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

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# Summary of the June 2015 Final Rule Provisions for Accountable Care Organizations (ACOs) 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 in November 2011, as revised in June 2015, to help doctors, hospitals, and other health care providers better coordinate care for Medicare Fee-For-Service beneficiaries 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) rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care. Provider participation in an ACO is purely voluntary.

### Shared Savings Goals

- **Better** care for patients
- **Better** health for our communities
- **Lower** Medicare Fee-for-Service costs through improvements for the 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 Medicare-enrolled providers and suppliers to review the program regulations, including the revisions made in the June 2015 final rule, 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 separate fact sheets to address in greater detail specific aspects of the program regulations, such as the quality measures and beneficiary assignment. Visit the Medicare Shared Savings Program webpage for links to the fact sheets at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram on the CMS website.

## Background

Section 3022 of the Affordable Care Act added section 1899 to the Social Security Act, requiring the Secretary to establish the Shared Savings Program. This program encourages providers of services and suppliers (for example, 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 the quality and experience of care for a population of assigned Medicare beneficiaries while reducing the rate of growth in health care spending for that population. Studies have shown that better, more coordinated care often costs less, because care coordination 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 Fee-For-Service 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 see any Medicare-enrolled provider they choose.

Under the Shared Savings Program, CMS assesses an ACO's quality and financial performance based on a population of assigned beneficiaries to determine whether the ACO has met the quality performance standards and reduced growth in expenditures compared to a historical financial benchmark. ACOs that meet or exceed a minimum savings rate (MSR) and satisfy minimum quality performance standards are eligible to receive a portion of the savings they generated (shared savings). This means that an ACO has an incentive to improve the coordination and quality of care for all patients seen by its participating providers and suppliers.

### Notifying the Beneficiary

The regulations require providers and suppliers (ACO participants) participating in an ACO to notify beneficiaries that they are participating in an ACO and that the ACO is eligible for additional Medicare payments if it satisfies certain quality performance standards while reducing growth in costs. The beneficiary may then choose to receive services from the provider or supplier or seek care from another provider or supplier that is not part of the ACO. A provider or supplier 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 and suppliers they see.

The regulations also require each provider in an ACO to notify the beneficiary that the beneficiary's Medicare claims data may be shared with the ACO. This data sharing is intended to make it easier to coordinate the beneficiary's care. Beneficiaries may decline data sharing by calling 1-800-MEDICARE. For Medicare beneficiaries who choose not to decline data sharing, 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

A Medicare ACO is formed by a group of providers and suppliers of services (for example, 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 is a patient-centered organization where the patient and providers are true partners in care decisions.

## Eligible Providers and Suppliers

The following types of groups of providers and suppliers may form an ACO:

- ACO professionals (i.e., physicians and certain non-physician practitioners) in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture 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 allow certain critical access hospitals, federally qualified health centers, and rural health clinics to form an ACO independently in the Shared Savings Program. The listed types of providers and suppliers are eligible to form ACOs because they furnish primary care services that are 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 formed by one or more of the types of providers or suppliers listed above. However, non-primary care services furnished by these providers and suppliers will not be used for purposes of assigning patients to the ACO. All providers and suppliers participating in an ACO must agree to become accountable for the quality, cost, and overall care of the beneficiaries assigned to the ACO. The Shared Savings Program regulations set forth requirements for such agreements.

## Other Eligibility Requirements

An ACO is eligible to participate in the Shared Savings Program if it satisfies the program requirements set forth in the regulations. For example, an ACO must have at least 5,000 assigned Medicare Fee-For-Service beneficiaries to be eligible to participate in the Shared Savings Program. Each ACO must establish a governing body representing ACO participants and Medicare beneficiaries. The program regulations require each ACO to be responsible for routine self-assessment, monitoring, and reporting of the care it delivers to continuously improve the care delivered to their Medicare beneficiaries.

The regulations require a prospective Shared Savings Program ACO to complete an application providing the information requested by CMS, including how the ACO plans to deliver high quality care and lower the rate of growth in expenditures for the beneficiaries it serves. If the ACO's 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 automatically be 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 aggregate reports;
- Performing site visits; and
- Reviewing the results of beneficiary surveys.

Monitoring may also include audits, if necessary.

Under the regulations, there are 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 furnished to Medicare beneficiaries assigned to an ACO as it currently does under the Medicare Fee-For-Service payment systems. In order to determine whether an ACO is to receive shared savings or is responsible for losses (for those ACOs that have elected to operate under a two-sided performance-based risk model), CMS develops a financial benchmark based on historical expenditures for beneficiaries assigned to the ACO. Additionally, the amount of an ACO's shared savings or losses depends on its quality performance.

The regulations establish quality performance measures and a method for linking quality and financial performance that set a high bar on the delivery of 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 ACOs to have in place procedures and processes to promote evidence-based medicine, beneficiary engagement, and coordination of care. ACOs must report quality measures to CMS and give timely feedback to providers and suppliers for continuous improvement of care to beneficiaries. CMS expects that ACOs invest continuously 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. In addition, CMS publicly reports quality and financial performance data on https://data.cms.gov and CMS' Physician Compare website.

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 by a specified percentage. The regulations also hold those ACOs that choose to participate in a two-sided performance-based risk model accountable for sharing losses by requiring ACOs to repay Medicare for a portion of losses (expenditures above the ACO's updated benchmark by a specified percentage). 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 three program tracks. The first track allows an ACO to operate on a shared savings only arrangement for the duration of its first agreement, as well as their second agreement period, if they chose to renew their participation in the program. The second and third tracks allow the ACO 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 2015 Shared Savings Program final rule can be downloaded at https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf on the Government Publishing Office (GPO) website. The 2011 Shared Savings Program final rule can be downloaded at https://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the GPO website. Many of the policies adopted in the first final rule remain in effect.

For information about applying to participate in the Shared Savings Program, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram on the CMS website.



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