

DEPARTMENT OF HEALTH & HUMAN SERVICES
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MEDICARE FACT SHEET

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Medicare Shared Savings Program: a new proposal to foster better, patient-centered care

What patients need to know about Accountable Care Organizations

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create 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 will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

By focusing on the needs of patients and linking payment rewards to outcomes, this delivery system reform, as part of the Affordable Care Act, will help improve the health of individuals and communities while lowering the cost of the system – up to an estimated \$960 million over three years in Medicare savings.

ACOs to Deliver Improved Care to Medicare Beneficiaries

The physicians, hospitals, and other providers participating in an ACO would work together to coordinate patient care and keep track of patients’ conditions and treatments, regardless of where the patient seeks care. The goal of the program is to prevent beneficiaries from retelling their story and medical history to each provider that cares for them.

ACO providers also would carefully coordinate their patients’ care as they move among physicians’ offices, hospitals, and lab and other facilities in an effort to eliminate duplication,

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medication errors, and mismanagement. In doing so, beneficiaries may save time and money when the ACO effectively coordinates the beneficiary's care because improved care coordination would reduce duplication and waste.

ACOs would be required to have in place processes to promote treatments and procedures based on the best medical evidence available in order to promote patient health. Beneficiaries would be able to obtain their regular Medicare fee-for service benefits, such as the annual wellness visit and relevant screening tests, from ACO providers.

ACOs to Provide Patients with More Health Care Quality Information

An ACO will publicly provide information about the quality of care the ACO providers deliver each year. ACOs also would track and report patient outcomes and experiences on over 60 different quality measures. In addition, beneficiaries obtaining care from ACOs would be surveyed annually about their experience with the ACO's providers. ACOs in turn would report publicly the different quality measures and survey results so that beneficiaries can have the information to better manage their own health care.

ACO Providers would Notify Beneficiaries of their Participation in an ACO

CMS is proposing to require ACO providers to notify beneficiaries, at the time they seek services, that the provider is participating in an ACO. The providers would offer beneficiaries information about the ACO including how the ACO would improve the care that they receive. Providers in an ACO also would be required to post signs in their facilities indicating their participation in an ACO and to make available written information about the ACO to Medicare beneficiaries.

Even if a beneficiary seeks care from a physician, hospital, or other facility that is a member of an ACO, the beneficiary would still be able to see or visit any provider they choose. An ACO would be prohibited from using managed care techniques such as limiting the beneficiary to certain providers, utilization management, or requiring prior authorization for services for Medicare beneficiaries.

Beneficiaries Can Opt Out of Sharing Personal Health Information with ACO Providers

To better coordinate care among ACO providers, an ACO would be able to request personal health information about the patient from CMS claims data. Before doing so, ACOs would be

required to provide written notice to beneficiaries during an office visit that it would request the beneficiary's personal health information from CMS. ACOs would be required to allow beneficiaries to opt-out of having their personal health information shared with the physician and the ACO.

The Shared Savings Program NPRM will appear in the XX, 2011 issue of the *Federal Register*. CMS will accept comments on the proposed rule until XX, and will respond to them in a final rule to be issued later this year. The Shared Savings Program will begin operating on January 1, 2012.

For more information, please see:

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