APPENDIX

Proposed Rule versus Final Rule for Accountable Care Organizations (ACOs) In the Medicare Shared Savings Program.

Topic	Proposed Rule	Modifications in Final Rule
Transition to risk in Track 1	ACOs could choose from two tracks, each entailing a 3-year agreement. Track 1 would comprise 2 years of one-sided shared savings with a mandatory transition in year 3 to performance-based risk under a two-sided model of shared savings and losses. Track 2 would comprise 3 years all under the two-sided model.	Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.
Prospective vs. retrospective	Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.	A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year based on patients served by the ACO.
Proposed measures to assess quality	65 measures in 5 domains, including patient experience of care, utilization claims–based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years. Alignment of proposed measures with existing quality programs and private-sector initiatives	33 measures in 4 domains. (Note: Claims-based measures not finalized to be used for ACO-monitoring purposes) Longer phase-in measures over course of agreement: first year, pay for reporting; second year and third year, pay for reporting and performance. Finalize as proposed.
Sharing savings	One-sided risk model: sharing beginning at savings of 2%, with some exceptions for small, physician-only, and rural ACOs. Two-Sided Risk Model: sharing from first dollar.	Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.

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Sharing beneficiary ID Claims Data	Claims data shared only for patients seen by ACO primary care physician during performance year; beneficiaries given opportunity to decline at the point of care.	The ACO may contact beneficiaries from provided quarterly lists to notify them of data sharing and opportunity to decline.
Eligible entities	The four groups specified by the Affordable Care Act, as well as critical access hospitals paid through Method II, are eligible to form an ACO. ACOs can be established with broad collaboration beyond these providers.	In addition to groups included in the proposed rule, Federally Qualified Health Centers and Rural Health Clinics are also eligible to both form and participate in an ACO. In order for beneficiaries to be assigned on the basis of utilization of primary care services, these organizations must provide a list of practitioners who directly render primary care services in their facilities.
Start date	Agreement for 3 years with uniform annual start date; performance years based on calendar years.	Program established by January 1, 2012; first round of applications are due in early 2012. First ACO agreements start 4/1/2012 and 7/1/2012. ACOs will have agreements with a first performance "year" of 18 or 21 months. ACOs starting 4/1/2012 and 7/1/2012 have option for an interim payment if they report CY 2012 quality measures. ACO must report quality measures for CY 2013 to qualify for first-performance-year shared savings.
Aggregate reports and preliminary prospective list	Reports will be provided at the beginning of each performance year and include: name, date of birth, sex, and health insurance claim number.	Additional reports will be provided quarterly.
Electronic health record (EHR) Use	Aligning ACO requirements with EHR requirements, 50% of primary care physicians must be defined as meaningful users by start of second performance year.	No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.

Topic	Proposed Rule	Modifications in Final Rule
Assignment process	One-step assignment process: beneficiaries assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians (internal medicine, general practice, family practice, and geriatric medicine).	Two-step assignment process: • Step 1: for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services rendered by primary care physicians. • Step 2: for beneficiaries who have not received any primary care services from a primary care physician, use plurality of allowed charges for primary care services rendered by any other ACO professional.
Marketing guidelines	All marketing materials must be approved by the Center for Medicare and Medicaid Services (CMS).	"File and use" 5 days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language.