Medicare Shared Savings Program
A Detailed Analysis of the Final Rule

Health care is too important to stay the same.™

Cerner™
A more balanced program
Few initiatives in recent history have cultivated as much enthusiasm as the Medicare Shared Savings Program (MSSP). The degree with which the industry embraced the possibilities under this model was eclipsed only by the rate at which it fled from it once the Centers for Medicare and Medicaid Services (CMS) released the program’s proposed regulations. CMS had to do right in the final rule-making to breathe new life back into the Medicare Accountable Care Organization (ACO) concept, and, it appears the recently released final regulations might just do that. If your organization was interested in becoming a Medicare ACO before the proposed rule, we suggest you take another look at the new MSSP program requirements. You might find a program with a more balanced risk-reward scenario.

An initial analysis
This document summarizes the MSSP final rule and provides an initial analysis of its various features and conveyances. In it, we explain key differences between the proposed and final rules as well as suggest recommended strategic and tactical actions your organization can take as you consider participation. By taking into account public feedback offered by more than 1,300 commenters, CMS has addressed most of the issues with the proposed rule that made it a non-starter.
Although most of the core program concepts and fundamentals remain the same, some important provisions did change for the better.

Highlights of those changes include:

**Participation**
- Prospective assignment of patients so the ACO knows beforehand who is in the population
- Ability for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs) to form ACOs

**Greater flexibility**
- In start dates in 2012 (April and July) as opposed to only January
- In governance, legal structure of the organization
- In timing for evaluation of sharing savings (claims run-out reduced to three months)
- In antitrust review, timing for repayment of losses

**Quality measures**
- Number of quality and process measures decreased from 65 to 33
- Change from all-or-none scoring methodology

**Financial**
- Increase financial incentives to participate
- Increase in maximum shared savings amounts
- No down-side risk
- First-dollar sharing in Track 1
- Removal of 25 percent withhold of shared savings earned

You can find additional differences between provisions in the proposed and final rules in the “What’s Changed” section on page 4.
Executive Summary

Not for everyone
The MSSP may still not be for everyone.
It’s possible that the economics aren’t sustainable or that the program is too complex to administer efficiently. CMS may have to rehash significant portions of the plan or scrap it altogether.
Medicare beneficiaries also may not like being treated by an ACO and their powerful lobbies may make it an unpopular program.
Many critical program details (performance and expenditure benchmarks) remain unknown, or need improvement (risk adjustment methodology).
The beneficiary assignment methodology in the final rule does not guarantee that all beneficiaries who meet the criteria will be assigned to the ACO. This may allow CMS to cherry-pick its beneficiaries into the program.
Finally, the application process remains onerous.
These reservations notwithstanding, the program meshes with industry trends involving clinical integration or related reimbursement models.
Many aspects of the program have been restructured. And lastly, by all indications, CMS is moving toward sharing more risk with providers.

A good starting point
If your organization is interested in participating in the program as a Medicare ACO, start by performing a full organizational assessment in the context of the MSSP requirements.
This will help you understand areas of program risk, address organizational misalignments, and identify gaps in supporting processes and infrastructure.
By understanding where your organization needs to go in contrast with where it is today, you can develop and execute a successful plan for strategic change.

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The final rule for ACO formation addresses a number of areas that were problematic in the earlier rule.

**Eligibility**
Many organizations expressed concern with the eligibility rules. CMS listened and, in the final rule, took steps to ease eligibility requirements.

While CMS still expects ACOs to form legal organizations, there is more flexibility for legal and management structures.

For example, CMS still expects 75 percent of an ACO’s board to be made up of participants, but ACOs can propose other structures and still be eligible.

For organizations ready to start in 2012, there will be two mid-year start dates, April 1, 2012, and July 1, 2012. These start dates will be followed by first-year performance periods of 21 and 18 months respectively.

Finally, FQHCs and RHCs will be allowed to independently form and participate in ACOs, a major significant change from the proposed rule. This change also means that ACOs will not earn a higher sharing rate for including FQHCs or RHCs.

**Quality measures**
CMS has cut the number of quality measures from 65 to 33, lessening the burden on many organizations that felt the higher threshold was too prescriptive.

CMS is phasing in the measures that will contribute to the pay for performance scoring in performance years 2 and 3.

Finally, CMS has dropped the all-or-nothing performance requirement, allowing ACOs to score poorly on some measures without sacrificing their ability to receive shared savings.

**Financial rewards**
CMS also has simplified the one-sided risk model.

Under the final rule, in all three performance years, the one-sided risk model will not put the ACO at risk for shared losses. The new one-sided model should create additional incentives for organizations that were unsure or unwilling to participate because of the downside risk.

In contrast with the proposed rule’s net sharing rate, shared savings are also available on a first-dollar basis once the ACO meets the minimum savings rate.

In addition, CMS said it would no longer withhold 25 percent of shared savings, allowing organizations to receive expedited payments.

**A shorter claims run-out period**
The original six-month claims run-out period was intended to balance the amount of time required to process performance year claims with the need to pay shared savings. This proposed timeframe would have prevented organizations from realizing any shared savings for at least six months.

In the final rule, CMS shortened the claims run-out period to three months, which will ensure faster payments. Loss repayment will be made within 90 days of notice from CMS.

**Antitrust review**
CMS also has changed the mandatory antitrust review for many organizations to an optional review.

For organizations that fall outside the antitrust safety zone, CMS still recommends the optional review to prove that ACOs are pro-competitive. The Federal Trade Commission (FTC) has pledged to expedite all such voluntary reviews.

Overall, the final rule provides more flexibility to organizations looking to form an ACO.

The rule gives these organizations improved incentives with more dollars available through shared savings. It also minimizes some of the difficulties of organizing and forming the ACO organization by allowing for a variety of leadership and management structures.

Additionally, CMS has simplified quality measures reporting, and it has expanded start dates.
Program Fundamentals

First, the MSSP is an evolutionary step in a broad, longer-term CMS strategy to shift to value-based reimbursement with its providers. MSSP draws heavily from past and current programs and pilots such as the Physician Group Practice (PGP) demonstration and the Medicare Health Care Quality Demonstration. For the purposes of this document, you should understand three key terms:

- **ACO** is a legal entity recognized and authorized under applicable state law. It is identified by a taxpayer identification number (TIN) and is composed of an eligible group of participants.
- **ACO professional** is a physician; (a doctor of medicine or osteopathy) or a practitioner. (physician assistant, nurse practitioner or clinical nurse specialist).
- **ACO participant** is a Medicare enrolled provider of services and/or a supplier with a TIN. These participants must work together to manage and coordinate care for Medicare Fee-for-Service beneficiaries, and they must establish a mechanism for shared governance. This mechanism must provide all participants with appropriate, proportionate control over ACO decisions.
- **ACO provider/supplier** is a provider of services and/or a supplier that bills for items and services it furnishes to Medicare beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant.

**Program structure**

The MSSP is a voluntary program to which ACOs must apply to participate and be accepted before executing a contractual agreement with CMS. The Affordable Care Act requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish the MSSP by Jan. 1, 2012. An ACO’s agreement with CMS must be for a minimum of three years. In compliance with the statute, CMS has proposed the following program structure.
## MSSP PROGRAM LAYOUT

### ADMINISTRATIVE

**PROGRAM APPLICATION PERIOD**
Year -1  
ACOs must prepare all application materials and associated documentation, obtain FTC review (if necessary) and submit application to CMS for program participation.

**QUALITY BENCHMARKS CALCULATED**
Year -1 to Year 1 (est)  
Benchmarks for quality measures are calculated using a national sample of Medicare FFS, MA quality data or a flat percentage if such data is not available.

### BENCHMARKS

**QUALITY BENCHMARKS CALCULATED**
Year -1 to Year 1 (est)  
Benchmarks for quality measures are calculated using a national sample of Medicare FFS, MA quality data or a flat percentage if such data is not available.

**EXPENDITURE BENCHMARKS CLAIMS PERIOD FOR 1st AGREEMENT PERIOD**
Year -3 to Year -1  
Using Parts A & B claims data from the 3 years prior to the agreement period, CMS calculates the risk-adjusted, per-beneficiary expenditure benchmark for the ACO. Year -3 is weighted at 10%, Year -2 at 30% and Year -1 at 60%.

**EXPENDITURE BENCHMARKS FOR SUBSEQUENT AGREEMENT PERIODS**
Year 1 to Year 3  
Using Parts A & B claims data from the 3 years prior to the 2nd agreement period, CMS calculates the risk-adjusted, per-beneficiary expenditure benchmark for the ACO. Weightings remain the same.

### PERFORMANCE

**PERFORMANCE PERIODS 1, 2 & 3**
Year 1, Year 2 & Year 3  
The agreement period is composed of three performance periods (years). In Track 1, the ACO participates in all a shared savings-only model for 3 years. In Track 2, the ACO participates in a shared savings and loss model for all 3 years.

**SUBSEQUENT PERFORMANCE PERIODS Year 4, Year 5 & Year 6**
If the ACO chooses to continue participation in the program beyond the first agreement period, it is limited to the Track 2 (downside risk) model only. Each subsequent agreement period is composed of 3 performance periods.

### PRE-AGREEMENT PERIOD | FIRST AGREEMENT PERIOD | SECOND AGREEMENT PERIOD (optional)
---|---|---
Year -3 | Year -2 | Year -1
Year 1 | Year 2 | Year 3
Year 4 | Year 5 | Year 6
CMS will establish an application period prior to April 1, 2012, July 1, 2012, or the beginning of the calendar year in 2013 and beyond.

The agreement period for each ACO is three years, (unless starting April 1 or July 1, 2012) with each calendar year in the agreement referred to as a performance period.

In addition, CMS will establish the application period annually, with agreement start dates of Jan. 1 for each year after 2012.

**Defining eligibility**

This prevents attribution of the same beneficiary to different ACOs in the same geography.

Among other things, CMS will use claims submitted by providers and suppliers of beneficiaries to determine the ACO’s eligibility to receive a shared savings payment.

In the current claims-based payment system, there is an inherent delay between the time a service is rendered and when a claim is submitted for payment.

As such, before calculating ACO cost performance, CMS will wait a certain amount of time after each performance period for most/all of the claims to be submitted.

**Expenditure benchmarks**

Specifically, for the MSSP, CMS will use a three-month claims run-out period after each performance year to calculate the benchmark.

CMS also will use a three-year expenditure benchmark prior to each performance year to give it a target for comparing expenditures during the performance period.

This expenditure benchmark is essentially a surrogate measure of what Part A and B expenditures would have been for attributed beneficiaries in the absence of the ACO. As such, CMS will adjust the benchmark each performance year to match the trend in the national growth rate.

**Benchmarks for quality measures**

CMS will also establish performance benchmarks for its quality measures.

To do this, CMS will use a the most recent data prior to the start of each performance period.

In the final rule, CMS outlines other administrative aspects of program, such as what happens if:

- The number of beneficiaries drops below the minimum threshold
- An ACO wants to drop from the program
- An ACO wants to add or subtract individual participants, etc.

**Altering terms**

In the final rule, CMS says it will be able to unilaterally alter terms of the MSSP agreement within the agreement period to flex program details based on what it learns from year to year.

According to the rule, ACOs will be subject to future regulation changes, except for the following areas:

- Eligibility requirements concerning the structure and governance of ACOs
- Calculation of sharing rate
- Beneficiary assignment

An ACO can opt out of the MSSP due to program changes.
**Program risk tracks**

CMS has proposed two different tracks in which ACOs may participate at the outset of the agreement. The tracks are based on the ACO’s experience and ability to manage risk.

Track 1 provides for a one-sided, shared-savings-only approach during its first agreement period. In this track, the ACO is not responsible for any losses above the program expenditure target and can share in up to 50 percent of the savings. Because this track is only available during the first agreement period, if the ACO participates in future agreements, it will be required to adopt the two-sided model in Track 2.

In contrast, Track 2 participants enter the shared savings program under a two-sided payment model for all three years of the agreement. In the second track, the ACO cannot escape downside risk, but the reward for taking on greater risk is an opportunity to share in up to 60 percent of achieved savings.
Beneficiary data, communication

For an ACO to understand and stratify the risk of the population, it must have up-front information about the assigned population.

CMS will provide ACOs with prospective data about the beneficiaries who are likely to be assigned that performance year.

ACOs also may request claims data from CMS about their patients.

First, however, the ACO must notify the beneficiary (in writing) that the ACO will request his or her data, allowing the beneficiary to opt out of data sharing.

The data sharing opt-out letter is an example of what CMS considers marketing materials and activities.

CMS will control an ACO’s use of such materials and activities by requiring it to submit them for approval prior to use.

This requirement, however, would not include:

- Informational materials customized or limited to a subset of beneficiaries
- Materials that do not include information about the ACO or ACO providers
- Materials that cover beneficiary-specific billing and claims issues or other specific health-related issues
- Educational information on specific medical conditions (i.e. flu shot reminders)
- Referrals for Medicare covered items and services.

In addition, CMS proposes that all ACO providers tell their Medicare beneficiaries they are participating in an ACO and explain what this means for their health and care.

ACO participants also are required to post signs in their buildings and offices, which state they are participating in an ACO. They must also provide additional written information to beneficiaries about the ACO.
Beneficiary Assignment

Relationship of beneficiary population to minimum savings rate

For most ACOs participating in the MSSP in a performance year under a one-sided model, the number of beneficiaries attributed to it directly impacts how it achieves shared savings. This is because the minimum savings rate (MSR) decreases as the number of assigned beneficiaries increases.

The MSR is the threshold savings rate that an ACO must achieve before it can share in any additional savings.

To eliminate opportunities for achieving savings due to normal variations in annual expenditures, CMS proposes that the MSR floor be 2 percent for the largest ACOs and 3.9 percent for the smallest.

For ACOs participating in the two-sided risk model in any performance year, the MSR would be a flat 2 percent.

The figure (below) summarizes the relationship between MSRs and attributed beneficiary size.

THE ACO SIZE-TO-PERFORMANCE CHALLENGE

Small ACOs will be challenged to achieve nearly twice the amount of savings as the largest ACOs before qualifying to share in any savings.

Large ACOs will be challenged to implement care and quality improvement processes that are scalable to populations that are 10-12 times larger than the smallest ACOs.

= 1,000 Medicare ACO beneficiaries

= Track 1 Minimum Savings Rate

= Track 2 Minimum Savings Rate
How a Medicare Beneficiary is Attributed to an ACO

The MSSP final rule establishes a method of attributing beneficiaries to an ACO based on the provision of primary care services. This “step-wise” methodology allows CMS to make a preliminary prospective beneficiary assignment but retrospectively reconcile that assignment based on actual provision of services during the performance year.

Eligibility

Not all Medicare enrollees are assigned.

CMS starts by considering only those enrollees in Medicare’s original Part A & B programs.

National Breakdown of Medicare Enrollment by Program

Section 1876 Cost Plans

Medicare Advantage

Original Parts A & B

Percentage of Medicare Beneficiaries who visit a primary care physician in a given year

77.6%

Codes for Medicare Qualified Primary Care Services

HCPSCS

99201 – 99215

99304 – 99340

99341 – 99350

G-Codes

G0402

G0438

G0439

For those beneficiaries with a triggering event, CMS then evaluates all allowed charges for primary care services.

Typical Distribution of Primary Care Physicians by Specialty

- OR -

1. From a primary care physician in the ACO

2. From other physicians of any specialty in the ACO

Your ACO vs. Other ACOs

The beneficiary is assigned!
In the MSSP, quality measures ensure ACOs deliver better care and improved health.

In essence, the measures establish a quality performance standard for all participating ACOs.

Throughout the rule-making process, CMS struggled to pick measures to effectively gauge the ACO’s performance and determine how many there should be.

In the final rule, Medicare settled on 33 quality metrics (Table 1) with 23 scored measures across four domains.

Of the 33 measures:
- Seven are collected via patient survey
- Three are calculated via claims
- One is calculated from Electronic Health Record (EHR) Incentive Program data
- 22 are collected via the Group Practice Reporting Option (GPRO) Web interface

### Quality Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Total Individual Measures</th>
<th>Total Measures for Scoring Purposes</th>
<th>Total Potential Points per Domain</th>
<th>Domain weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Giver Experience</td>
<td>7</td>
<td>1 measure with 6 survey module measures combined plus 1 individual measure</td>
<td>4</td>
<td>25%</td>
</tr>
<tr>
<td>Care Coordination/ Patient Safety</td>
<td>6</td>
<td>6 measures, plus the EHR measure double-weighted (4 points)</td>
<td>14</td>
<td>25%</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>8</td>
<td>8 measures</td>
<td>16</td>
<td>25%</td>
</tr>
<tr>
<td>At-Risk Population</td>
<td>12</td>
<td>7 measures, including 5 component diabetes composite measures and 2 component CAD composite measures</td>
<td>14</td>
<td>25%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33</td>
<td>23</td>
<td>48</td>
<td>100%</td>
</tr>
</tbody>
</table>
All of the measures are based on National Quality Foundation (NQF) indicators, and many are shared with other federal pay-for-reporting or pay-for-performance initiatives.

**Increasing difficulty**

For the first performance year of the first agreement period, ACOs will have met the quality performance standard by merely reporting on all of the measures. In subsequent years, however, ACOs will only be able to meet the quality performance standard by comprehensive reporting on all measures and achieving performance benchmark levels on a large subset of those measures.

The levels and the corresponding quality points are shown in Table 2.

By performance year three, all but one measure will become a performance benchmark requirement.

**Changing measures**

CMS may update or revise the quality indicators for the program.

CMS also plans to change the measures during the life of the MSSP to reflect changes in quality of care, practice and other quality programs.

**Scoring**

CMS requires ACOs to meet the quality performance standard on 70 percent of the measures in each domain. This is different than the “all-or-none” approach in the proposed rule.

The 70 percent rule effectively allows an ACO to score below the performance benchmark in one or more individual measures in each domain and still be eligible to share in savings.

However, an ACO cannot score a zero for an entire measure domain and remain eligible for shared savings.

If an ACO fails to meet this performance standard, CMS will place the ACO on notice and require it to develop a corrective action plan with reevaluation in the following year.

CMS will terminate the agreement if the ACO continues to underperform.

**Care coordination**

CMS views EHR use and health care information technology (IT) as a strategic underpinning of any ACO.

To wit, of all 33 EHR measures, only the Care Coordination domain has a double-weighting.

Because of this weighting, failing to completely and accurately report on the EHR measure will cause an ACO to miss the 70 percent cut-off for the Care Coordination domain and will affect its potential sharing rate.

<table>
<thead>
<tr>
<th>ACO Performance Level</th>
<th>Quality Points (all measures except EHR)</th>
<th>EHR Measure Quality Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>90+ percentile FFS/MA rate or 90+percent</td>
<td>2 points</td>
<td>4 points</td>
</tr>
<tr>
<td>80+ percentile FFS/MA rate or 80+percent</td>
<td>1.85 points</td>
<td>3.7 points</td>
</tr>
<tr>
<td>70+ percentile FFS/MA rate or 70+percent</td>
<td>1.7 points</td>
<td>3.4 points</td>
</tr>
<tr>
<td>60+ percentile FFS/MA rate or 60+percent</td>
<td>1.55 points</td>
<td>3.1 points</td>
</tr>
<tr>
<td>50+ percentile FFS/MA rate or 50+percent</td>
<td>1.4 points</td>
<td>2.8 points</td>
</tr>
<tr>
<td>40+ percentile FFS/MA rate or 40+percent</td>
<td>1.25 points</td>
<td>2.5 points</td>
</tr>
<tr>
<td>30+ percentile FFS/MA rate or 30+percent</td>
<td>1.10 points</td>
<td>2.2 points</td>
</tr>
<tr>
<td>&lt;30 percentile FFS/MA rate or &lt;30 percent</td>
<td>No points</td>
<td>No points</td>
</tr>
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</table>

Table 2
<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>NQF/AMA-PCPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Caregiver Experience</td>
<td>Getting Timely Care, Appointments and Information</td>
<td>NQF #5</td>
</tr>
<tr>
<td></td>
<td>How Well Your Doctors Communicate</td>
<td>NQF #5</td>
</tr>
<tr>
<td></td>
<td>Patient’s Rating of Doctor</td>
<td>NQF #5</td>
</tr>
<tr>
<td></td>
<td>Access to Specialists</td>
<td>NQF #5</td>
</tr>
<tr>
<td></td>
<td>Health Promotion and Education</td>
<td>NQF #5</td>
</tr>
<tr>
<td></td>
<td>Shared Decision Making</td>
<td>NQF #5</td>
</tr>
<tr>
<td></td>
<td>Health Status/Functional Status</td>
<td>NQF #6</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>Risk-Standardized, All Condition Readmission</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Medication Reconciliation after Discharge from an Inpatient Facility</td>
<td>NQF #554</td>
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<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disease (PKI 5)</td>
<td>NQF #275</td>
</tr>
<tr>
<td></td>
<td>Congestive Heart Failure (PKI 8)</td>
<td>NQF #277</td>
</tr>
<tr>
<td></td>
<td>All Physicians who Qualify for Payment</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Falls: Screening for Fall Risk</td>
<td>NQA #101</td>
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<tr>
<td>Preventive Health</td>
<td>Influenza Immunization</td>
<td>NQF #41</td>
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<tr>
<td></td>
<td>Pneumococcal Vaccination</td>
<td>NQF #44</td>
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<tr>
<td></td>
<td>Mammography Screening</td>
<td>NQF #31</td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer Screening</td>
<td>NQF #34</td>
</tr>
<tr>
<td></td>
<td>Adult Weight Screening and Follow-up</td>
<td>NQF #421</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Measurement</td>
<td>NQF #13</td>
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<tr>
<td></td>
<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
<td>NQF #28</td>
</tr>
<tr>
<td>At-Risk Population</td>
<td>Diabetes Mellitus: Low Density Lipoprotein (&lt;100)</td>
<td>NQF #0729 MN Community Measurement</td>
</tr>
<tr>
<td></td>
<td>Diabetes Mellitus: Hemoglobin A1c Control (&lt;8%)</td>
<td>NQF #0729 MN Community Measurement #575</td>
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<td></td>
<td>Diabetes Mellitus: Tobacco Non-Use</td>
<td>NQF #0729 MN Community Measurement</td>
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<tr>
<td></td>
<td>Diabetes Mellitus: Aspirin Use</td>
<td>NQF #0729 MN Community Measurement</td>
</tr>
<tr>
<td></td>
<td>Diabetes Mellitus: Blood Pressure Control in Diabetes Mellitus &lt;140/90</td>
<td>NQF #0729 MN Community Measurement</td>
</tr>
<tr>
<td></td>
<td>Diabetes Mellitus: Hemoglobin A1C Poor Control (&gt;9%)</td>
<td>NQF #59 NOQA</td>
</tr>
<tr>
<td></td>
<td>Hypertension (HTN): Blood Pressure Control</td>
<td>NQF #18</td>
</tr>
<tr>
<td></td>
<td>Ischemic Vascular Disease: Complete Lipid Profile and LDL Control &lt;100mg/dl</td>
<td>NQF #75 NOQA</td>
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<tr>
<td></td>
<td>Use of Aspirin or other Antithrombotic</td>
<td>NQF #68 NOQA</td>
</tr>
<tr>
<td></td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>NQF #83 AMA-PCPI</td>
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<tr>
<td></td>
<td>Heart Failure: Beta-Blocker Therapy for LVSD</td>
<td>NQF #83</td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol</td>
<td>NQF #4 CMS composite AMA-PCPI (individual composite)</td>
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<tr>
<td></td>
<td>CAD: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or LVSD</td>
<td>NQF #66 CMS composite AMA-PCPI individual composite</td>
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<tr>
<td>CMS Uses Measure to Assess</td>
<td>Method of Data Submission</td>
<td></td>
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<tr>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Patient survey results for adult outpatient primary care, pediatric outpatient care and adult outpatient specialist care regarding health status and functional status.</td>
<td>CAHPS</td>
<td></td>
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<tr>
<td>Patient survey results for adult outpatient primary care, pediatric outpatient care and adult outpatient specialist care regarding how well the physician communicates.</td>
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<td>Patient survey results for adult outpatient primary care, pediatric outpatient care and adult outpatient specialist care regarding the patient's rating of the physician.</td>
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<tr>
<td>Patient survey results for getting timely care, appointments and care specialist.</td>
<td>CAHPS</td>
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<td>Patient survey results for adult outpatient primary care, pediatric outpatient care and adult outpatient specialist care regarding health promotion and education.</td>
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<td>Patient survey results for adult outpatient primary care, pediatric outpatient care and adult outpatient specialist care regarding shared decision-making.</td>
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<tr>
<td>Patient survey results from adult health plan members regarding health status and functional status.</td>
<td>CAHPS</td>
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<tr>
<td>Rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.</td>
<td>Claims</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients 65 and older discharged from any inpatient facility and seen within 60 days following discharge in the office by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</td>
<td>GPRO</td>
<td></td>
</tr>
<tr>
<td>Number of discharges for chronic obstructive pulmonary disease for patients 18 and older per 100,000 population.</td>
<td>Claims</td>
<td></td>
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<tr>
<td>Number of discharges for congestive heart failure for patients 18 and older per 100,000 population.</td>
<td>Claims</td>
<td></td>
</tr>
<tr>
<td>Percentage of physicians who qualify for payment under the EHR incentive payment programs.</td>
<td>GPRO</td>
<td></td>
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<tr>
<td>Patients being assessed for fall risk.</td>
<td>GPRO</td>
<td></td>
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<tr>
<td>Percentage of patients 50 and older who received an influenza immunization during the flu season (September through February).</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients 65 and older who have ever received a pneumococcal vaccine.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of women 40-69 years who had a mammogram to screen for breast cancer within 24 months.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients 50-75 who received the appropriate colorectal cancer screening.</td>
<td>GPRO</td>
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</tr>
<tr>
<td>Percentage of patients 18 and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patient visits with blood pressure measurement recorded for patients aged greater than 18 with diagnosed hypertension.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients who were queried about tobacco use and the percentage of patients identified as tobacco users who received cessation intervention.</td>
<td>GPRO</td>
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</tr>
<tr>
<td>Percentage of adult patients 18-75 with diabetes whose most recent (LDL-C) test result during the measurement year was less than 100mg/dl.</td>
<td>GPRO</td>
<td></td>
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<tr>
<td>Diabetes Mellitus: Hemoglobin A1c Control (&lt;8%)</td>
<td>GPRO</td>
<td></td>
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<tr>
<td>Percentage of patients who were queried about tobacco use. This measure is also used to assess the percentage of patients identified as tobacco users who received cessation intervention.</td>
<td>GPRO</td>
<td></td>
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<tr>
<td>The percent of patients with diabetes and cardiovascular disease who have a documented daily use of aspirin.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients 18-75 with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).</td>
<td>GPRO</td>
<td></td>
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<tr>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control (&gt;9%)</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients with last BP &lt;140/90mmG.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients 18 and older with a diagnosis of IVF who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients prescribed aspirin or other antithrombotic drugs.</td>
<td>GPRO</td>
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<tr>
<td>Percentage of patients 18 and older with a diagnosis of heart failure who also have LVSD (LVEF &lt; 40%) and who were prescribed beta-blocker therapy.</td>
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<td>GPRO</td>
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<tr>
<td>Percentage of patients 18 and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
<td>GPRO</td>
<td></td>
</tr>
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<td>Percentage of patients 18 and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
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<td>Percentage of patients 18 and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
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</tbody>
</table>
CMS has clarified what providers and provider organizations are eligible to form ACOs and what governance requirements ACOs must meet to protect both the integrity of the program and its beneficiaries, and to ensure success.

Because the MSSP is voluntary, and the requirements for participation are rigorous, potential Medicare ACOs would have to organize themselves, file appropriate application documentation and submit that application to CMS for approval.

**Eligible entities**

Within the MSSP, there are two primary areas of interest to providers: 1) formation and 2) participation.

The list of entities that are eligible to form Medicare ACOs is smaller and different than the list of entities that are eligible to participate in the MSSP. The bulk of provider groups eligible to form ACOs come from the Affordable Care Act statute:

- ACO professionals in group practices (physicians and hospitals that meet the statutory definition)
- Networks of individual practices of ACO professionals

- Partnerships of joint ventures between hospitals and ACO professionals
- Hospitals employing ACO professionals

CMS relies on the discretion given to the Secretary of HHS in determining additional entities that are eligible to form ACOs:

- Critical Access Hospitals that bill for ACO professional services (utilizing method II billing)
- FQHCs and RHCs that can fulfill the beneficiary assignment requirements based on the amount of primary care services delivered by their physicians

ACO professionals are physicians or practitioners (physician assistants, nurse practitioners and clinical nurse specialists). Correspondingly, hospitals are defined as a limited set of subsection (d) hospitals (acute care hospitals paid under the hospital inpatient prospective payment system).

To participate in the MSSP, any other Medicare-enrolled entities can simply join an eligible ACO.
**Participant Exclusivity:** CMS requires some ACO participants (providers or provider organizations identified at the TIN-level) to be exclusive to one ACO if the CMS beneficiary assignment process is dependent on that ACO participant.

However, all other ACO participants whose inclusion does not affect beneficiary assignment calculations are required to be non-exclusive with the flexibility to join other ACOs.

Individual providers participating in an ACO, unless they are sole-practitioners billing under their own Social Security Number (SSN), Employer Identification Number (EIN) or TIN, are not exclusive to any ACO.

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**A legal entity**

CMS requires that the ACO be a legal entity for MSSP program functions (primarily to receive and distribute shared savings, repay shared losses, ensure provider compliance with performance standards and establish reporting).

Accordingly, the ACO must have a TIN. It also must be recognized under state, federal or tribal law, authorized by the state to conduct its business while meeting all applicable state laws.

Although some states are beginning to license ACOs, such licensure is not required by CMS for the MSSP unless it is also required by the state.

When the ACO is not formed within a single existing entity, such as an integrated delivery network, and instead has multiple ACO participants, the organization must prove that it is a legal entity separate from its participants.
Governance

The foundation for CMS’ rules around ACO governance stems from the statutory requirement that ACOs have “established mechanisms of shared governance,” and that ACOs “shall have in place a leadership and management structure that includes clinical and administrative systems.”

Every ACO must have an identifiable governing body that oversees strategic direction and holds management accountable for activities and the three-part aim.

At least 75 percent control of the ACO governing body should reside with ACO participants that must be enrolled in Medicare and have a TIN.

There may be instances where local statutes or other factors impede such an arrangement. Therefore, CMS will consider alternative governance models in which participants are part of the governing body.

Because patient centeredness is critical, CMS believes all ACOs should integrate community resources and Medicare beneficiaries into the organization. Therefore, CMS strongly suggests beneficiary representation on the ACO governing body.

In cases where such representation runs contrary to local law or presents other unwieldy challenges, CMS is open to alternative proposals on how best to achieve meaningful beneficiary participation.

Structure

The MSSP allows for some flexibility in organizational structure within the ACO, but it makes a few discrete requirements.

The ACO must:

- Have an executive/manager appointed by the ACO governing body with demonstrable experience influencing or directing “clinical practice to improve efficiency processes and outcomes.”

- Have a “senior-level” medical director, who is also a board-certified physician, to provide clinical management and oversight on at least a “part-time” basis. The medical director must be licensed and physically present in one of the states in which the ACO operates.

- Require a meaningful commitment (financial, time or effort) from all ACO participants in the mission of the ACO (e.g. signed agreement to comply with policies and be accountable for process and performance measures).

- Describe how it will implement an ongoing quality assurance and improvement process led by an appropriately qualified health care professional.

Any existing organizations that meet all of CMS’ legal, structural and governance components for an ACO would not have to establish a new legal structure. However, the organization would be required to provide supporting evidence upon submission of its application to the MSSP.

The governing board, leadership and management structure are intended to ensure that the ACO can deliver on its four statutory functions:

1. Promote evidence-based medicine
2. Report cost and quality metrics
3. Promote patient engagement
4. Coordinate care

Additionally, the ACO must adopt a patient-centered focus.

Required ACO Governance, Leadership & Management

- Executive Director/Manager
  - Medical Director (required)
  - Director of Quality Assurance & Improvement (required)
  - Other management, committees and teams as needed

CMS Recommends...

- 75% control resides with Medicare-enrolled ACO participants
- Direct beneficiary representation
- Community resource representation
Antitrust laws
The federal government wants to make sure health care providers understand potential antitrust issues and have the information they need to form “pro-competitive” ACOs in both the Medicare and commercial markets.

To wit, the FTC and Department of Justice (DOJ) created a Statement of Antitrust Enforcement Policy.

This policy statement applies to ALL collaborations of otherwise independent providers or provider groups that seek to participate, or have been approved to participate, as ACOs in the MSSP.

The statement, however, does not apply to single, fully integrated entities or to mergers of health care providers.

According to the policy statement, CMS’s ACO eligibility criteria are generally consistent with principles historically used for determining whether health care providers are clinically integrated.

Additionally, organizations meeting the MSSP eligibility criteria are likely to be “bona fide arrangements,” intended to benefit consumers through better quality care and lower costs.

‘Rule of reason’
The statement stipulates that the agencies (FTC and DOJ) will apply a “rule of reason” to an ACO that qualifies for and participates in the MSSP, if the ACO uses the same governance, leadership structure, clinical and administrative processes in the commercial market.

This rule accommodates some anticompetitive effects of the ACO if they outweigh its pro-competitive effects.

To evaluate the competitive effects of an ACO, the agencies will examine the organization’s share of services in each participant’s primary service area.

The agencies also will monitor an ACO’s performance by evaluating the cost, utilization and quality metrics collected by CMS.

‘Antitrust safety zone’
The policy statement also creates the concept of an “antitrust safety zone” based on a market share evaluation of the primary service area (PSA).

The safety zone will remain in effect during the MSSP agreement.
ACOs with a market share that falls within the safety zone likely will not create a competitive concern. The agencies, therefore, likely will not challenge the ACO’s antitrust status.

However, if an ACO has a market share outside the antitrust safety zone, it will likely receive additional scrutiny.

The determination of the ACO participant PSA safety zone depends on two factors:
- Exclusivity of the participant
- Delivery of certain health care services (physician specialty, major diagnostic categories for inpatient facilities and outpatient categories)

ACOs with two or more participants that provide any common service in the same primary service area must calculate their respective market share for services and apply the logic shown in the table to the right.

**Fraud and abuse laws**

The Interim Final Rule with Comment period from the Office of Inspector General and HHS details waivers of certain provisions of the physician self-referral law, anti-kickback statute and civil monetary penalties law for specific financial arrangements involving ACOs in the MSSP.

The waivers apply to the ACO, ACO participants and ACO providers/suppliers participating in the MSSP. Because the waivers are self-implementing, there is no special action required by the ACO to be covered by one or more of the waivers. There are five waivers:

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Applicable Laws/Statutes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ACO Pre-Participation</td>
<td>• Physician self-referral law</td>
<td>• Applies to ACO-related startup arrangements</td>
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<tr>
<td></td>
<td>• Anti-kickback statute</td>
<td>• Covers the ACO, ACO participants and ACO providers/suppliers starting one year prior to an MSSP application due date and ending on the date the MSSP agreement is accepted or denied.</td>
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<td></td>
<td>• Gainsharing civil monetary penalty (CMP)</td>
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<tr>
<td>ACO Participation</td>
<td>• Physician self-referral law</td>
<td>• Applies to ACO-related arrangements during the term of the participation agreement and for six months following the expiration or termination of the agreement</td>
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<tr>
<td></td>
<td>• Anti-kickback statute</td>
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<tr>
<td></td>
<td>• Gainsharing CMP</td>
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<tr>
<td>Shared Savings Distribution</td>
<td>• Physician self-referral law</td>
<td>• Applies to distributions and uses of shared savings payments earned under the MSSP</td>
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<tr>
<td></td>
<td>• Anti-kickback statute</td>
<td></td>
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<tr>
<td></td>
<td>• Gainsharing CMP</td>
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<tr>
<td>Compliance with Physician Self-Referral Law</td>
<td>• Anti-kickback statute</td>
<td>• Applies to ACO arrangements that implicate the physician self-referral law and meet an existing exemption</td>
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<tr>
<td></td>
<td>• Gainsharing CMP</td>
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<tr>
<td>Patient Incentive</td>
<td>• Anti-kickback statute</td>
<td>• Applies to medically related incentives offered by ACOs under the MSSP to beneficiaries to encourage preventive care and compliance with care plans</td>
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<td></td>
<td>• Beneficiary Inducements CMP</td>
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</table>

**Antitrust Safety Zone**

| Less than 30% | Inside the Safety Zone —  |
|               | There is no additional antitrust review required. |

| Greater than 30% | Outside the Safety Zone —  |
|                 | There is voluntary antitrust review available. ACO can proceed without agency scrutiny if it does not impede the functioning of a competitive market. The ACO should avoid the agencies’ list of five types of anticompetitive conduct or it may seek expedited antitrust review. |
Recommendations

We understand the decision to form an ACO or participate in the MSSP is a major undertaking. While every health care organization is unique, we offer a few key recommendations that apply to most organizations that are considering the accountable care question or starting an ACO.

1. **Assess your future and organizational readiness**
   
   You must understand your organizational “fit” in the context of the ACO model and the MSSP details. A formal assessment process can help. Activities within this recommendation include some level of shaping or anticipating the future of health care and how it will evolve in your market. Ask yourself: What are you really good at? What are some possible future scenarios? What opportunities exist in those future states?

   In the context of one or more of those scenarios, you should conduct a formal organizational assessment. You should evaluate your strengths and weaknesses, and inventory your assets in various areas such as:
   - Governance and organizational structure
   - Clinical, financial and operational processes
   - Quality improvements
   - Data collection, management and reporting
   - Change management and communication
   - Value-oriented network and network reach
   - IT infrastructure
   - Risk tolerance

   From this assessment, you will find areas in need of improvement, risks and gaps in capabilities. You’ll be able to discern areas that will require remediation and mitigation planning — and perhaps even the need for a new organizational focus.

2. **Develop a strategic technology plan**

   ACOs have a distinct need for technology to enable more complex functions and efficiencies. CMS emphasizes the importance of an ACO technology infrastructure by double-weighting the EHR measure. This facilitates more coordinated care for the beneficiary.

   Beyond the EHR, achieving the goals and objectives set forth for ACOs requires infrastructure that stand-alone health care institutions usually don’t have. This infrastructure includes:
   - Clinical data liquidity between provider organizations
   - Collaborative tools for care management and coordination
   - Patient engagement
   - Data management and warehousing
   - Reporting and analytics

   The risk is that many ACOs will be developing a coordinated strategic technology plan and executing it in the face of an ever-mounting list of challenges facing today’s health care CIO. CEOs may be putting together a vision and plan for transforming their organization into an ACO. Most CIOs, however, are consumed with maintenance and support of their existing systems and reacting to mandatory compliance initiatives like meaningful use, ICD-10, 5010, etc.

   It’s easy to see how the plans can become disconnected, especially if your organization’s IT leadership is consumed with “keeping the lights on.” We recommend that you focus on technology initiatives that are key enablers for the ACO. Consider establishing separate budgets and program metrics for ACO technology initiatives.

   If your IT organization is dominated by a reactive focus on maintenance and support/compliance items, and the ACO initiatives must be completed, your organization should consider outsourcing some of tasks to third parties.
3. Focus on quality and quality improvement

CMS designed the ACO model to achieve lower costs, better health and improved care. Simultaneously, health care providers face many other quality initiatives that require a focus on quality performance and measurement (e.g. PQRS, NHIQM, value-based purchasing, etc.).

In view of the convergence of the various quality programs and the MSSP final rule requirements, your organization should renew its focus on quality and organizational excellence. Your leadership should focus on quality assurance and improvement.

Ideally, the ACO’s quality improvement processes will be based on best practices, driven by data and supported by the technology infrastructure.

There are many different quality improvement methodologies that can help your organization implement a structured process and achieve results, such as Lean or Six-Sigma. You should focus on three key focus areas:

1. The delivery of quality care through the integration of evidence and best practices and systematic assurance that your clinicians are initiating and following appropriate care processes.

2. The monitoring of care in real-time by your entire care team so that it can assess the clinical information to attain measures and take appropriate action on missing or incomplete documentation.

3. The reporting of quality measures to appropriate stakeholders using data generated as a byproduct of care delivery and existing processes in views and reports that analyze performance and allow for the quick identification of opportunities for improvement.

In closing

CMS has created an intricate set of regulations to define the Medicare Shared Savings Program. Participation will be a complex undertaking for any health care organization.

From structural and governance decisions to optimizing clinical pathways and care management processes to information management and reporting strategies — the prospect of creating an ACO can be daunting.

We have the expertise to help you navigate this maze and build a top quality ACO.

Join us as we work to make health care all it should be.
**Analyzing policy, regulatory changes**

Cerner Accountable for Health Consulting Services helps clients assess and plan for the realities of becoming an ACO and “accountable for health.”

By tracking and analyzing market, policy and regulatory changes, our team can help your organization establish new positions in the increasingly competitive and complex post-health-care-reform environment.

Specifically, Cerner Accountable for Health Consulting Services:

- Supports clients with current and future-state process evaluation and documentation
- Maximizes client investments to support ACO objectives with proven, predictable processes
- Assimilates and presents client and industry data to provide tactical approaches for operational and care delivery improvements and planning
- Models the financial impact of accountable care and other medical management strategies

**For more information**

If you have any questions, please email cernerhealthcarereform@cerner.com.