



**Medicare Shared Savings Program, SNF
3-Day Rule Waiver, and Beneficiary
Incentive Program**

**APPLICATION REFERENCE
MANUAL FOR
AGREEMENT PERIOD BEGINNING
JANUARY 1, 2020**

Guidance

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MEDICARE
SHARED SAVINGS
PROGRAM

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1 Introduction

The Medicare Shared Savings Program (Shared Savings Program) promotes accountability for a population of Medicare beneficiaries, improves the coordination of fee-for-service (FFS) items and services, encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery, and promotes higher value care. Under the Shared Savings Program, providers of services and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare FFS payments under Parts A and B. ACOs that successfully meet quality and savings requirements share a percentage of the savings with Medicare. ACOs under a performance-based risk track, including Levels C, D, or E of the BASIC track or the ENHANCED track, may also be required to repay Medicare for shared losses.

The Centers for Medicare & Medicaid Services (CMS) accepts applications for ACOs to participate in the Shared Savings Program. An ACO may also separately apply to use the Skilled Nursing Facility (SNF) 3-Day Rule Waiver or to establish a Beneficiary Incentive Program (BIP).

1.1 PURPOSE OF THE APPLICATION REFERENCE MANUAL

This *Application Reference Manual* provides advice and details to help ACOs complete the Shared Savings Program, SNF 3-Day Rule Waiver, and BIP Applications.

Sample January 1, 2020, applications are available on the [Application Types & Timeline webpage](#) as an additional resource to help ACOs gather and prepare necessary information.

For more detailed information, review the additional resources and guidance available in the [Application Toolkit](#). Section 4 of this guide includes information on withdrawing a pending application. In addition to this manual, please refer to the [Shared Savings Program Pathways to Success Final Rule](#).

1.2 OVERVIEW OF THE APPLICATION PROCESS

The application process begins with the submission of a Notice of Intent to Apply (NOIA). Additional information on the NOIA process is available in the *NOIA Guidance* posted on the [Application Types & Timeline webpage](#). ACOs must submit a NOIA to be eligible to submit an application to the Shared Savings Program, SNF 3-Day Rule Waiver, and/or BIP. However, because a NOIA is non-binding, ACOs may choose to submit or not submit an application during the application submission period. After application submission, applicants will have several opportunities to correct errors in their application(s) prior to CMS issuing final dispositions later in the year. Upon

application approval, ACOs sign a participation agreement with CMS.¹ Figure 1 below depicts an overview of the application process.



Figure 1. Application Process

Visit the [Application Types & Timeline webpage](#) for deadlines and sample applications. This webpage includes actions ACOs can take for each RFI (refer to RFI Response Actions and Deadlines table).

ACOs apply electronically to the Shared Savings Program through ACO-MS. **CMS does not accept paper applications or emailed applications, and will not accept late or incomplete submissions.** Resources for how to use the system are available in the [Contact Us/FAQ](#) tab of ACO-MS.

Additional guidance on various aspects of the application is available in the [Application Toolkit](#) and referenced throughout this document.

1.3 APPLICANT COHORTS

Table 1. ACO Applicant Cohorts

Cohort	Definition
Currently Participating ACO	An ACO currently participating in the Shared Savings Program and, if applicable, the Track 1+ Model.
Initial Applicant	An ACO that is applying to participate in the Shared Savings Program that is not considered to have previously participated in the Shared Savings Program. If the ACO legal entity, or during the most recent 5 past performance years more than 50 percent of the ACO participants, participated in the same Shared Savings Program ACO, the ACO is not considered an Initial Applicant.
Renewal Applicant	An ACO that started its most recent ACO Participation Agreement in 2017 and intends to renew its participation for a new agreement period starting on January 1, 2020.
Early Renewal Applicant	An ACO currently participating in the Shared Savings Program that elects to voluntarily terminate its ACO Participation Agreement on December 31, 2019, and intends to apply for a new agreement period under the BASIC track or ENHANCED track starting on January 1, 2020.

¹ Currently participating ACOs that submit a SNF 3-Day Rule Waiver Application and/or BIP Application will not have to sign a participation agreement upon approval.

Cohort	Definition
Re-entering Applicant	An ACO that previously participated in the Shared Savings Program and is applying to participate in the Shared Savings Program after a break in participation. This includes ACOs that CMS determines to be re-entering because greater than 50 percent of their ACO participants have prior participation in the same Shared Savings Program ACO in any of the 5 most recent past performance years.
+ Supplemental Applications	Definition
<i>BIP Applicant</i>	<i>An ACO applying to establish a BIP. Available for ACOs currently participating under Track 2 or the ENHANCED track and ACOs applying to Levels C, D, or E of the BASIC track or the ENHANCED track.</i>
<i>SNF 3-Day Rule Waiver Applicant</i>	<i>An ACO applying for approval of a SNF 3-Day Rule Waiver. Available for ACOs currently participating under the ENHANCED track or the Track 1+ Model and ACOs applying to Levels C, D, or E of the BASIC track or the ENHANCED track.</i>

1.4 APPLICATION TYPES

There are four different applications associated with the Shared Savings Program.

Table 2: Application Types

Application Type	Summary of Application Information
Initial Application	<p>ACOs identified as initial or re-entering applicants will complete an Initial Application</p> <ul style="list-style-type: none"> Enter general organizational information about the ACO (some of this information will be pre-populated from your NOIA) Select a track Provide organizational chart and governing body information Submit a complete ACO Participant List Submit sample ACO Participant Agreement(s) and/or SNF Affiliate Agreement(s), executed ACO Participant Agreement(s) and/or SNF Affiliate Agreement(s), and repayment mechanism(s) (if applicable) Complete certifications Complete supplemental applications for a SNF 3-Day Rule Waiver and/or a BIP (optional)
Renewal/Early Renewal Application	<p>ACOs identified as renewal or early renewal applicants will complete a Renewal/Early Renewal Application</p> <ul style="list-style-type: none"> Verify accuracy of organizational information in the ACO Management System (ACO-MS) Select a track Provide organizational chart and governing body information

Application Type	Summary of Application Information
	<ul style="list-style-type: none"> ▪ Submit a complete ACO Participant List ▪ Submit sample ACO Participant Agreement(s) and/or SNF Affiliate Agreement(s), executed ACO Participant Agreement(s) and/or SNF Affiliate Agreement(s), and repayment mechanism(s) (if applicable) ▪ Complete certifications ▪ Complete supplemental applications for a SNF 3-Day Rule Waiver and/or a BIP (optional)
BIP Application	<p>All ACOs currently participating or applying to participate under an eligible track have the option to complete a BIP Application, if eligible</p> <ul style="list-style-type: none"> ▪ Currently participating under Track 2 or Track 3 (herein referred to as the ENHANCED track) ▪ Apply to participate under Levels C, D, or E of the BASIC track or the ENHANCED track ▪ Complete attestations and provide narratives
SNF 3-Day Rule Waiver Application	<p>All ACOs currently participating or applying to participate under an eligible track have the option to complete a SNF 3-Day Rule Waiver Application, if eligible</p> <ul style="list-style-type: none"> ▪ Currently participating under the ENHANCED TRACK ▪ Apply to participate under Levels C, D, or E of the BASIC track or the ENHANCED track ▪ Submit communication, beneficiary evaluation and admission, and care management plans ▪ Submit a complete SNF Affiliate List ▪ Submit sample SNF Affiliate Agreement(s) and executed SNF Affiliate Agreement(s) ▪ Complete certifications

To select your track and determine which application(s) to complete, refer to [Appendix A: Financial Description of Models](#) and [Appendix B: Participation Options](#).

2 Initial and Renewal/Early Renewal Application

There are five sections in the Shared Savings Program Initial and Renewal/Early Renewal Applications:

- **ACO Legal Entity Information:** General information about your ACO, such as legal entity name, address, taxpayer identification number (TIN), banking information, and contact information.
- **Program Participation Options:** Questions about how your ACO would like to either continue participation or apply to participate in the Shared Savings Program, such as level of performance-based risk, beneficiary assignment, repayment

mechanism arrangement, and to apply for a SNF 3-Day Rule Waiver and/or to establish and operate a BIP.

- **Leadership and Governance:** Questions about the leadership and organization of your ACO, such as organizational structure, governing body members, and conflict of interest policy.
- **ACO Participant List and Agreements:** Information about your ACO participants and their relationship to your ACO, including executed agreements between the ACO and the ACO participant. Information submitted in this section must be consistent with answers in the other sections of your ACO’s application.
- **Certifications:** Attestations that the ACO has procedures in place to perform ACO operations, such as ensuring data privacy and security, distributing shared savings payments, assuring and improving quality, promoting evidence-based medicine, engaging beneficiaries, and certifying that the ACO has appropriate clinical and operational management and is a legal entity under applicable law.

2.1 ACO LEGAL ENTITY INFORMATION

2.1.1 ORGANIZATIONAL INFORMATION

In the first section of the application, ACOs confirm organizational information pre-populated from the submitted NOIA, such as legal entity name, “doing business as” (DBA) or trade name, address, date of formation (DOF), and TIN. This information should match the information on the ACO’s entity formation documentation (e.g., Certificate of Incorporation) and any additional documentation submitted with the application (e.g., history and mission narrative, sample ACO Participant Agreement). If the ACO is owned or operated by a management company or parent company, indicate as such in this section. Refer to § 425.204(c)(4).

Also, in this section, indicate whether the ACO is considered “newly formed.” ACOs that have signed or jointly negotiated any contracts with private payers after March 23, 2010, must agree to permit CMS to share a copy of this application with the Antitrust Agencies. An ACO is not newly formed if it is comprised solely of providers and suppliers that signed or jointly negotiated contracts with private payers on or before March 23, 2010.

ADDITIONAL RESOURCE

[Federal Trade Commission \(FTC\) and Department of Justice’s \(DOJ\) Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations](#)

2.1.2 PUBLIC REPORTING WEBPAGE

Upon approval to participate in the Shared Savings Program, ACOs are required to create and maintain a designated webpage to post organizational and programmatic information about the ACO, as specified in § 425.308. If the ACO already has a public reporting webpage in place, provide the webpage URL in the application. If your ACO’s

public reporting webpage is not operational at the time of application submission, you will be required to describe your ACO’s plan for ensuring that the webpage is operational and fully compliant with program requirements by January 1, 2020.

FOR RENEWAL APPLICANTS (INCLUDING EARLY RENEWAL APPLICANTS) ONLY: Confirm that your public reporting webpage URL has not changed.

2.1.3 BANKING INFORMATION

Applicants must provide their banking information to CMS. In order to receive any earned shared savings payments, Shared Savings Program ACOs must submit a completed Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS-588) to CMS.

**ADDITIONAL
RESOURCES**

[Form CMS-588](#)

[ACO Banking Form Guidance](#)

FOR RENEWAL APPLICANTS (INCLUDING EARLY RENEWAL APPLICANTS) ONLY:

Renewal applicants and currently participating ACOs do not need to submit a Form CMS-588 unless changes are made to any of the following:

- Legal entity name
- TIN
- Financial institution information
- Authorized/Delegated Official
- Contact person(s)
- Address

2.1.4 CONTACT INFORMATION

ACOs must submit contact information for the roles described in the [Overview of ACO-MS User Access and ACO Contacts](#) tip sheet. Keep in mind the following guidelines:

- An individual can serve as more than one ACO contact. However, CMS recommends that applicants diversify their contacts by assigning a different person to each role.
- Primary and secondary contacts must be two different people, and the Data Use Agreement (DUA) Requestor and DUA Custodian must be two different people.
- Applicants may submit consultant and management company contact information; however, they may not be the only contacts for an ACO. Individual(s) directly from the ACO must also be listed as ACO contacts.
- Update the Contact Data page in ACO-MS with the appropriate contact information when there is

 **TIPS FOR SUCCESS**

It is critical that all ACO contacts log into the system to verify that their contact role(s) and contact information is correct. Please verify email addresses and phone numbers, in particular.

You can have more than one person designated as secondary contact(s). For example, having more than one person that can sign documents on behalf of your ACO (i.e., Authorized to Sign secondary contact) may save individuals’ time when executing ACO Participant Agreements or completing Annual Certification.

a change in ACO contacts within your ACO (e.g., new personnel, departing personnel, changes in roles).

**FOR RENEWAL APPLICANTS (INCLUDING EARLY RENEWAL APPLICANTS)
ONLY:** Renewal applicants should update and confirm contact information for all roles.

2.2 PROGRAM PARTICIPATION OPTIONS

2.2.1 SHARED SAVINGS PROGRAM TRACKS

Applicants apply to participate in a Shared Savings Program in either the BASIC track or the ENHANCED track. The BASIC track includes a glide path, for eligible ACOs, which begins under a one-sided model and incrementally phases-in increasing levels of performance-based risk over the course of the ACO's agreement period.

Applicants applying to the BASIC track would choose between the following:

- BASIC track Levels A through E (for eligible ACOs): Applicants select the level of risk and reward to enter for their first performance year. ACOs are automatically advanced through the levels of the glide path. ACOs also have the option to elect to advance more rapidly to higher levels of risk and reward each performance year.
- An agreement period under Level E of the BASIC track: Applicants ineligible for the BASIC track's glide path, but eligible for an agreement period in the BASIC track may participate under Level E for all performance years of the agreement period.

[Appendix A](#) provides a summary of features of each track (and the levels of the BASIC track's glide path). The factors used to determine eligibility for the program's tracks are summarized in section 2.2.2.

Initial and renewal applicants (including early renewal applicants) can change tracks during the application cycle in accordance with the guidance on the [Application Types & Timeline webpage](#) (refer to Track Changes for Agreement Period Beginning on January 1, 2020, in the following table: Application Cycle: RFI Response Actions and Deadlines).

2.2.2 DETERMINING PARTICIPATION OPTIONS

The eligibility criteria for the BASIC track, including the glide path, and the ENHANCED track recognize differences in ACO participants' Medicare FFS revenue and the experience of the ACO and its ACO participants with performance-based risk Medicare ACO initiatives. CMS uses a combination of the following factors to determine an ACO's participation options: (1) whether applicants are low revenue ACOs or high revenue ACOs; and (2) whether applicants are experienced or inexperienced with performance-based risk Medicare ACO initiatives. During each RFI cycle of the application review period, CMS provides applicants with feedback on these criteria, evaluated based on the ACO's latest ACO Participant List.

⚠ IMPORTANT

Due to the ACO Participant List changing during each RFI cycle, participation options, for which ACOs are eligible, may vary based on the low or high revenue calculations as well as the experienced or inexperienced calculations as described above.

- If an ACO is identified as a **high revenue ACO**, the following options apply:
 - An ACO determined to be inexperienced with performance-based risk Medicare ACO initiatives may choose from the following options:
 - BASIC track's glide path
 - Eligible ACOs that are new to the program, and identified as initial applicants rather than re-entering ACOs, may enter the BASIC track's glide path at any one of the five levels (Levels A through E).
 - An ACO that previously participated in Track 1, or a new ACO identified as a re-entering ACO because more than 50 percent of its ACO participants have recent prior experience in the same Track 1 ACO, may enter the BASIC track's glide path under Levels B, C, D, or E.
 - ENHANCED track
 - An ACO determined to be experienced with performance-based risk Medicare ACO initiatives may only enter the ENHANCED track.

Note: An ACO in a first or second agreement period beginning in 2016 or 2017 identified as experienced with performance-based risk Medicare ACO initiatives based on participation in the Track 1+ Model may renew, or early renew, for a consecutive agreement period beginning either under Level E of the BASIC track or the ENHANCED track.
- If an ACO is identified as a **low revenue ACO**, the following options apply:
 - An ACO determined to be inexperienced with performance-based risk Medicare ACO initiatives may choose from the following options:
 - BASIC track's glide path
 - Eligible ACOs that are new to the program, and identified as initial applicants rather than re-entering ACOs, may enter the BASIC track's glide path at any one of the five levels (Levels A through E).

Note: Prior to the automatic advancement of the ACO to Level C, an ACO may elect to remain in Level B for performance year 3 (performance year 4 in the case of ACOs entering an agreement period beginning on July 1, 2019). In the case of an ACO that elects to remain in Level B for an additional performance year, the ACO is automatically advanced to Level

E at the start of performance year 4 (or performance year 5 in the case of ACOs entering an agreement period beginning on July 1, 2019).

- An ACO that previously participated in Track 1 or a new ACO identified as a re-entering ACO because more than 50 percent of its ACO participants have recent prior experience in the same Track 1 ACO may enter the BASIC track's glide path under Levels B, C, D, or E.
- ENHANCED track
- An ACO determined to be experienced with performance-based risk Medicare ACO initiatives may choose from the following options:
 - Agreement period under Level E of the BASIC track for all performance years.

Note: Low revenue ACOs are limited to two agreement periods of participation under the BASIC track. We monitor for changes in revenue during the agreement period. ACOs that become high revenue during the agreement period are required to take corrective action and if the issue is not remedied, the ACO may be terminated.

- ENHANCED track

2.2.3 AGREEMENT PERIOD ACO IS ENTERING FOR POLICIES THAT PHASE-IN OVER TIME

For ACOs with agreement periods beginning on or after July 1, 2019, CMS will determine the agreement period an ACO is entering for purposes of applying the following program requirements that phase-in over multiple agreement periods:

- The quality performance standard as described in § 425.502(a)
- The weight used to calculate the regional adjustment to the ACO's historical benchmark as described in § 425.601(f)
- The use of equal weights to weight each benchmark year as specified in § 425.601(e)

An ACO entering an initial agreement period is considered to be entering a first agreement period in the Shared Savings Program. A renewing ACO is considered to be entering the next consecutive agreement period in the Shared Savings Program.

A re-entering ACO is considered to be entering a new agreement period in the Shared Savings Program as follows:

- An ACO whose participation agreement expired without having been renewed re-enters the program under the next consecutive agreement period in the Shared Savings Program.

- An ACO whose participation agreement was terminated under § 425.218 or § 425.220 re-enters the program at the start of the same agreement period in which it was participating at the time of termination from the Shared Savings Program, beginning with the first performance year of that agreement period.
- A new ACO identified as a re-entering ACO enters the program in an agreement period that is determined based on the prior participation of the ACO in which the majority of the new ACO's participants participated. Regarding this third category of ACOs, if the participation agreement of the other ACO was terminated or expired, the previously described rules for re-entering ACOs would also apply. However, if the other ACO is currently participating in the program, 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.

There is a phase-in for the regional adjustment weights for ACOs with start dates in the program before July 1, 2019.

2.2.4 EXAMPLES OF PHASE-IN OF MODIFIED REGIONAL ADJUSTMENT WEIGHTS BASED ON AGREEMENT START DATE AND APPLICANT TYPE

Table 3 below includes examples of the phase-in of the modified regional adjustment weights based on agreement start date and applicant type (initial, renewal, or re-entering ACO). This table illustrates the weights that would be used to determine the regional adjustment to the ACO's historical benchmark under this final rule to differentiate initial, renewal (including early renewal applicants), and re-entering ACOs for purposes of policies that phase-in over time. CMS provides additional information describing the regional adjustment in the *Shared Savings and Losses and Assignment Methodology Specifications* available on the [Program Guidance & Specifications webpage](#).

Table 3: Examples of Phase-in of Modified Regional Adjustment Weights Based on Agreement Start Date and Applicant Type (83 FR 67908)

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
<u>New entrant</u> 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
<u>Renewing ACO</u> 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
<u>Early renewal</u> 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
<u>Re-entering ACO</u> with initial start date in 2014 whose agreement expired December 31, 2016, (did not renew) and <u>re-enters</u> second agreement period starting on July 1, 2019	Applicable to second agreement period starting on July 1, 2019, (ACO considered to be re-entering a second agreement period)	Applicable to third agreement period starting in 2025	Applicable to fourth agreement period starting in 2030	Applicable to fifth agreement period starting in 2035 and all subsequent agreement periods

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
<u>Re-entering ACO</u> with second agreement period start date in 2017 terminated during performance year 2 (2018) and <u>re-enters</u> second agreement period starting on July 1, 2019	Applicable to second agreement period starting on July 1, 2019, (ACO considered to be re-entering a second agreement period)	Applicable to third agreement period starting in 2025	Applicable to fourth agreement period starting in 2030	Applicable to fifth agreement period starting in 2035 and all subsequent agreement periods

2.2.5 BENEFICIARY ASSIGNMENT METHODOLOGY SELECTION

ACOs will select which methodology CMS uses to determine the population of beneficiaries for which an ACO is accountable (reference below). Prior to the start of each performance year, the ACO may change its beneficiary assignment methodology selection during Annual Certification.

Prospective

- Beneficiaries are assigned to an ACO before the start of each benchmark and performance year. Beneficiaries that become ineligible for assignment during the calendar benchmark or performance year, will be excluded from final financial calculations.
- Once a beneficiary is prospectively assigned for a benchmark or performance year, the beneficiary will not be eligible for assignment to a different ACO, even if the beneficiary obtains a plurality of his or her primary care services from ACO professionals in a different ACO during the benchmark or performance year
- CMS provides prospective assignment lists to all ACOs following Annual Certification prior to the start of each performance year, and provides quarterly assignment lists that reflect beneficiary exclusions for the year-to-date period. CMS also provides assignment lists for each benchmark year as part of the historical benchmark package.

Retrospective

- Beneficiaries are preliminary prospectively assigned and then final beneficiary assignment is determined retrospectively at the end of the year for each benchmark and performance year.
- CMS provides preliminary prospective assignment lists to all ACOs following Annual Certification prior to the start of the performance year and on a quarterly basis to let ACOs know which beneficiaries have received care from their organization. The list of beneficiaries may change from quarter to quarter.

2.2.6 MINIMUM SAVINGS RATE/MINIMUM LOSS RATE

To qualify for shared savings, ACOs must meet or exceed their Minimum Savings Rate (MSR), fulfill the minimum quality performance standard, and maintain their eligibility to participate in the Shared Savings Program. To be liable for shared losses, ACOs must meet or exceed their Minimum Loss Rate (MLR).

ACOs applying under Levels A or B of the BASIC track will have a MSR that varies based on the number of beneficiaries assigned to the ACO.

ACOs applying under Levels C, D, or E of the BASIC track or applying to the ENHANCED track must select one of the following:

- Zero percent MSR/MLR;
- A symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2 percent; or
- A symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO. The MSR is the same as the MSR that would be used by Levels A or B of the BASIC track and the MLR is equal to the negative MSR.

ACOs that select a higher MSR/MLR have the protection of having to meet a higher threshold before being liable for losses; however, they will also have a higher threshold to meet before being eligible for shared savings. ACOs that select a lower MSR/MLR will have less protection against liability for losses but may benefit from a lower threshold for shared savings.

For more information, refer to the *Shared Savings and Losses and Assignment Methodology Specifications* located on the [Program Guidance and Specifications](#) webpage.

2.2.7 REPAYMENT MECHANISM

If an ACO selects Level C, D, or E of the BASIC track or the ENHANCED track, it must have a repayment mechanism that it can use to repay CMS for any shared losses incurred.

ACOs may use funds placed in escrow, a surety bond, a line of credit the Medicare program can draw upon (as evidenced by a letter of credit), or a combination of these arrangements.

For more information, refer to the [Repayment Mechanism Arrangements Guidance](#) for more details.

ADDITIONAL RESOURCE

[Repayment Mechanism Arrangements Guidance](#)

FOR RENEWAL APPLICANTS (INCLUDING EARLY RENEWAL APPLICANTS)

ONLY: Renewal applicants can keep their previously approved method of repayment mechanism (i.e., surety bond, letter of credit, funds placed in escrow), but must submit amendment documentation to the previously approved repayment mechanism arrangement. Please see the Repayment Mechanism Arrangements Guidance for further details.

2.2.8 SNF 3-DAY RULE WAIVER

The SNF 3-Day Rule Waiver waives the requirement for a prior inpatient stay for eligible beneficiaries to SNF affiliates and provides SNF waiver-approved ACOs additional flexibility to increase quality and decrease costs.

ACOs applying to participate in Levels C, D, or E of the BASIC track or the ENHANCED track, or ACOs currently participating in Track 3 (herein referred to as the ENHANCED track) or the Track 1+ Model, have the option to elect to apply for a SNF 3-Day Rule Waiver. If your ACO intends to apply for a SNF 3-Day Rule Waiver, you must submit a SNF 3-Day Rule Waiver Application.

ADDITIONAL RESOURCE

[SNF 3-Day Rule Waiver Guidance](#)

For more information, refer to the [SNF 3-Day Rule Waiver Guidance](#) for more details.

2.2.9 BENEFICIARY INCENTIVE PROGRAM

ACOs participating under certain two-sided models may apply to establish and operate a BIP to provide incentive payments to assigned beneficiaries who receive qualifying services. Beginning July 1, 2019, currently participating Track 2 and Track 3 (herein referred to as the ENHANCED track) ACOs, as well as ACOs in Levels C, D, or E of the BASIC track or the ENHANCED track, have the option to apply to establish a BIP. If your ACO intends to apply to establish a BIP, you must submit a BIP Application.

2.3 LEADERSHIP AND GOVERNANCE

As part of an Initial or Renewal/Early Renewal Application, applicants provide information about the ACO's leadership. The description submitted in this section provides context about the ACO's ability to meet eligibility requirements, its structure, history, relationships, and mission. Refer to the regulatory requirements at § 425.204(c)(1)(iii).

FOR RENEWAL APPLICANTS (INCLUDING EARLY RENEWAL APPLICANTS)

ONLY: Submit a narrative describing any substantive changes to your organization and/or affiliations since the approval of your Initial Application.

2.3.1 ORGANIZATIONAL CHART

Applicants must submit an organizational chart. The chart should clearly depict the flow of responsibility and reporting structure and be consistent with information included in

the ACO's historical narrative. The organizational chart should include the following roles:

- Medical director/chief medical officer and name;
- Compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body and name;
- ACO Executive and name;
- A list of committees (include names of committee members) and the committee structures; and
- Qualified healthcare professional responsible for the ACO's quality assurance and improvement program and name.

Refer to the regulatory requirements at § 425.204(c)(1)(iii), § 425.112(a)(2), § 425.300, and § 425.108.

2.3.2 GOVERNING BODY

General

ACOs must submit information about their governing body and confirm that specific governance procedures are in place. As part of the application, ACOs must provide governing body members, membership type, voting power, and the ACO participant legal business name (LBN). Additionally, in the Initial and Renewal/Early Renewal Applications, ACOs must attest that:

- The governing body is the same as the governing body of the legal entity that is the ACO;
- The governing body is separate and unique to the ACO and is not the same as the governing body of any ACO participant in the case where the ACO comprises two or more ACO participants;
- The governing body has responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities;
- The governing body has a transparent governing process; and
- The governing body members have a fiduciary duty to the ACO, including the duty of loyalty, and must act according to that fiduciary duty.

Refer to regulatory requirements at §§ 425.106(a) and (b) and 425.204(c)(1)(iii).

Composition and Control

The ACO must establish a mechanism for shared governance among the ACO participants that formed the ACO. ACO participants must represent at least 75 percent of the voting power for all voting members. CMS determines whether ACO participants

hold 75 percent control of the ACO's governing body by calculating the percentage of voting power held by the ACO participant representatives. CMS does not include non-voting governing body members in the calculation.

CMS does not require an ACO's governing body to include a representative from each ACO participant listed on its ACO Participant List. However, the program rules require an ACO to provide meaningful participation in the composition and control of the ACO's governing body for ACO participants and/or their designated representatives. For example, if one ACO participant holds 85 percent voting power and all other ACO participants hold 15 percent voting power, the ACO must provide an explanation of why it seeks to differ from this requirement and how this design provides a sufficient mechanism for shared governance and ensures all ACO participants have meaningful participation in the governing body.

The ACO must also provide meaningful representation for Medicare FFS beneficiaries on its governing body. For example, the ACO could include a Medicare FFS beneficiary on its governing body as a voting member. Any Medicare FFS beneficiary on the governing body must be served by the ACO, cannot be an ACO provider or supplier, cannot have a conflict of interest with the ACO and cannot have an immediate family member with a conflict of interest with the ACO. If an ACO chooses to include a Medicare FFS beneficiary on the governing body without voting power the ACO must provide an explanation of why it seeks to differ from this requirement and how the ACO demonstrates meaningful representation of Medicare FFS beneficiaries in governance.

Refer to regulatory requirements at § 425.106.

2.3.3 CONFLICT OF INTEREST POLICY

While CMS does not require applicants to submit conflict of interest policy documentation, ACOs must certify they have a policy in place that will be made available to CMS upon request. This conflict of interest policy should:

- Require each member of the governing body to disclose relevant financial interests;
- Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
- Address remedial action for members of the governing body that fail to comply with the policy.

Refer to regulatory requirements at § 425.106(d)

2.3.4 COMPLIANCE PLAN

While CMS does not require applicants to submit their compliance plans in the application, ACOs must certify they have a plan in place that will be made available to CMS upon request. The compliance plan should include the following elements:

- A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body;
- Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;
- A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, or for other entities performing functions or services related to ACO activities, to report anonymously suspected problems to the compliance officer;
- Compliance training for the ACO, ACO participants, and ACO providers/suppliers; and
- A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

Refer to regulatory requirements at §§ 425.300 and 425.204(c)(1)(vi).

2.3.5 SHARED SAVINGS PROGRAM PRIOR PERFORMANCE AND PARTICIPATION

For ACOs renewing or re-entering the program, in your ACO's application you are required to disclose:

- Whether your ACO has failed to meet the Shared Savings Program quality performance standard for two or more years;
- Whether your ACO has failed to timely repay shared losses;
- Whether your ACO has generated losses outside its negative corridor for two or more years; and
- Whether your ACO has voluntarily or involuntarily been terminated from the Shared Savings Program.

If your ACO answered yes to any of the above, then you will be required to provide a narrative for each selection that demonstrates your ACO has corrected the deficiencies that caused any noncompliance, and how your ACO will remain in compliance with the terms of the new participation agreement, per §425.224(b).

2.4 ACO PARTICIPANT LIST

In your ACO's application, you must submit information on the ACO participants that have agreed to form the ACO and certify that they are accountable for the quality, cost, and overall care of the ACO's beneficiaries. An ACO Participant List identifies all of an ACO's participants by their Medicare-enrolled TINs. For initial applicant ACOs, you will create the ACO Participant List directly in ACO-MS by submitting change requests to add new ACO participants. For renewal applicant ACOs (including early renewal applicant ACOs), you will select which of your current ACO participants will continue

with your ACO for its new agreement period and submit change requests to upload new supporting documentation for those selected TINs.

When an ACO starts a change request to add an ACO participant or a SNF affiliate, ACO-MS compares the ACO’s entry to the Provider Enrollment, Chain, and Ownership System (PECOS) data for the TIN and the TIN’s LBN, Medicare enrollment, sole proprietor status, and Medicare exclusion. Please note that ACOs can submit a change request that does not pass the ACO-MS PECOS check at the time of submission. However, the participant must ultimately pass all checks at the time of CMS’ final ACO-MS PECOS refresh in order to be approved for participation.

Whether your ACO is composed of one or multiple ACO participants has important implications for your ACO’s structure and agreement submission requirements. Table 4 below describes a few of these implications.

Table 4: Common ACO Structures

ACO STRUCTURE	NOTES
TRADITIONAL ACO (MOST COMMON ACO STRUCTURE)	<ul style="list-style-type: none"> Multiple ACO participants join to form the ACO The ACO is a separate legal entity from the ACO participants Submit sample ACO Participant Agreement and all executed ACO Participant Agreements
SINGLE TIN ACO	<ul style="list-style-type: none"> The ACO is comprised of one ACO participant The ACO and ACO participant are the same legal entity Under this structure, you will need to contact the Shared Savings Program if you want to modify your ACO Participant List in the future Submit sample employment agreement and/or sample ACO Provider/Supplier Agreement
SINGLE TIN ACO SET UP AS TRADITIONAL ACO	<ul style="list-style-type: none"> The ACO is comprised of one ACO participant The ACO and ACO participant are different legal entities Submit sample ACO Participant Agreement and executed ACO Participant Agreement

Applicants will submit TINs and their LBNs for the ACO participants that have agreed to participate in their ACO. For ACO participants that are enrolled in Medicare as sole proprietors, ACOs may need to submit both Social Security numbers (SSNs) and Employer Identification Numbers (EINs). Each ACO participant must have executed supporting documentation (e.g., executed agreements) uploaded in ACO-MS demonstrating the ACO participant’s agreement to participate in the ACO. Please remember that if you are submitting TINs that have merged with or acquired another

ADDITIONAL RESOURCE

[ACO Participant List and Participant Agreement Guidance](#)

TIN, you will need to provide the appropriate supporting documentation per § 425.204(g).

For more information, refer to the [ACO Participant List and Participant Agreement Guidance](#) for more details.

2.5 ACO PARTICIPANT AGREEMENTS

2.5.1 SAMPLE ACO PARTICIPANT AGREEMENTS

In this section of the application, if a sample agreement was not uploaded with the NOIA, applicants must submit its sample agreement(s) for CMS review. Applicants must also complete the sample ACO Participant Agreement requirements table in ACO-MS and note the section and page number of the sample agreement that fulfills each requirement. Deficiencies identified in response to the sample agreement submitted with the NOIA and/or the application submission must be corrected.

Applicants must certify that their ACO participants will make a meaningful commitment to the goals of the ACO. Meaningful commitment may include a sufficient financial or human investment (e.g., time and effort) in the ongoing operations of the ACO such that the potential loss or recoupment of the investment is likely to motivate the ACO participant and ACO provider/supplier to achieve the ACO's mission under the Shared Savings Program. A meaningful commitment can be shown when an ACO participant or ACO provider/supplier agrees to comply with and implement the ACO's processes required by § 425.112 and is held accountable for meeting the ACO's performance standards for each required process.

For more information, refer to the [ACO Participant List and Participant Agreement Guidance](#).

2.5.2 EXECUTED ACO PARTICIPANT AGREEMENTS

ACOs are expected to employ good contracting practices when executing ACO Participant Agreements with ACO participants. CMS must receive a copy of each fully executed agreement (first page and signature page only) and any amendments (if applicable). A fully executed agreement or amendment is one that includes digital or handwritten signatures for both the ACO and the ACO participant. CMS may request complete, original, wet signature-executed agreements.

2.6 CERTIFICATIONS

2.6.1 ACO'S LEGAL ENTITY

Applicants must certify that the ACO is a legal entity under applicable state, federal, or tribal law. This legal entity:

- Receives and distributes shared savings;
- Repays shared losses or other monies determined to be owed to CMS;

- Establishes, reports, and ensures provider compliance with health care quality criteria, including quality performance standards; and
- Fulfills other ACO functions identified in 42 CFR part 425.

Applicants must certify they have all documents available that effectuate the formation and operation of the ACO (e.g., charters, by-laws, articles of incorporation, etc.) and that the ACO legal entity is separate from that of the ACO participants as described in § 425.204(c)(iii)(4)(ii). CMS may request charters, by-laws, articles of incorporation, partnership, joint venture, management or asset purchase agreements, financial statements and records, resumes, and other documentation required for ACO leadership.

2.6.2 DATA SHARING

Applicants must certify that they are requesting the minimum necessary data on beneficiaries assigned to their ACO. The CMS data files are covered in the DUA your ACO will sign upon application approval (the DUA is not required at the time of application submission—ACOs will submit their DUA upon approval to the program and during the Annual Certification period).

ACOs may also request to receive beneficiary-identifiable Part A, B, and/or D claims data, which CMS provides in Claim and Claim Line Feed (CCLF) files. For more information, refer to the [CCLF File Data Elements Resource](#).

You must certify that you are requesting this information as a HIPAA-covered entity or as a business associate of a HIPAA-covered entity and that the requested data reflects the minimum data necessary for your ACO to conduct your own health care operations or the health care operations of your covered entity ACO participants and ACO providers/suppliers.

ACOs must certify they have a plan to ensure data privacy and security in place that will be made available to CMS upon request. This plan should include how your ACO intends to use the data to evaluate the performance of ACO participants and providers/suppliers, conduct quality assessment and improvement activities, and conduct population-based activities to improve the health of your assigned beneficiary population.

2.6.3 ACO LEADERSHIP AND MANAGEMENT

Applicants must certify that their ACO's operations are managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body, and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes, and outcomes.

The ACO must have administrative and clinical leadership:

- **Administrative:** Operations must be managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency processes and outcomes.
- **Clinical:** Medical director must be a board-certified physician, licensed in a state in which the ACO operates, and physically present on a regular basis at any clinic, office, or other location of the ACO, an ACO participant, or an ACO provider/supplier.

Refer to regulatory requirements at §§ 425.108 and 425.204.

2.6.4 MANAGING SHARED SAVINGS

ACOs must certify they have a plan to distribute shared savings that will be made available to CMS upon request. This plan should include how your ACO intends to share savings with ACO participants and ACO providers/suppliers, or to use the shared savings to reinvest in the ACO's infrastructure, redesigning care processes, etc. The plan should also describe the percentage of savings the ACO intends to distribute as re-investment into the ACO's resources and, if the ACO intends to distribute shared savings among ACO participants and ACO providers/suppliers, a description of the criteria the ACO intends to use for distributing these payments.

2.6.5 QUALITY ASSURANCE AND IMPROVEMENT PROGRAM

Applicants must certify that their ACO has a qualified health professional responsible for the ACO's quality assurance and improvement program that encompasses the four required processes (evidence-based medicine, beneficiary engagement, quality and cost metrics, and coordination of care).

Applicants must certify they have a plan to require participants to comply with and implement quality assurance and improvement programs that will be made available to CMS upon request. The quality assurance and improvement plan must also include your ACO's remedial processes and penalties that apply to ACO participants and/or ACO providers/suppliers that fail to comply with these required processes.

Applicants must certify they have a plan to promote evidence-based medicine that will be made available to CMS upon request. This plan should cover diagnoses with significant potential for the ACO to achieve quality improvements for overall care practices, taking into account the circumstances of individual beneficiaries and internal assessments of this process to continuously improve your ACO's care practices.

ACOs must certify they have a plan to promote beneficiary engagement that will be made available to CMS upon request.

ACOs must certify they have a plan to support internal reporting on quality and cost metrics that will be made available to CMS upon request. This plan should explain how

your ACO monitors, provides feedback on, and evaluates ACO participant and provider/supplier performance. The plan should also explain how your ACO will use these results to improve care and service over time and how internal assessment processes enable your ACO to continuously improve the ACO's care practices.

ACOs must certify they have a plan to coordinate care that will be made available to CMS upon request.

Finally, applicants must attest on behalf of the ACO, ACO participants, and ACO providers/suppliers that they will be held accountable for quality, cost, and overall care of Medicare FFS beneficiaries assigned to the ACO.

Refer to regulatory requirements at § 425.204 (a).

3 SNF 3-Day Rule Waiver Application

The SNF 3-Day Rule Waiver waives the requirement for a prior inpatient stay for eligible beneficiaries to approved SNF affiliates. As part of the application process, the ACO will be required to certify that it has processes in place to implement the SNF 3-Day Rule Waiver. The ACO will also be required to submit the following documents:

Communication Plan, Beneficiary Evaluation and Admission Plan, Care Management Plan Policy, SNF Affiliate List, and Sample SNF Affiliate Agreement. For renewal applicants (including early renewal applicants) that currently have an approved SNF 3-Day Rule Waiver and that elect to continue to use the SNF 3-Day Rule Waiver, you will select which of your current SNF affiliates will continue with your ACO for its new agreement period. Renewal applicant ACOs (including early renewal applicants) that elect to continue to use the SNF 3-Day Rule Waiver and need to make changes to their previously approved SNF 3-Day Rule Waiver Application should contact the SSPACO_applications@cms.hhs.gov mailbox and copy their CMS coordinator.

3.1 COMMUNICATION, BENEFICIARY EVALUATION & ADMISSION, AND CARE MANAGEMENT PLAN POLICY

As part of the SNF 3-Day Rule Waiver Application, applicants must be prepared to provide CMS with the following documents.

Communication Plan



The Communication Plan must include:

- A process to evaluate and update the Communication Plan
- A process for identifying persons at the ACO and SNF affiliate responsible for communications and coordinating admissions
- A process for sharing information/data
- The frequency of communications
- A process for communicating the Beneficiary Evaluation and Admissions Plan and Care Management Plan Policy to SNF affiliates and other individuals providing care under the waiver
- A process for responding to questions and complaints

Beneficiary Evaluation & Admissions Plan



The Beneficiary Evaluation and Admissions Plan must include protocols for:

- An ACO provider/supplier (physician) to evaluate and approve SNF affiliate admissions
- Educating and training SNF affiliates regarding waiver requirements and the ACO's Communication Plan, Beneficiary Evaluation and Admission Plan, and Care Management Plan Policy
- Admitting beneficiaries to a SNF directly from home or an outpatient setting
- Admitting beneficiaries to a SNF when the beneficiary does not need the full 3-day inpatient hospital stay
- Informing beneficiaries about the waiver and their options for care settings

Care Management Plan Policy



The Care Management Plan Policy must include:

- Designated points of contact at the ACO provider/supplier and the SNF affiliate to initiate the admission and accept the beneficiary
- Certification by designated points of contact at both the ACO provider/supplier and the SNF affiliate that the beneficiary meets waiver requirements
- A plan for how the beneficiary's care will be managed and communicated at the SNF affiliate, including seamless transition upon discharge from the SNF affiliate
- Provision for high-quality care, including facilitating optimum length of stay
- Aspects of the Communication Plan to be implemented by ACO providers/suppliers for the beneficiary before, during, and after SNF admission
- Contact information for the ACO's medical director and health care professional responsible for the ACO's quality assurance and improvement program as resources for stakeholder inquiries

3.2 SNF AFFILIATE LIST AND AGREEMENTS

3.2.1 REQUIREMENTS

SNF Affiliates

- SNF affiliates must bill through a Medicare-enrolled TIN
- SNF affiliates must maintain an overall rating of three stars or higher under the CMS 5-Star Quality Rating System
- SNF affiliates are not required to be ACO participants or ACO providers/suppliers and they can choose to partner with more than one ACO

SNF Affiliate List

The SNF Affiliate List must include the following information for each SNF affiliate:

- LBN
- TIN
- CMS Certification Number (CCN)
- CCN LBN

SNF Affiliate Agreements

Each SNF affiliate on the SNF Affiliate List must have a valid agreement with the ACO that includes the following elements:

- An agreement to comply with the requirements and conditions of the Shared Savings Program
- Effective date
- An agreement to implement and comply with the ACO's Beneficiary Evaluation and Admissions Plan and Care Management Plan
- An agreement to validate the eligibility of beneficiaries to receive covered SNF services
- Remedial processes and penalties for noncompliance



TIPS FOR SUCCESS

CMS may ask ACOs to revise and/or re-execute their SNF Affiliate Agreements if they do not meet program requirements. Executed SNF Affiliate Agreements must:

- Expressly state the only parties of the agreement are the ACO and SN F affiliate.
- Be signed by individuals who are authorized to bind the ACO and SNF affiliate, respectively.
- Include the first page and signature page of the executed agreement within the SNF Affiliate List they submit to ACO-MS.
- Match the approved sample agreement submitted with the application.
- Include the SNF affiliate's CCN and CCN LBN, associated with its Medicare-enrolled TIN. This information must match the information in PECOS.

3.3 CERTIFICATIONS

ACOs must certify that they have processes in place to successfully facilitate use of the SNF 3-Day Rule Waiver in accordance with Shared Savings Program regulations and requirements.

4 Withdrawing a Pending Application

Pending applicants that submit an application but do not intend to participate in the Shared Savings Program, SNF 3-Day Rule Waiver, and/or BIP have the ability to withdraw their pending application by following the below steps:

- Submit a written request on your ACO's letterhead, signed by the ACO Executive. The letter must include:
 - The organization's legal entity name;
 - ACO ID;
 - Complete address;
 - Point of contact information (phone number and email address); and
 - Statement indicating the ACO's request to withdraw.
- Send the request to withdraw as a PDF to SSPACO_Applications@cms.hhs.gov with the ACO ID and the phrase "Withdrawal Request" in the subject line of the email.

FOR EARLY RENEWAL APPLICANTS ONLY: RFI-2 is the last opportunity to withdraw your pending Early Renewal Application. After the deadline to respond to RFI-2 has passed, early renewal applicants that choose to withdraw their application will be terminated from the Shared Savings Program effective December 31, 2019.

If you decide to withdraw, you must submit a written request on your organization's letterhead, signed by your ACO Executive. The letter must include the organization's legal entity name, ACO ID, complete address, point of contact information (phone number and email address), statement indicating your ACO's request to withdraw and the reason for your withdrawal. Send the request to withdraw as a PDF to SSPACO_Applications@cms.hhs.gov with the ACO ID and the words "Withdrawal Request" in the Subject line of the email.

Appendix A: Financial Description of Models

COMPARISON OF RISK AND REWARD UNDER BASIC TRACK AND ENHANCED TRACK (83 FR 67852)

	BASIC Track's Glide Path				ENHANCED Track
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Shared Savings (once MSR met or exceeded)	1 st dollar savings at a rate of up to 40% based on quality performance; not to exceed 10% of updated benchmark	1 st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1 st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1 st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1 st 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	1 st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1 st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1 st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (for example, 8% of ACO participant revenue in 2019 – 2020), capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard (for example, 4% of updated benchmark in 2019 – 2020)	1 st dollar losses at a rate of 1 minus final sharing rate (between 40% - 75%), not to exceed 15% of updated benchmark
Annual choice of beneficiary assignment methodology?	Yes	Yes	Yes	Yes	Yes

	BASIC Track's Glide Path				ENHANCED Track
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Annual election to enter higher risk?¹	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?^{2 3}	No	No	No	Yes	Yes

Notes: ¹An eligible new legal entity (not identified as a re-entering ACO), identified as a low revenue ACO and inexperienced with performance-based risk Medicare ACO initiatives that elects to enter the BASIC track's glide path at Level A is automatically advanced to Level B for performance year 2 (or performance year 3 in the case of ACOs entering an agreement period beginning on July 1, 2019). Prior to the automatic advancement of the ACO to Level C, the ACO may elect to remain in Level B for performance year 3 (performance year 4 in the case of ACOs entering an agreement period beginning on July 1, 2019). In the case of an ACO that elects to remain in Level B for an additional performance year, the ACO is automatically advanced to Level E at the start of performance year 4 (or performance year 5 in the case of ACOs entering an agreement period beginning on July 1, 2019).

²To be an Advanced APM, an APM must meet the following three criteria: 1. CEHRT criterion: requires participants to use certified electronic health record technology (CEHRT); 2. Quality Measures criterion: provides payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and 3. Financial Risk criterion: either (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses. See, for example Alternative Payment Models in the Quality Payment Program as of February 2018, available at <https://www.cms.gov/Medicare/Quality-Payment-Program/ResourceLibrary/Comprehensive-List-of-APMs.pdf>

³ As proposed, BASIC track Levels A, B, C and D would not meet the Financial Risk criterion and therefore would not be Advanced APMs. Level E of the BASIC track and the ENHANCED track would meet all three Advanced APM criteria and thus would qualify as Advanced APMs. These preliminary assessments reflect the policies discussed in this final rule. CMS will make a final determination based on the policies adopted in the [December 2018 Shared Savings Program final rule](#).

Appendix B: Participation Options

PARTICIPATION OPTIONS FOR LOW REVENUE ACOs BASED ON APPLICANT TYPE AND EXPERIENCE WITH RISK (83 FR 67911)¹

Applicant type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options			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; new legal entities (not re-entering ACOs) that are low revenue ACOs may elect to enter in Level A, transition to Level B, and remain in Level B for an additional performance year prior to being automatically advanced to Level E for the remaining performance years of their agreement period.	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 ² for new ACO identified as re-entering because of ACO

Applicant type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options			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)	
					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 ² 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.

² We consider the participation of the ACO in which a majority of the new ACO's participants were participating: (1) If the participation agreement of the other ACO was terminated, then the new ACO reenters the program at the start of the same agreement period in which the other ACO was participating at the time of termination from the Shared Savings Program, beginning with the first performance year of that agreement period. (2) If the participation agreement of the other ACO expired without having been renewed, then the new ACO re-enters the program under the other ACO's next consecutive agreement period in the Shared Savings Program. (3) If the other ACO is currently participating in the program, 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.

PARTICIPATION OPTIONS FOR HIGH REVENUE ACOs BASED ON APPLICANT TYPE AND EXPERIENCE WITH RISK (83 FR 67913)¹

Applicant type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options			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 ² 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 ² for new ACO identified as re-entering because of ACO participants' experience in the same ACO

Applicant type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options			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)	
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

Notes: ¹ High revenue ACOs that have participated in the BASIC track are considered experienced with performance-based risk Medicare ACO initiatives and are limited to participating under the ENHANCED track for subsequent agreement periods.

² We consider the participation of the ACO in which a majority of the new ACO's participants were participating: (1) If the participation agreement of the other ACO was terminated, then the new ACO reenters the program at the start of the same agreement period in which the other ACO was participating at the time of termination from the Shared Savings Program, beginning with the first performance year of that agreement period. (2) If the participation agreement of the other ACO expired without having been renewed, then the new ACO re-enters the program under the other ACO's next consecutive agreement period in the Shared Savings Program. (3) If the other ACO is currently participating in the program, 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.