A decorative graphic on the left side of the page. It features a stethoscope in shades of blue and green, overlaid on a background of binary code (0s and 1s) and faint grid lines. A thick, dark blue curved line separates this graphic from the rest of the page.

A Primer on the Medicare Shared Savings Program Final Rule

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Introduction

On October 20, 2011, CMS (Centers for Medicare & Medicaid Services) released the highly anticipated final rule on the Medicare Shared Savings Program. Under the program, groups of providers will be able to form *accountable care organizations* (ACOs), assuming responsibility for the quality, cost and overall care provided to a defined population of Medicare beneficiaries. ACOs that meet quality performance requirements, while keeping costs under a defined threshold, will be eligible to share in a percentage of the savings achieved.

The Shared Savings Program received a considerable amount of attention—most of it negative—when the [proposed version of the rule](#) was published in April 2011. Almost universally, providers felt the requirements would be overly burdensome and that the program offered too little flexibility while imposing too much risk. Even organizations with previous experience in ACO-type arrangements indicated they would be unable to participate under what was proposed.

CMS responded to these concerns by making a number of changes in the final rule; the end result is a program that will likely attract a larger number of providers. The program is not without risk though, especially given the degree of organizational change and IT investment required in order to be successful.

This primer looks at the underlying concepts of the Shared Savings Program, highlights the important changes in the final rule, and outlines key considerations for providers.

Timing

The Medicare Shared Savings Program is voluntary and begins in 2012. Participation requires committing to three *performance years*. Typically, each performance year runs from January 1 to December 31. Given the short window of time between publication of the final rule and January 2012, CMS will give ACOs that want to participate in the program immediately a choice of two start dates, each with an extended initial performance year to help participants gain experience with managing population-based data:

- **April 1, 2012** – In this option, the ACO's first performance year will be 21 months, ending on December 31, 2013. The ACO's second and third performance years will be CY2014 and CY2015, respectively.
- **July 1, 2012** – In this option, the ACO's first performance year will be 18 months, ending on December 31, 2013. The ACO's second and third performance years will be CY2014 and CY2015.

Note the flexible start dates and extended first performance year apply *only* to ACOs that participate in 2012. ACOs that enter the program in 2013 or later will start on January 1 and have performance years aligned with the calendar year.

Participants

Each ACO will consist of one or more *participants*, identified by their Medicare-enrolled Taxpayer Identification Number (TIN). Any of the following participants can form an ACO (either independently or in conjunction with others):

- Physicians in group practice arrangements
- Networks of individual physician practices
- Hospitals partnering with or employing physicians, NPs, PAs and specialists
- Critical access hospitals that bill under Method II
- Federally qualified health centers (added under the final rule)
- Rural health clinics (added under the final rule)

Other entities with a Medicare-enrolled TIN (such as nursing homes or long-term care facilities) can also join as participants, but only if the ACO already includes one of the groups listed above.

Beneficiary Assignment

In order to participate in the Shared Savings Program, an ACO must assume responsibility for the cost and quality of care provided to at least 5,000 Medicare beneficiaries. Beneficiaries are *assigned* to an ACO retrospectively, or after the end of each performance year, based on utilization of primary care services. The concept of patients being assigned to an ACO only exists to establish a measureable way of quantifying performance; assignment in no way restricts where a patient can seek care.

One of the criticisms of the proposed rule was that assigning beneficiaries *after* a performance year would limit the ACO's ability to proactively manage the patients they would ultimately be responsible for. Assignment is still retrospective under the final rule, but to facilitate outreach and care management activities, CMS will provide each ACO with a quarterly list of "preliminary prospectively assigned" beneficiaries who are likely to be part of the ACO based on recent claims data.

Assignment will first be based on primary care services provided by primary care physicians. However, under the final rule, a patient who did not see a primary care physician during the performance year can also now be assigned to an ACO if he or she receives enough primary care services from specialists or other providers.

Quality Requirements

CMS made a number of changes to the quality reporting requirements of the Shared Savings Program in an effort to lessen the burden on participants and reduce the number of duplicative measures. Under the final rule, ACOs will be responsible for 33 measures across four domains (see Table 1). A minimum performance level must be achieved each year in order to continue in the program.

Domain	Total Individual Measures
Patient / Caregiver Experience	7
Care Coordination / Patient Safety	6
Preventative Health	8
At-Risk Population	12
Total	33

Table 1 – Required Quality Measures

In the first performance year, the minimum performance level will be “full and accurate reporting” of all 33 quality measures. In the second and third years of the agreement, to remain in the program, ACOs will need to achieve a minimum score (defined by CMS) on at least 70 percent of the individual measures in each of the four domains. An increasing number of measures will also be pay-for-performance in the second and third years, meaning higher scores will result in higher shared savings payments (see Figure 1).

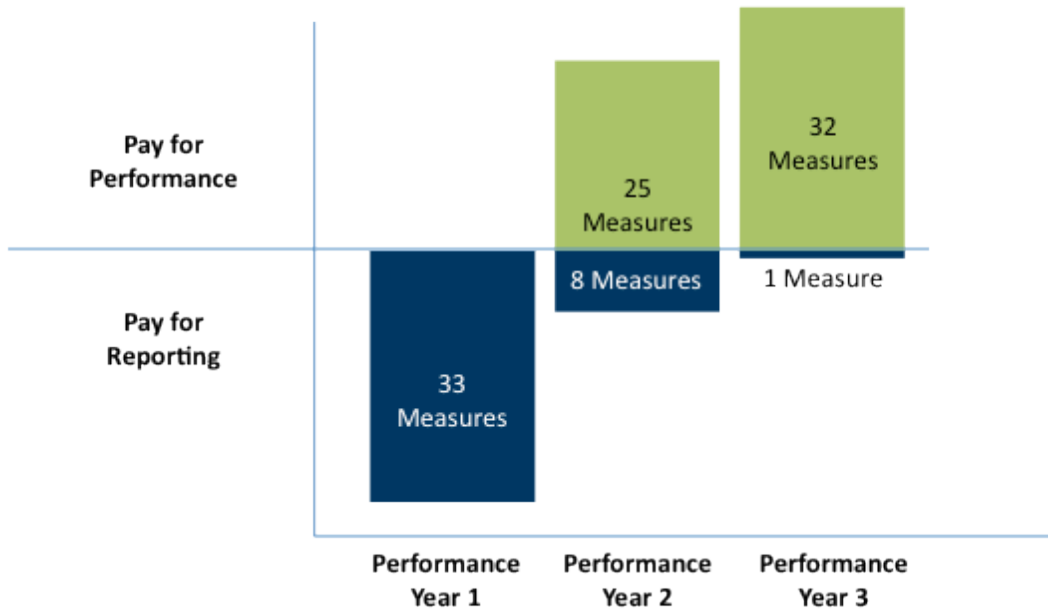


Figure 1 – A Shift Towards More Pay-for-Performance Measures

The proposed rule included a provision that would have required that at least 50 percent of the ACO’s primary care providers be “meaningful EHR users” by the start of the second performance year. CMS has eliminated that requirement in the final rule, but “Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment” remains one of the quality measures ACOs must report on – and CMS has doubled its weight to underscore the importance of IT.

Shared Savings and Losses

ACOs that meet quality requirements while keeping expenditures for the patient population below a defined threshold will be eligible for bonus (or *shared savings*) payments, equal to a percentage of the difference between actual expenditures for the patient population during the performance year and the benchmark established by CMS (see Figure 2). The specific percentage of savings the ACO will be eligible for depends on a number of factors, including performance on quality measures and whether the ACO is willing to assume risk.

Participating ACOs will have to choose one of two options for shared savings payments:

- **Track 1:** A shared savings only (or “one-sided”) model with no penalty if expenditures for the patient population exceed the benchmark established by CMS. This option is intended for ACOs with less experience managing care for a defined population.
- **Track 2:** A shared savings *and* shared losses (or “two-sided”) model, which offers greater potential incentive payments than the one-sided model, but requires the ACO to share in any losses if costs exceed the defined benchmark.

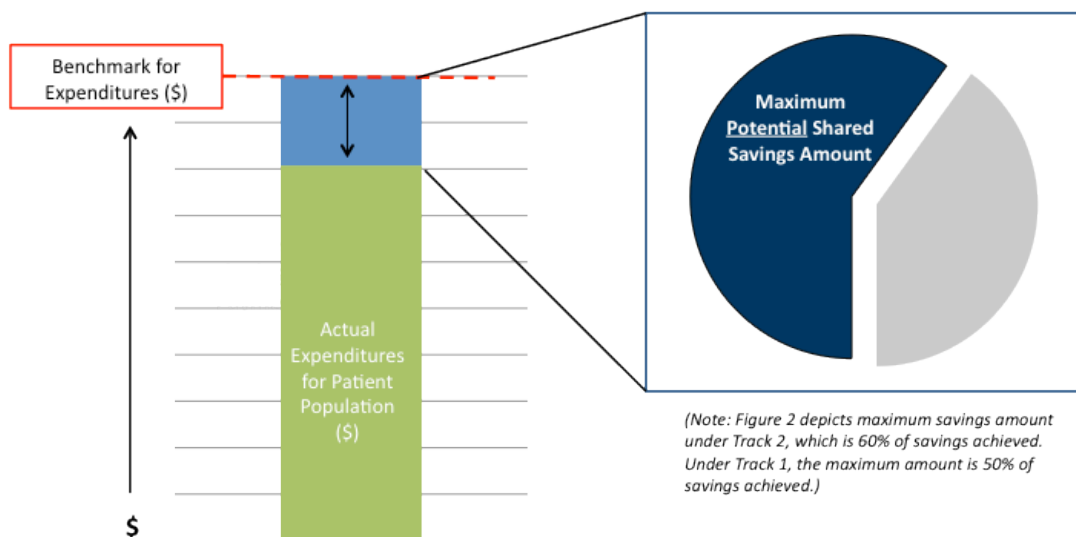


Figure 2 – Maximum Savings Amount Under Track 2

One of the biggest criticisms of the proposed rule was the requirement that ACOs in Track 1 automatically transition to Track 2 for their final performance year, which would have effectively put all ACOs at risk if costs exceed the benchmark. The final rule eliminates that provision, allowing ACOs to remain on the one-sided model for all three performance years. Track 2 would only be required if an ACO decides to participate in the Shared Savings Program for a second time.

The Bottom Line

CMS made a number of changes to the Shared Savings Program in the final rule, almost all of which would appear to benefit potential participants. Whether those changes are

dramatic enough to overcome the initial skepticism remains to be seen. Some considerations for all provider organizations include:

- **The amount of risk providers will need to take on has been lowered but has not been eliminated.** There is still a significant amount of organizational change and IT investment that will be required in order to be successful. Providers considering ACO formation/participation must fully understand and be prepared for the costs that are specific to their organization.
- **Don't be fooled by the "elimination" of the requirement that at least 50 percent of primary care physicians need to be meaningful EHR users.** A similar measure has been retained as one of the 33 quality measures ACOs will need to report, and CMS will count it twice. The reality is that being remaining competitive under any ACO-type model will require a robust EHR, with capabilities far beyond what is needed just to achieve the minimum requirements under Stage 1.
- **The Shared Savings Program is voluntary; the underlying concepts behind it will soon not be.** Regardless of whether organizations formally participate, they must build a foundation that will enable coordinating care across settings and managing data at the population level.

About Impact Advisors

Impact Advisors provides high-value strategy and implementation services to help healthcare clients drive clinical and operational performance excellence through the use of technology. We partner with industry-leading organizations to identify and implement improvements in quality, safety and value. Our Associates are experienced professionals with deep domain expertise and a commitment to delivering results.

Impact Advisors achieved Best in KLAS: Planning and Assessment in 2008, 2009 and 2010, was voted as a Best Small Consulting Firm to Work For in 2009 and 2010 (Consulting Magazine) and most recently earned #3 Best Place to Work in Healthcare (Modern Healthcare).

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