

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



Accountable Care Organizations: What Providers Need to Know



Overview

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), established the Medicare Shared Savings Program (Shared Savings Program) on January 1, 2012, as required by the Affordable Care Act. The Shared Savings Program is a voluntary program designed to provide better care for patients, better health for our communities, and lower costs through improvements in the health care system. Specifically, the program allows doctors, hospitals, and other health care providers to better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). Participation in an ACO creates incentives for health care providers to work together to treat an individual patient across care settings—including doctor's offices, hospitals, and

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

long-term care facilities. The Shared Savings Program will financially 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.

CMS issued regulations implementing the Shared Savings Program in November 2011. Those regulations were revised in a final rule issued in June 2015. 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 the program regulations and consider participating in the Shared Savings Program.

This fact sheet provides an overview of Medicare ACOs.

What Is an ACO?

Under the program regulations, an ACO refers to a group of Medicare providers and suppliers (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. A Medicare ACO is a patient-centered organization where the patient and providers are true partners in care decisions.

Who Can Form an ACO?

The following groups of providers and suppliers of Medicare-covered services are eligible to 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 ventures arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals;
- Certain critical access hospitals;
- Federally qualified health centers, and;
- Rural health clinics.

Any Medicare-enrolled provider or supplier may join an ACO formed by the entities identified above. Any Medicare provider or supplier in good standing is encouraged to participate in an ACO since all health care providers are important for the ACO to achieve its goal of better coordinating care. However, providers and suppliers who are already participating in another program or initiative involving shared savings under Fee-For-Service Medicare are not eligible to participate in a Shared Savings Program ACO.

If an ACO is formed by more than one provider or supplier, the ACO must be a legal entity separate from the providers or suppliers that formed it. An ACO formed by a single Medicare provider or supplier need not form a separate legal entity to participate in the Shared Savings Program as an ACO, as long as it satisfies the same organization and governance requirements applicable to all ACOs.

How Can Providers Participate?

To participate in the Shared Savings Program, eligible providers and suppliers must form 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 serve at least 5,000 Medicare Fee-For-Service patients, meet all other eligibility and program requirements, and agree to participate in the program for at least 3 years.

The statute and program regulations specify the eligibility and program requirements. For example, each ACO is required to establish a governing body that includes a Medicare beneficiary and provides ACO participants with meaningful participation in ACO governance. In addition, the ACO is responsible for developing processes to promote evidence-based medicine, promote patient engagement, internally report on quality and cost measures, and coordinate care. The ACO is responsible for maintaining a patient-centered focus.

How Are ACOs Paid?

Under the program regulations, Medicare continues to pay individual ACO providers and suppliers for covered items and services as it currently does under the Medicare Fee-For-Service payment systems. CMS also develops a benchmark for each ACO against which ACO performance is measured to assess whether the ACO generated savings or losses for the Medicare program during a performance year. ACOs that meet or exceed a minimum savings rate (MSR), satisfy minimum quality performance standards, and otherwise maintain their eligibility to participate in the Shared Savings Program are eligible to receive a portion of the savings they generate (“shared savings”). In addition, if an ACO has chosen to operate under a two-sided risk model, and it meets or exceeds a minimum loss rate (MLR), it must repay a portion of the losses it generates (“shared losses”).

What Are the Risk Sharing Options?

Medicare ACOs can choose to accept either one-sided or two-sided financial risk. Under the one-sided model (Track 1), an ACO may receive shared savings if it meets the applicable requirements, but it will not be liable for shared losses. Under the two-sided models (Track 2 and Track 3), the ACO may share both savings and losses. An ACO may opt for a one-sided or two-sided model for its first 3-year agreement period. An ACO that completes its first agreement period under the one-sided model may apply for a second agreement period under this model. CMS believes this approach will allow organizations that have less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a two-sided model in which they will be accountable for shared losses. In addition, this policy provides an opportunity for more experienced ACOs to enter a sharing arrangement that provides a greater share of savings, but with the responsibility of repaying Medicare a portion of any losses.

How Are Shared Savings and Losses Calculated?

CMS develops a benchmark for each ACO against which ACO performance is measured to assess whether the ACO generated savings or losses for the Medicare program during a performance year. The benchmark is an estimate of what the total Medicare Fee-For-Service Parts A and B expenditures for assigned ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services were not provided by providers or suppliers in the ACO. The benchmark takes into account beneficiary characteristics. This benchmark is adjusted for beneficiary characteristics and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare Fee-For-Service Program for each performance year within the agreement period.

CMS also establishes an MSR and an MLR to account for normal variations in health care spending. The MSR is a percentage of the benchmark that ACO 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 is accountable for repaying shared losses. Under the program regulations, ACOs in the one-sided model that have smaller populations (and thus more variation in expenditures) will have a larger MSR and ACOs with larger populations (and thus less variation in expenditures) have a smaller MSR. Under the two-sided models, ACOs have a choice between a symmetrical MSR/MLR from 0.0 percent to 2.0 percent in increments of 0.5 percent, or an MSR/MLR that varies based upon the number of beneficiaries assigned to the ACO (determined using the same methodology as used to determine the MSR under the one-sided model).

Under the one-sided and two-sided models, if an ACO meets the quality performance standards and achieves savings that meet or exceed the MSR, the ACO shares in savings, based on the quality score of the ACO. ACOs 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 share in all losses, up to a loss sharing limit.

How Do Shared Savings and Shared Losses Vary Among the Three Risk Tracks?

To provide a greater incentive for ACOs to become accountable for shared losses, two-sided risk models offer the opportunity for greater reward in comparison to the one-sided model. Track 1 ACOs can receive a shared savings payment of up to 50 percent of all savings under the updated benchmark; whereas, Track 2 and Track 3 ACOs have a maximum sharing rate of 60 percent and 70 percent, respectively. Under all tracks, CMS bases the actual savings percentage for an individual ACO (up to the maximum for that track) on its performance score for the quality measures. Under Track 1, shared savings may not exceed 10 percent of the ACO's updated benchmark, whereas under Track 2 the performance payment limit is 15 percent of the ACO's updated benchmark, and under Track 3 the limit is 20 percent of ACO's updated benchmark.

The program regulations also provide the methodology for determining shared losses for ACOs in a two-sided model if the per capita costs for the ACO's assigned beneficiary population are above its updated benchmark by an amount equal to or greater than its MLR. As with shared savings, the amount of shared losses is based in part on the ACO's quality performance score. While CMS caps the ACO's loss sharing rate at 60 percent for Track 2 ACOs and 75 percent for Track 3 ACOs, quality performance cannot reduce the loss sharing rate below 40 percent of the ACO's updated benchmark under the two-sided models. CMS also limits the total amount of losses owed through loss sharing limits. Under Track 2, the loss sharing limit is 5 percent of the updated benchmark in the first performance year under Track 2, 7.5 percent in the second performance year, and 10 percent in the third performance year or any subsequent performance year. Under Track 3, the loss sharing limit is 15 percent of the ACO's updated benchmark in each performance year.

How Does Beneficiary Assignment Vary Among the Three Risk Tracks?

The three tracks under the Shared Savings Program are also distinguished by how CMS assigns beneficiaries to participating ACOs. Assignment under Tracks 1 and 2 is based on preliminary prospective assignment with retrospective reconciliation. While ACOs participating in Tracks 1 and 2 are provided with preliminary prospective assignment lists on a quarterly basis during the performance year, they are held financially accountable for any Medicare Fee-For-Service beneficiaries who choose to receive a plurality of their primary care services from ACO professionals billing through the Tax Identification Numbers (TINs) of ACO participants during the performance year. In contrast, Track 3 uses a prospective beneficiary assignment methodology under which an ACO's prospectively assigned beneficiary list provided at the start of the performance year encompasses all beneficiaries for whom the ACO will be held accountable in that performance year.

How Does an ACO Satisfy the Quality Performance Standards?

CMS encourages providers and suppliers to participate in ACOs under the Shared Savings Program by setting the quality performance standard for the first performance year of an ACO's first agreement period at complete and accurate reporting and providing a phase-in to performance over the second and third performance years of that agreement period. This means that ACOs are eligible for the maximum sharing rate (50 percent for Track 1 ACOs, 60 percent for Track 2 ACOs, and 75 percent for Track 3 ACOs) if the ACO generates sufficient savings and completely and accurately reports on all required quality measures. After the first year, the ACO must not only report on all measures but must also perform well on selected quality measures. This gradual phase-in allows 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.

How Are the Quality Performance Standards and Reporting Aligned with Other CMS Quality Initiatives?

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

The quality measures reported for purposes of the Shared Savings Program are aligned with the measures used in other CMS programs, such as the Medicare Electronic Health Record (EHR) Incentive Program, Physician Value Modifier, and Physician Quality Reporting System (PQRS). Eligible professionals participating in an ACO that satisfactorily reports the quality measures required under the Shared Savings Program avoid the PQRS payment adjustment and the Value Modifier automatic downward adjustment. Additional information on the PQRS adjustment can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html> on the CMS website. Also, please visit the Physician Feedback and Value Modifier program web page for additional information: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram>.

Eligible professionals (EPs) participating in an ACO may meet clinical quality measure (CQM) requirements for the Medicare EHR Incentive Program if the EPs use Certified EHR Technology for extracting data and the ACO completely reports Shared Savings Program quality measures. EPs must still meet all other Medicare EHR Incentive Program requirements and complete an attestation.

How Do 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 often don't know about all the services provided to the beneficiary by other health care providers. To better treat patients and to coordinate their care, ACOs may request Medicare claims information about their patients from CMS. Beneficiaries have the opportunity to decline sharing their claims information and may do so by calling 1-800-Medicare. A beneficiary's decision not 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 the ACO's performance on quality or cost measures.

Resources

The Shared Savings Program final rules can be downloaded from the Government Publishing Office (GPO) website at <https://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> (November 2011 final rule) and <https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf> (June 2015 final rule) on the GPO website.

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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