ACO gain/loss sharing

A framework for allocating savings within an accountable care organization

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The Centers for Medicare and Medicaid Services (CMS) has proposed a shared savings arrangement with hospitals, physicians, and other healthcare providers that integrate and coordinate their services through accountable care organizations (ACOs) and achieve cost savings to Medicare as a result. In return, CMS offers, through the Medicare Shared Savings Program (MSSP), to return a portion of the amounts saved to the ACOs.[1]

CMS issued the final rule for MSSP on October 20, 2011. An overview of MSSP and a comparison of the final and interim rules are contained in Appendix A. MSSP applications are due early in 2012 for ACO starting dates of April 1 or July 1, 2012. An application must include a plan for distributing shared savings or losses to providers within the proposed ACO, but CMS has not spelled out procedures for developing such a plan. Drawing up a savings-distribution plan requires careful, detailed decisions potentially affecting every provider entity within the new system.

Any risk/reward system should be guided by certain principles: that provider compensation be part of an overall program that relates medical cost to the marketplace premium level; that the incentive program be simple, easy to implement, fair to all, and capable of monitoring quality; and that the program encourage high-quality, cost-effective patient care consistent with the ideas of the Triple Aim.[2] The system should be the product of collaboration among a wide section of the organization's constituents who share a high degree of agreement on what constitutes success or failure.

The framework described in this paper emphasizes rewards for an ACO's component entities based on their relative contributions to the organization's total shared savings and quality performance. We are focusing on CMS-contracted MSSP ACOs, as contained in the Patient Protection and Affordable Care Act (PPACA) of 2010, because they are facing the task as an immediate issue. However, the approach could also be applied to risk-sharing arrangements within any integrated delivery system.

BEFORE TAKING THE PLUNGE

Before your organization decides to contract with CMS as an ACO eligible for shared savings, it would be a good idea to benchmark your current status. This would entail conducting an operational gap analysis to evaluate current programs and processes and to identify areas for improvement, asking questions about your organization's capabilities for, among other things:

- Effective care management
- Network adequacy
- Continuum of care
- Population management
- Performance measurement

Additional questions to answer would address your ability to organize or enable provider control, and to move toward aligning the incentives of all entities within the prospective ACO. To the extent possible, both process and outcome information should be reviewed. That is, policies and procedures for managing patients and communicating with providers within the organization should be evaluated. In addition, statistical evidence of those capabilities should be sought (e.g., days per 1,000, length of stay, ER usage, etc.)[3]

If gaps are found, the ACO must determine if the cost of remediation is justified based on the extent to which any improvements are likely to be attainable and sustainable.[4]

When you have satisfied yourself that your organization is ready to make application for a CMS contract, then you can begin to plan how you will allocate your anticipated savings share among the various entities within your organization, including hospitals, primary care physicians (PCPs), and specialty care physicians (SCPs).

[1] A second Medicare ACO program, the Pioneer program, closed its application process in August 2011. It also offers to return a portion of achieved savings to ACOs that reach both financial and quality performance targets.

[2] The Triple Aim was first articulated by Donald Berwick in a 2008 *Health Affairs* article, and consists of better care for individuals, better health for populations, and lower per capita costs.

DIVIDING THE GAINS

The framework proposed below is one of many possible approaches. The structure and associated parameters may be modified to suit the needs of specific organizations. In the case of larger ACOs, a preliminary step in allocating savings to providers may be to break the organization out into geographic regions, or by some other scheme of division, and then apply the methodology described below to each division.

The next step is to allocate regional (or other division) savings by provider pool. Most commonly, this will be three pools–hospitals, primary care providers (PCPs), and specialty care providers (SCPs)–but other segments may be appropriate depending on the situation. The financial performance of the provider pools is measured by type of service category. These categories typically include inpatient, outpatient, professional services (separately for PCPs and SCPs), prescription drugs, and ancillary services, but other categories may be used depending on the goals of the ACO. For example, radiology might be split out if the ACO wants to put a particular emphasis on managing radiology costs.

Performance is measured by allocating the total claims target by type of service category, and then comparing the allocated target amounts to actual claims by type of service. Savings by type of service are allocated to the various provider pools using percentages that vary by service category, such as those shown in the table in Figure 1.

FIGURE 1

POOL	IP	OP	PCP	SPECIALIST	RX	ANCILLARY
HOSPITAL	30–60%	30–60%	0%	0–10%	0%	0%
PCP	15–30%	15–30%	100%	20–50%	50–75%	25–75%
SCP	10–25%	10–25%	0%	30–60%	25–50%	25–60%
TOTAL	100%	100%	100%	100%	100%	100%

Reading across the "Hospital" row in Figure 1, hospitals have significant responsibility for the cost of inpatient and outpatient services (a 30%–60% share each in this example), very little for primary care services (0% assumed here), a small amount for specialist services (0%–10% assumed here), and little or none for outpatient drug and ancillary services. Applying these percentages and summing across service categories generates the allocation of shared savings by provider pool.

The next step in allocating savings is to distribute the amounts by provider pool to the specific hospitals, primary care physicians, and specialists. Ideally, the allocation to individual providers would be based on both financial and quality measures. This better aligns incentives at the individual provider level with those of the organization as a whole. The individual provider quality measures would be based on those that apply to the ACO. The financial measures would necessarily vary by provider pool.

Once the measures are defined, each provider receives a score for each measure based on their individual performance. The score might be dependent on a ranking of providers or it might be based on comparison to a benchmark. The benchmark could be based on external data, or it could be based on the ACO's own data. The scores for the financial and quality measures are then weighted together to develop a composite score.

The quality measures might be grouped into families (or "domains" in CMS terminology); the scores are weighted within a family, and then across families, to develop a composite quality score. The weights applied could be customized to be consistent with the ACO's goals. For example, equal weight might be given to financial and quality measures, as shown in Figure 2.

FIGURE 2

MEASURES	ILLUSTRATIVE WEIGHTS %
QUALITY INDICATORS (50%)	
BETTER CARE FOR INDIVIDUALS	
- PATIENT/CAREGIVER EXPERIENCE OF CARE	12.5
- CARE COORDINATION/PATIENT SAFETY	12.5
BETTER HEALTH FOR POPULATIONS	
- PREVENTIVE HEALTH	12.5
- AT-RISK POPULATION/FRAIL ELDERLY HEALTH	12.5
FINANCIAL PERFORMANCE (50%)	50.0
TOTAL	100.0

Once the composite score is developed, it is multiplied by a measure of patient volume to develop total points. The points serve as the basis for allocating savings to the individual providers within each provider pool. In the next few sections, we discuss the development of financial measures for each provider pool. This is followed by a discussion of some of the challenges an ACO faces when implementing arrangements of this type.

PCP allocation

For primary care physicians, ACOs will often use population-based statistics such as total claims per member per month (PMPM) as the basis of financial performance measurement. This is because, in an ACO, PCPs bear the overarching responsibility for managing and coordinating patient care. All providers must work in concert to give the most cost-effective treatments in the most timely fashion, but the PCPs are the ones who will manage patient care.

The illustration in Figure 3 shows one approach to PCP allocation. The example assumes that $1,000,000 of savings has been allocated to the PCP pool using the process described above. The $1,000,000 is then allocated to specific PCPs as shown in Figure 3.

[3] Fitch, K., Murphy-Barron, C., Mirkin, D. "Nuts and bolts of ACO financial and operational success: Calculating and managing to actuarial utilization targets." Available at http://publications.milliman.com/publications/healthreform/pdfs/828_HDP.pdf

[4] Kipp, R., Mattie, L. "Controlling healthcare costs the old, new way." Available at http://insight.milliman.com/article.php?cntid=7263&utm_source=search&utm_medium=web&utm_content=7263&utm_campaign=Search.

FIGURE 3: POTENTIAL PROVIDER RISK-SHARING METHODOLOGY: PRIMARY CARE PHYSICIANS (ILLUSTRATIVE METHODOLOGY FOR ALLOCATING REGIONAL INCENTIVE POOL TO CLINICS)

	MEMBERS	TARGET PMPM	RISK SCORE	RISK-ADJ TARGET PMPM	ACTUAL PMPM	DIFFERENCE	SCORE	MEMBERS X SCORE	ALLOCATION	ALLOCATED SAVINGS
PCP 1	3,000	$800.00	1.030	$824.00	$790.00	($34.00)	2	6,000	30.0%	$300,000
PCP 2	5,000	$800.00	0.950	$760.00	$800.00	$40.00	0	0	0.0%	$0
PCP 3	4,000	$800.00	1.060	$848.00	$820.00	($28.00)	2	8,000	40.0%	$400,000
PCP 4	6,000	$800.00	0.970	$776.00	$760.00	($16.00)	1	6,000	30.0%	$300,000
TOTAL	18,000	$800.00	0.994	$795.56	$789.44	($6.11)		20,000	100.0%	$1,000,000

PMPM amounts reflect all services.

Scores can be assigned in a variety of ways.

In this approach, we are comparing a risk-adjusted target with actual claims. We assign a score based on the savings achieved relative to the benchmark. The allocation is based on total points, which equal the score multiplied by the number of members attributed to the PCP.

A number of other measures could be considered for inclusion in the allocation methodology. Even if not included explicitly, measures such as the following should be monitored on an ongoing basis:

- Days/1,000
- ER use
- Urgent care use
- Referrals (by specialty type)
- Generic dispensing rate
- High-cost radiology
- Overutilized services: endoscopies, catheters, angioplasties
- Setting for radiology and pathology (i.e., hospital-based versus lower-cost settings)
- Hospice use
- Bill-aboves (in commercial arrangements that include capitation)
- C-section rates (for obstetricians)

Specialist allocation

Various methods may be used to allocate savings among specialists. In general, accountability by specific providers increases as the complexity and sophistication of the allocation method increases. An ACO needs to find the right balance; accountability must be sufficient to create incentives for efficient delivery of care at the individual provider level, but simple enough that the method is not administratively burdensome, is understood by providers, and can be performed on a timely basis.

Method 1: Based on risk-adjusted patient counts. On the simple end of the spectrum, allocation might reflect the volume of services performed by each specialist, without any regard to efficiency. Such methods do not create strong incentives at the individual provider level, but they are simple to calculate and understand, and providers generally find them reasonably fair. The simplest of these is to base the allocation on risk-adjusted patient counts, as shown in Figure 4.

FIGURE 4: METHOD 1

	PATIENTS	AVERAGE RISK SCORE	RISK-ADJUSTED PATIENTS	ALLOCATION
SPECIALIST 1	3,000	1.030	3,090	17.3%
SPECIALIST 2	5,000	0.950	4,750	26.5%
SPECIALIST 3	4,000	1.060	4,240	23.7%
SPECIALIST 4	6,000	0.970	5,820	32.5%
TOTAL	18,000	0.994	17,900	100.0%

Method 2: Based on RVUs for specialty services. A more refined method, one that would more accurately reflect the mix of services performed by each specialist, might base the allocation on relative value unit (RVU) counts by specialist. This is shown in Figure 5.

FIGURE 5: METHOD 2

	SPECIALTY RVUS	ALLOCATION
SPECIALIST 1	3,000	16.7%
SPECIALIST 2	5,000	27.8%
SPECIALIST 3	4,000	22.2%
SPECIALIST 4	6,000	33.3%
TOTAL	18,000	100.0%

FIGURE 6: METHOD 3

	EPISODES	COST/ EPISODE	SEVERITY INDEX	SEVERITY-ADJUSTED COST/EPISODE	BENCHMARK COST/EPISODE	DIFFERENCE	SCORE	EPISODES X SCORE	ALLOCATION
SPECIALIST 1	3,000	$4,500	1.030	$4,369	$4,000	$369	0	0	0.0%
SPECIALIST 2	5,000	$4,000	0.950	$4,211	$4,000	$211	0	0	0.0%
SPECIALIST 3	4,000	$4,000	1.060	$3,774	$4,000	($226)	1	4,000	25.0%
SPECIALIST 4	6,000	$3,500	0.970	$3,608	$4,000	($392)	2	12,000	75.0%
TOTAL	18,000	$3,917	0.994	$3,939		($61)		16,000	100.0%

Method 3: Severity-adjusted cost per episode. This is a more sophisticated method that introduces the concept of efficient delivery of care into the allocation methodology. The average cost per episode for each specialist is calculated and adjusted by a severity index, which reflects the mix and complexity of the patient's needs and of services performed. The "standardized" cost per episode is a measure of each specialist's relative efficiency. Each specialist's score is based on relative efficiency, and that score, multiplied by the number of patients, produces the specialist's total points. The total points are then used to allocate the savings.

There are a number of different ways for assigning the relative efficiency score. One way is to rank the specialists from most to least efficient and assign a decreasing score as efficiency decreases, e.g., assigning a score of 2 to the top third, 1 to the middle third, and 0 to the bottom third.

Alternatively, as shown in Figure 6, the score could be based on a comparison of the severity-adjusted cost per episode to a benchmark. The benchmark could be based on internal data, such as the current or prior period average severity-adjusted cost per episode, or external data. The scoring might then work by assigning a score of 2 to the half of providers farthest below the benchmark (i.e., those with lowest costs) and 1 to the other half below the benchmark, while those above the benchmark get 0.

Other measures that one might consider include:

- Services per patient
- High-cost radiology use
- Tests/procedures subject to overutilization (varies according to specialty)

Hospital allocation

Similar to specialty services, there is a range of methods that can be used to allocate savings attributed to the hospital pool, from simple measures of volume of services to measures that compare the cost per case to mix and severity-adjusted targets. Other measures that could be reflected–and, at a minimum, should be monitored–include:

- Length of stay
- Readmission rates
- Infection rates
- Preventable events
- Admissions through the emergency room (ER)
- Intensive care unit (ICU) days
- Observation days
- Hospice use
- ER visits (top five diagnoses)
- Utilization of high-cost or frequently overutilized procedures, e.g., MRI, CAT, PET, and endoscopy
- Discharge planning: skilled nursing facility, home healthcare

The percentage of the savings that a hospital should receive depends on the hospital's role in the healthcare system's operations. A hospital that is a major financial backer of a healthcare organization, providing the system's capital and infrastructure, may deserve a higher share in the savings than one that is more passively involved.

CHALLENGES

Setting up performance-measurement standards is a multilayered process, and there are a number of tasks that pose particular challenges to developing an effective risk-management plan.

Setting targets: One of the keys to a fair accounting of provider performance is the development of targets that appropriately reflect the risk characteristics of the patients served and the mix and complexity of services performed. For quality measures it is wise to use measures consistent with CMS's program. For financial measures an organization should select them based on known or suspected weaknesses that have been identified through a benchmarking/gap analysis exercise. In all cases the target setting

should be done in a transparent and replicable way and done with the help and cooperation of the providers in the organizations or their surrogates (i.e., advisory groups by provider type).

Low-volume providers: The claim cost statistics for providers with a low volume of services may not be credible—in other words, the statistic varies too much based on random fluctuation that is beyond the control of the provider. The ACO needs an alternative method to deal with these providers.

Outliers: A provider may be performing efficiently but receive little or no allocation of savings, due to the impact of a small number of members with very high claim levels. These outliers may be largely beyond the control of the provider. To protect against this, stop-loss provisions may be applied to actual claims prior to calculating the measures. For the same reason, certain services may be carved out from both targets and the data used to calculate the performance measures. These carve-out services are usually infrequent, high-cost services that providers have limited opportunity to manage. CMS has adopted an approach for this which could be used as is, or modified.

SCP incentives: It can be difficult to find the measurement standards for specialist physicians that will give them incentives to manage their patients. Some of the key specialties, such as cardiology and orthopedics, are high-cost, high-volume fields, and it is important to involve them in a major way because they have a significant bearing on the ACO's financial performance. Different specialties require different indicators (e.g., dermatology vs. cardiology). Smaller specialties (e.g., otorhinolaryngology) pose the problem of defining incentives for lower-volume practices that have relatively less financial impact and where the measures may be less credible. An ACO might consider phasing certain specialties in over time once they exhibit consistency in their measures.

Dealing with losses: Adequate planning must also confront the likely prospect of some years in which the ACO will experience losses, which must be paid back to CMS. How should an ACO distribute a loss under the arrangements described here? It is crucial to have procedures and risk capital in place for years when there is a loss.

Excessive financial risk: If losses are to be shared in some fashion, the sharing mechanics will need to be tested to be sure no provider is exposed to excessive financial risk.

Information systems: The ACO must have information systems that facilitate effective communication among care providers. Particularly important is the ability to pass health records from one physician to another—which is why CMS encourages the adoption of electronic health records (EHR) systems and the notion of interoperability.

Benchmark comparison groups: The ACO must decide how to establish the peer groups against which it wants to compare its providers—and how to get the needed statistics from each group. The possibilities include:

- Peer-group physicians at hospitals where the ACO's physicians practice
- Peer-group physicians who practice in the local area
- Peer-group physicians who practice in the same geographic region
- All peer-group physicians in the state
- Appropriate "best practices" levels

IN SUMMARY

Developing a successful plan requires the collaboration of all elements in the ACO system. All sides need to be included in the conversation, represented at least by advisory groups if not a wider provider constituency. It is important that their interests be represented at the beginning of the process and through to the establishment of final measuring standards.

At the same time, ACO management needs to understand that meeting new benchmarks takes work and does not come easily. To succeed, ACO providers need management's full support.

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APPENDIX A[5] - MSSP OVERVIEW

BACKGROUND

The Medicare Shared Savings Program (MSSP) was authorized within the 2010 PPACA legislation. An interim rule for the formation and functioning of ACOs was issued in April 2011. The final rule, issued October 20, 2011, contain a number of key changes that address industry concerns. (See "Comparison of proposed to final ACO rules," below, for a summary of these changes.)

An organization operating as an ACO contracts with CMS on the basis of a three-year agreement ending December 31, 2015. An ACO must accept responsibility for at least 5,000 beneficiaries under one of two risk-sharing options. (See "Financial performance options," below.) To assist the ACO's care coordination efforts, CMS will provide the ACO with claim data for all services patients receive under Medicare Parts A, B, and D.

Beneficiaries are not required to use ACO providers and may seek care from non-ACO providers without a referral. For beneficiary assignment, the ACO provides data on probable members prospectively, on a quarterly basis; final reconciliation, however, takes place retrospectively at year's end on the basis of patients actually served.

CMS'S SHARED SAVINGS MECHANISM

CMS will pay providers on a fee-for-service (FFS) basis during the year. End-of-year reconciliation of savings or loss will be based on the ACO's financial performance (actual claims versus targets) and quality measures.

Financial performance options

An ACO can choose between two program "tracks" for calculating savings. On Track 1, the ACO has a 50% share in gains, but not losses, during all years of the contract period; however, the shared gains are capped at 10% of the target. Renewal of the three-year contract will be on Track 2.

Track 2 offers a higher share of savings (60% capped at 15%) but shares in both gains and losses.

Calculation of both tracks' gains or losses is on a first-dollar basis once a minimum saving requirement (MSR) has been met. Track 1 MSR varies from 2% to 3.9%, based on ACO size; Track 2 MSR is a flat 2%. Caps on losses for both tracks are 5% for year one, 7.5% for year two, and 10% for year three of the contract period.

Shared amounts are adjusted according to the ACO's score on quality measures. The ACO must be above a minimum level of quality performance to be eligible for any gain sharing.

Financial performance targets will be based on what Medicare Parts A and B services would cost in the absence of an ACO, drawn from the most recent three years of its own data, weighted 60% for the third (most recent) year, 30% for the second, and 10% for the first year. Data will be adjusted annually for prospective age, gender, and risk, using hierarchical condition category (HCC) risk adjusters. The targets will not be adjusted retrospectively, but performance-year claims will be adjusted to account for changes in severity and mix. Targets will be updated each year using the projected absolute growth amount nationally. Variation is minimized by using the 99th-percentile cost as a maximum charge for a member.

Quality performance reporting

CMS groups the 33 quality indicators into four "domains": patient/caregiver experience of care, care coordination and patient safety, preventive health, and at-risk populations. Points will be assigned for each measure, based on percentile; no points will be assigned for scores lower than the 30th percentile. An ACO must be at or above the 30th percentile for 70% of the measures in each domain to qualify for shared savings distributions. The indicators within each domain are weighted equally, except that implementation of an EHR system receives a double weight. The composite scores for each domain are then weighted equally to develop a total score.

To encourage organizations to begin in 2012, ACOs will not be required to meet the quality measures for the first year, but they must still report that year's performance. Starting with year two, the ACO will be evaluated on 25 of the 33 criteria; for the third year, it will be evaluated on 32 of the 33.

Comparison of proposed to final ACO rules

Persons familiar with the proposed CMS rules for ACOs, issued in April 2011, must be aware that some of the rules have changed in the final version, issued October 20, 2011. The following table summarizes the changes.

[5] For a discussion of the MSSP proposed rule, see Pyenson, B., Fitch, K., Iwasaki, K., Berrios, M. "The Two Medicare ACO Programs: Medicare Shared Savings and Pioneer – Risk/Actuarial Differences." Available at http://www.premierinc.com/quality-safety/tools-services/ACO/form/14849_Milliman-Report-on-Pioneer-vs-MSSP070811.pdf

TOPIC	PROPOSED RULE	MODIFICATIONS IN FINAL RULE
Transition to risk in Track 1	ACOs could choose from two tracks, each entailing a three-year agreement. Track 1 would comprise two years of one-sided shared savings with a mandatory transition in year three to performance-based risk under a two-sided model of shared savings and losses. Track 2 would comprise three years, all under the two-sided model.	Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.
Prospective vs. retrospective	Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.	A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year based on patients served by the ACO.
Proposed measures to assess quality	65 measures in 5 domains, including patient experience of care, utilization claims-based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years. Alignment of proposed measures with existing quality programs and private-sector initiatives	33 measures in 4 domains. (Note: Claim-based measures not finalized to be used for ACO-monitoring purposes.) Longer phase-in measures over course of agreement: first year, pay for reporting; second year and third year, pay for reporting and performance. Finalize as proposed.
Sharing savings	One-sided risk model: sharing beginning at savings of 2%, with some exceptions for small, physician-only, and rural ACOs. Two-sided risk model: sharing from first dollar.	Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.
Sharing beneficiary ID claim data	Claim data shared only for patients seen by ACO primary care physician during performance year; beneficiaries given opportunity to decline at the point of care.	The ACO may contact beneficiaries from provided quarterly lists to notify them of data sharing and opportunity to decline.
Eligible entities	The four groups specified by the Patient Protection and Affordable Care Act, as well as critical access hospitals paid through Method II, are eligible to form an ACO. ACOs can be established with broad collaboration beyond these providers.	In addition to groups included in the proposed rule, federally qualified health centers and rural health clinics are also eligible to both form and participate in an ACO. In order for beneficiaries to be assigned on the basis of utilization of primary care services, these organizations must provide a list of practitioners who directly render primary care services in their facilities.
Start date	Agreement for three years with uniform annual start date; performance years based on calendar years.	Program established by January 1, 2012; first round of applications is due in early 2012. First ACO agreements start April 1, 2012, and July 1, 2012. ACOs will have agreements with a first performance "year" of 18 or 21 months. ACOs starting April 1, 2012, and July 1, 2012, have an option for an interim payment if they report CY 2012 quality measures. ACO must report quality measures for CY 2013 to qualify for first-performance-year shared savings.
Aggregate reports and preliminary prospective list	Reports will be provided at the beginning of each performance year and include name, date of birth, sex, and health insurance claim number.	Additional reports will be provided quarterly.

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TOPIC	PROPOSED RULE	MODIFICATIONS IN FINAL RULE
Electronic health record (EHR) use	Aligning ACO requirements with EHR requirements, 50% of primary care physicians must be defined as meaningful users by start of second performance year.	No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.
Source: Center for Medicare and Medicaid Services. "Proposed Rule Versus Final Rule for Accountable Care Organizations (ACOs) In the Medicare Shared Savings Program." Available at https://www.cms.gov/ACO/Downloads/Appendix-ACO-Table.pdf		
Assignment process	One-step assignment process: beneficiaries assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians (internal medicine, general practice, family practice, and geriatric medicine).	Two-step assignment process: Step 1: For beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services rendered by primary care physicians. Step 2: For beneficiaries who have not received any primary care services from a primary care physician, use plurality of allowed charges for primary care services rendered by any other ACO professional.
Marketing guidelines	All marketing materials must be approved by the Centers for Medicare and Medicaid Services (CMS).	"File and use" five days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language.

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