

**Medicare “Accountable Care Organizations”
Shared Savings Program – New Section 1899 of Title XVIII**

Preliminary Questions & Answers

CMS/Office of Legislation

The Affordable Care Act (ACA) improves the health care delivery system through incentives to enhance quality, improve beneficiary outcomes and increase value of care. One of these key delivery system reforms is the encouragement of Accountable Care Organizations (ACOs). ACOs facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. This document provides an overview of ACOs and the Medicare Shared Savings Program.

Q: What is an “accountable care organization”?

A: An Accountable Care Organization, also called an “ACO” for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

For ACO purposes, “assigned” means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

Q: What forms of organizations may become an ACO?

A: The statute specifies the following:

- 1) Physicians and other professionals in group practices
- 2) Physicians and other professionals in networks of practices
- 3) Partnerships or joint venture arrangements between hospitals and physicians/professionals
- 4) Hospitals employing physicians/professionals
- 5) Other forms that the Secretary of Health and Human Services may determine appropriate.

Q: What are the types of requirements that such an organization will have to meet to participate?

A: The statute specifies the following:

- 1) Have a formal legal structure to receive and distribute shared savings
- 2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
- 3) Agree to participate in the program for not less than a 3-year period

- 4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
- 5) Have a leadership and management structure that includes clinical and administrative systems
- 6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
- 7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

Additional details will be included in a Notice of Proposed Rulemaking that CMS expects to publish this fall.

Q: How would such an organization qualify for shared savings?

A: For each 12-month period, participating ACOs that meet specified quality performance standards will be eligible to receive a share (a percentage, and any limits to be determined by the Secretary) of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.

Q: What are the quality performance standards?

A: While the specifics will be determined by the HHS Secretary and will be promulgated with the program's regulations, they will include measures in such categories as clinical processes and outcomes of care, patient experience, and utilization (amounts and rates) of services.

Q: Will beneficiaries that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?

A: No. Medicare beneficiaries will continue to be able to choose their health care professionals and other providers.

Q: Will participating ACOs be subject to payment penalties if their savings targets are not achieved?

A: No. An ACO will share in savings if program criteria are met but will not incur a payment penalty if savings targets are not achieved.

Q: When will this program begin?

A: We plan to establish the program by January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date.

Q: How do I get more specific information?

A: CMS plans to hold a listening session to hear stakeholder ideas on ACOs this summer. Further details about this listening session, to be held as a special open door forum, will be posted by June 11 on the following special open door forum website:

http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPage

Further details for the shared savings program will be provided in a Notice of Proposed Rulemaking which CMS expects to publish this fall.