

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






## Medicare Shared Savings Program and Rural Providers



### Overview

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), finalized regulations under the Affordable Care Act to allow 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 long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will 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.

### 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

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 ACOs for rural providers.

## **Rural Providers and ACOs**

CMS recognizes the unique needs and challenges of rural communities and the importance of rural providers in assuring access to health care. Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) play an important role in the nation's health care delivery system by serving as safety net providers of primary care and other health care services in rural and other underserved areas and for low-income beneficiaries. In November 2011, CMS released regulations to allow doctors, hospitals, and other health care providers to better coordinate care for Medicare patients through ACOs. The regulations included several specific provisions designed to increase rural participation in the Shared Savings Program. A final rule issued in June 2015 included modifications to program regulations to facilitate participation by ACOs that include rural providers.

## **Provisions to Allow FQHCs and RHCs to Fully Participate in the Shared Savings Program**

The regulations provide for FQHCs and RHCs to participate in the Shared Savings Program by forming their own ACOs, or by joining an ACO as an ACO participant along with other organizations. Data from the FQHCs and RHCs will be used to assign beneficiaries to ACOs for purposes of measuring quality and financial performance under the program. In order to do this, we included certain revenue center codes indicative of primary care services in the definition of primary care services when they are submitted on claims by FQHCs/RHCs.

However, ACOs that are formed by or include FQHCs and RHCs are required to submit a special attestation listing the physician National Provider Identifiers (NPIs) that provide direct patient primary care services in FQHCs and RHCs. This special attestation is needed to supplement their claims data because FQHCs and RHCs have not historically submitted all the data elements needed for assignment, as required by the statute.

## Beneficiary Assignment Rules for FQHCs and RHCs

Beneficiaries will be eligible for assignment to an ACO that includes FQHCs and RHCs as ACO participants if they receive at least one primary care service from a physician who either appears on the attestation list submitted by the ACO or who bills through another ACO participant. Beneficiaries are assigned to an ACO if they receive a plurality of their primary care services from physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO. This methodology is helpful for assigning beneficiaries to ACOs in rural areas with few physicians.

## Critical Access Hospitals and ACOs

The Affordable Care Act specifies that certain groups of providers of services and suppliers, including physicians and hospitals, may form their own ACO as long as they meet the eligibility criteria, including minimum beneficiary assignment. The statute permits the Secretary to use her discretion to permit other Medicare providers of services and suppliers to form their own ACO. In the program regulations, the Secretary has used her discretion to include CAHs that elect to bill for outpatient services under the optional method (Method II) as entities that are eligible to form an ACO, assuming they meet all of the other eligibility requirements. This is helping expand access to ACOs in rural areas.

CAHs billing for outpatient services under the standard method (Method I), similar to acute care hospitals, may not independently form their own ACOs because such CAHs do not submit claims for physicians' services, which is information needed in order to assign beneficiaries to the ACO. However, a CAH billing under the standard method may join with other ACO participants upon whom assignment is based to form an ACO.

## Confidence Interval for Setting the Minimum Savings Rate for Smaller ACOs

Under the regulations, ACOs can participate under the program's one-sided shared savings model for their first agreement period, and eligible ACOs may continue under the one-sided model for a second agreement period. Alternately, ACOs can apply to participate under one of the program's two-sided shared savings and losses models. Under the one-sided model, CMS specifies a Minimum Savings Rate (MSR) to account for the normal variation in expenditures, based upon the number of Medicare Fee-For-Service beneficiaries assigned to the ACO. The MSR helps ensure that savings are a result of the ACO's performance instead of normal variation in Medicare expenditures.

While recognizing the higher uncertainty regarding expenditures for smaller ACOs, the program regulations improve smaller ACOs' ability to achieve shared savings under the one-sided model by using a lower confidence interval to set the MSR that must be met in order to share savings relative to larger ACOs. For the one-sided model, CMS implemented a sliding scale confidence interval based on the number of assigned beneficiaries, resulting in a range of MSRs between 2 and 3.9 percent. ACOs with the minimum number of 5,000 assigned beneficiaries have an MSR based on a 90 percent confidence interval, while an ACO with 50,000 assigned beneficiaries has an MSR of 2.2 percent based on a 99 percent confidence interval.

Under the two-sided models, the program regulations require each ACO to select a MSR and a symmetrical Minimum Loss Rate (MLR), to serve as a threshold to be met or exceeded before the ACO is eligible to share in savings or accountable for shared losses. ACOs may choose from one of the following options for the MSR/MLR:

- 0.0 percent MSR/MLR;
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5–2.0 percent; or
- Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO (applying the same methodology used to determine the MSR under the one-sided model).

This MSR/MLR selection, made at the time of an ACO's application to the program, applies for the duration of the ACO's agreement period. These MSR/MLR options give ACOs flexibility in setting the threshold they must meet to be eligible to share in savings or accountable for losses. By choosing the option for a MSR/MLR based on the size of the ACO's population, a smaller ACO will have a relatively higher threshold to meet before being accountable for losses and therefore greater protection against performance-based risk, but it will have a correspondingly higher threshold to meet before sharing in savings.

## Resources

The Shared Savings Program final rules can be downloaded 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 Government Publishing Office (GPO) website. The Shared Savings Program was established January 1, 2012.

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.



The Medicare Learning Network® Disclaimers are available at <http://go.cms.gov/Disclaimer-MLN-Product> on the CMS website.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Check out CMS on:

