# Medicare Shared Savings Program: Accountable Care Organizations final rule

Summary

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**Background**

Sec. 3022 of the *Affordable Care Act* (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared Savings program "*by Jan. 1, 2012 that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery*". Participating entities, referred to as Medicare Accountable Care Organizations (ACOs), that meet quality and performance standards are eligible to receive payments for shared savings.

On March 31, several documents were proposed implementing Sec. 3022:

- CMS released the proposed Medicare Shared Savings Program: Accountable Care Organization;
- CMS and the Office of Inspector General released a joint notice with comment period soliciting public input on possible waivers of the Physician Self-Referral Law (Stark), Federal anti-kickback statute and certain civil monetary penalties provisions;
- The Internal Revenue Service (IRS) issued a notice soliciting comments regarding the need for additional tax guidance for tax-exempt organizations planning to participate in the Medicare Shared Savings Program through ACOs; and
- The Federal Trade Commission (FTC) and Department of Justice released an antitrust enforcement policy statement regarding the application of antitrust laws to health care collaborations among otherwise independent providers and provider groups, formed after March 23, 2010, that seek to participate or have been approved to participate as a Medicare ACO.

In response to these proposals, the AAFP:

- Created a summary of the proposed rule in early April;
- Offered extensive comments and suggestions in a May 20 letter to CMS, emphasizing the important role that primary care physician practices should play, and describing how the proposed regulations should be changed to enable that to happen;
- Responded in a May 25 letter to the FTC and Department of Justice on the proposed antitrust enforcement policy regarding the Medicare ACO program. This letter outlines concerns with antitrust barriers to physician collaboration. The letter also expresses concern that the revised policy only applies to groups integrating after March 23, 2010 and that the "rule of reason" analysis applies only to the three-year Medicare ACO program period instead of a longer timeframe; and

- Joined with presidents from the Society of Teachers of Family Medicine, the Association of Family Medicine, the Association of Family Medicine Residency Directors, and the North American Primary Care Research Group in a June 6 comment letter submitted to CMS on the proposed Medicare ACO regulation. The letter discussed concerns that the proposed Medicare ACO regulation could have significant negative effect on the Graduate Medical Education (GME) training infrastructure.

On October 20, several documents were released that finalize the proposals:

- CMS put on display the Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations final rule;
- CMS announced the Advance Payment Model which is designed for participants in the Medicare Shared Savings Program in need of prepayment of expected shared savings. It will test whether and how pre-paying a portion of future shared savings could increase participation in the Medicare Shared Savings Program, and whether advance payments will increase the amount of and speed at which ACOs can effectively coordinate care to generate Medicare savings;
- The FTC and Department of Justice issued a final Policy Statement of Antitrust Enforcement Regarding Accountable Care Organizations;
- CMS and the U.S. Department of Health & Human Services' Office of Inspector General issued an interim final rule that creates five additional waivers to provide protection from fraud and abuse laws; and
- The IRS issued a fact sheet adding a series of questions and answers to its previous guidance.

**Executive Summary**

The final rule and announcements differ significantly from the earlier proposals and reflect several AAFP recommended changes. In the final rule, CMS discusses many of the commenter found the proposed requirements to be "too prescriptive and burdensome". CMS then states their belief that "the policies in this final rule will be more attractive to participants". The final rule largely recognizes that small- to medium-sized physician practices cannot convert their administrative procedures and health record systems overnight, and the final rule is designed to provide both time and resources to make the program more attractive. On October 21, the AAFP issued a statement commending CMS for improving the rule and for announcing the Advance Payment Model. CMS accepted the AAFP suggestions to finalize policies that:

- Allow Medicare ACO participants to avoid penalties if they do not meet savings targets by eliminating all down-side risk for low-risk ACOs participating in the Track 1 option;
- Eliminate the proposed retrospective beneficiary assignment method and instead use a preliminary prospective assignment method with beneficiaries identified quarterly;
- Significantly reduce — from 65 to 33 — the number of individual quality measures used to determine if an ACO qualifies for shared savings as well as provide quality reporting requirements for years two and three of the program;
- Technically allows primary care physicians to participate in more than one Medicare ACO (Tax identification numbers remain exclusive to a single ACO, while National Provider Identifiers may be associated with more than one ACO);
- Require only a "pay for reporting" approach to quality measure reporting for Performance Year 1 and phase in over 3 years the number of "pay for performance" measures used to calculate the Medicare ACO's performance score;
- Encourage greater use of electronic health records, for overall Medicare ACO scoring purposes, by double weighting a quality measure that represents the percent of primary care providers who successfully qualify for the EHR Incentive Program payment;
- Allow Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals to participate in the program;
- Give physicians access to up-front capital through an "advanced payment" program;
- Eliminate indirect medical education (IME) and direct graduate medical education (DGME) payments from spending estimates, as requested by the AAFP and the Council of Academic Family Medicine;
- No longer require Medicare ACOs to face a mandatory antitrust review from either the FTC or Department of Justice; and
- Offer multiple start dates within 2012.

CMS envisions the final rule will help create as many as 270 Medicare ACOs, significantly more than the 75 to 150 Medicare ACOs that CMS had estimated in conjunction with the proposed regulation. This voluntary program will be implemented on January 1, 2012. Medicare ACO applications will be due after the first of the year. CMS will provide for two application periods for the first year of the Shared Savings Program:

- ACO starts April 1, 2012: First performance year is 21 months, ending on December 31, 2013. Agreement period is 3 performance years, ending on December 31, 2015.
- ACO starts July 1, 2012: First performance year is 18 months, ending on December 31, 2013. Agreement period is 3 performance years, ending on December 31, 2015.

**Medicare ACO Eligibility**

An ACO refers to a group of physicians, hospitals and other suppliers of services that will work together to provide coordinated care to Medicare beneficiaries. The statute lists the following groups of providers of services and suppliers as eligible to participate as an ACO:

- ACO professionals in group practice arrangements.
- Networks of individual practices of ACO professionals.
- Partnerships or joint venture arrangements between hospitals and ACO professionals.
- Hospitals employing ACO professionals.
- Such other groups of providers of services and suppliers as the Secretary determines appropriate.

In the final regulation, CMS reiterates that there is no requirement that an ACO include a hospital. In the final rule, CMS also used its authority expand the statutory list of eligible ACO participants to Include Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals billing under Method II.

To be eligible to participate in the Shared Savings Program, the ACO must define, establish, implement, and periodically update processes to promote patient engagement. An ACO must describe in its application how it intends to evaluate the health needs of the ACO's assigned population, communicate clinical knowledge and evidence-based medicine to beneficiaries, engage with beneficiaries in shared decision-making, provide written standards for beneficiary access and communication, and establish a process for beneficiaries to access their medical records.

CMS also finalized requirements that ACOs define their care coordination processes among primary care physicians, specialists, and acute and post-acute providers. The ACO must define its methods to manage care throughout an episode of care and during its transitions. The ACO must submit a description of its individualized care program as part of its application along with a sample care plan and explain how this program is used to promote improved outcomes for, at a minimum, their high-risk and multiple chronic condition patients.

CMS and other federal agencies did not finalize an earlier proposal that would have required ACOs to seek an antitrust review from the IRS, FTC, and Department of Justice. These agencies had proposed that ACOs seek confirmation that the antitrust agencies has, “no present intent to challenge, or recommend challenging, an ACO formed after March 23, 2010, that does not qualify for the rural exception articulated in the final Antitrust Policy Statement, and that has a Primary Service Area (PSA) share above 50 percent for any common service that two or more ACO participants provide to patients from the same PSA”. Thus, the Administration will not condition eligibility for participation in the Shared Savings Program on whether an ACO has obtained the requisite letter from the antitrust agencies, which removes a significant regulatory hurdle for prospective ACO applicants. However, the agencies discuss monitoring these policies and possibly adjusting them as more experiences are gained with the Shared Savings Program.

**Medicare ACO Structure and Governance**

A Medicare ACO is a legal entity with a shared governance structure and identified by a Taxpayer Identification Number (TIN). A Medicare ACO may be structured in a variety of ways, such as a corporation, partnership, limited liability company, foundation or other entity permitted under state law. An existing legal entity may qualify as an ACO only if it meets all requirements applicable to the Medicare ACOs, including shared governance. Medicare ACOs must be able to receive and distribute shared savings; repay shared losses; establish, report, and ensure provider compliance with health care quality criteria, including quality performance standards; and perform other ACO functions.

ACOs may be licensed under federal, state, or tribal law. An ACO formed among multiple ACO participants must provide evidence in its application that it is a legal entity separate from any of its ACO participants. CMS finalized the operational definition of an ACO as a collection of Medicare-enrolled TINs that identify and periodically update their ACO participant TINs and National Provider Identifiers (NPIs). CMS allows ACO participants and ACO providers and suppliers to be added and subtracted over the course of the agreement period if the ACO notifies CMS within 30 days of any additions or subtractions. In the event of "significant changes", defined as an event that results in an ACO being unable to meet the eligibility or program requirements of the Shared Savings Program, the ACO must also notify CMS within 30 days. Such changes may necessitate, for example, adjustments to the ACO's benchmark, but could allow the ACO to continue participating in the Shared Savings Program. Such changes may also cause the ACO to no longer meet eligibility requirements, if, for example, the ACO loses a large primary care practice that would cause the ACO assignment to fall below 5,000.

CMS finalized the requirement that the ACO's operations be managed by someone whose appointment and removal of such persons are under the control of the organization's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes, and outcomes.

CMS finalized the requirement that an ACO must maintain an identifiable governing body with authority to execute the functions of the ACO, including but not limited to, the definition of processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinating care. The governing body must have responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities. The governing body must have a transparent governing process that requires the ACOs to publically report the identity of each member of the governing body. The governing body members shall have a fiduciary duty to the ACO and must act consistent with that fiduciary duty. The ACO must have a conflicts of interest policy for the governing body. The ACO must provide for meaningful participation in the composition and control of the ACO's governing body for ACO participants or their designated representatives.

CMS proposed that each ACO participating entity type (or its representative) be on the ACO's governing body. To ensure that Medicare ACOs are primary care driven, the AAFP urged CMS to specify that Medicare ACO governance structures must utilize primary care physicians in the top leadership positions. However, citing the belief that ACOs should have flexibility to determine their management structure, CMS declined to specify additional requirements for the ACO's leadership. CMS did finalize a policy requiring a beneficiary representative on the governing body. CMS finalized the proposal that at least 75 percent of ACO participants control the Medicare ACO's governing body. CMS did not finalize the proposal that all ACO participants must have seats on the governing body; rather, CMS will require an ACO to provide for meaningful participation in the composition and control of the ACO's governing body for ACO participants or their designated representatives.

CMS proposed that ACOs include a full time senior-level medical director with responsibility for clinical management and oversight. Noting that this physician level position is important for ACOs to achieve their goals, CMS concluded in the final rule that the requirement could pose a financial burden for small or rural Medicare ACOs. As such, CMS eliminated the full time requirement and instead will require the clinical management and oversight be managed by a senior-level medical director who is one of the ACO's physicians, who is physically present on a regular basis in an established ACO location, and who is a board-certified physician and licensed in one of the states in which the ACO operates.

CMS previously proposed that ACOs include a physician-directed quality assurance and process improvement committee. CMS eliminated this requirement in the final rule, concluding that its inclusion could be unduly onerous in rural areas. Instead, an ACO application must describe how the ACO will establish and maintain an ongoing quality assurance and improvement program, led by an appropriately qualified health care professional. In addition, all ACO participants must demonstrate a meaningful commitment to the mission of the ACO. A meaningful commitment can be shown when ACO participants and ACO providers and suppliers agree to comply with and implement the ACO's processes and are held accountable for meeting the ACO's

performance standards. As part of their applications, ACOs must submit certain documentation regarding their leadership and management structures, including clinical and administrative systems, money and time to ensure that the ACO meets the eligibility requirements.

**Shared Savings Methodology**
Providers and suppliers participating in a Medicare ACO will continue to receive traditional Medicare fee-for-service payments under Medicare Parts A and B and also will be eligible to receive a portion of the shared savings if successfully satisfying quality performance standards and reducing health care costs.

CMS finalized the proposal requiring Medicare ACOs to provide a description in their application of the criteria they plan to employ for distributing shared savings among ACO participants and how these shared savings will be used to align with the three-part aim (better care for individuals, better health for populations, and lower growth in Medicare Parts A and B expenditures.) CMS will make any shared savings payments directly to the ACO as identified by its TIN.

CMS did not include the proposal to require a 25 percent withhold of any shared savings realized to offset any future losses or to be forfeited if an ACO fails to complete the terms of its agreement. For the first year (CY 2012) of the Shared Savings Program, ACOs will be afforded the flexibility to begin participation in the program on April 1 (resulting in an agreement period of 3 performance years with the first performance year of the agreement consisting of 21 months) or July 1 (resulting in an agreement period of 3 years with the first performance year of the agreement consisting of 18 months). During all calendar years of the agreement period, including the partial year associated with both the April 1, 2012 and July 1, 2012 start dates, the eligible providers participating in an ACO that meets the quality performance standard but does not generate shareable savings will qualify for a PQRS incentive payment.

CMS finalized a policy of using 3 months of claims run-out data, with the application of an appropriate completion percentage, to calculate the benchmark and per capita expenditures for the performance year. CMS will monitor ACO providers and suppliers for any deliberate delay in submission of claims that would result in an unusual increase in the claims incurred during the performance year, but submitted after the 3 month run-out period immediately following each performance year. CMS will consider such deliberate behavior grounds for termination.

CMS finalized the proposal that bases the Shared Savings Program on existing fee-for-service payments, offering ACOs a choice between a shared savings only (Track 1) approach or a shared savings and losses approach (Track 2). CMS modified Track 1 so that it will be a shared savings only model for the duration of the ACO's first agreement period. CMS finalized the proposal that ACOs electing Track 2 will be under the two-sided model for the duration of their first agreement period. CMS also finalized the requirement that all ACOs must participate in the two-sided model in agreement periods subsequent to the initial agreement period. CMS will allow continued participation by ACOs electing to do so who experience a net loss during their first agreement period. Specifically, CMS requires ACOs, which experience a net loss in their initial agreement period and apply to participate in a subsequent agreement period, to identify in their application the cause(s) for the net loss and to specify what safeguards are in place to enable the ACO to potentially achieve savings in its next agreement period.

CMS will establish an ACO's initial benchmark based on the Parts A and B fee-for-service expenditures of beneficiaries who would have been assigned to the ACO in any of the 3 years prior to the start of an ACO's agreement period using the ACO participants' TINs identified at the start of the agreement period. CMS will calculate benchmark expenditures by categorizing beneficiaries in the following cost categories, in the order in which they appear: End Stage Renal Disease, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries. This benchmarking methodology will apply to all ACOs, including those consisting of FQHCs or RHCs (either independently or in partnership with other eligible entities). CMS will truncate an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each benchmark and performance year; weight the most recent year of the benchmark, BY3, at 60 percent, BY2 at 30 percent and BY1 at 10 percent; and reset the benchmark at the start of each

agreement period. Further, CMS will use a 3-month run-out of claims data and a completion factor to calculate benchmark expenditures.

CMS will use a sliding scale, based on the size of the ACO's assigned population, to establish the Minimum Savings Rate (MSR) for ACOs participating under the one-sided model. See Table 6. CMS will apply a flat 2 percent MSR to all ACOs participating under Track 2. Per Table 7, CMS will not impose a sliding scale-based increase in the shared savings rate, up to 2.5 additional percentage points under Track 1 and up to 5 additional percentage points under the two-sided model, for ACOs that include an FQHC or RHC as an ACO participant.

CMS eliminated the 2 percent net sharing rate and will allow for sharing on first dollar savings for ACOs under the one-sided model once savings meet or exceed the MSR. CMS similarly allows sharing on a first dollar savings for ACOs under the two-sided model once savings meet or exceed the MSR.

CMS raised the payment limit from 7.5 percent to 10 percent of an ACO's updated benchmark for ACOs under the one-sided model and raised the payment limit from 10 percent to 15 percent of an ACO's updated benchmark for ACOs that elect the two-sided model. CMS also finalized that the amount of shared losses for which an eligible ACO is liable may not exceed the following percentages of its updated benchmark: 5 percent in the first performance year of participation in a two-sided model under the Shared Savings Program, 7.5 percent in the second performance year, and 10 percent in the third performance year. Because CMS eliminated the requirement for ACOs under the one-sided model to accept risk in their third performance year, it did not finalize the provision regarding the limits on shared losses for ACOs transitioning from the one-sided to two-sided model.

CMS will allow ACOs flexibility to specify their preferred method for repaying potential losses, and how that would apply to ACO participants and ACO providers and suppliers. During the application process and annually, each ACO under the two-sided model will be required to demonstrate that it is has established a repayment mechanism. One-sided model ACOs requesting interim payment must make a similar demonstration at the time of application. CMS will determine the adequacy of an ACO's repayment mechanism prior to the start of each year under the two-sided model. CMS requires that the repayment mechanism must be sufficient to ensure repayment of potential losses equal to at least 1 percent of total per capita Medicare Parts A and B fee-for-service expenditures for assigned beneficiaries based either on expenditures for the most recent performance year or expenditures used to establish the benchmark. To the extent that an ACO's repayment mechanism does not enable CMS to fully recoup the losses for a given performance year, CMS will not carry forward unpaid losses into subsequent performance years and agreement periods.

CMS will enable ACOs with start dates of April 1 and July 1, 2012, to opt for an interim payment calculation, to determine shared savings and losses, at the end of their first 12 months of program participation. For ACOs with start dates of April 1 or July 1, 2012, reconciliation for the first performance year will occur after the completion of the ACO's first performance year, defined as 21 months for April 1 starters and 18 months for July 1 starters. ACOs must indicate in their application whether they are requesting an interim payment calculation. ACOs that opt for interim payment during their first performance year must demonstrate as part of their application that they have an adequate repayment mechanism in place, consistent with the requirements for two-sided model ACOs in this final rule. ACOs that generate shared losses under the interim payment calculation must repay such losses within 90 days of notification of losses. Further, any monies determined to be owed by an ACO after first year reconciliation, whether as a result of additional shared losses or an overpayment of shared savings, must be repaid to CMS, in full, within 90 days of receipt of notification.

As requested by the AAFP and Council of Academic Family Medicine (CAFM), CMS recognized the role of teaching hospitals in providing high quality, medically necessary care to beneficiaries and will exclude Indirect Medical Education and Direct Graduate Medical Education payments from ACO benchmark and performance year expenditures.

**Role of Quality Measures**

As advocated by the AAFP, CMS drastically reduced the 65 proposed quality measures to 33 quality measures. See Table 1 in the appendix. ACOs will be required to completely and accurately report on all 33 measures in each performance year of their agreement period. CMS also defined the quality performance for

the first year to be “pay for reporting” while subsequent years to be “pay for performance”, as outlined in Table 2. All 33 measures used for scoring purposes will be “pay for reporting” in year 1 of the agreement. In year 2, 8 measures will continue to be pay for reporting, while 25 measures will be used for pay for performance. In year 3 (and 4 if applicable), 32 measures will be pay for performance and 1 measure, the health status/functional status module, will be pay for reporting.

Of the 33 final measures, 7 are collected by means of a patient survey, 3 are calculated from claims, one is calculated from EHR Incentive Program data, and 22 are collected via the Group Practice Reporting Option (GPRO) web interface. The GPRO web interface evolved from a tool used for the Physician Group Practice demonstration, was further refined by the Medicare Care Management Performance demonstration, and had 35 large group practices use it as part of the 2010 Physician Quality Reporting System (PQRS).

The AAFP called on CMS to remove hospital-based measures since a hospital is not required to be part of the Medicare ACO. In response, CMS removed the hospital patient safety measures from the final measures set, though CMS noted they will use claims-based hospital measures as part of their ACO monitoring efforts. Detailed measure specifications, including the measure title, for the 2012 Shared Savings Program quality measures will be made available during the 4th quarter of 2011 or 1st quarter of 2012.

Since CMS hopes ACOs will have robust EHR capabilities, it finalized one quality measure that rewards and encourages greater EHR use, which is the percent of primary care providers who successfully qualify for an (Medicare or Medicaid) EHR Incentive Program payment. CMS will also double weight this measure for scoring purposes as well as for determining poor performance, to reflect the importance of HIT in redesigning care, providing practitioners actionable information at the point of care, and aligning incentives and encouraging broader EHR adoption.

CMS finalized the policy to use survey-based measures, claims and administrative data based measures, and the GPRO web interface as a means of ACO quality data reporting for measures listed in Table 1. For the ACO GPRO measures, CMS finalized the policy to use the same sampling method used in the 2011 PQRS GPRO I. CMS also finalized the right to validate the data ACOs enter into the GPRO web interface.

CMS requires that each eligible professional in a Medicare ACO meet the criteria for satisfactory reporting by reporting data on all of the final ACO GPRO measures, but CMS did not finalize the proposal to condition the PQRS incentive payment on the reporting of all of the other ACO quality measures under the Shared Savings Program. That is, if an ACO, on behalf of its participants, satisfactorily reports ACO GPRO measures, the ACO participant’s TIN will receive the PQRS incentive even if the ACO does not meet the quality performance standards and lower growth in costs requirements to share in savings under the Shared Savings Program. ACOs that start their agreement in April or July 2012 will also qualify for the 2012 PQRS incentive under the Shared Savings Program by satisfactorily reporting the ACO GPRO measures for the full 2012 PQRS calendar year reporting period.

The minimum attainment level for a measure is finalized at a national flat percent or, where applicable, the national 30th percentile level of performance of fee-for-service or Medicare Advantage quality rates. With the first year of the agreement period being “pay for reporting” only, ACOs would earn their maximum sharing rate for completely and accurately reporting 100 percent of the required data. CMS plans to release performance benchmarks in further guidance at the start of the second year of the performance period so that ACOs are aware of the actual performance rates they will need to achieve to earn the maximum quality points under each domain.

CMS finalized the policy to weight each of the 4 measure domains (patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population) equally at 25 percent for purposes of determining an ACO's overall quality performance score. CMS requires that ACOs achieve the quality performance standard on 70 percent of the measures in each domain. If an ACO fails to achieve the quality performance standard on at least 70 percent of the measures in each domain, CMS will place the ACO on a corrective action plan and re-evaluate the following year. If the ACO continues to underperform in the following year, the agreement would be terminated. This approach means that an ACO could fail one or more individual measures in each domain measure and still earn shared savings. ACOs must achieve the minimum attainment

level on at least 70 percent of the measures in each domain in order to continue in the program. However, in any year that an ACO scores a zero for an entire measure domain, it would not be eligible to share in any savings generated. If an ACO fails to report completely and accurately the EHR measure, the ACO would miss the 70 percent cut-off for the Care Coordination domain, since this measure is double-weighted for both scoring purposes and for purposes of determining poor performance. CMS also finalized the proposal that if an ACO fails to report one or more measures, it would send the ACO a written request to submit the required data by a specified date and to provide reasonable explanation for its delay in reporting the required information. If the ACO fails to report by the requested deadline or does not provide a reasonable explanation for delayed reporting, CMS would immediately terminate the ACO for failing to report quality measures. ACOs that exhibit a pattern of inaccurate or incomplete reporting or fail to make timely corrections following notice to resubmit may be terminated from the program. An ACO that has been terminated from the program is disqualified from sharing in savings.

**Role of Primary Care**

The Medicare Shared Savings Program is a voluntary program for primary care providers. As directed by the *Affordable Care Act*, ACOs must "*include primary care ACO professionals that are sufficient for the number of Medicare fee for-service beneficiaries assigned to the ACO*" and "*at a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it*".

For purposes of the Medicare Shared Savings Program, a "primary care physician" is defined as a physician who has a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, a physician included in an attestation by the ACO.

Largely following Section 5501 of the *Affordable Care Act*, which established the Primary Care Incentive Program, CMS finalized the definition of "primary care services" as the set of services identified by the following HCPCS codes:

(1) 99201 through 99215.
(2) 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits);
(3) Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

Under the proposed rule, Medicare ACO primary care providers on which beneficiary assignment is based would have been exclusive to one Medicare ACO agreement, although other ACO participants (e.g., hospitals, specialists) could participate in multiple ACOs. The AAFP strongly urged CMS to allow primary care physicians, specialty physicians, and other healthcare professionals to have the option to participate in multiple ACOs if they have multiple TINs. Instead CMS finalized policy that each ACO participant TIN is required to commit to an agreement and each ACO participant TIN upon which beneficiary assignment depends must be exclusive to one ACO for purposes of the Shared Savings Program. ACO participant's TINs upon which beneficiary assignment is not dependent are not required to be exclusive to a single ACO for purposes for the Shared Savings Program. While this technically allows primary care physicians to participate in multiple Medicare ACOs, this approach is only practical for primary care physicians that are willing and able to bill under multiple TINs. CMS states that "*exclusivity of an ACO participant leaves individual NPIs free to participate in multiple ACOs if they bill under several different TINs*". The final regulation also indicates that "*solo practitioners who have joined an ACO as an ACO participant and upon whom assignment is based may move during the agreement period, they may not participate in another ACO for purposes of the Shared Savings Program unless they will be billing under a different TIN in that ACO*".

CMS cites concerns, especially in certain areas with shortages of primary care physicians, that the proposed method to assign beneficiaries to the Medicare ACO based on the plurality of primary care services performed by primary care physicians might not adequately account for primary care services delivered by specialists. CMS adopted "*a more balanced assignment process that simultaneously maintains the primary care-centric approach of our proposed approach to beneficiary assignment, while recognizing the necessary and appropriate role of specialists in providing primary care services*". CMS finalized the proposal to adopt a plurality rule as the basis for assignment as adoption of a majority standard for assignment might result in the assignment of fewer beneficiaries to each ACO.

Therefore in the final rule, CMS states the Medicare ACOs will employ a stepwise approach as the basic beneficiary assignment methodology. Under this approach:

- Step 1: CMS identifies beneficiaries who had received at least one primary care service from a primary care physician who is a provider or supplier in an ACO. In this step, a beneficiary can be assigned to an ACO only if he or she has received at least one primary care service from a primary care physician who is an ACO provider or supplier during the most recent year (for purposes of preliminary prospective assignment), or the performance year (for purposes of final retrospective assignment). If this condition is met, the beneficiary will be assigned to the ACO if the allowed charges for primary care services furnished by primary care physicians who are providers or suppliers of that ACO are greater than the allowed charges for primary care services furnished by primary care physicians who are providers or suppliers of other ACOs, and greater than the allowed charges for primary care services provided by primary care physicians who are unaffiliated with any ACO (identified by Medicare-enrolled TINs or other unique identifiers, as appropriate).
- Step 2: Beneficiaries who have not received any primary care services from a primary care physician either inside or outside the ACO will be assigned to an ACO only if he or she has received at least one primary care service from any physician (regardless of specialty) in the ACO during the most recent year (for purposes of preliminary prospective assignment), or the performance year (for purposes of final retrospective assignment). If this condition is met, the beneficiary will be assigned to an ACO if the allowed charges for primary care services furnished by ACO professionals who are ACO providers or suppliers of that ACO (including specialist physicians, NPs, PAs, and CNSs), are greater than the allowed charges for primary care services furnished by ACO professionals who are ACO providers or suppliers of each other ACO, and greater than the allowed charges for primary care services furnished by any other physician, NP, PA, or CNS, (identified by Medicare-enrolled TINs or other unique identifiers, as appropriate) who is unaffiliated with any ACO.

ACOs that include FQHCs or RHCs are required to provide, through an attestation, a list of the physician NPIs that provide direct patient primary care services in an FQHC or RHC. This attestation will be part of the application process for all ACOs that include FQHCs or RHCs as ACO participants. CMS will then use the combination of the ACO's TINs and the provided NPIs through the attestation process to identify beneficiaries who receive a primary care service in an FQHC or RHC from a physician, and to assign those beneficiaries to the ACO if they received the plurality of their primary care services, based on allowed charges for the HCPCS codes and revenue center codes listed in the definition of primary care services, from ACO providers or suppliers.

Since CMS hopes ACOs have robust EHR capabilities, CMS finalized one quality measure that rewards and encourages greater EHR use, which is the percent of primary care providers who successfully qualify for an (Medicare or Medicaid) EHR Incentive Program payment. CMS will also double weight this measure for scoring purposes as well as for determining poor performance to reflect the importance of HIT for ACOs to redesign care, provide practitioners actionable information at the point of care, and to align incentives and encourage broader EHR adoption.

**Involvement of Medicare Beneficiaries in an ACO**

Participation of Medicare beneficiaries in a Medicare ACO is voluntary and there is no enrollment of beneficiaries in the Medicare ACO. Medicare beneficiaries will be able to receive care outside of the Medicare ACO at no penalty to the patient. Medicare ACOs may not require patients to actively choose a primary care physician. Under a statutory requirement, "*at a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it*".

CMS refers to "beneficiary assignment" as an operational term needed to determine whether a beneficiary received a sufficient level of requisite services from physicians associated with a specific Medicare ACO. CMS finalized the proposal concerning the eligibility of Medicare fee-for-service beneficiaries for assignment to an ACO under the Shared Savings Program. Specifically, only individuals enrolled in the original Medicare fee-for-service program under Parts A and B are eligible. Individuals enrolled in Medicare Advantage plans under Part C, an eligible HMO organization under section 1876, or a PACE program cannot be assigned to an ACO.

Medicare ACOs must notify patients that they are participating in an ACO. ACO participants are required to post signs in their facilities indicating their associated ACO provider's or supplier's participation in the Shared Savings Program and to make available standardized written notices developed by CMS to Medicare fee-for-service beneficiaries whom the ACO serves. All standardized written information provided by CMS will be in compliance with the Plain Writing Act of 2010 and must be furnished in settings in which fee-for-service beneficiaries are receiving primary care services. In instances where either an ACO does not renew its agreement or an ACO's participation agreement is terminated, ACOs will not be required to provide beneficiaries notice that the ACO, its ACO participants and its ACO providers or suppliers will no longer be participating in the Shared Savings Program.

CMS will allow the Medicare ACO the option of contacting beneficiaries from the list of preliminary prospectively assigned beneficiaries in order to notify them of the ACO's participation in the program and the Medicare ACO's intent to request from CMS the beneficiaries' identifiable data. If, after a period of 30 days from the date the ACO provides such notification, neither the ACO nor CMS has received notification from the beneficiary to decline data sharing, the ACOs would be able to request beneficiary identifiable data. The ACO would be responsible for repeating the notification and opportunity to decline sharing information during the next face-to-face encounter with the beneficiary in order to ensure transparency, beneficiary engagement, and meaningful choice. If a beneficiary declines to have the individual's claims data shared with the ACO, this does not preclude physicians from sharing medical record information as allowed under HIPAA among themselves. For example, a referring primary care physician may provide medical record information to a specialist.

The AAFP strongly opposed the CMS proposal to utilize a retrospective beneficiary assignment method. Fortunately, CMS acknowledged this limitation and instead will use a prospective beneficiary assignment method. CMS will provide the ACO with a list of beneficiary names, dates of birth, sex, and Health Insurance Claim number (HCIN) derived from the beneficiaries whose data was used to generate the preliminary prospective aggregate reports. CMS will provide for prospective assignment of beneficiaries to ACOs in a preliminary manner at the beginning of a performance year based on most recent data available. Assignment will be updated quarterly based on the most recent 12 months of data. Final assignment is determined after the end of each performance year based on data from that year.

**Advance Payment Model**

The Advance Payment model is intended to provide additional support to physician-owned and rural providers participating in the Medicare Shared Savings Program who also would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems. The advance payments would be recovered from any future shared savings achieved by the Accountable Care Organization.

Under the Advance Payment ACO Model, participating ACOs will receive three types of payments:

- Each ACO will receive an upfront fixed payment.
- Each ACO will receive an upfront payment based on the number of its historically-assigned beneficiaries.
- Each ACO will receive a monthly payment based on the number of its historically assigned beneficiaries.

The Advance Payment ACO Model is open only to two types of organizations participating in the Shared Savings Program:

- 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.

Only ACOs that enter the Shared Savings Program in April 2012 or July 2012 will be eligible for advance payments. ACOs that are co-owned with a health plan will be ineligible, regardless of whether they also fall into one of the above categories.

Organizations applying for the Advance Payment Model must complete applications for both the Shared Savings Program and the Advance Payment Model. Both applications must be submitted by deadlines

consistent with the Shared Savings Program. CMS will accept applications to participate in the Medicare Shared Savings Program in late 2011.

**Overlap with other CMS Shared Savings Initiatives**
The statute includes a provision that precludes participation in other initiatives involving shared savings. CMS identified several programs or demonstrations that include a shared savings component and thus participation in the following prohibits participation in the Shared Savings Program:

- The Independence at Home Medical Practice Demonstration program;
- Medicare Health Care Quality (MHCQ) Demonstration Programs;
  - Indiana Health Information Exchange (IHIE)
  - North Carolina Community Care Network (NCCCN),
- Multipayer Advanced Primary Care Practice (MAPCP) demonstration;
- The Physician Group Practice (PGP) Transition Demonstration;
- Care Management for High-Cost Beneficiaries Demonstrations;
- The Pioneer ACO Model; and the
- Comprehensive Primary Care Initiative.

CMS indicates that there may be other demonstrations or programs that will be implemented or expanded as a result of the *Affordable Care Act* and that the agency will update its list of duplicative shared savings efforts periodically to inform prospective Shared Savings Program participants.

**Further Information**
The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association support the establishment of ACOs within public and private settings that are consistent with these principles.

The AAFP created a Practice Affiliation Options website for members only, containing resources for family physicians regarding ACOs, including:

- The Family Physician Practice Affiliation Guide
- The Family Physician's ACO Blueprint for Success - Preparing Family Medicine for the Approaching Accountable Care Era
- Resources for Employed Physicians
- State Restrictions on Owning a Practice
- Interested in ACOs?
- Other Practice Affiliation Options

CMS created a website dedicated to the shared savings program and released several educational materials.

**Table 1 Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings**

| | Domain | Measure Title | NQF Measure #/ Measure Steward | Method of Data Submission | Pay for Performance Phase In R = Reporting P=Performance | | |
|---|---|---|---|---|---|---|---|
| | | | | | Performance Year 1 | Year 2 | Year 3 |
| **AIM: Better Care for Individuals** | | | | | | | |
| 1. | Patient/Caregiver Experience | CAHPS: Getting Timely Care, Appointments, and Information | NQF #5, AHRQ | Survey | R | **P** | **P** |
| 2. | Patient/Caregiver Experience | CAHPS: How Well Your Doctors Communicate | NQF #5 AHRQ | Survey | R | **P** | **P** |
| 3. | Patient/Caregiver Experience | CAHPS: Patients' Rating of Doctor | NQF #5 AHRQ | Survey | R | **P** | **P** |
| 4. | Patient/Caregiver Experience | CAHPS: Access to Specialists | NQF #5 AHRQ | Survey | R | **P** | **P** |
| 5. | Patient/Caregiver Experience | CAHPS: Health Promotion and Education | NQF #5 AHRQ | Survey | R | **P** | **P** |
| 6. | Patient/Caregiver Experience | CAHPS: Shared Decision Making | NQF #5 AHRQ | Survey | R | **P** | **P** |
| 7. | Patient/Caregiver Experience | CAHPS: Health Status/Functional Status | NQF #6 AHRQ | Survey | R | R | R |
| 8. | Care Coordination/ Patient Safety | Risk-Standardized, All Condition Readmission* | NQF #TBD CMS | Claims | R | R | **P** |
| 9. | Care Coordination/ Patient Safety | Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator (PQI) #5) | NQF #275 AHRQ | Claims | R | **P** | **P** |
| 10. | Care Coordination/ Patient Safety | Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 ) | NQF #277 AHRQ | Claims | R | **P** | **P** |
| 11. | Care Coordination/ Patient Safety | Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment | CMS | EHR Incentive Program Reporting | R | **P** | **P** |
| 12. | Care Coordination/ Patient Safety | Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility | NQF #97 AMA-PCPI/NCQA | GPRO Web Interface | R | **P** | **P** |
| 13. | Care Coordination/ Patient Safety | Falls: Screening for Fall Risk | NQF #101 NCQA | GPRO Web Interface | R | **P** | **P** |
| AIM: Better Health for Populations | | | | | | | |
| 14. | Preventive Health | Influenza Immunization | NQF #41 AMA-PCPI | GPRO Web Interface | R | **P** | **P** |

| | Domain | Measure Title | NQF Measure #/ Measure Steward | Method of Data Submission | Pay for Performance Phase In R = Reporting P=Performance | | |
|---|---|---|---|---|---|---|---|
| | | | | | Performance Year 1 | Year 2 | Year 3 |
| 15. | Preventive Health | Pneumococcal Vaccination | NQF #43 NCQA | GPRO Web Interface | R | **P** | **P** |
| 16. | Preventive Health | Adult Weight Screening and Follow-up | NQF #421 CMS | GPRO Web Interface | R | **P** | **P** |
| 17. | Preventive Health | Tobacco Use Assessment and Tobacco Cessation Intervention | NQF #28 AMA-PCPI | GPRO Web Interface | R | **P** | **P** |
| 18. | Preventive Health | Depression Screening | NQF #418 CMS | GPRO Web Interface | R | **P** | **P** |
| 19. | Preventive Health | Colorectal Cancer Screening | NQF #34 NCQA | GPRO Web Interface | R | R | **P** |
| 20. | Preventive Health | Mammography Screening | NQF #31 NCQA | GPRO Web Interface | R | R | **P** |
| 21. | Preventive Health | Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years | CMS | GPRO Web Interface | R | R | **P** |
| 22. | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent) | NQF #0729 MN Community Measurement | GPRO Web Interface | R | **P** | **P** |
| 23. | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100) | NQF #0729 MN Community Measurement | GPRO Web Interface | R | **P** | **P** |
| 24. | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90 | NQF #0729 MN Community Measurement | GPRO Web Interface | R | **P** | **P** |
| 25. | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Tobacco Non Use | NQF #0729 MN Community Measurement | GPRO Web Interface | R | **P** | **P** |
| 26. | At Risk Population - Diabetes | Diabetes Composite (All or Nothing Scoring): Aspirin Use | NQF #0729 MN Community Measurement | GPRO Web Interface | R | **P** | **P** |
| 27. | At Risk Population - Diabetes | Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) | NQF #59 NCQA | GPRO Web Interface | R | **P** | **P** |
| 28. | At Risk Population - Hypertension | Hypertension (HTN): Blood Pressure Control | NQF #18 NCQA | GPRO Web Interface | R | **P** | **P** |

| | Domain | Measure Title | NQF Measure #/ Measure Steward | Method of Data Submission | Pay for Performance Phase In R = Reporting P=Performance | | |
|---|---|---|---|---|---|---|---|
| | | | | | Performance Year 1 | Year 2 | Year 3 |
| 29. | At Risk Population – Ischemic Vascular Disease | Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 mg/dl | NQF #75 NCQA | GPRO Web Interface | R | **P** | **P** |
| 30. | At Risk Population – Ischemic Vascular Disease | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic | NQF #68 NCQA | GPRO Web Interface | R | **P** | **P** |
| 31. | At Risk Population - Heart Failure | Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | NQF #83 AMA-PCPI | GPRO Web Interface | R | R | **P** |
| 32. | At Risk Population – Coronary Artery Disease | Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol | NQF #74 CMS (composite) / AMA-PCPI (individual component) | GPRO Web Interface | R | R | **P** |
| 33. | At Risk Population – Coronary Artery Disease | 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) | NQF # 66 CMS (composite) / AMA-PCPI (individual component) | GPRO Web Interface | R | R | **P** |

*We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.

**Table 2: ACO Agreement Period Pay for Performance Phase-In Summary**

| | Performance Year 1 | Performance Year 2 | Performance Year 3 |
|---|---|---|---|
| **Pay for Performance** | 0 | 25 | 32 |
| **Pay for Reporting** | 33 | 8 | 1 |
| **Total** | 33 | 33 | 33 |

**Table 3: Sliding Scale Measure Scoring Approach**

| ACO Performance Level | Quality Points (all measures except EHR) | EHR Measure Quality Points |
|---|---|---|
| 90+ percentile FFS/MA Rate or 90+ percent | 2 points | 4 points |
| 80+ percentile FFS/MA Rate or 80+ percent | 1.85 points | 3.7 points |
| 70+ percentile FFS/MA Rate or 70+ percent | 1.7 points | 3.4 points |
| 60+ percentile FFS/MA Rate or 60+ percent | 1.55 points | 3.1 points |
| 50+ percentile FFS/MA Rate or 50+ percent | 1.4 points | 2.8 points |
| 40+ percentile FFS/MA Rate or 40+ percent | 1.25 points | 2.5 points |
| 30+ percentile FFS/MA Rate or 30+ percent | 1.10 point | 2.2 points |
| <30 percentile FFS/MA Rate or <30 percent | No points | No points |

**Table 4: Total Points for Each Domain within the Quality Performance Standard**

| Domain | Total Individual Measures (Table F1) | Total Measures for Scoring Purposes | Total Potential Points Per Domain | Domain Weight |
|---|---|---|---|---|
| Patient/Caregiver Experience | 7 | 1 measure with 6 survey module measures combined, plus 1 individual measure | 4 | 25% |
| Care Coordination/ Patient Safety | 6 | 6 measures, plus the EHR measure double-weighted (4 points) | 14 | 25% |
| Preventative Health | 8 | 8 measures | 16 | 25% |
| At Risk Population | 12 | 7 measures, including 5 component diabetes composite measure and 2 component CAD composite measure | 14 | 25% |
| **Total** | **33** | **23** | **48** | **100%** |

## TABLE 5. SHARED SAVINGS PROGRAM OVERVIEW

| | One-Sided Model | | Two-Sided Model | |
|---|---|---|---|---|
| **Issue** | **Proposed** | **Final** | **Proposed** | **Final** |
| Transition to Two-Sided Model | Transition in third year of first agreement period | First agreement period under one-sided model. Subsequent agreement periods under two-sided model | Not Applicable | Not Applicable |
| Benchmark | Option 1 reset at the start of each agreement period. | Finalizing proposal | Option 1 reset at the start of each agreement period. | Finalizing proposal. |
| Adjustments for health status and demographic changes | Benchmark expenditures adjusted based on CMS-HCC model. | Historical benchmark expenditures adjusted based on CMS-HCC model. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries (using demographic factors alone unless CMS-HCC risk scores result in a lower risk score). Updated benchmark adjusted relative to the risk profile of the performance year. | Benchmark expenditures adjusted based on CMS-HCC model. | Historical benchmark expenditures adjusted based on CMS-HCC model. Performance year : newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries (using demographic factors alone unless CMS-HCC risk scores result in a lower risk score). Updated benchmark adjusted relative to the risk profile of the performance year. |
| Adjustments for IME and DSH | Include IME and DSH payments | IME and DSH excluded from benchmark and performance expenditures | Include IME and DSH payments | IME and DSH excluded from benchmark and performance expenditures |

| | One-Sided Model | | Two-Sided Model | |
|---|---|---|---|---|
| **Issue** | **Proposed** | **Final** | **Proposed** | **Final** |
| Payments outside Part A and B claims excluded from benchmark and performance year expenditures; | Exclude GME, PQRS, eRx, and EHR incentive payments for eligible professionals, and EHR incentive payments for hospitals | Finalize proposal | Exclude GME, PQRS, eRx, and EHR incentive payments for eligible professionals, and EHR incentive payments for hospitals | Finalize proposal |
| Other adjustments | Include other adjustment based in Part A and B claims such as geographic payment adjustments and HVBP payments | Finalize proposal | Include other adjustment based in Part A and B claims such as geographic payment adjustments and HVBP payments | Finalize proposal |
| Maximum Sharing Rate | Up to 52.5 percent based on the maximum quality score plus incentives for FQHC/RHC participation | Up to 50 percent based on the maximum quality score | Up to 65 percent based on the maximum quality score plus incentives for FQHC/RHC participation | Up to 60 percent based on the maximum quality score |
| Quality Sharing Rate | Up to 50 percent based on quality performance | Finalizing proposal | Up to 60 percent based on quality performance | Finalizing proposal |
| Participation Incentives | Up to 2.5 percentage points for inclusion of FQHCs and RHCs | No additional incentives | Up to 5 percentage points for inclusion of FQHCs and RHCs | No additional incentives |
| Minimum Savings Rate | 2.0 percent to 3.9 percent depending on number of assigned beneficiaries | Finalizing proposal based on number of assigned beneficiaries | Flat 2 percent | Finalizing proposal: Flat 2 percent |
| Minimum Loss Rate | 2.0 percent | Shared losses removed from Track 1 | 2.0 percent | Finalizing proposal |
| Performance Payment Limit | 7.5 percent. | 10 percent | 10 percent | 15 percent |
| Performance payment withhold | 25 percent | No withhold | 25 percent | No withhold |
| Shared Savings | Sharing above 2 percent threshold once MSR is exceeded | 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. |
| Shared Loss Rate | One minus final sharing rate | Shared losses removed from Track 1 | One minus final sharing rate | One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate not to exceed 60 percent |

| | One-Sided Model | | Two-Sided Model | |
|---|---|---|---|---|
| **Issue** | **Proposed** | **Final** | **Proposed** | **Final** |
| Loss Sharing Limit | 5 percent in first risk bearing year (year 3). | Shared losses removed from Track 1. | Limit on the amount of losses to be shared phased in over 3 years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3. Losses in excess of the annual limit would not be shared. | Finalizing proposal |

**TABLE 6. PROPOSED MINIMUM SAVINGS RATE BY NUMBER OF ASSIGNED BENEFICIARIES (ONE-SIDED MODEL)**

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

**TABLE 7: SLIDING SCALE PAYMENT BASED ON NUMBER OF BENEFICIARY VISITS AT AN ACO PARTICIPANT FQHC OR RHC**

| Percentage of ACO Assigned Beneficiaries With 1 or More Visits to an ACO participant FQHC/RHC During the Performance Year | Percentage Point Increase in Shared Savings Rate (One-Sided Model) | Percentage Point Increase in Shared Savings Rate (Two-Sided Model) |
|---|---|---|
| 1-10 percent | 0.5 | 1.0 |
| 11-20 percent | 1 | 2.0 |
| 21-30 percent | 1.5 | 3.0 |
| 31-40 percent | 2 | 4.0 |
| 41-50 percent | 2.5 | 5.0 |

**TABLE 8: ESTIMATED NET FEDERAL SAVINGS, COSTS AND BENEFITS, CYs 2012 THROUGH 2015**

| | CY 2012 | CY 2013 | CY 2014 | CY 2015 | CYs (2012-2015) |
|---|---|---|---|---|---|
| **Net Federal Savings** | | | | | |
| 10th Percentile | -$30 Million | -$20 Million | $10 Million | $0 Million | $0 Million |
| Median | $20 Million | $90 Million | $160 Million | $190 Million | $470 Million |
| 90th Percentile | $70 Million | $210 Million | $320 Million | $370 Million | $940 Million |
| **ACO Bonus Payments** | | | | | |
| 10th Percentile | $60 Million | $180 Million | $280 Million | $360 Million | $890 Million |
| Median | $100 Million | $280 Million | $410 Million | $520 Million | $1,310 Million |
| 90th Percentile | $170 Million | $420 Million | $600 Million | $740 Million | $1,900 Million |
| **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. | | | | |
| **Benefits** | Improved healthcare delivery and quality of care and better communication to beneficiaries through patient centered-care. | | | | |

*Note that the percentiles for each individual year do not necessarily sum to equal the percentiles estimated for the total four year impact, in the column labeled CYs 2012-2015, due to the annual and overall distributions being constructed independently.