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Office of Media Affairs

MEDICARE FACT SHEET

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What Providers Need to Know:

Accountable Care Organizations

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

Under the proposal, ACOs – teams of doctors, hospitals and other health care providers working together – would coordinate and improve care for patients with Original Medicare – Medicare Parts A and B. ACOs would have to meet high quality standards to ensure patients are happy with the care they receive and have better health outcomes. And if ACOs can help save money by getting patients the right care at the right time, they can share in those savings with Medicare. As proposed, ACOs could also have to pay back Medicare for failing to provide efficient, cost-effective care. The new program would begin on January 1, 2012.

This fact sheet describes the proposals to ensure that ACOs provide high-quality care, including proposed quality measures, and a proposed method for scoring the performance of the ACO for purposes of the Medicare Shared Savings Program. There will be a 60 day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as it develops final regulations on the program.

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What is an ACO?

Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve in Original Medicare. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from different providers receiving different, disconnected payments. The ACO would be a patient-centered organization where the patient and providers are partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals.
- Other Medicare providers and suppliers as determined by the Secretary

In the proposed rule, the Secretary has made clear that certain critical access hospitals are eligible to participate in the Shared Savings Program.

How Could Providers Participate?

To participate in the Shared Savings Program, providers must form or join an Accountable Care Organization (ACO) and apply to CMS. An existing ACO will not be automatically accepted into the Shared Savings Program. If accepted, they would serve at least 5,000 Medicare patients and agree to participate in the program for three years. Medicare providers who join an ACO that participates in the Program would continue to receive payment under Original Medicare fee-for-service (FFS) rules.

The statute also requires each ACO to establish a governing body representing ACO providers of services, suppliers, and Medicare beneficiaries. The ACO would be responsible for monitoring

and reporting of the care it delivers. The proposed rule outlines a monitoring and reporting plan that includes analyzing claims and specific financial and quality data, producing quarterly and annual aggregated reports, performing site visits, and conducting beneficiary surveys.

How Would Shared Savings Work?

Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or be held accountable for losses. The benchmark is an estimate of what the total Medicare fee-for-service Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services would not have been provided by providers in the ACO. The benchmark would take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark would be updated for each performance year within the three-year performance period.

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for one or the other models. CMS believes this approach would have the advantage of providing an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.

CMS is also proposing to establish a minimum sharing rate that would account for normal variations in health care spending. The minimum savings rate is a percentage of the benchmark that ACO expenditure savings must exceed in order for an ACO to qualify for shared savings in any given year. Under the proposed rule, ACOs in the one-sided risk program that have smaller populations (and having more variation in expenditures) would have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided approach, CMS is proposed a flat 2 percent minimum sharing rate.

If an ACO meets quality standards and achieves savings exceeding the minimum saving rate, the ACO would share in savings, based on the quality score of the ACO. The proposed rule would

provide for additional shared savings for ACOs that include beneficiaries who receive services from a Federally Qualified Health Center or Rural Health Clinic during the performance year.

ACOs that Participate in the Two-Sided Risk Model Can Obtain Greater Shared Savings

To qualify for shared savings, ACOs must meet certain quality and performance standards and have total per capita costs for assigned beneficiaries in the performance year to be both below the estimated updated benchmark and above the minimum savings rate. Once the ACO surpasses the minimum savings rate, it may share in savings if it is eligible to receive shared savings based on its quality performance score. To provide a greater incentive for ACOs to adopt the two-sided risk approach, the maximum sharing percentage is 60 percent for ACOs in the two-sided model compared to 50 percent in the one-sided model. In addition, under the two-sided model, ACOs would receive shared savings for the first dollar after the minimum savings rate is achieved. In contrast, under the one-sided model, ACOs would share on savings after a 2 percent threshold is met, with an exemption for small ACOs in rural or underserved communities. Under both models, an ACO would be eligible for a greater portion of shared savings the higher its quality and performance score.

The proposed rule also provides a methodology for determining shared losses for ACOs in the two-sided model (or year three of the one-sided model) if the per capita cost per beneficiary were more than 2 percent higher than the benchmark. As with shared savings, the amount of shared losses would be based in part on the ACO's quality performance score. Additionally, CMS is also proposing a shared loss cap of 5 percent of the benchmark in the first year of the Shared Savings Program, 7.5 percent in the second year, and 10 percent in the third year.

Participation in the First Program Year Allows for ACOs to Obtain the Maximum Sharing Rate if they Successfully Report Quality Measures

CMS is encouraging providers to participate in the Shared Savings Program in 2012 by setting the quality performance standard to reporting only. ACOs would be eligible for the maximum sharing rate (60 percent for the two-sided model and 50 percent for the one-sided model) if the ACO generates sufficient savings and successfully reports the required quality measures. This flexibility would allow newly formed ACOs a grace period as they start up their operations and learn to work together to better coordinate patient care.

The Proposed Quality Measurement is Aligned with Other CMS Quality Initiatives

CMS has proposed to measure quality of care using nationally recognized measures in five key domains: patient experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. These measures are aligned with the measures in other CMS programs such as the Electronic Health Records (EHR) and Physician Quality Reporting System (PQRS). An ACO that successfully reports the quality measures required under the Shared Savings Program would be deemed eligible for the PQRS bonus.

ACOs may not participate, however, in any other shared savings program or demonstration under the Center for Medicare and Medicaid Innovation or Independence At Home Medical Practice pilot program to ensure that savings are not counted twice.

Existing Clinically Integrated Entities Need Not Form New Entities to Participate in the Shared Savings Program

If an ACO is already comprised of a self-contained financially and clinically integrated entity that has a pre-existing board of directors or other governing body, the ACO need not form a separate governing body or create a new legal entity. The existing entity, however, must be recognized under applicable State law, be capable of receiving and distributing shared savings and repaying shared losses, and meet the other ACO functions identified in the statute.

How ACOs Help Doctors Coordinate Care

Health care providers have reported that an important barrier to improving care coordination is lack of information. While they may know about the services they provide to the beneficiary, they don't know about other services provided to the beneficiary. To better treat patients and to coordinate their care, ACOs would be able to request claims information about their patient from CMS. Before doing so, ACOs must notify a beneficiary in writing that it would request the beneficiary's claims information from CMS. ACOs must allow beneficiaries to opt-out of having their claims information shared with the physician and the ACO. This opting out of having claims information shared, however, does not affect the patient's participation in the ACO or CMS's use of the patient's data for purposing of assessing quality or cost measures. This notification must happen the first time the ACO cares for the beneficiary.

Alignment of CMS Requirements and Other Federal Laws

CMS has worked closely with agencies across the Federal government to facilitate participation in the Shared Savings Program by coordinating federal fraud and abuse requirements, tax guidance, and antitrust considerations. In particular, the Federal Trade Commission and the Antitrust Division of the Department of Justice have proposed an antitrust policy statement that clarifies application of the antitrust laws to Medicare Shared Savings Program -approved ACOs that negotiate and contract with commercial payers. See: *Medicare Fact Sheet: Federal agencies address legal issues regarding Accountable Care Organizations*

The Shared Savings Program NPRM will appear in the XX, 2011 issue of the *Federal Register*. CMS will accept comments on the proposed rule until XX, and will respond to them in a final rule to be issued later this year. The Shared Savings Program will begin operating on January 1, 2012.

For more information, please see:

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