DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

Medicare Shared Savings Program and Rural Providers

FACT SHEET http://www.cms.gov/sharedsavingsprogram

Overview

On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), finalized 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 (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

In developing this final rule, CMS worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Shared Savings Program.

CMS encourages all interested providers and suppliers to review this final rule and consider participating in the Shared Savings Program.

This fact sheet provides an overview of ACOs for rural providers.

Rural Providers and ACOs

CMS recognizes the unique needs and challenges of rural communities and the importance of rural providers in assuring access to health care. Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) play an important role in the nation's health care delivery system by serving as safety net providers of primary care and other health care services in rural and other underserved areas and for low-income beneficiaries. On October 20, 2011, CMS released final rules to help doctors, hospitals, and other health

care providers better coordinate care for Medicare patients through ACOs. The final rule includes several specific provisions designed to increase rural participation in the Shared Savings Program.

Provisions to Allow FQHCs and RHCs to Fully Participate in the Shared Savings Program

The final rule provides for FQHCs and RHCs to participate in the Shared Savings Program by becoming their own ACOs, or by joining an ACO as an ACO participant along with other organizations. Data from the FQHCs and RHCs will be used to assign beneficiaries to ACOs for purposes of measuring quality and financial performance under the program. In order to do this, we added certain revenue center codes indicative of primary care services to the definition of primary care services when they are submitted on claims by FQHCs/RHCs.

However, ACOs that are formed by or include FQHCs and RHCs are required to submit a special attestation listing their physician National Provider Identifiers (NPIs) that provide direct patient primary care services, that is, the physicians that deliver the FQHC's/RHC's primary care services. This special attestation is needed to supplement their claims data because FQHCs and RHCs have not historically submitted all the data elements required for assignment, as required by the statute.

Modification to Beneficiary Assignment Rules for FQHCs and RHCs

Beneficiaries will be assigned to an ACO, in a two step process, if they receive at least one primary care service from a physician within the ACO. The assignment process is described in more detail in a separate fact sheet, but we would note here that under the second step of the two step process, beneficiaries are assigned to an ACO if the beneficiary receives a plurality of primary care services from physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO. This is expected to be helpful for rural areas with few physicians.

Critical Access Hospitals and ACOs

The Affordable Care Act specifies that certain groups of providers of services and suppliers, including physicians and hospitals, may form their own ACO as long as they meet the eligibility criteria, including minimum beneficiary assignment. The statute permits the Secretary to use her discretion to permit other Medicare providers of services and suppliers to form their own ACO. In the final rule, the Secretary has used her discretion to include CAHs that elect to bill for outpatient services under the optional method (Method II) as an eligible entity to form an ACO, assuming the CAH meets all of the other eligibility requirements. This is expected to help expand access to ACOs in rural areas.

CAHs billing for outpatient services under the standard method (Method I), similar to acute care hospitals, may not form their own ACOs because such CAHs do not submit claims for physicians' services, which is information needed in order to assign beneficiaries to the ACO. However, a CAH billing under the standard method may join with other ACO participants upon whom assignment is based to form an ACO.

Confidence Interval for Setting the Minimum Savings Rate for Smaller ACOs

Under the final rule, ACOs can participate under the program's one-sided shared savings model for their first agreement period. Alternately ACOs can apply to participate under the two-sided shared savings and losses model. The statute requires CMS to specify a Minimum Savings Rate (MSR) to account for the normal variation in expenditures, based upon the number of Medicare Fee-For-Service beneficiaries assigned to the ACO. The MSR helps ensure that savings are a result of the ACO's performance instead of normal variation in Medicare expenditures.

While recognizing the higher uncertainty regarding expenditures for smaller ACOs, the final rule improves smaller ACOs' ability to achieve shared savings under the one-sided model by using a lower confidence interval to set the MSR that must be met in order to share savings relative to larger ACOs. For the one-sided model, CMS will implement a sliding scale confidence interval based on the number of assigned beneficiaries, resulting in a range of MSRs between 2 and 3.9 percent. ACOs with the minimum number of 5,000 assigned beneficiaries will have an MSR based on a 90 percent confidence interval while an ACO with 50,000 assigned beneficiaries will have an MSR based on a 99 percent confidence interval. A flat 2 percent MSR applies to all ACOs under the two-sided model, to recognize that ACOs are taking on accountability for losses in addition to shared savings.

Resources

The Shared Savings Program final rule can be downloaded at http://www.ofr.gov/inspection.aspx on the Internet.

It will appear in the November 2, 2011, issue of the "Federal Register." The Shared Savings Program will be established January 1, 2012.

For information about applying to participate in the Shared Savings Program, visit http://www.cms.gov/sharedsavingsprogram on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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