# Health Law Bulletin

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## ACOs AND SHARED SAVINGS IN A NUTSHELL
## Applications to Participate Available Now

Earlier this month, the Center for Medicare and Medicaid Services (CMS) published the final rules on the Medicaid Shared Savings Program and Accountable Care Organizations. More recently, CMS published application materials for entities that wish to participate in the Medicaid Shared Savings Program (MSSP) as an Accountable Care Organization (ACO). Providers who may be considering joining or forming an ACO should understand what an ACO is and how the Medicaid Shared Savings Program works as well as what will be required in the Medicare application process.

Medicare has three stated aims for the MSSP: (1) better care for individuals, (2) better health care for populations, (3) lower growth in Medicare expenditures. CMS has concluded that ACOs are the best vehicle for accomplishing these three aims.

CMS issued proposed rules earlier this year on ACOs and MSSP. While the final regulations are an improvement from a provider standpoint, there are still many issues to consider in deciding whether to join or form an ACO.

### What is an ACO?

An ACO is a legal entity recognized under state law that must include one the following:

- ACO Professionals[1] in a group practice
- Networks of ACO Professionals practices
- Partnerships or joint ventures between hospitals and ACO Professionals
- Hospitals employing ACO Professionals

[1] Includes physicians, physician assistants, nurse practitioners, and certified nurse specialists.

- Certain Critical Access hospitals
- Federally Qualified Health Centers
- Rural Health Clinics

Although one of these entities is required to form an ACO, other Medicare providers and suppliers may participate in an ACO or, in some cases, more than one ACO.

An ACO must be willing to become accountable for the quality, cost, and overall care of at least 5,000 Medicare beneficiaries assigned to it. However, an ACO is not an HMO. Beneficiaries will not enroll. Beneficiaries will not be locked into one provider. In fact, beneficiaries will not have a choice as to whether they are included in a particular ACO. Providers will continue to be paid by Medicare on a fee-for-service basis as they are now. The purpose of the program is to save money through improvements in coordination and quality of care, not through avoiding costly beneficiaries or placing limits on beneficiary access to care.

An ACO must have a governing body to provide oversight and strategic direction as well as an executive officer whose appointment and removal are under the control of the governing body. At least 75% of the governing body must be controlled by ACO participants (providers). The Board must include at least one beneficiary assigned to the ACO unless the ACO can provide other means for beneficiary participation in governance.

Providers have great flexibility in determining who joins an ACO. There is no requirement for any provider to join an ACO. The ACO just has to be formed by one of the seven entities listed above. In some cases, that entity may be the only member of the ACO.

ACOs will be required to enter into an agreement with CMS for at least three years.

**How are beneficiaries assigned to the ACO?**

ACO beneficiaries do not enroll in an ACO and are not locked into an ACO. The assignment of beneficiaries is determined by who provides primary care to the beneficiary. CMS has developed an assignment process that looks at each beneficiary to determine where that beneficiary received more of his or her primary care. The beneficiary will be assigned to the ACO of that provider, if that provider is a participant in an ACO. The assignment process looks first at primary care physicians, but also recognizes that some beneficiaries receive more of their primary care from specialists; in those cases, the beneficiary is assigned to an ACO that includes that specialist. If a beneficiary received no primary care, that beneficiary is not assigned to an ACO.

CMS will give the ACO a preliminary list of beneficiaries who are likely to be assigned to an ACO based on most recent claims data and will update that list quarterly. At the end of each year, the list will be reconciled to determine which beneficiaries actually met the criteria for assignment during that year. Beneficiaries may receive care from providers in one or more ACOs, but their final assignment for the year will be tied to where they received more of their

primary care services during the year. Expenditures for those beneficiaries will determine whether there were savings (or losses) during the year.

**How are savings calculated?**

CMS will "look back" three years and establish a "benchmark" for each ACO. This will be CMS's estimate of what the total amount of Medicare expenditures would have been for the ACO's assigned beneficiaries in the absence of any of the efforts of the ACO. The benchmark is updated annually to reflect increases in overall Medicare costs.

CMS will then compare the "benchmark" to the actual Medicare expenditures for the ACO assigned beneficiaries. The result will be either a savings or a loss.

**How do ACOs share in the savings or losses?**

ACOs may choose between two tracks. Track 1 ACOs will share only in savings during their first three-year agreement period. In other words, if there are losses in a year, the ACO will not have to repay that loss. An ACO may only be in Track 1 for one three-year agreement period. Thereafter, every ACO will be required to move to Track 2.

Track 2 ACOs will share in savings AND losses for each year of the agreement period. Savings will not be shared on a "first dollar" basis. Because some random variations in expenditures for a given population from one year to the next would be expected, the first part of the savings (called the "minimum savings rate") is not eligible to share with the ACOs. For Track 1 ACOs, this minimum savings rate ranges from 2.0% to 3.9%, depending on the number of beneficiaries. For Track 2, the minimum savings rate is 2.0%.

For any savings beyond these minimum savings rates, each ACO can earn a percentage of its savings. A Track 1 ACO can receive up to 50% of the savings beyond the minimum savings rate; a Track 2 ACO can receive up to 60% of the savings beyond the minimum savings rate.

Track 2 ACOs who experience a loss in a year will be liable for repayment to Medicare of a portion of the loss, determined in a way that is similar to the shared savings.

However, these savings or losses calculations only determine how much an ACO *potentially* will be able to share. The actual savings returned to the ACO (or losses payable by the ACO) are determined by multiplying the potentially shareable savings or losses by the ACO's score on a set of quality measures.

**What are the quality measures and how are they determined?**

The program will use 33 quality measures broken down into four "domains":

- Patient/caregiver experience
- Care coordination/patient safety

- Preventative health
- At-risk populations

Each domain is weighted equally in determining an ACO's quality score. An ACO must meet a 30% or 30th percentile score for any measure in order to receive credit for that measure. In addition, an ACO must attain a level of at least 70% of the measures in each domain to stay in the program.

The ACO's quality score will be applied to the maximum sharing rate (50% or 60%) to determine the amount of savings to be shared with the ACO for a given year. In the first year, ACOs will only be required to report quality measures to get credit—they do not have to meet any threshold requirement. Over the next two years, the ACO's quality score will be based on the ACO's actual performance on the quality measures.

**How do the savings get distributed?**

CMS will calculate the shared savings (or loss) as described above for each ACO for each year. If there are shared savings, CMS will pay the savings *to the ACO*, not to particular providers. If there are shared losses, the ACO is responsible for repaying the loss amount to CMS.

The method by which savings or losses are distributed among the participating providers in an ACO will be determined by the ACO governing body at the beginning of the ACO's operation and must be included in the ACO's application to CMS. *CMS will not proscribe how savings or losses are to be shared nor require that every ACO participating provider receive a share.*

**If beneficiaries don't "join" an ACO, how can the ACO do anything to improve their care and reduce cost?**

Although Medicare beneficiaries will not enroll in ACOs, ACOs will have data that will allow them to identify beneficiaries who will likely be assigned to each ACO, and the ACOs may contact those individuals within certain guidelines provided by CMS to encourage activities and behaviors that promote health and wellness.

ACOs may use marketing materials to market their ACO to beneficiaries. The marketing materials must meet CMS requirements and are subject to discontinuation if CMS disapproves. Each ACO will receive basic information on its potential beneficiaries from CMS at the beginning of the agreement period, quarterly, and in conjunction with annual reports. In addition, ACOs can request on a monthly basis patient-specific data for beneficiaries who have received at least one service from an ACO provider in the last year. The beneficiary must be given the opportunity to opt out of this information sharing. From the potential list received up front, the ACO can contact the beneficiaries before their first visit; if the beneficiary does not opt out of data sharing within 30 days, their data is assumed to be available. *If a beneficiary opts out of the data sharing requirement, the ACO cannot drop him or her from the ACO.*

In the normal course of business, ACOs will have data of their own that they can use in coordinating care and promoting wellness. An ACO cannot give inducements for receiving services or remaining in an ACO or with a particular provider in an ACO. However, the ACO can provide free items or services if the ACO is in good standing, there is a reasonable connection between the items or services and the beneficiary's medical care, and the items or services are preventive care items or services that advance adherence to a treatment regimen, adherence to a drug regimen, adherence to a follow-up care plan, or management of a chronic disease or condition.

**When does the program start?**

CMS originally planned for ACOs to be operational by January 1, 2012. But the agency has come to realize that such an early date is not practical. For 2012 only, CMS will allow ACOs to begin operation on one of two dates, April 1 or July 1. In subsequent years, ACO agreement periods will coincide with calendar years.

CMS has published the application materials for ACOs on its website. The deadlines for April 1 and July 1 start-ups are different, but the process generally requires an ACO to file a brief Notice of Intent by early January (for April start-ups) or mid-February (for July start-ups). After filing the NOI, an ACO must file a formal application. The application is very lengthy and requires large amounts of information about the ACO—legal structure, governance and leadership, compliance plans, plans for distributing shared savings (or losses), provider agreements, data sharing, and other items. An April 1 start-up ACO must submit its application by January 20; a July 1 start-up must submit its application by March 30. CMS will issue final approval or denial decisions in mid-March for April 1 ACOs and May 31 for a July 1 ACO.

The regulations and guidance from CMS are very lengthy. They can be found at http://www.cms.gov/sharedsavingsprogram/.