Medicare Shared Savings Program

BENEFICIARY INCENTIVE PROGRAM

Guidance

May 2021
Version #4

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

Revision History (From Version 3 to Version 4)

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
4	May 2021	Revised to remove reference to Track 2 and rename Annual Certification to Yearly ACO Signing Event	Section 2.1 and FAQ 9; Section 2.4
4	May 2021	Section 2.4: "Withdrawing a Beneficiary Incentive Program Application" removed as the *Application Reference Manual* contains comprehensive instructions on how to withdraw an application.	

Table of Contents

1 Background

In accordance with section 1899(m)(1)(A) of the Social Security Act (as added by section 50341 of the Bipartisan Budget Act), and consistent with the Centers for Medicare and Medicaid Services' (CMS') goal to strengthen beneficiary engagement, CMS finalized policies at 42 CFR § 425.304(c) to allow certain Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (Shared Savings Program) to offer incentive payments to encourage assigned beneficiaries to obtain medically necessary primary care services. Under these policies, ACOs participating in certain two-sided models may apply to establish and operate a Beneficiary Incentive Program (BIP) to provide an incentive payment with a value of up to $20 to each assigned beneficiary for each qualifying primary care service received.

2 Eligibility and How to Apply

2.1 ELIGIBILITY

Any ACO participating under Levels C, D, or E of the BASIC track, or the ENHANCED track, is eligible to apply to establish and operate a BIP.

An ACO that is approved to operate a BIP is required to conduct the program for at least one year (unless CMS terminates the ACO's BIP).

2.2 APPLICATION TIMING

An eligible ACO may apply to establish a BIP during the Shared Savings Program application cycle. An ACO that is approved to establish a BIP must operate its CMS-approved BIP for an initial period of 12 months beginning on January 1st of the relevant performance year.

An eligible ACO that is mid-agreement may apply to establish a BIP during the application cycle prior to the performance year in which the ACO seeks to begin implementing its BIP. This policy applies to:

- ACOs that enter a two-sided model at the start of an agreement period but that do not apply to establish a BIP at the time of their initial or renewal application to the Shared Savings Program.
- ACOs that enter the BASIC track's glide path under a one-sided model and that apply to establish a BIP beginning with a performance year under a two-sided model.

2.3 APPLICATION PROCESS

An ACO must complete and submit a BIP application through the ACO Management System (ACO-MS) by the deadline specified on the Application Types & Timeline webpage.

As part of the application, the ACO must describe in writing the nature of its proposed BIP and how, if approved, the ACO will establish and operate its BIP. The narrative must include the following:

- The value of each incentive payment that the ACO would issue for each qualifying service (up to $20 per qualifying service);
- The form of incentive payment (e.g., check, debit card, or specified traceable cash equivalent);
- How the ACO would notify ACO participants and assigned beneficiaries of the BIP;
  - (Please note that CMS provides template language to notify beneficiaries of the BIP. ACOs are prohibited from offering incentive payments as part of marketing materials and activities.)
- How the ACO would distribute incentive payments to beneficiaries (e.g., by mail, electronically, etc.);
- When incentive payments would be distributed and by whom;
- How the ACO would track whether a beneficiary is entitled to receive an incentive payment;
- How the ACO would track whether a beneficiary has been furnished an incentive payment; and
- How the ACO would maintain records related to the BIP in accordance with 42 CFR §§ 425.304(c)(4) and 425.314. Refer to Section 3.4 for details on the specific records that must be maintained.

Please include sufficient detail in your narrative and, when describing processes, include who in the ACO will perform activities, any tools or systems used, and how often activities will be performed.

2.4 YEARLY ACO SIGNING EVENT

Each year during Yearly ACO Signing Event, an ACO establishing a BIP and an ACO that seeks to continue operating its BIP beyond the initial 12-month term must certify that it intends to continue operating its BIP for the entirety of the relevant performance year and that its BIP continues to meet all applicable requirements.

3 Program Details

An ACO that operates a BIP must comply with all applicable regulations, including CMS' regulations regarding incentive payments (42 CFR § 425.304), record retention (42 CFR § 425.314), public reporting (42 CFR § 425.308), and beneficiary notifications (42 CFR § 425.312). Failure to comply with the requirements set forth in 42 CFR Part 425 may result in the termination of a BIP or of an ACO from the Shared Savings Program.

An ACO must implement its BIP in the manner described in its CMS-approved BIP application. Any material change to a BIP, as described in the ACO's CMS-approved application, must be approved by CMS under 42 CFR § 425.304(c)(2)(iii). For example, a change in the dollar amount of the incentive payment or a termination of the ACO's BIP are considered to be material changes that must be approved by CMS. An ACO should submit its request to SharedSavingsProgram@cms.hhs.gov and include "Request for BIP Change" in the subject line of the email. Please note that an ACO may not terminate its CMS-approved BIP during the initial 12-month period.

An ACO must not use funds from any entity or organization outside of the ACO to establish or operate its BIP. An ACO may, however, use shared savings received under the Shared Savings Program to establish or operate its BIP.

Additionally, an ACO must not directly, through insurance or otherwise, bill or shift the cost of establishing or operating a BIP to a federal health care program (42 CFR § 425.304(c)(4)(ii)).

3.1 BENEFICIARY INCENTIVE PAYMENT REQUIREMENTS

The following applies with regard to incentive payments furnished under a CMS-approved BIP:

- The ACO must directly furnish incentive payments to eligible beneficiaries. No other entity or individual, including ACO participants or ACO providers/suppliers, may directly or indirectly furnish incentive payments to beneficiaries. The ACO is in the best position to ensure that any incentive payments offered are distributed only to eligible beneficiaries and that other program requirements are met.
- An incentive payment must only be made for a qualifying service. A qualifying service is a primary care service, as defined in 42 CFR § 425.20, with respect to which coinsurance applies under Part B, that is provided through the ACO by an ACO professional who has a primary care specialty designation; an ACO professional who is a physician assistant, nurse practitioner, or certified nurse specialist; a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC). Any service furnished by an ACO professional who is a physician but does not have a specialty designation included in the definition of a primary care physician at 42 CFR § 425.20, is not considered to be a qualifying service for which an incentive payment may be furnished.
- An incentive payment must be in the form of a check, debit card, or traceable cash equivalent.
- The value of an incentive payment cannot exceed $20 per qualifying service. The ACO may indicate that it will adjust the amount of the incentive payment annually by the percentage increase in the consumer price index for all urban consumers.

- An ACO must furnish incentive payments in the same amount to each eligible beneficiary. The ACO cannot offer different values of incentive payments for particular qualifying services or particular beneficiaries.
- The ACO must provide an incentive payment each time the beneficiary receives a qualifying service.
- The ACO must provide an incentive payment to an eligible beneficiary no later than 30 days after a qualifying service is furnished. If the beneficiary refuses payment, the ACO must provide documentation showing the refusal (e.g., something to show the incentive payment was returned to the ACO or an affirmation from the provider that the beneficiary refused the payment) to CMS upon request.
- ACOs should also inform beneficiaries that incentive payments are not considered income or resources for purposes of determining eligibility for benefits or assistance under any federal, state, or local program financed in whole or in part with federal funds or for purposes of any federal or state laws relating to taxation.

3.2 BENEFICIARY NOTIFICATION REQUIREMENTS

The following applies with regard to operation of a CMS-approved BIP:

- An ACO operating a CMS-approved BIP must notify assigned beneficiaries of the availability of the BIP in accordance with 42 CFR § 425.312(b). Beneficiary notifications regarding incentive payments must be maintained and made available for inspection in accordance with 42 CFR § 425.314.
- Notification will comply with the beneficiary notice requirements set forth in 42 CFR § 425.312 and must be carried out by providing each assigned beneficiary with a standardized written notice provided by CMS prior to or at the first primary care visit of the performance year (after the ACO's application has been approved). Please note that customizable beneficiary notification templates that include information for ACOs that have an approved BIP are available in the Marketing subtab in ACO-MS.
- Except for the beneficiary notifications required under 42 CFR § 425.304(c)(4)(iii), an ACO is prohibited from offering an incentive payment as part of marketing materials and activities. This includes, but is not limited to, an advertisement or solicitation to a beneficiary or any potential patient whose care is paid for in whole or in part by a federal health care program (as defined at 42 U.S.C. § 1320a-7b(f)).

3.3 BENEFICIARY INCENTIVE PAYMENT RECORDS

An ACO that establishes a BIP must maintain records that include the following:

- The identification of each beneficiary who received an incentive payment (including the beneficiary's name and the Health Insurance Claims Number (HICN) or Medicare Beneficiary Identifier (MBI));

- The type and amount of each incentive payment made to each beneficiary;
- The date each beneficiary received a qualifying service;
- The corresponding Healthcare Common Procedure Coding System (HCPCS) code for the qualifying service;
- The identification of the ACO provider/supplier that furnished the qualifying service; and
- The date the ACO provided each incentive payment to each beneficiary.

Per 42 CFR § 425.314, the ACO must maintain, and CMS may request, records regarding the operation of a BIP, including any notifications to beneficiaries regarding the availability of a BIP.

3.4 PUBLIC REPORTING REQUIREMENTS

An ACO with a CMS-approved BIP is subject to the public reporting and transparency requirements of 42 CFR § 425.308(b)(7).

An ACO must publicly report, for each performance year, the following information:

- The total number of beneficiaries who received an incentive payment;
- The total number of incentive payments furnished;
- HCPCS codes associated with any qualifying service for which an incentive payment was furnished;
- The total value of all incentive payments furnished; and
- The total of each type of incentive payment (e.g., check, debit card) furnished.

3.5 TERMINATION OF A BENEFICIARY INCENTIVE PROGRAM

CMS may require an ACO to terminate its BIP at any time for failure to comply with the requirements of the Shared Savings Program or for any of the grounds for ACO termination set forth in 42 CFR § 425.218(b). There is no administrative or judicial review of CMS' decision to terminate an ACO's BIP. Any ACO that wishes to reestablish a BIP after termination must reapply in accordance with 42 CFR § 425.304(c)(2). The ACO would need to wait until the application period commences and would need to follow the same procedures as an ACO that is establishing a BIP for the first time.

4 Questions and Answers

Q1. Will establishing a BIP affect an ACO's program calculations, such as benchmarks?

No. CMS disregards incentive payments made by an ACO under a CMS-approved BIP in calculating an ACO's benchmarks, estimated average per capita Medicare expenditures, and shared savings or losses.

Q2. Does CMS provide templates or guidelines regarding the language ACOs can use to notify assigned beneficiaries of the availability of a BIP?

Yes. The standardized written notice that an ACO must use to notify its assigned beneficiaries about the availability of a BIP is available in the ACO Marketing and Outreach Toolkit. In addition, customizable beneficiary notification templates that include information for ACOs that have an approved BIP are available in the Marketing subtab in ACO-MS.

Q3. May an ACO vary the value of an incentive payment based on the qualifying service that a beneficiary receives?

No. All incentive payments distributed by an ACO under its BIP must be of equal monetary value. In other words, an ACO is not permitted to offer higher-valued incentive payments for particular qualifying services or to particular beneficiaries. An ACO may, however, provide different types of incentive payments (e.g., a gift card to some beneficiaries and a check to others) depending on a beneficiary's preference, so long as all incentive payments offered by the ACO under its BIP are of equal monetary value.

Q4. May an ACO make an incentive payment in the form of cash?

No. ACOs are prohibited from distributing incentive payments to beneficiaries in the form of cash. Cash incentive payments are inherently difficult to track for reporting and auditing purposes since they are not necessarily tied to documents providing written evidence that a cash incentive payment was furnished to an eligible beneficiary for a qualifying service. CMS cannot trace a cash incentive to ensure that an ACO has uniformly furnished incentive payments to all eligible beneficiaries and has not made excessive payments or otherwise used incentive payments to improperly attract "healthier" beneficiaries while disadvantaging beneficiaries who are less healthy or who have a disability. Incentive payments must be in the form of a cash equivalent, which includes instruments convertible to cash or widely accepted on the same basis as cash, such as checks and debit cards.

Q5. May I advertise my BIP in marketing materials?

No. ACOs are prohibited from marketing or advertising their BIP. ACOs may only inform their assigned beneficiaries through the dissemination of the standardized

beneficiary notice and by including the required public reporting elements on their website.

Q6. Is an ACO required to operate a BIP if they apply to do so?

Yes. An ACO will be required to operate a BIP in the manner described in its CMS-approved BIP application for an initial term of 12 months (in the case of an ACO approved to operate a BIP beginning on January 1st of a performance year). CMS also notes that any material change to a BIP, as described in the ACO's CMS-approved application, must be approved by CMS under 42 CFR § 425.304(c)(2)(iii). Thus, CMS recommends that ACOs consider the cost of operating a BIP before submitting an application. Eligible ACOs are not required to establish a BIP; rather, each eligible ACO has the discretion to decide whether to apply to operate a BIP.

Q7. Is an ACO required to pay for more than one qualifying primary care service for each eligible beneficiary?

Yes. An ACO with a CMS-approved BIP is required to furnish an incentive payment to an eligible beneficiary each time the beneficiary receives a qualifying service. Thus, if a beneficiary is prospectively assigned to an ACO participating in the ENHANCED track and receives two primary care services that each meet the definition of a qualifying service during the performance year, and the ACO operates a BIP, the ACO would be required to furnish two incentive payments to the beneficiary (i.e., one for each qualifying service).

Q8. May an ACO participant or ACO provider/supplier distribute incentive payments to beneficiaries?

No. The ACO legal entity must furnish incentive payments directly to its beneficiaries. No entity or individual other than an ACO, including ACO participants or ACO providers/suppliers, may directly or indirectly furnish incentive payments to beneficiaries. ACOs have access to claims data and Medicare enrollment information for their assigned beneficiaries and, in most instances, are better equipped to implement and standardize necessary reporting and record-keeping requirements.

Q9. Which beneficiaries are eligible to receive incentive payments?

Any beneficiary assigned to an ACO that is participating under Levels C, D, or E of the BASIC track, or the ENHANCED track is eligible to receive an incentive payment under that ACO's CMS-approved BIP. If a beneficiary opts out of Medicare claims data sharing, they are still eligible to receive incentive payments. Please note that even if a beneficiary opts out of Medicare claims data sharing, Medicare will still use their information for some purposes, and the ACO would be able to identify this beneficiary because they would still appear on the assignment lists and Claim and Claim Line Feed (CCLF) files.

Q10. May an ACO limit the type of primary care service or range of primary care services that would be eligible for an incentive payment under the BIP?

No. Per 42 CFR § 425.304(c)(3)(iv), an ACO with a CMS-approved BIP is required to furnish an incentive payment to an eligible beneficiary each time the beneficiary receives a qualifying service. A qualifying service is defined as a primary care service (as defined in 42 CFR § 425.20) with respect to which coinsurance applies under Part B. An ACO cannot limit its BIP to a subset of qualifying services. In addition, CMS encourages ACOs to review the regulatory language under 42 CFR § 425.304(b), as well as the corresponding preamble language on page 68066 of the Shared Savings Program Pathways to Success Final Rule (December 2018), regarding other types of incentives that are permissible under the Shared Savings Program.

Q11. May an ACO offer a BIP to a particular subset of beneficiaries based on their medical diagnosis to promote wellness?

No. Per 42 CFR § 425.304(c)(3)(ii), a fee-for-service (FFS) beneficiary is eligible to receive an incentive payment under a BIP if the beneficiary is assigned to the ACO through either preliminary prospective assignment, as described in 42 CFR § 425.400(a)(2), or prospective assignment, as described in 42 CFR § 425.400(a)(3). In addition, per 42 CFR § 425.304(c)(3)(iv), an ACO with an approved BIP must provide an incentive payment for each qualifying service furnished to any such assigned beneficiary. Your ACO may not furnish incentive payments to a subset of assigned beneficiaries.

Q12. May an ACO add eligibility requirements to its BIP aside from what is in the regulations and statute, such as having the beneficiary complete a health care management program in order to receive its incentive payment?

No. An ACO cannot further limit or qualify the conditions under which a beneficiary is eligible to receive an incentive payment. Per 42 CFR § 425.304(c)(3)(iii), a qualifying service for which an incentive payment must be furnished under a CMS-approved BIP is a primary care service (as defined in 42 CFR § 425.20) with respect to which coinsurance applies under Part B, if the service is furnished through an ACO by either an ACO professional that has a primary care specialty designation included in the definition of primary care physician under 42 CFR § 425.20; an ACO professional that is a physician assistant, nurse practitioner, or certified nurse specialist; or an FQHC or RHC. In addition, per 42 CFR § 425.304(c)(3)(iv), an ACO with a CMS-approved BIP is required to furnish an incentive payment to an eligible beneficiary each time the beneficiary receives a qualifying service.

Q13. May an ACO require the beneficiary to receive services from certain ACO participants or providers in order to receive an incentive payment for a qualifying service?

No. An ACO cannot further limit or qualify the conditions under which a beneficiary is eligible to receive an incentive payment. Per 42 CFR § 425.304(c)(3)(iii), a qualifying service for the program is a primary care service (as defined in 42 CFR § 425.20) with respect to which coinsurance applies under Part B, if the service is furnished through an ACO by either an ACO professional that has a primary care specialty designation included in the definition of primary care physician under 42 CFR § 425.20; an ACO professional that is a physician assistant, nurse practitioner, or certified nurse specialist; or an FQHC or RHC. In addition, per 42 CFR § 425.304(c)(3)(iv), an ACO with a CMS-approved BIP is required to furnish an incentive payment to an eligible beneficiary each time the beneficiary receives a qualifying service. All ACOs' BIPs must comply with 42 CFR §§ 425.304(c)(3)(iii) and 425.304(c)(3)(iv).

Q14. Is there any limitation to the form of the beneficiary incentive payment?

An ACO may provide the beneficiary with an incentive payment in an amount up to $20 per qualifying service. Each BIP incentive payment must be in the form of a check, debit card, or a traceable cash equivalent (e.g., Visa or Amazon gift card). An ACO should include as part of its narrative how its BIP will comply with 42 CFR § 425.304(c)(3)(iv).