

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services  
Room 352-G  
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Washington, DC 20201



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## FACT SHEET

FOR IMMEDIATE RELEASE

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### **Finalized Changes to the Medicare Shared Savings Program Regulations**

#### **OVERVIEW**

On June 4, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update and improve policies governing the Medicare Shared Savings Program (Shared Savings Program). CMS is making these modifications to the program regulations after considering the over 270 comments received on a wide range of issues specified in the December 2014 notice of proposed rulemaking. The changes improve the program in a number of areas including:

- Increasing the emphasis on primary care services in the beneficiary assignment methodology;
- Streamlining data sharing to provide improved access to data necessary for Accountable Care Organization (ACO) health care operations such as quality improvement and care coordination, while maintaining beneficiary protections;
- Adding a new performance-based risk option (Track 3) that includes prospective beneficiary assignment and a higher sharing rate;
- Providing ACOs choice of symmetric threshold for savings and losses under performance-based risk tracks;
- Addressing participation agreement renewals including allowing eligible ACOs to continue participation under the one-sided model (Track 1) for a second agreement period;
- Establishing a waiver of the 3-day stay SNF rule for beneficiaries that are prospectively assigned to ACOs under Track 3;
- Refining the methodology for resetting benchmarks to help ensure that the program remains attractive to ACOs and continues to provide strong incentives for ACOs to

improve the efficiency and quality of patient care, and generate savings for the Medicare Trust Funds; and

- Refining eligibility and other requirements.

In this final rule we also indicate that we will develop policies and procedures for beneficiaries to voluntarily align with ACOs participating in a track with two-sided performance risk.

Additionally, the final rule announces our intent to propose further improvements to the program's benchmark rebasing methodology later this year that would shift to basing benchmarks in part on trends in regional fee-for-service FFS costs in order to strengthen ACOs' incentives to provide efficient care and improve the long-term sustainability of the program.

This fact sheet summarizes the major changes to the Shared Savings Program adopted in the May 2015 final rule.

## **BACKGROUND**

Section 3022 of the Affordable Care Act added a new section 1899 to the Social Security Act, which established the Shared Savings Program. The Shared Savings Program encourages providers of services and suppliers (e.g., physicians, hospitals and others involved in patient care) to create a new type of health care entity, an ACO. ACOs agree to be held accountable for improving the quality of care for patients they serve while reducing the rate of growth in health care spending. If the ACOs are successful in improving quality and reducing spending, they receive a share of the savings achieved. Studies have shown that better care often costs less, because coordinated care helps to ensure that the patient receives the right care at the right time, avoids unnecessary duplication of services, and prevents medical errors. In November 2011, CMS published a final rule to implement the Medicare Shared Savings program under the Affordable Care Act. In December 2014, we published a proposed rule for the Shared Savings Program to advance the ACO models, codify existing guidance, reduce administrative burden and improve program function and transparency in a number of program areas.

The Shared Savings Program now includes more than 400 ACOs and more than [170,000] Medicare-enrolled practitioners. The Shared Savings Program ACOs function in 49 states, in addition to DC and Puerto Rico. More than 7.3 million beneficiaries receive care from these ACOs.

On November 7, 2014, CMS released the first financial reconciliation and quality performance results for the 220 Shared Savings Program ACOs with start dates in 2012 and 2013. Details can be found at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-10.html>

We are encouraged by the early results and, in this final rule, are making adjustments and improvements to the program to support its continued success. Some of the key changes being made through this final rule include:

### ***Participation Agreement Renewal and Continued Participation in Track 1***

Prior regulations required that ACOs participating in Track 1, which share in savings but not losses, may continue in the program after their initial 3-year agreement period only if they enter a performance-based risk (two-sided) track.

We finalized new rules that will permit ACOs to participate in one additional three-year agreement period under Track 1 and maintain the same maximum sharing rate applicable in their first agreement period. This policy will be available to ACOs that have met the quality performance standard in at least one of the first two years of their initial three-year agreement period and are otherwise in good standing with the program.

### ***Beneficiary Assignment***

The previous methodology assigns beneficiaries in two steps based on the plurality of primary care services furnished 1) by primary care physicians, and 2) by specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists.

In the final rule, we are revising the assignment methodology to remove certain specialty types whose services are not likely to be indicative of primary care services from Step 2, which places greater emphasis on primary care physicians. Additionally, we will include primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists in Step 1 to recognize the primary care delivered by these professionals. Finally, through rulemaking in the 2017 Physician Fee Schedule, we expect to propose that beneficiaries may attest that their main doctor is participating in a performance-based risk track ACO and be assigned to that ACO.

### ***Data Sharing***

The previous rule permitted CMS to share claims data with ACOs that is necessary for health care operations, but only after ACOs requested the data from CMS, notified beneficiaries and provided them an opportunity to decline to have their data shared with the ACO among other requirements. ACOs could mail notices to beneficiaries, wait 30 days before requesting data, and then follow up with the beneficiary at the next primary care service office visit, or they could notify beneficiaries at the point of care and request data immediately. This process created beneficiary confusion, and delays in data sharing.

In the final rule, we streamlined the process for ACOs to access Medicare beneficiary claims data necessary for health care operations, while retaining the opportunity for beneficiaries to decline to have their Medicare claims data shared with the ACO. Specifically, ACO participants will continue to provide written notification at the point of care through signs posted in their facilities that include template language regarding data sharing and the opportunity for beneficiaries to decline data sharing by calling 1-800-Medicare. Beneficiaries can express their data sharing preferences directly to CMS through 1-800 Medicare rather than passing the information through the ACO. This means that ACOs will no longer send out letters that may confuse beneficiaries, and beneficiaries will no longer have to sign and return forms to the ACO.

### ***Resetting ACO Financial Benchmarks:***

In the previous rule, we adopted a methodology for establishing ACO financial benchmarks used for determining shared savings and losses.

In this rule, we finalized the following methods for resetting the ACO's benchmark at the start of its second or subsequent agreement period:

- Equally weighting the historical benchmark years, as opposed to weighting these years 10% for benchmark year (BY) 1, 30% for BY2, and 60% for BY3;
- Accounting for savings generated by the ACO in its prior agreement period; and
- In addition, to address concerns that rebasing diminishes ACOs' incentives to provide efficient care by reducing future benchmarks for ACOs that succeed in reducing spending, we indicated our intent to commence rulemaking later this year to implement a methodology that would reset ACO benchmarks in part based on trends in regional fee-for-service costs rather than solely ACOs' own recent spending.

### ***Encouraging ACOs to Take on Greater Performance-Based Risk***

We encourage ACOs to progress along the performance-based risk continuum and we believe certain aspects of the Shared Savings Program could be improved to increase interest in performance risk-based options.

We finalized several modifications to encourage ACOs to accept performance based risk. See the Appendix for an overview of the features of the program's financial models, which include:

- Adding a new performance-based risk model (Track 3) for ACOs to participate in the Shared Savings Program. Track 3 offers a higher sharing rate than Tracks 1 and 2 and beneficiaries will be prospectively assigned to the ACO rather than preliminarily assigned to ACOs with a retrospective reconciliation;
- Modifying Track 2 (the performance-based risk track established with the November 2011 final rule) to allow ACOs to choose from a menu of options for setting their minimum savings rate (MSR) and minimum loss rate (MLR), the thresholds an ACO's expenditures must meet or exceed for the ACO to be eligible to share in savings or be accountable for losses. This same flexibility is extended to Track 3 ACOs;
- Reducing the burden of the repayment mechanism requirement for ACOs applying to enter Tracks under the two-sided model; and
- Conducting further development and testing of other selected waivers through the Innovation Center prior to implementation in the Shared Savings Program. We intend to initially focus on further development and testing of a waiver of the billing and payment requirements for telehealth services through the Next Generation ACO Model (see the CMS website at: <http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>, page 22). We anticipate a telehealth waiver being available to ACOs no earlier than January 1, 2017 after public comment and formal rulemaking.

### ***Eligibility Requirements***

We finalized several minor modifications to the eligibility requirements for ACO participation including:

- Codifying and expanding requirements related to the agreements the ACOs have with Medicare-enrolled entities so that ACO participants understand their obligations and responsibilities. For example, agreements must include information about how the ACO plans to distribute shared savings and an agreement for the ACO participant to assist with quality reporting;
- Governing body and leadership requirements -- for example, currently, the ACO's medical director is required to be an ACO provider/supplier; we propose to remove this requirement to permit more flexibility;
- The process the ACO has for coordinating care, requiring ACOs to articulate how they will encourage and promote the use of enabling technologies for improving care coordination; and
- Application procedures, establishing a streamlined process to allow prior Pioneer ACOs to apply for participation in the Shared Savings Program.

The Shared Savings Program June 2015 final rule can be downloaded at <https://www.federalregister.gov/public-inspection> on the Federal Register website.

### **Pioneer ACO Model**

The Pioneer ACO Model is the first model designed and tested by the Centers for Medicare & Medicaid Innovation to be certified for expansion by the CMS Office of the Actuary and the Secretary of HHS. CMS has elected to use the Shared Savings Program as the vehicle through which to incorporate learnings and design elements of the Pioneer ACO Model into Medicare ACOs on a permanent basis. Elements of the Pioneer Model incorporated into Track 3 of the Shared Savings Program include prospective beneficiary assignment, higher shared savings and loss rates, flexibility for ACOs to select their minimum savings and loss rates and caps, a waiver of the 3 day hospitalization rule for skilled nursing facility services, and voluntary alignment for beneficiaries in future years.

**APPENDIX: OVERVIEW OF SHARED SAVINGS PROGRAM FINANCIAL MODEL FINAL**

**POLICY CHANGES**

Issue	Track 1: One-Sided Model (shared savings only)	Two-Sided Model (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Transition to Two-Sided Model	Remove requirement to transition to two-sided model for a second agreement period.	No change. ACOs may elect Track 2 without completing a prior agreement period under a one-sided model. Once elected, ACOs cannot go into Track 1 for subsequent agreement periods.	Same as Track 2
Assignment	No change. Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	No change. Preliminary prospective assignment for reports; retrospective assignment for financial reconciliation	Prospective assignment for reports, quality reporting and financial reconciliation; Beginning in 2017, beneficiaries may attest that their main doctor is participating in a performance-based risk track ACO and be assigned to that ACO (through PFS rulemaking)
Benchmark	Modifications to rebasing methodology for ACO's second or subsequent agreement period: equally weighting benchmark years, and including a per capita amount reflecting savings generated during prior agreement period.	Same as Track 1	Same as Tracks 1 and 2

Issue	Track 1: One-Sided Model (shared savings only)	Two-Sided Model (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Adjustments for health status and demographic changes	No change. Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the assigned beneficiary population for the performance year. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score.	No change. Same as Track 1.	Same as Tracks 1 and 2.
Final Sharing Rate	No change. Up to 50% based on quality performance (maintained for second agreement period under Track 1)	No change. Up to 60% based on quality performance	Up to 75% based on quality performance
Minimum Savings Rate (MSR) / Minimum Loss Rate (MLR)	No change. 2.0% to 3.9% MSR depending on number of assigned beneficiaries. MLR is not applicable to Track 1 ACOs.	Instead of a fixed 2.0% MSR/MLR ACOs will have a choice of a symmetrical MSR/MLR: (i) no MSR/MLR; (ii) symmetrical MSR/MLR in 0.5% increments between 0.5% - 2.0%;(iii) symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1)	Same as Track 2
Performance Payment Limit	No change. 10%	No change. 15%	20%
Shared Savings	No change. First dollar sharing once MSR is met or exceeded.	No change. Same as Track 1.	Same as Tracks 1 and 2
Shared Loss Rate	No change. Not applicable.	No change. One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 60%	One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared loss rate may not be less than 40% or exceed 75%

Issue	Track 1: One-Sided Model (shared savings only)	Two-Sided Model (shared savings / losses)	
		Track 2	Track 3 (newly established track)
Loss Sharing Limit	No change. Not applicable	No change. Limit on the amount of losses to be shared in phases in over 3-years starting at 5% in year 1; 7.5% in year 2; and 10% in year 3 and any subsequent year. Losses in excess of the annual limit would not be shared.	15%. Losses in excess of the annual limit would not be shared.
Payment and Program Rule Waivers and Part 425	Not applicable	Not applicable	Beginning in 2017, ACOs may elect to apply for a waiver of the SNF 3-Day Rule;  As early as 2017 begin to phase-in a waiver of certain billing and payment requirements for telehealth services after it is tested in the Innovation Center

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