PROPOSED RULES FOR ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM: WHAT DO THEY SAY?

The Affordable Care Act authorizes the Centers for Medicare and Medicaid Services (CMS) to establish a Medicare Shared Savings Program that will allow a new form of health care provider, the accountable care organization (ACO), to participate in the Medicare program. On March 31, 2011, CMS released a much anticipated Notice for Proposed Rule-Making, which contains proposed rules for implementing the new program.[1] CMS is soliciting public comment on the proposal, which will be incorporated into the final rule to be published later this year. A summary of the proposal is provided below.

OPERATIONAL DEFINITION OF AN ACCOUNTABLE CARE ORGANIZATION

CMS defines an ACO as a legal entity recognized and authorized under applicable state law and composed of certified Medicare providers or suppliers. These participants work together to manage and coordinate care for a defined population of Medicare fee-for-service beneficiaries and have established a mechanism for shared governance that provides appropriate proportionate control over the ACO's decision-making process. ACOs that meet specified quality performance standards are eligible to receive payments for shared savings if they can reduce spending growth below target amounts.

REQUIREMENTS TO PARTICIPATE IN THE MEDICARE SHARED SAVINGS PROGRAM

Eligible Providers. A core principle of the Shared Savings Program is that providers should be enabled to innovate in the way they deliver care. Accordingly, CMS makes a concerted effort to avoid being overly prescriptive in the proposed eligibility requirements. In fact, CMS proposes to expand the list of providers eligible to apply for the program beyond the four specified in the Affordable Care Act: 1) professionals in group practice arrangements; 2) networks of individual practices; 3) joint venture arrangements between hospitals and professionals; and 4) hospitals employing professionals. However, at this point, the expansion will be limited to only a subset of critical access hospitals (CAHs).

CMS considered expanding the group of eligible providers to federally qualified health centers (FQHCs), rural health centers (RHCs), and all CAHs. However, limitations in the cost and utilization data collected on these providers, which are manifested by how they are reimbursed, would impair the ability to attribute patients to FQHCs, RHC, and some

CAHs. CMS will be investigating ways to overcome these limitations in order to broaden eligibility to these providers and others in future rule-making.

It should be noted that FQHCs, RHCs, and other Medicare providers can still participate in the ACO program by partnering with eligible providers. For example, an FQHC can partner with a network of individual practices. This ability will allow for participation by a broad range of provider configurations. Additionally, in recognition of the important role of FQHCs and RHCs in the health care system, CMS proposes to increase the percentage of shared savings that ACOs can receive if RHCs and FQHCs are included as participants.

Legal Entities. CMS proposes to require an ACO to be a legal entity (e.g., corporation, partnership, limited liability company, or foundation) recognized and authorized to conduct its business under applicable state law and capable of: receiving and distributing shared savings; repaying shared losses; establishing, reporting, and ensuring that all of its participating providers comply with program requirements; and performing the other requisite ACO functions identified in the statute. An ACO with operations in multiple states would have to certify that it is recognized as a legal entity in the state in which it was established and that it is authorized to conduct business in each state in which it operates.

Existing organizations that meet the legal requirements can participate—that is, a self-encompassing ACO entity, such as a hospital employing providers, is eligible and would not have to form a new legal entity.

Each ACO must have a tax identification number that will become the basis for identifying all ACO participants. This does not mean that the ACO itself must be enrolled in the Medicare program (i.e., be a certified Medicare provider), which could lead to the unusual situation of Medicare payments being made to nonproviders.

Governance Requirements. CMS proposes that an ACO must establish and maintain a governing body (e.g., a board of directors, or board of managers) with adequate authority to execute the statutory functions of an ACO. This governing body must be comprised of its participating providers (or their designated representatives), include Medicare beneficiaries served by the ACO, and possess broad responsibility for the ACO's administrative, fiduciary, and clinical operations. To satisfy a requirement to partner with groups in their community, ACOs are also encouraged to have community stakeholder

representation on the board. The representatives on the ACO governing body could be serving in a similar manner for a participant within the ACO.

Providers within the ACO must have at least 75 percent control of the ACO's governing body. CMS aimed to find a percentage to help ensure that ACO providers can be accountable for the care they deliver while still leaving room on the board to accommodate some nonprovider participation. This may be needed as it is expected that some ACOs, particularly those composed of small group practices, will partner with managerial companies and health plans to make up for a lack of adequate capital or infrastructure.

Leadership and Management Structure. CMS is proposing that ACOs must exhibit that they have a leadership and management structure that encompasses clinical and administrative systems and meets the following criteria:

- Management of ACO operations by an executive, who must certify on behalf of all the ACO participants the willingness to become accountable for the quality, cost, and overall care of Medicare beneficiaries assigned to the ACO and to report to CMS information on these domains. In addition, the appointment and removal of the executive must be under the control of the organization's governing body, and the executive's leadership team must have demonstrated the ability to effectively direct clinical practice to improved efficiency processes and outcomes.
- Clinical management and oversight managed by a senior-level medical director who is a board-certified physician, licensed in the state in which the ACO operates, and physically present in that state.
- Meaningful commitment (e.g., financial or human investment) by the ACO providers to the ACO's clinical integration program.
- An ongoing quality assurance and process improvement program, overseen by a physician-directed committee, to hold ACO providers accountable for meeting performance standards through specific processes and procedures to identify and correct poor compliance.
- An information technology infrastructure that enables the ACO to collect and evaluate data and provide feedback to its providers, including providing information to influence care at the point of care, feedback from patient care experience surveys or other quality and utilization assessments

CMS allows flexibility for innovative management and leadership structures, but ACOs will have to provide evidence that alternative structures can meet the same goals. For example, if an ACO does not have a physician-directed quality assurance and process improvement committee, the ACO would need to describe how it plans to oversee an ongoing quality assurance and improvement program.

Promoting Evidence-Based Medicine, Patient Engagement, Reporting, Care Coordination, and Patient Centeredness. CMS is proposing that in order to be eligible to participate in the Shared Savings Program, an ACO must provide documentation in its application describing its plans to: 1) promote evidence-based medicine; 2) promote beneficiary engagement; 3) report internally on quality and cost metrics; and 4) coordinate care. The proposal allows ACOs to choose the tools for meeting these functional requirements that are most appropriate for their practitioners and patient populations. Over time, as CMS learns more about successful strategies in these areas, CMS may become more prescriptive. CMS will be monitoring strategies undertaken by ACOs to ensure that they do not impede the ability of the beneficiary to seek care from providers outside of the ACOs network.

In their plans to improve care management and coordination, ACOs must also exhibit a strong element of patient-centeredness. This means developing individualized care plans, based on a patient's unique needs, preferences, values, and priorities, that are regularly assessed and evaluated for improvement opportunities. Care should also be integrated with community resources that beneficiaries require to maintain well-being. In addition, beneficiaries (and their caregivers or family members, where applicable) should be encouraged to be partners in care and should have access to their own medical records and to clinical knowledge so that they may make informed choices about their care. Furthermore, transitions in care among providers in the ACO, as well as other providers outside the ACO from whom the beneficiaries may also seek care, should be supported consistent with the patient-centeredness goals. Based on these principles, CMS proposes several specific actions to ensure patient-centeredness:

- Having a beneficiary care experience survey in place and a description in the ACO application of how the ACO will use the results to improve care over time. This survey would be used as part of the ACO performance assessment. As such, CMS proposes that ACOs use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey so that performance data in this area can be standardized across ACOs.
- Involving patients in ACO governance through representation in the governing body.

- Creating a process for evaluating the health needs of the ACO's assigned population, including consideration of diversity within their patient populations and a plan to address the needs of their population.
- Having systems in place to identify high-risk individuals and processes to develop individualized care plans for targeted patient populations, including integration of community resources (e.g., employers, commercial health plans, local businesses, local government agencies, local quality improvement organizations, or health information exchanges) to address individual needs.
- Putting in place a mechanism for coordinating care, such as through enabling technologies or care coordinators.
- Communicating clinical knowledge and evidence-based medicine to beneficiaries through a process that is understandable to them. This process should allow for beneficiary engagement and shared decision-making, taking into account the beneficiaries' unique needs, preferences, values, and priorities.
- Developing written standards for beneficiary access and communication and a process for beneficiaries to access their medical record.
- Establishing internal processes for measuring clinical or service performance by physicians across practices, and using these results to improve care and service over time.

The patient-centeredness requirements are more extensive and prescribed than those for promoting evidence-based medicine, beneficiary engagement, internal quality and cost reporting, and care coordination. However, CMS notes that many of the patient-centeredness requirements can serve to meet those process objectives as well.

Sufficient Number of Primary Care Providers and Beneficiaries. All ACOs will be required to have at least 5,000 Medicare beneficiaries assigned to it for each performance year. If the number of assigned beneficiaries falls below 5,000 during the performance period, CMS will issue a warning and place the ACO on a corrective action plan. The ACO agreement will be terminated if the ACO fails to meet the 5,000-beneficiary requirement by the completion of the next performance year, and the ACO will not be eligible for shared savings that year. It should be noted that there are no explicit requirements for the number of different provider types, such as primary care providers, that an ACO will need to be eligible to participate.

Program Integrity Requirements. Under the proposal, ACOs must also have a compliance plan that addresses how the ACO will meet applicable legal requirements.

The plan should include a lead compliance official who reports to the governing body, mechanisms for identifying compliance problems, a method for ACO employees or contractors to report suspected problems, compliance training, and a requirement to report suspected violations to the appropriate law enforcement agency. In addition, the ACO must have a conflict-of-interest policy. CMS recommends that the ACO coordinate compliance programs with those of its participating provider groups.

CMS is also still considering whether to screen ACOs for a history of program integrity issues. Typically, screens would be conducted to certify Medicare providers, but since ACOs may not be Medicare providers, a different screening process may be needed. Also, CMS is still considering ways to prohibit referral agreements with its ACO providers for care to beneficiaries that ACOs know will not get assigned, which could result in inappropriate cost-shifting. That is, CMS wants to make sure ACOs do not overutilize care for beneficiaries that are not assigned to the ACO in order to make up for reduction in services to assigned beneficiaries.

ACO MARKETING GUIDELINES

CMS wants to ensure that ACOs avoid engaging in activities that prevent their assigned beneficiaries from taking advantage of the full range of benefits to which they are entitled under Medicare fee-for-service. In addition, CMS wants to limit the potential that ACOs market themselves as endorsed Medicare ACOs or that marketing materials misrepresent the Shared Savings Program. Thus, CMS proposes that all ACO marketing communication materials get approval prior to use. Any revisions would need approval as well. An ACO's failure to comply would mean failure to meet the patient-centeredness requirements, and as a result the ACO would be placed on a corrective action plan.

REQUIREMENTS FOR AN ACO TO COMMIT TO A THREE-YEAR PARTICIPATION AGREEMENT

By statute, ACOs must agree to participate in the Shared Savings Program for at least three years, and CMS is proposing to limit it to three years for this first round of the program. To encourage enrollment for the full period, CMS proposes to withhold 25 percent of any shared savings. In recognition of the fact that some providers may need to discontinue participation before three years, CMS is requiring 60 days' notice of such intentions. CMS will retain any portion of a 25 percent withhold of the shared savings for ACOs in the event the ACOs' three-year agreement is terminated prematurely.

There are administrative concerns about when to start the ACO performance periods. Having ACOs start at the same time, as opposed to starting on a rolling basis, would be

the easiest option administratively. For example, having a rolling start may lead to patients being attributed to multiple ACOs, assuming patients are assigned retrospectively and may switch providers at any time. Thus, CMS proposes to have an annual assignment period. Applications will be approved prior to the end of a calendar year and the three-year requisite period will begin on the January 1, following approval.

New Program Standards Established During the Three-Year Agreement Period. It is likely that CMS will make changes to the ACO regulations in future rules. During the three-year contract, CMS proposes that ACOs be subject to all regulation changes, with the exception of eligibility requirements concerning the governance of ACOs, the calculation of the sharing rate, and beneficiary assignment. Thus, ACOs would have to comply with any changes related to quality performance standards. For these and other required changes, ACOs would have to submit a supplement to their original application explaining how they propose to address them, or face a corrective action plan and potential termination.

Managing Significant Changes to the ACO During the Agreement Period. An ACO may also initiate changes during the three-year contract period. Changes to ACO provider composition are of particular concern. To avoid antitrust violations that could result in ACO termination, CMS proposes that an ACO may not add providers during the three-year agreement. However, ACOs would be allowed to remove providers. An ACO must give CMS 30 days' notice of such action, and CMS will determine whether the ACO will have to terminate, start over, continue as is, or be subject to a new antitrust review.

Data-Sharing. Each ACO will be required to submit a tax identification number (TIN) and a national provider identification (NPI) number for each participating provider and to update these numbers annually. This information will support beneficiary assignment and allow CMS to create data reports tailored to ACO-specific populations.

CMS will make available aggregated data reports on the ACO populations at the beginning of the first performance period and then on a quarterly basis. This includes doing so in conjunction with yearly financial and quality performance reports used to assess performance.

CMS also proposes to make limited beneficiary identifiable data (name, date of birth, sex, and health insurance claim number), on the ACO's historically assigned population, available at the beginning of the first performance year. This information can be very useful to ACOs for planning how to target their resources to improve care.

CMS also proposes to make a limited amount of historically assigned beneficiary claims data available to each ACO on a monthly basis. This data would cover Parts A, B, and D costs and utilization, and would come in a standardized format that is limited to the minimum information required to meet the ACO's needs. Thus, the ACO will be required explain how it intends to use data to evaluate the performance of its providers, conduct quality assessment and improvement activities, and conduct population-based activities to improve the health of its assigned beneficiaries. In addition, the ACO will need to sign a data use agreement and give beneficiaries for which they are requesting data a chance to opt out of having their data shared. However, it should be noted opting out will not affect their assignment to the ACO.

METHODOLOGY FOR ASSIGNING BENEFICIARIES TO AN ACO AND PATIENT NOTIFICATION

According to the proposed assignment methodology, beneficiaries can only be assigned to primary care providers (i.e., general practice, family practice, internal medicine, and geriatric medicine physicians) that provide specified evaluation and management—primary care and preventive—services.[2] CMS explicitly excludes specialists from the assignment process to avoid antitrust issues and limits on patient choice, which could occur if specialist were to become exclusive to a single ACO.

CMS proposes to use TINs to identify providers within an ACO, so ACOs will need to disclose all the TINs that its providers operate under. ACO providers within a TIN that are used for patient assignment must be exclusive to one ACO Shared Savings Program agreement.

CMS proposes to assign patients to ACOs that serve the plurality, rather than the majority, of the patients' primary care services. Furthermore, it is the plurality of allowed charges, as opposed to services, that will be used; charges provide a better indication for the intensity of services and are less likely to result in the need for tiebreakers.

Retrospective beneficiary assignment is proposed, to help ensure that ACOs provide care similarly to all patients and avoid many of the administrative problems that prospective enrollment would incur as a result of changes in where beneficiaries choose to receive their care. To assist ACOs in targeting care improvement resources, CMS will provide cost and utilization data to ACOs at the beginning of the first performance year on the beneficiaries that would have been assigned to it during the three most recent available historical years of data. This is the same period that will be used to generate the spending benchmarks.

In terms of patient notification, CMS proposes to require ACO participants to post signs in their facilities that indicate they participate in the Shared Savings Program, as well as to make available standardized written information. The written notification will cover the patient's potential participation in the Shared Savings Program along with data-sharing. A form will accompany the written notification for beneficiaries that want to opt out of data-sharing. CMS also proposes requiring that ACOs make beneficiaries aware if a provider ceases to operate in the Shared Savings Program.

QUALITY MEASURES AND THE METHODOLOGY FOR MEASURING ACO PERFORMANCE

According to the proposal, ACOs participating in shared-savings-only payment models (i.e., one-sided models) will be able to share in up to 50 percent of the savings. The sharing rate potential is higher—60 percent—for ACOs sharing in the losses as well as the savings (i.e., two-sided models). In both cases, the sharing rate is determined by how well the ACOs meet their performance standards. Any shared-savings payment is contingent upon meeting quality performance standards, regardless of the amount of cost reduction.

Measures. CMS proposes to use 65 measures in performance year 1 (Appendix A). Measures for the remaining two years may be changed in future rule-making. The measure set includes process, outcome, and patient experience-of-care measures. Measures are grouped into five domains:

1. Patient/caregiver experience (7 measures)
2. Care coordination (16 measures)
3. Patient safety (2 measures)
4. Preventative health (9 measures)
5. At-risk population/frail elderly health (31 measures)

If an ACO fails to meet minimum performance standards in one or more domains, the ACO has one year to improve performance or the agreement will be terminated. Failure to report a measure or the reporting of inaccurate information could also result in termination.

Data Sources. CMS lists the following data sources for these measures: patient claims, Electronic Prescribing (eRx) and Health Information Technology for Economic and Clinical Health Act (HITECH) program data, Hospital Compare or the Centers for Disease Control and Prevention (CDC), the Group Practice Reporting Option (GPRO)

data collection tool, and survey instruments, such as CAHPS. The GPRO tool is based on the data collection tool currently used in the Physician Quality Reporting System (PQRS) and Physician Group Practice (PGP) demonstration. In fact, CMS proposes to allow ACOs to qualify for the PQRS incentive payment on behalf of all of its providers—not just those used for assignment—thus potentially alleviating some reporting requirements for ACO providers. The payment incentive is equal to 0.5 percent of the ACO's eligible providers' total estimated Medicare Part B Physician Fee Service charges during the performance year. ACOs that meet the reporting requirements but do not generate sharable savings will still get the PQRS bonus.[3]

CMS proposes to supply all the claims data and will make the GPRO tool available to all ACOs. The GPRO tool will be used for enhanced claims data (e.g., from electronic medical records and registries) and will require a minimum random sample of assigned beneficiaries for each measure domain. CMS plans on auditing this data.

Scoring and Measure Standards. According to the proposal, shared-savings payments in the first year will essentially be for reporting on measures, which will provide ACOs an opportunity to ramp up and CMS an opportunity to learn about the process and establish improvement targets. In other words, ACOs will be eligible for shared savings if they report accurately on 100 percent of the measures, regardless of their actual performance.

After the first year, a scoring system will be used to determine how much of the 50 percent (or 60 percent for ACOs with a two-sided risk model) in shared savings ACOs will receive. In the system CMS is currently leaning toward, each measure within a domain would be worth a maximum of two points and a minimum of zero points. An ACO would get a single score for the domain based on the percentage of total points achieved. The average of the five domain scores would be the overall score, which determines the percentage of the shared savings ACOs receive.

The measure-specific benchmarks ACOs must achieve for scoring purposes will be made known prior to the performance year and will be mostly based on fee-for-service (FFS) and Medicare Advantage (MA) performance levels (Table 1). ACO performance in the first year may also be taken into account when developing benchmarks.

Table 1. Potential Sliding-Scale Measure Scoring Approach

ACO Performance Level	Quality Points
90+ percentile FFS/MA rate or 90%+	2
80+ percentile FFS/MA rate or 80%+	1.85
70+ percentile FFS/MA rate or 70%+	1.7
60+ percentile FFS/MA rate or 60%+	1.55
50+ percentile FFS/MA rate or 50%+	1.4
40+ percentile FFS/MA rate or 40%+	1.25
30+ percentile FFS/MA rate or 30%+	1.10
<30 percentile FFS/MA rate or <30%	0

Source: Centers for Medicare and Medicaid Services, Notice for Proposed Rule-Making, March 31, 2011, p. 204.

In the scoring system CMS is currently considering, performing above the 90th percentile of the MA or FFS distribution for the measures will result in the full two points. CMS considers the 30th percentile of the MA or FFS rate as the minimum attainment level. There are also two composite measures, for diabetes and coronary artery disease, that will be all-or-nothing measures (i.e., no sliding scale).

Public Reporting. Public reporting is important for holding ACO providers accountable for providing high-value care. CMS proposes that each ACO is responsible for making available organizational information, including a list of all participants and members of the governing body, as well as a primary contact. In addition, quality performance scores and shared savings or losses paid must be reported. The information will need to be publically available in a standardized format.

SHARED SAVINGS PAYMENT METHODOLOGY

CMS proposes two tracks for the ACO payment models. Under track 1, shared savings would be reconciled annually for the first two years of the contract period using a one-sided approach, with a two-sided model used for the third year. Thereafter, ACOs would have to continue on to track 2 when renewing the contract. Under track 2, the ACO would immediately participate in a two-sided model. Either track will require the development of baseline expenditure estimates to project spending benchmarks that will be used to determine shared savings.

Developing the Expenditure Baseline. For the purpose of developing an expenditure baseline, CMS proposes to use Medicare beneficiaries that would have been assigned to the ACO in the most recent available three-year historical period. The assignment methodology would be applied to each of the three years.

CMS proposes to use the CMS-Hierarchical Condition Categories to adjust for variation in beneficiary health status. Also, to minimize variation from catastrophically large claims, per capita expenditures would be truncated at the 99th percentile for each benchmark year.

The three years used for the expenditure baseline would be indexed to the most recent benchmark year, using Medicare growth rates estimated by the Office of the Actuary at CMS. The growth rates will be based upon national spending growth levels, as opposed to local or ACO specific levels of growth. Moving toward a national standard baseline was a major consideration for the use of national growth levels.

CMS proposes to use a weighted average of the risk- and time-trend-adjusted historical spending amounts. The three years of data will be combined by weighting the most recent year at 60 percent, the middle year at 30 percent, and the earliest year at 10 percent.

Using the Baseline to Develop Spending Benchmarks. For there to be savings to share, ACOs must reduce spending below benchmark amounts. By statute, benchmark spending amounts are calculated by updating the baseline by projected absolute growth in national per capita expenditures (expressed in absolute dollars) for Parts A and B services under the original Medicare FFS program.

CMS proposes to use national growth without any locality adjustments. In addition, it proposes to use the ACO's average baseline risk score to adjust for health status variation during the projection period. Using the baseline helps to preclude upcoding issues.[4] Changes in assigned beneficiaries will not be incorporated in the risk adjustment, which essentially assumes that the relative risk characteristics of the assigned ACO population remain relatively stable over time.

Geographic and Other Payment Policy Adjustments. CMS makes no adjustments to the benchmarks for factors affecting the level of payments that providers receive, such as geographic adjustments (e.g., wage index or Geographic Practice Cost Indices) and indirect medical education (IME) adjustments, as well as additional payments made to providers that serve a large share of low-income patients (i.e., disproportionate share payments). A major factor for these decisions is the fact that the Affordable Care Act limits the ability to remove these adjustments only to the benchmark and not to performance period expenditure calculations, or observed expenditures. Hence, making adjustments to the benchmark would lead to a discord when judging performance spending relative to observed spending levels.

CMS recognizes that by not making these adjustments, it may incentivize unintended consequences. For example, ACOs may have greater motivation to redirect referrals away from academic medical centers that receive IME payments, as those payments would count as higher performance costs during shared-savings determinations.

CMS will not count incentive payments authorized under the HITECH Act (e.g., PQRS and eRx incentives) in the calculation of benchmark or performance payments, as it has the statutory authority to do so. However, CMS does not have authority to exclude other incentives, such as hospital inpatient value-based purchasing incentives. Not adjusting for these incentives may also lead to unintended consequences. For example, if ACOs did not qualify for the incentives in the baseline years, but do so in the performance years, it will be harder to qualify for shared savings.

Minimum Savings Rates and Estimating Shared Savings. A certain degree of year-to-year variation in actual ACO spending amounts is expected, regardless of the innovations undertaken to improve health care. Thus, the Affordable Care Act mandated that CMS include a minimum savings rate (MSR) to help ensure that fluctuations below the benchmark stem from improved performance and not simply random chance—that is, ACOs would need to reduce spending below the MSR to be eligible for shared savings. Similarly, a minimum loss rate can help reduce the likelihood of penalizing ACOs for excessive costs that result from adverse events beyond the ACO's control.

For ACOs participating in the one-sided risk model, CMS proposes to set an MSR as a function of both the number of assigned beneficiaries and a chosen confidence interval. Higher numbers of assigned beneficiaries will result in lower MSR thresholds, as the greater sample size will make it easier to attain a given level of confidence that the observed spending levels are an accurate depiction of the ACOs' ability to control costs.

Confidence intervals were chosen to recognize the greater difficulty that smaller ACOs may face when revamping their infrastructure to better coordinate and manage care.[5] Thus, smaller ACOs would have lower confidence intervals. ACOs with 5,000 beneficiaries assigned are proposed to have a confidence interval of 90 percent, whereas ACOs with 20,000 and 50,000 beneficiaries would require a 95 percent and 99 percent confidence interval, respectively. As the ACOs increase in size between 5,000 and 20,000, as well as between 20,000 and 50,000, confidence intervals are blended together. The resulting MSRs are depicted in Table 2. The lowest MSR, at 2 percent, is reached when approaching 60,000 or more beneficiaries assigned.

Table 2. Proposed Minimum Savings Rates and Confidence Interval by Number of Assigned Beneficiaries for ACOs Participating in the One Sided-Model

Number of Beneficiaries	MSR (low end of assigned beneficiaries)	MSR (high end of assigned beneficiaries)
5,000–5,999	3.9%	3.6%
6,000–6,999	3.6	3.4
7,000–7,999	3.4	3.2
8,000–8,999	3.2	3.1
9,000–9,999	3.1	3.0
10,000–14,999	3.0	2.7
15,000–19,999	2.7	2.5
20,000–49,999	2.5	2.2
50,000–59,999	2.2	2.0
60,000+	2.0	2.0

Source: Centers for Medicare and Medicaid Services, Notice for Proposed Rule-Making, March 31, 2011, p. 269.

ACOs in the two-sided risk model are proposed to have a flat 2 percent MSR as the risk of rewarding reductions in costs not resulting from improved performance is somewhat mitigated by the fact that ACOs will also share in the excess costs.

As described above, ACOs can become eligible for shared savings if they successfully control spending by more than the MSR amount. Similarly, ACOs will need to share in the losses if their costs exceed the spending benchmark by more than their MLR amount. CMS proposes that most ACOs would only be able to share in savings above a 2 percent threshold, regardless of their MSR. There are some exceptions for small ACOs that would share on a first-dollar basis. These include ACOs that have less than 10,000 beneficiaries assigned to them and that satisfy at least one of the following four conditions:

1. Comprise only individual practices;
2. Have 75 percent of assigned beneficiaries reside outside of an MSA;
3. Have 50 percent of assigned beneficiaries or more assigned to certain critical access hospitals; or
4. Have 50 percent of assigned beneficiaries with at least one encounter to a federal qualified health center (FQHC) or rural health center (RHC).

ACOs in the two-sided model are proposed to share in both losses and savings on a first-dollar basis.

Shared-Savings Percentage for the ACO. CMS proposes that ACOs participating under a one-sided risk model will be able to receive up to 50 percent of the shared savings, whereas ACOs with a two-sided model will receive up to 60 percent of shared savings. In addition, an ACO that uses a one-sided model and includes FQHCs or RHCs as participants can get from a 0.5- to a 2.5-percentage-point increase in their shared-savings rate during the first two years of its agreement. Higher proportions of the assigned patients visiting a participating FQHC or RHC will lead to higher percentage-point increases in the shared-savings rate. At least 41 percent of the ACO's patients must visit a RHC or FQHC to be eligible for the full 2.5 percentage points. These percentage-point incentives are doubled for ACOs with two-sided risk.

Cap on Shared Savings and Losses. There are proposed caps to the amount of savings that can be shared with ACOs, with a cap of 7.5 percent for ACOs using one-sided models and 10 percent for ACOs with two-sided models. The higher cap with the two-sided risk model is intended to help offset the greater risk for losses ACOs take on in that model. CMS also proposes to phase in a cap on shared losses that will reach 10 percent by the third year.

Timing and Process for Evaluating Shared Savings. There will be a delay of at least several months between the end of the performance period and the disbursement of shared savings (or the sharing of losses), as CMS is proposing to use a six-month run-out of claims to calculate shared savings. The run-out is needed to ensure that claims from the performance period have time to be processed. A three-month run-out was considered as well, but the risk of inaccurate calculations, due to an incomplete picture of claims, particularly high-cost claims, is felt to be too great.

Distribution of Shared Savings. CMS proposes to pay shared savings directly to the ACO based on the TIN, which CMS notes could pose integrity problems because sending payments to non-Medicare providers could make it more difficult to recoup these payments later on. In addition, although CMS does not feel like it has the authority to specify how ACOs distribute the shared savings, CMS does propose to require ACOs to provide a description in the application of how ACOs will use the shared savings to meet the program's goals. The intent is to guard against improper incentives and ensure appropriate beneficiary protections.

Repaying Shared Losses. CMS proposes that ACOs establish a self-executing method for repaying losses to the Medicare program. This can include indicating funds that may be recouped from Medicare payments to its providers, reinsurance, surety bonds, a line of credit, or some other payment mechanism, including higher shared-savings withhold amounts (i.e., higher than the proposed automatic 25 percent withhold). Each ACO must provide documentation, annually, of its ability to repay up to 1 percent of per capita expenditures of its assigned beneficiaries from the most recent year available. ACOs electing to start with one-sided risk will still need to meet these requirements, as they will eventually participate in the two-sided model.

ACOs will be notified about shared losses in writing and are required to make payments within 30 days. CMS will calculate the shared losses or savings, but the ACO will be required to certify the accuracy of the information, as well as to submit a written request to CMS for the shared-savings payment.

DIFFERENCES UNDER THE ONE-SIDED AND TWO-SIDED MODELS

Table 3 summarizes the key differences in the ACO program under the proposed one-sided and two-sided models. For the most part, there are no differences in the eligibility requirements, as eventually all ACOs will be moved to a two-sided model. This includes not having extra patient notification for ACOs with two-sided models. The same quality performance requirements are also used, although there is a greater emphasis on quality in the two-sided model (i.e., 60 percent quality sharing rate instead of 50 percent) to help protect against greater incentives to stint on care.

Table 3. Summary of Differences Between One-Sided Model and Two-Sided Model

Design Element	One-Sided Model (performance years 1 and 2)	Two-Sided Model
Maximum Sharing Rate	52.5% (50%quality sharing rate plus up to a 2.5-percentage-point FQHC/RHC participation bonus)	65% (60% quality sharing rate plus up to a 5-percentage-point FQHC/RHC participation bonus)
Quality Sharing Rate	Up to 50%based on quality performance levels	Up to 60% based on quality performance levels
FQHC/RHC Participation Incentives	Up to 2.5 percentage points based on proportions of assigned beneficiaries visiting a participating FQHC or RHC	Up to 5 percentage points based on proportions of assigned beneficiaries visiting a participating FQHC or RHC
Minimum Savings Rate	From 2% to 3.9% based on the size of the assigned population	Flat 2%, regardless of size
Minimum Loss Rate	Not Applicable	Flat 2%, regardless of size
Maximum Sharing Cap	Payment capped at 7.5% of ACO's benchmark	Payment capped at 10% of ACO's benchmark. The cap will be phased in over 3 years with 5% and 7.5% used in the first two years, respectively.
Shared Savings	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2% threshold; up to 52.5% of net savings up to cap.	Savings shared on a first-dollar basis once MSR is exceeded; up to 65% of gross savings up to cap.
Shared Losses	Not Applicable	First-dollar shared losses once the minimum loss rate is exceeded, up to cap. Actual amount of shared losses would be based on final sharing rate that reflects ACO quality performance and any additional incentives for including FQHCs and/or RHCs using the following methodology (1 minus final sharing rate).

Source: Centers for Medicare and Medicaid Services, Notice for Proposed Rule-Making, March 31, 2011, p. 292.

MONITORING ACO PERFORMANCE AND PROPOSED GROUNDS AND PROCEDURES FOR TERMINATING AGREEMENTS

CMS proposes requiring an ACO, including its providers, suppliers, and contracted entities, to give the federal government the right to inspect all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared-savings distributions, and other financial arrangements related to ACO activities) sufficient to enable an audit, evaluation, and inspection of the ACO's compliance with Shared Savings Program requirements and the ACO's right to any shared-savings payment. ACOs will need to maintain such evidence for 10 years from the end of the agreement period or from the date of completion of audits, evaluations, or inspections, whichever is later. CMS will be monitoring the ACO's

impact on "at risk" beneficiaries in particular, which will start with analyses of trends in claims data.[6]

ACOs found to be in noncompliance and put under a corrective action plan will not receive shared savings until problems are resolved. CMS proposes to terminate an agreement with an ACO before the end of the three-year agreement period for any of the following reasons:

- avoidance of at-risk beneficiaries;
- failure to meet the Shared Savings Program's quality performance standard;
- any material change in the ACO participant composition that affects the ability to meet eligibility requirements;
- failure of the ACO to effectuate required regulatory changes during the agreement period;
- failure of an ACO to demonstrate that it has adequate resources in place to repay losses;
- noncompliance with requirements regarding beneficiary notification;
- noncompliance with public reporting and other CMS reporting requirements;
- not sharing beneficiary summary of care or medical records from providers and suppliers both within and outside of the ACO;
- failure to offer beneficiaries the option to opt out of sharing claims information;
- improper use or disclosure of claims information received from CMS in violation of applicable laws or regulations;
- violation of physician self-referral prohibition, civil monetary penalty laws, the federal anti-kickback statute, other antifraud laws, antitrust laws, or other applicable Medicare laws, rules, or regulations that are relevant to ACO operations;
- submission to CMS of false, inaccurate, or incomplete data and or information, including but not limited to, information provided in the Shared Savings Program application, quality data, financial data, and information regarding the distribution of shared savings; or
- failure to submit payment due to us in a timely manner.

Future participation of previously terminated program participants. Under the CMS proposal, most ACO providers that were previously expelled from the program can reapply as their own ACOs or as part of another ACO, but they will need to wait until the

end of the original three-year period. The application must also note the reason for termination and the safeguards implemented to address the shortcomings. The exceptions are ACOs that experienced a net loss during the original three-year agreement period. These ACOs are proposed not to be allowed to participate again, so as not to give underperforming organizations a second chance.

Reconsideration review process. The statute states that there will be no administrative or judicial review of patient assignment, criteria for quality performance standards, and assessments made with regard to quality standards or shared-savings amounts, including termination of ACOs for failure to meet quality performance standards and determination of shared savings paid to ACOs or shared losses owed to CMS.

The statute is silent regarding the right of ACOs to contest decisions on eligibility to participate or termination for avoidance of at-risk beneficiaries. Accordingly, CMS proposes administrative processes to allow ACOs to request reviews of these decisions.

COORDINATING DEVELOPMENT OF THE PROPOSED RULE WITH OTHER FEDERAL AGENCIES

A document issued jointly by CMS, the Department of Health and Human Service, and the Office of Inspector General describes and solicits public input regarding possible waivers of the application of certain civil monetary penalty law provisions, the federal anti-kickback statute, and the physician self-referral law to specified financial arrangements involving ACOs under the Shared Savings Program. CMS also expects that the waivers applicable to ACOs participating in the Program will be issued concurrently with publication of the final rule. In addition, the Internal Revenue Service is soliciting comments regarding the need for additional tax guidance for tax-exempt organizations, including tax-exempt hospitals, that are participating in the Shared Savings Program.

In addition, the Federal Trade Commission and Department of Justice issued guidance on what characteristics would cause antitrust challenges for ACOs. A “safety zone” is set forth, absent extraordinary circumstance, for ACOs whose providers have a combined market share of 30 percent or less of each common service in their primary service area. However, there is a “rural exception” for ACOs with a greater than 30 percent market share, and it is noted that ACOs with market shares between 30 percent and 50 percent are highly unlikely to be challenged. ACOs that have a greater than 50 percent market share and do not qualify for the rural exception are likely to be challenged.

CMS will make public the necessary information to designate common services and primary service areas. It also proposes to require that ACOs having a greater than 50 percent market share and not qualifying for the rural exception obtain a letter from the Justice Department or the Federal Trade Commission confirming there is no present intent to challenge or recommend challenging the ACO.

Overlap in Medicare programs and how this might affect Shared Savings Program participants. The statute precludes duplication in participation in shared-savings programs. At this point, CMS deems the following programs as duplicative:

- Independence at Home Medical Practice Demonstration;
- Medicare Health Care Quality Demonstration;
- Medical home demonstrations with a shared-savings element (currently, the only such Medicare demonstration that includes a shared-savings component is the Multipayer Advanced Primary Care Demonstration); and
- Physician Group Practice Demonstration.

This list may be updated as future programs are created. The limitation only applies to Medicare shared-savings programs, so ACOs could participate in both the Medicare Shared Savings Program and state initiatives, such as the program to establish community health teams to support patient-centered medical homes (authorized by section 3502 of the Affordable Care Act).

A Physician Group Practice (PGP) participant can remain in the Medicare PGP program or switch to the Medicare Shared Savings Program, which has different requirements. Recognizing their relevant experience, CMS plans to develop a condensed application form for the PGP sites.

Since providers can be linked to multiple TINs in different shared-savings programs, CMS will work with the developers of other demonstration initiatives to ensure that a provider operating under multiple TINs is not receiving shared-savings payments for the same Medicare beneficiaries. CMS also plans on working with the Center for Medicare and Medicaid Innovation to test alternative payment models that may potentially be incorporated into future Medicare Shared Savings Program rule-making.

REGULATORY IMPACT ANALYSIS

In its Notice for Proposed Rule-Making, CMS provides estimates for the expected net savings to the Medicare program, costs to ACOs, and benefits to Medicare beneficiaries

(Table 4). The estimates for net savings take into account actual Medicare expenditures for more efficient care, shared-savings payments to ACOs, and payments to CMS for shared losses. CMS estimates a range of $170 million to $960 million in net savings over the first three years of the program, assuming participation of from 75 to 150 ACOs. At the high end, this would amount to 0.5 percent of projected total Medicare expenditures for 2012 through 2014.[7] The estimates assume that 1.5 million to 4 million beneficiaries are aligned with a participating ACO during this period. The wide range in the estimates is a function of the large degree of uncertainty involved in implementing a new program with new types of providers.

Table 4. Estimated Net Federal Savings, ACO Costs, and Benefits to Medicare Beneficiaries During First Three Years of Medicare Shared Savings Program

Federal Savings	Year 1	Year 2	Year 3	Total (Years 1–3)
90th Percentile	$30 Million	$90 Million	$50 Million	$170 Million
Median	$100 Million	$210 Million	$200 Million	$510 Million
10th Percentile	$190 Million	$380 Million	$390 Million	$960 Million
Costs	Total ACO start-up investment and first year operating expenditures average from $131,643,825 to $263,287,650, for the estimated range of 75 to 150 participating ACOs.			
Benefits	Improved healthcare delivery and quality of care and better communication to beneficiaries through patient centered-care.			

Source: Centers for Medicare and Medicaid Services, Notice for Proposed Rule-Making, March 31, 2011, p. 350.

Appendix A. Proposed Measures for Use in Establishing Quality Performance Standards That ACOs Must Meet for Shared Savings

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Clinician/Group CAHPS: Getting Timely Care, Appointments, and Information	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Clinician/Group CAHPS: How Well Your Doctors Communicate	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Clinician/Group CAHPS: Helpful, Courteous, Respectful Office Staff	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Clinician/Group CAHPS: Patients' Rating of Doctor	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Clinician/Group CAHPS: Health Promotion and Education	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Clinician/Group CAHPS: Shared Decision Making	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Medicare Advantage CAHPS: Health Status/Functional Status	Patient/Caregiver Experience	Survey (CAHPS)	Patient Experience of Care
Risk-Standardized, All Condition Readmission: The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.	Patient/Caregiver Experience	Claims	Outcome
30-Day Post Discharge Physician Visit	Care Coordination/ Transitions	GPRO Data Collecting Tool	Process
Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility Percentage of patients age 65+ discharged from any inpatient facility and seen within 60 days following discharge in the office by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	Care Coordination/ Transitions	GPRO Data Collecting Tool	Process
Care Transition Measure: Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely, 1) understanding one's self-care role in the posthospital setting; 2) medication management; and 3) having one's preferences incorporated into the care plan.	Care Coordination/ Transitions	Survey or GPRO Data Collecting Tool	Patient Experience of Care
Ambulatory Sensitive Conditions Admissions: Diabetes, Short-Term Complications (AHRQ Prevention Quality Indicator (PQI) #1) All discharges of age 18+ with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma), per 100,000 population.	Care Coordination	Claims	Outcome
Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes (AHRQ Prevention Quality Indicator (PQI) #14) All discharges of age 18+ with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication, per 100,000 population.	Care Coordination	Claims	Outcome

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator (PQI) #5) All discharges of age 18+ with ICD-9-CM principal diagnosis code for COPD, per 100,000 population.	Care Coordination	Claims	Outcome
Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8) All discharges of age 18+ with ICD-9-CM principal diagnosis code for CHF, per 100,000 population.	Care Coordination	Claims	Outcome
Ambulatory Sensitive Conditions Admissions: Dehydration (AHRQ Prevention Quality Indicator (PQI) #10) All discharges of age 18+ with ICD-9-CM principal diagnosis code for hypovolemia, per 100,000 population.	Care Coordination	Claims	Outcome
Ambulatory Sensitive Conditions Admissions: Bacterial Pneumonia (AHRQ Prevention Quality Indicator (PQI) #11) All nonmaternal discharges of age 18+ with ICD-9-CM principal diagnosis code for bacterial pneumonia, per 100,000 population.	Care Coordination	Claims	Outcome
Ambulatory Sensitive Conditions Admissions: Urinary Infections (AHRQ Prevention Quality Indicator (PQI) #12) All discharges of age 18+ with ICD-9-CM principal diagnosis code of urinary tract infection, per 100,000 population.	Care Coordination	Claims	Outcome
% All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements	Care Coordination/ Information Systems	GPRO Data Collecting Tool / EHR incentive Program Reporting	Process
% of PCPs Meeting Stage 1 HITECH Meaningful Use Requirements	Care Coordination/ Information Systems	GPRO Data Collecting Tool / EHR incentive Program Reporting	Process
% of PCPs Using Clinical Decision Support	Care Coordination/ Information Systems	GPRO Data Collecting Tool / EHR incentive Program Reporting	Process
% of PCPs Who Are Successful Electronic Prescribers Under the eRx Incentive Program	Care Coordination/ Information Systems	GPRO Data Collecting Tool / EHR incentive Program Reporting	Process
Patient Registry Use	Care Coordination/ Information Systems	GPRO Data Collecting Tool	Process

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Health Care Acquired Conditions Composite: • Foreign Object Retained After Surgery • Air Embolism • Blood Incompatibility • Pressure Ulcer, Stages III and IV • Falls and Trauma • Catheter-Associated UTI • Manifestations of Poor Glycemic Control • Central Line Associated Blood Stream Infection • Surgical Site Infection • AHRQ Patient Safety Indicator (PSI) 90 Complication/Patient Safety for Selected Indicators (composite) ▪ Accidental puncture or laceration ▪ Iatrogenic pneumothorax ▪ Postoperative DVT or PE ▪ Postoperative wound dehiscence ▪ Decubitus ulcer ▪ Selected infections due to medical care (PSI 07: Central Venus Catheter-related Bloodstream Infection) ▪ Postoperative hip fracture ▪ Postoperative sepsis	Patient Safety	Claims or CDC National Healthcare Safety Network	Outcome
Health Care Acquired Conditions: Central Line–Associated Blood Stream Infection Bundle	Patient Safety	Claims or CDC National Healthcare Safety Network	Process
Influenza Immunization: Percentage of patients age 50+ who received an influenza immunization during the flu season (September through February).	Preventive Health	GPRO Data Collecting Tool	Process
Pneumococcal Vaccination: Percentage of patients age 65+ who have ever received a pneumococcal vaccine.	Preventive Health	GPRO Data Collecting Tool	Process
Mammography Screening: Percentage of women age 40 through 69 years who had a mammogram to screen for breast cancer within 24 months.	Preventive Health	GPRO Data Collecting Tool	Process
Colorectal Cancer Screening: Percentage of patients age 50 to 75 years who received the appropriate colorectal cancer screening.	Preventive Health	GPRO Data Collecting Tool	Process
Cholesterol Management for Patients with Cardiovascular Conditions: • The percentage of members 18–75 years who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year. • LDL-C screening • LDL-C control (<100 mg/dL)	Preventive Health	GPRO Data Collecting Tool	Process and Outcome

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Adult Weight Screening and Follow-Up: Percentage of patients age 18+ with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. Parameters: Age 65 and older BMI ≥ 30 or < 22; Age 18-64 BMI ≥ 25 or < 18.5	Preventive Health	GPRO Data Collecting Tool	Process
Blood Pressure Measurement: Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients age >18 years with diagnosed hypertension.	Preventive Health	GPRO Data Collecting Tool	Process
Tobacco Use Assessment and Tobacco Cessation Intervention: Percentage of patients who were queried about tobacco use. Percentage of patients identified as tobacco users who received cessation intervention.	Preventive Health	GPRO Data Collecting Tool	Process
Depression Screening: Percentage of patients age 18+ screened for clinical depression using a standardized tool and follow-up plan documented.	Preventive Health	GPRO Data Collecting Tool	Process
Diabetes Composite (All or Nothing Scoring): • Hemoglobin A1c Control (<8%) • Low Density Lipoprotein (<100) • Blood Pressure <140/90 • Tobacco Non Use • Aspirin Use	At Risk Population-Diabetes	GPRO Data Collecting Tool	Process and Outcome
Diabetes Mellitus: Hemoglobin A1c Control (<8%) Percentage of patients ages 18 to 75 with diabetes mellitus who had most recent hemoglobin A1c less than 8%.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Outcome
Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus Percentage of patients ages 18 to 75 with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl).	At Risk Population-Diabetes	GPRO Data Collecting Tool	Outcome
Diabetes Mellitus: Tobacco Non Use Tobacco use assessment and cessation.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Process
Diabetes Mellitus: Aspirin Use Daily aspirin use for patients with diabetes and cardiovascular disease.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Process
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%): Percentage of patients ages 18 to 75 with diabetes mellitus who had most recent hemoglobin A1c greater than 9%.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Outcome
Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus: Percentage of patients ages 18 to 75 with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).	At Risk Population-Diabetes	GPRO Data Collecting Tool	Outcome

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients Percentage of patients ages 18 to 75 with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Process
Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients Percentage of patients ages 18 to 75 with a diagnosis of diabetes mellitus who had a dilated eye exam.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Process
Diabetes Mellitus: Foot Exam The percentage of patients ages 18 to 75 with diabetes who had a foot examination.	At Risk Population-Diabetes	GPRO Data Collecting Tool	Process
Heart Failure: Left Ventricular Function (LVF) Assessment Percentage of patients age 18+ with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process
Heart Failure: Left Ventricular Function (LVF) Testing Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of heart failure (HF) during the measurement period.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process
Heart Failure: Weight Measurement Percentage of patient visits for patients age 18+ with a diagnosis of heart failure with weight measurement recorded.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process
Heart Failure: Patient Education Percentage of patients age 18+ with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) Percentage of patients age 18+ with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Percentage of patients age 18+ with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process
Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation Percentage of all patients age 18+ with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	At Risk Population-Heart Failure	GPRO Data Collecting Tool	Process

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Coronary Artery Disease (CAD) Composite: All or Nothing Scoring • Oral Antiplatelet Therapy Prescribed for Patients with CAD • Drug Therapy for Lowering LDL Cholesterol • Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) • LDL Level <100 mg/dl • Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	At Risk Population-Coronary Artery Disease	GPRO Data Collecting Tool	Process and Outcome
Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD Percentage of patients age 18+ with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	At Risk Population-Coronary Artery Disease	GPRO Data Collecting Tool	Process
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol Percentage of patients age 18+ with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines). The LDL-C treatment goal is <100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDLC 130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program (NCEP).	At Risk Population-Coronary Artery Disease	GPRO Data Collecting Tool	Process
Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) Percentage of patients age 18+ with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	At Risk Population-Coronary Artery Disease	GPRO Data Collecting Tool	Process
Coronary Artery Disease (CAD): LDL level < 100 mg/dl	At-Risk Population: Coronary Artery Disease	GPRO Data Collecting Tool	Process
Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD) Percentage of patients age 18+ with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	At Risk Population-Coronary Artery Disease	GPRO Data Collecting Tool	Process

Measure Title and Description	Domain	Method of Data Submission	Measure Type
Hypertension (HTN): Blood Pressure Control Percentage of patients with last BP < 140/90 mmHg	At Risk Population-Hypertension	GPRO Data Collecting Tool	Outcome
Hypertension (HTN): Plan of Care Percentage of patient visits for patients age 18+ with a diagnosis of HTN with either systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension.	At Risk Population-Hypertension	GPRO Data Collecting Tool	Process
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation Percentage of patients age 18+ with a diagnosis of COPD who had spirometry evaluation results documented.	At Risk Population-COPD	GPRO Data Collecting Tool	Process
Chronic Obstructive Pulmonary Disease (COPD): Smoking Cessation Counseling Received	At Risk Population-COPD	GPRO Data Collecting Tool	Process
Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1 Percentage of patients age 18+ with a diagnosis of COPD and who have an FEV1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator.	At Risk Population-COPD	GPRO Data Collecting Tool	Process
Falls: Screening for Fall Risk Percentage of patients age 65+ who were screened for fall risk at least once within 12 months	At Risk Population-Frail Elderly	GPRO Data Collecting Tool	Process
Osteoporosis Management in Women Who had a Fracture Percentage of women age 65+ who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture	At Risk Population-Frail Elderly	GPRO Data Collecting Tool	Process
Monthly INR for Beneficiaries on Warfarin Average percentage of monthly intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period	At Risk Population-Frail Elderly	Claims	Process

Source: Centers for Medicare and Medicaid Services, Notice for Proposed Rule-Making, March 31, 2011.

NOTES

[1] The published Notice as well as relevant legislation related to the Medicare Shared Savings Program is available on the CMS Web site at: http://www.cms.gov/sharedsavingsprogram/30_Statutes_Regulations_Guidance.asp.

[2] The services are identified using evaluation and management services as identified by Healthcare Common Procedure Coding System (HCPCS) codes 99201 through 99215; 99304 through 99340; and 99341 through 99350, as well as code G0402 for the "Welcome to Medicare" visit and G0438 and G0439 for annual wellness visits. The services are based on a list in section 5501 of the Affordable Care Act that makes incentive payments to certain primary care providers.

[3] At this point CMS is not proposing to incorporate EHR Incentive or Electronic Prescribing Incentive Program payments, although related metrics are included in the required measure set. In addition, at least 50 percent of the ACOs' primary care providers will need to be "meaningful users" by the second performance year in order to continue participation.

[4] Upcoding refers to the notion that providers may have more incentive to code more accurately and comprehensively when risk scores are used for payment purposes. Thus, higher risk scores will not be indicative of changes to the relative risk characteristics of their patients, but rather of changes to diagnosis and procedure coding practices. In the case of ACOs, higher risk scores can yield more shared-savings payments, as they will result in lower observed costs in the performance period relative to a baseline that did not include upcoding efforts.

[5] It should be noted that CMS proposes to use confidence intervals generated from national expenditure variations, which may differ substantially from local variation amounts.

[6] It should be noted that CMS is soliciting comments on the definition of "at-risk beneficiaries."

[7] Total Medicare spending projections are taken from the Centers for Medicare and Medicaid Services. Available as of April 5, 2011, at: http://www.cms.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp - TopOfPage.