Medicare ACO

2023 ***Proposed*** Regulatory Updates

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Medicare ACO participation has declined over the past 3 years

ACO Track	ACOs	Percent
One Sided (41% of ACOs)		
Basic Track Levels A&B	199	41%
Two Sided (59% of ACOs)		
Basic Track Levels C&D	40	8%
Basic Level E (Advanced APM)	98	21%
ENHANCED TRACK (Advanced APM)	146	30%
Total ACOS 2022	483	100%

Medicare Proposals to Boost ACO Participation

Limit Risk & Extend Time Periods

- Limit Initial Risk
- Incentivize multiple agreement period participation

2024 ACO Advanced Payments

- Low Revenue ACOs will be able to get advanced savings payments from CMS
- Builds on the AIM Model

2024 Administrative Benchmarking

- Move away from fee-for-service as the comparison
- Moves from beating the neighbor to beating the projection which solves some of the rural issues

2024 Risk Score Changes

- Demographic aspects of risk scores no longer capped
- Will allow risk scores to rise more than current

2023 Quality Changes

- A sliding scale approach to quality so it is not all or nothing cut off
- Incentives for eCQM reporting in 2023 and 2024
- Requirement for eCQM reporting in 2025

2023 Administrative Simplification

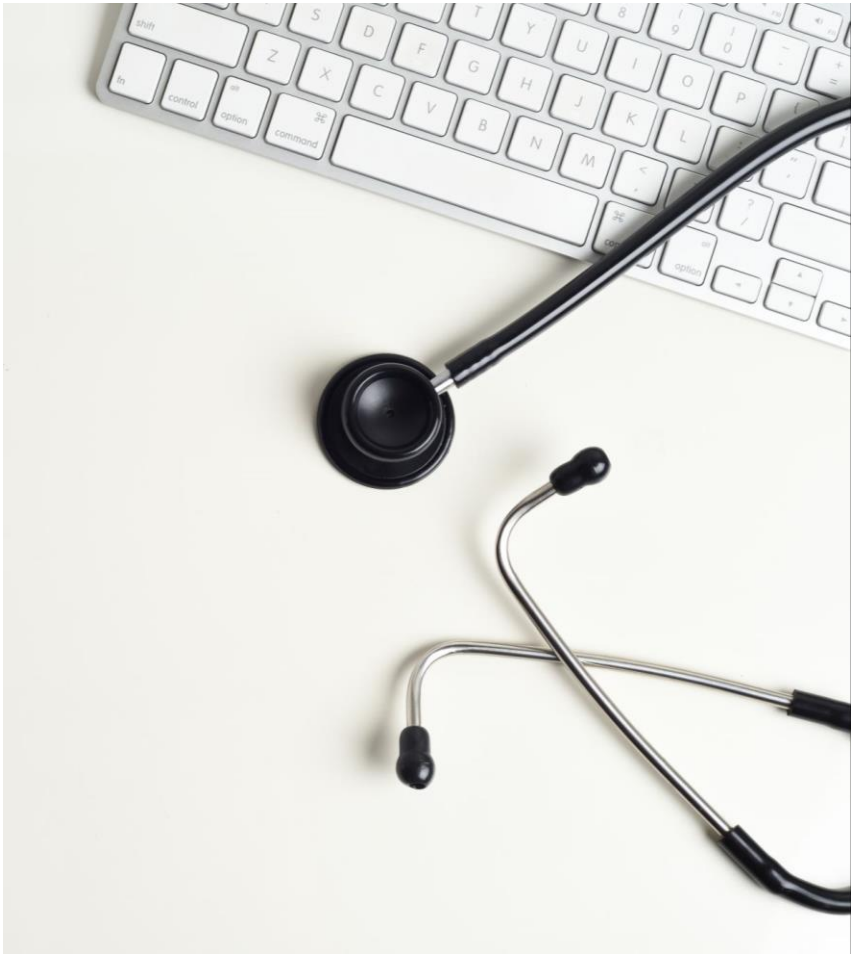
- No marketing material review
- Simpler SNF 2-day waiver application
- Simpler beneficiary notifications

Limit Risk - Ability to Remain in Level A or Level B of the BASIC Track

Proposal for eligible ACOs currently in Level A or Level B of the BASIC track's glide path ***to have the opportunity to indicate interest in continuing participation at their current level during the current change request cycle.***

- In Level A or B
- In an agreement period
- Inexperienced with risk

The annual Application and Change Request Cycle for PY 2023 began on June 8, 2022.



Experienced with Risk

Experienced with performance-based risk Medicare ACO initiatives means an ACO that CMS determines meets the criteria in either paragraph (1) or (2) of this definition.

(1) The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO initiative as defined under this section, or that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e).

(2) Forty percent or more of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative, as defined under this section, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e), in any of the 5 most recent performance years prior to the agreement start date.

What about adding new TINs with risk experience to our Level A or Level B ACO

Ability to Remain in Level A or Level B of the BASIC Track

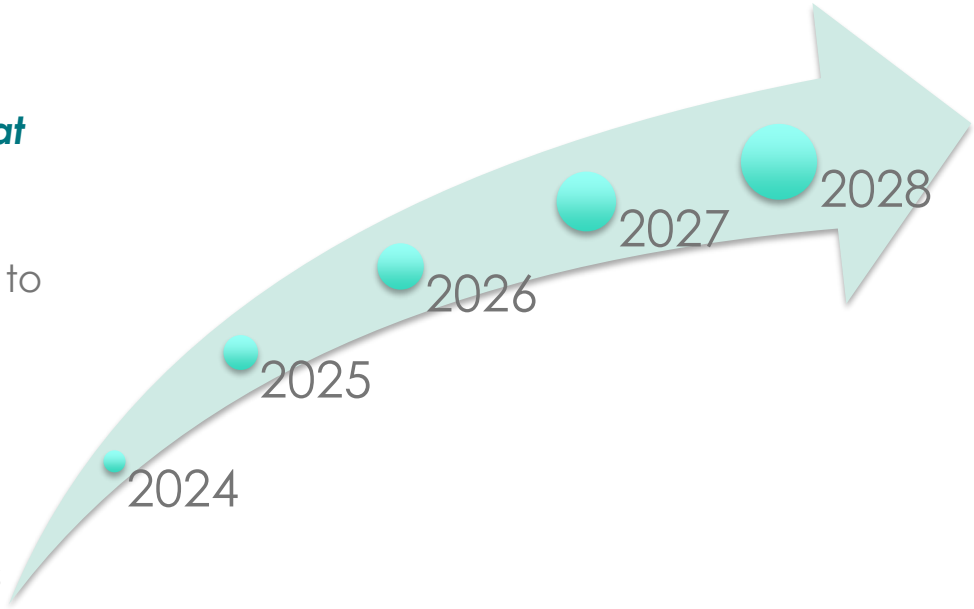
- ***Starting July 22, 2022, eligible ACOs that want to indicate interest in the proposed policy to remain in their current Level A or Level B of the BASIC track's glide path must do so via the ACO Management System (ACO-MS)***.
- Navigate to the My ACOs tab of ACO-MS.
- Click on the applicable ACO.
- During both Phase 1 RFI response periods, eligible ACOs will see a banner describing the voluntary election.
- Click on the banner to remain in current Level A or Level B of the BASIC track.
- Confirm the selection when prompted.
- Once confirmed, and if the proposed policy is finalized, the change will automatically take effect in ACO-MS, as this election does not require CMS adjudication. The banner will then become a read-only message confirming the ACO's election.

The last opportunity to indicate interest in remaining in Level A or Level B of the BASIC track's glide path in ACO-MS is September 9, 2022, at 12:00 p.m. (noon) Eastern Time (ET). In the event this proposed policy is not finalized and your ACO is required to advance from Level A or Level B to a two-sided risk model for PY 2023, your ACO will have a limited opportunity to submit a repayment mechanism, resolve any deficiencies, and have it approved in time for the start of the performance year.

5-Year Agreement Period No Risk

Allow ACOs applying to the program that are ***inexperienced with performance-based risk*** to participate in ***one 5-year agreement under a one-sided shared savings model.***

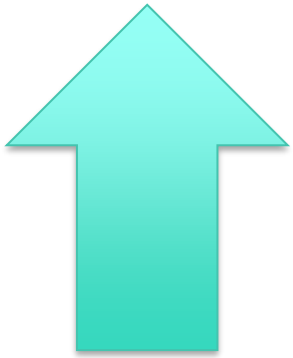
While the proposal for currently participating ACOs to elect to maintain their participation at Level A or Level B for the remainder of their current agreement period would apply beginning January 1, 2023, we are proposing to ***make all other policies outlined in the participation section effective for agreement periods starting on or after January 1, 2024,*** rather than January 1, 2023, because the majority of the application cycle for the 2023 performance year will occur before this rule is finalized.



No agreement period limitation Level E

Revise limitation on number of agreement periods an ACO participate in Basic track Level E

Remove Time Limit



- section III.G.2.b.(3) of proposed rule

Advance Investment Payments

Low revenue ACO

- Part A and Part revenue of its ACO participants is less than 35% of the Part A and Part B expenditures for the ACO's assigned beneficiaries for most recent calendar year for which 12 months of data are available.

New to Shared Savings Program

- Not renewing or re-entering
- Applied to any level of the BASIC track glide path
- Inexperienced with performance-based risk Medicare ACO initiatives

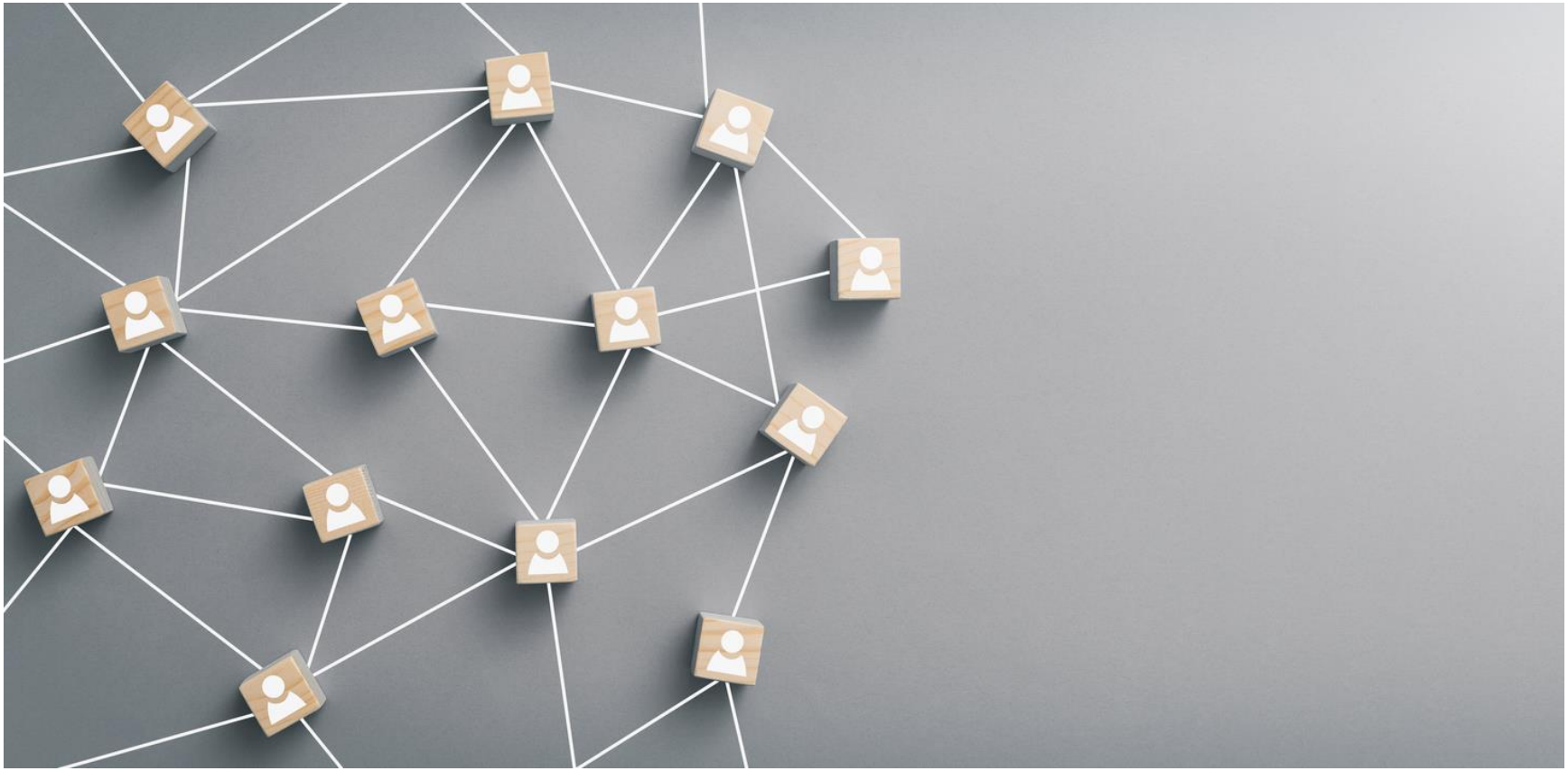
Advance Investment Payments

TABLE 42: Proposed Quarterly Per Beneficiary Payment Amounts

Risk Factors-Based Score	1-24	25-34	35-44	45-54	55-64	65-74	75-84	85-100
Per beneficiary payment amount	$0	$20	$24	$28	$32	$36	$40	$45

- Fixed one-time payment of $250,000
- Quarterly payments for first 2 years of 5-year agreement based on risk factors-based score set to 100 if dual eligible Medicare and Medicaid
- Supplemental application with spend plan submitted with application to participate in Shared Savings Program
- CMS to recoup AIPs from any shared savings earned by the ACO in any performance year until CMS has recouped all AIPs.
- If there are insufficient shared savings to recoup the AIPs made to an ACO for a performance year, CMS would carry forward that remaining balance owed to the subsequent performance year(s)

Proposed participation options



ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
New legal entity (An ACO that has never participated in the Shared Savings Program and is not identified as a re-entering ACO or a renewing ACO)	Inexperienced*	A, A, A, A, A via one-time election prior to the start of the second performance year	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
New legal entity (An ACO that has never participated in the Shared Savings Program and is not identified as a re-entering ACO or a renewing ACO)	Experienced	E, E, E, E, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track

Any ACO, regardless of type or experience level, may elect to progress more quickly along the BASIC track glide path or to apply to enter a new agreement period under the ENHANCED track at any time.

*Under the newly proposed § 425.600(h), if an inexperienced ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives (as specified in § 425.20), that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track, but would be ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives and would be automatically advanced to Level E of the BASIC track at the start of the next performance year.

Experienced with Risk

Experienced with performance-based risk Medicare ACO initiatives means an ACO that CMS determines meets the criteria in either paragraph (1) or (2) of this definition.

(1) The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO initiative as defined under this section, or that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e).

(2) Forty percent or more of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model in any of the 5 most recent performance years prior to the agreement start date.

TABLE 45: Proposed Participation Options

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
Re-entering ACO	Inexperienced– former BASIC track Level A or B	A, B, C, D, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Inexperienced* – former Track 1	A, A, A, A, A via one-time election prior to the start of the second performance year	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Experienced – participated under Track 2, 3, BASIC track Level C, D, or E, ENHANCED track, the Track 1+ ACO Model, or another performance-based risk ACO initiative	E, E, E, E, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track

Any ACO, regardless of type or experience level, may elect to progress more quickly along the BASIC track glide path or to apply to enter a new agreement period under the ENHANCED track at any time.

*Under the newly proposed § 425.600(h), if an inexperienced ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives (as specified in § 425.20), that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track, but would be ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives and would be automatically advanced to Level E of the BASIC track at the start of the next performance year.

TABLE 45: Proposed Participation Options

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
Currently participating ACO in Level A or B for PY 2022	Inexperienced* – BASIC track Level A or B	Current level (remain at A or B for remainder of current agreement period)	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
ACOs in Level A or B with agreement periods beginning on January 1, 2023	Inexperienced* – BASIC track Level A or B	Current level (remain at A or B for remainder of current agreement period)	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track

Any ACO, regardless of type or experience level, may elect to progress more quickly along the BASIC track glide path or to apply to enter a new agreement period under the ENHANCED track at any time.

*Under the newly proposed § 425.600(h), if an inexperienced ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives (as specified in § 425.20), that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track, but would be ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives and would be automatically advanced to Level E of the BASIC track at the start of the next performance year.

TABLE 45: Proposed Participation Options

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
Renewing ACO	Inexperienced	A, B, C, D, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track
Renewing ACO	Experienced – participated under Track 2, 3, BASIC track Level C, D, or E, or ENHANCED track, the Track 1+ ACO Model, or another performance-based risk ACO initiative	E, E, E, E, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track

Any ACO, regardless of type or experience level, may elect to progress more quickly along the BASIC track glide path or to apply to enter a new agreement period under the ENHANCED track at any time.

*Under the newly proposed § 425.600(h), if an inexperienced ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives (as specified in § 425.20), that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track, but would be ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives and would be automatically advanced to Level E of the BASIC track at the start of the next performance year.

Quality

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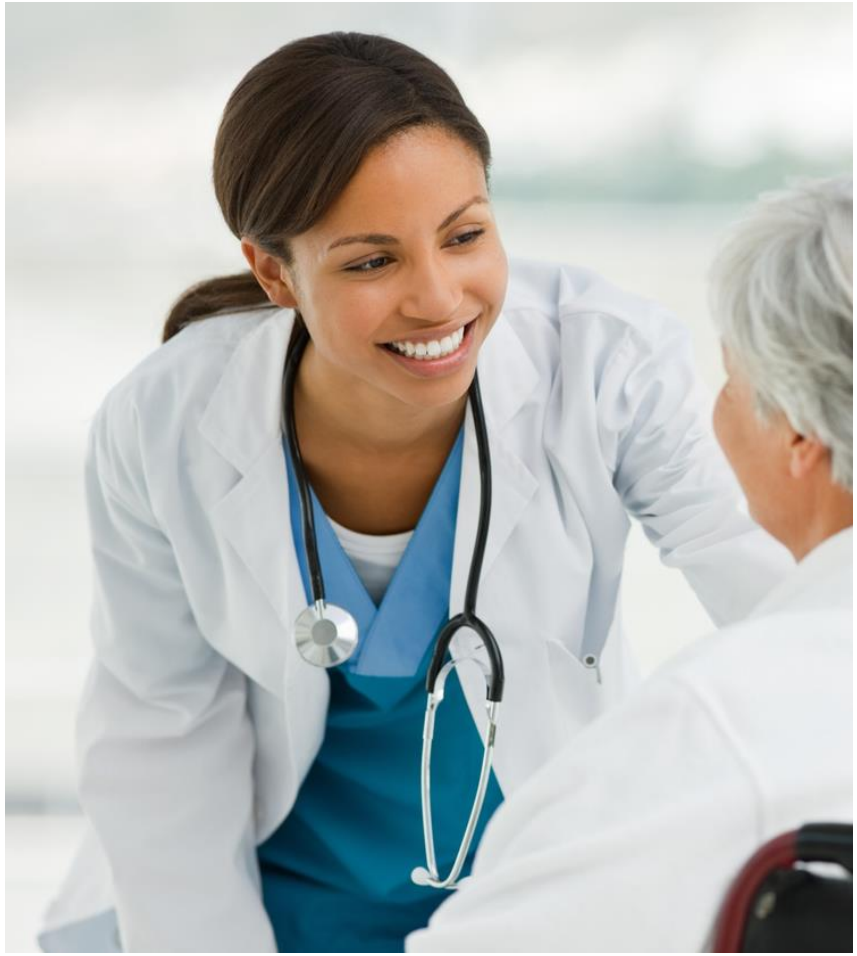
Quality Reporting Cliff

CMS is concerned with the ***current structure of the quality performance standard creates a cliff of "all-or-nothing" scoring where an ACO may be ineligible to share in savings due to a minor difference between its MIPS*** Quality performance category score and the quality performance standard required to share in savings.

Proposal is to **establish an alternative quality performance standard for ACOs that do not meet the quality performance standard to share in savings at the maximum rate by reinstating a sliding scale approach** for determining shared savings for ACOs.

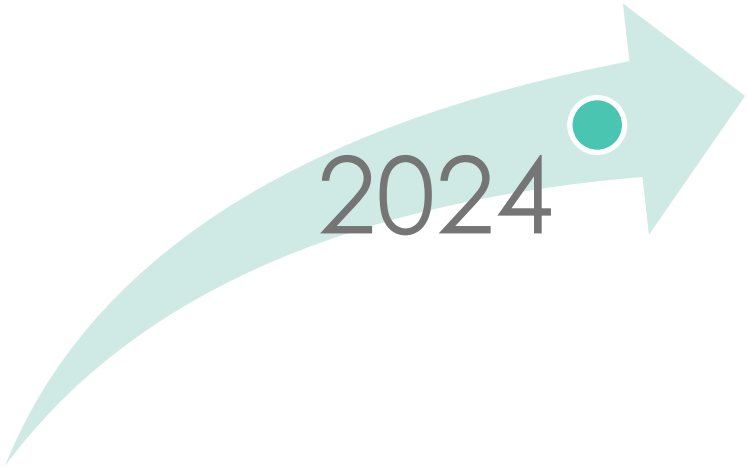
Health Equity Adjustment

CMS is proposing to establish a ***health equity adjustment*** that would upwardly adjust an ACO's quality performance score when it delivers high quality care to underserved populations in order to support those ACOs serving a high proportion of underserved individuals, while also encouraging all ACOs to treat underserved populations.



Extend eCQM Reporting Incentive

Extend the incentive for reporting ***eCQMs/MIPS CQMs*** through performance year 2024 to align with the sunsetting of the CMS Web Interface reporting option.



eCQM Reporting Barriers

If your ACO is comprised of **multiple TINs and EHRs**, then you will have **barriers** so far unresolved by Medicare

1) duplication when you combine all the QRDA III files as not patient-level files. Duplication may be solved by instead using QRDA I files and combining those into a QRDA III for final reporting; and

2) when submitting eCQM the ACO will need to enter an EHR identifier and Medicare has not determined which identifier to use from the multiple TINs and EHRs;

3) It is under review by Medicare if an ACO can aggregate the QRDA I into QRDA III.

ACO Quality Myth

- **Myth**: Medicare ACOs can only do eCQM reporting starting in 2025.
  - Medicare ACOs may do either eCQM or CQM reporting in 2025. One of the primary differences between eCQM and CQM are the allowed data sources.
- **Myth**: 70% of patients is the denominator
  - 100% of patients from all payers is the denominator. 70% is the required completeness factor. The following question was submitted to Medicare QPP: May an ACO choose to submit for only 8 of their 10 TINs if this is 70% of the patients? Answer: No, all providers must participant in quality reporting for 100% of qualified patients.

MIPS Adjustments Sunset to Payment Increases

- MIPS (Not APM)
  - Currently, beginning in 2026, all physicians participating in MIPS may receive an **annual 0.25 percent increase** in their fee schedule payments.
- Advanced Payment Model (APM)
  - APM or value-based care program qualifying participants will receive a ***5 percent lump sum bonus*** on Medicare Part B payments each year from 2019 to 2024.
  - Beginning in 2026, they may receive **a fee schedule update of 0.75 percent each year**. Qualifying APM participant will be excluded from MIPS and partial qualifying APM participants can elect to be excluded from the MIPS program.

Administrative Claims

Change administrative claims measure Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS ***to***

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions to align with the MIPS program.

TABLE 51: Proposed APP Reporting Requirements and Quality Performance Standard for Performance Year 2023 and Subsequent Performance Years

	Performance Year 2023	Performance Year 2024	Performance year 2025 and Subsequent Performance Years*
Shared Savings Program ACO Quality Reporting requirements	ACOs are required to report the 10 measures under the CMS Web Interface or the 3 eCQMs/MIPS CQMs and administer the CAHPS for MIPS survey. CMS will calculate the two claims-based measures.	Same as performance year 2023	ACOs are required to report on the 3 eCQMs/MIPS CQMs and field the CAHPS for MIPS survey. CMS will calculate the two claims-based measures.
Shared Savings Program ACO Quality Performance Standard	Achieving a health equity adjusted quality performance score that is equivalent to or higher than the **30th** percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility based-scoring; or Reporting the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement and the case minimum requirement for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set, or An ACO that fails to meet either of the criteria above but meets the alternative quality performance standard by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set would share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score If an ACO (1) does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and (2) does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative quality performance standard.	Achieving a health equity adjusted quality performance score that is equivalent to or higher than the **40th** percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility based-scoring, or Reporting the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement and the case minimum requirement for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set, or An ACO that fails to meet the criteria above but meets the alternative quality performance standard by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure would share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score. If an ACO (1) does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and (2) does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative quality performance standard.	Achieving a health equity adjusted quality performance score that is equivalent to or higher than the **40th** percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility based-scoring, or An ACO that fails to meet the criterion above but meets the alternative quality performance standard by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set would share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score. If an ACO (1) does not report any of the three eCQMs/MIPS CQMs and (2) does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative quality performance standard.

*The CMS Web Interface reporting option sunsets after performance year 2024 and is no longer available beginning with performance year 2025.

Summary

2023 – 30th percentile with health equity adjustment and sliding scale possible

2024 – 40th percentile with health equity adjustment and sliding scale possible

2025 - 40th percentile with health equity adjustment and sliding scale possible and only APP measure set

TABLE 52: Measures included in the Final APM Performance Pathway Measure Set for Performance Year 2022 and Subsequent Performance Years [a]

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measures 2.0 Area	Measure Type
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Person-Centered Care	PRO-PM*
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Affordability and Efficiency	Outcome^
Measure # 484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Affordability and Efficiency	Outcome^
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/CMS Web Interface**	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome^
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/CMS Web Interface**	APM Entity/Third Party Intermediary	Behavioral Health	Process
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM/CMS Web Interface**	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome^
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface**	APM Entity/Third Party Intermediary	Safety	Process
Quality ID#: 110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface**	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface**	APM Entity/Third Party Intermediary	Behavioral Health	Process
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface**	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface**	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface**	APM Entity/Third Party Intermediary	Chronic Conditions	Process
Quality ID#: 370	Depression Remission at Twelve Months***	CMS Web Interface**	APM Entity/Third Party Intermediary	Behavioral Health	Outcome^

[a] We note that we are proposing to not score the following CMS Web Interface measures: the Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID#438) and Depression Remission at Twelve Months (Quality ID #370); as these measures do not have benchmarks and we are therefore proposing for them not to be scored for performance year 2022; they are however required to be reported in order to complete the Web Interface data set.

^ Indicates this is an outcome measure.

* Patient-reported outcome-based performance measure (PRO-PM) is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable healthcare entity.

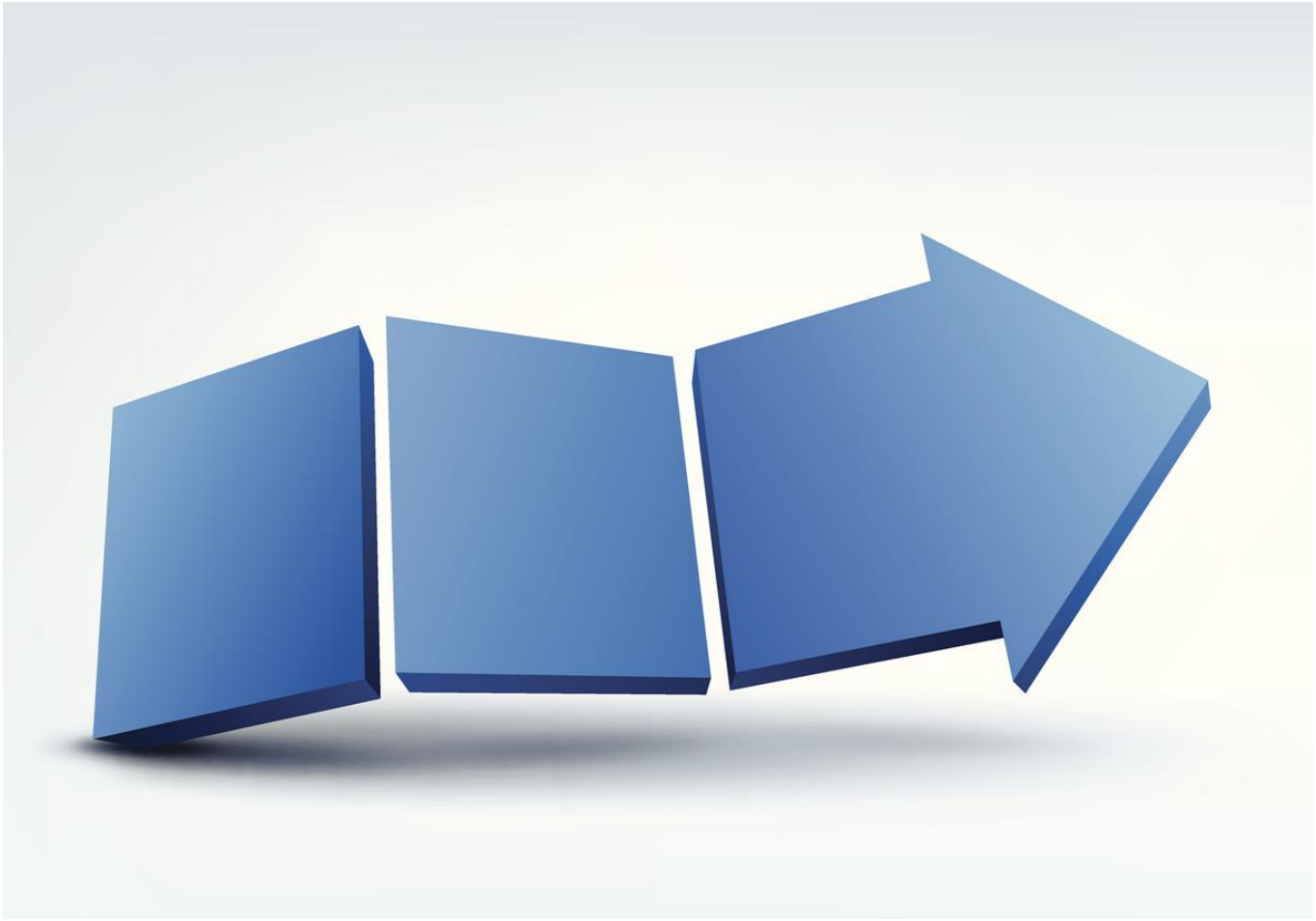
**ACOs will have the option to report via the Web Interface for the 2022, 2023, and 2024 performance years only.

*** This measure is not included as one of the four outcome measures for purposes of the Quality Reporting Standard as this measure is not scored.

TABLE 53: Proposed APP Measure Set for eCQM/MIPS CQM Reporting for Performance Year 2023

Measure #	Measure Title	Measure Type	SSP Quality Performance Standard	
			MIPS Comparable Measure	Outcome Measure
Quality ID#: 321	CAHPS for MIPS	Patient-Reported Outcome	Yes	No
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Outcome	Yes	Yes
Measure # 484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Outcome	Yes	Yes
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Intermediate Outcome	Yes	Yes
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	Yes	No
Quality ID#:236	Controlling High Blood Pressure	Intermediate Outcome	Yes	Yes

Benchmarking



2024 Proposal for Administrative Benchmarking

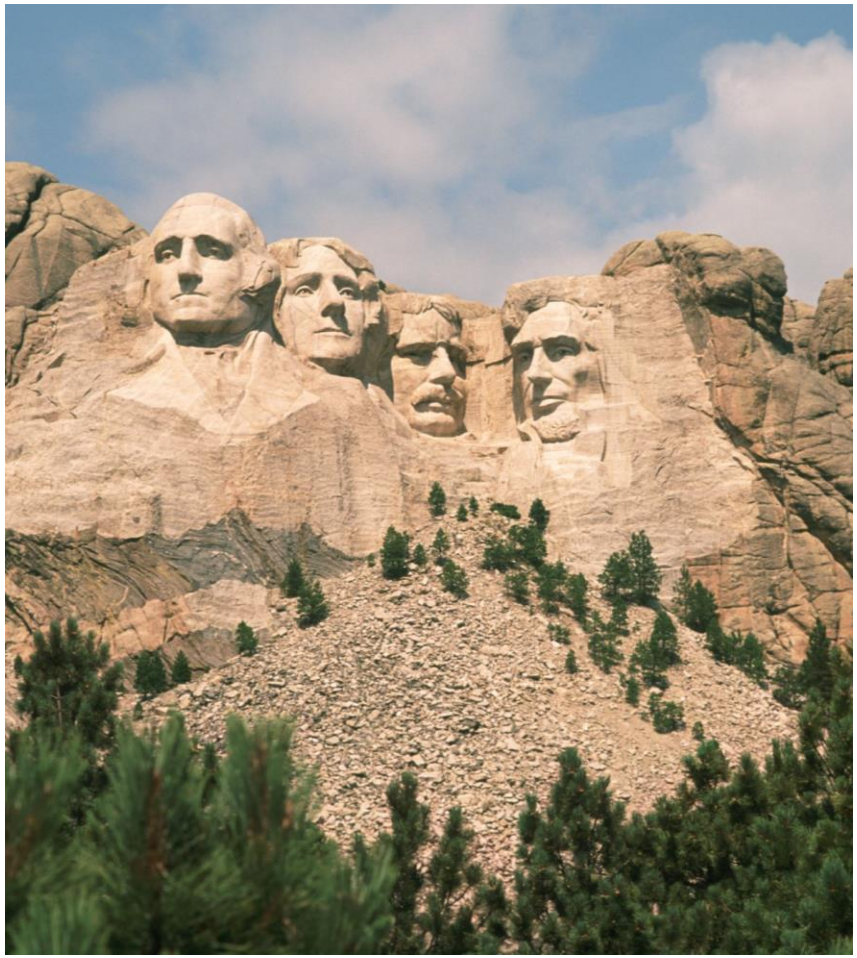
- Use a modified version of the United States Per Capita Cost (USPCC) update for 5 years for 1/3 of the annual benchmark update to address ACO market saturation regions. ***This will solve some of the issues faced by rural ACOs***.

2024 Proposal for Administrative Benchmarking

- Adjust benchmarks to account for prior savings to ***mitigate lowering of an ACO's benchmark over time by returning to an ACO's benchmark an amount that reflects its success in lowering growth in expenditures*** from the previous agreement period

Regional Adjustments

- Reduce the impact of negative regional adjustments on ACO benchmarks by **reducing the cap on negative regional adjustments** and
- Gradually ***decreasing the negative regional adjustment amount*** as an ACO's weighted-average prospective HCC risk score increases, or the proportion of dually eligible Medicare and Medicaid beneficiaries increases, or both



3% Cap

- Currently risk scores are capped both on the demographic risk score and clinical conditions risk score at 3% over BY3
- Proposal would only cap the clinical conditions.

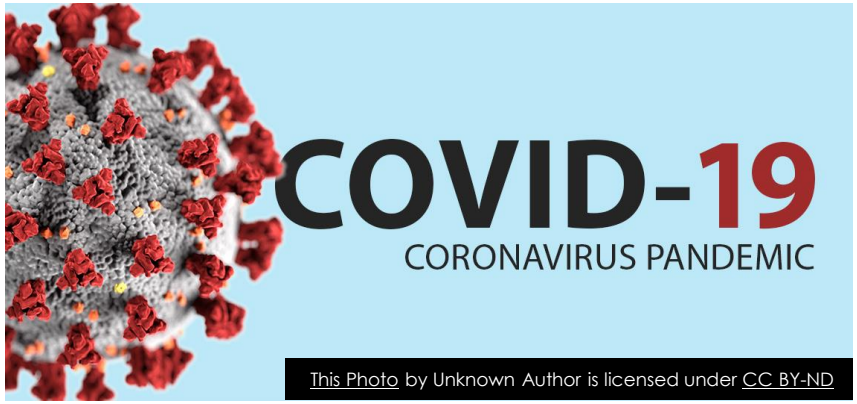
TABLE 65: Share of ACOs Subject to Actual or Proposed Risk Score Cap by Enrollment Type

	ESRD	Disabled	Aged/dual	ESRD, disabled and/or aged/dual	Aged/non-dual
Capped under Current Policy (Actual)	22%	22%	23%	47%	17%
Capped under Proposed Policy (Simulated)	5%	10%	10%	14%	14%

Other Topics

PHE for COVID-19

Medicare to discuss ongoing considerations regarding the impact of the PHE for COVID-19 on ACO expenditures although there are no associated proposed revisions to the regulations at this time.



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Marketing Materials

Medicare proposes to remove the requirement to submit marketing materials prior to use.

ACOs would be required to submit marketing materials only upon request from CMS, but would retain the requirement that an ACO must discontinue use of any marketing materials or activities for which CMS has issued a notice of disapproval.

Beneficiary Notification Requirements

Amend the beneficiary notification requirements to ***reduce the frequency with which beneficiary information notices*** are provided to beneficiaries ***from annually to a minimum of once per agreement period***, with a follow up beneficiary communication serving to promote beneficiary comprehension of the standardized written notice and occurring no later than 180 days following the date that the standardized written notice was provided to the beneficiary.

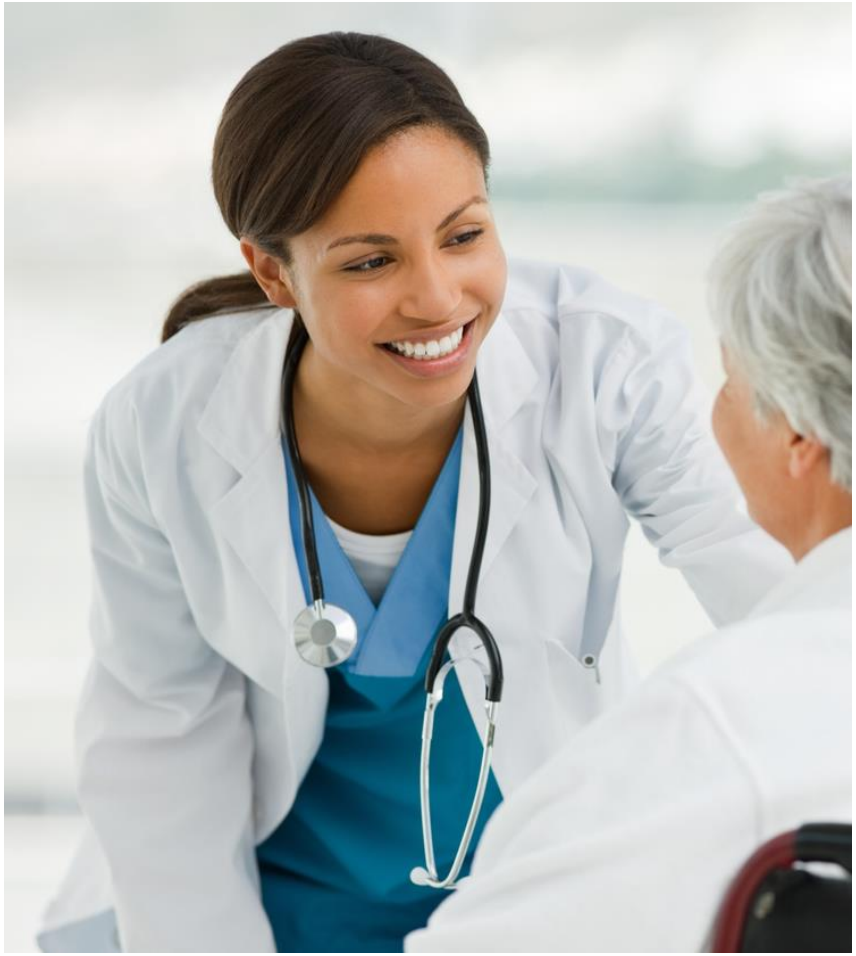
Amend the beneficiary notification requirements to clarify that ACOs and ACO participants ***are required to post signs in all facilities and make standardized written notices available upon request in all settings in which beneficiaries receive primary care services***

Determining Beneficiary Assignment

- Update the definition of primary care services used in beneficiary assignment at § 425.400(c).
  - CMS proposed to revise the definition of primary care services used for assignment in the Shared Savings Program ***regulations to include the following additions***:
    - (1) Prolonged services HCPCS codes GXXX2 and GXXX3, if finalized; and
    - (2) Chronic Pain Management HCPCS codes GYYY1 and GYYY2, if finalized.

SNF Waiver Narratives

Remove the requirement for an ACO to submit certain narratives when applying for the SNF 3-day rule waiver and replace with a requirement that an ACO submit an attestation that it has established the narratives and will make them available to CMS upon request



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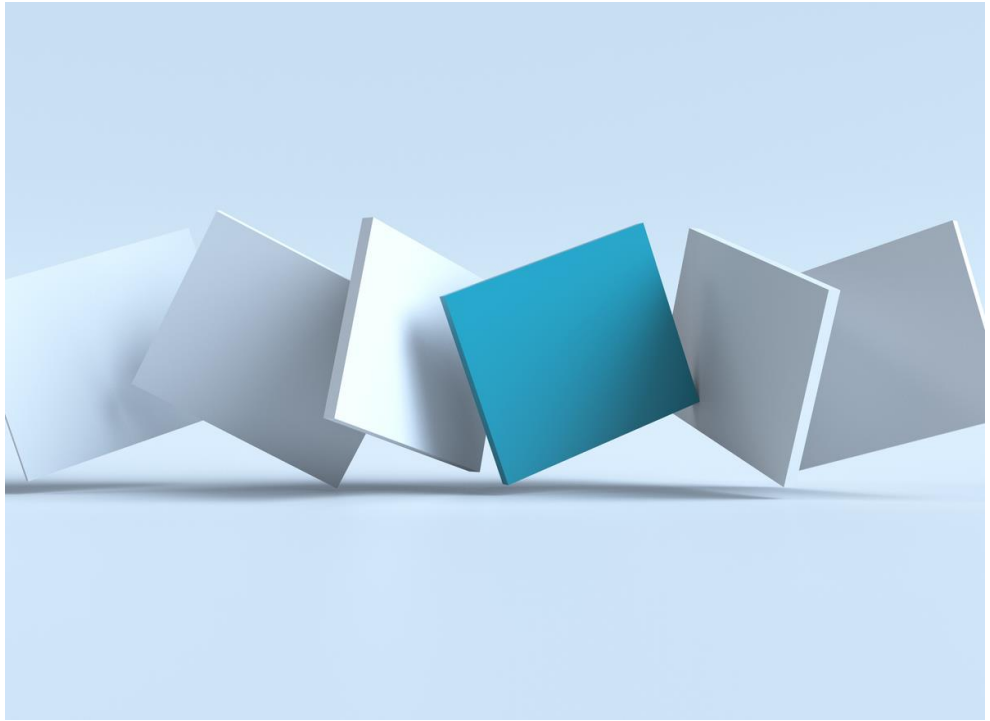

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