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

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Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program

Overview

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), finalized regulations 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.

Shared Savings Goals

- **Better** care for patients
- **Better** health for our communities
- **Lower** costs through improvements for our health care system

In developing the program regulations, 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 program's regulations and consider participating in the Shared Savings Program.

This fact sheet describes the policies defining what ACOs are, how they can be created, and other general topics. CMS has posted separate fact sheets on its website to address in greater detail specific aspects of the program regulations, such as the quality measures and beneficiary assignment.

Background

Section 3022 of the Affordable Care Act added a new section 1899 to the Social Security Act that requires the Secretary to establish the Shared Savings Program. This program is intended to encourage providers of services and suppliers (e.g., physicians, hospitals, and others involved in patient care) to create a new type of health care entity, an ACO, that agrees to be held accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending. Studies have shown that better care often costs less, because coordinated care helps to ensure that the patient receives the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors.

ACOs and the Medicare Beneficiary

An ACO provides an opportunity for Medicare beneficiaries to receive high quality evidence-based health care that eliminates waste and reduces excessive costs through improved care delivery. However, there are significant differences between ACOs, as described in the program regulations, and the private managed care plans offered under the Medicare Advantage program. ACOs are part of the traditional Medicare Fee-For-Service Program and beneficiaries continue to have the ability to choose any provider they choose.

The program's regulations call for Medicare to assess the ACO's quality and financial performance based on a population's use of primary care services at the end of each year to determine whether a particular ACO should be credited with improving care and reducing growth in expenditures compared to a benchmark population. This means that an ACO has an incentive to improve the quality of care for all patients seen by its participating providers and suppliers.

The regulations require providers participating in an ACO to notify beneficiaries that they are participating in an ACO, and that the provider is eligible for additional Medicare payments for improving the quality and coordination of care the beneficiary receives while reducing overall costs or may be financially responsible to Medicare for failing to provide efficient, cost-effective care. The beneficiary may then choose to receive services from the provider or seek care from another provider that is not part of the ACO. A provider may not require a beneficiary to obtain services from another provider or supplier in the same ACO, as beneficiaries maintain the freedom to choose which providers they see.

The regulations also require each provider in an ACO to notify the beneficiary that the beneficiary's claims data may be shared with the ACO at the ACO's request. This data sharing is intended to make it easier to coordinate the beneficiary's care. The provider must give the beneficiary the opportunity to decline the data sharing arrangements. For Medicare beneficiaries who choose not to decline the data sharing arrangement, the regulations limit data sharing to the purposes of the Shared Savings Program and require compliance with applicable privacy rules and regulations, including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Eligibility Requirements for an ACO

The program regulations define an ACO as a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that work together to coordinate care for the Medicare Fee-For-Service beneficiaries they serve. The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries, instead of the fragmented care that has so often been part of Fee-For-Service health care. 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 program regulations, the Secretary has used her discretion to add certain critical access hospitals, federally qualified health centers, and rural health clinics as eligible to participate independently in the Shared Savings Program. The above providers may become ACOs and be used to assign patients to the ACO.

Recognizing that all Medicare enrolled providers and suppliers play an important role in improving the quality and coordination of care delivered to patients, any other Medicare enrolled provider or supplier in good standing may participate in an ACO; however, they may not be used for purposes of assigning patients to the ACO.

The statute also requires each ACO to establish a governing body representing ACO providers of services and suppliers and Medicare beneficiaries. The program regulations require each ACO to be responsible for routine self-assessment, monitoring, and reporting of the care it delivers, and to use the information to continually improve the care delivered to their Medicare beneficiaries.

An ACO must agree to accept responsibility for at least 5,000 Medicare Fee-For-Service beneficiaries to be eligible to participate in the Shared Savings Program. The regulations require a prospective Medicare ACO to complete an application providing the information requested by CMS, including how the ACO plans to deliver high quality care and lower the growth of expenditures for the beneficiaries it serves. If the application is approved, the ACO must sign an agreement with CMS to participate in the Shared Savings Program for a period of at least 3 years. An ACO will **not** be automatically accepted into the Shared Savings Program.

Monitoring ACO Performance and Termination of Agreement

The program regulations outline CMS' plans for monitoring ACOs to ensure their compliance with eligibility and program requirements. The monitoring plan includes analyzing claims and specific financial and quality data as well as the quarterly and annual aggregated reports, performing site visits, and performing beneficiary surveys. Monitoring may also include audits if necessary.

Under the regulations, there are a number of circumstances under which CMS may terminate the agreement with an ACO, including failure to comply with eligibility and program requirements, avoidance of at-risk beneficiaries, and failure to meet the quality performance standards.

Tying Payment to Improved Care at Lower Cost

Under the program regulations, Medicare continues to pay individual providers and suppliers for specific items and services as it currently does under the Fee-For-Service payment systems. The regulations require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings or for ACOs that have elected to accept responsibility for losses. Additionally, the amount of an ACO's shared savings or losses depends on its performance on quality standards.

The regulations establish quality performance measures and a methodology for linking quality and financial performance that set a high bar on delivering coordinated and patient-centered care by ACOs, and emphasize continuous improvement around the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures. The regulations require the ACO to have in place procedures and processes to promote evidence-based medicine, beneficiary engagement, and coordination of care. The regulations require ACOs to report quality measures to CMS and give timely feedback to providers for continual improvement of care to beneficiaries. CMS expects that ACOs invest continually in the workforce and in team-based care. To assure program transparency, the regulations require ACOs to publicly report certain aspects of their performance and operations and CMS to publicly report certain quality data.

Under the program regulations, an ACO that meets the program's quality performance standards may receive a share of the savings if its assigned beneficiary expenditures are below its own specific updated expenditure benchmark. The regulations would also hold certain ACOs accountable for sharing losses by requiring ACOs to repay Medicare for a portion of losses (expenditures above its updated benchmark). To provide an entry point for organizations with varied levels of experience with and willingness to share losses, the regulations allow an ACO to choose one of two program tracks. The first track allows an ACO to operate on a shared savings only arrangement for the duration of their first agreement. The second track allows ACOs to share in savings and losses for the duration of the agreement, in return for a higher share of any savings it generates.

Resources

The Shared Savings Program final rule can be downloaded at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website.

The Shared Savings Program was 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.

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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