CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Accountable Care Organizations —
Highlights of the Final Rules
October 2011

The following information is not intended to be a complete summary of the Centers for Medicare & Medicaid Services (CMS) final rule and additional agency guidance. Rather it highlights some of the key provisions important to California hospitals and health systems.

On October 20, CMS released its final rule implementing Section 3022 of the Affordable Care Act (ACA), which contains provisions relating to Medicare fee-for-service payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs). At the same time, CMS and the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ) in conjunction with the Federal Trade Commission (FTC), and the Internal Revenue Service (IRS) issued guidance regarding the establishment of ACOs. This additional guidance is briefly discussed at the end of this summary.

CMS also announced the creation of the Advanced Payment ACO Model through the Center for Medicare & Medicaid Innovation that will provide upfront capital resources for certain physician-based and rural ACOs. The Advance Payment ACO Model is not discussed in this summary.

The final rules will be published in the *Federal Register* on November 2, 2011, and are effective January 1, 2012. CMS received more than 1,300 comments on the proposed rule and made significant changes, many of which CHA advocated for in its comments, that CMS believes will make the ACO program more attractive to providers. Additional information regarding the final rule and agency guidance can be found at www.calhospital.org/aco-final-rule.

Eligibility, Legal Structure and Governance

In response to overwhelming public comments, CMS made changes to the eligibility, legal structure and governance for ACOs. Eligible participants include 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 other groups of providers of services and suppliers as the HHS Secretary determines appropriate.

CMS finalized its proposal to allow Critical Access Hospitals (CAHs) billing under method II the opportunity to form ACOs independently. In a change from its proposed rule, CMS will allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to both join as ACO participants *and* to form independent ACOs. Due to some of the data limitations that are necessary for beneficiary assignment, FQHC and RHC ACOs will be required to submit special attestation listing their physician National Provider Identifiers (NPIs) that provide primary-care services. Further, CMS added several new revenue codes indicative of primary-care services to

the definition that will be required to ensure appropriate assignment of beneficiaries who have received the plurality of primary-care services from the FQHC or RHC.

CMS finalized its proposals that ACOs be constituted as separate legal entities appropriately recognized and authorized to conduct business under applicable state, federal and tribal laws (as appropriate), and they must have a Tax Identification Number (TIN). The ACO's legal entity may be structured in a variety of ways, including as a corporation, partnership, limited liability company, foundation or other entity permitted by state law. The ACO must be capable of 1) receiving and distributing shared savings; 2) repaying shared losses; 3) establishing, reporting and ensuring ACO participant and ACO provider/supplier compliance with program requirements, including the quality performance standards; and 4) performing the other ACO functions identified in the statute.

CMS does not require existing legal entities to form a separate new entity for the purpose of participating in the Shared Savings Program. However, to participate, the ACO must meet all eligibility requirements noted above and detailed in the final rule. Many commenters, including CHA, expressed concern regarding the requirement that ACOs formed among multiple ACO participants form a separate legal entity, because it was costly, inefficient and wasteful to do. CHA argued, and CMS disagreed, that a separate legal entity disadvantages hospitals in states like California with a prohibition on the corporate practice of medicine.

CMS finalized, with some modification, its proposal that at least 75 percent control of the ACO's governing body must be held by the ACO's participants. The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises multiple, otherwise independent entities that are not under common control (for example, several independent physician group practices). Each ACO should provide for beneficiary representation on its governing body. CMS notes that in cases in which the composition of an ACO's governing body does not meet the 75 percent ACO participant control threshold or include the required beneficiary governing body representation, the ACO must describe in its application why it seeks to differ from the established requirements and provide for meaningful participation by all parties. CMS believes that these provisions will allow for hospitals that have elected boards (e.g., public and district hospitals) the flexibility to still meet the requirements of state law, as well as the eligibility requirements noted above. CMS does not provide specific details as to the criteria that will be considered that would allow for the approval of such an exemption.

Medicare providers and suppliers may not participate in the program if they are already participating in other Medicare shared savings models, programs or initiatives, including the Independence at Home Pilot Program, Pioneer ACO Model, Medical Health Care Quality Demonstration, Multipayer Advanced Primary Care Practice, Physician Group Practice Transition Demonstration, and Care Management for High-Cost Beneficiaries Demonstrations.

Establishing an Agreement

CMS finalized its proposal to limit participation agreements to a three-year period. In the final rule, CMS summarizes the following timeline for applications and performance periods:

ACO starts April 1, 2012: First performance year is 21 months, ending December 31, 2013. Agreement period is three performance years, ending December 31, 2015.

ACO starts July 1, 2012: First performance year is 18 months, ending December 31, 2013. Agreement period is three performance years, ending December 31, 2015.

CMS notes that ACOs will begin receiving data immediately upon entry to the program (historical and quarterly aggregate reports along with rolling information on their preliminary prospective assigned beneficiary population discussed below). After completing its first performance year, the ACO will be evaluated on its performance on the ACO quality metrics and a shared savings payment will be calculated. All ACOs will be eligible to receive the Physician Quality Reporting System (PQRS) incentive payments for each calendar year in which they fully and completely report the Group Practice Reporting Option (GPRO) measures (discussed below), regardless of their start date.

Organizations applying to be an ACO must provide their ACO participant TINs. CMS finalized that ACOs could not participate in other Medicare programs or demonstrations that involve shared savings; however, an ACO provider/supplier that submits claims under multiple Medicare-enrolled TINs may participate in both shared shavings program under one ACO TIN and another shared savings program under a different non-ACO participation TIN if the patient population is unique to each program. Beneficiaries are assigned to an ACO through a TIN based on the plurality of primary-care services they received from physicians billing under that TIN.

In the proposed rule, ACO participants that perform primary-care services for an ACO and provide the basis for assigning beneficiaries to the ACO cannot perform primary-care services as part of any other ACO. The final rule only applies this restriction at the level of the ACO participant (i.e., the entity with a Medicare-enrolled TIN), thus allowing individuals to perform services in other ACOs under different TINs.

The final rule also provides ACOs more flexibility in planning and the ability to address care management challenges that emerge during a performance year by allowing the ACO to add to, or subtract from, its list of participants.

Assignment of Medicare Fee-For-Service Beneficiaries, Beneficiary Notification
In response to significant comments received, CMS revised its beneficiary assignment methodology. Beneficiaries will be assigned to an ACO, in a two-step process, if they receive at least one primary-care service from a physician within the ACO:

- The first step assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary-care services from primary-care physicians within the ACO. Primary-care physicians are defined (as proposed) as those with one of four specialty designations: internal medicine, general practice, family practice and geriatric medicine.

- The second step only considers beneficiaries who have not had a primary-care service furnished by any primary-care physician. Under this second step, a beneficiary is assigned to an ACO if the beneficiary receives a plurality of his or her primary-care ser-

vices from physicians (including specialty physicians) and certain non-physician practitioners (nurse practitioners, clinical nurse specialists and physician assistants) within the ACO.

CHA is very pleased with the inclusion of services provided by non-physician practitioners, including nurse practitioners, clinical nurse specialists and physician assistants. In addition, as discussed in the proposed rule, a plurality means a greater proportion of primary-care services, measured in terms of allowed charges, but it can be less than a majority of services. Primary-care services are defined as a select set of HCPCS codes identified in Section 5501 of ACA (99201 through 99215, 99304 through 99340), including certain evaluation and management codes and codes associated with the annual wellness visit (HCHPC code G0438 and G0439) and Welcome to Medicare visit (HCHPC code G0402), and certain revenue center codes for services furnished by FQHCs and RHCs.

In a change from the proposed rule, CMS states that at the beginning of the performance year, beneficiaries will be preliminarily assigned to ACOs (prospectively) based on the most recent available data. That is, providers will get a list of potential beneficiaries who may be assigned to the ACO. This list will be updated on a quarterly basis. However, final assignment, for the purposes of determining an ACO's quality and financial performance under the program, will be made at the end of the performance year (retrospectively).

CMS adopted "preliminary" prospective assignment with final retrospective reconciliation in the final rule in response to many commenters, including CHA, which advocated for prospective assignment. CMS notes that by allowing preliminary prospective assignment, ACOs will develop care plans and undertake appropriate quality initiatives on the basis of some knowledge regarding the beneficiaries for whom they will ultimately be held accountable. However, a final retrospective reconciliation allows CMS to assess an ACO's performance based on where beneficiaries have chosen to receive services during the performance year.

CMS finalizes its proposal requiring ACO participants to notify patients at the point of care that they are participating in an ACO. The ACO must inform beneficiaries of its ability to request claims data about them and afford beneficiaries the ability to opt-out of sharing their protected health information with the ACO.

Quality and Other Reporting Requirements

CMS had proposed 65 quality measures that spanned five important domains: patient/caregiver experience, care coordination, patient safety, preventative health and at-risk population/frail elderly. CHA supported this framework and the requirement for full and accurate reporting for year one to ensure that any data-collection issues or unforeseen, unintended consequences could be addressed. However, CHA called for a significant decrease in the number of measures and for the measures to be phased in over the three-year period.

In response to CHA comments and others, CMS has adopted 33 measures of quality performance that span four domains: patient experience of care, care coordination/patient safety, preventive health and at-risk population. The complete list of measures is included as Attachment A.

The 33 measurers will be reported through a patient experience survey (seven measures), administrative billing data (three measures) and the Group Practice Reporting Option (GPRO) web interface currently in use in the PQRS program (22 measures) and one measure of meaningful use adoption. CMS notes that it intends to release all the measure specifications in the fourth quarter of 2011 and the first quarter of 2012.

While the first performance year will be either 18 months (if the ACO starts April 1) or 21 months (if the ACO starts July 1), quality data will be collected on a calendar year basis beginning January 1, 2012, through December 31, 2012, for hospitals that may elect an interim payment to be calculated during the first performance year (see below). Thus, the first performance year of the ACO agreement period begins April 1, 2012, or July 1, 2012, and ends December 31, 2013, while quality performance for this first performance year will be based on complete and accurate reporting of measures January 1, 2013, through December 31, 2013. Quality data submitted via the GPRO web interface for the 2012 reporting period would also be used for purposes of the PQRS incentive under the Shared Savings Program and for those that elect an optional interim payment calculation.

In year one, CMS is defining the quality performance standard at the level of complete and accurate reporting on all 33 measures. In year two, pay for performance will apply to 25 measures and pay for reporting will apply to eight measures. And in year three, pay for performance will apply to 32 measures and pay for reporting of one measure (Attachment A).

CMS states that it will administer and pay for the patient experience of care survey for two years (2012 and 2013). However, the ACO will be responsible for administering and paying for the survey in 2014.

CMS finalized its proposal to establish a minimum attainment level for each measure at a national flat 30 percent, or where applicable the national 30th percentile level of performance of Medicare fee for service (FFS) or Medicare Advantage (MA) quality rates for each measure. Performance at or above 90 percent or the 90th percentile of the performance benchmark will earn the maximum points available for the measure. A summary of the sliding scale of points awarded is in Table 3 on pages 357 and 358 of the display copy.

CMS will add the points earned for each measure in a domain for the four domains. The domains will be weighted equally at 25 percent, with the exception of the electronic health record (EHR) incentive program participation measure, which will be double weighted in the care coordination domain to encourage EHR adoption. ACOs will need to achieve the minimum attainment level on at least 70 percent of the measures in each domain to avoid being placed on a corrective action plan. If the ACO continues to under perform in the following year, the agreement would be terminated.

Total Points for Each Domain Within the Quality Performance Standard

(Table 4: Page 358 of the display copy)

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%**

Meaningful Use

CMS had proposed requiring that at least 50 percent of an ACO's primary-care physicians be determined "meaningful EHR users," as defined in 42 CFR 495.4, by the start of the second performance year in order to continue participation in the Shared Savings Program. In response to public comment, CMS has removed this requirement and included a structural measure of EHR adoption in the 33 quality measures required.

Public Reporting

The final rule requires, as proposed, ACOs to publicly report the identity of each member of the governing body, not just the ACO participants. In addition, the ACO will be considered a group practice under PQRS, and therefore CMS notes that it will report ACO quality performance GPRO measures on Physician Compare along with the performance of all other PQRS group practices. This is contingent on the final policies regarding public reporting under the PQRS, which will be announced in the CY 2012 Physician Fee Schedule final rule that will be issued on or about November 1. Other public reporting requirements for ACOs are detailed in the final rule.

Shared Savings Determination

Benchmark Calculation

The benchmark is an estimate of what the total Medicare FFS Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all those services would not have been provided by providers in the ACO. CMS finalizes its proposed risk-adjustment methodology (CMS Hierarchal Condition Category model used in MA) that will account for beneficiary characteristics in setting the benchmark. In contrast to its proposed rule, CMS removed indirect medical education and disproportionate-share hospital payments from both the spending and benchmark estimates; however despite CHA opposition, it did not remove the incentive payments for hospital VBP or adjustments for area wage index.

CMS is implementing both a one-sided and a two-sided model for shared savings (defined below) with modifications. As noted in the proposed and final rule, CMS believes that by offering two tracks, newly formed ACOs can gain experience with population management before transi-

tioning to a risk-based model, while more experienced ACOs that are ready to share in losses are able to enter into an arrangement that provides for a greater share of savings.

Track 1 – Shared Savings Only for the Initial Agreement: Under Track 1, shared savings will be calculated for each performance year during the term of an ACO's first agreement. In a change from the proposed rule, ACOs will not be held accountable for losses in this track. ACOs that wish to continue participating in the Shared Savings Program beyond the first agreement period must do so in Track 2, that is, under the two-sided model.

Track 2 – Shared Savings and Shared Losses for All Years of the Agreement: Alternatively, more experienced ACOs that are ready to share in losses in return for the opportunity for a higher share of savings may elect to enter the two-sided model. ACOs that enter the Shared Savings Program under Track 2 will be under the two-sided model for the term of their initial agreement and any subsequent agreement. Under this model, the ACO will be eligible for a higher sharing rate, with a higher performance payment limit, than will be available under the one-sided model.

Interim Payment Calculation
In the final rule, CMS adopts a policy that will enable ACOs with start dates of April 1 and July 1, 2012, to opt for an interim payment calculation of the shared savings as part of their application. For ACOs opting for Track 2, they will have already demonstrated a mechanism for repayment of losses as part of their application which is sufficient to meet this requirement. ACOs under Track 1, however, will need to demonstrate an adequate repayment mechanism if they wish to elect the optional interim payment calculation. This requirement will not apply to Track 1 ACOs with start dates of April 1 or July 1, 2012, that do not elect interim payment calculation.

The table below summarizes the provisions of the shared savings models under Track 1 and Track 2 in comparison to the proposed rule. Of particular note, CMS made several changes requested by CHA, including but not limited to following:

- The final rule eliminates the downside risk for Track 1 ACOs. CMS had originally proposed that ACOs would share in losses in the third year of Track 1.
- The rule allows all ACOs to share in first dollar savings, as opposed to those only entering through Track 2.
- CMS will not annually withhold any portion of the ACO's earned bonus. CMS had originally proposed a 25 percent withhold.
- Unfortunately, CMS does not make changes to the sharing rates or adjust for patient severity year to year.

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SHARED SAVINGS OVERVIEW
TABLE 5: CMS FINAL RULE, DISPLAY COPY, PAGE 396

	One-sided Model		Two-Sided Model	
Issue	**Proposed Rule**	**Final Rule**	**Proposed Rule**	**Final Rule**
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**
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

	One-sided Model		Two-Sided Model	
Issue	**Proposed Rule**	**Final Rule**	**Proposed Rule**	**Final Rule**
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
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

ACO Monitoring and Termination

CMS finalized with no substantive changes its proposal to employ many of the methods developed for purposes of the MA and Medicare prescription drug programs to monitor and assess ACOs and their participating providers and suppliers. In general, the methods CMS could use to monitor ACO performance may include, but are not limited to, analysis of specific financial and quality data, as well as aggregated annual and quarterly reports; site visits; assessment and following-up investigation of beneficiary and provider complaints; and audits (including, for example, analysis of claims, chart review, beneficiary surveys, coding audits).

ACOs will be required to give CMS 60 days' advance written notice of their intention to terminate their agreement to participate in the Shared Savings Program and the effective date of the termination. The final rule articulates a number of circumstances under which CMS may terminate the agreement with an ACO, including avoidance of at-risk beneficiaries and failure to meet the quality performance standards.

ACOs that are terminated from the program will be afforded the opportunity to re-apply to participate in the shared savings again only after the date on which the term of the original participation agreement would have expired if the ACO had not been terminated. An ACO that was terminated less than half way through its agreement under the one-sided model will be allowed to re-enter the one-sided model at the conclusion of the term of their original agreement. ACOs that were terminated more than half way through the agreement will only have the option of entering under Track 2 at the conclusion of the term of their original agreement.

Waivers, Antitrust and Tax-Exempt Considerations

HHS Office of Inspector General

CMS and OIG released an interim final rule that addressed many of the concerns raised by CHA, by providing additional waiver protections that now address the Physician Self-Referral Law (known as the Stark Law), the federal anti-kickback statute (AKS) and the Civil Monetary Penalty (CMP) laws that prohibit gain sharing (hospital payments to physicians to reduce services) and beneficiary inducements.

Unlike the proposed rules, the interim final rule now contains waivers that protect the myriad of ACO activities required prior to acceptance and operations in the Medicare Shared Savings Program. Although the pre-enrollment waivers sunset at the time an ACO is enrolled in the program, there are also waiver protections that shield ACOs post-enrollment from Stark, AKB and CMPs related to gain sharing arrangements and shared savings distributions of an ACO with one or more ACO participants, or ACO providers and suppliers. Other waivers include waiver protection for providing patient with incentives as long as they are associated with preventive care or help a beneficiary toward reaching clinical goals for better health, such as compliance with a medication treatment plan.

CMS and OIG jointly described the goals for the additional waiver protection as avoiding "application of these fraud and abuse laws to ACOs formed in connection with the Shared Savings Program so that the laws do not unduly impede development of beneficial ACOs, while also en-

suring that ACO arrangements are not misused for fraudulent or abusive purposes that harm patients or Federal health care programs."

CMS and OIG have gone a long way to address many of the concerns raised by CHA and its member hospitals in previous comment letters. CHA will again be soliciting member comments and input as it prepares comments regarding the newly developed waivers, and any specific concerns members may have regarding their application to ACO operations. Comments are due in late December.

Internal Revenue Service

The IRS, as part of the multi-agency roll out of the final ACO rules and guidance, issued a Fact Sheet (FS-2011-11) in a Q&A format that provides additional information for charitable organizations participating in an ACO. Most importantly, the Fact Sheet confirms that the notice the IRS issued April 18, 2011, (Notice 2011-20) regarding the proposed ACO rule continues to reflect IRS expectations regarding the ACO program. The IRS acknowledges a wide range of possible ACO structures and will apply existing tax rules to specific facts when considering questions regarding tax-exempt status. There are no "special" federal income tax rules related to ACOs. The IRS affirms that tax-exempt organizations participating in an ACO can further charitable purposes, and in some circumstances even if the ACO conducts activities unrelated to the Shared Savings Program. The Fact Sheet also clarifies that a charitable organization participating in an ACO does not necessarily have to satisfy all five factors described in the April 18, 2011, notice to avoid impermissible private benefit. Part of the analysis clarifies that any ownership interest in an ACO does not necessarily have to be directly proportional to capital contributions, and that shared savings do not always have to be distributed in proportion to ownership interest. The IRS instead applies a "totality of the circumstances" analysis to determine if the economic benefits derived from the ACO are proportional to the contributions the tax-exempt participant provides to the ACO.

Statement of Antitrust Enforcement Policy Regarding ACO Participating in Medicare Shared Savings Program

The final Policy Statement issued by FTC and the Antitrust Division of DOJ makes two significant changes:

1. Mandatory antitrust agency review of ACOs exceeding the 50 percent Primary Service Area (PSA) threshold has been eliminated.
2. The Policy Statement applies to all ACOs, not just those formed after March 23, 2010.

In all other respects the final Policy Statement is virtually identical to the proposed Policy Statement released in March 2011. The final Policy Statement still applies the "rule of reason" antitrust analysis to an ACO, which evaluates the balance of anticompetitive and procompetitive effects. It also continues to provide an antitrust safety zone applicable to ACOs that have a combined share of 30 percent or less for each common service in a PSA.

For ACOs that fall outside of the safety zone, the Policy Statement continues to list the same five criteria that may be an indicia of market power that raises competitive concerns:

1. Improper sharing of competitively sensitive information;
2. Preventing or discouraging private payers from directing or incentivizing patients to chose certain providers;
3. Tying sales;
4. Exclusive contracting;
5. Restricting a private payer's ability to make cost and quality information available to the plan's enrollees.

The final Policy Statement is a significant improvement from the proposed Policy Statement because it eliminates the mandatory antitrust agency review for ACOs with "dominant" providers. However, because little else was changed, many of the concerns raised in CHA's May 31, 2011, comment letter to FTC and DOJ (available at www.calhospital.org/member/cha-submits-letter-federal-agencies-addressing-aco-antitrust-issues) remains relevant:

1. While application of the "rule of reason" antitrust analysis is helpful, meaningful guidance specific to ACOs is still lacking.
2. The PSA formula is costly, burdensome and untested and should be abandoned. (However, this concern is mitigated since the formula no longer is used for mandatory antitrust review for dominant ACO providers, but only for determining the safety zone threshold.)
3. The 30 percent PSA safety zone threshold is too low and should be increased.
4. The five indicia of market power, while not a per se antitrust violation, may discourage certain contracting practices that improve competition.

Additional Information

For more information on the ACO final rule and agency guidance, please contact Dietmar Grellmann at (916) 552-7572 or dgrellmann@calhospital.org, Alyssa Keefe at (202) 488-4688 or akeefe@calhospital.org, or Jana Du Bois at (916) 552-7636 or jdubois@calhospital.org. For more information about the web seminar, please contact the CHA Education Department at (916) 552-7637 or education@calhospital.org.

Attachment A: Quality Measures for Accountable Care Organizations

	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**

Attachment A: Quality Measures for Accountable Care Organizations

	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**

Attachment A: Quality Measures for Accountable Care Organizations

	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**

*CMS notes 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. CHA opposed inclusion of this measure until such time as the methodology excluded all planned and unrelated readmissions. The proposed specifications of this measure are available at