

THE FINAL RULE FOR THE MEDICARE SHARED SAVINGS PROGRAM

The Affordable Care Act authorizes the Centers for Medicare and Medicaid Services (CMS) to establish a Medicare Shared Savings Program that would create a new category of health care provider, called accountable care organizations (ACOs), in the Medicare program. On March 31, 2011, CMS released a proposed rule for implementing the new program and solicited public comment.¹ On October 20, 2011, CMS released the final rule for implementing the new program.² The following is a detailed summary of the final rule.

OPERATIONAL DEFINITION OF AN ACCOUNTABLE CARE ORGANIZATION FOR THE MEDICARE SHARED SAVINGS PROGRAM

CMS defines an ACO as a legal entity that is recognized and authorized under applicable state, federal, and tribal 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 (FFS) beneficiaries and have established a mechanism for shared governance that provides appropriate 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.

ELIGIBILITY REQUIREMENTS TO PARTICIPATE IN THE MEDICARE SHARED SAVINGS PROGRAM

Eligible Providers

A core principle of the Medicare Shared Savings Program is that providers should be able to innovate in terms of care delivery. Accordingly, CMS has made an effort to avoid being overly prescriptive in the eligibility requirements. In fact, CMS expands the list of providers eligible to apply for the program beyond the four specified in the Affordable Care Act: 1) professionals (i.e., physicians and other clinicians) in group practice arrangements; 2) networks of individual practices; 3) joint venture arrangements between hospitals and professionals; and 4) hospitals employing professionals. In addition to these four, eligibility will be open to a subset of critical access hospitals (CAHs), rural health clinics (RHCs) and federally qualified health clinics (FQHCs).

The eligibility of CAHs is limited to those that are paid by Medicare in a manner that supports the collection of cost and utilization data needed to assign patients to providers. It should also be noted that while other providers (such as home health agencies, hospice facilities, and dialysis centers) cannot independently participate in the ACO program, any provider can participate in the program by partnering with eligible providers. For example, a home health agency can partner with a network of individual practices. This will allow for participation from a broad range of provider configurations.

Legal Entities

ACOs that want to participate in the Medicare Shared Savings Program are required to be a legal entity such as a corporation, partnership, limited liability company, or foundation recognized and authorized to conduct its business under applicable state, federal, and tribal law. It must be capable of:

- receiving and distributing shared savings;
- repaying shared losses;
- establishing, reporting, and ensuring all its participating providers comply with program requirements, including quality performance standards; 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. However, an ACO formed by two or more otherwise independent participants (such as a hospital and a large physician group) must form a new legal entity separate from any of its participants.

Each ACO must have a tax identification number (TIN) that will be used to identify all ACO participants. The ACO itself is not required to be a certified Medicare provider separately from its component providers.

Governance Requirements

The final rule requires that an ACO must establish and maintain a governing body, such as a board of directors or board of managers, with adequate authority to execute the statutory functions of an ACO. This governing body is to be largely composed 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. ACOs are also encouraged to have community representation on the board to satisfy a requirement for partnering with community stakeholders.

If the ACO is composed of multiple participants (such as multiple physician group practices), it will need to form a new governing body that is separate and unique to the ACO. However, the representatives on the ACO governing body could serve in a similar manner for organizations that are components within the ACO. On the other hand, if the ACO is an existing entity, the ACO governing body may be the same as the governing body of the existing entity.

The ACO participants (i.e., providers) must have at least 75 percent control of the ACO's governing body. This leaves room on the board for nonprovider participation, as it is expected that some ACOs, particularly those composed of small-group practices, will need to partner with managerial companies and health plans, as they may not have the capital or infrastructure necessary to administer an ACO.

If the ACO cannot meet the 75 percent criteria or explicitly include a Medicare beneficiary on the board, the ACO must describe why it cannot meet those requirements and identify alternative ways to meaningfully involve its participants and beneficiaries in the governance process. This flexibility will allow existing entities with consumer-led boards that have more than 25 percent participation to meet eligibility requirements. It will also allow ACOs in states with Corporate Practice of Medicine restrictions to structure beneficiary representation accordingly. It should also be noted that although CMS requires ACO participants to have at least 75 percent control of the governing body, it does not require "proportionate control" by each ACO participant (thus, not every provider group or other participant needs to have equal voting rights). This should add further flexibility for ACOs to develop an effective governance structure.

Leadership and Management Structure

ACOs must have a leadership and management structure that includes clinical and administrative systems. In addition, ACOs must meet the following criteria:

- Operations are managed by an executive who must certify that all ACO participants are willing to become accountable to and report on quality, cost, and overall care of the Medicare beneficiaries assigned to the ACO. 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 improve efficiency processes and outcomes.
- Clinical management and oversight is managed by a senior-level medical director who is a board-certified physician, licensed in the state in which the ACO operates, and reside in that state.
- Providers must make a meaningful commitment—either financial or human (i.e., labor) investment—to the ACO's clinical integration program.

The final rule allows flexibility for innovative management and leadership structures, but ACOs will have to provide evidence that alternative structures can meet the same goals. Also, as part of its application, the ACO must describe how it will establish and maintain an ongoing quality assurance and process improvement program, overseen by an appropriately qualified health care professional.

Processes to Promote Evidence-Based Medicine, Patient Engagement, Reporting, Coordination of Care, and Patient-Centeredness

The ACO must provide documentation in its application that describes its plans to: 1) promote evidence-based medicine; 2) promote beneficiary engagement; 3) report internally on quality and cost metrics; and 4) coordinate care. ACOs are given the flexibility 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 the ACO's network.

In their plans to improve care management and coordination, ACOs must also exhibit a strong patient-centeredness element. This includes developing individualized care plans—based on the person'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 to make informed choices about their care. Furthermore, transitions in care among providers in the ACO, as well as providers outside the ACO, should be supported, consistent with the patient-centeredness goals. Based on these principles, ACOs must demonstrate how they will meet several specific actions to ensure patient-centeredness, including:

- 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 will be used as part of the ACO performance assessment. CMS is requiring that ACOs use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in their efforts so performance data can be standardized across ACOs.
- Patient involvement in ACO governance by representation in the governing body.
- A process for evaluating the health needs of the ACO's assigned population, including diversity considerations and a plan to address the needs of their population.
- 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 collaboratives such as health information exchanges) to address individual needs.
- A mechanism in place for the coordination of care (e.g., via use of enabling technologies or care coordinators).
- A process in place for communicating clinical knowledge/evidence-based medicine to beneficiaries in an understandable way. This process should allow for beneficiary

engagement and shared decision-making that takes into account beneficiaries' unique needs, preferences, values, and priorities.

- Written standards in place for beneficiary communication and a process to allow beneficiaries to access their medical record.
- Development of an infrastructure and internal processes for measuring clinical or service performance by physicians across the 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, 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 this 5,000-beneficiary requirement by the completion of the next performance year and the ACO will not be eligible for shared savings that year.

The Affordable Care Act specifies that each ACO must include sufficient primary care professionals for the number of Medicare FFS beneficiaries assigned to it. However, CMS has chosen not to be prescriptive as to the specific number, type, or location of providers that are included as ACO participants.

Program Integrity Requirements

ACOs must also have a compliance plan that addresses how the ACO will meet applicable legal requirements. The plan must include: 1) a lead compliance official who reports to the governing body; 2) mechanisms for identifying compliance problems; 3) a method for ACO employees or contractors to report suspected problems; 4) compliance training; and 5) 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 its compliance programs with those of its participating provider groups.

CMS will screen ACOs, including ACO participants, for a history of program integrity issues. Although the Medicare program includes screening procedures for enrolling providers and suppliers, ACOs may not be subject to those procedures to the extent that they are not Medicare-eligible entities separate from their components. ACOs and the component providers and suppliers that are eligible to enroll in Medicare will be subject to screening in accordance with applicable regulations, and their program integrity experience will be considered when reviewing the ACO's application for the Shared Savings Program.

The final rule prohibits ACOs from utilizing preferential referral agreements with its ACO providers for care to beneficiaries that ACOs know will not be assigned. Such arrangements could result in inappropriate cost-shifting, as ACOs are not held accountable for the cost of nonassigned patients. ACOs will also be prohibited from providing gifts, cash, or other remuneration (such as gift certificates) to beneficiaries as inducements for receiving services. ACOs could use such incentives to keep patients within their ACO provider network. However, consistent with guidance from the Office of the Inspector General describing waivers of certain fraud and abuse protections (which are discussed below), ACOs may provide beneficiaries certain services or items for free or below fair-market value. The items or services must be directly related to the medical care of the beneficiary. They must also be either preventive or advance a clinical goal for the beneficiary (e.g., adherence to treatment or drug regimen). For example, an ACO provider could give blood pressure monitors to patients with hypertension to encourage regular blood pressure monitoring.

ACO MARKETING GUIDELINES

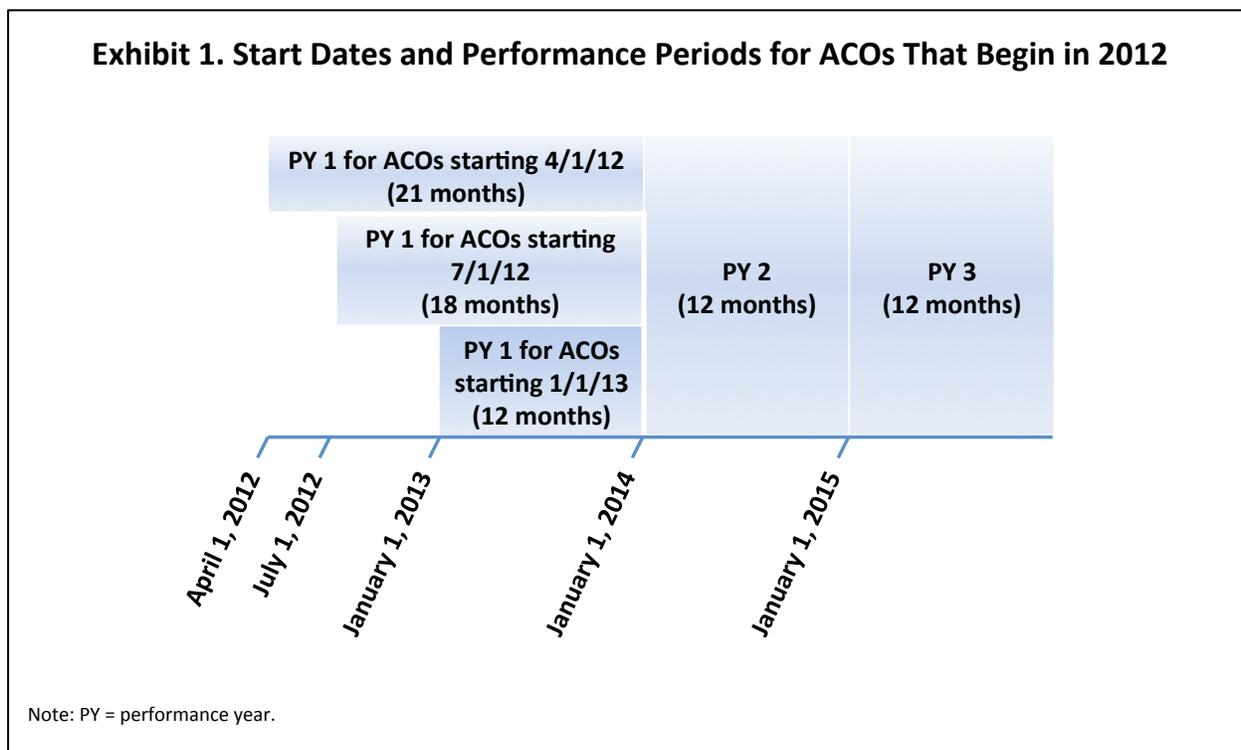
The Centers for Medicare and Medicaid Services wants to ensure that accountable care organizations avoid engaging in activities that prevent its assigned beneficiaries from taking advantage of the full range of benefits they are entitled to under the traditional Medicare fee-for-service program. In addition, CMS wants to limit the potential for ACOs to market themselves as endorsed Medicare ACOs or for marketing materials to misrepresent the Shared Savings Program. Toward those ends, all ACO marketing communication materials must be filed with CMS. After five days, if CMS has not disapproved the materials, ACOs are permitted to use them. However, CMS can still disapprove the marketing materials at any time and require that they be withdrawn, even after the five-day period.

ACOs must also certify in advance that any marketing materials they use comply with the applicable marketing requirements. In addition to avoiding the concerns discussed above, these requirements include using template language supplied by CMS whenever available and being clear, concise, and well-organized in compliance with the Plain Writing Act of 2010. Failure to comply will render the ACO not in compliance with patient-centeredness requirements and result in it being 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. According to the final rule, for applications that are approved to participate in 2012, the start date will be either April 1, 2012, or July 1, 2012. The first performance period for ACOs that begin in 2012 will be from their start date through December 31, 2013. The following two performance periods will be on a calendar-year basis, extending through December 31, 2015 (Exhibit 1).

For applications approved for 2013 and subsequent years, the start date will be January 1st of that year and the term of the agreement will be three years, with the performance period on a calendar-year basis.



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, ACOs will 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 would address them or would face a corrective action plan and potential termination. ACOs will also have the option of voluntarily terminating their agreement without penalty.

Managing Significant Changes to the ACO During the Agreement Period

ACOs may initiate changes during the three-year contract period. Changes to ACO provider composition are of particular concern. ACOs may be allowed to add or subtract providers during the three-year agreement, but must notify CMS within 30 days of the change. More generally, an ACO must notify CMS within 30 days of any event that would result in it being unable to meet eligibility or program requirements. These changes could result in adjustments to the ACO's benchmark or risk-adjustment calculations, but continue to allow the ACO to participate in the Medicare Shared Savings Program. However, some changes may result in a termination of

agreement, such as losing a primary care practice that would cause the ACO's assigned patient population to dip below the minimum requirement of 5,000 Medicare beneficiaries.

DATA SHARING

ACOs will be required to submit TINs and national provider identification numbers for each participating provider. 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. It will do this in conjunction with yearly financial and quality reports used to assess performance. In addition, CMS will make available limited beneficiary identifiable data (name, date of birth, sex, and health insurance claim number). This information can be very useful to ACOs for planning how to target their resources to improve care.

ACOs will also be able to receive claims data on assigned beneficiaries on a monthly basis. This data would cover Medicare Part 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. The ACO will be required to 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 a chance to opt out of having their data shared. However, even if beneficiaries opt out, it will not impact their assignment to an ACO.

METHODOLOGY FOR ASSIGNING BENEFICIARIES TO AN ACO AND PATIENT NOTIFICATION

Medicare beneficiaries will be assigned to ACOs based on where they receive specified evaluation and management (i.e., primary care and preventive) services for the most recent 12 months.³ CMS will assign beneficiaries to ACOs that serve the plurality of the beneficiaries' primary care services. The plurality of allowed charges—as opposed to the volume of services—will be used for this purpose.

CMS will use a two-step process to make beneficiary assignments. In the first step, beneficiaries will be assigned based on their visits to primary care physicians (specified as general practice, family practice, internal medicine, and geriatric medicine physicians). A beneficiary is assigned to an ACO if the primary care physicians in that ACO account for the largest amount of total Medicare allowable charges for that beneficiary's primary and preventive services in comparison with primary care physicians in any other ACOs or all those not participating with any ACO.

In the second step, CMS will review the claims for the remaining, unassigned beneficiaries who have had at least one primary or preventive service by a provider, regardless of specialty, in an ACO. This excludes all beneficiaries who had any primary and preventive services from primary care physicians, whether in or out of any ACO. This step recognizes that many Medicare beneficiaries may get their primary and preventive care from specialists and other providers aside from primary care physicians (i.e., specialist physicians, as well as nurse practitioners, physician assistants, and clinical nurse specialists). CMS will assign beneficiaries to ACOs whose professionals (regardless of specialty) account for the largest total amount of Medicare allowed charges for primary care and preventive services in comparison with professionals in any other ACO or all professionals unaffiliated with an ACO.

It should be noted that any providers used for assignment must be exclusive to the ACO. Other ACO participants who are not used for assignment need not be exclusive.

For each performance period, CMS will use a preliminary prospective assignment methodology with a final retrospective reconciliation. This means that ACOs will receive a preliminary list of assigned beneficiaries before each performance year using the most recent 12 months of claims data. During the performance period, CMS will update the list quarterly using a rolling 12-month claims history. A final reconciliation will be conducted at the end of the performance year using the claims incurred during the performance period.

The initial list should help ACOs in identifying opportunities to improve care and enable ACOs to provide beneficiaries with advance notification of their participation in the Medicare Shared Savings Program and their intention to request beneficiary-identifiable data. The quarterly lists will allow the ACO to track newly assigned beneficiaries, as well as those who leave the ACO. Savings and losses will be based on the final reconciliation.

In terms of patient notification, the final rule requires ACO participants to post signs in their facilities indicating participation in the Shared Savings Program and to make standardized written information available in all settings where primary care services will be delivered to traditional Medicare FFS beneficiaries. 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 who want to opt out of data sharing.

QUALITY MEASURES AND THE METHODOLOGY FOR MEASURING ACO PERFORMANCE

ACOs participating in the shared-savings-only payment model (i.e., the one-sided model) will be able to share in up to 50 percent of their achieved savings, depending on how well they exceed minimum quality performance standards. For ACOs sharing in the losses as well as savings, the percentage is 60 percent. Any shared-savings payment is contingent on meeting quality performance standards, regardless of the amount of cost reduction. Before describing how the

shared savings will be determined, the following section describes the measures that will be used to gauge ACO performance and how they will be scored.

Measures

CMS will require ACOs to report on 33 measures in performance year 1. (See [Appendix](#) for a complete list.) The measure set includes process, outcome, and patient experiences-of-care measures. Measures are grouped into the following four domains: patient/caregiver experience (seven measures); care coordination/patient safety (six measures); preventive health (eight measures); at-risk population (12 measures).

CMS is working with the measure development community to ensure specifications are as up-to-date as possible. Because the measures are frequently updated by their developers (such as the National Quality Forum) to take into account evolving clinical guidelines and best practices, CMS expects to release the specifications for performance year 1 for most of the measures in the fourth quarter of 2011 or the first quarter of 2012. The specifications for the CAHPS survey measures will be released later in 2012. For future years, CMS will add and remove measures as appropriate through the rule-making process.

Data Sources

CMS lists data sources for these measures as survey instruments (7), claims (3), electronic health record (EHR) incentive program data (1), and the Web interface for the Group Practice Reporting Option (GPRO) data collection tool (22). 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 will allow ACOs to qualify for the PQRS incentive payment on behalf of all of its providers (not just those used for assignment), which could alleviate some of the burden of 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 schedule charges during the performance year. The PQRS bonus for ACO providers is not contingent on meeting the ACO's requirements for shared savings.

CMS will supply all the claims data, fund the survey for the first two performance years, 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 random sample of assigned beneficiaries for each measure domain of at least the minimum of 411, or 100 percent of the assigned beneficiaries. CMS plans on auditing this data.

Scoring and Standards

According to the final rule, the first year will essentially be a pay-for-reporting arrangement in order to allow ACOs an opportunity to ramp up and CMS an opportunity to learn about the process and establish improvement targets. Thus, 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 performance period, most of the measures will begin to be used on a pay-for-performance basis. In performance period 2, 25 of the 33 measures will be based on actual performance, with the other eight continuing to be on a pay-for-reporting basis. In performance period 3, 32 measures will be based on actual performance and one measure—the health status/functional status survey-based measure—will continue to be on a pay-for-reporting basis. (See [Appendix](#) for more details on when each measure moves to pay-for-performance status.)

After the first performance period, a scoring system will be used to determine how much of the 50 percent (or 60 percent for ACOs with two-sided risk models) in shared savings ACOs will receive. With the exception of the EHR measure, each measure within a domain would be worth a maximum of two points and a minimum of zero. The EHR measure is double-weighted to signal the importance of EHR adoption for ACO success. However, the final rule diverges from the proposed rule by not requiring meaningful use of EHRs by a majority of providers in the ACO. An ACO would get a single score for the domain based on the percentage of total points it achieved. The average of the four domain scores would be the overall score, which determines the percentage of shared savings ACOs receive.

The measure-specific benchmarks ACOs must achieve for scoring purposes will be made known prior to the second performance year and will be mostly based on national FFS and Medicare Advantage (MA) performance levels. Exhibit 2 describes the basis of the scoring system CMS plans on using after the first performance year.

Exhibit 2. ACO Scoring System for Quality Measures

ACO Performance Level	Quality Points (all measures except EHR)
90+ percentile FFS/MA Rate or 90+ percent	2 points
80+ percentile FFS/MA Rate or 80+ percent	1.85 points
70+ percentile FFS/MA Rate or 70+ percent	1.7 points
60+ percentile FFS/MA Rate or 60+ percent	1.55 points
50+ percentile FFS/MA Rate or 50+ percent	1.4 points
40+ percentile FFS/MA Rate or 40+ percent	1.25 points
30+ percentile FFS/MA Rate or 30+ percent	1.10 point
<30 percentile FFS/MA Rate or <30 percent	No points

Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS-1345-F.

According to the scoring system, performing above the 90th percentile of the MA or FFS for a measure will result in the full two points for that measure. CMS considers the 30th percentile of the MA or FFS rate as the minimum attainment level.

Note that only 23 measures will be scored in this way, as the patient experience survey measures will be scored as one measure and the two composite measures (for diabetes and coronary artery disease) will be scored as all-or-nothing measures (i.e., not on a sliding scale).

Public Reporting

Public reporting is important for holding ACO providers accountable for high-value care. Each ACO will be responsible for making organizational information available, 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 publicly available in a standardized format. In an attempt to align performance measurement activities across programs, the final policies on how to report the Shared Savings Program measures are pending final policies regarding how measures in other programs (e.g., Physician Compare and PQRI) will be reported. Thus, CMS still needs to issue guidance on public reporting of the Shared Savings Program quality measures.

SHARED SAVINGS PAYMENT METHODOLOGY

ACOs will be able to choose between two payment model tracks. Under track 1, shared savings would be reconciled using a one-sided approach (i.e., a shared-savings-only model) for the full duration of the contract. That is, ACOs would share in any savings (i.e., receive bonus payments from CMS) if the ACO reduced Medicare expenditures below target amounts. Under track 2, the ACO would participate in a two-sided model, in which case the ACO shares in costs in excess of spending targets, as well as any savings when Medicare expenditures are reduced below target amounts. Participation under a one-sided model is limited to one contract term, after which the ACO must renew with a two-sided model to continue participating in the Shared Savings Program. 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 will use the spending data from 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 will use the CMS–Hierarchical Condition Category (CMS–HCC) methodology to adjust for variation in beneficiary health status. Also, to minimize variation from catastrophically large claims, per capita expenditures will be truncated at the 99th percentile for each benchmark year. Moreover, CMS will calculate benchmark expenditures separately for certain cohorts of beneficiaries based on the following characteristics: end-stage renal disease, disability, aged and dually eligible for Medicare and Medicaid, and aged and not dually eligible. Beneficiaries will be categorized based on the order of the characteristics listed.

The three years used for the expenditure baseline will be indexed to the most recent benchmark year using Medicare growth rates estimated by CMS's Office of the Actuary. The growth rates will be based on 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 will 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 oldest year at 10 percent.

CMS also intends to reset the expenditure baseline only at the beginning of each contract period (e.g., after the third performance year for ACOs that plan to renew their contract). This will help account for changes in an ACO's assigned population over time, as turnover in the ACO assigned population has been estimated to reach about 25 percent per year.

Using the Baseline to Develop Spending Benchmarks

To generate any savings, ACOs must reduce spending below their benchmark amount. By statute, benchmark spending amounts are calculated by updating costs in the baseline period by the projected absolute growth in national per capita expenditures (expressed in absolute dollars) for Part A and B services under the original Medicare FFS program.

CMS will use national growth without any locality adjustments; however, CMS will make some adjustments for potential changes in health status over time of an ACO's assigned population. As with the baseline calculations, risk scores (calculated by using CMS-HCCs, the model currently applied to private plan payment rates under the MA program) will be used to control for variations in health status.

For newly assigned beneficiaries (i.e., beneficiaries assigned for the current performance year, but not assigned in previous years), CMS will update the ACO's risk score to account for the fact that the new enrollees may be sicker or healthier than the continuously enrolled population.

For the continuously enrolled population, unless their CMS-HCC risk scores decline, CMS will use only demographic factors (e.g., age and sex) to adjust for severity and case mix relative to the historical benchmark period. This approach will help avoid concerns of upcoding.⁴ CMS intends to monitor and evaluate the adjustments used for case mix and severity for future rule-making and to use an auditing process to ensure the appropriateness of ACO coding practices that could influence the risk scores of the assigned populations.

Geographic and Other Payment Policy Adjustments

CMS will exclude from both the benchmark and performance year calculations payments that are made to providers through indirect medical education (IME) adjustments to teaching hospitals and disproportionate share hospital (DSH) adjustments to hospitals that treat a disproportionate

share of poor patients to avoid unintended consequences that could disadvantage those hospitals. For example, ACOs could be motivated to redirect referrals away from hospitals that receive IME or DSH payments if those payments were counted as higher performance costs in the determination of shared savings.

Also excluded from the benchmark and performance spending estimates will be any incentive payments made outside the Medicare Part A and Part B payment systems (and not captured by claims data), such as those authorized under the Health Information Technology for Economic and Clinical Health Act, such as PQRS and electronic prescribing incentives.

Other incentives and payment adjustments that are captured by the claims data, such as hospital inpatient value-based purchasing incentives and geographic adjustments to provider payment rates to reflect geographic differences in input prices, will be included in the calculations. CMS does not believe that those adjustments would result in significant incentives to steer patients away from particular providers.

Minimum Savings Rates and Estimating Shared Savings

A certain degree of year-to-year variation in actual ACO spending amounts might be expected regardless of any innovations that ACOs undertake to improve health care. Consequently, the Affordable Care Act mandated that CMS include a minimum savings rate (MSR) to help ensure that costs below the benchmark are likely to reflect improved performance and not simply random fluctuations. That is, ACOs would need to reduce spending below the MSR before being eligible for any shared savings. This is particularly important because of the availability of the one-sided risk model, in which the opportunity of potential rewards for an ACO's costs below its target is not offset by the risk of penalty for excess costs.

For ACOs participating in the one-sided risk model, CMS will set the 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 affect costs.

Although the MSRs for smaller ACOs are higher than for larger ACOs, they were adjusted somewhat to recognize the greater difficulty that smaller ACOs may face in revamping their infrastructures to better coordinate and manage care. The resulting MSRs are in Exhibit 3. An ACO with 5,000 assigned Medicare beneficiaries will need to achieve 3.9 percent in savings before it can share in savings, while an ACO with 60,000 assigned Medicare beneficiaries will need to achieve 2 percent in savings before it can receive any shared-savings payments.

Exhibit 3. 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%

MSR = minimum savings rate.

Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS–1345–F.

ACOs in the two-sided risk model will have a flat 2.0 percent MSR, as the risk of rewarding reductions in costs not due to 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. However, ACOs under both the one-sided and two-sided models will be able to share in all of the savings on a first-dollar basis if the MSR is met or exceeded. For example, an ACO with 5,000 assigned Medicare beneficiaries that achieves 3.9 percent in savings relative to its target will be eligible to share in all of those savings (including the initial 3.9 percent).

Shared Savings and Losses Percentage for the ACO

As mentioned above, ACOs participating in a one-sided model can receive up to 50 percent of the shared savings, whereas ACOs with two-sided models can receive up to 60 percent of the shared savings. It should be noted that ACOs will not be able to receive additional bonuses or higher shared-savings rates for care of dual eligible beneficiaries or other factors related to the composition of the ACO (e.g., inclusion of an RHC or FQHC) or its activities.

The final shared savings rates are determined by the performance measurement scores (see section above on Scoring and Standards). As an example, if an ACO achieves between the 30th and 40th percentile on all applicable measures and maximizes the all-or-nothing measures, the ACO will share in up to 54 percent of the allowed percentage of shared savings if it is able to reduce costs below the applicable spending targets (Exhibit 4). This amounts to 27 percent

(0.54 x 0.50) of the shared savings for ACOs participating in a one-sided model and 32 percent (0.54 x 0.60) for ACOs under a two-sided model.

Exhibit 4. Example of Using Performance Measurement Scoring to Determine Final Shared Savings or Losses

Domain Name	Total Measures (33 total)	Total Measures for Scoring Purposes (23 total)	Total Points Possible	Points Scored, if ACO Attains Between 30th and 40th Percentile*	Domain Percentage
Patient/Caregiver Experience Measures	7	1 measure with 6 survey module measures combined, plus 1 individual measure	4	2	50%
Care Coordination/ Patient Safety	6	6 measures, with EHR measure double weighted	14	7	50%
Preventive Health	8	8 measures	16	8	50%
At-Risk Population/ Frail Elderly Health	12	7 measures, 2 of which are composites (diabetes composite has 5 separate measures, coronary artery disease composite has 2)	14	9	64%
Average percentage across four domains used to calculate final shared savings or losses (domain percentages are equally weighted)					54%

* Assumes that full scoring is reached for all-or-nothing measures.

Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS-1345-F.

Scoring on performance measurement will also determine the shared-loss percentage for ACOs exceeding the spending target under a two-sided payment model. The shared-loss percentage is determined as the inverse of the would-be final sharing rate, as described above (i.e., 1 minus the final sharing rate), with an upper limit of 60 percent. Thus, in the example above with the ACO performing around the 30th to 40th percentile for all measures, the ACO would be responsible for 60 percent of the losses ($1 - 0.32 = 0.68$, which gets capped at 0.60). An ACO that maximizes its performance score (and hence its shared-savings rate) would be responsible for only 40 percent of the shared losses ($1 - 0.60 = 0.40$), if it exceeds the spending targets.

Cap on Shared Savings and Losses

There are caps to the amount of savings that can be shared with ACOs, with a cap of 10 percent for ACOs using one-sided models and 15 percent for ACOs with two-sided models. The higher cap in the two-sided risk model is intended to help offset the greater risk. CMS will also have a cap on shared losses that will gradually increase from 5 percent in the first performance period to 7.5 percent in the second and 10 percent in the third.

Timing and Process for Evaluating Shared Savings

There will be at least a several month delay between the end of the performance period and payments for shared savings or shared losses, as CMS will need to use a three-month run-out of claims (after the end of the performance period) to make the final determination of shared savings.

Distribution of Shared Savings

CMS will pay the 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 will not specify how ACOs distribute the shared savings, ACOs will be required to provide a description in the application of how they will use the shared savings to meet the goals of the program. The intent is to guard against improper incentives and ensure appropriate beneficiary protections.

ACOs with start dates of April 1 and July 1, 2012, will have the option for an interim payment calculation to determine shared savings or losses at the end of their first 12 months of program participation. This can allow some ACOs to make better use of the shared savings in terms of supporting a quicker return on investment, which can help with ongoing operational costs. A final reconciliation will be calculated for the first performance year encompassing the full 21 months (for those starting on April 1) or 18 months (for those starting on July 1).

Repaying Shared Losses

ACOs must 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 such as a withhold of a portion of any previous shared savings achieved. ACOs must provide documentation, annually, of the ability to repay up to 1 percent of per capita expenditures of its assigned beneficiaries from the most recent year available or the expenditures used to establish the benchmark. This requirement applies to ACOs under the two-sided model and one-sided model ACOs requesting interim payments.

ACOs will be notified about shared losses in writing and are required to make payments within 90 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. ACOs that generate shared losses under the interim payment calculation must also repay the losses within 90 days. In addition, any money determined to be owed by an ACO after the first performance year reconciliation, whether as a result of additional shared losses or an overpayment of shared savings (from the interim payment), must be paid to CMS within 90 days.

DIFFERENCES BETWEEN THE ONE-SIDED AND TWO-SIDED MODELS

Exhibit 5 summarizes the key differences in the ACO program under the one-sided and two-sided models. For the most part, there are no differences in the eligibility requirements. The two models both include the same patient notification requirements. The same quality performance requirements apply, 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 incentives to stint on care.

Exhibit 5. One-Sided and Two-Sided Models in the Medicare Shared Savings Program

Design Element	One-Sided Model	Two-Sided Model
Maximum Sharing Rate	Up to 50%	Up to 60%
Quality Scoring	Up to 50% of shared savings is conditional on quality performance	Up to 60% of shared savings is conditional on quality performance
Minimum Savings Rate (MSR)	Varies by population size	Flat 2% regardless of size
Minimum Loss Rate (MLR)	Not applicable	Flat 2% regardless of size
Maximum Sharing Cap	Payment capped at 10% of ACO's benchmark	Payment capped at 15% of ACO's benchmark
Shared Savings	First-dollar sharing once MSR is met or exceeded	First-dollar sharing once MSR is met or exceeded
Shared Losses	None	One minus final sharing rate applied to first dollar losses once MLR is met or exceeded; shared-loss rate not to exceed 60%
Loss Sharing Limit	None	Cap on the amount of losses to be shared is phased in over three years starting at 5% in year 1, 7.5% in year 2, and 10% in year 3

Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS-1345-F.

MONITORING ACO PERFORMANCE AND GROUNDS AND PROCEDURES FOR TERMINATING AGREEMENTS

The Centers for Medicare and Medicaid Services will be using many methods to monitor and assess accountable care organizations for noncompliance with statutory and regulatory eligibility and other program requirements. The methods include the collection of beneficiary complaints, analysis of quality data, site visits, and audits.

ACOs, including their providers, suppliers, and contracted entities, will be required 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. This

includes materials needed to allow for an audit, evaluation, and inspection of the ACO's compliance with Medicare 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 analysis of trends in claims data.⁵

ACOs found to be in noncompliance can be given a warning, be put on under a corrective action plan, or be placed on a special monitoring plan. CMS will terminate an agreement with an ACO before the end of the three-year agreement period for any of the following reasons:

- noncompliance with eligibility and other requirements, such as avoidance of at-risk beneficiaries and failure to meet the Shared Savings Program's quality performance standard;
- the imposition of sanctions or other actions taken against the ACO by an accrediting organization or state, federal, or local government agency that leads to inability of the ACO to comply with the requirements of the Shared Savings Program; or
- violation of the physician self-referral prohibition, civil monetary penalty laws, anti-kickback statute, other antifraud laws, antitrust laws, or other applicable Medicare laws, rules, or regulations that are relevant to ACO operations.

An ACO can even be terminated immediately in appropriate cases.

Future Participation of Previously Terminated Program Participants

ACO providers that were previously expelled from the program can reapply as their own ACO or as part of another ACO, but will need to wait until the end of the original three-year period. The application must also note the reason for the termination and the safeguards implemented to address the shortcomings. An ACO that has terminated less than halfway through its agreement under the one-sided model will be allowed to reenter the one-sided model at the conclusion of the original agreement. ACOs that were terminated more than half way through will only have the option of the two-sided model.

Reconsideration Review Process

By statute, 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 reasons other than those specified by statute (e.g., avoidance of at-risk beneficiaries). Accordingly, CMS has set up an administrative process to allow ACOs to request reviews of these decisions.

WORKING WITH OTHER AGENCIES TO ENSURE COORDINATION AND ALIGNMENT

Fraud and Abuse Waivers

A joint CMS and Department of Health and Human Services/Office of the Inspector General document, released in conjunction with the final rule, establishes five fraud and abuse waivers for ACOs that participate in the Medicare Shared Savings Program. These waivers protect providers against the application of certain civil monetary policy law provisions, the federal anti-kickback statute, and the physician self-referral law (known as the Stark law). These waivers include:

- 1) an “ACO pre-participation” waiver that is available for a limited duration to cover start-up arrangements between providers in anticipation of participation in the Shared Savings Program;
- 2) an “ACO participation” waiver that extends for the term of participation in the Shared Savings Program as well as a six-month period after expiration or termination;
- 3) a “shared-savings distribution” waiver that applies to distributions of shared-savings payments and their uses;
- 4) a “compliance with the Physician Self-Referral Law” waiver that is applicable to ACO arrangements implicating the Physician Self-Referral Law meeting an existing Stark exemption; and
- 5) a “patient incentive” waiver that will allow ACOs to offer incentives to beneficiaries to encourage preventive care and compliance with treatment regimens.

While these waivers are still open to comments and further revision, they will be applied as final waivers on an interim basis. The waivers apply uniformly to ACOs and their participants in the Medicare Shared Savings Program.

Guidance for Tax-Exempt ACO Participants

Also in conjunction with the final rule, the Internal Revenue Service (IRS) updated its guidance for charitable (i.e., tax-exempt) organizations, including tax-exempt hospitals, participating in the Shared Savings Program. The IRS will review ACO arrangements on a case-by-case basis, but, in general, is likely to view ACO participation (even with participation outside of the Medicare Shared Savings Program) as consistent with charitable purposes. The IRS also states that tax-exempt participants in an ACO need not necessarily have control over the ACO in order to ensure that its participation furthers its charitable purpose.

Antitrust Guidelines

The Federal Trade Commission and Department of Justice issued a final statement, also released in conjunction with the final rule, which describes the characteristics that would cause antitrust

challenges for ACOs. The statement applies to all ACOs, not just those formed after March 23, 2010. This allows preexisting and otherwise independent providers, such as independent practice associations or physician–hospital organizations, to rely on the statement to establish antitrust compliance.

Also, the agencies note that ACOs meeting the CMS eligibility criteria will also meet the criteria to conduct negotiations with private-sector payers, as long as the ACO uses the same governance and leadership structures, in addition to the same clinical and administrative processes it uses in the Shared Savings Program.

Perhaps the most important guidance in the final statement is that no antitrust review is required to participate in the Shared Savings Program. From a time perspective, this will help interested provider groups join the Medicare Shared Savings Program in 2012, as it could take months to conduct the review. Not mandating reviews also creates a less prescriptive framework for antitrust enforcement in connection with ACO formation and operation. However, newly formed ACOs can obtain a voluntary expedited (90 days) antitrust review. This process will be useful for provider groups who have not jointly negotiated contracts with private payers prior to March 23, 2010.

Also, a “safety zone” is specified for ACOs that have providers with a combined market share of 30 percent or less of each “common service” in their primary service area (PSA). The federal antitrust agencies will not challenge ACOs in the safety zone, absent extraordinary circumstances. The “service” is based on each primary specialty of the providers in the service area. The PSA is defined as the lowest number of contiguous postal zip codes from which the ACO draws at least 75 percent of its patients for that service.

ACOs in rural areas may qualify for the safety zone even with PSA shares greater than 30 percent. This will allow ACOs in isolated rural areas to have at least one relevant provider in each common service category without breaching the safety zone. An exception is also allowed for dominant providers (defined as a provider with over 50% market share) to participate in an ACO, as long as it is on a nonexclusive basis, and still be eligible for the safety zone.

An ACO outside the safety zone is not inherently illegal, but as the PSA share for any common service increases so does the risk of antitrust action. The agencies identify types of conduct to avoid to reduce the likelihood of antitrust enforcement action. In general, these include anything that might facilitate collusion and reduce competition in the provision of services outside of the ACO, leading to increased prices or reduced quality or availability of services. Such conduct includes the following:

- sharing competitively sensitive information (e.g., exchanging pricing information) among the ACO’s participants that could be used to set prices or other terms for services provided outside the ACO;

- preventing private payers from directing their patients to certain providers, even if they are outside the ACO network;
- tying sales of the ACO's services to a private payer's purchase of other services from providers outside the ACO (like affiliates of a hospital);
- contracting on an exclusive basis with physicians, hospitals, or other providers, thereby preventing those providers from contracting with private payers outside the ACO; and
- restricting a private payer's ability to provide cost, quality, efficiency, and performance information to its enrollees to aid in evaluating and selecting providers in the health plan, if the information is similar to measures used in the Shared Savings Program.

CMS will work with the other regulatory agencies to identify potential anticompetitive harm and adjust these policies accordingly as experience is gained with the Medicare Shared Savings Program.

Overlap in Medicare Programs and the Impact on 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 for the Indiana Health Information Exchange and North Carolina Community Care Network sites;
- any Multi-Payer Advanced Primary Care Practice Demonstration sites involving shared savings
- Physician Group Practice (PGP) Transition demonstration;
- Care Management for High-Cost Beneficiaries demonstration; and
- the Pioneer ACO model.

ACOs may not participate in the Medicare Shared Savings program if any of its participants participates in the programs listed above. This list may be updated as future programs are created. The limitation only applies to Medicare Shared Savings Programs, so ACOs could participate in the Medicare Shared Savings Program and state initiatives, such as the program to establish community health teams to support patient-centered medical homes under section 3502 of the Affordable Care Act.

Since, providers can be linked to multiple TINs in different Shared Savings Programs or with multiple ACOs, 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.

REGULATORY IMPACT ANALYSIS

In the final rule, CMS actuaries provide estimates for the expected net savings to the Medicare program and costs to ACOs (Exhibit 6). 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 \$0 (10th percentile) to \$940 million (90th percentile) in net savings over the first three performance years of the program, assuming participation of 50 to 270 ACOs. The estimates assume that 1 million to 5 million beneficiaries are aligned with a participating ACO during this time period. The wide range in the estimates is due to the large degree of uncertainty involved with implementing a new program with new types of providers.

Exhibit 6. Estimated Net Federal Savings and ACO Costs

	Performance Year 1		Performance	Performance	Total (2012–2015)
	2012	2013	Year 2, 2014	Year 3, 2015	
New Federal Savings (in millions)					
10th percentile	–\$30	–\$20	\$10	\$0	\$0
Median	\$20	\$90	\$160	\$190	\$470
90th percentile	\$70	\$210	\$320	\$370	\$940
ACO Bonus Payments (in millions)					
10th percentile	\$60	\$180	\$280	\$360	\$890
Median	\$100	\$280	\$410	\$520	\$1,310
90th percentile	\$170	\$420	\$600	\$740	\$1,900
Costs	The estimated start-up investment costs for participating ACOs range from \$29 million to \$157 million, with annual ongoing costs ranging from \$63 million to \$342 million, for the anticipated range of 50 to 270 participating ACOs. With the mean participation of ACOs, the estimated aggregate average start-up investment and four-year operating costs is \$451 million.				

Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS–1345–F.

Appendix. Quality Performance Measures ACOs Must Meet for Shared Savings

Measure Title and Description	Domain	Method of Data Submission	Measure Type	Pay-for-Performance (P) or Pay-for-Reporting (R) Status		
				Year 1	Year 2	Year 3
Getting timely care, appointments, and information	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	P	P
How well your doctors communicate	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	P	P
Access to specialists	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	P	P
Patients' rating of doctor	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	P	P
Health promotion and education	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	P	P
Shared decision-making	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	P	P
Health status/functional status	Patient/caregiver experience	Survey (CAHPS)	Patient experience of care	R	R	R
Risk-standardized, all-condition readmission The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population	Care coordination/patient safety	Claims	Outcome	R	R	P
Ambulatory sensitive conditions admissions: chronic obstructive pulmonary disease (AHRQ prevention quality indicator #5) All discharges of age 18+ with ICD-9-CM principal diagnosis code for COPD, per 100,000 population	Care coordination/patient safety	Claims	Outcome	R	P	P
Ambulatory sensitive conditions admissions: congestive heart failure (AHRQ prevention quality indicator #8) All discharges of age 18+ with ICD-9-CM principal diagnosis code for CHF, per 100,000 population	Care coordination/patient safety	Claims	Outcome	R	P	P
Percent of all primary care providers who qualify for an electronic health record (EHR) incentive program payment	Care coordination/patient safety	EHR incentive plan reporting	Process	R	P	P

Measure Title and Description	Domain	Method of Data Submission	Measure Type	Pay-for-Performance (P) or Pay-for-Reporting (R) Status		
				Year 1	Year 2	Year 3
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/ patient safety	GPRO Web interface	Process	R	P	P
Screening for fall risk Percentage of patients age 65+ who were screened for fall risk at least once within 12 months	Care coordination/ patient safety	GPRO Web interface	Process	R	P	P
Influenza immunization Percentage of patients age 50+ who received an influenza immunization during the flu season (September–February)	Preventive health	GPRO Web interface	Process	R	P	P
Pneumococcal vaccination Percentage of patients age 65+ who have ever received a pneumococcal vaccine	Preventive health	GPRO Web interface	Process	R	P	P
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+ BMI ≥ 30 or < 22 ; Ages 18–64 BMI ≥ 25 or < 18.5	Preventive health	GPRO Web interface	Process	R	P	P
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 Web interface	Process	R	P	P
Depression screening: Percentage of patients age 18+ screened for clinical depression using a standardized tool and follow up plan documented	Preventive health	GPRO Web interface	Process	R	P	P
Colorectal cancer screening: Percentage of patients ages 50–75 who received appropriate colorectal cancer screening	Preventive health	GPRO Web interface	Process	R	R	P

Measure Title and Description	Domain	Method of Data Submission	Measure Type	Pay-for-Performance (P) or Pay-for-Reporting (R) Status		
				Year 1	Year 2	Year 3
Mammography screening: Percentage of women ages 40–69 who had a mammogram to screen for breast cancer within 24 months	Preventive health	GPRO Web interface	Process	R	R	P
Proportion of adults age 18+ who had blood pressure measured in past 2 years	Preventive health	GPRO Web interface	Process	R	R	P
Diabetes composite (all-or-nothing scoring): <ul style="list-style-type: none"> • hemoglobin A1c control (<8%) • low density lipoprotein (<100) • blood pressure <140/90 • tobacco non-use • aspirin use 	At-risk population—diabetes	GPRO Web interface	Process and outcome	R	P	P
Diabetes mellitus: hemoglobin A1c poor control (>9%)	At-risk population—diabetes	GPRO Web interface	Outcome	R	P	P
Hypertension: blood pressure control Percentage of patients with last BP <140/90 mmHg	At-risk population—hypertension	GPRO Web interface	Outcome	R	P	P
Ischemic vascular disease: compete lipid profile and LDL control <100 mg/dl	At-risk population—ischemic vascular disease	GPRO Web interface	Outcome	R	P	P
Ischemic vascular disease: use of aspirin or another antibiotic	At-risk population—ischemic vascular disease	GPRO Web interface	Process	R	P	P
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 Web interface	Process	R	R	P
Coronary artery disease (CAD) composite (all-or-nothing scoring) <ul style="list-style-type: none"> • drug therapy for lowering LDL cholesterol • angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy for patients with CAD and diabetes and/or LVSD 	At-risk population—coronary artery disease	GPRO Web interface	Process and outcome	R	R	P

Notes: CAHPS = Consumer Assessment of Healthcare Providers and Systems; AHRQ = Agency for Healthcare Research and Quality; GPRO = Group Practice Reporting Option.

Source: Centers for Medicare and Medicaid Services, Medicare Shared Savings Program Final Rule, CMS–1345–F.

NOTES

¹ Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Proposed Rule, *Federal Register*, April 7, 2011 76(67):19528–654, <http://www.gpoaccess.gov/fr/>.

² Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule, *Federal Register*, Nov. 2, 2011 76(212):67802–990, <http://www.gpoaccess.gov/fr/>.

³ The specified 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 upon a list in section 5501 of the Affordable Care Act that makes incentive payments to certain primary care providers. In addition, since HCPCS codes are not available in federally qualified health center and rural health clinic billing claims, certain revenue center codes will be used as a proxy for the primary care and preventive services in order to make assignments to federally qualified health center and rural health clinics.

⁴ Upcoding refers to the notion that providers may have more incentive to code more comprehensively when risk scores based on diagnosis and procedure codes (such as with the Center for Medicare and Medicaid Services Hierarchical Condition Categories approach) are used for payment purposes. When this happens, the higher risk scores may be indicative of changes to diagnosis and procedure coding practices, rather than changes to the relative risk characteristics of their patients. In the case of ACOs, higher risk scores can result in more shared-savings payments, as they will result in lower observed costs in the performance period relative to a baseline that did not reflect these upcoding efforts. Demographic factors such as age and gender are not susceptible to biases from changing coding practices, but still provide some indication of a patient population’s severity and case mix.

⁵ At-risk beneficiary is defined in the final rule as a beneficiary who: has a high risk score in the Center for Medicare and Medicaid Services Hierarchical Condition Categories risk adjustment model; has had two or more hospitalizations or emergency room visits each year; is dually eligible for Medicare and Medicaid; has a high utilization pattern; has one or more chronic conditions; has had a recent diagnosis that is expected to result in increased cost; is entitled to Medicaid because of disability; or is diagnosed with a mental health or substance abuse disorder.