COPE HEALTH SOLUTIONS

Medicare Direct Contracting: Shared Savings Program Fact Sheet

Program Structure and Features

The Medicare Shared Savings Program (Shared Savings Program) offers providers and suppliers an opportunity to create an Accountable Care Organization (ACO). An ACO agrees to be held accountable for the quality, cost and experience of care of an assigned Medicare Fee-for-service (FFS) beneficiary population. An ACO contracts with CMS to participate in one of the shared savings programs. In each performance year, ACOs share in a percentage of the savings generated if the expenditure of the assigned beneficiaries is below the calculated benchmark. ACOs participating in a two-sided model must also pay CMS a percentage of shared losses if expenditure for the ACO's beneficiaries exceeds the benchmark.

In 2019, CMS launched new participation options for the Shared Savings Program under "Pathways to Success," discontinuing tracks 1 and 2 and deferring renewal options. Applicants to the ACO model have two participation tracks:

- **Basic:** Allows eligible ACOs to initially begin in one-sided risk and incrementally move towards upside and downside risk using the glide path levels A – E
- **Enhanced:** Highest level of risk; allows additional tools and flexibility for ACOs to manage risk and reward

To participate in this program, an ACO must have a minimum of 5,000 aligned beneficiaries, have past ACO experience among its participants, and meet all criteria outlined in the RFA[1]. ACOs can enter the model at each of the available tracks. Entry point eligibility is determined by the following ACO conditions:

ACO Type	• **New ACOs** are new legal entities (TIN) that have not participated in the Shared Savings Program • **Re-entering ACOs** are existing ACOs that previously participated but are applying to the program after a break or new ACOs (TIN) where >50% of the participants have previously participated in the same ACO • **Renewing ACOs** are existing participants in shared savings programs that are renewing their participation for a consecutive agreement period
Risk Level Experience	• **Inexperienced ACOs** are entities where <40% of the ACO participants have previously participated in performance-based risk Medicare ACO in each of the five performance years prior to start date • **Experienced ACOs** can be existing or new ACOs where >40% of participants have previously participated in performance-based risk Medicare ACO
Medicare FFS Revenue	• **Low-Revenue ACOs** are entities whose Medicare Part A/B FFS revenue is <35% of the total Beneficiary Medicare Part A/B expenditure • **High-Revenue ACOs** are entities whose Medicare Part A/B FFS revenue is >35% of the total Beneficiary Medicare Part A/B expenditure

Experienced, high-revenue ACOs may enter only via the Enhanced model. For other combinations:

- Being New determines whether the ACO is eligible to enter into Track A
- Being Inexperienced determines whether the ACO can access the Basic glide path via track A or B
- Being High or Low Revenue determines whether an Experienced ACO is eligible to enter into Enhanced or Track E, respectively

ACO Descriptors			Track Eligibility		
ACO Types	**Risk Level Experience**	**Medicare FFS Revenue**	**Basic Track Glide Path**	**Basic Track Level E**	**Enhanced Track**
New	Experienced	High Revenue	No	No	Yes
		Low Revenue	No	Yes	Yes
	Inexperienced	High Revenue	Yes, Level A-E	Yes	Yes
		Low Revenue	Yes, Level A-E	Yes	Yes
Re-Entering or Renewing	Experienced	High Revenue	No	No	Yes
		Low Revenue	No	Yes	Yes
	Inexperienced	High Revenue	Yes, Level B-E	Yes	Yes
		Low Revenue	Yes, Level B-E	Yes	Yes

Program Payment Models

Each track has different level of risk/reward opportunities. While Level A-B allow for participation with upside only, Level C-E of the Basic track and the Enhanced track include progressive levels of downside risk.

ACOs participating in the Basic track will be automatically transitioned to the next level on an annual basis until they are at Basic Level E. In order to progress from the Basic track to the Enhanced track, ACOs must reapply into the program under the Enhanced track.

	Basic					Enhanced
	A	**B**	**C**	**D**	**E**	
Savings Rate	40%		50%			75%
Savings Cap	10% benchmark					20% benchmark
Loss Rate	-		30%			40% - 75%
Loss Cap	-		1% benchmark or 2% revenue	2% benchmark or 4% revenue	4% benchmark or 8% revenue	15% benchmark
APM	MIPS				Advanced	Advanced
Quality	30th percentile performance gate for P4P measures PY1 all measures are P4R; PY2 onward all measures are P4P					Quality Measure Score determines loss rate
Beneficiary Alignment	Both voluntary and claims-based alignment in all years. Annual choice between Preliminary Prospective Assignment with Retrospective Reconciliation[2] or Prospective Assignment Methodologies[3]					

Quality Measures

CMS judges ACO quality performance and improvement activity on four key domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventative Health, and At-Risk Population. Each domain is weighed equally at 25% while the number of measures within each domain have changed over time. Currently there are 23 measures across the four domains and the measures are equally weighted within each domain. The total points for each domain are calculated with consideration to relative performance against benchmarks for each measure as well as year-over-year improvement on each measure.

Domain	# of Individual Measures	Total Possible Points	Domain Weight
Patient/Caregiver Experience	10	20	25%
Care Coordination/ Patient Safety	4	8	25%
Preventative Health	6	12	25%
At-Risk Population	3	6	25%
Total	**23**	**23**	**100%**

Agreement Period and Application Timeline

For Agreements starting in July 2019 – The ACO will be participating in a 6 year period. The first performance year will consist of a shortened period from July 2019 – December 2019 and the five remaining performance years will run on a January to December calendar year. For ACOs participating in the Basic Glide path starting at Level A starting July 2019, they will be automatically progressed to Level B in performance year 2021 For those seeking to apply for the January 2022 performance year, the application timeline is as follows (all dates 2021).

June 1 - June 7	**Notice of Intent to Apply**
June 8 - June 28	**Phase 1 of Application**
July 21 - August 3	**Respond to the first Phase 1 request for information (RFI-1)**
August 25 - September 10	**Respond to Phase 1 RFI-2**
October 13 - October 19	**Submit Phase 2 of the application**
November 3 - November 9	**Respond to Phase 2 RFI**
November 29 - December 3	**ACO Signing Event including repayment mechanisms**

For more information on exploring Medicare Shared Savings Program, please contact info@copehealthsolutions.com or 213-259-0245.

Footnotes

[1] https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-0

[2] Method whereby an ACO receives an assignment list near the start of the PY, including beneficiaries preliminarily, prospectively assigned via claims-based assignment based on recent data and prospectively assigned beneficiaries resulting from voluntary alignment. The assignment list is updated quarterly based on the most recent 12 months of data and voluntarily aligned beneficiaries who continue to meet eligibility criteria.

[3] Method whereby an ACO receives an assignment list near the start of the PY, including beneficiaries prospectively assigned via claims-based assignment based on an offset assignment window (Oct – Sep) and prospectively assigned beneficiaries resulting from voluntary alignment. The assignment list is updated quarterly through a removal of beneficiaries who are no longer eligible for assignment to the ACO.