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Accountable Care Organizations: Improving Care Coordination for People with Medicare

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The Affordable Care Act includes a number of policies to help physicians, hospitals, and other caregivers improve the safety and quality of patient care and make health care more affordable. By focusing on the needs of patients and linking payments to outcomes, these delivery system reforms will help improve the health of individuals and communities and slow cost growth.

On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other 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.

Need for and Benefits of Coordinated, Accountable Care

Today, more than half of Medicare beneficiaries have five or more chronic conditions such as diabetes, arthritis, hypertension, and kidney disease. These patients often receive care from multiple physicians. A failure to coordinate care can often lead to patients not getting the care they need, receiving duplicative care, and being at an increased risk of suffering medical errors. On average, each year, one in seven Medicare patients admitted to a hospital has been subject to a harmful medical mistake in the course of their care. And nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days – a readmission many patients could have avoided if their care outside of the hospital had been aggressive and better coordinated.

Improving coordination and communication among physicians and other providers and suppliers through Accountable Care Organizations will help improve the care Medicare beneficiaries receive, while also helping lower costs.

According to the analysis of the proposed regulation for ACOs, Medicare could potentially save as much as $960 million over three years.

About Accountable Care Organizations

Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve with Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals, or
- Hospitals employing ACO professionals, and
- Other Medicare providers and suppliers as determined by the Secretary.

In the proposed rule, the Secretary has made clear that certain critical access hospitals are eligible to participate in the Shared Savings Program. The law requires each ACO to include health care providers, suppliers, and Medicare beneficiaries on its governing board. The ACO must take responsibility for at least 5,000 beneficiaries for a period of three years, also suggested in the law.

Sharing Savings

Under the proposed rule, Medicare would continue to pay individual health care providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses. CMS is also proposing to establish a minimum sharing rate that would account for normal variations in health care spending, so that the ACO would be entitled to shared savings only when savings exceeded the minimum sharing rate. The amount of shared savings depends on whether on an ACO meets or exceeds quality performance standards. The proposed rule would provide for additional shared savings for ACOs that include beneficiaries who receive services from a Federally Qualified Health Center or Rural Health Clinic during the performance year.

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for either model. This will help

organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.

Measuring Quality Improvement

The proposed rule links the amount of shared savings an ACO may receive to its performance on quality standards. The rule proposes quality measures in five key areas that affect patient care:

- Patient/caregiver experience of care;
- Care coordination;
- Patient safety;
- Preventive health; and
- At-risk population/frail elderly health.

The proposed rule sets out proposed performance standards for these measures and a proposed scoring methodology, including proposals to prevent providers in ACOs from being penalized for treating patients with more complex conditions.

Improving Care for Patients

Any patient who has multiple doctors probably understands the frustration of fragmented and disconnected care: lost or unavailable medical charts, duplicated medical procedures, or having to share the same information over and over with different doctors. Accountable Care Organizations are designed to 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 have better information about their patients' medical history and can communicate with a patient's other doctors. Medicare beneficiaries whose doctors participate in an ACO will still have a full choice of providers and can still choose to see doctors outside of the ACO. Patients choosing to receive care from providers participating in ACOs will have access to information about how well their doctors, hospitals, or other caregivers are meeting quality standards.

Antitrust Guidance for Providers in ACOs

The Department of Justice (DOJ) and the Federal Trade Commission (FTC) have worked together to facilitate the creation of ACOs by giving providers the clear and practical guidance they need to form innovative, integrated health care delivery systems without running afoul of antitrust laws. In conjunction with the proposed rule for the Shared Savings Program, the two agencies have issued a joint Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations

Participating in the Medicare Shared Savings Program (“Antitrust Policy Statement”). Under the proposed Antitrust Policy Statement, the agencies are proposing to establish different levels of antitrust scrutiny depending on the specific ACO arrangement. For example, DOJ and FTC are proposing to give rule of reason treatment to an ACO if, the ACO uses 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. For more details, visit www.ftc.gov/opp/aco/.

One Part of Quality Improvement

ACOs are just one piece of a broader effort by the Obama Administration to improve the quality of health care for all Americans. On March 21, HHS announced the first-ever National Quality Strategy, which will serve as a tool to better coordinate quality initiatives between public and private partners. In addition, the Affordable Care Act established a new Center for Medicare and Medicaid Innovation that will test innovative care and service delivery models. CMS is currently exploring how the Innovation Center will test alternative payment models for Accountable Care Organizations.

Before the rule is finalized, CMS will review all comments from the public and may make changes to its proposals based on those comments.

To read the Notice of Proposed Rule-making for ACOs, visit www.ofr.gov/inspection.aspx.

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