

Using Partial Capitation as an Alternative to Shared Savings to Support Accountable Care Organizations in Medicare

CONTENTS

Background	2
Problems with the Shared Savings Model	2
How CMS Could Structure Partial Capitation.....	3
Defining Eligible Provider Organizations	3
Identifying the Patients to Be Paid For Under Partial Capitation	4
Defining the Services for Which the ACO Would be Accountable	6
Determining the Non-Risk-Adjusted Payment Level	6
Adjusting Payment Levels for Differences in Patients	7
Paying for Services (Option 1).....	7
Paying for Services (Option 2).....	8
Improving Services and Incentives for Beneficiaries	9
Assuring the Quality of Services to Beneficiaries	10
Advantages of Partial Capitation Compared to Shared Savings	11
Advantages for CMS.....	11
Advantages for Medicare Beneficiaries	11
Advantages for Healthcare Providers	11
Challenges for Providers to Participate in the Partial Capitation Model	12
APPENDIX: Statutory Requirements for Provider Organizations to be Accountable Care Organizations	15

Background

Section 3022 of the Patient Protection and Affordable Care Act created a new Medicare payment program (Section 1899 of the Social Security Act) to support Accountable Care Organizations (ACOs). Although the program is titled the “Shared Savings Program,” and most discussions have focused on using “shared savings” to pay ACOs, Section 10307 of the Act added subsection (i) which allows HHS and CMS to use payment models other than shared savings to support ACOs.

One of these payment models is “partial capitation.” The law states that under partial capitation payment, an ACO would be at financial risk for some, but not all, of the items and services covered under parts A and B, such as some or all physicians’ services or all items and services under part B. The law states that payments to an ACO for items and services for beneficiaries for a year under the partial capitation model should be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by HHS/CMS. Finally, the law permits, but does not require, HHS/CMS to limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate.

Problems with the Shared Savings Model

Although the shared savings model defined in Section 3022 is designed to be an easy way for providers to benefit from managing costs and quality for Medicare fee-for-service beneficiaries, it has a number of serious weaknesses that make it undesirable for both experienced and inexperienced providers, as well as less desirable for the Medicare Program, including:

- It does nothing to help ACOs pay for the upfront costs of better managing patient care. For example, a clear focus for ACOs should be reducing the rate at which people with chronic diseases are admitted to the hospital. Numerous studies have shown that having nurses make home visits, encouraging patients to call their doctor early, and improving access to primary care practices on evenings and weekends can dramatically reduce ER visits and hospitalizations. But if an ACO can’t afford to pay for these services, it won’t be able to achieve the corresponding savings. Under shared savings, regardless of whether a physician is in the ACO or outside the ACO, they still get paid under the current fee-for-service system, and therefore they don’t get paid for any of these high-value services. This makes it particularly difficult for physician practices and physician IPAs to participate as ACOs, even if they are large and have experience implementing such services for other patient populations.
- It does nothing to eliminate the perverse incentives for volume in the current fee-for-service system. For example, under the current payment system, hospitals often lose money when they prevent infections. Under shared savings, the ACO has no ability to change the way hospitals inside or outside of the ACO are paid for higher-quality inpatient care. Consequently, hospitals will still lose money on

many of these types of quality improvement initiatives, at least in the short run. Several years in the future, the ACO may get a shared savings payment, part of which could go to the hospital, but since neither the ACO nor the hospital will know in advance how much that will be, it could merely mean the hospital will lose *less* money than it would have otherwise.

- Because of the above, ACOs for whom the only payment change is shared savings are likely to only pursue a limited set of initiatives to try and control costs – those which are relatively inexpensive and for which they will not be significantly penalized for success under the fee-for-service structure. If ACOs only pursue a limited set of interventions, this will inherently limit the level of savings for Medicare. The ACO will not be penalized financially if these initiatives fail, but Medicare will lose the opportunity to see ACOs implement a broader range of initiatives that could reduce spending more significantly.
- Shared savings also exacerbates the current inequities in the payment system. The communities and providers which have the most to gain from shared savings are the ones which are “wasting” the most resources today, through high rates of hospital admissions, use of unnecessary procedures, etc. In contrast, the communities with relatively low costs and high quality of care are already “saving” Medicare and other payers significant amounts of money but with no reward. Those in the first group have many opportunities to save money, if they can determine how to do so. The latter group, even if they can still improve further, may need to invest significantly more resources to do so, yet they will likely receive far less reward relative to the costs they incur.

A partial capitation payment model for ACOs could be structured in a way that would address these problems with the shared savings model and help CMS achieve greater cost savings for the Medicare program, without requiring changes in the benefit structure for Medicare beneficiaries. Moreover, this could be done in a way that uses the same types of methodologies for risk adjustment, quality measurement, etc. that will be used in the shared savings approach, thereby minimizing the extent to which CMS needs to develop new regulations, data systems, etc. to implement the partial capitation model. One approach to this is described below.

How CMS Could Structure Partial Capitation

Defining Eligible Provider Organizations

In order to participate as an ACO in the partial capitation program, a provider would have to meet the requirements in Section 1899(b) of the Accountable Care Act (see the Appendix). In addition, the provider would need to:

- demonstrate that it had experience in successfully managing partial capitation, full capitation, or other payment models involving financial risk for a broad range of inpatient and outpatient services, either for Medicare beneficiaries (through a Medicare Advantage plan) or for other types of patients (e.g., through a commercial or Medicaid capitation payment program); and

- maintain a minimum amount of reserved capital in order to cover the costs of services if claims payments exceed the partial capitation payment amounts.

No standards for organizational structure would be required for providers who have experience in managing risk-based payments. In particular, a provider would *not* be required to either have a health plan or a hospital as an integrated part of its organizational structure in order to participate as an ACO under the partial capitation model, nor would it be required to have employed physicians. A provider without its own health plan or sufficient reserves to meet state insurance regulatory requirements for accepting risk-based payments would likely need to participate under Payment Option 2 (described below).

After the partial capitation program has been implemented for providers with previous experience in managing risk-based payments, CMS should open the program to providers which do not have such experience, but which demonstrate that they have systems and relationships in place to enable them to successfully take accountability for the cost and quality of care for a large group of Medicare beneficiaries. This two-phase approach will allow less experienced providers sufficient time to build the capabilities and financial reserves needed to participate successfully.

Identifying the Patients to Be Paid For Under Partial Capitation

A provider organization which meets the minimum criteria to serve as an Accountable Care Organization under the partial capitation model would agree to accept accountability for the quality, cost, and overall care for (1) the Medicare fee-for-service beneficiaries who are currently receiving services from the primary care practices in the ACO (except for exclusion/exit standards defined below), and (2) any additional beneficiaries who become patients of those primary care practices during the period of the ACO agreement (no less than 3 years, and preferably 5 years). An ACO would need to have a reasonable expectation of serving at least 5,000 Medicare beneficiaries in each year of the agreement in order to participate.

The ACO would provide CMS a list of the Medicare fee-for-service beneficiaries whom the ACO views as its primary care patients. CMS would review the list to identify whether any of the patients have either been attributed to or requested as patients by other ACOs, and CMS would work with the ACO to resolve any conflicts. CMS could also request that the ACO accept the partial capitation payment for a patient who has received services from the ACO but was not included on the ACO's proposed list. The list of patients would become the initial "partial capitation payment roster" for the ACO; the ACO would receive the agreed-upon payment level (see below) for each of these patients, and the providers who are part of the ACO would receive no fee-for-service payments for services provided to these patients as long as they remain on the roster. Once the partial capitation payment arrangement begins, the ACO would be required to add to the partial capitation roster any Medicare fee-for-service beneficiary who receives a primary care service from the ACO's providers, unless the individual meets specific standards for exclusion of beneficiaries. For example, the following types of beneficiaries would *not* be added to the partial capitation payment roster in a given month:

- A beneficiary who receives a primary care service from the ACO but attests that they will spend a significant portion of the coming year (e.g., 6 months or more) living in a different part of the country.
- A beneficiary who attests that he or she is only obtaining primary care services from ACO providers on a temporary basis due to an emergency or other circumstance that precludes them from seeing their preferred primary care provider.

Attestations from beneficiaries would be obtained through a very simple form they would complete upon seeking primary care services for the first time from the ACO.

Standards for removal of beneficiaries from the partial capitation payment roster would be established, such as:

- A beneficiary who died prior to the beginning of the month.
- A beneficiary who moved outside of the geographic service area of the ACO prior to the beginning of the month.
- A beneficiary who transferred to a Medicare Advantage plan.
- A beneficiary who loses eligibility for Medicare coverage.

Ideally, beneficiaries in hospice care would be included in the partial capitation payment. If hospice care is not to be included, then a beneficiary who transferred to hospice care prior to the beginning of the month would also be excluded.

In addition, criteria would be established to allow (but not require) an ACO to remove a beneficiary from the partial capitation payment roster in specific circumstances, such as:

- A beneficiary who has not received a primary care service from the ACO within the past 12 months and who has received all other services during the previous 6 months from non-ACO providers.
- A beneficiary whom the ACO documents is failing to adhere to evidence-based components of treatment plans despite reasonable efforts to encourage and assist them to do so.

The ACO would be prohibited from requiring a beneficiary to agree in advance not to seek care from providers outside of the ACO before receiving primary care or any other services from the providers inside the ACO. The ACO would also be prohibited from excluding a Medicare beneficiary from becoming a patient of the primary care practice based on their health conditions (unless the ACO had a formal, publicly available policy that it would not accept such patients regardless of the type of health insurance the patient had). This could be operationalized through a notice to the beneficiary from the provider (similar to the notices currently given to beneficiaries regarding their rights relative to hospital discharge).

The ACO would notify CMS when a beneficiary met the entry or exit criteria, and CMS would add or remove beneficiaries from the partial capitation payment roster on a monthly basis. CMS would periodically compare the lists of beneficiaries on the ACO's partial capitation payment roster to its payment records for services delivered by the ACO (e.g., to verify that patients receiving primary care services from the ACO but not included in the partial capitation payment met the exclusion criteria) and would work with the ACO to resolve any discrepancies.

Defining the Services for Which the ACO Would be Accountable

In general, all services currently paid through Medicare Part A and Part B for participating beneficiaries would be considered as costs to be paid through the partial capitation payment. CMS would develop a limited list of specific types of services or circumstances to be paid separately from the partial capitation payment, based on input from prospective ACOs. Examples of such exclusions might be:

- services for a particular beneficiary in excess of a maximum annual amount (e.g., \$100,000 per year);
- emergency services delivered outside of the ACO's service area;
- services which are delivered relatively infrequently, involve relatively high costs, and are delivered by providers which are not part of the ACO (e.g., transplant services or other quaternary care services);
- hospice services, end-stage renal disease services, etc. that are currently paid for separately by CMS.

Alternatively, an ACO could agree to cover costs for these services and situations, either directly or through re-insurance, in return for a higher partial capitation payment amount (but the payment amount would still need to be less than what Medicare would otherwise pay).

CMS could also allow individual ACOs to propose specific exclusions based on unique characteristics of their healthcare delivery markets; CMS could accept or reject the exclusions proposed by the ACO, and the ACO could choose not to proceed with the program if CMS did not accept its proposals. These decisions could be made before or after the calculations described in the next section.

Determining the Non-Risk-Adjusted Payment Level

The prospective ACO would provide CMS with a list of the Medicare fee-for-service beneficiaries who (a) are currently receiving primary care services from the providers in the ACO and (b) do not meet the exclusion criteria. CMS would tabulate Medicare Part A and Part B expenditures made on behalf of those patients over the previous 2-3 years and provide that information to the prospective ACO. As part of this, CMS would separately tabulate expenditures for any specific categories of services that the provider organization proposed excluding from the partial capitation payment.

CMS would define the percentage by which it would expect the total expenditures to increase each year over the term of the participation agreement if the risk score (acuity) of the population remained unchanged. This calculation would be similar to the calculation used to establish projected spending levels in the shared savings program.

The prospective ACO would then propose per patient payment amounts that it would agree to accept in each of the years of the participation agreement in order to cover the costs of all Part A and Part B services delivered to the participating patients (including all services delivered by providers that are not part of the ACO provider organization), other than the specific services that the provider organization and CMS had agreed to exclude. The payment amounts would need to meet two criteria: (1) the per patient payment amount in *each* year would need to be less than or equal to the per capita amount that CMS projects expenditures to be in that year assuming the risk score of the population remained unchanged, and (2) the *cumulative* payment amounts over the multi-year term of the participation agreement would need to be at least 2% (or whatever threshold is established in the shared savings program based on the number of beneficiaries under the ACO's care) below the total expenditures projected for the participating patients over the term of the agreement. (This structure allows the ACO to define a ramp-up period in which it expects to be able to reduce costs; i.e., if it did not feel it would be able to achieve significant savings for Medicare in the first year of the agreement, it would need to provide greater savings in subsequent years.)

Adjusting Payment Levels for Differences in Patients

Each beneficiary who is added to the ACO's partial capitation payment roster would have a risk score defined for them using the risk scoring methodology used in the shared savings payment model (e.g., the CMS-HCC model used in the Medicare Advantage program and Physician Group Practice Demonstration). This risk score would be updated every six months based on the most recent diagnoses and demographic information about each beneficiary. ACOs would receive higher partial capitation payments for beneficiaries with higher risk scores, as defined below.

Paying for Services (Option 1)

Each month during the term of the payment agreement, the ACO would receive a partial capitation payment from CMS calculated as follows: First, the amount of the payment for each beneficiary on the partial capitation payment roster would be calculated as the product of (a) the risk-neutral monthly per patient amount agreed to by CMS and the ACO for that year, and (b) the risk score for that patient. Second, these payment amounts would be summed across all of the beneficiaries on the partial capitation payment roster, and from that amount would be subtracted the cost of all Part A and Part B claims CMS had paid to non-ACO providers in the previous month for beneficiaries on the ACO's partial capitation payment roster.

The ACO providers would continue to submit claims to CMS for all services that they provided to the patients covered by the partial capitation arrangement. However, none of those claims would be paid by CMS; the claims would merely be filed to allow

CMS to monitor the quality of care delivered by the ACO and compare it to other organizations. The ACO would accept the partial capitation payment as payment in full for all of the services its providers delivered to the beneficiaries on the partial capitation payment roster, and it would make its own arrangements for dividing the payment among the individual providers that are part of the ACO to compensate them for the services they delivered.

If a beneficiary on the ACO's partial capitation payment roster received a service from a provider that was not part of the ACO, CMS would pay the claim for that service as it would in the absence of the partial capitation payment program, but it would then also deduct the amount of that payment from the next month's partial capitation payment to the ACO. If the total amount of claims paid by CMS to non-ACO providers exceeded the total partial capitation payment in a particular month, the difference would be carried over and deducted from the following month's payment. (CMS could allow ACOs which have a health plan and the ability to pay claims for a broad range of providers in the community to pay all claims for the beneficiaries directly, similar to what is done by a Medicare Advantage plan.)

If the total amount of non-ACO claims exceeded the total partial capitation payment to the ACO for a period of time defined in the agreement between CMS and the ACO, both CMS and the ACO would have the option of terminating the payment agreement and reverting to standard fee-for-service payment.

Paying for Services (Option 2)

(Option 2 could be used to enable participation by provider organizations which (a) do not have the capability of paying claims to independent providers who agree to be part of the ACO, or (b) could not meet the requirements of their state insurance department to participate in Option 1.)

The ACO providers would continue to file claims with CMS for all services they delivered to the Medicare beneficiaries covered by the partial capitation arrangement, as would providers not included in the ACO provider organization if they delivered services to those beneficiaries. ACO providers would be paid quarterly, while other providers rendering services to the participating beneficiaries would be paid as they are today. Each quarter, CMS would calculate the total cost of claims filed by the ACO providers and by all other providers for services delivered to the beneficiaries covered by the partial capitation arrangement during that quarter. CMS would also calculate the partial capitation "budget" for the period by first multiplying (a) the risk-neutral monthly per patient amount agreed to by CMS and the ACO for that year by (b) the risk score for each patient, and then summing those amounts over all patients on the ACO's partial capitation payment roster over the three month period.

If the total claims paid by CMS in that three month period exceeded the partial capitation budget, then CMS would reduce the payments on the ACO's claims (but not those of providers not in the ACO) by a common percentage that would ensure that the sum of those reduced payment amounts and the (non-reduced) payment amounts to non-

ACO providers would equal the partial capitation payment. If the ACO also failed to meet quality standards, CMS could further reduce its payments by a predetermined amount. The ACO could, if it wished, specify a different formula for making the payment reductions; e.g., it might wish to limit the payment reductions for some of its providers, such as PCPs, and have higher reductions for other providers in the ACO.

If the total amount of claims paid over a 6-12 month period was less than the partial capitation budget, and if the ACO met the required quality standards, then CMS would pay the ACO a lump sum payment equal to the difference between the total claims and the budget, less a small amount that CMS would retain to cover the cost of claims for services that were delivered during the payment agreement period but which were filed and paid after the end of the period.

If the total claims were equal to the partial capitation budget, but the quality standards were exceeded, CMS and the ACO could agree that a quality bonus payment would be made to the ACO, but the sum of the quality bonus payment and the partial capitation budget would need to be less than what CMS would have expected to have spent for the recipients in the absence of the program.

Improving Services and Incentives for Beneficiaries

Neither CMS nor the ACO would be permitted to impose any requirements or limitations on the types of services, frequency of services, costs of services, or providers of services that Medicare beneficiaries covered by the partial capitation payment could receive (other than the requirements and limitations imposed on Medicare beneficiaries not participating in the program). In particular, the beneficiaries could not be “locked in” to any particular provider nor could they be required to seek approval from a “gatekeeper” in order to receive any services.

The ACO would be free to encourage beneficiaries covered by the partial capitation payment to use providers which are part of the ACO or which have coordination agreements with the ACO and to provide information to them on the relative quality of services and providers inside and outside of the ACO, but the ACO would be required in all communications to inform the beneficiaries of their freedom to obtain services not recommended by the ACO or to obtain services from providers which are not part of the ACO.

The ACO would be permitted to offer additional services to beneficiaries to help increase the quality or efficiency of the care they receive, such as medical home services, care management, shared decision-making, chronic disease education and self-management support, etc. The ACO would be responsible for paying for the costs of these services from the partial capitation payment (or from the lump sum payments under Option 2). These services would not be considered Medicare benefits and any patient cost-sharing requirements for these services would be established by the ACO, not by CMS. The ACO would also be permitted to offer incentives to Medicare beneficiaries, such as rebates on cost-sharing requirements, to encourage them to utilize high-value services, such as preventive care and screenings, or services delivered by providers which

are part of the ACO. CMS would exempt the ACO from restrictions under the Anti-Kickback statute and the Civil Monetary Penalty statute for offering such services or incentives. In addition, CMS would permit the ACO to institute gainsharing programs with its member providers consistent with the criteria established in OIG Advisory Opinions.

Assuring the Quality of Services to Beneficiaries

The ACO would submit data on the quality of care provided to the beneficiaries covered by the partial capitation payment using the same measures CMS requires for the shared savings program. CMS would also use the same quality performance standards for an ACO participating in the partial capitation program as in the shared savings program and/or the Medicare Advantage program.

If the ACO fails to meet the quality performance standards, then:

- If the ACO is being paid under Option 1, a pre-determined penalty would be assessed against the ACO and deducted from each monthly partial capitation payment until the quality standards are met. A schedule of the penalties for different levels of quality performance would be included in the payment agreement between CMS and the ACO.
- If the ACO is being paid under Option 2, and if expenditures are below the partial capitation budget, the ACO would only be eligible to receive a portion of the difference between the expenditures and the budget. If expenditures are above the partial capitation budget, the ACO would be subject to an additional reduction in payments beyond those necessary to keep expenditures within the partial capitation payment amount. A schedule of the reductions in the payment for different levels of quality performance would be included in the payment agreement between CMS and the ACO.

Advantages of Partial Capitation Compared to Shared Savings

Advantages for CMS

- The Medicare program would be guaranteed some savings for each participating ACO and the amount of savings would be defined in advance, rather than CMS facing the possibility that no savings would be achieved;
- The Medicare program would be protected against increases in costs, whereas under shared savings, there is no penalty to ACOs if costs increase;
- The Medicare program could expect to achieve greater savings because providers would have greater flexibility and upfront resources to implement programs that could reduce overutilization of services;
- Most of the administrative systems needed to implement the partial capitation program would be similar or identical to those in the shared savings program.

Advantages for Medicare Beneficiaries

- Medicare beneficiaries would be more likely to receive enhanced care management and self-management support services, since the ACO would have a means of paying for those services through the partial capitation payment;
- Medicare beneficiaries would be more likely to have access to primary care providers in the ACO because the ACO would have the ability to pay participating PCPs more generously and/or enable them to provide better access for patients through the use of phone calls, nurse care managers, etc.;
- Medicare beneficiaries would be informed in advance that they were being cared for by a provider who is participating in the ACO and they would be explicitly informed of their ability to use different providers if they wished to do so without any restrictions, whereas under shared savings, Medicare beneficiaries would at best find out they were “attributed” to the ACO long after services were received.
- The ACO would be financially penalized for delivering poor quality care in all cases, rather than only in situations where savings were achieved.

Advantages for Healthcare Providers

- Providers would receive the flexibility and resources through the partial capitation payment to restructure their services without losing reimbursement. For example, primary care physicians could talk to patients about their problems over the phone, rather than seeing them in the office, without losing reimbursement.
- Providers would know upfront which patients they are accountable for and would have the opportunity and ability to influence the way those patients receive healthcare. The ACO providers would not be “surprised” by having patients attributed to them with whom they had limited contact, or finding that patients to whom they had provided significant services were ultimately attributed to a different provider.
- Providers would know upfront the overall quality and cost targets they would need to meet and be able to establish and monitor internal objectives for quality and utilization to help assure the overall targets are met.

Challenges for Providers to Participate in the Partial Capitation Model

Although there are many advantages for providers to participate in the partial capitation payment approach compared to shared savings, there are also important challenges they would face:

- Because there are no restrictions on the providers or services that a patient could use, nor any incentives from Medicare for a patient to use providers within the ACO, the ACO providers would need to rely solely on high-quality patient service and any financial incentives they could offer directly to encourage beneficiaries to use the ACO providers vs. others. Although this would be desirable from the perspective of the beneficiary, it would create financial risks to smaller ACOs and ACOs in markets where a significant number of higher-cost providers exist and are actively working to market services to patients.
- A group of providers would likely need to have a significant number of patients managed under either the proposed partial capitation payment or some other form of capitation payment in order to cost-effectively implement the kinds of critical care management services needed to succeed as an ACO. (This is true for shared savings as well as partial capitation, but the downside risk of partial capitation would create a penalty for providers who were unable to implement the necessary care management services, whereas shared savings would not.) Consequently, providers who are already managing Medicare Advantage or commercial patients under capitation payments will likely be better positioned, at least in the short run, to participate successfully in the partial capitation payment model.
- Because the ACO will be accountable for total costs of care, it will be necessary for the ACO to have strong working relationships among primary care physicians, key specialty groups, and one or more hospitals, in order to effectively manage the full range of major cost drivers. However, this does not mean that only health systems that own all of these services could participate; Independent Practice Associations (IPAs) with contractual relationships with specialists and hospitals, and Physician-Hospital Organizations (PHOs) which include a broad network of primary care and specialty physicians, could also participate, since these entities already manage commercial and Medicare Advantage capitation contracts in many regions of the country.
- Many providers would likely prefer to manage Part D pharmacy benefits as well as Part A and Part B benefits, both because of the importance of ensuring the affordability of key medications for patients and because of the opportunities for reducing pharmacy expenditures through effective care coordination. However, it is likely infeasible to incorporate pharmacy benefits into the partial capitation payment system, at least in the short run, because of the separate way that it is currently administered.

COMPARISON OF SHARED SAVINGS vs. PARTIAL CAPITATION		
PROGRAM ELEMENT	PARTIAL CAPITATION	SHARED SAVINGS
Identification of Patients	The ACO would be accountable for all patients receiving any primary care services from the ACO unless they met predetermined exclusion criteria.	The ACO would only be accountable for patients receiving a majority or plurality of primary care services from the ACO.
Risk Adjustment	CMS-HCC classifications would be used to define relative risk scores.	CMS-HCC classifications would be used to define relative risk scores.
Projection of Expenditures	CMS would prospectively define a risk-adjusted benchmark spending level for the assigned beneficiaries.	CMS would define the benchmark spending level after beneficiaries had been retrospectively attributed to the ACO.
Services/Costs Included	The ACO would be accountable for the costs of all services delivered to assigned beneficiaries, other than the specific types of excluded services agreed to in advance.	The ACO would be accountable for the costs of all services delivered to attributed beneficiaries, except for exclusion rules defined by CMS (e.g., the \$100,000 per patient cap used in the PGP Demo).
Payment Determination	<p>Option 1: CMS would pay non-ACO providers as it does today, but would not pay the ACO providers for the individual services delivered; CMS would accumulate the cost of all non-ACO claims associated with the assigned beneficiaries, subtract them from the pre-defined payment amount, and pay the balance to the ACO.</p> <p>Option 2: CMS would pay both ACO providers and non-ACO providers as it does today; it would accumulate the cost of all</p>	CMS would pay both ACO providers and non-ACO providers as it does today. CMS would accumulate the cost of all claims associated with the attributed beneficiaries, determine whether savings had been achieved, and make a shared savings payment to the ACO.

	claims associated with the assigned beneficiaries, compare them to the pre-defined payment amount, and either reduce FFS payments to the ACO or pay the difference as a lump sum.	
Claims Payment	Under Option 1, CMS would no longer need to adjudicate and pay claims for any services delivered by the ACO providers, creating administrative savings for CMS.	CMS would continue to have to adjudicate and pay all claims for all services.
Quality Assurance	Payments to the ACO would be reduced if quality standards were not met.	Shared savings payments to the ACO, if any, would be reduced if quality standards were not met, but no quality penalties would be imposed if no savings were achieved.
Expectations of Beneficiaries	No requirements would be placed on beneficiaries, but the ACO could encourage assigned beneficiaries to use different providers or services or provide enhanced services to them.	No requirements would be placed on beneficiaries; the ACO could encourage beneficiaries to use different providers or services or provide enhanced services to them, but it might not be able to accurately predict which of the beneficiaries would ultimately be attributed to the ACO.

APPENDIX:
**Statutory Requirements for Provider Organizations to be
Accountable Care Organizations**

According to Section 1899(b)(1) and (b)(2) of the Patient Protection and Affordable Care Act, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program:

- (A) ACO professionals in group practice arrangements.
- (B) Networks of individual practices of ACO professionals.
- (C) Partnerships or joint venture arrangements between hospitals and ACO professionals.
- (D) Hospitals employing ACO professionals.
- (E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

In addition, an ACO must meet the following requirements:

- (A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- (B) The ACO shall enter into an agreement with the Secretary of HHS to participate in the program for not less than a 3-year period (referred to in this section as the ‘agreement period’).
- (C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.
- (D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.
- (E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).
- (F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.
- (G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
- (H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.