Accountable Care Organizations: Summary and Analysis of the Final Rule

» By Kathleen Kimmel, Chief Nursing Officer
  Greg Kotzbauer, Director of Product Management
  Ken Perez, Senior Vice President of Marketing
  Dan West, Product Marketing Manager, Payer Solutions
Background

The “accountable care organization” (ACO) is a major topic of discussion in American health policy. While many definitions of an ACO have been proposed, a general consensus has emerged, defining an ACO in simple terms as a voluntary group of physicians, hospitals and other healthcare providers that is willing to assume responsibility for the quality and cost of healthcare for a clearly defined population attributed to them on the basis of patients’ use of primary care services. If the ACO meets quality benchmarks and reduces per-beneficiary spending below what would otherwise have been expected, it will receive a share of the savings.

Though the ACO label has been around since 2006, it was mentioned in numerous healthcare reform bills proposed in 2009 and was ultimately included in section 3022, the Medicare Shared Savings Program, of the Patient Protection and Affordable Care Act (ACA), which was signed into law on March 23, 2010. Section 3022 did not address many details of the program, leaving it to the Secretary of Health and Human Services (HHS) to make decisions to expand and refine the program within the context of a notice of proposed rulemaking (NPRM) procedure.


“…Medicare beneficiaries should find their care experience enhanced by a program that supports providers in engaging with their patients to deliver on the three-part aim: better care for individuals, better health for populations, and lower cost growth through improvements in care.”

Donald M. Berwick
CMS Administrator

Summary of the Final Rule

Intent

The final rule implements section 3022 of the ACA, defining how physicians, hospitals and other key constituents can participate in ACOs under the Shared Savings Program.

Organization of the Final Rule

At a high level, the final rule’s 696 pages are organized primarily into four sections.

It starts with a background section (pages 7-17) that includes an introduction to and overview of value-based purchasing, which provides the philosophical underpinnings of ACOs. The background section also covers the statutory basis for and overview and intent of the Shared Savings Program, as well as a recapitulation of high-level public comments received on the proposed rule.

The second section (pages 17-589), covering the provisions of the proposed rule, summary of and responses to public comments, and provisions of the final rule, accounts for over 80 percent of the document. As with the same section of the proposed rule, it has a “discussion” feel to it, generally presenting for each issue three items: 1) selected public comments or summaries of public comments; 2) HHS’s response to the comments; and 3) the final decision on the issue. This section covers the following provisions:

» definitions of ACO, ACO participant and ACO provider/supplier

» eligibility and governance

» establishing the agreement with the HHS Secretary (including options for the start date of the performance year, timing and process for evaluating shared savings and legal issues)
Tone of the Final Rule

In view of the continued rancor surrounding healthcare reform and the 1,320 public comments on the proposed rule—some of which were quite critical—the final rule and public announcements made by government officials about it seem to reflect a tone of accommodation and optimism. The final regulation repeatedly points out how CMS has incorporated suggestions made by the public. In the press release announcing the final rule, HHS Secretary Kathleen Sebelius stated, “We are excited to give doctors, hospitals and other providers the flexibility and support they need to work together and focus on making sure patients get the care they need.” Similarly, in his op-ed in *The New England Journal of Medicine*, Berwick expressed his hope that the changes from the proposed rule “create a more feasible and attractive on-ramp for a diverse set of providers and organizations to participate as ACOs.”

Limitations of this White Paper

Due to the length and complexity of the final rule, this white paper’s analysis is necessarily limited to the most salient elements of the final regulation. Other pertinent documents and sources of information are available via MedeAnalytics’ ACO Resource Center at www.medeanalytics.com/aco.

Definition of an ACO

The final rule defines an ACO as a legal entity that is recognized and authorized under applicable state, federal or tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one...
or more ACO participants(s) that serve to manage and coordinate care for Medicare FFS beneficiaries. An ACO must have a minimum of 5,000 Medicare FFS beneficiaries, all of whom must be enrolled under both Medicare Parts A and B, but may not be enrolled in a Medicare Advantage plan under Part C.

To be accepted as an approved ACO, the organization must have at least one approved participant, have a mechanism for shared governance and have a formal legal structure that can receive and distribute shared savings, repay shared losses to CMS and ensure providers comply with quality criteria. Furthermore, the organization must have the management and clinical administrative systems to promote evidence-based medicine, patient engagement, care coordination and patient-centered care.

Structure of an ACO

Any of the following groups who meet eligibility requirements may serve as independent ACOs or serve as a leading entity for a group of health service providers:

» ACO professionals, which include physicians (a doctor of medicine or osteopathy) and practitioners (physician assistants, nurse practitioners and clinical nurse specialists) in group practice arrangements or networks of individual practices

» Partnerships or joint venture arrangements between ACO professionals and acute hospitals paid under the inpatient prospective payment system

» Acute care hospitals employing ACO professionals

» Critical access hospitals (CAHs)

» Federally qualified health centers (FQHCs)

» Rural health clinics (RHCs)

The final rule added FQHCs and RHCs to the list, and this change means that they are able to independently form ACOs. In addition, the final rule allows an ACO to add or subtract participants during the course of the agreement period.

ACO Application Process

Section 3022 of the ACA did not mention an application process for participation in the Shared Savings Program as an ACO. Thus, the proposed rule covered it in great detail, and the final...
rule mirrors the proposed rule. The most material application requirements include:

» a description of how the ACO will partner with community stakeholders

» submission of ACO documents (e.g., participation agreements, employment contracts and operating policies) that describe the ACO participants’ and ACO providers/suppliers’ rights and obligations in the ACO, the shared savings that will encourage ACO participants and ACO providers/suppliers to adhere to the quality assurance and improvement program and the evidence-based clinical guidelines

» documents that describe the scope and scale of the quality assurance and clinical integration program

» supporting materials documenting the ACO’s organization and management structure

» evidence that the ACO has a board-certified physician as its medical director

» evidence that the governing body includes persons who represent the ACO participants, and that these ACO participants hold at least 75 percent control of the governing body

» certification by the ACO executive that the ACO participants are willing to become accountable for and to report on the quality, cost and overall care of the Medicare FFS beneficiaries assigned to the ACO

» indication how the ACO plans to use potential shared savings to meet the goals of the program

» a description of the criteria the ACO plans to employ for distributing shared savings among ACO participants and ACO providers/suppliers, and how any shared savings will be used to align with the aims of better for individuals, better health for populations, and lower growth in expenditures

» documentation 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. These plans must include how the ACO intends to support the cost of the plans and how the leadership will require ACO participants and ACO providers/suppliers to comply with and implement each process (and sub element thereof), including the remedial processes and penalties (including the potential for
expulsion) applicable to ACO participants and ACO providers/suppliers for failure to comply.

- a description of the process for evaluating the health needs of the ACO’s assigned population and how it would consider diversity in its patient population and plans to address its population needs
- a description of its individualized care program, along with a sample care plan, and explanation of how this program is used to promote improved outcomes for, at a minimum, their high-risk and multiple chronic condition patients

**Shared Governance**

The final rule maintained the requirement that an ACO must establish and maintain a governing body that has fiduciary responsibility to ACO participants and has adequate authority to execute the functions of an ACO. In defining the oversight responsibility of the governing body, the final rule expanded the body’s responsibility to not only include care delivery processes, but also processes to promote evidence-based medicine, patient engagement, reporting on quality and cost, care coordination, distribution of shared savings and the establishment of clinical and administrative systems.

As previously mentioned, the final rule maintains that ACO participants must have at least 75 percent share of the ACO’s governing body. In addition, the final rule reaffirms that ACO beneficiaries must be represented on the governing body.

**Beneficiary Assignment**

Assignment—or “alignment” as CMS commented—will be done on a step-wise basis to account for beneficiaries who receive their primary care from a clinician other than a primary care physician. CMS has defined a primary care physician (PCP) as “a physician with a primary specialty designation of general practice, family practice, internal medicine, or geriatric medicine.”

In step 1, CMS first checks to see whether a beneficiary has received primary care from a PCP affiliated with an ACO. If that has occurred, assignment is based on the plurality of allowed charges for primary care services by a PCP. If the beneficiary has not received primary care services from a PCP, then step 2 applies. In step 2, CMS first checks to see whether a beneficiary has received primary care services from any physician. If that is true, then assignment is based on the plurality of allowed charges for any qualified ACO provider/supplier,
which can include physicians, nurse practitioners, physician assistants or clinical nurse specialists. Beneficiaries who have not received primary care services from a physician are not assigned.

In the beginning, beneficiary assignment is prospective to allow the ACO to better manage its patients. The ACO can use this list to estimate its benchmark target as well as request identifiable claims data on these beneficiaries. CMS will update the assigned membership list quarterly to adjust for changes in the population, and that updated list of beneficiaries at the end of the first performance year will be used for the final determination of shared savings.

**Knowledge of Participation**

The ACO is required to notify beneficiaries at the point of care that its providers are participating in the Shared Savings Program. The ACO must post signs in its facilities indicating its participation in the program. In addition, the ACO must provide written notice to beneficiaries of its participation in the program as well as the potential that CMS may share beneficiary-identifiable data with ACOs when a beneficiary receives primary care services from an ACO physician. Beneficiaries can choose to opt out of having their data shared.

**Provision of Data**

CMS will provide all ACOs with non-identifiable, aggregate cost and use reports at the beginning of the agreement period as well as quarterly and annually. These aggregate reports will be accompanied by lists of the beneficiaries—with beneficiary names, dates of birth, sex and Medicare Health Insurance Claim Number (HICN)—used to generate the reports. Even though beneficiaries will be given the opportunity to opt out of sharing their personal health information (PHI), these aggregate reports and beneficiary lists will still include their records.

Upon submitting a data use agreement, signing the appropriate business associate agreements, and giving beneficiaries the opportunity to opt out of sharing their data, an ACO may request identifiable claims data (excepting alcohol and substance abuse) for its population as often as monthly. Given administrative data’s limited accuracy and lack of timeliness, CMS has recommended implementing robust clinical and administrative data exchange and improving communication among providers to ameliorate those concerns. CMS will not provide quarterly shared savings reports due to the delay inherent in requiring three months of run-out.
Seeking Care Outside the ACO

Beneficiaries receiving care from and assigned to an ACO may receive care outside the ACO. While CMS expects that ACO providers will refer patients to other ACO providers and within their existing contractual referral networks, ACOs may not act in ways that restrict the full range of benefits to which patients are entitled under the Medicare FFS program. Furthermore, the ACO must not restrict the exchange of summary of care information when patients transition to another provider or setting of care, even when it is outside the ACO.

Legal Issues

There was broad consensus among stakeholders that key legal guidelines in the proposed rule would prevent widespread adoption of ACOs. Specifically, many believed the statutory and regulatory requirements concerning physician self-referrals, a mandatory antitrust review prior to setup, antitrust lawsuits post-setup, and potentially negative tax code implications for tax-exempt organizations would impede ACO development. To address these concerns, CMS worked closely with the Department of Justice (DOJ), the Inspector General, the Internal Revenue Service (IRS) and the Federal Trade Commission (FTC) to remove such barriers and improve participation in the Shared Savings Program.

Self-Referrals and Kickbacks

CMS, in coordination with the Inspector General, issued five waivers to address anti-competitive statutes in the physician self-referral law, the federal anti-kickback statute, and certain civil monetary penalties laws. The specific waivers applied to these laws are:

- ACO pre-participation waiver that applies to start-up accountable care arrangements
- ACO participation waiver during the term of the ACO participation or time thereafter
- Shared savings distributions waiver for payments earned under the program
- Compliance with physician self-referral law waiver
- Patient incentive waiver for medically related incentives to encourage preventive care and treatment compliance

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**Mandatory Pre-Review**

The final rule does not require a mandatory antitrust review as a condition of entry into the Shared Savings Program. As an alternative, the DOJ and FTC offer voluntary, expedited 90-day reviews for newly formed ACOs seeking additional antitrust guidance.

**Antitrust**

The DOJ and FTC will not challenge as “per se illegal” a Shared Savings Program ACO that jointly negotiates with private insurers to serve patients in commercial markets, as long as the ACO satisfies the eligibility requirements specified by CMS. The final rule establishes a “safety zone” for certain ACOs.

**Tax Code Compliance**

In coordination with the release of the final rule, the IRS published a separate notice (Notice 2011-20) clarifying the tax code guidelines for ACOs. The key guidelines from the notice are:

1) An ACO that meets the structure requirements specified by the CMS will be treated as a separate taxable entity from its participants.

2) Tax-exempt organizations can join an ACO as long as the tax-exempt organization continues to meet the requirements for tax exemption. For example, net earnings from the ACO cannot directly benefit private shareholders or individuals of the tax-exempt organization.

3) A tax-exempt organization’s share of an ACO’s shared savings payments will not be subject to the unrelated business income tax.

4) An ACO itself may qualify as a tax-exempt organization.

**The ACO Business Proposition**

At its most basic level, this is the business proposition offered by the Shared Savings Program: An ACO will receive a share of the Medicare savings it achieves if the ACO is able to meet certain quality performance standards and generate “shareable savings” (i.e., reducing the cost of that care to a level below a benchmark, what would have been otherwise expected). This business proposition is one example of the value-based purchasing concept that rewards providers for delivering high-quality, efficient patient care.

An ACO will receive a share of the Medicare savings it achieves if the ACO is able to meet certain quality performance standards and generate “shareable savings” (i.e., reducing the cost of that care to a level below a benchmark, what would have been otherwise expected).
Patient-Centeredness

The concept of patient-centeredness underpins the final rule. This begins during the application process. As noted earlier, an ACO must provide concrete documentation in its application of its plans to evaluate the health needs of its population, communicate evidence-based medicine to beneficiaries, promote beneficiary education and engagement, internally report quality and cost metrics, and coordinate care. It must also have a qualified healthcare professional responsible for the ACO’s quality assurance and improvement program and document how it intends to partner with community stakeholders. Once implemented, an ACO must demonstrate patient-centeredness. It would accomplish this, in part, by having a beneficiary experience of care survey in place, a process for evaluating the health needs of the ACO’s assigned population, systems to identify high-risk individuals, a means of internally reporting on quality and cost metrics, a mechanism for the coordination of care, and a way for patients to access their health records. It must also include a beneficiary representative on its board.

Quality Measures

Since one of the main goals of an ACO is to achieve quality care, quality measures have been established to determine and monitor adherence in three important areas:

1) Clinical process and outcomes;
2) Patient experience of care; and
3) Utilization. (Utilization refers to rates of hospital admission for ambulatory-sensitive conditions.)

The final rule adopted fewer validated measures (33 versus 65 in the proposed rule). These measures are aligned with the three-pronged approach to encourage participation and reduce the reporting burden. In selecting the final measures, there was a clear preference for ambulatory-related measures. This is consistent with the primary care focus and the beneficiary-minded assignment used in the Shared Savings Program. The 33 final required quality measures will be scored as 23 measures. [The patient experience survey models are scored as one measure and the all-or-nothing diabetes and coronary artery disease (CAD) measures are scored as one measure each.] Regarding future changes to the current 33 measures, ACOs will be required to comply with any updates to be penned in future rulemaking. For example, the final rule specifically mentions
Meaningful Use Stage 2 measures, which are expected in 2012. The ultimate goal is to align measures across programs.

As reflected in the patient and caregiver experience measures, the final rule clearly presses for a standardized patient experience. It is expected that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) will enable better comparisons of ACOs. Also, it will ensure that the patient survey is measuring patient experience for the ACO versus a specific practice. The administration of the annual CAHPS survey will be funded for ACOs that are participating in the Shared Savings Program in 2012 and 2013. In 2014, ACOs participating in the Shared Savings Program must select a CMS-certified vendor and pay for survey administration and reporting.

The final rule mentions that it may be necessary to add or remove measures from the Shared Savings Program as CMS learns from ACO experiences and better understands the types of measures that are most relevant to assess quality of care. The close alignment of payment to reporting requirements is intended to provide a compelling incentive for accurate reporting. The quality performance standard must be met in order for the ACO to be eligible for shared savings. A process to audit quality measures data along with a certification requirement will be necessary. The audit and validation process will focus on exclusions to determine if an ACO has excluded large numbers of patients from quality reporting as a way of either avoiding reporting or attempting to show more favorable results.

Risk adjustment is included in some of the measures, such as the Ambulatory Care Sensitive Conditions (ACSC), yet is generally limited to age and gender. Also, some measures specify exclusions, such as those for hospice patients, who may be unlikely to benefit from a measure. The following ACSC measures were not finalized for quality performance purposes, but may still be considered for calculation from claims data for monitoring and informational purposes only:

- diabetes, short-term claims
- uncontrolled diabetes
- dehydration
- bacterial pneumonia
- urinary infections

The ACSC measures for chronic obstructive pulmonary disease (COPD) and heart failure are currently in the process of being finalized.
Quality measures will have a 12-month, calendar year reporting period, regardless of ACO start date. ACOs starting on either April 1, 2012 or July 1, 2012 have the option of receiving an interim payment if they report calendar year 2012 quality measures.

CMS has designated the quality performance standard for each performance year. For the first performance year of an ACO’s agreement, CMS defines the quality performance standard at the level of complete and accurate reporting for all quality measures (pay for reporting). For the second performance year, all except one of the measures will be transitioned to pay for performance. The remaining measure, Health Status/Functional Status, will be transitioned in the third performance year.

Table 1: Comparison of Final Rule’s Quality Measures with Other Quality Reporting Programs

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<table>
<thead>
<tr>
<th>Domain</th>
<th>ACO Measure Title and Description</th>
<th>AHRQ</th>
<th>HEDIS</th>
<th>Meaningful Use Stage 1</th>
<th>PQRS</th>
<th>VBP</th>
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<tr>
<td>AIM: Better Care for Individuals</td>
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<td>1 Patient/Care Giver Experience</td>
<td>Clinician/Group CAHPS: Getting Timely Care, Appointments, and Information</td>
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<td>2 Patient/Care Giver Experience</td>
<td>Clinician/Group CAHPS: How Well Your Doctors Communicate</td>
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<td>3 Patient/Care Giver Experience</td>
<td>Clinician/Group CAHPS: Patients’ Rating of Doctor</td>
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<td>4 Patient/Care Giver Experience</td>
<td>CAHPS: Access to Specialists</td>
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<td>5 Patient/Care Giver Experience</td>
<td>Clinician/Group CAHPS: Health Promotion and Education</td>
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<td>6 Patient/Care Giver Experience</td>
<td>Clinician/Group CAHPS: Shared Decision Making</td>
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<td>7 Patient/Care Giver Experience</td>
<td>Medicare Advantage CAHPS: Health Status/Functional Status</td>
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<td>8 Care Coordination/Transitions</td>
<td>Risk-Standardized, All Condition Readmissions: The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.</td>
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<td>9 Care Coordination/Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease [AHRQ Prevention Quality Indicator (PQI) #5]</td>
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<td>10 Care Coordination/Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure [AHRQ Prevention Quality Indicator (PQI) #8]</td>
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<td>11 Care Coordination/Patient Safety</td>
<td>Percent of PCPs who successfully qualify for an EHR incentive program payment</td>
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<td>12 Care Coordination/Transitions</td>
<td>Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility</td>
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<td>13 Care Coordination/Patient Safety</td>
<td>Falls: Screening for Fall Risk</td>
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<td>14 Preventive Health</td>
<td>Influenza Immunization</td>
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<td>Pneumococcal Vaccination</td>
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<td>Adult Weight Screening and Follow-up</td>
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<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
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<td>Depression Screening</td>
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<td>Colorectal Cancer Screening</td>
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<td>20 Preventive Health</td>
<td>Mammography Screening</td>
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<td>21 Preventive Health</td>
<td>Portion of Adults 18+ who have had their Blood Pressure measured within the preceding two years</td>
<td>X</td>
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<td>22 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (&lt;8%)</td>
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<td>23 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (LDL) (&lt;100)</td>
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<td>24 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Blood Pressure &gt; 140/90 mmHg</td>
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<td>25 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Tobacco Non Use</td>
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<td>26 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing): Aspirin Use: Daily Aspirin use for patients with Diabetes and Cardiovascular Disease</td>
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<td>27 At Risk Population – Diabetes</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control (&gt;9%)</td>
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<td>28 At Risk Population – Hypertension</td>
<td>Hypertension (HTN); Blood Pressure Control: Percentage of patient visits for patients aged 18 years and older 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.</td>
<td>X</td>
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<td>29 At Risk Population - Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control &lt;100mg/dl</td>
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<td>30 At Risk Population - Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
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<td>31 At Risk Population - Heart Failure</td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
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<td>32 At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol</td>
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<tr>
<td>33 At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: 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 aged 18 years and older with a diagnosis of CAD who also have Diabetes Mellitus and/or LVSD (LVEF &lt;40%) who were prescribed ACE inhibitor or ARB therapy.</td>
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</tbody>
</table>
Per Table 1, all but one of the final rule's 33 quality measures overlap with at least one of the other quality reporting programs. With the final rule's shift in focus toward ambulatory care, there is little overlap with the Hospital Value-Based Purchasing (VBP) program. The significant overlap with Agency for Healthcare Research and Quality (AHRQ) indicators, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Meaningful Use Stage 1 metrics, and Physician Quality Reporting System (PQRS) measures leverages the data that hospital providers and health plans may already be capturing, measuring, monitoring and reporting.

Of these measures, seven are collected by survey, three are calculated via claims, one is calculated from the electronic health record (EHR) incentive program data, and 22 are collected via the Group Practice Reporting Option (GPRO) Web interface. Each of the four domains—1) patient/caregiver experience, 2) care coordination/patient safety, 3) preventive health, and 4) at-risk population—will be weighted at 25 percent. A proposal is currently being finalized to set the achievement mark at 30 percent for 70 percent of the measures in each domain. A maximum of two points per measure can be earned under both the one-sided and two-sided model based on the ACO's performance. The only exception is the EHR measure, which carries double weight and is worth four points. It is important to note that EHR participation is no longer a requirement for participation, but its double-weighting reflects CMS's belief that EHR adoption is critical for long-term success in the Shared Savings Program.

Plans to incorporate PQRS reporting requirements and incentive payments under the Shared Savings Plan are in the offing.

Shared Savings and Losses

The final rule significantly improves the financial attractiveness of participating in the program and reduces the burden and cost for participating ACOs. It offers them a choice between two tracks:

**Track 1**

Under Track 1, the ACO operates under a one-sided model, with potential for only shared savings for the agreement period, which will be a minimum of three years. (The first agreement periods will start either on: 1) April 1, 2012, with a first performance year of 21 months, ending on Dec. 31, 2013 and the agreement period ending on Dec. 31, 2015; or 2) July 1, 2012, with a first performance year of 18 months, ending on Dec. 13, 2013 and the agreement period...
Accountable Care Organizations: Summary and Analysis of the Final Rule

ending on Dec. 31, 2015.) This lower-risk model provides a more feasible and attractive on-ramp for providers to participate in the program. After the ACO completes its first agreement period, it will transition to a two-sided model of shared savings and shared losses.

**Track 2**

More experienced ACOs that are ready to share in losses with greater opportunity for reward may elect to immediately enter the two-sided model. An ACO participating in Track 2 would be under the two-sided model for the agreement period. Under this model, the ACO would be eligible for higher sharing rates than would be available under the one-sided model.

**Establishing the Benchmark**

Per capita Medicare Part A and Part B benchmark expenditures constitute the target against which the ACO’s financial performance will be measured by CMS. In computing an ACO’s fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, CMS determines the per capita Parts A and B FFS expenditures that would have been assigned to the ACO in any of the three most recent years prior to the agreement period. CMS’s computation incorporates numerous adjustments and calculations, such as exclusion of indirect medical education (IME) and disproportionate share hospital (DSH) payments, separate expenditure calculations for the specific beneficiary populations of ESRD (end-stage renal disease), disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries, and changes in severity and case mix.

CMS computes a three-year risk- and growth-trend adjusted per capita expenditure amount for patient populations (taking into consideration the proportions of the aforementioned specific beneficiary populations), weighting the most recent year at 60 percent, two years ago at 30 percent and three years ago at 10 percent. Then CMS employs the national growth rate in Medicare Parts A and B expenditures for FFS beneficiaries to trend forward the fixed benchmark to generate an expenditure projection, making separate calculations for the previously mentioned specific beneficiary populations. CMS updates the historical benchmark annually for each year of the agreement period.
Track 1 Terms and Conditions

Under the one-sided model, how much the expenditure target needs to be below the expenditure projection is determined on a sliding-scale basis per a Minimum Savings Rate (MSR) table that specifies MSR tiers ranging from 3.9 percent for 5,000 beneficiaries to 2.0 percent for 60,000+ beneficiaries.

Once an ACO has surpassed its MSR and assuming it has met the quality performance standards, the ACO would share in savings of up to 50 percent of all savings under the benchmark, based on quality performance. The final sharing rate applies to an ACO’s savings on a first dollar basis. There is a maximum sharing cap of 10 percent of the ACO’s benchmark. There are no shared losses.

Track 2 Terms and Conditions

Under the two-sided model, the MSR is a flat two percent regardless of the size of the beneficiary population. The sharing rate can be as high as 60 percent based on quality performance. There is a maximum sharing cap of 15 percent of the ACO’s benchmark.

The ACO is required to share losses with the Medicare program for expenditures over the benchmark, with its portion of shared losses determined by a shared loss rate, defined as the inverse of the ACO’s sharing rate (i.e., one minus the sharing rate). The shared loss rate may not exceed 60 percent. In addition, there are limits on the amounts of losses to be shared by the ACO, in terms of percentages of the ACO’s expenditure benchmark: 5 percent in the first performance year, 7.5 percent in the second performance year, and 10 percent in the third and any subsequent performance year.

Overall Conclusions on the Financial Provisions

Per Table 2, a summary of the terms and conditions for 16 financial issues pertaining to the Track 1 or the one-sided model indicates that half of them were made more attractive to ACOs by the final rule. Similarly, for Track 2 or the two-sided model, four of 15 financial issues were made more attractive.

Relative to the proposed rule, the final rule’s most significant changes from a financial perspective were:

» The elimination of shared losses from Track 1

» Under Track 1, replacement of the two percent shared savings threshold above the MSR with first dollar sharing once the MSR is met or exceeded
Increases to the maximum sharing caps, from 7.5 to 10 percent under Track 1 and from 10 to 15 percent under Track 2

Elimination of the 25 percent performance payment withhold (in which CMS would have withheld 25 percent to any earned shared savings payment for the first two years of the agreement period, with cumulate positive balances returned to the ACO at the end of the agreement)

**Distribution of Shared Savings**

The final rule does not establish any requirements for the manner in which shared savings payments are distributed, though it does require ACOs to provide a description in their application of the criteria they plan to employ for distributing shared savings among ACO participants and ACO providers/suppliers, as well as how any shared savings will be used to support the three-part aim of better care for individuals, better health for populations, and lower cost growth through improvements in care.

Table 2: Shared Savings Program Overview

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<table>
<thead>
<tr>
<th>Issue</th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proposed</td>
<td>Final</td>
</tr>
<tr>
<td>Transition to two-sided model</td>
<td>Transition in third year of first agreement period</td>
<td>First agreement period under one-sided model. Subsequent agreement periods under two-sided model.</td>
</tr>
<tr>
<td>Benchmark</td>
<td>Option 1 reset at the start of each agreement period</td>
<td>Finalizing proposal</td>
</tr>
<tr>
<td>Adjustments for indirect medical education (IME) and disproportionate share hospital (DSH)</td>
<td>Include IME and DSH payments</td>
<td>IME and DSH excluded from benchmark and performance expenditures</td>
</tr>
</tbody>
</table>
### Table 2 Continued: Shared Savings Program Overview

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<table>
<thead>
<tr>
<th>Issue</th>
<th>One-Sided Model</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payments outside Part A and B claims excluded from benchmark and performance year expenditures</strong></td>
<td>Exclude graduate medical education (GME), PQRS, electronic prescribing (eRx), and EHR incentive payments for eligible professionals, and EHR incentive payments for hospitals</td>
<td>Finalize proposal to Exclude GME, PQRS, eRx, and EHR incentive payments for eligible professionals, and EHR incentive payments for hospitals</td>
</tr>
<tr>
<td><strong>Other adjustments</strong></td>
<td>Include other adjustment based in Part A and B claims, such as geographic payment adjustments and hospital value-based purchasing (HVBP) payments Finalizing proposal</td>
<td>Include other adjustment based in Part A and B claims, such as geographic payment adjustments and HVBP payments Finalizing proposal</td>
</tr>
<tr>
<td><strong>Maximum Sharing Rate</strong></td>
<td>Up to 52.5 percent based on the maximum quality score plus incentives for FQHC/RHC participation</td>
<td>Up to 50 percent based on the maximum quality score Finalizing proposal</td>
</tr>
<tr>
<td><strong>Quality Sharing Rate</strong></td>
<td>Up to 50 percent based on quality performance Finalizing proposal</td>
<td>Up to 60 percent based on quality performance Finalizing proposal</td>
</tr>
<tr>
<td><strong>Participation Incentives</strong></td>
<td>Up to 2.5 percentage points for inclusion of FQHCs and RHCs No additional incentives</td>
<td>Up to 5 percentage points for inclusion of FQHCs and RHCs No additional incentives</td>
</tr>
<tr>
<td><strong>Minimum Savings Rate</strong></td>
<td>2.0 percent to 3.9 percent depending on number of assigned beneficiaries Finalizing proposal based on number of assigned beneficiaries</td>
<td>Flat 2 percent Finalizing proposal</td>
</tr>
<tr>
<td><strong>Minimum Loss Rate</strong></td>
<td>2 percent Shared losses removed from Track 1 2 percent Finalizing proposal</td>
<td>2 percent Finalizing proposal</td>
</tr>
<tr>
<td><strong>Performance Payment Limit</strong></td>
<td>7.5 percent 10 percent 10 percent 15 percent</td>
<td>25 percent No withhold 25 percent No withhold</td>
</tr>
<tr>
<td><strong>Performance Payment Withhold</strong></td>
<td>25 percent No withhold 25 percent No withhold</td>
<td>25 percent No withhold</td>
</tr>
<tr>
<td><strong>Shared Savings</strong></td>
<td>Sharing above 2 percent threshold once MSR is exceeded</td>
<td>First dollar sharing once MSR is met or exceeded First dollar sharing once MSR is exceeded First dollar sharing once MSR is met or exceeded</td>
</tr>
<tr>
<td><strong>Shared Loss Rate</strong></td>
<td>One minus final sharing rate</td>
<td></td>
</tr>
<tr>
<td><strong>Loss Sharing Limit</strong></td>
<td>5 percent in first risk-bearing year (year 3)</td>
<td></td>
</tr>
</tbody>
</table>
The Advance Payment Model

Also launched on Oct. 20, 2011, the Advance Payment Model is an initiative of the Center for Medicare and Medicaid Innovation designed to provide additional financial support to physician-owned and rural providers participating in the Shared Savings Program. The Advance Payment Model will test whether and how pre-paying a portion of future shared savings could increase participation in the Shared Savings Program, and whether advance payments will expedite and enhance the efforts of ACOs to effectively coordinate care to improve quality and reduce costs.

Only two types of organizations participating in the Shared Savings Program are eligible to receive advance payments:

» ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue

» 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

ACOs which qualify for participation in the Advance Payment Model will receive three types of payments: 1) an upfront, fixed payment; 2) an upfront, variable payment; and 3) a monthly payment that will vary depending on the number of Medicare beneficiaries historically attributed to the ACO. Payments to the selected ACOs will begin at the outset of the first performance year (either April or July 2012) and conclude at the settlement scheduled at the end of that performance year. Usually, advance payments will be recouped by CMS through the ACO’s earned shared savings. An ACO that fails to complete the full agreement period and/or does not earn shared savings will be required to repay the advance payment.⁴

Estimated Overall Fiscal Impact of the Shared Savings Program

The final rule includes a regulatory impact analysis which estimates a total aggregate median impact of $470 million in net federal savings (i.e., reduced Medicare outlays) for calendar years 2012-2015. These savings are slightly less than the $510 million estimate in the proposed rule (for savings through 2014), partially due to more generous financial terms, led by first dollar sharing. More importantly, the latest savings estimate pales in comparison to the Congressional Budget Office’s estimate of $5.3 billion in net federal savings for 2010-2019 that was used to support the passage of the ACA.⁵
Estimated Average ACO Financial Returns

The regulatory impact analysis estimates that the average Shared Savings Program ACO will require a start-up investment of $580 thousand and annual operating costs of $1.26 million. Over calendar years 2012-2015, these costs total $5.62 million. The average ACO is projected to receive shared savings bonus payments of $16.4 million during that same four-year period, resulting in an estimated benefit-cost ratio of 2.9. This suggests a positive return on both the start-up investment as well as the ongoing operating costs within the term of the initial agreement period for the average ACO participating in the program.

Table 3: Proposed Rule Versus Final Rule for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program

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<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Modifications in Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition to risk in Track 1</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Prospective vs. retrospective</td>
<td>Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.</td>
<td>A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year based on patients served by the ACO.</td>
</tr>
<tr>
<td>Proposed measures to assess quality</td>
<td>65 measures in 5 domains, including patient experience of care, utilization claims–based measures, and measures assessing process and outcomes.</td>
<td>33 measures in 4 domains. (Note: Claims-based measures not finalized to be used for ACO-monitoring purposes)</td>
</tr>
<tr>
<td></td>
<td>Pay for full and accurate reporting first year, pay for performance in subsequent years.</td>
<td>Longer phase-in measures over course of agreement: first year, pay for reporting; second year and third year, pay for reporting and performance.</td>
</tr>
<tr>
<td></td>
<td>Alignment of proposed measures with existing quality programs and private-sector initiatives.</td>
<td>Finalize as proposed.</td>
</tr>
<tr>
<td>Sharing savings</td>
<td>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.</td>
<td>Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.</td>
</tr>
<tr>
<td>Sharing beneficiary ID claims data</td>
<td>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.</td>
<td>The ACO may contact beneficiaries from provided quarterly lists to notify them of data sharing and opportunity to decline.</td>
</tr>
<tr>
<td>Topic</td>
<td>Proposed Rule</td>
<td>Modifications in Final Rule</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Eligible entities</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Start date</td>
<td>Agreement for 3 years with uniform annual start date; performance years based on calendar years.</td>
<td>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 19 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 quality for first-performance-year shared savings.</td>
</tr>
<tr>
<td>Aggregate reports and preliminary prospective list</td>
<td>Reports will be provided at the beginning of each performance year and include: name, date of birth, sex, and health insurance claim number.</td>
<td>Additional reports will be provided quarterly.</td>
</tr>
<tr>
<td>Electronic health record (EHR) use</td>
<td>Aligning ACO requirements with EHR requirements, 50% of primary care physicians must be defined as meaningful users by start of second performance year.</td>
<td>No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.</td>
</tr>
<tr>
<td>Assignment process</td>
<td>One-step assignment process: 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).</td>
<td>Two-step assignment process: 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.</td>
</tr>
<tr>
<td>Marketing guidelines</td>
<td>All marketing materials must be approved by CMS.</td>
<td>“File and use” 5 days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language.</td>
</tr>
</tbody>
</table>
Initial Responses to the Final Rule by Healthcare Provider Organizations

In general, healthcare provider associations’ first reactions to the final rule were positive.

Rich Umbdenstock, president and chief executive officer of the American Hospital Association, stated, “Today’s rules represent the direction in which the hospital field is moving – toward better coordinated patient care across care settings. We commend CMS for listening to the concerns of America’s hospitals. The hospital field is actively working on ways to improve care delivery and the final accountable care organization rule provides hospitals a better path to do so.”

Similarly, Peter Carmel, president of the American Medical Association, commented, “We are pleased that the final rule on Medicare Accountable Care Organizations (ACOs) includes many of the important changes recommended by the AMA to allow all interested physicians to lead and participate in these new models of care. The AMA has stressed throughout this rule-making process that, if well-implemented, the ACO model offers promise to improve care coordination and quality while reducing costs. This final rule requires a full, in-depth review to ensure it maximizes those potential benefits for Medicare patients and physicians.”

Commending CMS for its responsiveness to suggested changes, Donald Fisher, president and chief executive officer of the American Medical Group Association, said, “We are optimistic that the model will get rolled out nationally on January 1, 2012 with sufficient participation to allow the promise of this ideal of better, less costly, more coordinated care…[to] become a reality over time.”

Finally, Glen Stream, president of the American Academy of Family Physicians, echoed the other leaders’ comments, stating, “The Medicare Accountable Care Organization final rule recently released by the Centers for Medicare & Medicaid Services represents a substantial step toward mending America’s broken healthcare system. The final rule sets the stage for transforming the way patients receive care and promises to end the fragmentation, duplication and miscommunication that contribute to poor care and high costs.”
Conclusions

The long-awaited final rule—lengthy, highly detailed and mind-numbingly complex—constitutes the end of the road for the Medicare Shared Savings Program’s rulemaking process. While the draft regulation was collaborative in tone, it faced numerous critical reviews and a large volume of recommended changes during an extremely active and engaging public comment period. While the Medicare ACO debate has seemed to go on interminably, from the passage of the ACA until the release of the final ACO rule, commercial ACOs—led largely by innovative health plans—have continued to develop and flourish.

True to CMS’s promise to give serious consideration to each and every suggestion for improvement, the final rule strikes the dual tones of accommodation and optimism. In almost every aspect of the regulation—notably with respect to quality measures and the financial models—the final rule is more generous, flexible and supportive to providers. Time will tell whether this voluntary program will regain the momentum and sense of optimism about Medicare ACOs that preceded the proposed rule.

Additional Information

For more information about ACOs, please visit MedeAnalytics’ ACO Resource Center at www.medeanalytics.com/aco, which features background information and reference materials, additional complimentary white papers, and links to leading online resources.

About MedeAnalytics

Founded in 1994, MedeAnalytics delivers performance management solutions across the healthcare system—including hospitals, physician practices and payers—to ensure accountability and improve financial, operational and clinical outcomes. The company provides the essential building blocks for both Medicare and commercial ACOs, including role-based security, clinical and administrative data exchange, data aggregation, performance management, and reporting infrastructure. For more information, visit www.medeanalytics.com.
References


