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

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

Accountable Care Organizations: What Providers Need to Know

FACT SHEET

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.

What Is an ACO?

Under the final 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 Medicare Fee-For-Service patients they serve. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers

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receive different, disconnected payments. The ACO will be a patient-centered organization where the patient and providers are true 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., practitioners 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,
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

In the final rule, the Secretary has determined that certain critical access hospitals, federally qualified health centers, and rural health clinics are eligible to participate independently in the Shared Savings Program. Additionally, any other Medicare enrolled provider or supplier in good standing is encouraged to participate in an ACO since all providers are important for the ACO to achieve its goal of better coordinating care.

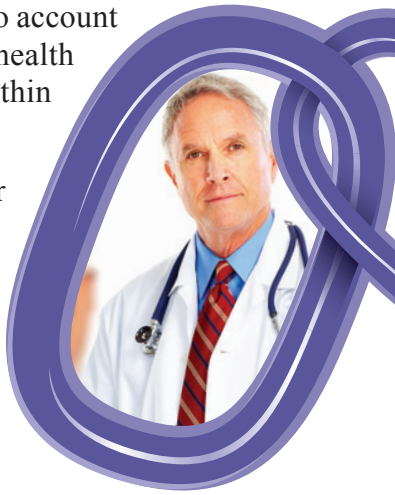
How Can Providers Participate?

To participate in the Shared Savings Program, providers must come together to become a Medicare ACO and the ACO must apply to CMS. An existing ACO will **not** be automatically accepted into the Shared Savings Program. To be accepted, ACOs must meet all eligibility and program requirements, must serve at least 5,000 Medicare Fee-For-Service patients and agree to participate in the program for at least 3 years. Medicare providers who participate in an ACO in the Shared Savings Program will continue to receive payment under Medicare Fee-For-Service rules.

The statute also requires each ACO to establish a governing body representing ACO providers of services, suppliers, and Medicare beneficiaries. The ACO will be responsible for developing processes to promote evidence-based medicine, promote patient engagement, internally report on quality and cost, and coordinate care. The ACO will be responsible for maintaining a patient-centered focus.

How Will Shared Savings Work?

Under the final rule, Medicare will continue to pay individual providers and suppliers for specific items and services as it currently does under the Medicare Fee-For-Service payment systems. CMS will also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or for ACO's that have elected to accept responsibility for losses, potentially 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



were not provided by providers in the ACO. The benchmark will take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark will be updated for each performance year within the agreement period.

CMS is implementing both a one-sided model (sharing savings, but not losses, for the entire term of the first agreement) and a two-sided model (sharing both savings and losses for the entire term of the agreement), allowing the ACO to opt for one or the other model for their first agreement period. CMS believes this approach will 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 shared losses 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 with the responsibility of repaying Medicare a portion of any losses.

CMS will also establish a Minimum Savings Rate (MSR) and a Minimum Loss Rate (MLR) to account for normal variations in health care spending. The MSR is a percentage of the benchmark that ACO expenditure savings must meet or exceed in order for an ACO to qualify for shared savings in any given year. Similarly, an ACO with expenditures at or above the MLR will be accountable for repaying shared losses. Under the final rule, ACOs in the one-sided model that have smaller populations (and having more variation in expenditures) will have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided model, CMS will apply a flat 2 percent MSR to all ACOs.

Under both models, if an ACO meets quality standards and achieves savings and also meets or exceeds the MSR, the ACO will share in savings, based on the quality score of the ACO. ACOs will share in all savings, not just the amount of savings that exceeds the MSR, up to a performance payment limit. Similarly, ACOs with expenditures meeting or exceeding the MLR will share in all losses, up to a loss sharing limit.

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

To provide a greater incentive for ACOs to adopt the two-sided approach, the maximum sharing percentage based on quality performance is higher for the two-sided model. ACOs adopting this model will be eligible for a sharing rate of up to 60 percent, while ACOs in the one-sided model will be eligible for a sharing rate of up to 50 percent. Under both models, CMS will base the actual savings percentage for the individual ACO (up to the maximum for that model) on its performance score for the quality measures.

The final rule also provides a methodology for determining shared losses for ACOs in the two-sided model if the assigned beneficiary per capita cost is at least 2 percent higher than the benchmark. As with shared savings, the amount of shared losses will be based in part on the ACO's quality

performance score. Additionally, CMS will limit losses by capping the ACO's loss sharing rate at 60 percent and by limiting the dollar amount at 5 percent of the updated benchmark in the first year of the Shared Savings Program, 7.5 percent in the second year, and 10 percent in the third year.

ACOs May Obtain the Maximum Sharing Rate in Their First Performance Year if They Successfully Report Quality Measures

CMS is encouraging providers to participate in the Shared Savings Program by setting the quality performance standard to reporting only for the first performance year of the ACO's agreement period and providing a longer phase in to performance over the second and third performance years. This means that ACOs will 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. After the first year, the ACO must not only report but also perform well on selected quality measures. This flexibility will allow newly formed ACOs a grace period as they start up their operations and learn to work together to better coordinate patient care and improve quality.

The Quality Measurement in the Final Rule Is Aligned with Other CMS Quality Initiatives

CMS will measure quality of care using nationally recognized measures in four key domains: patient experience, care coordination/patient safety, preventive health, and at-risk population.

These measures are aligned with the measures in other CMS programs such as the Electronic Health Records (EHR) and Physician Quality Reporting System (PQRS). Eligible professionals in an ACO that successfully report the quality measures required under the Shared Savings Program in any year of the program will be deemed eligible for the PQRS bonus, regardless of whether the ACO qualifies to share in savings.

Providers and suppliers who are already participating in another shared savings program or demonstration under Fee-For-Service Medicare, such as the Independence at Home Medical Practice pilot program, will not be eligible to participate in a Shared Savings Program ACO.

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

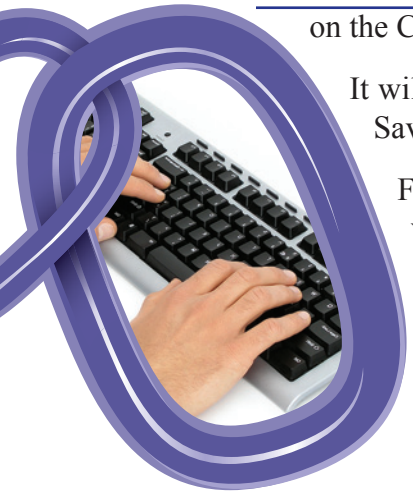
If a group of providers and suppliers are already a self-contained financially and clinically integrated entity that has a board of directors or other governing body, the organization need not form a separate governing body or create a new legal entity to participate in the Shared Savings Program. The existing organization, however, must be recognized under applicable State or tribal 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 a 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 all other services provided to the beneficiary. To better treat patients and to coordinate their care, ACOs will be able to request Medicare claims information about their patient from CMS. Before doing so, ACOs must notify a beneficiary in writing that it will request the beneficiary's claims information from CMS. ACOs must allow beneficiaries to decline having their claims information shared with the ACO. Declining to have this information shared, however, does not affect the provider's participation in the ACO or CMS' use of the patient's data for the purpose of assessing ACO's performance on quality or cost measures. This notification may happen by mail but must also happen the first time an ACO practitioner provides a primary care service to the beneficiary.

Resources

The Shared Savings Program final rule can be downloaded at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes_Regulations_Guidance.html on the CMS website.



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/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram on the CMS website.

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