CHCS Center for Health Care Strategies, Inc.

TECHNICAL ASSISTANCE BRIEF | JULY 2017

Medicaid Accountable Care Organization Shared Savings Programs: Options for Maximizing Provider Participation and Program Sustainability

By Rachael Matulis, Center for Health Care Strategies

IN BRIEF

Many states that have successfully launched Medicaid accountable care organization (ACO) programs in recent years have adopted a shared savings payment model. A general issue with shared savings programs is that they typically use a total cost of care (TCoC) benchmark that is based at least in part on an ACO's historical spending, which means that health systems with higher costs and more waste may be more likely to share in savings than more efficient providers. A related concern is that as ACOs achieve cost savings, there may be a threat of payment cuts down the road, given that payment rates are often based on historic costs and use.

This technical assistance brief, made possible by The Commonwealth Fund, explores strategies for adjusting shared savings payment methodologies — including approaches to TCoC benchmark setting — that could help states address concerns about program sustainability and keep savings in the health care system. It outlines theoretical examples based on different approaches used by the Medicare Shared Savings Program (MSSP), selected state Medicaid ACO programs, and suggestions from other research organizations. It also offers a suggested payment calculation that factors in startup costs paid by providers to form new ACOs.

Medicaid accountable care organizations (ACOs) are becoming increasingly prevalent throughout the United States. Ten states have successfully launched Medicaid ACO programs, with the goal of improving health outcomes and reducing health care costs. Many of the states with Medicaid ACO programs have adopted a shared savings payment model. Under this method, an ACO can receive an additional payment if spending for its attributed patients is lower than a cost target, often referred to as the total cost of care (TCoC) benchmark. The TCoC benchmark typically reflects average expenditures for a wide-range of health services and settings, including inpatient, outpatient, laboratory, radiology, and pharmaceuticals. This projected cost estimate is then compared to an ACO's actual spending to assess whether an ACO has generated savings or incurred losses during the performance year. When an ACO achieves a certain level of savings, an ACO can "share" in the savings with its payer, whether it be Medicare, Medicaid, or and/a commercial insurer. Generally speaking, shared savings payouts should be contingent upon quality performance to help ensure that ACOs are not withholding needed services in order to retain savings.

How are ACO Shared Savings Payment Rates Established?

State agencies with Medicaid ACO shared savings programs have historically relied on the Medicare Shared Savings Program (MSSP) as a foundation for developing their ACO payment models. In the MSSP model, shared savings and losses are measured by comparing actual expenditures to a benchmark of average expenditures for Medicare beneficiaries attributed to the ACO in the three years prior to the ACO's existence. The Centers for Medicare & Medicaid Services (CMS) annually updates the benchmark for national Medicare expenditure growth trends and changes in ACO participants, but otherwise MSSP ACOs have relatively stable benchmarks over the three-year MSSP agreement period. CMS then formally resets — or rebases — the benchmark after each three-year period. In some cases, Medicaid agencies have modified the MSSP methodology to account for differences in the populations served and the

Made possible through support from The Commonwealth Fund.

structure of their ACO programs.[1] For example, Minnesota's ACO program uses one year of historical claims or encounter data — rather than three years as Medicare does under MSSP — to set the TCoC benchmarks for its ACOs. Decisions regarding the shared savings payment methodology — including but not limited to how TCoC benchmarks are set and rebased — have significant implications on shared savings payout amounts, provider participation, and program sustainability.[2]

A general issue with ACO shared savings programs is that they typically use a TCoC benchmark that is based at least in part on an ACO's historical spending, which means that health systems with higher costs and more waste may be more likely to share in savings than more efficient providers. A related concern is that savings could be more difficult to obtain as an ACO program progresses, since successful ACOs would be graded against their continually improving benchmark (i.e., if an ACO saves money in one performance year, the target benchmark for the next performance year could be lower). Further, as ACOs successfully achieve cost savings, there may be a looming threat of payment cuts down the road for both ACOs and payers (including state Medicaid agencies and/or health plans), given that payment rates are typically set based on historic costs and utilization. A final concern, particularly for safety net providers, is finding the capital needed to become an ACO. CMS estimated in its June 2015 final rule that upfront investments for ACO formation under the MSSP — including health information technology (HIT), process development, staffing, population management, care coordination, quality reporting, and patient education — would be approximately $580,000.[3] Furthermore, CMS' estimated annual costs to manage day-to-day operations under an MSSP ACO were even higher, at $860,000 per year.

This technical assistance brief explores ways states can adjust the shared savings payment methodology, including approaches to TCoC benchmark setting and rebasing that could help address concerns about program sustainability and offer ways to help keep savings in the health care system. It also offers a suggested payment calculation that factors in startup costs paid by providers in order to form their ACOs. These suggestions include different approaches used by the MSSP, selected state Medicaid ACO programs, and suggestions from other research organizations.

Case Study Example: Wellness ACO

In order to walk through the impact of the different approaches to benchmark rebasing and shared savings payout calculations, following is a hypothetical example of the launch of a new ACO program, Wellness ACO.[4] Wellness ACO launched in 2014, and spent $600,000 on start-up program investment costs not reimbursed under traditional fee-for-service payments (e.g., spending on staffing, care coordination, population management, HIT, quality reporting, etc.).[5] Wellness ACO has a total of 5,000 attributed Medicaid beneficiaries each performance year. In this example, the state will share in 50 percent of any identified savings. Please note that the examples below are oversimplified and meant simply for illustration purposes. Many factors go into benchmark development, benchmark rebasing, and final reconciliation of shared savings payouts, including but not limited to: (1) annualizing beneficiary enrollment and expenditures; (2) risk-adjustment; (3) price normalization; (4) comparison of ACO spending to minimum savings or loss rates, as well as savings or loss caps; and (5) adjusting for impact of quality scores.

Hypothetical Example: Launch of Wellness ACO in 2014

Year	Status of Wellness ACO	Average per Member per Year (PMPY) Costs
2014	$600,000 in upfront investments to launch new Medicaid ACO program	$6,000
2015	ACO program provides high-quality care; maintains costs	$6,000
2016	ACO program provides high-quality care and reduces costs	$5,800
2017	ACO program continues providing high-quality, cost-effective care	$5,500 (projected)

Approach 1: Adjust Number of Years and Weights of Years Informing the TCoC Benchmark (MSSP)

CMS uses three years of historical claims data to set the initial TCoC benchmark for MSSP ACOs for the first three-year agreement period. CMS does make annual updates for national fee-for-services trends and changes in ACO participants, but otherwise MSSP ACOs have relatively stable benchmarks over the three-year period. CMS then formally resets (or rebases) the benchmark after each three-year MSSP ACO agreement period.

To set and rebase the MSSP ACO benchmark, Medicare used to weight the three years differently, with Year 1 at 10 percent, Year 2 at 30 percent, and Year 3 at 60 percent. This approach was solidified in the November 2011 final rule. According to CMS, this weighting created a benchmark that more accurately reflected the latest expenditures and health status of the ACOs' assigned patient population. In its June 2015 Final Rule, CMS updated its MSSP benchmark rebasing methodology.[6] Under the new rule, CMS now weights the three benchmark years equally, saying that this approach *"mitigates reductions to the benchmark that would result from placing a higher weight on more recent prior benchmark years, in which ACOs are anticipated to show greater expenditure reductions. This methodology was designed to encourage continued participation in the Shared Savings Program and performance improvement by ACOs […], and therefore improve the overall sustainability of the program."*[7]

Factors	Original MSSP Benchmark Approach	Updated MSSP Benchmark Approach – June 2015	Example Medicaid ACO Benchmark Approach
Case Study Example: Wellness ACO started in 2014 and had PMPY costs of $6,000 in 2014 (Year 1); $6,000 in 2015 (Year 2); $5,800 in 2016 (Year 3); and $5,500 projected PMPY for 2017 (Year 4)			
Methodology	Blended 3-year claims-based benchmark (Year 1 at 10%, Year 2 at 30%, Year 3 at 60%)	Blended 3-year claims-based benchmark (Year 1 at 33.3%, Year 2 at 33.3%, Year 3 at 33.3%)	1-year benchmark based on most recent year of claims and/or MCO encounter data (Year 3)
PMPY TCoC Benchmark for 2017	$5,880	$5,927	$5,800
Projected Savings for 2017	$1.90 million *Formula*: $5,880-$5,500 x 5,000 beneficiaries	$2.14 million *Formula*: $5,927-$5,500 x 5,000 beneficiaries	$1.50 million *Formula*: $5,800-$5,500 x 5,000 beneficiaries
Projected Shared Savings Payouts (50% sharing rate)	State: $950,000 Wellness ACO: $950,000	State: $1.07 million Wellness ACO: $1.07 million	State: $750,000 Wellness ACO: $750,000

Implications for States

States could consider incorporating multiple years into the TCoC benchmark, and adjusting the weight on the earlier years to mitigate reductions to the benchmark that could occur from ACOs successfully demonstrating cost savings. While CMS weights the three years equally, a state could even consider weighting the earlier years more heavily (e.g., Year 1 at 60 percent, Year 2 at 30 percent, Year 3 at 10 percent). As indicated in the table above, this approach could increase the total amount of money that states would need to payout to ACOs each year, due to higher TCoC benchmarks, when compared to an approach that uses only one year (i.e., the most recent year of spending) to set benchmarks. Therefore, a state might consider creating an ACO "savings pool," so that money saved by the state in one year of the ACO program could be used to help subsidize additional "savings" resulting from artificially high TCoC benchmarks in future years.

Approach 2: Apply Regional Expenditures to the ACO's Rebased TCoC Benchmark (MSSP, Massachusetts)

Initially, Medicare based MSSP benchmarks solely on an ACO's historical Medicare spending and reset (or rebased) the benchmarks every three years. In the June 2016 MSSP Final Rule,[8] CMS also modified the methodology for rebasing and updating ACO historical benchmarks to incorporate regional expenditures, thereby making the ACO's cost target more independent of its historical expenditures and more reflective of FFS spending in its region.[9] CMS is now using a phased-in approach to transition to higher weights in calculating the regional adjustment. More specifically, in the 2nd MSSP performance year, CMS will apply a 35 percent adjustment for regional expenditures, or a 25 percent adjustment if the ACO is determined to have higher spending compared to its region. In the 3rd MSSP performance year, CMS will apply a 70 percent adjustment, or 50 percent if an ACO is determined to have higher spending compared to its region. Ultimately, CMS will apply a weight of 70 percent to calculate the regional adjustment for all ACOs.

Following is a high-level review of the methodology behind the MSSP regional adjustment for 2017:

- **Step 1**: Calculate the difference between the average per capita expenditure for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark.
- **Step 2**: Multiply this amount by the appropriate regional adjustment (i.e., 35 percent if the ACO had lower spending compared to its region; 25 percent if it had higher spending compared to its region).
- **Step 3**: Add this amount to the ACO's prior year's TCoC benchmark.

Note that regional expenditures are risk-adjusted to account for differences in severity of health status and case mix for the ACO's assigned population versus the ACO's regional service area. This helps to mitigate the incentive for ACOs to avoid relatively higher cost providers and higher-cost, higher-acuity beneficiaries. For example, if an ACO's attributed patient population is healthier than the ACO's regional service area, with lower average risk scores, the risk adjustment would reduce the amount of the regional FFS adjustment. Similarly, if the ACO's assigned beneficiary population is comparably sicker than the beneficiaries in the ACO's region, with higher average risk scores for the relevant period, the risk adjustment would increase the amount of the regional FFS adjustment. For the MSSP program, CMS uses Hierarchical Condition Categories (HCC) to develop average risk scores for the ACO's assigned beneficiaries and average risk scores in the ACO's regional service area. The HCC coding system uses demographic and diagnosis data to predict the relative healthcare needs for a population of participants.

Factors	Updated MSSP Benchmark Approach: Regional Adjustment – June 2016	Hypothetical Medicaid ACO Benchmark Approach
Case Study Example: Wellness ACO's PMPY in performance year 2016 was $5,800, and its projected PMPM for 2017 is $5,500. Assume the average PMPY in the ACO's region was $6,000 in 2016, and Wellness ACO's cost benchmark is $5,800.		
Methodology	Apply a 35% regional adjustment to cost benchmark (a 35% adjustment is applied because the ACO had lower spending compared to its region) *Formula*: $6,000 - $5,800 = $200; $200 * 35% = $70; $70 + $5,800 = $5,870	1-year benchmark based on ACO's historical spending in most recent year; does not factor in regional spending
PMPY TCoC Benchmark for 2017	$5,870	$5,800
Projected Savings for 2017	$1.85 million *Formula*: $5,870 -$5,500 x 5,000 beneficiaries	$1.50 million *Formula*: $5,800-$5,500 x 5,000 beneficiaries
Projected Shared Savings Payouts (50% sharing rate)	State: $925,000 Wellness ACO: $925,000	State: $750,000 Wellness ACO: $750,000

Massachusetts plans to take a similar phased approach to moving from a benchmark based on historical performance to one based on regional spending. More specifically MassHealth intends to move its pricing structure over time to an approach in which all ACOs are, after accounting for the risk profile of the members they serve, accountable to the same market-based TCoC standard; this is in lieu of using an ACO-specific benchmark based on each ACO's historical spending.[10] Given the variation in TCoC performance among providers in the state, MassHealth plans to take a gradual approach to shifting ACOs toward full market-based accountability. MassHealth intends to do this by reducing the weight of its ACOs' historical experience and increasing the weighting of the market based standard over time. MassHealth anticipates that in Year 1 of the ACO program, each ACO's historical experience will be weighted between 70 percent and 90 percent. MassHealth anticipates making the transition to a full, market-based standard over seven to 10 years.

Implications for States

States could consider applying a regional adjustment to their TCoC benchmark methodology, especially if the state has high-performing ACOs that are already considered efficient providers. As indicated in the table above, this approach could increase the total amount of money that states would need to payout to ACOs each year, due to higher TCoC benchmarks. However, if ACOs are relatively *inefficient* compared to the region, their benchmarks would be revised downward, potentially resulting in lower savings payouts to the ACOs.

Approach 3: Do Not Rebase Benchmarks for Relatively Efficient ACOs (MedPAC)

A relatively simple approach recommended by the Medicare Payment Advisory Commission (MedPAC) is not to rebase benchmarks downward in the second agreement period for relatively efficient ACOs that reduce the cost of care in the first ACO contract cycle.[11] For example, ACOs that have relatively low risk-adjusted service use would not have their benchmark reduced in the second cycle if they reduce spending in the first cycle. In contrast, ACOs that have historically had high levels of risk-adjusted service use would have their benchmark reduced in the second cycle if they improve, because they are believed to have more room to continue to improve.

Implications for States

States could consider not rebasing benchmarks for relatively efficient ACOs. This strategy would be in lieu of Approach #2 above. It is important that comparisons between ACOs and regional spending be risk-adjusted to account for differences in severity of health status and case mix for an ACO's assigned population versus the ACO's regional service area.

Approach 4: Add Savings from Prior Performance Period into Next Year's TCoC Benchmark (old MSSP)

CMS used to make an additional adjustment to MSSP ACOs' historical benchmarks to add back in a portion of the savings from the prior agreement period. In the June 2015 Final Rule, CMS solidified this approach, which was designed as a way to encourage continued participation by successful ACOs and to improve the incentive to achieve savings.[12] However, CMS eliminated this adjustment in the June 2016 MSSP Final Rule.[13] CMS did not directly address why it eliminated this adjustment, but it did note in the June 2016 rule the importance of monitoring TCoC benchmarks to ensure that they are not becoming overly inflated *"to the point where ACOs need to do little to maintain or change their care practices to generate savings."*[14] CMS also indicated that other changes it made to the MSSP benchmark methodology in the June 2016 final rule — i.e., adjusting for regional trend factors and re-weighting the benchmark years —

should encourage continued participation and improve overall sustainability of the program, helping to mitigate the effects of eliminating the addition of savings from prior periods.

To help prevent a situation in which the reset benchmark becomes overly inflated, CMS finalized an approach in the June 2015 Final Rule whereby it accounted for savings generated by an ACO in rebasing its benchmark if the ACO generated net savings across the three performance years under its first agreement period, and also accounted for the ACO's quality performance in each performance year under its first agreement period. Here is a high-level review of the MSSP methodology used to add savings into the rebased benchmark:

- **Step 1**: Determine whether the ACO generated net savings across the three performance years.
- **Step 2**: Calculate an average per beneficiary savings amount that is adjusted for quality performance.
- **Step 3**: Add the average per beneficiary amount of savings back to the ACO's rebased historical benchmark.

Factors	MSSP Benchmark Approach: Savings Added to Benchmark – June 2015	Hypothetical Medicaid ACO Benchmark Approach
Case Study Example: Wellness ACO started in 2014 and invested $600,000 in the program. Wellness ACO had PMPY costs of $6,000 in 2014 (Year 1); $6,000 in 2015 (Year 2); $5,800 in 2016 (Year 3); and a TCoC benchmark of $6,000 in all 3 years. Wellness ACO therefore generated net savings of $1 million from 2014 through 2016 ($6,000 - $5,800 = $200 in per member savings in 2016 x 5,000 beneficiaries; no savings in 2014 or 2015). Assume a quality score of 75%, for a quality-adjusted savings amount of $750,000, or $150 per beneficiary. For 2017, the projected PMPY is $5,500, and the standard TCoC benchmark is $5,800.		
Methodology	Add per beneficiary savings adjusted for ACO's quality performance to the historical TCoC benchmark	1-year benchmark based on most recent year of claims and/or encounter data; does not factor in savings from prior period
PMPY TCoC Benchmark for 2017	$5,950 ($5,800 + $150 in quality-adjusted per beneficiary savings)	$5,800
Projected Savings for 2017	$2.25 million *Formula*: $5,950-$5,500 x 5,000 beneficiaries	$1.5 million *Formula*: $5,800-$5,500 x 5,000 beneficiaries
Projected Shared Savings Payouts (50% sharing rate)	State: $1.23 million Wellness ACO: $1.23 million	State: $750,000 Wellness ACO: $750,000

Implications for States

States could consider adding savings from prior performance periods into future TCoC benchmark development. However, this could increase the total amount of money that states would need to payout to its ACOs, and the state would want to be mindful of not developing overly-inflated benchmarks. This approach could be used as a short-term strategy to implement along with a gradual move toward more regional or market-based TCoC benchmarks.

Approach 5: Calculate Shared Savings Payouts Net of ACO Investments

A final strategy recommended by Harold Miller in *How to Create Accountable Care Organizations* is for the ACO and the payer to divide the *net* savings (after factoring in the ACO's unreimbursed costs on investments like technology, new staff, etc.) rather than the *gross* savings based only on claims or encounter data.[15]

Factors	Net Savings Approach	Hypothetical Medicaid ACO Approach
Case Study Example: Wellness ACO started in 2014 and invested $600,000 in the program. Wellness ACO had PMPY costs of $6,000 in 2014 (Year 1); $6,000 in 2015 (Year 2); $5,800 in 2016 (Year 3); and a TCoC benchmark of $6,000 in all 3 years. Wellness ACO therefore generated net savings of $1 million from 2014 through 2016 ($6,000 - $5,800 = $200 in per member savings in 2016 x 5,000 beneficiaries; no savings in 2014 or 2015).		
Methodology	Calculate shared savings payouts based on *net* savings (after factoring in ACO investment costs)	Calculate shared savings based solely on claims/encounters (i.e., payments made to ACOs for services) compared to cost targets
ACO Investment in 2014	$600,000	$600,000
Total Savings (2014-2016)	$1,000,000	$1,000,000
Repayment to Wellness ACO for upfront costs	(-$600,000)	n/a- not generally factored into Medicaid ACO shared savings arrangements
Net Savings (2014-2016)	$400,000	$1,000,000
Projected Shared Savings Payouts (50% sharing rate)	State: $200,000 Wellness ACO: $200,000 *Note: Under this approach Wellness ACO also receives an additional $600,000 repayment for upfront costs, for a total payment of $800,000*	State: $500,000 Wellness ACO: $500,000 *Note: Under this approach, Wellness ACO does not recoup its initial investment of $600,000.*

Implications for States

States could consider tweaking the shared savings payouts to be net of any ACO investments, rather than basing them solely on savings based on claims or encounter data. Miller recommends that this be operationalized through a prospective and collaborative process between the ACO and the payer(s) (i.e., the ACO would identify in advance how much it expected to spend on a new program and what result it expected to achieve in terms of expected savings).[16] Another option is to apply the same approach, but reconcile after the performance year is over once it has been determined what the ACO spent and if it actually produced savings. It is important to note that this approach would *reduce* the amount of shared savings payouts recouped by the state and increase overall payouts to ACOs. The state would also have to operationalize a procedure for determining what types of investments are reimbursable and how to track those expenditures.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ADDITIONAL RESOURCES

State-based Medicaid ACOs are becoming increasingly prevalent, with more states pursuing this model as a way to improve health outcomes and control costs. CHCS' **Medicaid Accountable Care Organization Resource Center**, made possible through The Commonwealth Fund, houses practical resources to help states design, implement, and refine ACO programs. Visit www.chcs.org/aco-resource-center.

ENDNOTES

[1] R. Houston and T. McGinnis. Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations. Center for Health Care Strategies, March 2013. Available at: https://www.chcs.org/media/PaymentReform031813_4.pdf.

[2] B. Herman. CMS Fixed Its ACO Benchmarking Problem: That May Not Be Enough. Modern Healthcare, June 2016. Available at: http://www.modernhealthcare.com/article/20160611/MAGAZINE/306119963.

[3] Federal Register. 42 CFR Part 425: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule. June 9, 2015. Available at: https://www.federalregister.gov/documents/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations.

[4] To help inform case study estimates, CHCS referred to average annual Medicaid spending per enrollee estimates compiled by the Henry J. Kaiser Family Foundation for calendar year 2014, available at: http://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/. These estimates ranged from $10,392 in North Dakota to $3,620 in Nevada, with a national average of $5,326 annual spending per Medicaid enrollee. CHCS also referred to savings generated by Medicare Shared Savings Program (MSSP) ACOs in performance year 2015 based on publicly available data published by CMS, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/. According to CMS data, average savings for the 26 MSSPs with between 4,000 and 6,000 attributed Medicare beneficiaries were approximately $4.34 million for performance year 2015. Average savings amounts were estimated using only those MSSPs that had generated savings (i.e., MSSPs with losses were excluded from the calculation).

[5] This is aligned with CMS's projections for MSSP startup costs. See https://www.federalregister.gov/documents/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations.

[6] Federal Register. 42 CFR Part 425: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule. June 9, 2015. Available at: https://www.federalregister.gov/documents/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations.

[7] Ibid.

[8] Federal Register. 42 CFR Part 425: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations — Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations; Final Rule. June 10, 2016. Available at: https://www.federalregister.gov/documents/2016/06/10/2016-13651/medicare-program-medicare-shared-savings-program-accountable-care-organizations-revised-benchmark.

[9] Ibid.

[10] For more information, see "ACO Rate and Benchmark Setting Methodology" at the MassHealth ACO procurement link available at: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-00000009207&external=true&parentUrl=bid and the Summary of Pricing Methodology for ACOs and MCOs available at http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/170208-summary-pricing-methodology-aco-and-mco.pdfz.

[11] Medicare Payment Advisory Commission letter to Centers for Medicare & Medicaid Services. June 16, 2014. Available at: http://www.medpac.gov/docs/default-source/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-june-16-2014-.pdf?sfvrsn=0.

[12] Federal Register. 42 CFR Part 425: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule. June 9, 2015. Available at: https://www.federalregister.gov/documents/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations.

[13] Federal Register. 42 CFR Part 425: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations — Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations; Final Rule. June 10, 2016. Available at: https://www.federalregister.gov/documents/2016/06/10/2016-13651/medicare-program-medicare-shared-savings-program-accountable-care-organizations-revised-benchmark.

[14] Ibid.

[15] H. Miller. How to Create Accountable Care Organizations. Center for Healthcare Quality & Payment Reform, September 2009. Available at http://www.chqpr.org/downloads/howtocreateaccountablecareorganizations.pdf.

[16] Ibid.