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HealthCare.gov

New Affordable Care Act Tools Offer Incentives for Providers to Work Together When Caring for People with Medicare

People with Medicare will be able to benefit from a new program designed to encourage primary care doctors, specialists, hospitals, and other care providers to coordinate their care under a final regulation on Accountable Care Organizations issued today by the Department of Health and Human Services (HHS).

On October 20, 2011, HHS announced final rules and a new opportunity for financial support to help doctors, hospitals, and other health care providers work together to improve the care for Medicare patients. By choosing to become Accountable Care Organizations, providers will be able to share in savings by better coordinating patient care, providing high quality care, and using health care dollars more wisely.

These new final rules, which were made final after an extensive review of comments and additional stakeholder input on the proposed rule, add a new option for providers looking for support in coordinating patient care. The Accountable Care Organization model of delivering care may not be right for every doctor, practice, clinic, or hospital, but it adds to the extensive menu of options offered through the Affordable Care Act to provide better health, better care and lower costs not only for Medicare beneficiaries, but for all Americans.

The new rules establish a new voluntary **Medicare Shared Savings Program** that helps doctors, hospitals, and other providers improve their ability to coordinate care across all health care settings. Providers who meet certain quality standards can share in any resulting savings.

The quality measures are organized into four domains:

- Patient experience
- Care coordination and patient safety
- Preventive health
- Caring for at-risk populations

The higher the quality of care providers deliver and the greater the effectiveness of their care coordination, the more savings they may keep. Federal savings could be up to $940 million over four years.

In a complementary program announced today, HHS is accepting applications from providers to help test the **Advance Payment** model. This model will test whether pre-paying a portion of future shared savings will increase participation of physician-owned and rural Accountable Care Organizations in the Medicare Shared Savings Program, and whether advance payments will allow teams of providers to improve care for beneficiaries and generate Medicare savings more

quickly. The advance payments would be recovered from any future shared savings achieved by the team of providers.

These two new opportunities create incentives for health care providers to work together to treat an individual patient across care settings – including doctors' offices, hospitals, and long-term care facilities. Providers are not required to participate in Accountable Care Organizations, and patients of providers who participate continue to have control over which doctors they see and what care they receive.

Improving Care for Patients

Any patient who sees multiple doctors understands the frustration of fragmented and disconnected care: lost or unavailable medical charts, duplicated medical procedures, or having to provide the same information over and over to different health care providers. This lack of coordination is even worse for patients with multiple chronic conditions who receive care from multiple health care providers.

Improved care coordination supported by these programs will lift this burden from patients, while improving the partnership between patients and doctors in making health care decisions. People with Medicare will have better control over their health care, and their doctors can provide better care because they will communicate with the patient's other care providers.

Patients choosing to receive care from providers participating in an Accountable Care Organization will have access to information about how well the organization is meeting the quality standards.

People with Medicare who receive care from a provider participating in an Accountable Care Organization will retain their rights to see any physician or hospital that participates in the Medicare program. In other words, an Accountable Care Organization cannot restrict care or limit a Medicare beneficiary's access to a physician or other health care professional. Medical decision making remains the responsibility of the patient and his or her doctor.

Helping Providers Coordinate Care

The two programs announced on October 20, 2011 are part of a broader effort by the Obama Administration to improve the quality of health care not only for Medicare beneficiaries, but for all Americans. The Affordable Care Act supports several programs that help health care providers coordinate care.

- Through the **Partnership for Patients,** more than 6,000 organizations including hospitals, doctors, and others have pledged to reduce hospital-acquired conditions and improve transitions in care.
- The **Bundled Payments** initiative gives providers flexibility to work together to coordinate care for patients over the course of a single episode of an illness.

- The **Comprehensive Primary Care Initiative** will allow Medicare to join with other health care payers such as employer-based health plans and/or Medicaid programs to invest in strengthening primary care.
- The testing of the **Pioneer Accountable Care Organization Model** is designed for organizations with experience providing integrated care across settings.
- The Federally Qualified Health Center (FQHC) **Advanced Primary Care Practice Demonstration** program is helping FQHCs provide more coordinated care and better access to primary care for Medicare patients.

Medicare Shared Savings Program

The new Medicare Shared Savings Program is intended to give Medicare fee-for-service beneficiaries the advantages of better coordination of care whether they get care in the hospital, a nursing facility, their doctor's office, or their home. The goal is to deliver seamless, high quality care for Medicare beneficiaries, and to make patients and providers true partners in care decisions.

Providers Eligible to Participate

Under the final rule, a group of providers and suppliers of services agree to work together with the goal that patients get the right care at the right time in the right setting. The final rule requires that each group of providers be held accountable for at least 5,000 beneficiaries annually for a period of three years. Each group must include health care providers and Medicare beneficiaries on its governing board.

All Medicare providers can participate in an Accountable Care Organization to coordinate care, but only certain types of providers are able to sponsor one. Those providers include physicians in group practice arrangements, networks of individual practitioners, and hospitals that are partnering with or employ eligible physicians, nurse practitioners, physician assistants, and specialists. To help providers serving rural and other underserved areas, the final rule allows Rural Health Clinics (RHCs) and Federally Qualified Health Centers to work together to coordinate care for patients. In addition, in the final rule, certain critical access hospitals are also eligible.

Measuring Quality Improvement

The final rule links the amount of shared savings an Accountable Care Organization may receive, and in certain instances shared losses it may be accountable for, to its performance on: 1) quality standards on patient experience; 2) care coordination and patient safety; 3) preventive health; and 4) at-risk populations. These standards will be measured in a way that accounts for providers who treat patients with more complex conditions.

To earn shared savings the first performance year, providers must fully and accurately report across all four domains of quality. Providers will begin to share in savings based on how they perform in some of those 33 quality measures in the second and third performance years.

Sharing Savings and Sharing Losses

CMS is implementing two models: a one-sided shared savings model, in which providers only share in savings; and a two-sided shared savings and losses model, in which providers also share in losses if growth in costs go up. The proposed rule had required Accountable Care Organizations in the one-sided shared savings model to share losses in the third year of the agreement period. In response to comments, CMS has modified the proposal, and the final rule allows Accountable Care Organizations to participate under the one-sided shared savings-only model for the entire length of their first agreement period. This will help organizations with less experience coordinating care, such as some physician organizations or small or rural providers, to gain experience before taking on the responsibility of sharing losses. It also allows more experienced providers to take on the responsibility of losses in exchange for greater potential rewards. Accountable Care Organizations may share up to 50% of the savings under the one-sided model and up to 60% of the savings under the two-sided model, depending on their quality performance.

For each year, CMS will develop a target level of spending for each ACO to determine its financial performance. Because health care spending for any group of patients normally varies from year to year, CMS will also establish a minimum savings and minimum loss rate that would account for these variations. This protects the Medicare Trust Funds from sharing savings, and providers against sharing in losses, due to normal variation in Medicare spending. Both shared savings and shared losses will be calculated on the total savings or losses, not just the amount by which the savings or losses exceed the minimum savings or loss rate. In addition, the amount of shared savings would depend on how well the team of providers performs on the quality measures specified in the rule.

To view a chart highlighting some of the key differences between the proposed and final rules visit: http://www.cms.gov/aco/downloads/Appendix-ACO-Table.pdf (PDF- 106 KB)

Advance Payment Model

The Advance Payment Model tests whether advancing a portion of an Accountable Care Organization's future shared savings will increase participation from physician-owned and rural providers in the Medicare Shared Savings Program, and whether advance payments will allow those teams of providers more quickly improve care for beneficiaries and generate Medicare savings. The Advance Payment Model was designed to support physician-owned and rural ACOs with upfront infrastructure investments. These providers will receive payments in advance that will be recouped as they achieve savings.

There are three ways provider groups may receive these payments:

- Upfront fixed payment
- Upfront payment based on the number of Medicare patients served
- Monthly payment based on the number of Medicare patients

This model is open only to physician-owned organizations, critical access hospitals, and rural providers participating in the Shared Savings Program, helping them become Accountable Care Organizations to improve care for their patients. Application deadlines will match the Shared

Savings Program. For more details, visit http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/.

Antitrust Guidance for Providers

CMS has worked closely with the Department of Justice (DOJ) and the Federal Trade Commission (FTC) to facilitate the creation of Accountable Care Organizations by giving providers clear and practical guidance to form innovative, integrated health care delivery systems without raising antitrust issues.

Along with the final rule for the Shared Savings Program, DOJ and FTC have issued a joint Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program ("Antitrust Policy Statement"). Under the Antitrust Policy Statement, the agencies will give rule of reason treatment to an Accountable Care Organization if they use the same governance and leadership structure and the same clinical and administrative processes in the commercial market as it uses to qualify for and participate in the Shared Savings Program.

In addition, the Antitrust Policy Statement outlines an expedited process that Accountable Care Organizations can use to obtain further guidance about their antitrust concerns. For more details, visit www.ftc.gov/opp/aco/ and http://www.justice.gov/atr/public/health_care/aco.html.

For More Information

The Shared Savings Program final rule is posted at: www.ofr.gov/inspection.aspx.

The Advanced Payment solicitation is posted at: http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/.

For more information on these two topics, fact sheets are posted at http://www.cms.gov/center/press.asp.

The joint CMS and Department of Health and Human Services Office of Inspector General (OIG) Interim Final Rule with Comment Period addressing waivers of certain fraud and abuse laws in connection with the Shared Savings Program is posted at: www.ofr.gov/inspection.aspx.

The Antitrust Policy Statement is posted at: www.ftc.gov/opp/aco/ and http://www.justice.gov/atr/public/health_care/aco.html.

The Internal Revenue Service (IRS) Fact Sheet, Tax-Exempt Organizations Participating in the Medicare Shared Savings Program Through Accountable Care (FS-2001-11), will be posted at: http://www.irs.gov (PDF 52 KB).

Source: http://www.healthcare.gov/news/factsheets/2011/10/accountable-care