9. Future Participation of Previously Terminated Program Participants

As described in section II.H. of the proposed rule, there are a number of circumstances under which we may terminate our agreement with an ACO, including avoidance of at-risk beneficiaries and failure to meet the quality performance standards. In contrast, there are also many reasons why an ACO participant TIN, used for assigning Medicare FFS beneficiaries to an ACO, may no longer be representative of the organization to whom it was assigned. Specifically, this subsection establishes that “a physician (as defined in section 1861(r)(1))” is an “ACO professional” for purposes of the Shared Savings Program. Section 1861(r)(1) of the Act in turn defines the term physician as “* * * * * a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action.” In addition, subsection 1899(h)(1)(A) defines an ACO professional to include practitioners described in section 1842(b)(18)(C)(i) of the Act, such as PAs and NPs.

Thus, although the statute defines the term “ACO professional” to include both physicians and non-physician practitioners, such as advance practice nurses, physician assistants, and nurse practitioners, for purposes of beneficiary assignment to an ACO, the statute requires that we consider only beneficiaries’ utilization of primary care services provided by ACO professionals who are physicians. The method of assigning beneficiaries therefore must take into account the beneficiaries’ utilization of primary care services rendered by physicians. Therefore, for purposes of the Shared Savings Program, the inclusion of practitioners described in section 1842(b)(18)(C)(i) of the Act, such as PAs and NPs in the statutory definition of the term “ACO professional” is a factor in determining the entities that are eligible for participation in the program (for example, “ACO professionals in group practice arrangements” in section 1899(h)(1)(A) of the Act). However, assignment of beneficiaries to ACOs is to be determined only on the basis of primary care services provided by ACO professionals who are physicians.

Assigning Medicare beneficiaries to ACOs also requires several other elements: (1) An operational definition of an ACO (as distinguished from the formal legal identification of the ACO and the eligibility requirements that we discuss in section II.B. of this proposed rule) so that ACOs can be efficiently identified, distinguished, and associated with the beneficiaries for whom they are providing services; (2) a definition of primary care services for purposes of determining the appropriate assignment of beneficiaries; (3) a determination concerning whether to assign beneficiaries to ACOs prospectively, at the beginning of a performance year on the basis of services rendered prior to the performance year, or retrospectively, on the basis of services actually rendered by the ACO during the performance year; and (4) a determination concerning the proportion of primary care services that is necessary for a beneficiary to receive from an ACO in order to be assigned to that ACO for purposes of this program.

The term “assignment” in this context refers only to an operational process by which Medicare will determine whether a beneficiary has chosen to receive a sufficient level of the requisite primary care services from physicians associated with a specific ACO so that the ACO may be appropriately designated as exercising basic responsibility for that beneficiary’s care. Consistent with section 1899(b)(2)(A), the ACO will then be held accountable “for the quality, cost, and overall care of the Medicare FFS beneficiaries assigned to it.” The ACO may also qualify to receive a share of any savings that are realized in the care of these assigned beneficiaries due to appropriate efficiencies and quality improvements that the ACO may be able to implement. It is important to note that the term “assignment” of this provision in no way implies any limits, restrictions, or diminishment of the rights of Medicare FFS beneficiaries to exercise complete freedom of choice in the physicians and other health care practitioners and suppliers from whom they receive their services.

Thus, while the statute refers to the assignment of beneficiaries to an ACO, we would characterize the process more as an “alignment” of beneficiaries with an ACO as the exercise of free choice by beneficiaries in the physicians and other health care providers and suppliers from whom they receive their services is a presupposition of the Shared Savings Program. Therefore, an important component of the Shared Savings Program will be timely and effective communication with beneficiaries concerning the Shared Savings Program, their possible assignment to an ACO, and their retention of freedom of choice under the Medicare FFS program. The issues of beneficiary information and communication were discussed at the end of this section.
1. Operational Identification of an ACO

The first step in developing a method for assigning beneficiaries is to establish a clear operational method of identifying an ACO that correctly associates health care professionals and providers with the ACO. It is designed to be consistent with the statutory definition of an ACO as well as the eligibility and other requirements for an organization to participate in the Shared Savings Program as an ACO. As discussed in section II.B. of this proposed rule, section 1899(a)(1)(A) of the Act defines ACOs as “groups of providers of services and suppliers” who work together to manage and coordinate care for Medicare fee-for-service beneficiaries. More specifically, the Act refers to group practice arrangements of individual practices of ACO professionals, partnerships or joint venture arrangements between hospitals and ACO professionals, hospitals employing ACO professionals, or other combinations that the Secretary determines appropriate.

From a technical, operational perspective, there are two data sources that could be used to identify the specific providers of services and suppliers participating in these kinds of arrangements as ACOs—specifically, their—(1) National Provider Identifier (NPI); and (2) TIN. Under the Medicare program, individual practitioners are defined by their NPI, but generally file and receive payment for Medicare claims based on their TIN. The TIN may be an employer identification number (EIN) or social security number (SSN). Some individual physicians and other ACO professionals, for example, do not have EINs, and enroll in the Medicare program through their SSNs. Physicians and other ACO professionals who are members of a group practice and bill for their services through the group may not have individual EINs but may use a group EIN for billing Medicare rather than their individual SSNs. While all physicians and practitioners have TINs (either EINs or SSNs), not all physicians and practitioners have Medicare enrolled TINs. For example, physicians and other ACO professionals who are members of a group practice often bill for their services through the group and may not have individual Medicare enrolled TINs. Groups of physicians and practitioners, however, necessarily have TINs which they employ for billing Medicare, because a TIN must be used for billing purposes. It should be noted that, under the Shared Savings Program, the standard restrictions on disclosure of information apply. (For a discussion regarding the public disclosure of information under the Shared Savings Program, see the discussion in section I.E. of this proposed rule.)

Under the PGP demonstration, beneficiaries were assigned and group quality performance was measured by identifying practices operationally as a collection of Medicare enrolled TINs. Through this demonstration we found that TINs provide the most direct link between the beneficiary and the practice providing primary care services. Further, TINs are more stable than NPIs and more likely to provide complete longitudinal data required for benchmarking and beneficiary assignment, and to promote the stability necessary for the ACO to commit to redesigning care processes and complete the required 3-year agreement period. The reason NPIs tend to be less stable is because individual physicians and practitioners often change from one practice to another, potentially rendering data continuity and beneficiary assignment problematic when only NPIs are available. In the PGP demonstration, the individual NPIs associated with the TIN were identified from claims data and provider enrollment information, providing for more effective monitoring of performance within the ACO. Finally, reporting at the TIN level appeared to reduce the reporting burden for practices participating in the PGP demonstration.

Therefore, we are proposing to identify an ACO operationally as a collection of Medicare enrolled TINs. More specifically, an ACO will be identified operationally as a set of one or more TINs currently practicing as a “group practice arrangement” or in a “network” such as where “hospitals are employing ACO professionals” or where there are “partnerships or joint ventures of hospitals and ACO professionals” as stated under section 1899(b)(1)(A) through (E) of the Act. For example, a single group practice that participates in the Shared Savings Program would be identified by its TIN. A network of independent practices that forms an ACO would be identified by the set of TINs of the practices constituting the ACO. We are proposing to require that organizations applying to be an ACO provide their ACO participant TINs. Each TIN can be systematically linked to an individual physician specialty code by us. Therefore, under this approach, beneficiaries would be assigned to an ACO through a TIN based on the primary care services they received from physicians billing under that TIN.

We also propose that ACO professionals within the respective TIN on which beneficiary assignment is based, will be exclusive to one ACO agreement in the Shared Savings Program. This exclusivity will only apply to the primary care physicians (defined as physicians with a designation of internal medicine, geriatric medicine, family practice, and general practice, as discussed in this rule) by whom beneficiary assignment is established. ACO participant TINs upon which beneficiary assignment is not dependent (for example, acute care hospitals, surgical and medical specialties, RHCs, and FQHCs) would be required to agree to participate in the ACO for the term of the 3-year agreement, but would not be restricted to participation in a single ACO. As stated in section II.G. of this proposed rule, competition in the marketplace promotes quality of care for Medicare beneficiaries, protects access to a variety of providers, and helps sustain the Medicare program by controlling cost pressures. All of these benefits to Medicare patients would be reduced or eliminated if we allow the creation of ACOs with significant market power. This is especially important in certain areas of the country that might not have many specialists. In addition, exclusivity of ACO participant TINs upon which beneficiary assignment is not dependent might also contribute to the prospects that ACOs could develop excessive market power, especially in areas with shortages of physicians. In turn, greater market power could provide opportunities for these organizations to engage in activities that raise issues of fraud and abuse, such as those related to self-referrals. For these reasons, physicians upon whom assignment is dependent would be committed for a 3-year period and be exclusive to one ACO. Conversely, to ensure that physicians and other entities upon which assignment is not dependent (that is, hospitals, FQHC, RHCs, specialists) can participate in more than one ACO, and thereby facilitate the creation of competing ACOs, these providers and suppliers would be committed to the 3-year agreement but would not be exclusive and would have the flexibility to join another ACO.

Based on our experience, we recognize that the TIN level data alone will not be entirely sufficient for a number of purposes in the Shared Savings Program. In particular, NPI data will be useful to assess the quality of care furnished by an ACO. For example, NPI information will be necessary to determine what percent of physicians
and other practitioners in the ACO are registered in the HITECH program (discussed in section II.E. of this proposed rule). NPI data will also be helpful in our monitoring of ACO activities (which we discuss in section II.H. of this proposed rule). Therefore, we are also proposing to require that organizations applying to be an ACO provide not only their TINs but also a list of associated NPIs for all ACO professionals, including a list that separately identifies physicians that provide primary care. As we discuss in more detail later in the document, for purposes of the Shared Savings Program, we are proposing to define primary care physicians as those physicians that practice in the areas of internal medicine, general practice, family practice, and geriatric medicine. We welcome comments on our proposal to require reporting of TINs along with information about the NPIs associated with the ACO.

In summary, we believe that our proposal to define the ACO operationally as a group of Medicare-enrolled TINs, while also collecting information about the NPIs associated with those TINs, allows us to link the beneficiary, type of service provided, and the type of physician providing the services for purposes of beneficiary assignment to the ACO as required by statute. This approach also offers the most complete longitudinal data required for benchmarking and beneficiary assignment, most effectively limits administrative burden for participating providers and suppliers, and makes it possible for us to take advantage of infrastructure and methodologies already developed for group-level reporting and evaluation. Moreover, this option affords us the most flexibility and statistical stability for monitoring and evaluating quality and outcomes for the population of patients assigned to the ACO.

2. Definition of Primary Care Services

Section 1899(c) of the Act requires the Secretary to assign beneficiaries to an ACO “based on their utilization of primary care services” provided by a physician. However, the statute does not specify which kinds of services should be considered “primary care services” for this purpose, nor the amount of those services that would be an appropriate basis for making assignments. We discuss issues concerning the appropriate proportion of such services in the next section. In this section of this proposed rule, we discuss how to identify the appropriate primary care services on which to base the assignment and our proposal for defining primary care services for this purpose.

In order to ensure the statistical reliability of the required performance measurements and benchmarks, ACOs must have a sufficient number of assigned beneficiaries. Having too few beneficiaries assigned to a participating ACO will impede determining whether changes in cost and quality measures are likely a reflection of normal variation rather than real improvement in the delivery of care. Section 1899(b)(2)(D) of the Act specifically provides that the composition of the ACO shall include sufficient numbers of ACO primary care professionals so that at least 5,000 beneficiaries are assigned to the ACO.

Primary care services can generally be defined based on the type of service provided or the type of provider specialty that provides the service. The PGP demonstration has helped inform assignment methodologies. Under the PGP demonstration, the assignment methodology incorporates outpatient evaluation and management (E&M) services provided by both primary care and specialist providers. One reason for this is that certain specialists (for example, cardiologists, endocrinologists, neurologists, oncologists) are often the primary care provider for elderly and chronically ill patients who do not otherwise have a primary care provider, and it is reasonable to expect them to take responsibility for these patients’ care. Another reason is that the assignment methodology provided an opportunity for specialists to take responsibility for ensuring that their patients’ primary care needs were being met even if the specialist provided care initially on a referral basis.

We would note that in defining primary care services, certain Affordable Care Act provisions also rely on a blend of the type of service and type of provider delivering the service. For example, section 5501 of the Affordable Care Act makes incentive payments available to primary care practitioners for whom primary care services account for at least 60 percent of the allowed charges under Part B. For purposes of this provision, a “primary care practitioner” is defined as a physician “who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine,” or as a “nurse practitioner, clinical nurse specialist, or physician assistant.” In that section, “primary care services” are defined as a set of HCPCS codes: 99201 through 99215; 99304 through 99340; and 99341 through 99350. Additionally, we would consider the Welcome to Medicare visit (G0402) and the annual wellness visits (G0438 and G0439) as primary care services for purposes of the Shared Savings Program.

In developing our proposal, we have considered three options with respect to defining “primary care services” for the purposes of assigning beneficiaries under the Shared Savings Program: (1) Assignment of beneficiaries based upon a predefined set of “primary care services”; (2) assignment of beneficiaries based upon both a predefined set of “primary care services” and a predefined group of “primary care providers;” and (3) assignment of beneficiaries in a step-wise fashion. Under this option, beneficiary assignment would proceed by first identifying primary care physicians (internal medicine, family practice, general practice, geriatric medicine) who are providing primary care services, and then identifying specialists who are providing these same services for patients who are not seeing any primary care professional.

The first option would assign beneficiaries by defining “primary care services” on the basis of the select set of E&M services, specifically those defined as “primary care services” in section 5501 of the Affordable Care Act, and including G-codes associated with the annual wellness visit and Welcome to Medicare benefit regardless of provider specialty. This option would increase the number of potential beneficiaries assigned to the ACO in areas with primary care shortages (where specialists would necessarily be providing more primary care services as defined by the code set). It is also administratively straightforward, and we have experience with the similar methodology initially used in the PGP demonstration. However, assigning beneficiaries to ACOs based only on primary care services without distinction of caregiver specialty increases the likelihood of assigning beneficiaries to a specialist over a primary care provider. In addition, it would appear to be somewhat inconsistent with section 5501 of the Affordable Care Act, which, for purposes of establishing an incentive payment for primary care services, first defines a set of primary care practitioners, and then identifies a set of HCPCS codes as “primary care services.” The primary care services are recognized for the incentive payment only when they are provided by primary care practitioners. It is dubious whether these codes identified in section 5501 of the Affordable Care Act alone, when they are not provided by primary care
ensuring competition among ACOs by addition, it could undermine our goal of operational complexity compared to the primary care core in the Shared Savings Program, by failing to place any priority on the services of designated primary care providers (for example, internal medicine, general practice, family practice, and geriatric medicine) in the assignment process.

The second option that we have considered is therefore to assign beneficiaries to physicians designated as primary care providers (internal medicine, general practice, family practice, and geriatric medicine) who are providing the appropriate primary care services to beneficiaries. As in the case of the first option, we would define "primary care services" on the basis of the select set of HCPCS codes identified in section 5501 of the Affordable Care Act, including G-codes associated with the annual wellness visit and Welcome to Medicare visit. This option more closely aligns the definition of primary care services with the definition in section 5501 of the Affordable Care Act. As in the case of the first option, this option would be relatively straightforward administratively. However, this option could reduce the number of beneficiaries assigned to an ACO, by excluding primary care services delivered by specialists, especially in some areas that may have shortages of primary care physicians but a relatively greater number of specialists. Consequently, this option could make it difficult for ACOs to form in some geographic regions with such primary care shortages.

The third option we have considered is to assign beneficiaries in a step-wise fashion. Under this option, beneficiary assignment would proceed by first identifying primary care physicians (internal medicine, family practice, general practice, geriatric medicine) who are providing primary care services, and then identifying specialists who are providing these same services for patients who are not seeing any primary care professional. This option would introduce a greater level of operational complexity compared to the two other options we considered. In addition, it could undermine our goal of ensuring competition among ACOs by reducing the number of specialists that can participate in more than one ACO, since specialists to whom beneficiaries are assigned would be required to be exclusive to one ACO. As noted previously, the ability of specialists to participate in more than one ACO is especially important in certain areas of the country that might not have many specialists. On the other hand, a "step-wise approach" would not affect all specialists and it would reflect many of the advantages of the other two approaches, balancing the need for emphasis on a primary care core with a need for increased assignment numbers in areas with primary care shortages.

After considering these options, we are proposing the second option, which would assign beneficiaries with physicians designated as primary care providers (internal medicine, general practice, family practice, and geriatric medicine) who are providing the appropriate primary care services to beneficiaries. We believe that this option best aligns with other Affordable Care Act provisions related to primary care by placing an appropriate level of emphasis on a primary care core in the Shared Savings Program. That is, this option places priority on the services of designated primary care physicians (for example, internal medicine, general practice, family practice, and geriatric medicine) in the assignment process. This option also allows ACOs to focus their efforts to coordinate and redesign care for patients seeing primary care providers and creates incentives for ACOs to establish primary care linkages for their patients who may not have a primary care provider. The option is also relatively straightforward administratively.

However, we are also concerned that this proposal may not adequately account for primary care services delivered by specialists, especially in certain areas with shortages of primary care physicians, and that it may make it difficult to obtain the minimum number of beneficiaries to form an ACO in geographic regions with such primary care shortages. Therefore, while we are proposing to assign beneficiaries to physicians designated as primary care providers (internal medicine, general practice, family practice, and geriatric medicine) who are providing the appropriate primary care services to beneficiaries, we invite comments on this proposal and other options that may better address the delivery of primary care services by specialists. In the final rule, we could consider adopting another option; therefore we are seeking comments on the definition of primary care services approach as well as the "step-wise" approach as described previously.

3. Prospective vs. Retrospective Benefit Assignment To Calculate Eligibility for Shared Savings

Section 1899(d)(1) of the Act provides that an ACO may be eligible for shared savings with the Medicare program if the ACO meets performance standards established by the Secretary (which we discuss in section I.E. of this proposed rule) and meets the requirements for realizing savings for its assigned beneficiaries against the benchmark established by the Secretary under section 1899(d)(1)(B) of the Act. Thus, for each year of an agreement period each ACO will have an assigned population of beneficiaries. Eligibility for shared savings will be based on whether the requirements for receiving shared savings payments are met for this assigned population. We refer to each year for which such determinations must be made as a "performance year."

There are two basic options for assigning beneficiaries to an ACO to calculate eligibility for shared savings for a performance year. The first option is that beneficiary assignment could occur at the beginning of the performance year, or prospectively, based on utilization data demonstrating the provision of primary care services to beneficiaries in prior periods. The second option is that beneficiary assignment could occur at the end of the performance year, or retrospectively, based on utilization data demonstrating the provision of primary care services to beneficiaries by ACO physicians during the performance year.

Many observers and prospective ACO managers have argued that it is essential for an ACO to know who is included in its assigned population prior to the start of the performance year. While they intend to treat all patients the same, they assert that it is fundamental to population management to be able to profile a population, identify individuals at high risk, develop outreach programs, and proactively work with patients and their families to establish care plans. These observers also argue that, as with any well managed enterprise, it is essential to have operational goals and targets to manage effectively. Thus, they would like to be able to track prospective targeted expenses, in order to gauge their results as they go through the performance year. These observers also understand that even prospective assignment methodologies will require a retrospective definition of the population to adjust for a variety of changes in the population that occur during a performance year. Some current patients of the practice will
become eligible for Medicare. Some will join a Medicare Advantage (MA) plan and, although they may continue to receive care furnished by the ACO, these beneficiaries can no longer be considered part of the assigned population of the ACO for purposes of computing shared savings. Individuals will move in and out of the service area during the year. For all these reasons, any methodology will require a retrospective redefinition of the assigned population.

Advocates for the retrospective approach argue that the actual population seen by a set of physicians changes significantly from year to year. Medicare FFS beneficiaries’ right to see any enrolled physician typically leads to more year-to-year variability in treating physicians compared to patients in managed care programs. Analysis of the PGP population did show approximately a 25 percent variation in assignment from year to year. Prospective assignment of a population seems inherently inaccurate from this perspective. If beneficiary assignment changes by 25 percent from year to year, a prospective assignment would not be an accurate reflection of those beneficiaries that were actually seen by physicians in the ACO during the performance year. Retrospective assignment of the population, on the other hand, appropriately holds the ACO accountable for the actual population it cared for during the performance year.

Proponents of the retrospective approach also make a second argument. They suggest that identifying a population prospectively may lead an ACO to focus only on providing care coordination and other ACO services to this limited population, ignoring other beneficiaries in their practices or hospitals. Given that the goal of the Shared Savings Program is to change the care experience for all beneficiaries, ACOs should not be told who among their patients are likely to be in their assigned population. ACO participants and ACO providers/suppliers should have incentives to treat all patients equally, using standardized evidence-based care processes, to improve the quality and efficiency of all of the care they provide, and in the end they should see positive results in the retrospectively assigned population. We believe there are merits in both approaches. It does seem appropriate for an ACO to have information regarding the population it will likely be responsible for in order to target its care improvement activities to a subset of their patients that they believe may be assigned to them. Finally, we believe it is critical that the assessment of ACO performance in any year be based on patients who received the plurality of their primary care from the ACO in that year, rather than an earlier period. As noted previously, even under a prospective assignment approach, a retrospective redefinition of the assigned population to account for changes from prior periods would be required or the ACO would be held accountable for patients that it did not provide services for during the performance year. Under a prospective system, the assignment would have to be adjusted every year to account for beneficiaries entering and leaving FFS Medicare as well as for those patients who move in and out of the geographic area of the ACO, as well as potentially other adjustments such as when a beneficiary remains in the area but chooses to receive their care outside of the ACO based upon where the plurality of their primary care services are being performed. Considering the merits of both approaches, we believe that the retrospective approach to beneficiary assignment for purposes of determining eligibility for shared savings is compelling. We believe that the assignment process should accurately reflect the population that an ACO is actually caring for, in order to ensure that the evaluation of quality measures is fair and that the calculation of shared savings, if any, accurately reflects the ACO’s success in improving the quality and efficiency of the care provided to the beneficiaries for which it was actually accountable. In contrast, as we noted previously, a prospective approach has intrinsic inaccuracies, and requires additional adjustments in order to achieve the requisite level of accuracy for purposes of the Shared Savings Program.

In response to the November 17, 2010 RFI, of the few commenters favoring retrospective alignment, a group of commenters suggested the use of retrospective alignment for determining utilization and shared savings, but prospective assignment for purposes of CMS sharing beneficiary identifiable data with ACOs. We agree that, given appropriate safeguards for maintaining the confidentiality of patient information, providing ACOs with meaningful information about their “expected assigned population” with the potential to identify an estimated benchmark target will be helpful. We address our proposals for providing information to ACOs to help them understand their patient populations and better manage their care in section II.C. of this proposed rule.

Therefore, we are proposing the combined approach of retrospective beneficiary assignment for purposes of determining eligibility for shared savings balanced by the provision of aggregate beneficiary level data for the assigned population of Medicare beneficiaries during the benchmark period. (As we discuss in section II.C. of this proposed rule, we will provide ACOs with a list of beneficiary names, date of birth, sex, and other information derived from the assignment algorithm used to generate the 3-year benchmark.) Although the assignment methodology for the PGP demonstration was different from the proposed Shared Savings Program assignment methodology, when the PGP data is modeled with the Shared Savings Program assignment methodology, the assigned patient population would vary by approximately 25 percent from year to year. We believe that providing data on those beneficiaries that are assigned to an ACO in the benchmark period is a good compromise that will allow ACOs to have information on the population they will likely be responsible for in order to target their care improvements to that population while still not encouraging ACOs to limit their care improvement activities to only the subset of beneficiaries they believe will be assigned to them in the performance year. We believe that such a combined approach provides the best of both approaches while minimizing the disadvantages of either. ACO physicians will have the information they need to manage their population and estimate a target to manage towards, while they will still be encouraged to provide high-quality, efficient, and well-coordinated services to all Medicare FFS beneficiaries because they will not know for sure who will be in the assigned population. However, the ultimate evaluation of their effectiveness will be based on the actual population they served. We solicit comments on this combined approach of retrospective beneficiary assignment for purposes of determining eligibility for shared savings balanced by the provision of beneficiary data (names, date of birth, etc.) and aggregate beneficiary level data for the assigned population of Medicare beneficiaries during the benchmark period. We also seek comment on alternate assignment approaches, including the prospective method of assignment.
4. Majority vs. Plurality Rule for Beneficiary Assignment

Section 1899(c) of the Act requires that Medicare FFS beneficiaries be assigned to “an ACO based on their utilization of primary care services” furnished by an ACO professional who is a physician, but it does not prescribe the methodology for such assignment, nor criteria on the level of primary care services utilization that should serve as the basis for such assignment. Rather, the statute requires the Secretary to “determine an appropriate method to assign Medicare FFS beneficiaries to an ACO” on the basis of their primary care utilization.

An obvious general approach is to make such an assignment on the basis of some percentage level of the primary care services a beneficiary receives from an ACO physician. The more specific issue under such an approach is whether to assign beneficiaries to the ACO when they receive a plurality of their primary care services from that ACO, or to adopt a stricter standard under which a beneficiary will be assigned to an ACO only when he or she receives a majority of their primary care services from an ACO.

Under the PGP demonstration beneficiaries were assigned to a practice based on the plurality rule. By employing a plurality standard for primary care services, our analysis indicates that between 78 and 88 percent of the patients seen for primary care services at the PGP during the year were subsequently assigned to that PGP group. As measured by allowed charges (evaluation and management CPT codes), the PGP provided on average 95 percent of all primary care services provided to the assigned patients.

Alternatively, it could be argued that adopting a majority standard might enhance an ACO’s sense of responsibility for its assigned patients, which is certainly consistent with the general goals of the Shared Savings Program. However, adopting a majority standard would likely somewhat reduce the number of beneficiaries assigned to an ACO and more beneficiaries would be unassigned to any ACO. On balance, we believe that a majority rule for assignment is too strict a standard to employ in a system where many Medicare beneficiaries may regularly receive primary care services from two or more primary care practitioners (for example, an internal medicine physician and a geriatric medicine physician). As such, this standard could undermine the development and sustainability of ACOs. Therefore, we are proposing to assign beneficiaries for purposes of the Shared Savings Program to an ACO if they receive a plurality of their primary care services from primary care physicians within that ACO. We believe that the plurality rule provides a sufficient standard for assignment because it ensures that beneficiaries will be assigned to an ACO when they receive more primary care from that ACO than from any other provider. This will result in a greater number of beneficiaries assigned to ACOs, which may enhance the viability of the Shared Savings Program, especially in its initial years of operation. We welcome comments on our proposal to assign patients based upon a plurality rule. Additionally we would also welcome any comments on whether there should be a minimum threshold number of primary care services that a beneficiary should receive from physicians in the ACO in order to be assigned to the ACO under the plurality rule and if so, where that minimum threshold should be set.

Finally, we can determine when a beneficiary has received a plurality of primary care services from an ACO either on the basis of a simple service count or on the basis of the accumulated allowed charges for the services delivered. The method of using a plurality of allowed charges would provide a greater weight to more complex primary care services in the assignment methodology, while a simple service method count would weigh all primary care encounters equally in determining assignment. We have previous experience with the method of using a plurality of allowed charges in the PGP demonstration. One advantage of this method is that it would not require tie-breaker rules, since it is unlikely that allowed charges by two different entities would be equal. On the other hand, this method does not necessarily assign the beneficiary to the entity that saw the patient most frequently, but rather to the entity that provided the highest complexity and intensity of primary care services.

Assignment of beneficiaries on the basis of plurality in a simple service method count would require tie-breaker rules for those rare occasions when two or more entities delivered an equal number of services to a beneficiary. One possible tie-breaker for such cases is to assign the beneficiary to the ACO if it is the entity that most recently provided primary care services.

We propose to implement the method of using a plurality of allowed charges for primary care services to assign beneficiaries to ACOs. Allowed charges are reasonable proxy for the resource use of the underlying primary care services, so the method of using a plurality of allowed charges assigns beneficiaries to ACOs according to the intensity of their primary care interactions, not merely the frequency of such services.

5. Beneficiary Information and Notification

Section 1899(c) of the Act, as added by section 3022 of the Affordable Care Act, does not state whether beneficiaries should be informed in any way about the Shared Savings Program. Thus, it does not specify any information to be provided to beneficiaries about the Shared Savings Program in general, whether they are receiving services from an ACO participant or ACO provider/supplier, or whether they have been assigned to an ACO for purposes of determining that ACO’s performance with respect to the quality standards and its possible shared savings under the Shared Savings Program.

As discussed previously, the term “assignment” as used in the statute for purposes of this provision in no way implies any limits, restrictions, or diminishment of the rights of Medicare FFS beneficiaries to exercise freedom of choice in the physicians and other health care practitioners from whom they receive their services. Rather, the statutory term “assignment” in this context refers only to an operational process by which Medicare will determine whether a beneficiary has chosen to receive a sufficient level of the requisite primary care services from a specific ACO so that the ACO may be appropriately designated as being accountable for that beneficiary’s care. For example, if a beneficiary’s physician becomes part of an ACO and the beneficiary does not wish to receive health care services under the ACO care coordination and management efforts, the beneficiary has the freedom of choice to go to a different physician. The continued exercise of free choice by beneficiaries in selecting the physicians and other health care practitioners from whom they receive their services is thus a presupposition of the Shared Savings Program. The exercise of free choice, however, can be undermined or even nullified if beneficiaries do not possess adequate information to assess the possible consequences of available choices, or to evaluate which available options are most consistent with their values and preferences concerning their own health care. We therefore believe that an important component of the Shared Savings Program must be timely and effective communication with beneficiaries concerning the Shared Savings Program, their potential
assignment to an ACO, and what that may mean for the beneficiaries’ care.

Furthermore, the Shared Savings Program lays the foundation for a beneficiary-centered delivery system that should create a strong relationship between beneficiaries and care providers based, in large part, on patient engagement in the new care system. Such engagement would be more difficult when beneficiaries are not aware of the new delivery system available from ACOs, and the possibility of being included in the population assigned to an ACO. In short, transparency must be a central feature of the Shared Savings Program.

Therefore, we intend to develop a communications plan, including educational materials and other forms of outreach, to provide beneficiaries in a timely manner with accurate, clear, and understandable information about the Shared Savings Program in general, about their utilization of services furnished by a provider or supplier participating in an ACO, about the possibility of their being assigned to an ACO for quality and shared savings purposes, and about the potential that their health information may be shared with the ACO, and their ability to opt-out of that data sharing. Accordingly, we will update the annual Medicare handbook to contain information about the Shared Savings Program, ACOs, and what receiving care from an ACO means for the Medicare FFS beneficiary.

One limitation on the timing of the information that we provide to beneficiaries arises from our proposal to assign beneficiaries to an ACO retroactively, that is, after the end of a performance year, on the basis of a beneficiary’s actual primary care service utilization during the year. It is therefore not possible to inform beneficiaries of their assignment to an ACO in advance of the period in which they may seek services from the ACO. However, we believe that it is essential for beneficiaries to receive some form of advance notification that a physician or other provider from whom they are receiving services is participating in an ACO. The only practical manner in which such notification could be provided in a timely manner is to require ACOs to provide such notification to beneficiaries when they seek services from ACO providers/suppliers. Specifically, we propose to require ACOs to post signs in the facilities of participating ACO providers/suppliers indicating their participation in the Shared Savings Program available standardized written information to Medicare FFS beneficiaries whom they serve. ACOs would provide standardized written notice to beneficiaries of both their participation in the Shared Savings Program and the potential for CMS to share beneficiary identifiable data with ACOs when a beneficiary receives services from a physician on whom assignment to ACO is based. We also plan to instruct ACOs to supply a form allowing beneficiaries to opt-out of having their data shared. The form would be provided to each beneficiary as part of their office visit with a primary care physician, and must include a phone number, fax or e-mail for beneficiaries to contact and request that their data not be shared.

Likewise, in instances where either an ACO chooses to no longer participate in the Shared Savings Program or we have terminated a participation agreement with an ACO, beneficiaries should be made aware of this change. Thus, we are proposing that ACOs be required to provide beneficiaries notice in a timely manner if they will no longer be participating in the Shared Savings Program. It should include the effective date of the termination of their agreement with us. As discussed in section II.C. of this proposed rule, we are also proposing to require an ACO seeking to terminate its participation in the Shared Savings Program to provide us with advanced notice.

We recognize that such a requirement could place an administrative burden on ACOs. However, we believe that such notification is essential to enhance patient engagement and understanding of their care. As discussed in section ILB. of this proposed rule, section 1899(b)(2)(H) of the Act requires that the “ACO * * * demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary * * *.” We believe that providing notice of participation in or termination from the Shared Savings Program to beneficiaries is essential to the ability of beneficiaries to exercise free choice, and therefore would be an appropriate patient-centered criterion to be designated by the Secretary. In addition to notifying beneficiaries that they are seeking services from a provider or supplier participating in an ACO under the Shared Savings Program, this proposed notification will inform beneficiaries how assignment with an ACO is likely to affect (and not affect) the care they receive from the providers they have chosen. We seek comment on the appropriate form and content of this notification. For example, we seek comment on the utility of informing consumers about those objectives of the Shared Savings Program that might have the most impact on the beneficiary as a consumer of services from an ACO professional, such as the following:

- Easing the burden on consumers to coordinate their own care among different providers,
- Fostering follow-up with patients as they receive care from different providers,
- Facilitating greater dialogue between and among beneficiaries and providers about how health care is delivered, and
- Providing beneficiaries with quality measures by which they can evaluate the performance of their providers compared to regional and national norms.

We also seek comment on the most important items to communicate to beneficiaries about matters that will not change under the Shared Savings Program, including the fact that their cost-sharing will continue to be the same, and they remain free to seek care from providers of their choosing.

We welcome comments not only on our proposal to establish these notification requirements, but also on all matters concerning the appropriate form and content of such notification. If we adopt a notification requirement in the final rule, we will take comments on the issues such as the appropriate form and content of such a notification into account as we develop more detailed instructions for ACOs on beneficiary notification through guidance.

E. Quality and Other Reporting Requirements

1. Introduction

As discussed in section I. of this proposed rule, the intent of the Shared Savings Program is to: (1) Promote accountability to Medicare beneficiaries; (2) improve the coordination of FFS items and services; and (3) encourage investment in infrastructure and redesigned care processes to achieve high health care quality and efficient service delivery. In conjunction with the Shared Savings Program and other provisions of the Affordable Care Act, we have adopted three goals for improvement of the health care of Medicare beneficiaries and, by extension, of all Americans. These goals include: (1) Better care for individuals; (2) better health for populations; and (3) lower growth in expenditures. (We define better health care for individuals as health care that is safe, effective, patient-centered, timely, efficient, and equitable, as described in the IOM’s six aims for changing U.S. health care delivery.)

14 Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality