

# Fact Sheet: Medicare Shared Savings Program under the Affordable Care Act



The Affordable Care Act and recent proposed regulations incorporate a concept that some health reform proponents have advocated for several years: the Accountable Care Organization (ACO). An ACO is a group of health care providers, such as physicians and hospitals, that work together to manage and coordinate care for a group of patients—across the entire spectrum of care for those patients—and accept responsibility for the quality and cost of that care. The ACO structure is intended to encourage more integrated care for patients, resulting in quality improvements and reduced costs. Under some arrangements, including the Medicare Shared Savings Program,<sup>1</sup> if an ACO achieves a benchmark level of cost savings, while maintaining a measurably high quality level, the ACO shares in the cost savings.

While the Affordable Care Act has created interest in and opened the door for ACOs in the private sector, it specifically creates a program in the public sector: the Medicare Shared Savings Program (MSSP). This fact sheet provides a basic overview of the MSSP and how ACOs are addressed in the Act generally.

## Medicare Shared Savings Program (MSSP)

### *What are the requirements to become an ACO under the Medicare Shared Savings Program?*

To be eligible to participate in the MSSP, the ACO must meet certain requirements:

- Have a formal legal structure to receive and distribute shared savings;
- Have a sufficient number of primary care professionals for the number of assigned beneficiaries (5,000 at a minimum);
- Agree to participate in the program for not less than three years;
- Have sufficient information regarding participating ACO health care professionals to support HHS in quality reporting, beneficiary assignment, and the

determination of shared savings payments;

- Have a leadership and management structure that includes clinical and administrative systems;
- Have defined processes to promote evidence-based medicine, report the necessary data to evaluate cost/quality measures, and coordinate care;
- Demonstrate it meets patient-centered criteria.

### *What does it mean for a beneficiary to be assigned to the ACO?*

- For Medicare ACO purposes, “assigned” beneficiaries are those for whom the professionals in the ACO provide the bulk of primary care services.
- Assignment to an ACO will not affect the guaranteed benefits or choice of doctor for ACO members. 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.

### *What are shared savings?*

- For each 12-month period, ACOs that meet specified quality performance standards will be eligible to receive a share of any savings if the costs of their assigned Medicare beneficiaries are a sufficient percentage below a specified benchmark amount.
- The benchmark for each ACO will be based on the most recently available three years of per-beneficiary expenditures for Parts A and B services for Medicare FFS beneficiaries assigned to the ACO.

### *What delivery systems structures can be utilized by ACOs?*

- The Affordable Care Act offers a flexible definition of the various structures that can become ACOs, but there are four existing delivery systems that have a higher potential of becoming ACOs: integrated delivery systems, multispecialty groups with a significant primary care component, physician-

<sup>1</sup>Proposed rule to implement Section 3022 of ACA related to ACOs: <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>

hospital organizations, and independent practice associations.

- The level of integration in each of these systems varies, along with their ability to bear risk. In general, more integrated systems have greater capacity to take on risk.

## Other Affordable Care Act Applications

*Beyond the MSSP, how does the Affordable Care Act encourage the creation of ACOs?*

- The Centers for Medicare & Medicaid Services (CMS) can allow ACOs that operate under a partial capitation or other payment model, as long as the quality and efficiency of care for patients are improved.
- In evaluating ACOs for inclusion in the MSSP, HHS can give preference to ACOs participating in similar projects with other payers.
- States are given the ability to authorize pediatric ACOs eligible for shared savings under the Medicaid program.

## ACOs and Patient Centered Medical Homes (PCMH)

*What are patient centered medical homes and how do they differ from ACOs?<sup>2</sup>*

- PCMHs are organized medical groups in which the primary care physician takes the lead in coordinating care for patients.<sup>3</sup> The Affordable Care Act also provides grants to create health teams and promote capitation arrangements with primary care providers.
- PCMH pilots have focused on primary care physicians, most often within Medicaid programs.
- ACOs are targeted toward broad programs and major organizations—working with major hospitals or physician groups.

- A PCMH, as the center for coordinating patient care, would be an important component of an ACO.

## Actuarial Considerations for Implementing ACOs

*What are some of the actuarial considerations that need to be considered when designing and implementing an ACO or similar program?*

- How risk is correlated with various population characteristics and the potential for adverse selection resulting from how populations are enrolled in these programs.
- How to support the need for continued enhancement of measurement approaches for quality, efficiency, and resource use.
- How the various potential payment arrangements affect the financial risk borne by an ACO, as well as how risk is allocated within the ACO.
- How risk adjustment can help mitigate any concerns that ACOs might select against unhealthy risks.
- How risk-based capital models adapt to new risk arrangements, including ACOs.
- How risk-based capital models are applied to new risk-bearing entities.
- How data is integrated and why having the ACO take responsibility for that integration may result in more comprehensive information on how the ACO delivers efficient, quality care.

Other significant issues include the creation of a level playing field between ACOs and traditional providers, the up-front costs associated with the development of a new information technology infrastructure, and a change in the approach to health care delivery.

For a more detailed discussion of these and other significant considerations, see American Academy of Actuaries' Health Care Quality Work Group issue brief, *Accountable Care Organizations* (June 2011).

<sup>2</sup>Patient-Centered Primary Care Collaborative, Pilots and Demonstrations: <http://www.pcpcc.net/pcpcc-pilot-projects>

<sup>3</sup>American Academy of Family Physicians, *Joint Principles of the Patient-Centered Medical Home*, February 2007: [http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf)

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