On October 20, 2011, the Centers for Medicare and Medicaid Services (CMS) released its final Accountable Care Organization (ACO) rule, and the official text of the rule was published in the Federal Register of November 2, 2011. Concurrent with the final ACO payment rule, CMS and the HHS Office of Inspector General (OIG) issued an interim final rule setting forth waivers to the federal fraud and abuse laws for ACOs, and the Federal Trade Commission (FTC) and the Department of Justice (“DOJ”) issued enforcement guidelines on treatment of ACOs under the antitrust laws. Shortly afterwards, the Internal Revenue Service issued a new Fact Sheet which clarifies some of its earlier guidance on participation by tax exempt organizations in ACOs.

The final versions of the various rules and guidance address many of the concerns that MGMA and others expressed in both formal and informal comments at the proposed rule stage. By doing so, the government appears to have generated new interest in the provider community in the ACO “shared savings” payment model, at least for now. At the same time, it remains an open question as to how many MGMA members’ medical groups will ultimately want to form, join, or otherwise participate with an ACO doing business with Medicare.

Even more uncertain is whether this hybrid payment model—still based in fee-for-service but sharing some characteristics and incentives with managed care—will be an enduring part of the Medicare program, or simply a phase through which the program passes on the route to more fundamental payment reforms. One suspects that its longevity will be largely dependent on its ability to show savings for Medicare, and show them quickly. Based on the results of Medicare’s multi-year, large group practice demonstration program from which the ACO concept evolved, a certain skepticism on that score seems warranted.
Background

The Affordable Care Act (ACA) required CMS to establish a shared savings or ACO program by January 1, 2012. After publication of a proposed rule in April of this year that met with widespread rejection by the health care provider community, the agency’s final rule generally lessens requirements for participation, and improves the risk-reward trade-offs inherent in the shared savings payment model. Another potential “sweetener” comes in the form of a separate CMS notice announcing an “Advance Payment Model” in which some physician-led practices and rural hospitals are eligible to receive upfront payments for ACO participation. This money would be available to help defray start-up costs necessary for ACO development and initial operation.

The Final ACO Rule Makes Major Changes from the Proposed Rule

The final rule addresses a number of issues raised by the health care community, which had been extremely critical of the draft rule. Some of the more significant changes include the following:

Elimination of required loss sharing during the first three contract years. The greatest concern expressed by providers with regard to the draft rule was the requirement that all ACOs bear risk by year three. Under the final rule, providers can participate in a three year shared-savings only (“one-sided”) model. However, risk sharing will be required if the ACO continues to participate for a subsequent three-year term. CMS has also retained the “two-sided” risk model as an ACO option, which requires participants to share in losses from the start. ACOs electing this model could be eligible for a greater share of savings, depending on how well they perform on quality standards.

Lower start-up costs. Under the final regulations, “meaningful use” of electronic health records is a performance measure, rather than an early requirement for ACO implementation, and CMS will subsidize the patient survey that ACOs are required to conduct for the initial two years. CMS has lowered its estimates of ACO start-up costs from an average of $1.75 million in the proposed rule to $0.58 - $1.27 million in the final rule.

Increased financial incentives. The formula for distributing savings has been revised so that ACOs that achieve savings beyond specified minimums (2% to 3.9% depending upon the size of the ACO) will receive the appropriate share of the first dollar savings (which varies according to risk-track and quality performance). The ACO savings share will be up to 50% for the one-sided model, and up to 60% for the two-sided model. The final rule also eliminates provisions in the draft ACO rule under which CMS would have withheld 25% of savings eligible to be shared, in order to ensure repayment against potential future CMS losses.

Fewer performance measures. The number of performance measures is reduced from the original 65 to 33, with a more gradual ramp up from pay-for-reporting (year one) to pay for performance (phased in over years two and three).
A revised beneficiary assignment approach. The approach to assigning Medicare beneficiaries to the ACO has been revised from a retrospective assignment methodology to a prospective methodology with a year-end reconciliation. ACOs will receive a list of beneficiaries assigned to them up-front with quarterly updates of the beneficiaries whose cost of care CMS believes are likely to be attributed to the ACO. This presumably will enable an ACO to better manage care for the population at risk, although the final rule is careful to preserve beneficiary “freedom of choice.” The final beneficiary list will be reconciled at the end of the year, so that the ACO is not held responsible for those beneficiaries who shift their care to other providers during the year. As discussed in greater detail below, CMS is also revising the beneficiary assignment methodology to take into consideration primary care services provided by physicians and others who are not primary care physicians under the rule.

No mandatory antitrust review and increased protection from anti-kickback, self-referral and beneficiary inducement laws. MGMA and others were highly critical of the proposed ACO Stark and fraud and abuse law waivers, and of the very limited guidance offered by the antitrust enforcement agencies. The final rule is much better with respect to the former, and somewhat more helpful for the latter. A more detailed discussion of these issues is below.

Less burdensome governance and structural requirements. The governance requirements are less burdensome and more flexible, although a separate legal entity is still required.

The Basic Structure of the ACO Model Remains Unchanged.

The final ACO regulation does not change the basic structure or (with modest exceptions) the types of entities eligible to form ACOs. To contract with CMS on the shared savings model, the ACO must be a defined legal entity, with a defined governance structure, and not just a contractual joint venture. Eligible participants (i.e., entities that can sponsor an ACO) must be physician groups or networks of physician practices, hospitals that employ physicians, joint ventures owned by hospitals and physicians, or certain critical access hospitals (CAHs). CMS has also added federally qualified health centers (FQHCs) and rural health centers (RHCs) as entities that can independently form an ACO.

A large multi-specialty medical group could consider being the ACO entity, contracting directly with CMS. Similarly, a very large primary care practice might consider direct sponsorship. Smaller single specialty practices, although eligible, would not appear to be logical sponsors of an ACO, although they could be part-owners of one. And, of course, any medical group could have a contractual relationship to provide services to the patients of an ACO created by others. Nothing in the final rule changes our view that the most likely sponsor of an ACO is either a large already integrated health system, or a sizeable hospital joint venturing with either an allied multi-specialty practice and/or one or more sizeable primary care practices. For most, smaller MGMA practices, we think the more likely role is that of a service provider, and not an owner or lead sponsor of an ACO.
How Beneficiaries Are Assigned to ACOs.

Prospective Assignment with Reconciliation

Medicare beneficiaries are “assigned” to an ACO to determine the population for which the ACO is accountable and with respect to which it is eligible for share savings. Assignment does not in any way restrict the patient’s ability to get care outside the ACO, nor do patients enroll in an ACO, or otherwise “choose” an ACO, other than by getting their primary care from ACO primary care physicians as described below. Thus, the ACO program is fundamentally different from most managed care approaches.

Under the final rule, an ACO will be provided with a preliminary list of beneficiaries that would qualify to be assigned to the ACO based on historical utilization patterns, and would receive quarterly updates of that list. Final ACO assignment would be determined retrospectively at the end of the contract year for the purpose of calculating shared savings. Thus, the final rule reflects a combination of prospective and retrospective methodologies for beneficiary assignment.

Assignment Based on Primary Care Services

Like the proposed rule, patient assignment under the final rule is driven by use of primary care services from an ACO’s primary care physicians. A patient is assigned to a particular ACO, as opposed to another ACO, or not being assigned to any ACO, if the patient gets a plurality of his or her primary care services for the year from one ACO’s primary care physicians. However, the final rule provides an additional route in the case of Medicare patients who did not utilize any primary care services from any primary care physician, inside or outside the ACO, during the contract year, if the patient obtains any primary care service from a non-primary care ACO physician. If the patient receives any primary care services from a non-primary care ACO physician, that beneficiary will be assigned to the ACO if the allowed charges for primary care services furnished to the beneficiary by all ACO providers/suppliers (both physicians and non-physicians) are greater than the allowed charges for primary care services furnished by non-primary care providers/suppliers who are in another ACO or who are not affiliated with any ACO. Again, assignment based on primary care provided by specialist is only relevant if the patient saw no primary care physician for a primary care service during the relevant period.

While this change represents a small concession to specialists, it still leaves primary care physicians as the primary drivers in ACO patient assignment. For example, even if large numbers of Medicare patients received chronic care management from an ACO’s specialists, if they get any primary care services from any primary care physician inside or outside the ACO, it’s those primary care services that determine whether the patients are assigned to the ACO, another ACO, or not assigned at all.
Access to Specialty Care.

A concern of many specialty practices is whether patients assigned to an ACO based on primary care utilization will be effectively, though not legally, “locked into” the ACO for specialty care. The final rule addresses this concern tangentially, but probably not persuasively. For example, the patient satisfaction survey, which is a quality measure under the final rule, will query patients on access to specialists, but that query only measures subjective patient perception, not actual referral patterns.

Further, an ACO may not condition the participation of a provider in the ACO on the provider’s agreement to refer non-ACO patients to the ACO, or require those providers to refer assigned patients only to other ACO providers/suppliers. However, this latter prohibition does not apply to referrals made by ACO physician employees or contractors who are operating within the scope of their employment or contractual arrangements, unless the patient affirmatively expresses a preference for a different provider, an insurer selects the provider, or an outside referral is in the patient’s best medical interests in the judgment of the referring party.

It seems reasonable to assume that, despite these modest safeguards against patient “lock-in,” an ACO’s providers and suppliers are very likely to refer their assigned patients to other providers in the ACO wherever possible, particularly for expensive specialty care. After all, the potential shared savings, and in the two-sided model, the potential downside risks, give the ACO providers a strong incentive to manage the patient’s care, and that, generally, will be most easily accomplished inside rather than outside the ACO.

How Attractive Is the ACO Program and For Whom?

Discussed below are several factors which have a bearing on how the ACO program is utilized and by whom.

Relationship to Other Medicare Innovation Programs

Since the ACO draft rules were issued, CMS has announced a number of programs that have similar objectives—for example, the “Pioneer ACO” demonstration projects (announced by the Centers for Medicare and Medicaid Innovations (CMMI)), the “Bundled Payments for Care Improvement” (BPCI) projects (also launched by CMMI), and the “Comprehensive Primary Care Initiative” which, while led by CMS, will involve multiple payers. In addition, the Independence at Home (IAH) Demonstration project, which begins January 1, 2012 also allows providers to share in savings for a defined group of higher-cost beneficiaries with chronic conditions for which cost savings may be more easily accomplished them in the general Medicare population. While CMS will allow providers to participate in both an ACO and some of these other programs (e.g., the BPCI), for others, providers will be required to chose one or the other. It is unclear whether, and to what extent, the availability of these other initiatives will prove more attractive to providers than the ACO model, even with the increased flexibility in the final ACO rule. For example, it is possible that some less tightly integrated providers—those that do not already employ most or all of their physicians—may prefer to begin their integration
efforts by submitting applications to participate in the Independence at Home demonstration which begins in January 2012 or BPCI projects later in 2012, both of which generally involve less risk and fewer start up expenses.

**Role of Advance Payment ACO Demo**

The “Advance Payment ACO” demonstration launched by CMMI probably increases the likelihood that at least some ACOs will be sponsored by medical groups, without direct hospital participation, and thus without hospital capital to subsidize start-up costs. The Advance Payment ACO Model gets extra payment to a physician-led ACO earlier, as an advance against shared savings presumed to be earned later. It is open only to two types of organizations, and only at such time as those organizations become participating ACOs in the Medicare shared savings program:

- ACOs that do not include any inpatient facilities AND have less than $50 million in total annual revenue.
- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than $80 million in total annual revenue.

Under this program, participating ACOs will receive three types of payments:

- **An upfront, fixed payment:** Each ACO will receive a fixed payment.
- **An upfront, variable payment:** Each ACO will receive a payment based on the number of its historically-assigned beneficiaries.
- **A monthly payment of varying amount depending on the size of the ACO:** Each ACO will receive a monthly payment based on the number of its historically-assigned beneficiaries.

CMS will recoup advance payments through an ACO’s earned shared savings. If the ACO does not generate sufficient savings to repay the advance payments as of the scheduled settlement (midway through the ACO’s second performance year), CMS will recoup the balance from earned shared savings in the subsequent performance year. *CMS will not pursue recoupment on any remaining balance of advance payments after the ACO completes its first agreement period.*

**Opportunities for Providers in Rural and Under-Served Areas**

By expanding eligible ACO sponsors to include FQHCs and RHCs, the final rule also makes more likely the formation of at least some ACOs designed specifically to serve rural and underserved populations. CMS presumably hopes that this change, combined with the advance payment demonstration, will overcome the perceived lack of financial capacity to experiment
with the shared savings model for these populations. Furthermore, by eliminating a number of hospital-centric performance measures from the ACO program, the ability to launch an ACO without significant hospital involvement, if not direction, is enhanced.

**Ability to Generate Shared Savings**

The economic viability of ACOs will turn, at least in the long run, on their ability to generate savings to the Medicare program. Those considering ACO participation need to assess the likelihood of generating savings above the minimum threshold and the sustainability of those savings in the long run, given that ACOs will continually be measured against previous benchmarks. Thus, the more an ACO reduces costs, the lower its benchmark against which future savings will be measured and the more difficult it will be over the years to demonstrate savings.

It is also worth considering that less than half of the programs in the Physician Group Practice (PGP) Demonstration, the sole model for the ACO program, achieved savings of more than 2 percent over a five year period.

Further, although ACOs will be permitted to enter the program with no downside risk for the first three years, once this initial period is over, ACOs will be held accountable for increased costs for their assigned populations and will be expected to make repayments to the program up to certain limits.

**Expanded OIG Waivers.**

The ACO final regulation is accompanied by an interim final rule setting forth five new waivers from physician self-referral, kickback, gainsharing, and beneficiary inducement prohibitions. Two of these waivers were previously issued with the proposed ACO rule; three additional waivers have been added.

The HHS OIG and CMS have jointly issued the waivers because of the breadth of fraud and abuse laws and regulations covered under the waivers. The waivers will not be codified in the federal regulations. The waivers do not protect against any self-referral prohibitions under state law, so it is possible that an ACO fitting under the federal waiver might still present compliance risk under state law. Nonetheless, the five waivers are designed to allow parties to develop ACOs relatively unhindered by the federal fraud and abuse laws.

The five waivers are the ACO Pre-Participation waiver, the ACO Participation waiver, the Shared Savings Distribution waiver, the Compliance with the Physician Self-Referral Law waiver, and the Patient Incentive waiver. Two of the waivers – the Shared Savings Distribution waiver and the Compliance with the Physician Self-Referral Law waiver – are essentially the same as previously proposed, but with additional detail. The other three waivers are new and are discussed below.
The ACO Pre-Participation and Participation waivers are designed to provide seamless protection to ACOs. They operate nearly identically, with the ACO Pre-Participation waiver applying to prospective ACOs, their participants and providers/suppliers, and the ACO Participation waiver applying to ACOs that have successfully completed the application process and entered into a participation agreement with CMS. Both waivers have nearly identical requirements and cover the same sorts of financial arrangements.

The ACO Pre-Participation waiver is particularly important because it applies to “start-up” arrangements entered into in connection with the formation of an ACO. The exemption permits ACO participants to provide facilities, services, and goods, or to pay for these items, in connection with the formation of an ACO, without incurring compliance risk under the anti-kickback statute, the Stark law, or the gainsharing Civil Monetary Penalties (CMP) law. For example, under the waiver, a hospital or health system may now pay the organizational costs of forming an ACO, even though it will result in a financial benefit to physician participants that might otherwise trigger the Stark or anti-kickback laws. The waiver comes, however, with a limited window of opportunity. It will protect parties forming an ACO only for a period of one year prior to the due date of the ACO’s application to participate. If the prospective ACO fails to submit its application on time, then the waiver expires unless the ACO submits a request for an extension, explaining the reasons for the delay. HHS may grant a one-time, one-year extension at its sole discretion to allow parties to continue with the ACO formation arrangements until the next target date.

The Pre-Participation waiver also requires the governing body of the prospective ACO to carefully document the terms of, and reasons for, the support arrangement in its minutes or similar records. These documentation requirements should be reviewed carefully. Lastly, the Pre-Participation waiver contains a requirement for public disclosure of the arrangement (excluding the financial terms). OIG/CMS intend to provide the details of this requirement at a later time.

The third new waiver will allow ACOs to offer incentives to patients to encourage cost-effective care. Absent the waiver, these incentives might run afoul of a prohibition in the CMP statute that prohibits any person from offering a benefit to a Medicare beneficiary that might steer business to a particular provider. (The CMP statute’s “prohibition against beneficiary inducements” is similar to the anti-kickback law, except that it is targeted directly at patient incentives.) The waiver will allow ACOs to offer patients preventive care items and services, or other items or services that promote adherence to patient care plans or chronic care management programs. The incentives may only be “in-kind;” that is, financial incentives such as cash or coupons are not protected by the waiver.

Importantly, the waivers are effective immediately and are self-implementing. There is no need to apply for a waiver. OIG/CMS indicated that they may narrow (or even eliminate) the waivers in the future, and they have solicited comments on a wide range of issues regarding potential additional requirements for the waivers as well as any additional categories of arrangements that should be protected through a waiver. Overall, we view the waivers as a significant improvement.
over the proposed rule. Indeed, the waivers should remove compliance risk as a significant impediment to ACO formation.

**Antitrust Policy Statement Related to ACOs.**

In addition to the ACO final rule that was issued by CMS, the DOJ and FTC (collectively, the Antitrust Agencies) jointly issued their *Final Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* (the Final Policy Statement). Under the Final Policy Statement, the Antitrust Agencies will not challenge outright (i.e., as *per se* illegal) an ACO that jointly negotiates with private insurers to serve patients in commercial markets if the ACO satisfies certain requirements. Specifically, the ACO must meet CMS’s eligibility requirements for, and participate in, the Shared Savings Program and use the same governance and leadership structures and clinical and administrative processes to serve patients in both Medicare and commercial markets. For ACOs that meet those criteria, the Antitrust Agencies will apply a “rule of reason” analysis in analyzing a potential antitrust violation. According to the Antitrust Agencies, a rule of reason analysis will evaluate whether the collaboration is likely to have anticompetitive effects and, if so, whether the collaboration’s potential pro-competitive efficiencies are likely to outweigh those effects.

The Final Policy Statement also provides for a new antitrust “safety zone” for ACOs that meet certain conditions. The safety zone is intended for ACOs that are highly unlikely to raise significant competitive concerns. The Antitrust Agencies will not challenge an ACO that falls within the safety zone, absent extraordinary circumstances. An ACO’s safety zone eligibility is determined by the combined Primary Service Area (PSA) shares of ACO participants that provide a common service (e.g., the same physician specialty or the same inpatient service) to patients from the same PSA. To fall within the safety zone, an ACO’s independent participants that provide a common service must have a combined share of 30 percent or less of each common service in each participant’s PSA, wherever two or more participants provide that service to patients from that PSA. There is an appendix to the Final Policy Statement that provides a very detailed explanation of how to calculate the PSA shares of common services.

Under the safety zone, hospitals and ambulatory surgical centers must be non-exclusive to the ACO regardless of share (i.e. they cannot limit themselves to participation in only one ACO). In addition, an individual ACO provider with greater than a 50 percent share may also not be exclusive to a single ACO. An ACO that exceeds 30 percent may still fall within the safety zone if it qualifies for a rural exception, which is further described in the Final Policy Statement. In addition, the Final Policy Statement clarifies that ACOs that fall outside the safety zone may still be pro-competitive and legal.

The Final Policy Statement includes specific circumstances under which an ACO would raise competitive concerns. Examples of improper conduct that are described by the Antitrust Agencies include improper sharing of competitively sensitive information regardless of market share. In addition, the Antitrust Agencies instruct ACOs that have market power to avoid certain conduct that could prevent private payors from obtaining lower prices and better quality service,
including ACO conduct of preventing or discouraging private payors from directing or incentivizing patients to choose non-ACO providers; tying ACO services to the purchase of non-ACO services; contracting with providers on an exclusive basis so that the provider can’t contract outside of the ACO with other payors; and restricting private payors from sharing certain provider information with beneficiaries. The Antitrust Agencies note that all ACOs should refrain from, and implement safeguards against, conduct that may facilitate collusion among ACO participants in the sale of competing services outside the ACO.

Finally, the Antitrust Agencies will offer voluntary expedited 90-day reviews (which may be extended) for new ACOs that are seeking additional assurances and antitrust guidance. Parties seeking expedited review must submit their request for review prior to entering into the program, and they will be required to produce business strategies or plans and other materials described in the Final Policy Statement before the 90-day review period will begin. Within 90 days of receiving all required documents and information, the reviewing agency will advise the ACO if its formation and operation as described in the documents and information raises competitive concerns.

Thus, the Antitrust Agencies appear to take that view that ACOs approved by CMS are reasonably likely to be sufficiently integrated (financial and clinical integration) to be eligible for more lenient antitrust treatment when they negotiate with private payers. This additional flexibility to essentially negotiate collectively in the private insurance market may be a significant inducement for hospitals and non-hospital networks of providers to seek to participate in the ACO program. In this regard, it is significant that, under the more flexible and less demanding final ACO rule adopted by CMS, an ACO is not actually required to integrate its operations, either financially or clinically, except to the extent necessary to meet the quality requirements and (ultimately) achieve savings.

In short, it is possible that many hospitals and non-hospital networks may calculate that they are unlikely to qualify for significant financial returns in terms of shared savings under the Medicare ACO program but may nonetheless apply for program approval in part to obtain additional protection from antitrust risks associated with jointly pursued (through the ACO) third party payer negotiations.

**IRS Guidance for Tax-Exempt Entities.**

On October 20, 2011, the IRS issued Fact Sheet 2011-21 entitled, “Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations.” The Fact Sheet follows on the heels of earlier ACO guidance issued in April of 2011 in IRS Notice 2011-20, which listed five factors which, if satisfied, would allow a charity to participate in an ACO without creating undue private benefit or private inurement. Those factors which have not changed under Fact Sheet 2011-12) were:

- The terms of the tax-exempt organization’s participation in the Medicare shared savings program through the ACO (including, its share of
payments or losses and expenses) are set forth in advance in a written agreement negotiated at arm’s length;

- CMS has accepted the ACO into, and has not terminated the ACO from, the program;

- The tax-exempt organization’s share of economic benefits derived from the ACO (including its share of payments) is proportional to the benefits or contributions the tax-exempt organization provides to the ACO. If the tax-exempt organization receives an ownership interest in the ACO, the ownership interest is proportional and equal in value to its capital contributions to the ACO and all ACO returns of capital, allocations and distributions are made in proportion to ownership interests;

- The tax-exempt organization’s share of the ACO’s losses does not exceed the share of ACO economic benefits to which the tax-exempt organization is entitled.

- All contracts and transactions entered into by the tax-exempt organization with the ACO and the ACO’s participants, and by the ACO with the ACO’s participants and any other parties, are at fair market value.

While the new Fact Sheet does provide some additional useful guidance on tax-exempt organization involvement in ACOs, there are still many questions left to be addressed. However, the Fact Sheet does make the following key points:

1. An ACO does not need to be structured as any particular type of legal entity, but it generally should be a legal entity separate from its participants (such as an LLC or corporation). The IRS noted the possible exception of a clinically-integrated organization such as a hospital employing physicians.

2. Tax-exempt organizations under section 501(c)(3) can participate in ACOs, provided that they do not allow undue private benefit or private inurement. This means that all transactions must be at arm’s length and at fair market value. The IRS expects that most charity participation in ACOs will further a charitable purpose.

3. While past IRS guidance on 501(c)(3) participation in joint ventures is generally applicable to ACOs as well, the IRS noted that a 501(c)(3) charitable organization may not necessarily need to have control over an ACO formed as a partnership and that compliance with CMS regulations and oversight might be good enough to ensure that a charitable purpose is accomplished. The IRS also noted that, in most cases, ACO income to a
charity participant will not be subject to unrelated business income tax (UBIT).

4. The IRS clarified that an ACO may conduct some activities outside the scope of a MSSP and that, depending on the facts and circumstances, such activities may not necessarily generate UBIT or subject a tax-exempt charity to loss of tax-exemption.

5. Finally, the IRS clarified that a tax-exempt organization’s participation in an ACO need not always meet all five of the factors that were set forth in IRS Notice 2011-20. Instead, the presence or absence of inurement and private benefit will be determined based on all the facts and circumstances. Nevertheless, it is prudent for organizations to try to satisfy all five of the factors whenever possible.

**Conclusion**

Overall, CMS and its colleagues at OIG, DOJ, FTC and the IRS have made a number of useful changes to the ACO program, in line with changes requested by MGMA in its public comments on the earlier proposals. These changes have the potential to increase interest among group practices in the shared savings payment model. The magnitude of that interest, however, remains to be seen. MGMA members considering ACO formation, participation or contracting are well advised to carefully compare the costs, risks and rewards of that participation with similar opportunities under other CMS payment innovations, and against the much more mature Medicare Advantage managed care options available to them.