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MEDICARE FACT SHEET

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Medicare Shared Savings Program and rural providers

The Centers for Medicare & Medicaid Services (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. On March 31, 2011, CMS released proposed new rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). The proposed rule includes four specific provisions designed to increase rural participation in the Medicare Shared Savings program.

ACOs in rural communities would be eligible for an exemption from the 2 percent net savings threshold

In order to provide an additional financial incentive to smaller ACOs, many of which may be caring for underserved populations in rural areas, the Medicare Shared Savings program proposed rule includes an exemption from the required 2% savings threshold under the one-sided model for ACOs with less than 10,000 assigned beneficiaries. ACOs of this size that satisfy the performance standards and generate savings as well as meet *one* of the following criteria would be eligible to share in first dollar savings under the one-sided model:

- The ACO is comprised only of ACO professionals in group practice arrangements or networks of individual practices of ACO professionals.
- Seventy-five percent or more of the ACO's assigned beneficiaries reside in counties outside a Metropolitan Statistical Area (MSA) in the most recent year for which CMS has complete claims data.

-More-

- Fifty percent or more of the ACO's assigned beneficiaries were assigned to the ACO on the basis of primary care services received from a CAH billing under method II.
- Fifty percent or more of the beneficiaries assigned to the ACO had at least one encounter with an ACO participant FQHC and/or RHC in the most recent year for which we have complete claims data.

All ACOs in the two-sided model that satisfy the performance standards and generate savings that exceed the minimum savings rate would be eligible to share in savings on a first dollar basis.

A lower confidence interval would be used to set the minimum savings rate for smaller ACOs

The proposed rule would also offer an incentive to smaller ACOs to participate by using a lower confidence interval to set the minimum savings rate that must be exceeded in order to share savings relative to larger ACOs. The statute requires CMS to specify a minimum savings rate to account for the normal variation in expenditures, based upon the number of Medicare fee for service beneficiaries assigned to the ACO. For the one-sided model, CMS is proposing a sliding scale confidence interval based on the number of assigned beneficiaries. Thus, ACOs with the minimum number of 5,000 assigned beneficiaries would have a minimum savings rate based on a 90 percent confidence interval while an ACO with 50,000 assigned beneficiaries would have a minimum savings rate based on a 99 percent confidence interval. This proposal recognizes the higher uncertainty regarding expenditures for smaller ACOs.

Certain critical access hospitals would be eligible entities to form their own ACO

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. The Secretary has proposed to exercise her discretion to include CAHs that elect to bill for outpatient services under the optional method (Method II) as an eligible entity to form an ACO, assuming the CAH would meet all of the other eligibility requirements. This proposal is expected to expand access to ACOs in rural areas.

Unfortunately, CAHs billing for outpatient services under the standard method (Method I) may not form their own ACOs because such CAHs do not submit claims for primary care physicians' services, which is information needed in order to assign beneficiaries to the ACO. However, a CAH billing under the standard method may join an ACO as an ACO participant along with other organizations, although assignment of beneficiaries to the ACO would not be based on data from the CAH billing under the standard method.

The proposal includes incentives for including FQHCs and RHCs in the ACO

Because FQHCs and RHCs do not submit the data elements required for assignment of beneficiaries in their Medicare claims, it is not possible at this time for FQHCs and RHCs to participate in the Medicare Shared Savings program by forming their own ACOs. However, FQHCs and RHCs may join an ACO as an ACO participant along with other organizations, but the assignment of beneficiaries to ACOs would not be based on data from the FQHCs and RHCs.

The proposed rule offers incentives to ACOs that include the participation of FQHCs and RHCs. The incentives are designed on a sliding scale according to the number of beneficiaries assigned to the ACO that visit the participating FQHC or RHC during a year. Specifically, the incentives are an increase in the sharing rate. ACOs in the one-sided model may earn up to a 2.5 percentage point increase in the sharing rate. ACOs in the two-sided model may earn up to a 5 percentage point increase in the sharing rate.

The proposed rule was published in the April 7, 2011 *Federal Register*. Comments on the proposed rule will be accepted until June 6, 2011. CMS will respond to all comments in a final rule to be issued later this year.

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