



Proposed Medicare Shared Savings Program

Background

Sec. 3022 of the *Affordable Care Act* (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared Savings program “by Jan. 1, 2012 that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” Participating entities, referred to as Accountable Care Organizations (ACOs), that meet quality and performance standards are eligible to receive payments for shared savings.

On March 31, four documents implementing Sec. 3022 were issued by five government agencies:

- CMS released the Medicare Shared Savings Program; Accountable Care Organization proposed [rule](#).
- CMS and the Office of Inspector General released a joint [notice](#) with comment period soliciting public input on possible waivers of the Physician Self-Referral Law (Stark), Federal anti-kickback statute and certain civil monetary penalties provisions. The notice includes proposals to waive the laws in three circumstances:
 - The distribution of shared savings payments received by an ACO to or among qualified ACO participants and ACO providers/suppliers.
 - An ACO’s distribution of shared savings payments to other individuals or entities for activities necessary for and directly related to the ACO’s participation in the Shared Savings Program.
 - For the anti-kickback statute and civil monetary penalties provisions only, “any financial relationship between or among the ACO, ACO participants, and ACO providers/suppliers necessary for and directly related to the ACO’s participation in and operations under the Medicare Shared Savings Program that implicates the physician Self-Referral Law and fully complies with an exception...”
- The Internal Revenue Service issued a [notice](#) soliciting comments regarding the need for additional tax guidance for tax-exempt organizations planning to participate in the Medicare Shared Savings Program through ACOs.
- The Federal Trade Commission and Department of Justice released an antitrust enforcement policy [statement](#) regarding the application of antitrust laws to health care collaborations among otherwise independent providers and provider groups, formed after March 23, 2010, that seek to participate or have been approved to participate as a Medicare ACO.

These documents constitute the first major health delivery reform initiative after the passage of the ACA. In the published regulations, CMS estimates that between 75 and 150 Medicare ACOs will launch in 2012, with the potential to save Medicare as little as \$510 million or as much as \$960 million during the first three years. Anticipated aggregate start-up investment and first-year operating expenditures will be between \$113 million - \$263 million. Of Medicare’s 47 million beneficiaries, an estimated 1.5 million to 4 million will receive care through a Medicare ACO. This program is expected initially to attract the established integrated health systems that already have the capital, infrastructure and participants to qualify as a Medicare ACO.

Comments on the proposed rule are due to CMS on June 6, 2011, and the program will be implemented on January 1, 2012.

Medicare ACO Eligibility

An ACO refers to a group of physicians, hospitals and other suppliers of services that will work together to provide coordinated care to Medicare beneficiaries. In the proposed rule, CMS defines five types of entities permitted to *form* ACOs and participate in the Medicare Shared Savings Program:

- ACO professionals (physicians, physician assistants, nurse practitioners and clinical nurse specialists) 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; and
- Critical Access Hospitals that bill for the facility and the professional services to their fiscal intermediary or their Medicare Part A/B MAC (also known as Method II).

Although only these five entities can form participating Medicare ACOs, other Medicare providers and suppliers may *participate* in a Medicare ACO. ACOs may be designed to include a broad range of healthcare providers and suppliers—including safety net providers, post-acute care facilities, federally qualified health centers, rural health clinics, and critical access hospitals. CMS purposefully proposed a broad interpretation of providers and suppliers to encourage innovation, offer more comprehensive care, and better serve rural communities.

Medicare ACO Structure and Governance

A Medicare ACO is a separate legal entity with a shared governance structure and identified by a Taxpayer Identification Number (TIN). Providers and suppliers participating in a Medicare ACO will continue to receive traditional Medicare fee-for-service payments under Medicare Parts A and B, but also will be eligible to receive a portion of the shared savings if successfully satisfying quality performance standards and reducing health care costs.

A Medicare ACO may be structured in a variety of ways, such as a corporation, partnership, limited liability company, foundation or other entity permitted under state law. An existing legal entity may qualify as an ACO only if it meets all requirements applicable to the Medicare ACOs, including shared governance. Medicare ACOs must be able to: receive and distribute shared savings; repay shared losses; establish report and ensure provider compliance with health care quality criteria, including quality performance standards; and perform other ACO functions.

CMS proposes to make payments directly to a Medicare ACO's TIN, allowing the ACO to distribute funds to participating providers according to the ACO's legal structure. Providers participating in the ACO continue to receive payments under original Medicare fee-for-service rules. A Medicare ACO must include each ACO participant's TIN and each ACO provider/supplier's National Provider Identifier in the CMS application. During the three-year agreement, ACOs may remove participating providers with at least 30 days' notice to CMS, but may not add participants.

The proposed regulation specifies that at least 75 percent of a Medicare ACO's leadership and governance structure must be participants, representing clinical (without regard to medical specialty) and administrative functions. Medicare ACOs must have Medicare beneficiary representation on the Board and a community stakeholder organization may also serve on an ACO's governing body. CMS also requires Medicare ACOs to employ a board-certified physician, licensed in the state in which the ACO operates, who is physically present in an established ACO location in the state. The physician must serve as a senior-level medical director and is responsible for clinical management and oversight. Medicare ACOs must also employ a physician-directed

quality assurance and process-improvement committee in order to guarantee continued quality improvement efforts.

After publication of the final ACO rule later this year, interested entities must then apply to CMS to become a Medicare ACO. If accepted, the ACO must participate in the Medicare shared savings program for three years.

Shared Savings Methodology

Under the proposed rule, Medicare will continue to pay participating providers under the traditional fee-for-service program under Parts A and B. However, to the extent participating providers meet certain quality standards and savings benchmarks, such providers shall also be entitled to receive payment for shared Medicare savings that are limited by benchmarks, thresholds and caps.

Participating ACOs will have the option to adopt one of two payment models depending on the experience level of the ACO and its willingness to assume a share of the risk for any potential losses. The available models are described as Track 1 and Track 2.

- Track 1 (one-sided model): Shared savings are reconciled annually for the first two years of the three-year term using a pure shared savings approach whereby the ACO is not responsible for any portion of any losses. In the third year, the ACO is required to share in any losses generated, as well as any savings.
- Track 2 (two-sided model): A risk-based model is used for the entire three-year term. The ACO is eligible for higher sharing rates and other benefits in return for the increased risk of sharing in any losses for all three years of the agreement.

The proposed rule sets forth a process for determining the shared savings amount available to Medicare ACOs, beginning when CMS establishes the ACO's Expenditure Benchmark, intended to measure likely Medicare expenditures in the absence of the ACO. The Expenditure Benchmark is calculated using the most recent available three years of per-beneficiary expenditures for Medicare Parts A and B services for those beneficiaries assigned to the ACO. Data are adjusted for beneficiary characteristics and updated annually based on the overall growth of national per capita expenditures for services under the traditional Medicare fee-for-service program.

ACOs are not automatically eligible for shared savings. The annual expenditures of the ACO must fall below the Expenditure Benchmark by the applicable "Minimum Savings Rate" that represents the percentage of savings below the Expenditure Benchmark to account for normal variation in health care spending. For Track 2 ACOs, the Minimum Savings Rate is a flat 2 percent. For Track 1 ACOs, the Minimum Savings Rate ranges from 2 percent for ACOs with over 60,000 beneficiaries to 3.9 percent for ACOs with only 5,000 beneficiaries.

Track 1 Medicare ACOs are entitled to receive up to 50 percent of the net savings beyond the initial threshold (2 percent of the Benchmark), up to the Maximum Sharing Cap of 7.5 percent of the Expenditure Benchmark. Track 2 Medicare ACOs may receive up to 60 percent of the gross savings beyond the Minimum Savings Rate and up to the Maximum Sharing Cap of 10 percent of the Expenditure Benchmark.

Special rules apply to certain Medicare ACOs in rural or underserved communities, such as sharing first dollar savings above the Minimum Savings Rate. A Medicare ACO that includes a federally qualified health centers or rural health clinics receives an increase in its sharing rate, depending on the percentage of ACO-assigned beneficiaries with one or more visits to the federally qualified health centers or rural health clinics during the applicable year.

Track 2 Medicare ACOs (and Track 1 Medicare ACOs in year three of the agreement) share a portion of the loss that is 2 percent above the Expenditure Benchmark. The amount of shared losses for which the ACO is

liable is partially based on the Medicare ACO's quality performance score and is capped at 5 percent of the Expenditure Benchmark in year one, 7.5 percent in year two and 10 percent in year three. The proposed rule includes a chart, reproduced below, that outlines the elements of the shared savings program.

To protect Medicare against future losses and to encourage Medicare ACOs to participate for the full three years of their agreements, CMS proposes adopting a flat 25 percent withhold rate applied annually to any earned performance payment. The withhold applies to both Track 1 and Track 2 ACOs. At the end of the three-year agreement period, any positive balance is returned to the ACO. However, if an ACO does not complete the three-year agreement term, the ACO forfeits the entire withhold amount.

Shared Savings Program Overview

(from the Medicare Shared Savings Program proposed rule, page 93)

Design Element	One-Sided Model (performance years 1 & 2)	Two-Sided Model
Maximum Sharing Rate	52.5 percent	65 percent
Quality Scoring	Sharing rate up to 50 percent based on quality performance	Sharing rate up to 60 percent based on quality performance
FQHC/RHC Participation Incentives	Up to 2.5 percentage points	Up to 5 percentage points
Minimum Savings Rate (MSR)	Varies by population	Flat 2 percent regardless of size
Minimum Loss Rate (MLR)	None	Flat 2 percent regardless of size
Maximum Sharing Cap	Payment capped at 7.5 percent of ACO's benchmark	Payments capped at 10 percent of ACO's benchmark.
Shared Savings	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 52.5 percent of net savings up to cap.	Savings shared once MSR is exceeded; up to 65 percent of gross savings up to cap
Shared Losses	None	First dollar shared losses once the MLR rate is exceeded. Cap on the amount of losses to be shared is phased in over three years starting at 5% in year 1; 7.5% in year 2; and 10 percent in year 3. Losses in excess of the annual cap would not be shared. Actual amount of shared losses would be based on final sharing rate that reflects ACO quality performance & any additional incentives for including FQHC's and/or RHC's using the following methodology (1 minus final sharing rate).

For the first year, CMS proposes that the Medicare ACOs report 65 quality measures grouped into five domains: (1) patient/care giver experience; (2) care coordination; (3) patient safety; (4) preventive health; and (5) at-risk population/frail elderly health. Quality measure reporting requirements for the second and third year will be created during future rule-making. Beginning in the second program year, CMS will consider performance on the reported measures when determining whether an ACO is eligible to receive shared savings payments. ACOs will receive larger percentages of shared savings if they demonstrate providing high quality care. As proposed, ACOs must publicly report information on ACO participating providers and suppliers, parties sharing in the governance of the ACO, quality performance standard scores, and general information on how an ACO shares savings with its members.

Role of Primary Care

Under a statutory requirement, ACOs must “include primary care ACO professionals that are sufficient for the number of Medicare fee for-service beneficiaries assigned to the ACO” and “at a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it”. For purposes of the Medicare Shared Savings Program, CMS defines “primary care professionals” as physicians who have a primary specialty designation as “internal medicine, general practice, family practice, or geriatric medicine” and who are providing the appropriate primary care services to beneficiaries. Pediatricians may participate in the ACO, though their services are not counted toward the requirement that ACOs include enough primary care professionals to treat at least 5,000 Medicare beneficiaries.

For purposes of the ACO, CMS proposes to define “primary care services” as services identified by HCPCS codes 99201 through 99215, 99304 through 99340, 99341 through 99350, the Welcome to Medicare visit (G0402), and the Annual Wellness Visits (G0438 and G0439) as primary care services.

CMS expresses concern that the definition of primary care professional “could reduce the number of beneficiaries assigned to an ACO, by excluding primary care services delivered by specialists, especially in some areas that may have shortages of primary care physicians but a relatively greater number of specialists. Consequently, this option could make it difficult for ACOs to form in some geographic regions with such primary care shortages.” The agency seeks public comments on this proposed definition.

Contrary to the AAFP principles on ACOs, as proposed, Medicare ACO professionals on which beneficiary assignment is based (i.e. primary care providers) must be exclusive to one Medicare ACO agreement; other ACO participants (e.g., hospitals, specialists) could participate in multiple ACOs. The AAFP and others have urged CMS to allow primary care physicians, specialty physicians, and other healthcare professionals to have the option to participate in multiple ACOs.

In the second year (2013), at least 50 percent of a Medicare ACO’s primary care physicians must be “meaningful users” of electronic health records.

Involvement of Medicare Beneficiaries in an ACO

In the proposed regulation and in the related CMS materials, the agency specifies that participation of Medicare beneficiaries is completely voluntary and that there is no enrollment or assignment of beneficiaries to the Medicare ACO. The proposed regulation allows Medicare beneficiaries to receive care outside of the Medicare ACO at no penalty to the patient and does not require patients to actively choose a primary care physician.

However, CMS refers to “beneficiary assignment” as an operational term needed to determine whether a beneficiary received a sufficient level of requisite primary care services from physicians associated with a

specific ACO. CMS will assign beneficiaries to a Medicare ACO's TIN based on the primary care services they received from primary care physicians billing under that TIN, if they receive a plurality (as opposed to a majority) of their primary care services (based on allowed charges) from primary care physicians within that ACO.

CMS intends to develop a communications plan to provide information on utilization of services furnished by a Medicare ACO and the possibility of being assigned to an ACO. Medicare ACOs must notify patients that they are participating in an ACO. To improve coordination of care, CMS proposes offering access to Medicare claims data to ACOs for patients they are treating if the beneficiary grants permission.

Further Information

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association support the establishment of ACOs within public and private settings that are consistent with these [principles](#).

The AAFP created a [Practice Affiliation Options](#) website for members only, containing resources for family physicians regarding ACOs, including:

- [The Family Physician Practice Affiliation Guide](#)
- [The Family Physician's ACO Blueprint for Success - Preparing Family Medicine for the Approaching Accountable Care Era](#)
- [Resources for Employed Physicians](#)
- [State Restrictions on Owning a Practice](#)
- [Interested in ACOs?](#)
- [Other Practice Affiliation Options](#)

CMS created a [website](#) dedicated to the shared savings program and released several educational materials pertaining to the proposed ACO regulation:

- [What providers need to know: Accountable Care Organizations](#)
- [Medicare shared savings program: a new proposal to foster better, patient-centered care](#)
- [Federal agencies address legal issues regarding participating Accountable Care Organizations](#)
- [Improving quality of care for Medicare patients: Accountable Care Organizations](#)
- [Summary of proposed rule provisions for Accountable Care Organizations under the Medicare shared savings program](#)