

“Medicare Shared Savings Program: Accountable Care Organizations” Final Rule Summary

On Thursday, October 20, CMS announced the final rules for Accountable Care Organizations (ACOs) participating in Medicare’s Shared Savings Program. Created by the Affordable Care Act, CMS’ goal for the program is to incentivize providers to proactively coordinate care across care settings so that beneficiaries receive higher-quality care at a lower cost. ACOs can share in savings that they generate for Medicare as compared to CMS estimates of what their patient population was estimated to cost.

The agency received more than 1300 comments on the proposed rules published last March. While the basic structure of the Medicare shared savings program remains as proposed, CMS made a number of revisions to respond to major criticisms of the rule and to encourage providers to participate. Although many stakeholders have praised the changes, it is still not clear how many organizations will ultimately decide to participate. The program will launch officially on January 1, 2012 and interested organizations must notify CMS of their intent to participate by January 6, 2012 to take advantage of the April, 1 2012 start date.

The Shared Savings Program final rule is available [here](#). Below is an analysis of specific provisions of interest to ASH. Following that is a chart comparing highlights of the proposed and final rules prepared by CMS.

Summary of Key Provisions

Eligible Providers

The final rule requires that each ACO be responsible for at least 5,000 beneficiaries annually for a period of three years. All Medicare providers can participate in an ACO, but only certain types of providers are able to sponsor one, including physicians in group practice arrangements, networks of individual practitioners, and hospitals that partner with or employ eligible physicians, nurse practitioners, physician assistants, and specialists. To help providers serving rural and other underserved areas, the final rule allows Rural Health Clinics (RHCs), certain critical access hospitals and Federally Qualified Health Centers (FQHCs) to participate. An ACO must have a medical director, but the final rule clarifies that the medical director can be an ACO participant who also sees patients, rather than a full-time administrator.

Beneficiary Assignment to ACOs

Only Medicare fee-for-service beneficiaries enrolled under parts A and B can be assigned to an ACO. Beneficiaries will be assigned to the ACO from which they received the plurality of their primary care services. CMS received comments on whether to use prospective or retrospective assignment, ultimately settling on an approach that incorporates both. There will be preliminary prospective assignment at the beginning of the performance year based on the most recent data available. ACOs will be given a list of the patients they had seen recently for primary care services that CMS predicts will be assigned to their ACO. The list of patients – and data on their Parts A, B and D services and spending – will be updated on a quarterly basis based on the most recent 12 months of data. At the end of the performance year, final assignment will be made based on those patients that actually did receive the plurality of their primary care services by the ACO.

Several commenters, including ASH, expressed concern about “primary care physician” being defined as those with a “primary specialty designation of internal medicine, general practice, family practice of

geriatric medicine,” since specialists are often the principal primary care provider for elderly and chronically ill patients. In the final rule, CMS agreed and decided to employ a “step-wise” approach to assigning beneficiaries to an ACO: first, all patients that had a primary care service with a physician who is an ACO participant will be identified; beneficiaries will first be assigned to an ACO based on utilization of primary care services provided by primary care physicians; beneficiaries that do not see a primary care physician may be assigned to an ACO on the basis of primary care services provided by other physicians.

For the purpose of assignment, CMS is defining “primary care services” as the set of services identified by the following HCPCS codes: 99201-99215, 99304-99340, 99341-99350, G0402 (the Welcome to Medicare visit), and G0438 and G0439 (the annual wellness visits). These codes will be used to determine if a beneficiary received a primary care service during the assignment period.

ACO Governance

CMS finalized the requirement that an ACO be a legal entity capable of all program functions described in the final rule. It must be able to accept and distribute the shared savings generated by the program, provide oversight and direction for the ACO, operate transparently and will have a fiduciary duty to the ACO.

ACO participants and Medicare beneficiaries must be included on the ACO’s governing board, but CMS has eliminated the proposed rule requirement that each ACO participant have proportionate control on the governing body.

In its comments on the proposed rule, ASH recommended that CMS require ACO governing boards to include representation of all medical specialties participating in the ACO. In the final rule, CMS declined to include this recommendation because while it believes that each ACO participant should have a voice in the ACO’s governance; it seeks to provide ACOs with flexibility to create the boards best suited to their entity. Instead, CMS will “require an ACO to provide meaningful participation in the composition and control of the ACO’s governing body for ACO participants or their designated representatives.”

Shared Savings and Shared Losses

CMS is implementing two models: a one-sided shared savings model, in which providers only share in potential savings; and a two-sided shared savings and losses model, in which providers also share in losses if costs grow. ACOs will share up to 50% of the savings under the one-sided model and up to 60% of the savings under the two-sided model, depending on their quality performance.

The proposed rule had required ACOs in the one-sided shared savings model to share losses in the third year of the agreement period. CMS modified the proposal in response to comments, and the final rule allows groups to participate under the one-sided model for the entire three-year agreement period.

For each year, CMS will develop a target level of spending for each ACO to determine its financial performance. Because health care spending for any group of patients normally varies from year to year, CMS will also establish a minimum savings and minimum loss rate that would account for these variations. Both shared savings and shared losses will be calculated on the total savings or losses, not just the amount by which the savings or losses exceed the minimum savings or loss rate. In addition, the amount of shared savings would depend on how well the team of providers performs on the quality measures specified in the rule.

Clarifying Referral Relationships

Both the proposed and final rules stressed that the Medicare beneficiary would retain the freedom to choose any participating Medicare provider, regardless of whether that provider was in the ACO. However, many specialty groups expressed concern about patient access to the specialist of his or her choosing and CMS recognized that there would be a strong incentive for ACOs to require referrals to be made within the ACO. The final rule outlined that CMS will monitor the actions of ACOs to determine whether an ACO, its participants or its providers/suppliers are interfering with the patient's freedom of choice by restricting referrals.

Quality Improvement Requirements

In order to share in any savings an ACO must meet quality standards. CMS will evaluate performance on risk-adjusted quality standards with measures relating to patient experience, care coordination and patient safety, preventive health, and at-risk populations. To earn shared savings the first year, providers must fully and accurately report across all four domains of quality identified by CMS. Providers will begin to share in savings based on their performance on 33 quality measures in the second and third performance years.

CMS had originally proposed 65 quality standards, but reduced the number after many providers, including ASH, commented that it would be burdensome for ACOs to complete all 65 measures. To eliminate over 30 measures, CMS removed those perceived as redundant, operationally complex or burdensome. Several claims-based measures were eliminated from the reporting requirements, but if reported, they will be used to monitor the ACO's activities to ensure that it is not avoiding risky or complex patients.

ACOs will be required to comply with measures updates made in future rulemaking. CMS also made it clear that it may add or remove measures in future years as the agency develops a better understanding of the types of measures most important to assess the quality of care provided. ASH had recommended to CMS that it consider adding potential quality measures related to hematology services and incentives tied to the proportion of beneficiaries enrolled in clinical trials. CMS rejected this comment as well as requests from other groups to include other specialty-specific measures and declined to provide further incentives to ACOs since they seek to provide ACOs with flexibility.

Incorporating Reporting Requirements Related to PQRS and EHR Technology

CMS finalized its proposal to incorporate PQRS reporting requirements and incentive payment in the ACO program. This means that ACOs will use the PQRS Group Practice Reporting Option (GPRO) web interface, and that eligible professionals who are ACO providers/suppliers will constitute a group practice under their ACO Tax Identification Number (TIN) to qualify for a PQRS incentive. Reporting on the GPRO quality measures in the ACO program will fulfill the reporting requirements to avoid the payment adjustment beginning in 2015.

While CMS received comments about standardizing its reporting requirements across programs, CMS reaffirmed its original position to not incorporate the EHR Incentive Program or eRx Incentive Program reporting requirements. CMS will further align the ACO program with the EHR Incentive Program in future rulemaking as more experience is developed with both programs.

Advance Payment Model

Many commenters expressed concern about the upfront costs of establishing an ACO. In response, CMS has established the Advance Payment Model. ACOs participating in this model will receive an upfront,

fixed payment, an upfront, variable payment based on the number of its historically-assigned beneficiaries and a monthly payment that will depend on the size of the ACO. These advance payments will be recouped through the ACO's earned shared savings. If sufficient savings is not generated for repayment through the midpoint of the second performance year, CMS will recoup the balance from shared savings in the subsequent performance year. CMS will not recoup any outstanding balances after the completion of the first agreement period.

This program is available only to: ACOs without inpatient facilities that have less than \$50 million in total annual revenue; and ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than \$80 million in total annual revenue

More details on the Advanced Payment Model are available [here](#).

Related Rulemakings

Several other agencies and departments, including the Federal Trade Commission, Department of Justice, HHS Office of Inspector General and Internal Revenue Service, issued rulemakings or other policy guidance addressing issues related to the shared savings program. Links to these documents are below:

- Details about the DOJ/FTC joint Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program is available [here](#) (FTC) and [here](#) (DOJ).
- The joint CMS and HHS Office of Inspector General (OIG) Interim Final Rule with Comment Period addressing waivers of certain fraud and abuse laws in connection with the ACO program is available [here](#).
- The Internal Revenue Service (IRS) Fact Sheet, Tax-Exempt Organizations Participating in the Medicare Shared Savings Program Through Accountable Care (FS-2001-11), is posted [here](#).

Chart Comparing Proposed Rule versus Final Rule for Accountable Care Organizations (ACOs)

Topic	Proposed Rule	Modifications in Final Rule
Transition to risk in Track 1	ACOs could choose from two tracks, each entailing a 3-year agreement. Track 1 would comprise 2 years of one-sided shared savings with a mandatory transition in year 3 to performance-based risk under a two-sided model of shared savings and losses. Track 2 would comprise 3 years all under the two-sided model.	Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.
Prospective vs. retrospective	Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.	A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year based on patients actually served by the ACO.
Proposed measures to assess quality	65 measures in 5 domains, including patient experience of care, utilization claims-based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years. Alignment of proposed measures with existing quality programs and private-sector initiatives	33 measures in 4 domains. (Note: Claims-based measures to be used for ACO-monitoring purposes) Longer phase-in measures over course of agreement: first year, pay for reporting; second year and third year, pay for reporting and performance. Finalize as proposed.
Sharing savings	One-sided risk model: sharing beginning at savings of 2%, with some exceptions for small, physician-only, and rural ACOs. Two-Sided Risk Model: sharing from first dollar.	Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.
Sharing beneficiary ID claims data	Claims data shared only for patients seen by ACO primary care physician during performance year; beneficiaries given opportunity to decline at the point of care.	The ACO may contact beneficiaries from provided prospective and quarterly lists to notify them of data sharing and opportunity to decline.
Eligible entities	The four groups specified by the Affordable Care Act, as well as critical access hospitals paid through Method II, are eligible to form an ACO. ACOs can be established with broad collaboration beyond these providers.	In addition to groups included in the proposed rule, Federally Qualified Health Centers and Rural Health Clinics are also eligible to both form and participate in an ACO. In order for beneficiaries to be assigned on the basis of utilization of primary care services, these organizations must provide a list of practitioners who directly render primary care services in their facilities.
Start date	Agreement for 3 years with uniform annual start date; performance years based on calendar years.	Program established by January 1, 2012; first round of applications are due in early 2012. First ACO agreements start 4/1/2012 and 7/1/2012. ACOs will have agreements with a first performance "year" of 18 or 21 months. ACOs starting 4/1/2012 and 7/1/2012 have option for an interim payment if they report CY 2012 quality measures. ACO must report quality measures for CY 2013 to qualify for first-performance-year shared savings.

Reports & preliminary prospective list	Reports will be provided at the beginning of each performance year and include: name, date of birth, sex, and health insurance claim number.	Additional reports will be provided quarterly.
Electronic health record (EHR) use	Aligning ACO requirements with EHR requirements, 50% of primary care physicians must be defined as meaningful users by start of second performance year.	No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.
Assignment process	<p>One-step assignment process:</p> <ul style="list-style-type: none"> Beneficiaries assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians (internal medicine, general practice, family practice, and geriatric medicine). 	<p>Two-step assignment process:</p> <ul style="list-style-type: none"> Step 1: for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services rendered by primary care physicians. Step 2: for beneficiaries who have not received any primary care services from a primary care physician, use plurality of allowed charges for primary care services rendered by any other ACO professional.
Marketing guidelines	All marketing materials must be approved by CMS.	"File and use" 5 days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language.