Contents
I. Background and Introduction .............................................................................................. 1
II. Statutory Authority ........................................................................................................... 4
   A. General Authority to Test Model .............................................................................. 4
   B. Financial and Payment Model Authorities ............................................................... 4
   C. Waiver Authority ....................................................................................................... 5
III. Scope and General Approach .......................................................................................... 7
IV. Application Process .......................................................................................................... 8
   A. Letter of Intent .......................................................................................................... 8
   B. Development and Application Process for States ...................................................... 10
   C. Application Process for ACOs .................................................................................. 11
   D. Withdrawal of Application ...................................................................................... 12
V. Eligibility and Participation Requirements ....................................................................... 12
   A. Eligible States ........................................................................................................... 12
   B. Eligible ACOs ............................................................................................................ 13
   C. State Licensure ......................................................................................................... 17
   D. Outcomes-Based Contracts with Other Purchasers .................................................. 17
VI. Model Design Elements .................................................................................................. 17
   A. Beneficiary Eligibility and Assignment to Medicare-Medicaid ACOs .................... 17
   B. Financial Benchmark, Risk Arrangements, and Shared Savings ............................ 18
   C. Pre-payment of Shared Savings for Safety-Net ACOs .............................................. 23
VII. Quality and Performance .............................................................................................. 23
   A. Quality Measures ...................................................................................................... 23
VIII. Monitoring and Oversight ............................................................................................ 24
   A. Monitoring and Oversight of States and ACOs ......................................................... 24
I. Background and Introduction

The Centers for Medicare & Medicaid Services (CMS) is committed to achieving better care for individuals, better health for populations, and reduced expenditures for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries. One mechanism for achieving this goal is for CMS to work with groups of health care providers who agree to accept joint responsibility for the cost and quality of care outcomes for a specified group of beneficiaries. CMS is currently pursuing such efforts through several initiatives, including the Medicare Shared Savings Program (Shared Savings Program), Pioneer Accountable Care Organization (ACO) Model, the Next Generation ACO Model, the ACO Investment Model, and the Comprehensive ESRD Care (CEC) Model.

Several objectives underlie CMS’ overall approach to testing accountable care models, including:

- Promoting changes in the delivery of care from fragmented to coordinated care systems as part of broader efforts to improve care integration, such as initiatives on advanced primary care and bundled payments;
- Promoting effective beneficiary engagement and protections;
- Protecting the Medicare Trust Funds while finding new ways of delivering care that will decrease expenditures over time;
- Learning and sharing best practices with providers to assist their pursuits of better care for individuals, better health for populations, and lower growth in expenditures for the Medicare fee-for-service population; and
- Developing close working partnerships with healthcare providers.

Some of the highest-need, highest risk Medicare beneficiaries are those enrolled in both Medicare and Medicaid (“Medicare-Medicaid enrollees” or “dual eligible individuals”); their care is complicated by varying priorities on the part of these two payers. CMS seeks to align with state Medicaid programs to test a Medicare-Medicaid ACO Model with ACOs in states that partner with CMS to offer the Model. Certain aspects of the Model may vary by state but the over-arching principles and parameters will be consistent across the Model. This document is a Request for Letters of Intent (LOIs) from states\(^1\) that are interested in partnering with CMS to test this Model in their state.

ACOs in this Model will be held accountable for the full spectrum of Medicare-Medicaid enrollees’ Medicare Part A and Part B expenditures and also for their Medicaid expenditures. The Medicare-Medicaid ACO Model offers ACOs financial arrangements that will align Medicare and Medicaid incentives, as well as coordinate access to Medicare and Medicaid data for the purpose of care coordination and investment in population health management. To be

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\(^1\) For the purposes of the Medicare-Medicaid ACO Model, the term “state” includes the District of Columbia.
eligible to participate in this Model, ACOs will also be required to participate in the Shared Savings Program. Because ACOs will be participating in the Shared Savings Program, they will continue to be accountable for Medicare beneficiaries assigned through that program who are not Medicare-Medicaid enrollees. Additionally, if a state wishes to include Medicaid beneficiaries in the Target Population, as defined in the glossary in Appendix B, who are not Medicare-Medicaid enrollees assigned through the Shared Savings Program, CMS will work with states to accommodate that to the extent possible, while still ensuring that the Model focuses on the unique care needs of Medicare-Medicaid enrollees, including in the quality measures selected and by ensuring that the financial methodology creates appropriate incentives to reduce expenditures for Medicare-Medicaid enrollees.

Similar to the Shared Savings Program, the Medicaid financial arrangements in the Model may include a selection of shared savings/shared losses risk arrangements to accommodate a range of ACOs with varying levels of experience. States that may have had only limited experience with previous Medicaid ACO or ACO-like initiatives and/or those with a small number of ACOs participating in current Medicare ACO initiatives are encouraged to consider participation in the Model.

After the end of each Shared Savings Program and Medicare-Medicaid ACO Model performance year when final savings and losses to the Medicare and Medicaid programs, respectively, have been calculated, CMS may share a portion of Medicare savings achieved by ACOs participating in the Medicare-Medicaid ACO Model within a participating state with that state. Any savings will be adjusted for Medicare shared savings/shared losses payments to/from ACOs and losses that may have accrued to the federal share of the state’s Medicaid expenditures. Further, any savings will be adjusted for quality and subject to a cap, as discussed in more detail below.

The Model will feature extensive learning system opportunities for states and ACOs. Ultimately, the Medicare-Medicaid ACO Model aims to build experience that can be used to promote participation by providers/suppliers that provide care to a significant number of uninsured patients, Medicaid enrollees, and high risk, high need populations (“safety-net providers”) in ACOs and the provision of high quality, cost effective care for high risk, high-need beneficiaries across ACO initiatives.

**Overview of Application Process**

CMS is offering three options for when the first Medicare-Medicaid ACO Model performance year will begin in any participating state: January 1, 2018, January 1, 2019, and January 1, 2020. Interested states are expected to submit a nonbinding LOI, which should be accompanied by letters of interest from the state’s Potential ACO Partners, as defined in Appendix B, which can be existing ACOs or providers not yet in ACO arrangements.

Submission of an LOI will begin a process of engagement during which CMS will work with each state and its Potential ACO Partners to determine the state-specific aspects of testing the Model in that state. Each state’s approach will reflect the characteristics of the state’s Medicaid
program, providers, and beneficiaries in its Target Population. Participation in the Model by ACOs that include safety-net providers is strongly encouraged. Each state will work with CMS and its Potential ACO Partners to develop the state’s Medicare-Medicaid ACO Model application. The application process is described in more detail in Section IV of this document. In addition to gaining approval by CMS for its Medicare-Medicaid ACO Model application, a state wishing to participate in the Medicare-Medicaid ACO Model must secure the necessary Medicaid approvals (e.g., State Plan Amendment (SPA)). Once all necessary approvals have been secured, CMS and the state will enter into a CMS-State Medicare-Medicaid ACO Model Participation Agreement (“CMS-State Participation Agreement”). CMS will enter into agreements with up to six states. Preference will be given to states with low Medicare ACO saturation. Deadlines for LOI submission and execution of the CMS-State Participation Agreement for each of the first performance year options being offered are included in the following chart. All submissions must be received no later than 11:59pm Eastern Time on or before the date listed:

<table>
<thead>
<tr>
<th>State’s Preferred 1st Performance Year Start Date</th>
<th>Deadline to Submit LOI</th>
<th>Deadline to execute CMS-State Participation Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>January 20, 2017</td>
<td>May 5, 2017</td>
</tr>
<tr>
<td>2019</td>
<td>August 4, 2017</td>
<td>March 30, 2018</td>
</tr>
<tr>
<td>2020</td>
<td>August 3, 2018</td>
<td>March 29, 2019</td>
</tr>
</tbody>
</table>

CMS encourages interested states to submit an LOI as early as possible to begin the development and application process. Because the steps necessary to finalize the state-specific aspects of the Model may vary by state, submitting an LOI prior to the applicable deadline is not a guarantee that the Medicare-Medicaid ACO Model in that state will begin on the state’s preferred first performance year start date. These deadlines represent the minimum amount of time CMS believes will be necessary for the development process and to allow sufficient time for ACOs to apply to the Model (and the Shared Savings Program), but many states may require more time for development of the state-specific aspects of the Model and approvals or may want to increase the amount of time that ACOs in the state have to prepare to maximize ACO participation. States that do not submit an LOI prior to the deadline will not be eligible to participate in the Medicare-Medicaid ACO Model beginning in the associated performance year.

States are required to submit letters of interest from Potential ACO Partners in their state along with the state’s LOI, but once a state is approved to participate in the Medicare-Medicaid ACO
Model, ACO participation will not be limited to those Potential ACO Partners that submitted letters of interest nor will letters of interest from Potential ACO Partners be considered binding. Once the CMS-State Participation Agreement has been executed, CMS and the state will jointly release a Request for Applications to ACOs in the state. Interested ACOs must apply to participate in the Medicare-Medicaid ACO Model in their state. Additionally, ACOs interested in participating in the Medicare-Medicaid ACO Model must apply to participate in or apply to renew their Participation Agreement with the Shared Savings Program.

This Request for LOIs provides background on the Model and information states will need to begin conversations with Potential ACO Partners and prepare an LOI and application. This Request for LOIs provides some information regarding ACO eligibility to participate in the Medicare-Medicaid ACO Model but is not intended to provide ACOs with a complete list of eligibility requirements or Model design elements; Requests for Applications from ACOs will be released at a later date once state-specific aspects of the Model have been defined.

II. Statutory Authority

A. General Authority to Test Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Center for Medicare & Medicaid Innovation (Innovation Center) and provides authority for the Innovation Center to test innovative health care payment and service delivery models that are expected to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries’ care.

B. Financial and Payment Model Authorities

Because of the federal-state partnership at the center of this Model, the Model relies on both federal and state authorities.

Section 1899 of the Act established the Shared Savings Program, which promotes accountability for a Medicare fee-for-service patient population, fosters coordination of items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient health care service delivery. ACOs in the Medicare-Medicaid ACO Model must participate in the Shared Savings Program and follow the rules of that program with the exception of certain limited waivers of Shared Savings Program regulations described later in this Request for LOIs.

Federal authority for the testing of the Medicare-Medicaid ACO Model is established by Section 1115A(b)(2) of the Act, which requires the Secretary to select for testing models that address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute provides a non-exhaustive list of examples of models that the Secretary may select for testing, which includes a model allowing states to test and evaluate fully integrating care for dual eligible individuals in the state, including the management and oversight of all funds under the applicable titles with respect to such
individuals (see Section 1115A(b)(2)(B)(x)). Section 1115A(b)(2)(B)(ii) of the Act provides another illustrative example of contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

The appropriate authority for states to implement the Medicaid ACO arrangements necessary for the testing of this Model may vary according to the state-specific aspects of the Model implementation. For example, states may wish to use the authority under Section 1905(t) of the Act, based on the approach outlined in State Medicaid Director Letter 12-002 and currently in use in several states around the country[1] to implement the Model. In this approach, states would recognize ACOs as state plan providers, offering primary care case management (PCCM) services authorized by section 1905(t) of the Act. If states wish to limit the services offered under the Model such that they are not made available to all Medicaid beneficiaries in the state, a waiver under Section 1115 of the Act, or other waivers, may be necessary. Depending on the state-specific aspects of the Model, a state may need to make conforming changes to their existing waivers under sections 1115, 1915(b), and 1915(c) (for Home and Community Based Services (HCBS)) of the Act, or obtain new waivers, as appropriate. States must follow all Medicaid coverage, payment and claiming regulations and requirements relevant to the approach they propose and CMS will work with states to determine the appropriate authority for their desired approach. State participation in the Model is contingent upon obtaining the necessary approvals from CMS.

C. Waiver Authority

Under section 1115A(d)(1) of the Act, the Secretary may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of testing models described in section 1115A(b) of the Act.

Section 1899(f) of the Act authorizes the Secretary to waive such provisions of sections 1128A and 1128B and title XVIII of the Act as may be necessary to carry out the Shared Savings Program.

Section 1115 of the Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Depending on the state-specific aspects of the Model implementation, an 1115 waiver may or may not be required.

Federal Fraud and Abuse Waivers

On October 29, 2015, CMS and the HHS Office of Inspector General (OIG) jointly issued waivers of certain fraud and abuse laws for the Medicare Shared Savings Program for certain arrangements entered into by ACOs, including a wide variety of start-up and operating activities.

that further the purposes of the Medicare Shared Savings Program.\(^2\)

Fraud and abuse waivers are not being issued in this document. Any waiver specifically for activities in connection with the testing of this Model would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Request for LOIs, individuals and entities must comply with all applicable federal laws and regulations, except as explicitly provided in a separately documented waiver. Any such waiver would apply solely to activities related to testing of the Medicare-Medicaid ACO Model and could differ in scope or design from waivers granted for other programs or models.

**State Fraud and Abuse Waivers**

The Secretary has no authority to waive state fraud and abuse laws that may be implicated by the testing of this Model. As noted in Section IV, states will need to assess the applicability of any state fraud and abuse laws and determine if waivers are necessary. Medicare-Medicaid ACOs must comply with state fraud and abuse laws or obtain waivers of any applicable state laws from the state.

**Medicare Program and Payment Rule Waivers**

Medicare-Medicaid ACOs will have access to any of the payment rule waivers offered to Shared Savings Program ACOs under 42 C.F.R. Part 425, subpart G, subject to the eligibility rules established under the Shared Savings Program regulations.

Medicare-Medicaid ACOs will participate in the Shared Savings Program and therefore be subject to the rules of that program, with certain exceptions. CMS will waive the following Shared Savings Program requirements in 42 C.F.R. Part 425:

- Participation in the Shared Savings Program and Innovation Center models involving Medicare shared savings—Qualified Shared Savings Program ACOs and their ACO Participants and ACO providers/suppliers will be allowed to participate in the Shared Savings Program and in the Medicare-Medicaid ACO Model.

Beneficiary Assignment—CMS will waive the Shared Savings Program regulations providing that beneficiary assignment for ACOs in Track 1 and Track 2 of the Shared Savings Program will be conducted “after the end of each performance year, based on data from the performance year” (42 C.F.R. 425.400(a)(2)(iii)). Under the Medicare-Medicaid ACO Model, beneficiaries shall be assigned to all participating ACOs prospectively, regardless of Track. This policy is described further in Section VI.A. of this Request for LOIs. Data sharing regulations under the Shared Savings Program will also be waived, such that beneficiary identifiable data for Track 1 and Track 2 Shared

Savings Program ACOs participating in the Medicare-Medicaid ACO Model, will only include prospectively assigned beneficiaries.

**Medicaid Payment Rule Waivers**

States may wish to propose new Medicaid benefits or waivers of Medicaid requirements, which would need to be presented to the Center for Medicaid and CHIP Services in an appropriate waiver request or SPA submission.

CMS provides no opinion on the legality of any contractual or financial arrangement that states, *Potential ACO Partners*, affiliated entities or any other relevant individuals or entities propose, document, or may implement. The receipt by CMS of any information regarding such arrangements in the course of the Request for LOIs or application processes or otherwise shall not be construed as a waiver or modification of any applicable laws, rules, or regulations, and will not preclude CMS, HHS, or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules, and regulations.

**III. Scope and General Approach**

CMS seeks to partner with up to six states and *Potential ACO Partners* in those states to develop and implement the Medicare-Medicaid ACO Model.

The goal of the Medicare-Medicaid ACO Model is to test whether engaging states and ACOs in a three-way partnership to take on accountability for Medicare and Medicaid costs for Medicare-Medicaid enrollees can improve quality of care and result in Medicare and Medicaid savings. CMS seeks to align payment incentives and support ACOs, especially ACOs that include safety-net providers, in the care of high risk, high need beneficiaries. Core principles of the Model are:

- Protecting Medicare and Medicaid fee-for-service beneficiaries’ freedom to seek the services and providers of their choice;³
- Aligning incentives across Medicare and Medicaid for providers/suppliers, beneficiaries, and the participating state and federal payers;
- Offering a range of financial options to engage ACOs with varying levels of experience managing financial risk and in population health management;
- Ensuring that Medicare-Medicaid enrollees are represented in ACO governance; and
- Ensuring that the Medicare-Medicaid ACO Model will generate useful information

³ Beneficiaries in the model retain their right to see any Medicare provider/supplier they choose. CMS is open to considering proposals from states for testing approaches that would encourage beneficiaries to obtain care from certain Medicaid providers as long as these policies would not restrict beneficiaries’ ability to choose providers or limit beneficiaries’ access to necessary services. Additionally, we would consider proposals by states that wish to limit beneficiary choice under clearly-defined circumstances for a specific clinical purpose (e.g. limitations on coverage for opioids to those prescribed by certain physicians). Any such restrictions may require waivers of the Act.
regarding the participation of safety-net providers in ACOs and the effect on the quality and cost effectiveness of care furnished to Medicare-Medicaid enrollees attributed to participating ACOs for use in other Medicare and Medicaid ACO initiatives.

States interested in participating in the Model will be expected to work with CMS and Potential ACO Partners in their states to develop certain aspects of how the Model would function in their states such as: designing a Medicaid financial methodology, selecting additional quality measures, and identifying any additional requirements for ACO eligibility. States will also need to determine if any state fraud and abuse laws are implicated by the Model and determine if a state-issued waiver is necessary. For purposes of the development, testing, monitoring, and evaluation of the Model, Medicaid state agencies will need to ensure CMS has access to timely and complete Medicaid claims data. This is described in further detail in Section IX of this Request for LOIs. We expect that interested states will need to complete other preparatory steps, such as obtaining state legislative approval. States will need to secure the necessary Medicaid approvals, likely involving submission of a SPA or waiver application for CMS review and approval. States approved for participation in the Model will enter into a CMS-State Participation Agreement with CMS before a Request for Applications is issued to ACOs in the state. Ultimately, CMS and states will enter into a Participation Agreement with ACOs in the state4 (“Medicare-Medicaid ACO Participation Agreement”). The Model in each state will consist of three one-year performance periods with the potential of two optional one-year extensions, subject to CMS approval. States may also be eligible to share in Medicare savings with CMS if savings accrue to CMS as a result of the performance of Medicare-Medicaid ACOs in the state. Eligibility criteria and an overview of the methodology that will be used to determine if and for how much Medicare savings the state is eligible are described in Section VI of this Request for LOIs.

While CMS is committed to improving care for beneficiaries, CMS reserves the right to decide not to move forward with the Medicare-Medicaid ACO Model for any reason, as is true for all models tested under Section 1115A of the Act. Similarly, CMS reserves the right to modify or terminate the Model or a particular state’s participation in the Model at any time if it is determined that it is not achieving the goals and aims established for the Model.

IV. Application Process

A. Letter of Intent

For consideration to begin the first performance year of the Model in the state on January 1 of the year indicated, interested states must submit an LOI no later than 11:59pm Eastern Time on

4 This may take the form a trilateral agreement between CMS, the state, and the ACO or two bilateral agreements: one between the state and the ACO and one between CMS and the ACO.
or before the following dates:

<table>
<thead>
<tr>
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</thead>
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<td>2020</td>
<td>August 3, 2018</td>
</tr>
</tbody>
</table>

An LOI template is provided in Appendix A. Each LOI must include the following:

- Description of the state’s vision for testing of the Medicare-Medicaid ACO Model in its state.
- Description of the state’s current approach to payment and care for Medicare-Medicaid enrollees, including a discussion of the state’s participation in any other delivery system innovations (for Medicare-Medicaid enrollees or other populations) and how participation in the Medicare-Medicaid ACO Model would complement and/or interact with those initiatives.
- Description of Potential ACO Partners with accompanying letters of interest (these letters of interest will not obligate ACOs or providers/suppliers not yet organized as an ACO to participate in the Model, nor will providers/suppliers that do not submit a letter of interest be barred from participating). At least one LOI from a Potential ACO Partner must be submitted.
- Description of how the state will meaningfully engage with Medicare-Medicaid enrollees and their unpaid caregivers in the state to develop the state-specific aspects of the Model.
- Description of how the state will meaningfully engage with providers/suppliers in the state to develop the state-specific aspects of the Model.
- Description of the state’s current status with respect to testing and reporting data through the Transformed Medicaid Statistical Information System (T-MSIS), as well as current claims lags.
- Contact information for staff from the state and Potential ACO Partners planning to participate in the state-specific Medicare-Medicaid ACO Model development process.

The LOI must be signed by the State Medicaid Director. If Medicaid services available to Medicare-Medicaid enrollees, such as community-based services and supports, are administered outside of the state’s Medicaid agency, the letter must be co-signed by an individual or individuals with authority over these relevant agencies or an additional letter from those agencies.
must be submitted. The LOI will be used only for planning purposes, and submitting an LOI will not bind an interested state or its Potential ACO Partners to moving forward under the Model. Interested states should send their LOI by email to MMACO@cms.hhs.gov.

States that do not submit an LOI prior to the deadline will not be eligible to participate in the Model for the associated starting performance year.

B. Development and Application Process for States

After a state submits an LOI, CMS will contact state and Potential ACO Partner staff to begin discussions around development of the state-specific aspects of the Medicare-Medicaid ACO Model. These discussions will occur over the months following submission of the LOI. Some discussions may occur in a group format, involving multiple states and their Potential ACO Partners, while others will be one-on-one. Some discussions may involve CMS and the state or states only, while others will also include Potential ACO Partners in the state or states. The specific information and actions required to finalize the state-specific aspects of the Medicare-Medicaid ACO Model may vary somewhat by state; CMS will work closely with each state that submits an LOI to determine the necessary documentation and appropriate timelines. States will be required to submit an application for CMS review and approval. The application must include the following items:

- Detailed description of the state-specific approach to the Medicare-Medicaid ACO Model,\(^5\) which must include but will not be limited to the following information:
  - Definition and rationale for selecting the state’s Target Population;
  - ACO eligibility criteria (in addition to those set by CMS) including any state-determined care model requirements;
  - Description of any legislative action needed to implement the Model including waivers of state fraud and abuse laws, if applicable.
- Detailed description of the Medicaid financial methodology;
- List of quality measures, proposed reporting mechanisms, and proposed quality benchmarking approach;
- Description of provider/supplier and beneficiary engagement activities that the state has conducted/participated in as part of the development process.\(^6\)

CMS is not setting a specific deadline for states to submit their applications as we expect that a state may submit these documents at different times rather than all at once and that finalization of the documents may require multiple rounds of review and revision in coordination with CMS during the development process. The state’s application will not be considered complete and

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\(^5\) This could take the form of a proposed Request for Applications from ACOs in the state if that format meets the needs of CMS and the state.

\(^6\) CMS may request additional documentation such as meeting minutes or letters of support to supplement the description submitted by the state.
CMS will not approve an application until all documents have been submitted, reviewed, and approved.

In addition to submitting an application, states will be required to complete the following activities during the state-specific application and development process:

1. Ensure timely, complete Medicaid data will be available to CMS (note: In addition to using data for Model activities such as calculating ACO Medicaid savings and losses, and conducting evaluation and monitoring of the Model, CMS will need access to three years of complete historical Medicaid claims data in order to assess the Medicaid financial methodology prior to a state’s application being approved by CMS);
2. State passes any necessary state-level legislation needed to move forward with the Model, including any waivers of state fraud and abuse laws and provisions to ensure that funds and mechanisms will be available to pay Medicaid shared savings to and collect Medicaid shared losses from ACOs;
3. State secures necessary Medicaid approvals from CMS to authorize the state-specific aspects of the Model.

The historical Medicaid data must be made available to CMS prior to approval of the state application with sufficient time for CMS to review the Medicaid financial methodology. Items two and three may occur in parallel with the state’s application process or following the application process. If they occur following the state’s submission of its application, CMS approval of the application will be contingent on completion of those activities. Once all necessary approvals have been secured, CMS and the State will enter into a CMS-State Medicare-Medicaid ACO Model Participation Agreement (“CMS-State Participation Agreement”).

CMS reserves the right to request interviews or additional information from state applicants during this process. Any questions that arise during the application process may be directed to the Medicare-Medicaid ACO Model mailbox: MMACO@cms.hhs.gov.

C. Application Process for ACOs

Although states must submit at least one letter of interest from a Potential ACO Partner in their state as part of their LOI, and we expect Potential ACO Partners in the state to participate in the development phase of the state-specific aspects of the Medicare-Medicaid ACO Model, participation in the Medicare-Medicaid ACO Model will not be limited to ACOs (or providers/suppliers who later form ACOs) that participate in the development process, nor does participation in the development phase obligate any ACO or provider/supplier in an ACO to participate or guarantee them approval to participate in the Model.

Once a state has been approved to participate in the Medicare-Medicaid ACO Model, ACOs in that state will be given the opportunity to apply to participate in the Model. A state-specific
Request for Applications from ACOs will be released at a later date. In addition to completing the Medicare-Medicaid ACO Model application, interested ACOs must apply to participate in the Shared Savings Program or apply to renew their Shared Savings Program Participation Agreement with CMS in accordance with the Shared Savings Program regulations.

The start of an ACO’s three-year agreement period in the Shared Savings Program (regardless of whether the ACO is entering the program for the first time or renewing its Participation Agreement) must align with the ACO’s start date in the Medicare-Medicaid ACO Model. CMS will work to align Medicare-Medicaid ACO Model application processes and timelines with the Shared Savings Program as much as possible. ACOs will be given the opportunity to participate in the Medicare-Medicaid ACO Model beginning in any of the first three years that the Model is offered in the ACO’s state. For example, if the Medicare-Medicaid ACO Model is offered in State A beginning in 2019, ACOs will be able to apply to participate beginning in 2019, 2020, or 2021. All performance periods will begin January 1. Additional information on the length of the Medicare-Medicaid ACO Participation Agreements, termination scenarios and the implications for Medicare-Medicaid ACOs that wish to remain in the Shared Savings Program after the Model or their participation in the Model is terminated, are provided in section XIII and XVI of this Request for LOIs.

D. Withdrawal of Application

State applicants seeking to withdraw an LOI must submit an electronic withdrawal request to CMS via the Medicare-Medicaid ACO Model mailbox: MMACO@cms.hhs.gov. The request must be submitted as a PDF on the state’s letterhead and signed by an authorized state official.

The state-specific Requests for Applications from ACOs will describe the application withdrawal process for ACOs.

V. Eligibility and Participation Requirements

The following section describes the eligibility requirements for states and ACOs that wish to participate in the Medicare-Medicaid ACO Model. These requirements are not a prerequisite for Potential ACO Partners to submit letters of interest as part of the state’s LOI, as those providers/suppliers may not have formed an ACO at the time of submission of the state’s LOI. However, any ACO or group of providers/suppliers wishing to form an ACO that wishes to participate in the Medicare-Medicaid ACO Model will have to meet all of these requirements prior to signing the Medicare-Medicaid ACO Participation Agreement, or in some cases at the time of application, in accordance with details to be specified in the state-specific Request for Applications from ACOs.

A. Eligible States

To participate, states must have the following characteristics:
• A sufficient number\(^7\) of Medicare-Medicaid enrollees in fee-for-service Medicaid (though individual services provided under Medicaid, such as transportation, may be capitated)

• Not concurrently participating in a Financial Alignment Initiative that includes the state’s Medicare-Medicaid ACO Model Target Population in its model population

• At least one identified Potential ACO Partner participating jointly in the state-specific development process

States participating as a State Innovation Model test state may be able to participate in the Medicare-Medicaid ACO Model, but eligibility will be assessed on a state by state basis by the State Innovation Model (SIM) and Medicare-Medicaid ACO Model staff at the CMS Innovation Center. States participating as a SIM test state who wish to discuss eligibility prior to submission of an LOI are encouraged to contact the Innovation Center through email at MMACO@cms.hhs.gov and/or through their SIM project officer. CMS will consider factors such as the degree of alignment between the state’s SIM goals and those of the Medicare-Medicaid ACO Model and CMS’ ability to evaluate the models when making a determination about state eligibility.

**B. Eligible ACOs**

To participate in the Medicare-Medicaid ACO Model, an ACO must participate in the Shared Savings Program. This includes meeting all eligibility requirements at 42 C.F.R. Part 425, subpart B, with the exception that CMS will waive the prohibition in § 425.114 against participation in both the Shared Savings Program and a model tested or expanded under section 1115A of the Act that involves shared savings in order to permit ACOs and their ACO participants and ACO providers/suppliers to participate in both the Shared Savings Program and the Medicare-Medicaid ACO Model. Because the Medicare-Medicaid ACO Model application period is likely to run parallel to the Shared Savings Program application timeline, ACOs do not need to have been accepted into the Shared Savings Program prior to submitting an application to the Medicare-Medicaid ACO Model, but will need to sign a Participation Agreement for the Shared Savings Program in order to participate in the Medicare-Medicaid ACO Model.

In addition to the requirements under the Shared Savings Program, ACOs wishing to participate in the Medicare-Medicaid ACO Model will need to meet the following requirements:\(^8\)

• An ACO must be a legal entity, formed under applicable state, Federal, or Tribal law, and authorized to conduct business in each state in which it operates for purposes of the

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\(^7\) The determination of whether a state has a sufficient number of Medicare-Medicaid enrollees in fee-for-service will be made by CMS by assessing factors including but not limited to the number of beneficiaries needed for reliable calculations of potential Medicare shared savings for the state, and the number needed to conduct a meaningful evaluation.

\(^8\) Additional detail on these requirements and any others will be provided to ACOs in the state-specific Request for Applications.
following:
- Receiving and distributing Medicaid shared savings;
- Repaying shared losses or other monies determined to be owed to the state and/or CMS;
- Establishing, reporting, and ensuring provider/supplier compliance with health care quality criteria, including quality performance standards under the Medicare-Medicaid ACO Model;
- Fulfilling all other ACO functions to be identified in the Medicare-Medicaid ACO Participation Agreement.

- The ACO must have a sufficient number of assigned beneficiaries for which it will take on Medicaid financial accountability (the minimum beneficiary threshold may vary by state and may include only Medicare-Medicaid enrollees or also Medicaid-only beneficiaries if the state includes Medicaid-only beneficiaries in its Target Population for the Medicare-Medicaid ACO Model). The minimum threshold will be determined as part of the Medicaid financial methodology development process.
- The ACO must include or have relationships with a diverse set of provider/supplier types to meet the needs of its beneficiary population (e.g. behavioral health providers/suppliers, HCBS providers/suppliers, long-term care facilities).
- The ACO governing body must include at least one Medicare-Medicaid enrollee served by the ACO who: (1) does not have a conflict of interest with the ACO; (2) has no immediate family member with a conflict of interest with the ACO; (3) is not a Medicare-Medicaid ACO Provider/Supplier, as defined in Appendix B; and (4) does not have a direct or indirect financial relationship with the ACO, or a Medicare-Medicaid ACO Provider/Supplier, except that such person may receive reasonable compensation by the ACO for his or her duties as a member of the governing body of the ACO. It is acceptable for this individual to be the same person as or a different person than the Medicare beneficiary representative required under Shared Savings Program regulations.
- The ACO governing body must include at least one consumer advocate representing the Medicare-Medicaid enrollee population, who may be the same person as the Medicare-Medicaid enrollee representative. A consumer advocate is a person with training or professional experience in advocating for the rights of consumers who: (1) does not have a conflict of interest with the ACO; (2) has no immediate family member with a conflict of interest with the ACO; and (3) is not a Medicare-Medicaid ACO Provider/Supplier; and (4) who does not have a direct or indirect financial relationship with the ACO, or a Medicare-Medicaid ACO Provider/Supplier, except that such person may receive reasonable compensation by the ACO for his or her duties as a member of the governing body of the ACO.  

9 In cases where beneficiary and/or consumer advocate representation is prohibited by state law, the Medicare-Medicaid ACO, with CMS approval, shall provide for an alternative mechanism to ensure policies and procedures...
• The ACO governing body must include at least one representative from each of the following provider/supplier entity types in the ACO’s service area that provides services to beneficiaries in the Model’s Target Population:
  o a long-term, institutional care provider/supplier entity;
  o a long-term, home and community-based services provider/supplier entity;
  o a behavioral health provider/supplier entity; and
  o a social services provider/supplier entity.
• The ACO and its Medicare-Medicaid ACO Providers/Suppliers must use certified EHR technology in a manner specified for an Alternative Payment Model to be an Advanced Alternative Payment Model at 42 C.F.R. § 414.1415.
• The ACO must meet any additional state-specific eligibility requirements determined during the development process and defined in the Request for Applications that will be released to ACOs in each participating state.

Program Overlap

Under Section 1899(b)(4) of the Act as implemented in 42 C.F.R. 425.114(a), a provider or supplier may not participate in the Shared Savings Program if they also participate in a model tested under section 1115A of the Act that involves Medicare shared savings. CMS will waive the requirement at section 1899(b)(4)(A) to allow ACOs and their ACO Participants and ACO providers/suppliers to participate in the Shared Savings Program and in the Medicare-Medicaid ACO Model simultaneously.

With the exception of this waiver for the purpose of participating in the Medicare-Medicaid ACO Model, the Shared Savings Program rules regarding participation in other shared savings initiatives as well as the Independence At Home medical practice pilot program under section 1866E of the Act will continue to apply to Shared Savings Program ACOs and their ACO Participants and ACO providers/suppliers. Non-Shared Savings Program MMACO Providers/Suppliers, as defined in Appendix B, may participate in other Innovation Center models and/or Medicare demonstrations or models involving Medicare shared savings, if otherwise eligible. CMS will work with each state to determine whether any restrictions on participation in other Medicaid shared savings models is necessary. CMS may issue guidance or work directly with ACOs in determining how participation in certain demonstrations or models can be combined with participation in the Medicare-Medicaid ACO Model. CMS will undertake program overlap reviews during the application process.

Eligible Providers/Suppliers

The Shared Savings Program ACO providers/suppliers as defined under 42 C.F.R. 425.20 will also be considered to be Medicare-Medicaid ACO Providers/Suppliers participating in the...
Medicare-Medicaid ACO Model if the Shared Savings Program ACO applies and is accepted into the Model, and signs a Medicare-Medicaid ACO Participation Agreement. These providers/suppliers are referred to as Shared Savings Program MMACO Providers/Suppliers.

While all Shared Savings Program MMACO Providers/Suppliers will be considered Medicare-Medicaid ACO Providers/Suppliers, Medicare-Medicaid ACOs may choose to include additional providers/suppliers in their Medicare-Medicaid ACO as Medicare-Medicaid ACO Providers/Suppliers that do not participate in the Shared Savings Program. These providers/suppliers must be enrolled in Medicaid and/or Medicare, and will be subject to program integrity screening by CMS. These providers/suppliers are referred to as Non-Shared Savings Program MMACO Providers/Suppliers.

Additional state-specific requirements may be set for provider/supplier eligibility and participation.

**ACO and Provider/Supplier Screening**

In addition to the program integrity screenings conducted by CMS for Shared Savings Program ACO applicants, Medicare-Medicaid ACO Model ACO applicants will be screened by CMS to determine prospective ACOs’ eligibility for participation in the Medicare-Medicaid ACO Model, using criteria detailed in this solicitation, the forthcoming state-specific Request for Applications from ACOs and in applicable law, including but not limited to 2 C.F.R. Parts 180 and 376. Applicants whose screening reveals a history of past or present program integrity issues or affiliations with individuals or entities that have a history of past or present program integrity issues may be subject to denial of their application, termination from the Model, or the imposition of additional safeguards or assurances against program integrity risks. CMS may also deny individual Non-Shared Savings Program MMACO Providers/Suppliers or any other relevant entity or individual from participation in the Model based on the results of a program integrity review. ACO applicants will be required to disclose any sanctions and investigations that have been imposed on the applicant or individuals in leadership positions in the last three years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, Board members, CEO, CFO, COO, CIO, medical director, compliance officer, and the individual responsible for maintenance and stewardship of clinical data.
C. State Licensure

To participate in the Medicare-Medicaid ACO Model, ACOs must demonstrate compliance with all applicable state laws and regulations with respect to risk-bearing entities, and produce documentation upon request. CMS may also request attestations of compliance from relevant state regulatory authorities, including state insurance commissioners. Each state has unique regulatory systems for health care delivery, the practice of medicine, and insurance (e.g. some states require providers/suppliers and/or ACOs to register with the Department of Insurance if bearing downside financial risk in a contract). It is the responsibility of the Medicare-Medicaid ACO, its Shared Savings Program ACO Participants and its Medicare-Medicaid ACO Providers/Suppliers to determine and meet their own licensure needs.

D. Outcomes-Based Contracts with Other Purchasers

CMS may require Medicare-Medicaid ACOs to report to CMS, in a form and manner and by a date determined by CMS, information regarding the scope of outcomes-based contracts held by the ACO and/or its Shared Savings Program ACO Participants and Medicare-Medicaid ACO Providers/Suppliers with other payers, such as commercial payers, Medicare Advantage plans, and Medicaid managed care plans. For purposes of this Model, outcomes-based contracts mean contracts that evaluate patient experiences of care, and include financial accountability (e.g., shared savings or financial risk) and/or quality performance standards.

VI. Model Design Elements

A. Beneficiary Eligibility and Assignment to Medicare-Medicaid ACOs

Like ACOs participating in other Medicare ACO initiatives, Medicare-Medicaid ACOs will earn shared savings or be accountable for shared losses (if in a two-sided track) and receive quality scores with regards to an attributed population of beneficiaries. The following sections describe how beneficiaries will be assigned to Medicare-Medicaid ACOs.

Assignment Methodology

For Medicare financial reconciliation and quality reporting purposes, Medicare-Medicaid ACOs will have beneficiaries assigned to the ACO using the Shared Savings Program beneficiary assignment methodology, with the exception that all Medicare-Medicaid ACOs, regardless of financial track, will have beneficiaries assigned prospectively. This methodology will be the same as that used for Track 3 ACOs under the Shared Savings Program but will apply to all Medicare-Medicaid ACOs regardless of which financial track under the Shared Savings Program the ACO selects. Prospective assignment will be used to assign all beneficiaries to a Medicare-Medicaid ACO under the Shared Savings Program, not just Medicare-Medicaid enrollees. The ACO’s assigned beneficiary population under the Shared Savings Program will include Medicare-only beneficiaries and Medicare-Medicaid enrollees. Those Medicare-Medicaid enrollees assigned to the ACO under the Shared Savings Program who meet the eligibility requirements for the Target Population determined as part of the state-specific development
process will be included in the population for which the Medicare-Medicaid ACO takes on Medicaid accountability.

During the state-specific development process, CMS will work with each state and its Potential ACO Partners to determine the Target Population. For example, a state may wish to include only Medicare-Medicaid enrollees with full Medicaid benefits or only beneficiaries over the age of 65 in the state’s Target Population. In addition, states may wish to identify additional fee-for-service Medicare-Medicaid enrollees or Medicaid-only populations to be included in the state’s Target Population for Medicaid financial and quality measurement calculations, and will develop appropriate eligibility criteria for these beneficiaries as well. These additional beneficiaries would not be considered in calculations of Medicare savings or losses under the Shared Savings Program. If a state chooses to include additional beneficiaries in the Target Population, CMS and the state will develop an appropriate beneficiary assignment methodology for those populations.

The inclusion of Medicare beneficiaries who are not Medicare-Medicaid enrollees in the ACO’s Medicare benchmark under the Shared Savings Program and the flexibility for states to include additional populations have several potential benefits, including allowing states to align participation in this Model with broader Medicaid payment reform efforts; increasing the number of ACOs eligible to participate by creating a path for more ACOs to meet the minimum assigned beneficiary threshold under the Shared Savings Program and for Medicaid financial calculations; and aligning financial incentives and quality measurement for a larger percentage of an ACO’s population.

**Minimum Assigned Population**

To be eligible for participation in the Shared Savings Program, ACOs must have at least 5,000 assigned Medicare beneficiaries. In addition to this requirement, Medicare-Medicaid ACOs will be required to have a certain number of beneficiaries assigned for purposes of Medicaid shared savings and shared losses calculations. Additionally, to ensure that there are a sufficient number of Medicare-Medicaid beneficiaries assigned for evaluation purposes, CMS may set a minimum number or percentage of Medicare-Medicaid enrollees that ACOs must have assigned to be eligible to participate in the Model. These minimum thresholds will be determined on a state-by-state basis during the state-specific development process. While CMS anticipates that the minimum number will be similar across states, factors such as the variability in costs for the state’s Target Population may necessitate higher minimum numbers in some states than in others to ensure validity of the Medicaid financial calculations, Medicare shared savings calculations for states, and evaluation of the Model.

**B. Financial Benchmark, Risk Arrangements, and Shared Savings**

The Medicare-Medicaid ACO Model seeks to test ACOs’ ability to provide and be accountable for the full spectrum of Medicare Part A and B and Medicaid benefits and services. Below are the descriptions of the Medicare-Medicaid ACO Model financial methodology, including risk
adjustment, risk arrangement options, shared savings and shared losses calculation methodology, and calculation of Medicare shared savings payments to eligible participating states. Briefly, CMS will first determine whether participating ACOs have achieved savings for assigned beneficiaries’ Medicare Part A and Part B expenditures through the Shared Savings Program. In parallel, participating states will hold ACOs accountable for their assigned beneficiaries’ Medicaid expenditures using an analogous (but not necessarily identical) benchmarking process. CMS will pay any shared savings or collect any shared losses associated with Medicare expenditures for assigned beneficiaries to/from each eligible ACO, consistent with the rules of the Shared Savings Program and the ACO’s financial track within that Program. The state will pay any shared savings or collect any shared losses associated with the Medicaid expenditures for assigned beneficiaries to/from each eligible ACO. Then, CMS will determine if the state is eligible to share in any Medicare savings with CMS, and, if the state is eligible, CMS will make this payment to the state. The eligibility criteria and process for calculating any Medicare shared savings with the state is described later in this section.

**Medicare and Medicaid Benchmarks**

The Medicare benchmarking methodology for Medicare-Medicaid ACOs will follow the Shared Savings Program specifications for benchmarking, trending, and risk adjustment.

CMS will work with states that submit an LOI to develop the specific Medicaid benchmarking methodology for ACOs in that state. Certain aspects of the methodology will be consistent across all states, while other aspects may need to vary depending on the Target Population selected by the state and the Medicaid program in the state. A high level overview of the methodology is described below. The specific Medicaid benchmarking methodology and risk arrangements for each state will be reviewed by CMS to ensure that they are consistent with the incentives and overall levels of financial risk under the Shared Savings Program.

The Medicaid financial calculations for Medicare-Medicaid ACOs will include expenditures for the ACO’s assigned Medicaid beneficiary population. This will include Medicaid expenditures for the Medicare-Medicaid enrollees assigned under the Shared Savings Program that meet the state’s beneficiary eligibility criteria for inclusion in the state’s Target Population, and may also include Medicaid-only beneficiaries and/or Medicaid expenditures for Medicare-Medicaid enrollees not assigned under the Shared Savings Program methodology, if the state chooses to include additional beneficiaries in the Target Population.

In each of the Model’s performance years, benchmarks for Medicaid expenditures will be set through the following steps, using the most up-to-date Medicaid expenditures and risk score data available at that point in time:

- Establish an historical benchmark using the Medicaid expenditures of beneficiaries that would have been assigned to the ACO in previous years
- Apply Medicaid regional trend to the historical benchmark
- Risk adjust Medicaid annual expenditures
To set the ACO’s Medicaid benchmark, CMS will use Medicaid beneficiary spending data, including spending on mandatory and optional benefits and on benefits and services authorized under sections 1115, 1915(b), and/or 1915(c) of the Act.

For the Medicaid historical benchmark (and in turn the performance year calculations), expenditure calculations will be stratified by:

- Three categories of care delivery: Medicaid medical institution, HCBS, and community-other,
- Two categories of mental illness: the presence or absence of serious mental illness (SMI) including substance use disorders,
- Two categories of age: 65 and older, and under 65.

CMS will use a single Medicaid risk adjustment methodology across all participating states. CMS is considering different models, and future analysis and modeling are necessary before deciding upon a risk adjustment methodology. However, under any risk adjustment methodology, CMS intends to recognize diagnosis changes while capping risk score growth for the Medicaid benchmark.

The Medicaid benchmark will be separate from and independent of the Shared Savings Program benchmark.

**Risk Arrangements**

Medicare-Medicaid ACOs will select their Shared Savings Program financial track in accordance with Shared Savings Program rules.

As part of the state-specific development process, states and Potential ACO Partners will develop risk arrangements for Medicaid shared savings/shared losses calculations that will be offered to Medicare-Medicaid ACOs in the state. The arrangements must have similar levels of risk, as assessed through the sharing percentage, caps, and other factors that contribute to the level of financial risk that an ACO is taking on, to those offered under the Shared Savings Program and will be subject to CMS review and approval.

**Payment of ACO Shared Savings and Losses**

CMS will be responsible for paying Medicare shared savings to eligible Medicare-Medicaid ACOs earned under the Shared Savings Program and states will be responsible for paying Medicaid shared savings to eligible Medicare-Medicaid ACOs. Medicare-Medicaid ACOs in two-sided risk arrangements will be responsible for paying Medicare shared losses to CMS under the rules of the Shared Savings Program and Medicaid shared losses to the state under the terms of the Medicare-Medicaid ACO Model. If a Medicare-Medicaid ACO earns savings under the Medicare or Medicaid financial methodology and losses under the other, CMS or the state may adjust or withhold payment of shared savings until owed shared losses have been paid by the Medicare-Medicaid ACO. Circumstances under which this would occur as well as requirements
around required repayment mechanisms/financial guarantees for Medicaid losses will be described further in the Requests for Applications from ACOs and the Medicare-Medicaid ACO Participation Agreement.

**State Eligibility for Medicare Shared Savings**

CMS will determine eligibility and calculate the state Medicare shared savings, if any, following the completion of year-end financial reconciliation for both Medicare and Medicaid with all of the Medicare-Medicaid ACOs in the state. Eligibility for a state to earn Medicare shared savings will be contingent on satisfaction of a precondition in which CMS assesses whether total combined Medicare savings for all Medicare-Medicaid ACOs in the state meet or exceed a minimum savings rate (MSR) corresponding to the total number of Medicare beneficiaries assigned to Medicare-Medicaid ACOs in the state and whether Medicare savings exist net of Medicare shared savings and shared loss payments to and from Medicare-Medicaid ACOs. If the pre-condition is met, calculation of a potential Medicare shared savings payment will involve a multi-step algorithm designed to identify statewide federal Medicare savings attributable to spending on Medicare-Medicaid enrollees assigned to Medicare-Medicaid ACOs in the state. A summary of the methodology is provided below. A more detailed specification document will be made available to states at a later date.

1. CMS will calculate the net Medicare savings/losses for Medicare-Medicaid enrollees assigned to Medicare-Medicaid ACOs in the state. This will be done by combining the Medicare Parts A and B savings/losses for these Medicare-Medicaid enrollees net of the Medicare shared savings or shared losses payments made to and from Medicare-Medicaid ACOs that are attributable to the assigned Medicare-Medicaid enrollee population.

   If net Medicare savings exist after these calculations, state-level reconciliation will continue. If no Medicare savings exist, the state will not be eligible for Medicare shared savings.

2. CMS will calculate the net federal Medicaid savings/losses for Medicare-Medicaid enrollees assigned to Medicare-Medicaid ACOs in the state. This will be done by combining the federal portion of the Medicaid savings/losses for these Medicare-Medicaid enrollees net of the federal portion of the Medicaid shared savings or shared losses payments made to and from Medicare-Medicaid ACOs attributable to the assigned Medicare-Medicaid enrollee population.

3. CMS will subtract federal Medicaid losses for the assigned Medicare-Medicaid enrollee population, if the losses meet or exceed a Medicaid Significance Factor (MSF), from the net Medicare savings for Medicare-Medicaid enrollees calculated in the first step. The MSF will vary based on the size of the assigned Medicare-
Medicaid enrollee population in the state, and could be as low as one percent. If there are federal Medicaid losses that meet or exceed the MSF, the net Medicare savings will be reduced by the total amount of federal Medicaid losses.

If net savings exist after adjusting the Medicare savings for any significant federal Medicaid losses, state-level reconciliation will continue. If no net savings exist, the state will not be eligible for Medicare shared savings.

4. CMS will adjust the net Medicare savings, determined after any necessary reduction applied in step 3, based on the aggregate quality performance of Medicare-Medicaid ACOs in the state. This will be done by taking the overall quality performance score under the Shared Savings Program for all Medicare-Medicaid ACOs in the state, and calculating an average score weighted by the number of Shared Savings Program assigned beneficiaries per Medicare-Medicaid ACO. If net savings exist after the quality performance adjustment is applied, state-level reconciliation will continue. If no savings exist, the state will not be eligible for Medicare shared savings.

5. CMS will ensure that the quality-adjusted net Medicare savings, adjusted for any significant federal Medicaid losses, from step 4, does not exceed either of the following caps on potential Medicare shared savings shared with the state:
   a. The total amount of Medicare savings (for all beneficiaries assigned to Medicare-Medicaid ACOs in the state under the Shared Savings Program) and federal Medicaid savings/losses for Medicare-Medicaid ACOs in the state, net of Medicare shared savings/shared losses payments made to/from Medicare-Medicaid ACOs in the state and the federal portion of Medicaid shared savings/losses payments to/from Medicare-Medicaid ACOs in the state.
   b. Six percent of the combined Medicare Parts A and B benchmark for the Medicare-Medicaid enrollees assigned to Medicare-Medicaid ACOs in the state.

If either or both caps are reached, the amount of Medicare shared savings for which the state is eligible will be reduced to the amount of the lower cap.

6. CMS will share 50 percent of resulting savings with the state.

Example: Assume a state with an FMAP of 50 has a single participating Medicare-Medicaid ACO that achieves savings of $3 million under the Shared Savings Program, with $1 million attributed to Medicare-Medicaid enrollees and $2 million to Medicare beneficiaries who are not Medicare-Medicaid enrollees assigned under the Medicare-Medicaid ACO Model. The ACO in the state receives a shared savings payment of $1.5 million under the Shared Savings Program. The $1.5 million savings remaining would be apportioned between Medicare-Medicaid enrollees ($500,000) and other Medicare beneficiaries who are not assigned Medicare-Medicaid enrollees...
($1 million), resulting in a net Medicare savings for Medicare-Medicaid enrollees of $500,000. Meanwhile, assume gross Medicaid losses for Medicare-Medicaid enrollees assigned to the Medicare-Medicaid ACO are measured to be $1 million and are offset by a $400,000 Medicaid shared losses payment from the Medicare-Medicaid ACO, and the federal share of such net Medicaid losses is $300,000 (i.e. 50% of the net $600,000 Medicaid loss), an amount exceeding the Medicaid Significance Factor. The $500,000 net Medicare savings for Medicare-Medicaid enrollees would be offset by the $300,000 net federal Medicaid losses for Medicare-Medicaid enrollees, and the net Medicare savings (after adjustments for federal Medicaid losses) amount of $200,000 would be scaled by a state quality score (let us assume it to be 90%) resulting in a scaled net savings of $180,000. Provided this amount is below the caps described in step 5 above, CMS would apply a sharing rate of 50% and $90,000 would be shared with the state.

C. Pre-payment of Shared Savings for Safety-Net ACOs

A subset of Medicare-Medicaid ACOs that apply and qualify as “Safety-Net ACOs” will be offered pre-payment of Medicare shared savings that can be invested in care coordination and ACO-related infrastructure. These funds will be recouped out of the Medicare-Medicaid ACO’s Medicare shared savings, in the event that savings are achieved, under the Shared Savings Program. The specific methodology for identifying Safety-Net ACOs, amount of prepaid funds available, and process by which ACOs will apply for these funds will be provided at a later date, prior to when ACOs must apply to participate in the Model.

VII. Quality and Performance

Quality measures and performance standards in the Medicare-Medicaid ACO Model will be aligned with those in the Shared Savings Program and other CMS quality measurement efforts, as well as with the quality measurement approach of participating states.

A. Quality Measures

All Medicare-Medicaid ACOs will be required to report the quality measures included in the Shared Savings Program. A Medicare-Medicaid ACO’s quality performance on the Shared Savings Program measures will factor into the Medicare shared savings or shared loss percentage paid to or from the ACO in accordance with Shared Savings Program rules. States will propose the additional quality metrics most appropriate for the Target Population, and are encouraged to select measures that align with those used in the Shared Savings Program and the Financial Alignment Initiative. Reporting and/or performance on the state-specific measures will affect the Medicaid shared savings or shared losses rate for Medicare-Medicaid ACOs. The measures proposed by the state may be measures currently in use in initiatives in the state or new measures. Selection of final quality measures is subject to CMS review and approval.
CMS will also select and administer a quality of life survey for the Medicare-Medicaid enrollee population. Performance on the quality of life survey may be factored into the Medicaid shared savings/shared losses financial calculations along with any measures selected by the state and approved by CMS.

VIII. Monitoring and Oversight

A. Monitoring and Oversight of States and ACOs

CMS will monitor states for compliance with the terms and conditions of the CMS-State Participation Agreement.

Medicare-Medicaid ACOs will be subject to the monitoring requirements of the Shared Savings Program as described in 42 C.F.R. Part 425, subpart D. Additionally, CMS will conduct monitoring of Medicare-Medicaid ACOs and Medicare-Medicaid ACO Providers/Suppliers in coordination with the state to ensure compliance with the Medicare-Medicaid ACO Participation Agreement and to ensure beneficiary protections that address the unique needs of Medicare-Medicaid enrollees. This monitoring may involve engagement with community-based organizations to assess beneficiary concerns. The Medicare-Medicaid ACO Participation Agreement will include additional requirements for Non-Shared Savings Program MMACO Providers/Suppliers and compliance with those provisions will be subject to monitoring.

B. Remedial Actions

In addition to the actions described in 42 C.F.R. Part 425, subpart C related to actions prior to termination and termination from the Shared Savings Program, Medicare-Medicaid ACOs will be subject to potential corrective actions under the Medicare-Medicaid ACO Participation Agreement. Medicare/Medicaid ACO Providers/Suppliers will also be subject to potential corrective actions under the Medicare-Medicaid ACO Participation Agreement. States that do not comply with their CMS-State Participation Agreement or the Medicare-Medicaid ACO Participation Agreement will be subject to potential corrective action as well.

Any infringement of agreement terms or Medicare or Medicaid standards will trigger appropriate actions based on the type of issue, degree of severity, and the state’s or Medicare-Medicaid ACO’s compliance record while participating in the Model. Such actions may include but will not be limited to:

- Educating the Medicare-Medicaid ACO on how to operate in compliance with relevant standards;
- Requiring submission of Corrective Action Plans (CAPs) detailing how a Medicare-Medicaid ACO or state will rectify violations;
- Placing the state, Medicare-Medicaid ACO or one or more of its Medicare-Medicaid ACO Providers/Suppliers on a compliance monitoring plan;
- Suspending data sharing rights if data sharing is implicated in the violation;
• Suspending or terminating pre-payment of Medicare shared savings due to the Medicare-Medicaid ACO (if applicable);
• Requiring the termination of a Medicare-Medicaid ACO Provider/Supplier from the Medicare-Medicaid ACO;
• Terminating the Medicare-Medicaid ACO’s participation in the Medicare-Medicaid ACO Model;
• Terminating the state’s participation in the Medicare-Medicaid ACO Model;
• Referring a Medicare-Medicaid ACO Provider/Supplier to the Secretary for temporary or permanent revocation of Medicare billing privileges;
• Referring the Medicare-Medicaid ACO or a Medicare-Medicaid ACO Provider/Supplier to law enforcement agencies for potential civil, administrative, and/or criminal violations.

IX. Data Sharing and Reports

Under appropriate data use agreements (DUAs) and upon request CMS will periodically provide participating Medicare-Medicaid ACOs with Medicare and Medicaid data in accordance with applicable law. Such reports would be intended to provide program performance and payment data to support Medicare-Medicaid ACOs’ care coordination and quality improvement work.

Specifically, Medicare-Medicaid ACOs may request Medicare data including aggregate reports and beneficiary identifiable claims data as described under the Shared Savings Program regulations (42 C.F.R. Part 425, subpart H), with the exception that because all Medicare-Medicaid ACOs will have beneficiaries assigned prospectively, data shared will reflect only the prospectively assigned population.

Medicare-Medicaid ACOs may also request Medicaid data from CMS consistent with the types of Medicare reports and claims data shared with ACOs under the Shared Savings Program. To ensure CMS has access to the data needed to generate such reports, participating states will be expected to ensure their state Medicaid agency’s timely contribution of Medicaid claims and encounter data through T-MSIS. Such disclosures are already required under Section 4753 of the Balanced Budget Act of 1997 and Section 6504 of the Affordable Care Act. CMS also intends to provide data and reports to Medicare-Medicaid ACOs that request it, that link beneficiary data across Medicare and Medicaid. The content of the data and reports provided to Medicare-Medicaid ACOs may include, but would not be limited to: Beneficiary Assignment Reports; Beneficiary Identifiable Claims Data; Aggregate Expenditure and Utilization Reports; Financial Benchmark Reports. If the additional time required for CMS to receive Medicaid data through T-MSIS and make it available to Medicare-Medicaid ACOs is significant enough to substantially affect the usefulness of the data to ACOs, CMS and the state may agree to have the state Medicaid agency provide certain files or reports directly to ACOs upon request, in accordance with applicable law. Regardless of who provides the data to ACOs, state Medicaid
agencies will need to provide Medicaid claims and encounter data to CMS through T-MSIS as required by law.

While state Medicaid agencies will already have access to the Medicaid data CMS intends to share with Medicare-Medicaid ACOs that request it, the corresponding Medicare data or linked Medicare and Medicaid data for Medicare-Medicaid enrollees may be necessary to support state Medicaid agencies in understanding the needs of the **Target Population** and the Medicare-Medicaid ACOs and the **Medicare-Medicaid Providers/Suppliers** that are accountable for the cost and quality of care of the **Target Population**. Upon request, CMS will provide to state Medicaid agencies the same Medicare and/or linked Medicare-Medicaid data that is provided to Medicare-Medicaid ACOs that request it and may also develop additional reports that aggregate information across all Medicare-Medicaid ACOs in the state.

Any data shared with state Medicaid agencies or Medicare-Medicaid ACOs will be disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and all other applicable laws.

X. Monitoring and Evaluation

All participating states and Medicare-Medicaid ACOs will be required to cooperate with the monitoring and evaluation activities of CMS and its contractors, including collecting and reporting such data (including protected health information as that term is defined under the HIPAA Privacy Rule) determined to be necessary for CMS to carry out those activities. The evaluation efforts will include an independent, federally funded evaluation of the Model, which may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive evaluation. The evaluation will assess the impact of the Medicare-Medicaid ACO Model on the goals of better health, better health care, and lower per beneficiary expenditures. The evaluation will be used to inform policy makers about the effect of the Medicare-Medicaid ACO Model relative to health care delivery under the traditional fee-for-service system and other models of care. To do so, the evaluation will seek to understand the behaviors of providers/suppliers and beneficiaries, the impacts of aligning two payers’ financial incentives, the effects of various payment arrangements, the impact of the Model on beneficiary engagement and experience, and other factors associated with patterns of results.

XI. Information Resources for Beneficiaries and Providers/Suppliers

The primary resource for beneficiaries with questions about the Medicare-Medicaid ACO Model will be 1-800-MEDICARE. CMS will work with participating states to develop scripts for customer service representatives (CSRs) that will answer anticipated questions related to the Model. Questions that CSRs cannot answer will be triaged to CMS Regional Offices. Medicare-Medicaid ACOs will also be required to establish processes to answer beneficiary queries. Finally, CMS will maintain an email inbox for inquiries from states and ACOs related to the
XII. Application Scoring and Selection

CMS will work with any state that submits an LOI on or before the specified deadline and with that state’s Potential ACO Partners to develop the state-specific aspects of the Model. CMS will enter into agreements with up to six states and preference will be given to states with low Medicare ACO saturation. States will be required to meet the requirements described in Section IV of this Request for LOIs to participate in the Model. Approval for a state to release a Request for Applications from ACOs and implement the Medicare-Medicaid ACO Model in the state is subject to CMS approval of the state’s application and the state’s securing necessary Medicaid approvals from CMS and waivers of state laws where applicable.

CMS will work with interested states to develop selection criteria for Medicare-Medicaid ACOs as described in Section IV.B of this Request for LOIs. These criteria will be in addition to the eligibility requirements under the Shared Savings Program. Information on state-specific Medicare-Medicaid ACO eligibility criteria and application processes will be included in state-specific Requests for Applications from ACOs.

Additionally, CMS will provide information about the definition and selection criteria for a Medicare-Medicaid ACO to qualify as a Safety-Net ACO for purposes of eligibility for pre-payment of shared savings in future guidance.

XIII. Duration of Model

In each state, the Medicare-Medicaid ACO Model will have a term that consists of three initial performance years with the potential for two optional one-year extensions (“option years”). The Model may begin in a given state in 2018, 2019, or 2020. All performance periods will begin on January 1 and last twelve months.

States that wish to extend for one or both of the two option years will be required to gain CMS approval. CMS will consider factors such as whether the state has demonstrated the ability to meet the terms and conditions of its agreements with CMS and Medicare-Medicaid ACOs (e.g. providing timely and complete data, making Medicaid shared savings payments to ACOs and collecting Medicaid shared losses from ACOs), the performance of the state and Medicare-Medicaid ACOs in the state, and the level of interest from Medicare-Medicaid ACOs in the state to continue in the Model.

ACOs may apply to participate in the Medicare-Medicaid ACO Model beginning in any of the first three years in which the Medicare-Medicaid ACO Model is offered in their state. ACOs that enter the Model in the first performance year of the Model within the state will have an initial term that consists of three performance years. ACOs that enter the Model in the second performance year within the state, will have an initial term that consists of two performance years; and ACOs that enter the Model in the third performance year within the state, will have an initial term of one performance year. Following the initial performance years, if option years are
being offered within the state there will be the potential for two additional one-year extensions regardless of entry year of the ACO. Prior to the end of the third performance year in which the Model is offered in the state, CMS will determine if the participating ACOs are approved to enter into the option year or years of the Model. CMS will consider the ACO’s performance on Medicare and Medicaid cost and quality, using the most recent data available, if any, and will also consider the ACO’s compliance with the requirements of the Medicare-Medicaid ACO Model and applicable laws when making this determination. If a Medicare-Medicaid ACO is not approved to participate in either or both of the option years or if the option years are not offered in the Medicare-Medicaid ACO’s state, this will not affect the Medicare-Medicaid ACO’s Shared Savings Program Participation Agreement and the ACO may continue in the Shared Savings Program subject to the rules of that program.

CMS reserves the right not to offer states, or ACOs within a state, the opportunity to continue in one or both option years.

XIV. Learning and Diffusion Resources

CMS will support participating states and Medicare-Medicaid ACOs in accelerating their progress by providing them with opportunities to learn about achieving performance improvements and to share experiences with one another and with participants in other Innovation Center initiatives. This will be accomplished through a “learning system” for Medicare-Medicaid ACOs and states, in addition to the learning system available to ACOs through the Shared Savings Program. The learning system will use various group learning approaches to help states and Medicare-Medicaid ACOs effectively share experiences, track progress, and rapidly adopt new methods for improving quality, efficiency, and population health. CMS expects Medicare-Medicaid ACOs and states to participate actively in the learning system by attending periodic conference calls and meetings and sharing tools and ideas through an online collaboration site.

XV. Public Reporting

The Medicare-Medicaid ACO Model emphasizes transparency and public accountability. Medicare-Medicaid ACOs will be required to comply with the public reporting requirements of the Shared Savings Program (42 C.F.R. § 425.308). Additionally, Medicare-Medicaid ACOs will be required to publicly report information regarding their financial performance in the Model, their organizational structure, and Medicare-Medicaid ACO Providers/Suppliers (to the extent that this information is not already reported under the Shared Savings Program requirements). CMS will publicly report the quality performance scores of Medicare-Medicaid ACOs, among other data and information, as appropriate. Specific public reporting requirements will be clearly described in the Medicare-Medicaid ACO Participation Agreement.

XVI. Termination
A. Termination of an ACO’s Participation

CMS reserves the right to review the status of a Medicare-Medicaid ACO and terminate its Medicare-Medicaid ACO Participation Agreement or require the ACO, as a condition of continued participation, to terminate its agreement with a Non-Shared Savings Program MMACO Provider/Supplier, or other individuals or entities performing functions or services for the Medicare-Medicaid ACO for reasons associated with poor performance, non-compliance with the terms and conditions of the Medicare-Medicaid ACO Participation Agreement, or program integrity history. Such termination will not automatically affect the Medicare-Medicaid ACO’s participation in the Shared Savings Program, but may be a relevant consideration in actions taken under the regulations of that Program.

Specific reasons and procedures for termination will be clearly outlined in the Medicare-Medicaid ACO Participation Agreement.

Termination procedures under the Shared Savings Program (42 C.F.R. Part 425, subpart C) will continue to apply for Medicare-Medicaid ACOs as it relates to their participation in the Shared Savings Program. ACOs that terminate from the Shared Savings Program during their participation in the Medicare-Medicaid ACO Model, will have their participation in the Medicare-Medicaid ACO Model terminated, effective as of the date of the ACO’s termination from the Shared Savings Program.

Termination of a State’s Participation

CMS reserves the right to review the status of a state and terminate its CMS-State Participation Agreement. States may terminate their participation in the model, effective at the end of a calendar year, unless changes in state law necessitate a mid-year termination. If a CMS-State Participation Agreement is terminated, the Medicare-Medicaid ACO Participation Agreements of all Medicare-Medicaid ACOs in that state will also be terminated. This termination will not affect the Medicare-Medicaid ACOs’ Shared Savings Program Participation Agreement and the ACOs may continue in the Shared Savings Program subject to the rules of that program. In such circumstances, certain waivers under the terms of this Model, such as the waiver of the preliminary prospective assignment used for Medicare-Medicaid ACOs participating in Track 1 and Track 2 of the Shared Savings Program may continue until the next available opportunity for CMS to revert the ACO to the existing regulations and processes for the Shared Savings Program.

Specific reasons and procedures for termination will be clearly outlined in the CMS-State Participation Agreement.

B. Termination of the Model

CMS may modify or terminate the Medicare-Medicaid ACO Model if required under Section 1115A(b)(3)(B) of the Act. Such termination will not affect the Medicare-Medicaid ACOs’ participation in the Shared Savings Program subject to the rules of that program. In such
circumstances, certain waivers under the terms of this Model, such as the waiver of the preliminary prospective assignment used for Medicare-Medicaid ACOs participating in Track 1 and Track 2 of the Shared Savings Program may continue until the next available opportunity for CMS to revert the ACO to the existing regulations and processes for the Shared Savings Program.

XVII. Amendment

CMS may modify the terms of the Medicare-Medicaid ACO Model in response to stakeholder comments or other considerations before finalizing the terms of the Medicare-Medicaid ACO Participation Agreement and CMS-State Participation Agreement. Thus, the terms of the Medicare-Medicaid ACO Model as set forth in this Request for LOIs may differ from the terms of the Medicare-Medicaid ACO Model as set forth in the Medicare-Medicaid ACO Participation Agreement and CMS-State Participation Agreement. Unless otherwise specified in the CMS-State and Medicare-Medicaid ACO Participation Agreements, the terms of these Participation Agreements, as amended from time to time, shall constitute the terms of the Medicare-Medicaid ACO Model.
Appendices

Appendix A: Letter of Intent Template

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

The LOI should be sent by email to MMACO@cms.hhs.gov. Questions about the LOI should also be directed to MMACO@cms.hhs.gov. States that do not submit an LOI prior to the deadlines specified in Section IV of this Request for LOIs will not be eligible to participate in the Medicare-Medicaid ACO Model for the associated starting performance year.

The LOI must include the following:

A. A Word or PDF document containing the following information:
   1. State Name
   2. Anticipated Model Start Date (2018, 2019, 2020)\footnotesize{10}:
   3. State Primary Contact
      First Name:
      Last Name:
      Title/Position:
      Business Phone Number:
      Business Phone Number Extension:
      Alternative Phone Number (e.g. cell phone):
      E-mail Address:
      Street Address 1:
      Street Address 2:
      City:
      State:
      ZIP Code:
   4. State Secondary Contact
      First Name:
      Last Name:
      Title/Position:
      Business Phone Number:
      Business Phone Number Extension:
      Alternative Phone Number (e.g. cell phone):
      E-mail Address:
      Street Address 1:

\footnotesize{10} The anticipated start date indicated here is not binding. States and/or CMS may choose to alter the start date. CMS is requesting this information for planning purposes.

31
Street Address 2:  
City:  
State:  
ZIP Code:  

5. State Contact Responsible for Submission of T-MSIS data  
First Name:  
Last Name:  
Title/Position:  
Business Phone Number:  
Business Phone Number Extension:  
Alternative Phone Number (e.g. cell phone):  
E-mail Address:  
Street Address 1:  
Street Address 2:  
City:  
State:  
ZIP code:  

6. Potential ACO Partner contact information (repeat for each Potential ACO Partner)  
Organization Name:  
Doing Business As (If applicable):  
Primary Contact Information  
First Name:  
Last Name:  
Title/Position:  
Business Phone Number:  
Business Phone Number Extension:  
Alternative Phone Number (e.g. cell phone):  
E-mail Address:  
Street Address 1:  
Street Address 2:  
City:  
State:  
ZIP Code:  
Website (if applicable):  

B. A Word or PDF document (can be the same file as Part A) with the following narrative responses:  
  o Description of the state’s vision for the Medicare-Medicaid ACO Model,  
    including the anticipated Target Population and estimated number of beneficiaries who would be eligible for assignment under the Model.  
  o Description of the state’s current approach to payment and care for Medicare-
Medicaid enrollees, including a discussion of the state’s participation in any other delivery system innovations (for Medicare-Medicaid enrollees or other populations) and how the Medicare-Medicaid ACO Model would coordinate with those initiatives.

- Description of how the state will meaningfully engage with providers and suppliers in the state to develop the state-specific aspects of the Model.
- Description of how the state will meaningfully engage with Medicare-Medicaid enrollees and their caregivers in the state to develop the state-specific aspects of the Model.
- Description of the state’s current status with respect to testing and reporting data through T-MSIS, as well as current claims lags. If there are any state laws that would affect CMS and/or the state’s ability to share T-MSIS data with CMS, CMS contractors, or Medicare-Medicaid ACOs, the state is encouraged to describe those in this section of the LOI.

C. PDF of signed letters of interest from the Potential ACO Partners listed in response to A.6. Each letter should include:
   a. a brief description of the provider/supplier organization, including the types of communities served (e.g. rural, urban, suburban).
   b. a statement that the provider/supplier is interested in partnering with the state to develop the state-specific aspects of the Medicare-Medicaid ACO Model.

D. PDF of a letter, signed by the State Medicaid Director, indicating the state is interested in partnering with CMS to offer the Medicare-Medicaid ACO Model in the state.

   Note: If Medicaid services available to Medicare-Medicaid enrollees, such as community-based services and supports, are administered outside of the state’s Medicaid agency, the letter must be co-signed by an individual or individuals with authority over these relevant agencies or an additional letter from those agencies must be submitted.

LOIs will be used only for planning purposes, and submitting an LOI will not bind an interested state or Potential ACO Partner to moving forward under the Model. Interested states should submit an LOI via email to MMACO@cms.hhs.gov.
Appendix B: Glossary of Key Terms

The following terms have the meaning set forth below:

**MEDICARE-MEDICAID ACO PROVIDER/SUPPLIER:** An individual or entity that is a Non-Shared Savings Program MMACO Provider/Supplier or a Shared Savings Program MMACO Provider/Supplier.

**NON-SHARED SAVINGS PROGRAM MMACO PROVIDER/SUPPLIER:** An individual or entity that:

1. is not a Shared Savings Program MMACO Provider/Supplier;
2. meets the definition of:
   a. a Medicare-enrolled provider or supplier (as described in 42 C.F.R. § 400.202), identified by a National Provider Identifier (NPI) or CMS Certification Number (CCN), that bills for items and services furnished to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations, and/or
   b. a Medicaid fee-for-service provider as defined in 42 C.F.R. § 400.203; and
3. appears on the final Medicare-Medicaid ACO Provider/Supplier list submitted by the ACO and approved by CMS for a given performance year.

**POTENTIAL ACO PARTNER:** A group of Medicare and/or Medicaid enrolled providers that expresses interest in participating in the development of the state-specific aspects of the Medicare-Medicaid ACO Model in a given state and submits a letter of interest with the state’s LOI. This group of providers can be a single legal entity or multiple entities or individuals who formally or informally work together. Existing Medicare, Medicaid, or commercial ACOs may be Potential ACO Partners but a group that submits a letter of interest as a Potential ACO Partner is not required to be an already formed ACO.

**SHARED SAVINGS PROGRAM MMACO PROVIDER/SUPPLIER:** An individual or entity that meets the definition of an ACO Provider/Supplier under the Shared Savings Program (as described in 42 C.F.R. 425.20) through participation in a Shared Savings Program ACO that is also participating in the Medicare-Medicaid ACO Model.

**TARGET POPULATION:** The Medicare-Medicaid enrollees or Medicare-Medicaid enrollees and Medicaid-only beneficiaries that meet the criteria to be eligible for assignment to a Medicare-Medicaid ACO. The Target Population will vary by state and is subject to CMS review and approval.