

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



Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program

FACT SHEET

Overview

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 (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.

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

This fact sheet describes the proposals addressing the proposals for 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 proposed rule, such as the quality measures and performance scoring.

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.

Background

Section 3022 of the Affordable Care Act added a new Section 1899 to the Social Security Act (the Act) that requires the Secretary to establish the Shared Savings Program by January 1, 2012. 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, which the statute calls an “Accountable Care Organization (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 would be significant differences between ACOs, as described in the proposed rule, and the private managed care plans offered under the Medicare Advantage program. Beneficiaries would not enroll in a specific ACO.

Instead, the proposed rule calls for Medicare to take a retrospective look at the beneficiary’s use of services to determine whether a particular ACO should be credited with improving care and reducing expenditures. This means that an ACO would have an incentive to improve the quality of care for all patients seen by its member providers and suppliers.

The proposed rule would require providers participating in an ACO to notify the beneficiary that they are participating in an ACO, and that the provider will be eligible for additional Medicare payments for improving the quality 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.

The proposed rule would also require each provider in an ACO to notify the beneficiary that the beneficiary’s claims data may be shared with the ACO. This data sharing is intended to make it easier to coordinate the beneficiary’s care; however, the provider may not require a beneficiary to obtain services from another provider or supplier in the same ACO. The provider must give the beneficiary the opportunity to opt-out of those data sharing arrangements. For Medicare beneficiaries who choose not to opt-out of the data sharing arrangements, the proposed rule would limit data sharing to the purposes of the Shared Savings Program and would require compliance with applicable privacy rules and regulations, including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).



Proposed Eligibility Requirements for 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 Medicare Fee-For-Service (FFS) 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 FFS health care. The ACO would 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., 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,
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

In the proposed rule, the Secretary has used her discretion to add certain critical access

hospitals as eligible to participate in the Shared Savings Program.

The statute also requires each ACO to establish a governing body representing ACO providers of services and suppliers and Medicare beneficiaries. The proposed rule would make each ACO responsible for routine self-assessment, monitoring, and reporting of the care it delivers.

To participate in the Shared Savings Program, the proposed rule would require an ACO to complete an application providing the information requested by CMS, including how the ACO plans to deliver high quality care at lower costs for the beneficiaries it serves. As proposed, the ACO must agree to accept responsibility for at least 5,000 beneficiaries. If the application is approved, the ACO must sign an agreement with CMS to participate in the Shared Savings Program for a period of three years. An ACO will **not** be automatically accepted into the Shared Savings Program.

The proposed rule outlines a monitoring plan that 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.

Under the proposed rule, there are a number of circumstances under which CMS may terminate the agreement with an ACO, including avoidance of at risk beneficiaries and failure to meet the quality performance standards.

Tying Payment to Improved Care at Lower Cost

Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the FFS payment systems. The proposed rule would require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive



shared savings, or be held liable for losses. Additionally, an ACO would be accountable for meeting or exceeding the quality performance standards to be eligible to receive any shared savings.

The proposed rule would establish quality performance measures and a methodology for linking quality and financial performance that will 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 proposed rule would require the ACO to have in place procedures and processes to promote evidence-based medicine and beneficiary engagement in their care. The proposed rule would require ACOs to report quality measures to CMS and give timely feedback to providers. CMS expects that ACOs will invest continually in the workforce and in team-based care. To assure program transparency, the proposed rule would require ACOs to publicly report certain aspects of their performance and operations.

Under the proposed rule, an ACO that meets the program's quality performance standards would

be eligible to receive a share of the savings it generates below a specific expenditure benchmark that would be set by CMS for each ACO. The proposed rule would also hold ACOs accountable for downside risk by requiring ACOs to repay Medicare for a portion of losses (expenditures above its benchmark). To provide an entry point for organizations with varied levels of experience with and willingness to take on risk, the proposed rule would allow an ACO to choose one of two program tracks. The first track would allow an ACO to operate on a shared savings only track for the first two years, but would then require the ACO to assume the risk for shared losses in the third year. The second track would allow ACOs to share in savings and risk liability for losses beginning in their first performance year, in return for a higher share of any savings it generates.

The Shared Savings Program Notice of Proposed Rulemaking (NPRM) appeared in the April 7, 2011, issue of the Federal Register. CMS will accept comments on the proposed rule until June 6, 2011, 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.



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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