MEMORANDUM

TO: AHCA Members

FROM: Elise Smith, Vice President, Finance Policy
William Hartung , Vice President, Research
Sandra Fitzler, Senior Director, Clinical Services

SUBJECT: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Centers for Medicare and Medicaid Services, Proposed Rule, 42 CFR Part 425; March 31, 2011

DATE: April 2, 2011

On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule implementing Section 3022 of the Affordable Care Act (ACA), providing guidance on the establishment of accountable care organizations. In addition, other federal agencies simultaneously issued related proposals and requests for comment. The proposed rule has been placed on display, and is expected to be published in the Federal Register on April 7, 2011. AHCA will provide comments to CMS before the 60-day comment period ends on June 6, 2011. If members wish to provide comments to AHCA, we ask that you do so by COB on May 2, 2011. Comments can be emailed to Elise Smith at esmith@ahca.org.

CMS has also worked closely with agencies across the federal government to try to ensure a coordinated and aligned inter- and intra-agency effort to address legal and tax implications related to the ACO program. In particular, CMS, the HHS Office of Inspector General (OIG), the Federal Trade Commission (FTC), the Antitrust Division of the Department of Justice (DOJ), and the Internal Revenue Service (IRS) have released three documents in conjunction with the proposed ACO rules on which they seek comment:

1. A joint CMS and OIG notice and solicitation of public comments, Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center: Notice with comment period, March 31, 2011.
2. An IRS notice, Notice 2011-20, requesting comments regarding the need for guidance on participation by tax-exempt organizations in the Medicare Shared Savings Program through ACOs.

Below, we provide a brief review of the enabling legislation and a summary of each of the issuances above. We focus primarily on the central CMS ACO proposed rule.
BACKGROUND

On March 23, 2010, Congress enacted the Patient Protection and Affordable Care Act (Pub. L. 111-148), which was subsequently amended on March 30, 2010 by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152). These two laws are collectively known as the Affordable Care Act, or ACA. The ACA includes a number of provisions designed to improve the quality of Medicare services, support innovation and the establishment of new payment models in the program, better align Medicare payments with provider costs, as well as to strengthen program integrity within Medicare.

Section 3022 of the ACA amended Title XVIII of the Social Security Act (SSA) (42 U.S.C. 1395 et seq.) by adding new section 1899 to the Act to establish, through ACOs, a Shared Savings Program that promotes accountability for a patient population, coordinates items and services under Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Section 3022 requires the Secretary to establish this program no later than January 1, 2012.

Congress, in Section 3022 of the ACA, provided broad authority for the Secretary to define elements of the Shared Savings Program and how providers and supplier could participate. The ACA provided that certain groups of health care providers and suppliers meeting criteria specified by the Secretary may work together to form an ACO to manage and coordinate care for Medicare fee-for-service beneficiaries. ACOs that meet quality performance standards established by the Secretary and achieve savings beyond a minimum savings rate are eligible to receive a percentage the savings achieved. To participate in the Shared Savings Program, the ACO would be required to enter into an agreement with CMS to participate in the program for not less than a 3-year period.

The ACA and the proposed rule for ACOs define the criteria for eligible ACOs, the required organizational structure, quality and other reporting requirements, fee for service payment and benchmarking, the option of payment models other than fee-for-service, and treatment of savings. Congress also granted authority to the Secretary to waive certain statutory provisions related to the physician self-referral law, the federal anti-kickback statute and civil monetary penalties law to carry out the program.

KEY POINTS

- CMS is proposing an option for provider ACO eligibility that would allow for a wide variety of ACO configurations that allow for the participation of a broad range of health care providers and suppliers, including safety net providers, post-acute care facilities, Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs), and Critical Access hospitals (CAHs), which CMS believes will enable ACOs to offer more comprehensive care and better serve the needs of rural communities.

- CMS is soliciting comment on the following:
  - The kinds of providers and suppliers that should or should not be included as potential ACO participants;
  - The potential benefits or concerns regarding including or not including certain provider or supplier types;
  - The administrative measures that would be needed to effectively implement and monitor particular partnerships;
• Other ways in which CMS could employ the discretion provided to the Secretary to allow the independent participation of providers and suppliers not specifically mentioned in the statute.

• The proposed ACO rule does not include any of the skilled nursing facility (SNF) short-stay (Medicare-based) measures. However, CMS plans to expand the ACO after its first year through additional rulemaking to include highly prevalent conditions and frailty. CMS plans to add measures for hospital-based care and for other settings such as home health services and nursing homes.

• The proposed rule calls for Medicare to take a retrospective look at the beneficiary’s use of services to determine whether a particular ACO should be credited with improving care and reducing expenditures. An ACO would have an incentive to improve the quality of care for Medicare patients seen by its participating providers and suppliers.

• The proposed rule would require providers participating in an ACO to notify beneficiaries of that fact, and inform beneficiaries that the provider will be eligible for additional Medicare payments for improving the quality of care the beneficiary receives while reducing overall costs or may be financially responsible to Medicare for failing to provide efficient, cost-effective care. The beneficiary may then choose to receive services from the provider or seek care from another provider that is not part of the ACO.

• Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the original Medicare payment systems. CMS would also develop a Medicare spending benchmark for each ACO against which spending on patients in the ACO is measured to assess whether it qualifies to receive shared savings, or be held accountable for losses.

• The benchmark is an estimate of what the total Medicare fee-for-service Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services would not have been provided by providers in the ACO.

• CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for one or the other models.

• CMS and OIG issued a joint notice with comment period outlining proposals for waivers of certain federal laws - the physician self-referral law, the anti-kickback statute, and the civil monetary penalty law - for the Shared Savings Program.

• The FTC and the DOJ also issued a Proposed Statement of Enforcement Policy regarding ACO compliance with the antitrust laws. The jointly proposed Antitrust Policy Statement would apply to collaborations, but not to mergers of providers who participate or seek to participate in an ACO.

• The IRS issued a notice soliciting comments on whether existing guidance is sufficient with respect to tax-exempt organizations that would participate in the Shared Savings Program as an ACO, or whether additional guidance is needed.
DISCUSSION

I. CMS ACO Proposed Rule

A. Proposed Provider Eligibility Requirements for an ACO to Participate in the Program

Section 3022 of the ACA establishes eligibility requirements for ACOs participating in the Shared Savings Program. It allows several designated groups of providers of services and suppliers to participate as an ACO under this program. 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, and
- Such other groups of providers of services and suppliers as the Secretary determines appropriate

Thus, while the statute enumerates certain kinds of provider and supplier groups that are eligible to participate in this program, it also provides the Secretary with discretion to tailor eligibility in a way that narrows or expands the statutory list of eligible ACO participants.

In this proposed rule, CMS considered three options for defining the range of potentially eligible providers and suppliers that would be eligible to form an ACO. CMS decided to propose the third and most flexible option.

The first option that CMS considered would be to limit eligibility initially to the groups specifically identified in the statute. Under this option, only the four groups specified in of the Act would be eligible to form an ACO and participate in the program.

The second option would be to narrowly define which groups of providers of services and suppliers are eligible to form an ACO and participate in the Shared Savings Program. One example of this option would require the participation of a hospital in the ACO so that only partnerships or joint venture arrangements between hospitals and ACO professionals or hospitals employing ACO professionals (groups specified in the ACA) would be eligible to participate in the program.

Another example of this option would be limiting participation to only those entities comprised of primary care professionals so that only ACO professionals in group practice arrangements or networks of individual practices of ACO professionals would be eligible to form an ACO and participate in the program. This approach would be grounded in the premise that ACOs should be

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1 The proposed rule and joint CMS/OIG notice are posted at: [www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1#special](http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1#special). They will appear in the April 7, 2011 issue of the Federal Register. Please note: Once the regulation is published on (April 7, 2011) the preceding link will be deactivated and the published version of the regulation will be available on the National Archives website at [http://www.archives.gov/federal-register/news.html](http://www.archives.gov/federal-register/news.html). Comments on the proposed rule will be accepted until June 6, 2011. CMS will respond to all comments in a final rule to be issued later this year. Comments on the joint CMS/OIG notice will be accepted until June 6, 2011.
primary care-focused and that primary care professionals are in the best position to both reduce the fragmentation of services and improve the overall quality of care delivered to Medicare beneficiaries.

Under the third option, the four groups specified in the ACA would be eligible to form an ACO and participate in the program, but in addition, CMS would employ the discretion provided to the Secretary to allow other Medicare enrolled entities, such as CAHs billing under method II to form an ACO.

This is the option that CMS chose. CMS explains that, employing Secretarial discretion to expand the definition of eligible providers or suppliers would allow other Medicare enrolled entities such as FQHCs and RHCs, to become ACO participants, if the ACO that is formed is able to meet the other qualifications to participate in the program. Under this proposal:

- The four groups specifically identified in law and CAHs billing under method II, would have the opportunity to form ACOs independently.

- In addition, the four statutorily indentified groups, as well as CAHs billing under method II, could establish an ACO with broader collaborations by including additional Medicare enrolled entities such as FQHCs and RHCs and other Medicare enrolled providers and suppliers as defined in the ACA as ACO participants.

- While this proposal potentially increases the administrative complexity of implementing the program and could also require stronger measures to oversee the varied kinds of ACO arrangements that might evolve, CMS believes this approach best serves the goals of the program by allowing greater opportunities for broadly transforming the health care delivery system and increasing access to high quality and lower cost care under the Shared Savings Program for Medicare beneficiaries regardless of where they live.

- Specifically, this option allows for a wide variety of ACO configurations that incorporate a broad range of health care providers and suppliers, including safety net providers, post-acute care facilities, FQHCs, RHCs, and CAHs, which CMS believes will enable ACOs to offer more comprehensive care and better serve the needs of rural communities.

CMS states clearly that the proposal also offers greater opportunity for innovation by ACOs in determining the most effective organizational structure to meet the needs of their respective populations. In addition to requesting comment on this proposal generally, CMS is soliciting comment on the following:

- The kinds of providers and suppliers that should or should not be included as potential ACO participants;
- The potential benefits or concerns of including or not including certain provider or supplier types;
- The administrative measures that would be needed to effectively implement and monitor particular partnerships;
- Other ways in which CMS could employ the discretion provided to the Secretary to allow the independent participation of providers and suppliers not specifically mentioned in the statute.
B. Quality Measures and the Methodology for Measuring ACO Performance

1. Proposed Quality Measures

The proposed ACO rule does not include any of the SNF short-stay (Medicare-based) measures. Out of the 65 proposed measures, 47 are related to Group Practice, 7 are based on surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and 11 measures are derived from claims data. For the first year of the program, ACO measure results would be calculated using the Group Practice Reporting Option (GPRO) data collection tool and the survey instruments.

CMS states that the GPRO would be a new tool for ACO program use but will be based on the data collection tool currently used in the Physician Quality Reporting System. CMS proposes that the measures would be reported to CMS through a combination of claims submission, surveys, and data collection using a tool designed for clinical quality measure reporting. In addition, CMS is proposing to define the first quality performance period as beginning January 1, 2012 and ending December 31, 2012.

However, CMS plans to expand the ACO program quality measures after its first year through additional rulemaking to include measures related to highly prevalent conditions and frailty. CMS plans to add measures for hospital-based care and for other settings such as home health services and nursing homes.

In the proposed rule, CMS is looking for comments on the implications of including or excluding any of the 65 proposed measures. The agency is requesting suggestions on a process for retiring or adjusting the weights of domains, modules or measures over time. Information related to measure numerator, denominator, exclusions and covariates are not included in the proposed rule. However, measure stewards like Physician Quality Reporting System, NQF, and AHRQ are identified along with the respective measure number.

AHCA will offer comments related to our concern about the use of only condition-specific measures like dehydration, congestive heart failure (CHF), bacterial pneumonia, chronic obstructive pulmonary disease (COPD), uncontrolled diabetes, and urinary infections for the patient population who is 65 years old or older. The over 65-year old population is at highest risk of having multiple chronic conditions (MCCs) and measures for this population need to be included in the ACO program when it is first implemented in anticipation that the program will encompass other healthcare settings in the future.

2. Proposed Quality Performance Scoring

As required by the ACA, before an ACO can share in any savings achieved, it must demonstrate that it is delivering high quality care. Thus, a calculation of the quality performance standard will indicate whether an ACO has met the quality performance goals to make it eligible for shared savings. The proposed method for scoring the measures and determining the performance level that must be achieved to share in savings under the Shared Savings Program is described in the proposed rule.

CMS proposes that the performance on each measure would be scored on a linear points scale and roll up into 5 scores for each of 5 domains. The percentage of points earned for each domain would be aggregated using an equal weighting method to arrive at a single percentage that will be applied to the maximum sharing rate for which the ACO is eligible.
For the first year of the Shared Savings Program, CMS intends to set the quality performance standard at the reporting level only. This means that during the first performance period, ACOs will be required to report the quality measures completely and accurately in order to share in savings. However, CMS proposes to nevertheless calculate the ACOs score for quality in the first year for informational purposes and to help define the benchmarks for future program years. CMS will set the quality performance standard at a higher level in subsequent years.

3. Proposed Incorporation of the Physician Quality Reporting System into the Shared Savings Program:

The ACA allows CMS to incorporate the Physician Quality Reporting System reporting requirements and incentive payments into the Shared Savings Program. ACO participant providers/suppliers who are also Physician Quality Reporting System eligible professionals may earn the Physician Quality Reporting System incentive as a group practice under the Shared Savings Program, by meeting its quality performance standard.

C. Beneficiary Participation In An ACO

As envisioned by the ACA and in the proposed rule, an ACO is intended to provide an opportunity for Medicare beneficiaries to receive high quality evidence-based health care that eliminates waste and reduces excessive costs through improved care delivery. However, there would be significant differences between ACOs, as described in the proposed rule, and the private managed care plans offered under the Medicare Advantage program. Beneficiaries would not enroll in a specific ACO. Instead, the proposed rule calls for Medicare to take a retrospective look at the beneficiary’s use of services to determine whether a particular ACO should be credited with improving care and reducing expenditures. An ACO would have an incentive to improve the quality of care for all patients seen by its member providers and suppliers.

The proposed rule would require providers participating in an ACO to notify the beneficiary that they are participating in an ACO, and that the provider would be eligible for additional Medicare payments for improving the quality of care the beneficiary receives while reducing overall costs or may be financially responsible to Medicare for failing to provide efficient, cost-effective care. The beneficiary may then choose to receive services from the provider or seek care from another provider that is not part of the ACO.

The proposed rule would also require each provider in an ACO to notify the beneficiary that the beneficiary’s claims data may be shared with the ACO. This data sharing is intended to make it easier to coordinate the beneficiary’s care; however, the provider may not require a beneficiary to obtain services from another provider or supplier in the same ACO. The provider must give the beneficiary the opportunity to opt-out of those data sharing arrangements. For Medicare beneficiaries who choose not to opt-out of the data sharing arrangements, the proposed rule would limit data sharing to the purposes of the Shared Savings Program and would require compliance with applicable privacy rules and regulations, including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
D. ACO Shared Savings Program


To participate in the Shared Savings Program, providers must form or join an ACO and apply to CMS. An existing ACO will not be automatically accepted into the Shared Savings Program. If accepted, the ACO would serve at least 5,000 Medicare patients and agree to participate in the program for three years.

Under the proposed rule, Medicare would continue to pay participating providers and suppliers for specific items and services as it currently does under the original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or be held accountable for losses.

The benchmark is an estimate of what the total Medicare fee-for-service Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services would not have been provided by providers in the ACO. The benchmark would take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark would be updated for each performance year within the three-year performance period.

2. Risk Models

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for one or the other models. CMS believes this approach would have the advantage of providing an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.

CMS is also proposing to establish a minimum sharing rate that would account for normal variations in health care spending. The minimum savings rate (MSR) is a percentage of the benchmark that ACO expenditure savings must exceed in order for an ACO to qualify for shared savings in any given year. Under the proposed rule, ACOs in the one-sided risk program that have smaller populations (and having more variation in expenditures) would have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided approach, CMS is proposed a flat 2 percent minimum sharing rate.

If an ACO meets quality standards and achieves savings exceeding the MSR, the ACO would share in savings, based on the quality score of the ACO. The proposed rule would provide for additional shared savings for ACOs that include beneficiaries who receive services from a Federally Qualified Health Center or Rural Health Clinic during the performance year.

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2 A chart illustrating the design components is provided in the Appendix.
3. Greater Shared Savings Available if ACO Willing to Share in Savings and Losses

To qualify for shared savings, ACOs must meet certain quality and performance standards and also have total per capita costs for assigned beneficiaries in the performance year that are below the estimated updated benchmark and exceed the minimum savings rate. Provided that the ACO meets the requirements of the quality performance standard, once the ACO surpasses the MSR, it may share in savings. To provide a greater incentive for ACOs to adopt the two-sided risk approach, the maximum sharing percentage is 60 percent for ACOs in the two-sided model compared to 50 percent in the one-sided model. Under the proposed rule, the MSR in the one-sided model varies depending on the number of beneficiaries assigned to the ACO, with smaller ACOs required to achieve a higher level of minimum savings to be eligible for shared savings.

The MSR under the one-sided model ranges from 3.9 percent for an ACO with the minimum 5,000 beneficiaries assigned, to 2 percent for ACOs with 60,000 or more beneficiaries assigned. The proposed MSR for all ACOs in the two-sided model would be 2 percent across the board. Certain rural ACOs and those serving underserved populations may be exempt from the MSR and therefore share in all the savings below the benchmark if they meet specified characteristics. In addition, ACOs in the one-sided model that include a strong FQHC/RHC presence would be eligible for up to a 2.5 percentage point increase in its shared savings rate for the first two years of its agreement. Under both models, an ACO would be eligible for a greater portion of shared savings the higher its quality and performance score.

The proposed rule also provides a methodology for determining shared losses for ACOs in the two-sided model (or year three of the one-sided model) if the per capita cost per beneficiary were more than 2 percent higher than the benchmark. As with shared savings, the amount of shared losses would be based in part on the ACO’s quality performance score. Additionally, CMS is proposing a shared loss cap of 5 percent of the benchmark in the first year of the Shared Savings Program, 7.5 percent in the second year, and 10 percent in the third year.

II. Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center, CMS and the Office of the Inspector General (OIG), Notice with Comment Period, March 31, 2011

Sections 1899 and 1115A of the SSA Act give the Secretary authority to waive certain fraud and abuse laws as necessary to achieve the goals of each section, respectively. In conjunction with the issuance by CMS of the proposed rule that would establish ACOs, CMS and OIG issued a joint notice with comment period outlining proposals for waivers of certain federal laws - the physician self-referral law, the anti-kickback statute, and the civil monetary penalty law for the Shared Savings Program. CMS and OIG have also solicited comments on further waiver design considerations for the Shared Savings Program and the Innovation Center.

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3 Id. The proposed rule and joint CMS/OIG notice are posted at: [www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1#special](http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1#special). Comments on the joint CMS/OIG notice will be accepted until June 6, 2011.
A. The Laws Addressed in the Notice

The joint CMS and OIG notice and solicitation of public comments addresses the application of the following federal laws to ACOs participating in the Shared Savings Program:

- The Physician Self-Referral Law (Section 1877(a) of the Social Security Act (SSA)), which prohibits physicians from making referrals for Medicare “designated health services,” including hospital services, to entities with which they or their immediate family members have a financial relationship, unless an exception applies.

- The federal anti-kickback statute (Section 1128B(b) of the SSA), which provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce or reward the referral of business reimbursable under any Federal health care program, as defined in section 1128B of the Act.

- The civil monetary penalties law (Section 1128A(b)(1) and (2) of the SSA) that prohibits a hospital from making a payment, directly or indirectly, to induce a physician to reduce or limit services to Medicare and Medicaid beneficiaries under the physician’s direct care (the CMP).

B. The Waivers that CMS and the OIG Are Proposing

The agencies have outlined proposals to waive the laws listed above in three circumstances (as further detailed in the notice and solicitation of public comments):

- The distribution of shared savings payments received by an ACO to or among qualified ACO participants and ACO providers/suppliers described in the notice with comment period.

- An ACO’s distribution of shared savings payments to other individuals or entities for activities necessary for and directly related to the ACO’s participation in the Shared Savings Program.

- For the anti-kickback statute and CMP only, certain financial relationships that are necessary for and directly related to the ACO’s participation in the Shared Savings Program and fully comply with an exception to the physician self-referral law.

These waivers would cover shared savings earned during the agreement period with CMS and, as applicable, financial relationships existing during the agreement period. The notice and solicitation of public comment explains the conditions that would apply to the waivers in more detail.

C. Solicitation of Comments

CMS and OIG solicit public comments on a list of topics regarding other waiver design considerations. For example, the notice solicits comment on exercising the waiver authority to address start-up costs, continuing operating expenses, non-shared savings relationships between ACO members or outside entities, and special considerations relating to two-sided risk. CMS and OIG ask specific questions about each of these topics and others in hopes of eliciting detailed information from the public. The notice also solicits comments on the best way to exercise the separate waiver authority under Section 1115A of the Act, which applies to the Innovation Center.
III. Tax Treatment

The Internal Revenue Service ("IRS") also issued a notice soliciting comments on whether existing guidance is sufficient with respect to tax-exempt organizations that would participate in the Shared Savings Program as an ACO, or whether additional guidance is needed. In the notice, the IRS identifies prohibitions applicable to tax-exempt organizations regarding inurement, or impermissible private benefit, and compliance with requirements that payments received under the Shared Savings Program by a tax-exempt entity must comply with requirements that generally prohibit the receipt of unrelated business taxable income.

IV. FTC/DOJ Guidance on Antitrust Issues

The FTC and the DOJ also issued a Proposed Statement of Enforcement Policy regarding ACO compliance with the antitrust laws. The jointly proposed Antitrust Policy Statement would apply to collaborations, but not to mergers of providers who participate or seek to participate in an ACO. The proposed policy would provide for rule of reason treatment for ACOs that use the same governance and leadership structure, as well as the same clinical and administrative processes in the commercial market as it uses for the Shared Savings Program.

The proposed policy would also establish a Safety Zone for ACOs. For situations where two or more ACO participants provide a common service to patients from the participants’ Primary Service Area, the Safety Zone would apply to ACOs where independent ACO participants that provide that common service have a combined share of 30 percent or less for each common service in each participant’s Primary Service Area (“PSA”). Under the proposal, it would be highly unlikely that ACOs in the Safety Zone would subject to challenge by antitrust agencies unless there are extraordinary circumstances involved.

ACOs that have a share above 50 percent for any common service would be subject to a mandatory antitrust review. These ACOs would be required to obtain a letter from one of the antitrust agencies indicating that there would be no intent to challenge the arrangement. If either DOJ or FTC advises that it is likely to challenge the arrangement, then the ACO would be ineligible to participate in the Shared Savings Program. ACOs that are outside the Safety Zone and below the 50 percent threshold would not be subject to antitrust review, as long as the arrangement does not impede the functioning of a competitive market or raise competitive concerns and may participate without agency review.

CONCLUSION

As indicated above, AHCA will provide comments to CMS before the 60-day comment period ends on June 6, 2011. If members wish to provide comments to AHCA, we ask that you do so by COB on May 2, 2011. We will be reaching out to members on the complex issues raised by the proposed rule and would very much appreciate hearing from you. Comments can be emailed to Elise Smith at esmith@ahca.org.

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## Appendix

### Design Components Of The Shared Savings Models

<table>
<thead>
<tr>
<th>Design Element</th>
<th>One-Sided Model (Performance Years 1 and 2)</th>
<th>Two-Sided Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Loss Rate</td>
<td>None</td>
<td>Flat 2 percent regardless of size</td>
</tr>
<tr>
<td>Maximum Sharing Cap</td>
<td>Payment capped at 7.5 percent of ACO’s benchmark</td>
<td>Payment capped at 10 percent of ACO’s benchmark</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 52.5 percent of net savings up to cap</td>
<td>Savings shared once MSR is exceeded; up to 65 percent of gross savings up to cap</td>
</tr>
<tr>
<td>Shared Losses</td>
<td>None</td>
<td>First dollar shared losses once the minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over three 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 cap would not be shared. Actual amount of shared losses would be based on the final sharing rate that reflects ACO quality performance and any additional incentives for including FQHCs and/or RHCs using the following methodology (1 minus final sharing rate).</td>
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