

# RUPRI Center for Rural Health Policy Analysis

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## **Medicare Accountable Care Organizations: Program Eligibility, Beneficiary Assignment, and Quality Measures**

*A. Clinton MacKinney, MD, MS; Keith J. Mueller, PhD; Xi Zhu, PhD; Thomas Vaughn, PhD*

### **Introduction**

Accountable Care Organizations (ACOs) are groups of providers (generally physicians and/or hospitals) that may receive financial rewards by maintaining or improving care quality for a group of patients while reducing the cost of care for those patients.<sup>1</sup> The Patient Protection and Affordable Care Act of 2010 (ACA) established a Medicare Shared Savings Program (MSSP) and accompanying Medicare ACOs to “facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce unnecessary costs.”<sup>2</sup> The MSSP now includes 343 ACOs; an additional 23 ACOs participate in the Medicare Pioneer ACO demonstration program, and there are approximately 240 private ACOs. Based on our analysis, among the Medicare ACOs 119 operate in both rural and urban counties and seven operate exclusively in rural counties. A little over 24 percent of non-metropolitan counties are included in Medicare ACOs.<sup>3</sup> To assist rural providers considering ACO formation, this policy brief describes MSSP eligibility and participation requirements, beneficiary assignment processes, and quality measures.

### **Medicare ACO Eligibility**

An “ACO professional” is defined as a physician (a doctor of medicine or osteopathy), or a practitioner (which includes physician assistants [PAs], nurse practitioners [NPs], and clinical nurse specialists [CNSs]). Participating ACO professionals may include:

- ACO professionals in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals;
- Section 1860d (prospective payment) hospitals employing ACO professionals; and
- Other Medicare providers and suppliers as the Secretary determines appropriate.<sup>4,5</sup>

The last category is important to rural providers. The Secretary used her discretion to make Critical Access Hospitals eligible to form an ACO if they have elected to bill for outpatient services under Method II (submitting physician claims with the CAH billing). Those using the standard billing method (Method I) may not form their own ACOs (because they do not submit claims for physician services), but they “may join other ACO participants upon who assignment is based to form an ACO.”<sup>6</sup>



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RUPRI Center for Rural Health Policy Analysis,  
University of Iowa College of Public Health,  
Department of Health Management and Policy,  
145 Riverside Drive, N232A, Iowa City, IA 52242  
(319) 384-3830  
<http://www.public-health.uiowa.edu/rupri>  
E-mail: [cph-rupri-inquiries@uiowa.edu](mailto:cph-rupri-inquiries@uiowa.edu)

The Secretary also used her discretion to declare Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) eligible to participate independently in the MSSP. Medicare added certain primary care revenue center codes for submission by FQHCs and RHCs. Due to absent data regarding physician specialties, FQHCs and RHCs must submit an attestation listing the National Provider Identifiers (NPIs) for their physicians providing primary care services.<sup>7</sup>

## **Medicare ACO Requirements**

Prospective Medicare ACOs must apply to the Centers for Medicare and Medicaid Services (CMS) for participation in the MSSP; CMS does not automatically accept an applicant. The ACA requires prospective and approved Medicare ACOs to fulfill certain eligibility requirements. Following are several (but not all) essential requirements for an application. A Medicare ACO must:

- Agree to Shared Savings Program participation for three years;
- Represent a new legal entity with a unique Taxpayer Identification Number (TIN), separate from any of its ACO participants;
- Establish a governing body representing the participating ACO professionals, other providers of Medicare services, and Medicare beneficiaries;
- Demonstrate that ACO participants (organizations providing services to beneficiaries, such as hospitals and skilled nursing care facilities) control at least 75 percent of the ACO's governing body authority;
- Submit documentation regarding leadership and management structures, including clinical and administrative systems;
- Describe how the ACO will establish and maintain an ongoing quality assurance and improvement program, led by an appropriately qualified health care professional;
- Be responsible for routine self-assessment, monitoring, and reporting of the care delivered, and use that information to continually improve care delivered to Medicare beneficiaries;
- Define, establish, implement, and periodically update processes to promote evidence-based medicine, patient engagement, and care coordination;
- Define methods to manage care throughout an episode of care and during care transitions;
- Describe how shared savings would be distributed among ACO participants.<sup>8,9</sup>

## **Beneficiary Assignment**

The ACA requires that a Medicare ACO agree to accept responsibility for a minimum of 5,000 Medicare beneficiaries.<sup>10</sup> CMS makes preliminary beneficiary assignment to ACOs using data from the most recent four quarters prior to ACO start. CMS then updates the list on a rolling four-quarter basis. CMS makes final Medicare beneficiary assignment to an ACO retrospectively at the end of the year. Thus, an ACO's beneficiary list will vary until CMS makes final beneficiary assignments at year-end.

Certain prerequisites are necessary for a Medicare beneficiary to be assigned to an ACO:

- Beneficiary must reside within the United States or United States territories;
- Beneficiary must be enrolled for at least one month in Medicare Part A and Part B (beneficiaries with Medicare as a second payer are not excluded);
- Beneficiary is not eligible if enrolled in a Medicare Advantage plan under Part C, cost contract plans, and Elderly PACE programs;
- Beneficiary can be assigned to only one Medicare shared savings initiative during benchmark and performance years; and
- Beneficiary must have at least one primary care service with a physician at the ACO.

If the above conditions are not met, the beneficiary is not assigned to an ACO. If the above conditions are met, the beneficiary may be assigned to an ACO in a two-step process. See the flowchart in Figure 1 for additional explanation.

- **Primary Care Physician-Based Assignment:** A beneficiary is assigned to an ACO if the beneficiary receives at least one primary care service<sup>i</sup> by a primary care physician<sup>ii</sup> affiliated with that ACO, and if the allowed charges for primary care services furnished by primary care physicians affiliated with that ACO are greater than the allowed charges for primary care services furnished by primary care physicians affiliated with other ACOs, and greater than the allowed charges for primary care services provided by primary care physicians who are unaffiliated with any ACO.<sup>iii</sup>
- **Non-Primary Care Physician-Based Assignment:** The beneficiary has received no primary care services from a primary care physician, regardless of ACO affiliation. A beneficiary will then be assigned to an ACO if he or she has received at least one primary care service from any physician (regardless of specialty) affiliated with that ACO, and if the allowed charges for primary care services furnished by ACO professionals who are affiliated with that ACO [including specialist physicians, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs)] are greater than the allowed charges for primary care services furnished by ACO professionals who are affiliated with another ACO, and greater than the allowed charges for primary care services furnished by any other physician, NP, PA, or CNS, who is unaffiliated with any ACO.
- **Special rules for FQHCs/RHCs:** All physicians included in an FQHC or RHC attestation are considered primary care physicians. For FQHCs/RHCs that are ACO participants, CMS considers a reported service to be primary care if the associated HCPCS or revenue center code meets the definition of a primary care service and if a primary care physician is the attending provider as reported on the claim (which for clinics is a claim submitted to a Part A intermediary) that will show the physician as the attending). For FQHCs/RHCs that are not ACO participants, CMS considers all primary care services (identified by HCPCS or revenue center codes) as provided by a primary care physician.<sup>11</sup>

## Quality Measures

Medicare ACO quality-of-care performance evaluation is based on 33 individual outpatient measures. An ACO's quality performance will determine if that ACO is eligible for shared savings. The quality performance measures align with other common quality programs such as the Physician Quality Reporting System, Electronic Health Record Incentive Programs, and the HHS National Quality Strategy.<sup>12</sup>

The 33 Medicare ACO quality measures fall within four domains:

- Patient and care giver experience (seven measures);
- Care coordination and patient safety (six measures);
- Preventive health (eight measures); and
- At-risk populations (12 measures total) – diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease.<sup>iv</sup>

<sup>i</sup> Set of services identified by the following HCPCS codes: 99201 through 99215, 99304 through 99340, 99341 through 99350, the Welcome to Medicare visit (G0402), and the annual wellness visits (G0438 and G0439).

<sup>ii</sup> Primary care includes internal medicine, general practice, family practice, and geriatric medicine providers who deliver appropriate primary care services to beneficiaries.

<sup>iii</sup> Beneficiary assignment to an ACO is determined by "plurality" of primary care services that is based on Medicare allowed charges. Although this method does not necessarily assign the beneficiary to the ACO that saw the patient most frequently, the beneficiary will be assigned to the ACO that provided the highest complexity and intensity of primary care services.

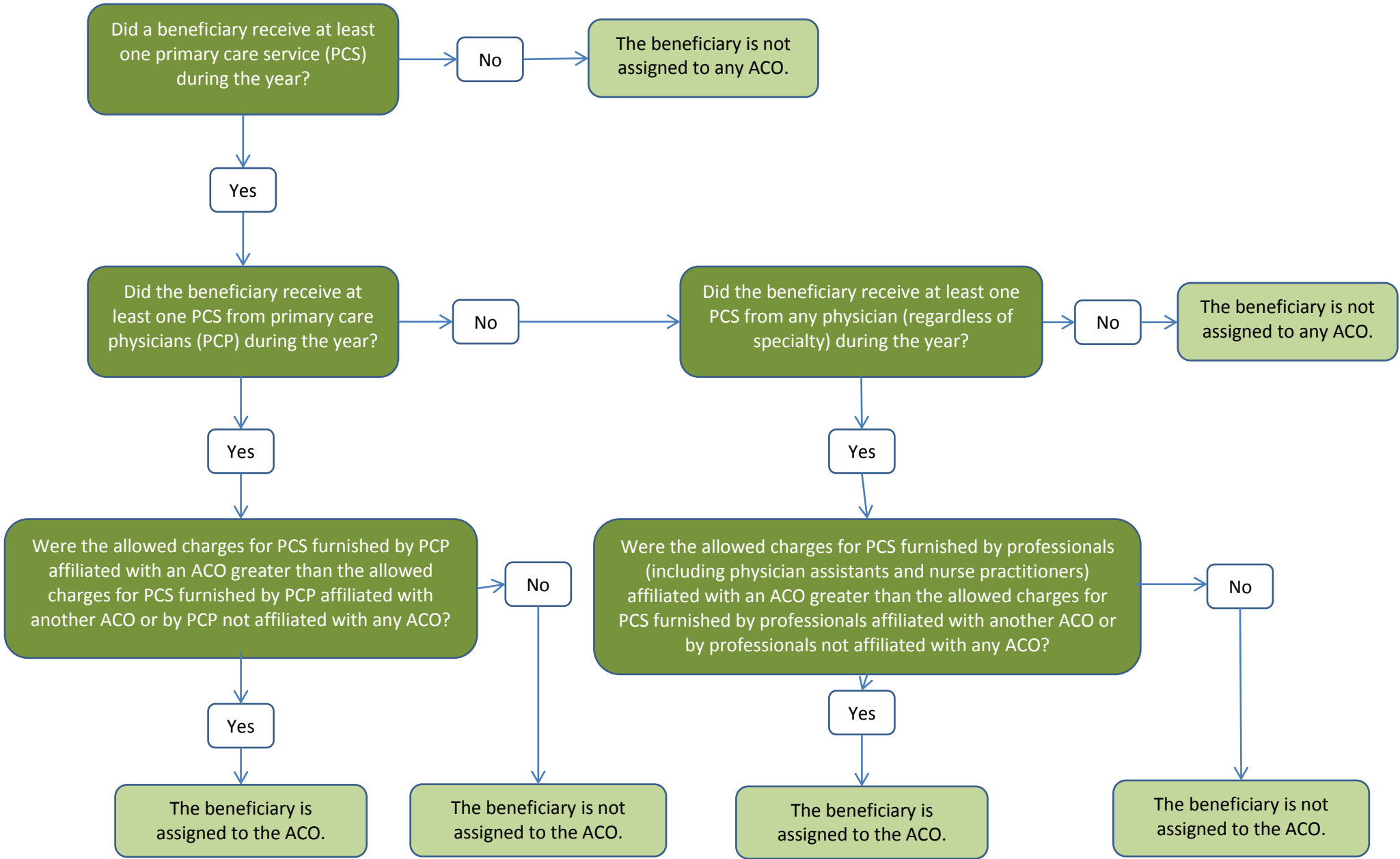
<sup>iv</sup> Quality-of-care measure details available at: Department of Health and Human Services. Improving Quality of Care for Medicare Patients: Accountable Care Organizations. Fact Sheet. November 2012.  
<http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CGAQFjAC&url=http%3A%2F>

For the first year, an ACO receives full quality performance credit if the ACO simply reports all 33 quality-of-care measures. However, in the subsequent two years, CMS will calculate a score for each quality-of-care domain and weight the domains equally in a composite score to adjust the shared savings. Medicare ACO quality of care less than the 90th percentile will result in a proportionate reduction in shared savings. Medicare ACOs will earn no points for measure performance below the 30th percentile.

## **Conclusion**

Organizations considering participating in the MSSP (Medicare ACO program) should carefully review program eligibility requirements and the beneficiary assignment process. Due to beneficiary assignment based on the greater of allowed Medicare charges, new Medicare ACOs may discover fewer assigned beneficiaries than anticipated. Potential shared savings will be reduced by suboptimal quality. Therefore, new Medicare ACOs must provide excellent care in 33 outpatient clinical quality and patient satisfaction measures to avoid shared savings reduction.

**Figure 1: Beneficiary Assignment to a Medicare ACO**



## References

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- <sup>2</sup> Shared Savings Program. Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>. Accessed October 4, 2013.
- <sup>3</sup> Updated analysis from an earlier brief (<http://www.public-health.uiowa.edu/rupri/>), presented to the National Rural Health Association Policy Institute, February 5, 2014
- <sup>4</sup> Federal Register. Vol. 76, No. 212. Wednesday, November 2, 2011. Rules and Regulations, p. 67812.
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- <sup>6</sup> Centers for Medicare and Medicaid Services. Medicare Shared Savings Program and Rural Providers. Fact Sheet. November 2012.
- <sup>7</sup> Centers for Medicare and Medicaid Services. Summary of Final Rule Provisions for ACOs under the Medicare Shared Savings Program. Fact Sheet. November 2012.
- <sup>8</sup> *Ibid.*
- <sup>9</sup> Federal Register, *op. cit.*, p. 67858.
- <sup>10</sup> Summary of Final Rule Provisions, *op. cit.*, p. 3.
- <sup>11</sup> Federal Register, *op. cit.*, pp. 67851-67870.
- <sup>12</sup> Centers for Medicare and Medicaid Services. Improving Quality of Care for Medicare Patients: Accountable Care Organizations. November 2012.