

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

[CMS-1345-NC]

Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: This document is a request for comments regarding certain aspects of the policies and standards that will apply to accountable care organizations (ACOs) participating in the Medicare program under section 3021 or 3022 of the Affordable Care Act.

DATES: Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--insert date 21 days after date of display in the **Federal Register**].

ADDRESSES: In commenting, please refer to file code CMS-1345-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

- Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow "Submit a comment" instructions.
- By regular mail. You may mail written comments to the following address

ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1345-NC,
P.O. Box 8013,
Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

- By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1345-NC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

- By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to one of the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT:

Thomas Carey, (410) 786-4560 or Thomas.Carey@cms.hhs.gov

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

The Affordable Care Act seeks to improve the quality of health care services and to lower health care costs by encouraging providers to create integrated health care delivery systems. These integrated systems will test new reimbursement methods intended to create incentives for health care providers to enhance health care quality and lower costs. One important delivery system reform is the Medicare Shared Savings Program under section 3022 of the Affordable Care Act, which promotes the formation and operation of accountable care organizations (ACOs). Under this provision, "groups of providers . . . meeting the criteria specified by the Secretary may work together to

manage and coordinate care for Medicare . . . beneficiaries through an [ACO]." An ACO may receive payments for shared savings if the ACO meets certain quality performance standards and cost savings requirements established by the Secretary. We are developing rulemaking for the establishment of the Shared Savings Program under section 3022 of the Affordable Care Act. In addition, section 3021 of the Affordable Care Act establishes a Center for Medicare and Medicaid Innovation (CMMI) within CMS, which is authorized to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. We are considering testing innovative payment and delivery system models that complement the Shared Savings Program in the CMMI. In both of these efforts, we are seeking to advance ACO structures that are organized in ways that are patient-centered and foster participation of physicians and other clinicians who are in solo or small practices.

We have already conducted substantial outreach and had discussions with and received feedback from a wide array of physician groups, as well as groups representing other clinicians, hospitals, employers, consumers, and other interested parties, about how ACO programs can best be structured. In particular, CMS, along with the Office of the Inspector General (OIG) of the Department of Health and Human Services (DHHS) and the Federal Trade Commission hosted a public workshop on October 5, 2010, to discuss the application and enforcement of the antitrust laws, physician self-referral prohibition, Federal anti-kickback statute, and civil monetary penalty law to the variety of possible ACO structures under the Shared Savings Program and other innovative payment models that CMMI is authorized to test under section 3021 of the Affordable Care Act. Prior to

the public workshop, the three agencies solicited written comments and statements from industry stakeholders regarding a variety of issues, including the planned legal structures and business models of ACOs.

II. Solicitation of Comments

As we develop our initial rulemaking for the Shared Savings Program and begin the development of potential models in the CMMI, we are seeking additional information, particularly from the physician community, on the following questions:

- What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?

- Many small practices may have limited access to capital or other resources to fund efforts from which "shared savings" could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

- The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACO's focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's

performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are aligned to it based upon services they receive from the ACO during the performance period. How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?

- How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?
- The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?
- In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?
- What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority under the CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

CMS-1345-NC

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: November 10, 2010

Donald M. Berwick,

Administrator,

Centers for Medicare & Medicaid Services.

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