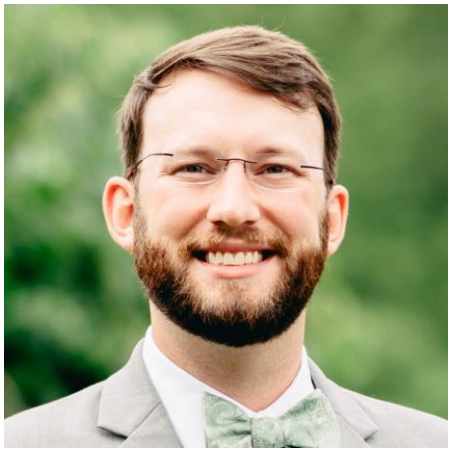

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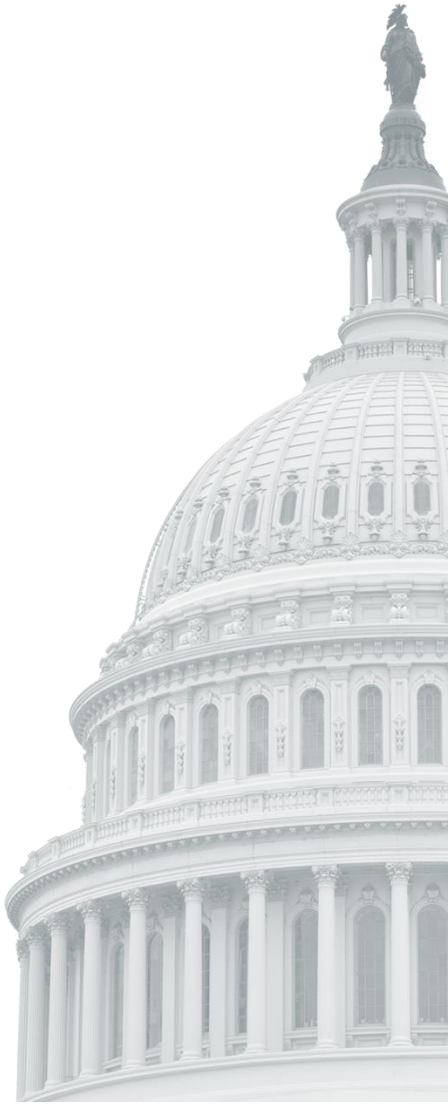
Agenda

- Model Overview
- BASIC and ENHANCED Tracks
- Risk Levels and Progression
- Participation Options
- Benchmarking
- Waivers
- Beneficiary Assignment
- Beneficiary Engagement



MSSP Proposed Rule Summary

- Released December 21, published December 31 Federal Register
- Eliminates Track 1 and 2 (can continue existing agreements)
- Establishes BASIC and ENHANCED (current Track 3) Tracks
- Expands SNF and Telehealth Waivers
- Provides choice in beneficiary assignment methodology
- Establishes beneficiary incentive program

Agreement and Performance Periods

- Agreement Period: 5 years
- Model Start: July 1, 2019
    - Agreement period would be 5 years and 6 months
- Performance Year: Calendar Year
- 6-month performance period
    - ACOs extending through June 30,2019 (Current agreements ending 2018)
    - ACOs starting July 1, 2019
- Automatic advancement to higher level of risk
  - Exception: ACOs that begin July 1, 2019 would stay in track they enter for first 1 year and 6 months
  - When Track E is reached, remain in Track for completion of 5 year agreement
  - Option to take on higher levels of risk than planned at start of any performance year
    - For example, In Track B, automatically advance to Track C, can elect to jump to Track D
    - Election must occur before start of performance period (timing similar to MSSP application)
    - Historical benchmark would not be rebased as a result of taking on more risk
- Beneficiary assignment methodology annual election
  - Option to choose either prospective assignment or preliminary prospective assignment with retrospective reconciliation (“retrospective”)
  - ACO maintains beneficiary assignment unless they choose to change before the start of a performance year (timing aligns with MSSP application)
  - Does not impact voluntary alignment process (beneficiary selection “main doctor”)
  - Will update the benchmark if ACO changes beneficiary assignment approach

Model Overview: BASIC and ENHANCED Track

	BASIC Track's Glide Path				ENHANCED Track (Current Track 3)
	Level A/B (one-sided model)	**Level C**	**Level D**	**Level E**	
Shared Savings (once MSR 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 **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	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** (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** (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**

Model Overview: BASIC and ENHANCED Track

	BASIC Track's Glide Path				ENHANCED Track (Current Track 3)
	Level A & Level B (one-sided model)	**Level C (risk/reward)**	**Level D (risk/reward)**	**Level E (risk/reward)**	
Annual choice of beneficiary assignment methodology?	Yes	Yes	Yes	Yes	Yes
Annual election to enter higher risk?	Yes	Yes	No; ACO will automatically transition to Level E at the start of the next performance year	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?	No	No	No	Yes	Yes
Beneficiary Incentive Program	N/A	Yes	Yes	Yes	Yes
Expanded Telehealth	No	Yes- prospective assignment	Yes- prospective assignment	Yes- prospective assignment	Yes- prospective assignment
3-DAY SNF Rule Waiver	N/A	Yes	Yes	Yes	Yes

BASIC Track: Sharing Loss Limit Determination

Percentage of ACO participant total Part A/B revenue, capped at % of historical benchmark

- ACOs with a hospital participant, generally under benchmark-based loss sharing limit

Sharing Loss Limit Determination:

- Determine Total A/B revenue for all providers and suppliers that bill under the TIN of each ACO participant
  - All FFS beneficiaries, not just assigned beneficiaries (no truncation)
  - Does not adjust/remove IME, DSH, uncompensated care
  - Includes payment adjustments (MIPS, HVBP) and identifiable payments under demo, pilot, time-limited program
- Apply Applicable percentage of phase-in schedule
- If % of Total A/B revenue > updated historical benchmark, use benchmark-based sharing loss limit instead of revenue based

Example: Loss Sharing Limit Amounts for ACO in Basic Track Level E

- A/B Revenue < Historical Benchmark- Use Revenue-based Benchmark

[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

- Low Revenue and High Revenue ACOs
  - High revenue ACOs: Total A/B revenue of participants> 35% of Total A/B expenditures for ACO assigned beneficiaries
  - Use most recent calendar year for which 12 months of data are available
- Renewing ACO
  - ACO whose participation agreement expired and that immediately enters a new agreement period to continue its participation in the program
  - ACO that terminated its current participation agreement immediately enters a new agreement period to continue its participation in the program
  - CMS has eliminated the “sit-out” period for terminated ACOs
- Re-entering ACO
  - Same legal entity that previously participated, identified by TIN, applying after a break due to expired agreement or terminated agreement
  - New legal entity that has never participated but more that 50% of participants were included on an ACO participant list in any of 5 most recent performance periods
- Experienced ACO
  - Same legal entity as current or previous ACO that participated in performance-based risk
  - 40% or more of ACO participants have participated in performance-based risk (look back at 5 most recent performance periods)
  - Performance-based risk: Track 1+, 2, 3, ENHANCED, Pioneer, Next Generation, Comprehensive ESRD two-sided models

Participation Options for Low Revenue ACOs Based on Applicant Type and Experience with Risk (Table 6)

Applicant Type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options [1]			Agreement period for policies that phase-in over time (benchmarking methodology and quality performance)
		BASIC track's glide path (option for incremental transition from one-sided to two-sided models during agreement period)	**BASIC track's Level E** (track's highest level of risk / reward applies to all performance years during agreement period)	**ENHANCED track** (program's highest level of risk / reward applies to all performance years during agreement period)	
New Legal Entity	Inexperienced	Yes - glide path Levels A through E *Option for a third year in upside only*	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

Participation Options for Low Revenue ACOs Based on Applicant Type and Experience with Risk (Table 6 continued)

Applicant Type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options [1]			Agreement period for policies that phase-in over time (benchmarking methodology and quality performance)
		BASIC track's glide path (option for incremental transition from one-sided to two-sided models during agreement period)	**BASIC track's Level E** (track's highest level of risk / reward applies to all performance years during agreement period)	**ENHANCED track** (program's highest level of risk / reward applies to all performance years during agreement period)	
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

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

Participation Options for High Revenue ACOs Based on Applicant Type and Experience with Risk (Table 7)

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

Participation Options for High Revenue ACOs Based on Applicant Type and Experience with Risk (Table 7 continued)

Applicant Type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options [1]			Agreement period for policies that phase-in over time (benchmarking methodology and quality performance)
		BASIC track's glide path (option for incremental transition from one-sided to two-sided models during agreement period)	**BASIC track's Level E** (track's highest level of risk / reward applies to all performance years during agreement period)	**ENHANCED track** (program's highest level of risk / reward applies to all performance years during agreement period)	
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 Track 1+ ACOs with a first or second agreement period in 2016 or 2017)*	Yes	Subsequent consecutive agreement period

Technical Changes

- Evaluation Criteria
  - History of compliance with quality performance standard
  - Repayment of shared losses
  - Financial performance history
  - Corrected deficiencies
- Financial Performance Monitoring
  - Beginning July 1, 2019 monitor whether the expenditures for the ACO's assigned beneficiary population are "negative outside corridor"
  - One performance period: pre-termination actions
  - More than one performance period: may terminate the ACO
- Repayment Mechanisms
  - Track 2: 1% total per capita A/B expenditures used to calculate benchmark
  - BASIC and ENHACED: Lesser of 1% total per capita A/B expenditures for ACO assigned beneficiaries OR 2% total A/B revenue of ACO participants
  - CMS will recalculate repayment amount before each performance year, if new amount exceeds prior amount by 50% or $1M, CMS will notify ACO, ACO must submit documentation in 90 days
  - Must be in place for agreement and 12 months after conclusion of agreement.
- Termination
  - Notice shortened from 60 days to 30 days
  - Termination after June 30 ACO is responsible for shared losses; 12-month reconciliation; prorated shared losses based on number months in program

Election of MSR/MLR

- Upside-only: Variable MSR based on number of assigned beneficiaries
  - Must choose MSR/MLR before entering downside risk track
- Two-sided model:
  - Zero percent MSR/MLR
  - Symmetrical MSR/MLR in a 0.5 percent increment between 0.5-2.0 percent
  - Symmetrical MSR/MLR that varies based on the number of assigned beneficiaries
- Modifications to MSR/MLR if population below 5000, regardless of having fixed or variable MSR/MLR
  - Ranges between 3.9%- 12.2%

Benchmarking Methodology

- CMS-Hierarchical Condition Category (HCC) risk scores impact on benchmarks
  - Adjust the benchmark each performance year regardless of alignment type
  - This adjustment will be restricted to a positive 3% over the agreement relative to the risk score for BY3
    - Did not finalize policy to cap negative risk score changes
    - The risk ratios applied to historical benchmark expenditures to capture changes in health status between BY3 and the performance year would never be higher than 1.030 for any performance year over the course of the agreement period
- Incorporating regional expenditures in benchmark determination
  - Incorporated int eh first agreement period; however weights continuer to differ for first and subsequent agreements
  - Reduce the maximum weight used in calculating the regional adjustment from 70 percent to 50 percent
  - Cap the amount of the adjustment at 5 percent of national FFS expenditures

Schedule for Level of Regional Adjustment		
Timing when subject to regional adjustment	ACO's historical spending is lower than its region	ACO's historical spending is higher than its region
First agreement period	Weight of 35 percent	Weight of 15 percent
Second agreement period	Weight of 50 percent	Weight of 25 percent
Third agreement period	Weight of 50 percent	Weight of 35 percent
Fourth or subsequent agreement period	Weight of 50 percent	Weight of 50 percent

- National-regional blend to trend forward BY1 and BY2 to BY3 or when resetting historical benchmark

Updates to Available Waivers: SNF 3-Day Rule Waiver

- Available to all two-sided ACOs (BASIC levels C, D, E as well as ENHANCED) regardless of assignment methodology selected (prospective and retrospective assignment)
  - ACOs will receive an initial performance year assignment list followed by assignment lists for quarters 1, 2, and 3 of each performance year, and the SNF 3-day rule waiver would be available with respect to all beneficiaries on all four lists
- CMS is offering the ability for current Track 1+ ACOs, Track 3 ACOs, and new ACOs in BASIC levels C, D, and E and ENHANCED to apply for the SNF waiver with a July 1, 2019 start date
- CMS also finalized the applicability of the waiver to providers furnishing SNF services under all swing bed arrangements to encourage greater participation and availability in rural settings
- CMS finalized revisions to the requirement that a SNF maintain a minimum 3-star rating requirement to only apply if the provider furnishing SNF services is eligible to be included in the CMS 5-star Quality Rating System

Updates to Available Waivers: Payment for Telehealth Services

- In accordance with Balanced Budget Act of 2018
- Payment to a physician or practitioner billing though the TIN of an ACO participant for furnishing telehealth services to beneficiaries prospectively assigned to the ACO
- Includes when the originating site is the beneficiary's home and without regard to the geographic limitations
- Available starting January 1, 2020 for ACOs in the following tracks: BASIC levels C, D, E, ENHANCED, current Track 1+ and 3 ACOs (but only 2018 starters due to January 1, 2020 start date)
  - ACOs must utilize prospective beneficiary assignment to be eligible for the waiver
- The approved list of telehealth services covered by this waiver is available at this link from CMS: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

Beneficiary Engagement: Beneficiary Incentive Programs

- Beginning July 1, 2019 (or January 1 of the relevant performance year) ACOs participating under Track 2, Track 3, Levels C, D, or E of the BASIC track, or the ENHANCED track can establish beneficiary incentive programs to provide incentive payments to assigned beneficiaries who receive qualifying services
- In order to establish or reestablish a beneficiary incentive program, an ACO must submit a complete application in the form and manner and by a deadline specified by CMS
- Beneficiary incentive programs must be operated for 18 months if starting on July 1, 2019 or 12 months if starting on any future January 1
- A FFS beneficiary would be eligible to receive an incentive payment if the beneficiary is assigned to an ACO through either prospective or retrospective assignment
- Payments can be made for each qualifying service:
  - Primary care service to which coinsurance applies under part B
  - Furnished through an ACO by an ACO professional who has a primary care specialty designation included in the definition of primary care physician, physician assistant, nurse practitioner, or clinical nurse specialist, or a FQHC or RHC

Beneficiary Engagement: Beneficiary Incentive Programs (Continued)

- Each incentive payment must meet the following criteria:
  1) Be in the form of a check, debit card, or a traceable cash equivalent;
  2) Not exceed $20, as adjusted annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, rounded to the nearest whole dollar amount; and
  3) Be provided by the ACO to the beneficiary no later than 30 days after a qualifying service is furnished.
- Payments must be the same amount for each beneficiary without regard to enrollment in other plans (Medicare supplemental policy, in a State Medicaid plan, or in any other health insurance policy)
- An ACO must not use funds from any entity or organization outside of the ACO to establish or operate a beneficiary incentive program
- In certain circumstances targeted “in-kind” gifts are acceptable so long as they have a reasonable connection to the beneficiary’s medical care

Beneficiary Engagement: Beneficiary Incentive Programs (Continued)

- ACOs must maintain records regarding specific pieces of the beneficiary incentive program and make these records available to CMS if requested, specifically:
  - the identification of each beneficiary that received an incentive payment, including beneficiary name and HICN or Medicare beneficiary identifier;
  - the type and amount of each incentive payment made to each beneficiary;
  - the date each beneficiary received a qualifying service, the corresponding HCPCS code for the qualifying service, and identification of the ACO provider / supplier that furnished the qualifying service;
  - and the date the ACO provided each incentive payment to each beneficiary.
- Incentive payments made by an ACO shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings / losses
- Incentive payments are also not considered taxable to beneficiaries who receive them

Beneficiary Engagement: Beneficiary Notification

- Beginning July 1, 2019, the ACO participant must notify beneficiaries about the following items:
  1) That each ACO participant and its ACO providers / suppliers are participating in MSSP
  2) The beneficiary's opportunity to decline claims data sharing
  3) Beginning July 1, 2019, the beneficiary's ability to, and the process by which, he or she may identify or change identification of the individual he or she designated for purposes of voluntary alignment
- Notification is required to be carried out through the following methods:
  1) By an ACO participant posting signs in its facilities and, in settings in which beneficiaries receive primary care services, making standardized written notices available upon request; and
  2) During the performance year beginning on July 1, 2019 and each subsequent performance year, by an ACO or ACO participant providing each beneficiary with a standardized written notice prior to or at the first primary care visit of the performance year in the form and manner specified by CMS
- Beginning July 1, 2019, an ACO that operates a beneficiary incentive program shall ensure that the ACO or its ACO participants notify assigned beneficiaries of the availability of the beneficiary incentive program, including a description of the qualifying services for which an assigned beneficiary is eligible to receive an incentive payment

2019 6-Month Performance Period

- Enter July 1 2019: Agreement is 5 years and 6 months
- Existing ACOs can voluntarily terminate for June 30, 2019 and enter BASIC or ENHACED
- Calculate performance for 12-month calendar year, prorate for 6-month period
- Participant list beginning July 1 2019 for beneficiary assignment
  - Prospective assignment window: October 1, 2017- September 30, 2018
- Quality performance for entire calendar year
  - ACO participant list used is based on agreement beginning July 1, 2019 if ACO has two six-month performance periods
- Can apply for SNF 3-day waiver
- Participation beginning July 1, 2019 is eligible to contribute to Advanced APM determination under QPP

Extreme and Uncontrollable Circumstances

- CMS extends the automatic extreme and uncontrollable circumstances policies that were established for performance year 2017 to performance year 2018 and subsequent performance years
- Additionally, CMS proposes that these policies would apply when they determine that an event qualifies as an automatic triggering event under the Quality Payment Program
- Modification of quality performance scores for all ACOs in affected areas
  - The ACO's minimum quality score would be set to equal the mean quality performance score for all Shared Savings Program ACOs for the applicable performance year
- If the ACO is able to completely and accurately report all quality measures, CMS would use the higher of the ACO's quality performance score or the mean quality performance score for all ACOs

Extreme and Uncontrollable Circumstances

- Mitigating shared losses for ACOs participating in a performance-based risk track
  - CMS will reduce the ACO's shared losses, if any, determined to be owed for the performance year by an amount determined by multiplying the shared losses by two factors:
    - The percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance; and
    - The percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance
  - ACOs would continue to be able to receive any earned shared savings
- Determination of historical benchmarks for ACOs in affected areas
  - CMS believes that application of regional factors when determining ACOs' historical benchmarks would be sufficient to address any changes in expenditures during an ACO's historical benchmark years as a result of extreme and uncontrollable circumstances

MSSP notice of intent to apply (NOIA)

- The MSSP notice of intent to apply (NOIA) is currently open
- The deadline for NOIAs is **January, 18th, at 12:00pm (noon) ET**
- Organizations must submit a non-binding NOIA if they wish to apply as an initial, renewal, early renewal, or re-entering applicant
- ACO's who current agreement does not end on 6/30 do not need to take any action if they want to continue participation in their current agreement
- The NOIA guidance document has been updated and is available at this link
- Premier's Premier Population Health Management Collaborative has a 100% success rate in helping over 100 member ACOs successfully apply for various Medicare ACO programs
- If you would like to learn more about how Premier can support you and your organization with the MSSP application please reach out to Seth Edwards (seth_edwards@premierinc.com)

Important Links

Premier Detailed Summary

Final Rule

Summary of the CY 2019 Physician Fee Schedule rule (includes MSSP provisions)

CMS Press Release

CMS Fact Sheet

Questions

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Transforming Healthcare TOGETHER

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APPENDIX

Medicare Shared Savings Program (MSSP): Quality Measures

- Patient Experience of Care Survey
  - In 2019 begin scoring **ACO-45 CAHPS: Courteous and Helpful Office Staff** and **ACO-46: CAHPS: Care Coordination**

- CMS Web Interface and Claims-Based Measures
  - Removes the following due to redundancy and overlap with other measures in the program:
    - **ACO-35-Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)**
    - **ACO-36-All-Cause Unplanned Admissions for Patients with Diabetes**
    - **ACO-37-All-Cause Unplanned Admission for Patients with Heart Failure**
    - CMS will continue to provide performance information to ACOs
  - Removes **ACO-44-Use of Imaging Studies for Low Back Pain** because the denominator is too small to make the measure meaningful and its removal would align with MIPS

Medicare Shared Savings Program (MSSP): Web Interface Measures

- Removes the following measures beginning with performance year 2019:
  - ACO-12 (NQF #0097) Medication Reconciliation Post-Discharge
  - ACO-15 (NQF #0043) Pneumonia Vaccination Status for Older Adults
  - ACO-16 (NQF #0421) Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up
  - ACO-41 (NQF #0055) Diabetes: Eye Exam
  - ACO-30 (NQF #0068) Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic

- Does not finalize adding ACO-47 (NQF #0101) Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls starting in PY 2019
  - Retains ACO-13 (NQF #0101) Falls: Screening for Future Fall Risk

MSSP: Pathways to Success Rule

CMS finalized a few provisions of the MSSP Pathways to Success proposed rule in the MPFS

- 6-month performance period extension through June 30,2019 (Current agreements ending 2018)
- Assignment: retrospective is CY 2019, prospective is most recent 12 months (Oct 1 2017- Sep 30 2018)
- CMS will reconcile performance on 12-month calendar year and pro-rate for the 6-month period
- Quality performance based on 2019 reporting period
- QPP: As long as ACO does not terminate prior to March 31, 2019, QPP interaction is as if model was for a full year
  - AAPM threshold assessed for time model is available (denominator is 6 months)
  - Able to use MIPS-APM scoring standard

MSSP Agreement Extension: Key information

- ACOs are now able to voluntarily extend their expiring agreements for six months in the ACO Management System (ACO-MS)
- ACOs will be able to extend beginning **November 5**
- The window to extend will close on **November 13, 12:00pm ET (noon)**
- The step by step process to extend can be found below:
  - Log into the ACO-MS and complete the ACO Extension task(s). *Only the ACO Executive contact can complete the ACO Extension task(s)*, which will appear in the task widget on the dashboard
  - Select “Yes” to indicate that the ACO will extend its participation agreement; or
  - Select “No” to indicate that the ACO will not extend its participation agreement and will end its participation agreement as scheduled on December 31, 2018

Source: ACO Spotlight Newsletter, Issue 43, November 1, 2018

MSSP Agreement Extension: Next steps for ACOs who extend

- Update the terms of their ACO Participant Agreements and, if applicable, Skilled Nursing Facility (SNF) Affiliate Participant Agreements before the beginning of the next performance year to reflect the extension
  - During Annual Certification, certify that they have notified their ACO participants and, if applicable, SNF affiliates of their continuation in the Shared Saving Program in 2019 and that their agreements have been updated
  - ACOs do not need to submit updated agreements reflecting the extension to CMS for review
- ACOs participating in a performance-based risk track also need to update the term of their repayment mechanism to reflect the extension
  - ACOs should submit their draft repayment mechanism documentation for review to CMS as soon as possible via the SSP mailbox
  - Upon conditional approval, ACOs should submit final repayment mechanism documentation to CMS via tracked mail by **December 14, 2018**

Source: ACO Spotlight Newsletter, Issue 43, November 1, 2018

