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The ACO Final Rule Is Released Are You Ready

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Health Care

On October 20, 2011, the Centers for Medicare and Medicaid Services (CMS) released an advance copy of the final rule for accountable care organizations (ACOs). Additional governmental guidance was issued to address antitrust and tax considerations. The following article summarizes the government's key points in the final rule.

ACOs Represent a Model for Seamless and Coordinated Care.

In its announcement of the final rule, the government highlighted that ACOs represent a major step forward for transforming Medicare and Medicaid to help assure high quality and seamless health care for continuous improvement. The government defines "seamless and coordinated care" in reference to what patients want. Patients want time with doctors, care that makes sense, is coordinated. Patients wants their doctors working together so they don't get confused or lost in the system. They want better communication, from reminders for appointments to more information about medical decisions. They want a promise that their own doctor will know if they have an issue and seek care elsewhere.

To obtain this type of seamless and coordinated care, the government recognizes that fundamental change to the way services are reimbursed must occur. Payment for services on a fee-for-service basis led to patients receiving pieces of care versus coordinated care. The government is encouraging coordinated care through various payment reforms, including bundled payments, payments based on episodes of care, among others. With ACOs, the government believes that care and reimbursement can be reorganized so that care (and associated charges) makes sense all of the time.

Options for Participating in Health Care Reform.

The government remains focused on attaining the triple aim: better health, better care, and lower cost to all Americans. The government sees ACOs and many other initiatives as designed to attain the triple aim, but recognizes that there are barriers to providers participating in these initiatives. The high cost of infrastructure (and the lack of necessary capital to invest in building this) needed to operate as an ACO led to the announcement of the Advance Payment Model (APM). Under the APM, providers receive payments to offset setup costs that will be recouped later as the providers receive savings. The government sees the APM as another "on ramp" for providers who want to participate in health

care reform.

ACOs, and their associated programs and rules, are part of a larger menu of options to reform health care. The government recognizes that ACOs alone will not accomplish the triple aim or health care reform. Additional programs and opportunities are needed and numerous initiatives have been announced to date, including:

- Partnership for Patients: with awards of up to $1 billion from the federal Department of Health and Human Services for improved care models.
- Bundled Payment Initiative: Payment reform initiative designed to improve care by fostering improved coordination and quality thru defined models of care.
- Comprehensive Primary Care Initiative: This CMS-led multi-payer initiative promotes payer collaboration to strengthen primary care for Americans. Private payers are invited to join Medicare to test service and payment models to implement quality improvement and change.
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: This demonstration will test the effectiveness of doctors and health professionals working as teams in the FQHC setting.
- State Demonstrations to Integrate Care for Dual Eligible Individuals: Fifteen states, including North Carolina, have been awarded contracts to participate in this demonstration to identify and validate delivery system and payment integration models of health care for beneficiaries eligible for both Medicare and Medicaid.
- Multiple Payer Advanced Primary Care Practice Demonstration: Eight states, including North Carolina, will participate in a demonstration project to evaluate the effectiveness of doctors and health professionals across the care system working in a more integrated fashion and receiving payment through congruent methods across government and commercial payers.
- State Engagement Models: Programs designed to achieve an integrated care approach for individuals who are eligible for Medicare or Medicaid.

We should expect this list to grow and change as service and payment models evolve.

Key Principles in the Final Rule.

In developing the final rule, CMS focused on:

- Creating a much stronger business case to choose to participate than in the proposed rules.
- Staying true to the principle that CMS wanted organizations to come in to the Shared Savings Program (SSP) using different tracks: (i) one-sided risk, (ii) two-sided risk, and (iii) Pioneer model track. CMS wanted to reward increased risk, while encouraging innovation through a variety of tracks.
- Maintaining the principle that higher quality scoring providers will have the opportunity for greater savings. CMS focused on what it perceived as the key indicators of quality care.
- Changing the rules for governance to be more flexible.
- Increasing the flexibility for beneficiary assignment to include more rural providers.
- Balancing better the need for ACOs to know beneficiary assignment upfront (as opposed at the end of the savings period) and the current reality of beneficiaries who change locations and care patterns over time. Assignment will be a rolling process, still protecting beneficiaries and their ability to choose their care.
- Keeping a strong commitment to help ACOs with data from Part A & B while maintaining patient privacy.
- Being committed to a strong partnership and collaboration with Federal Trade Commission,

Department of Justice and Office of Inspector General to give providers flexibility to form ACOs, while still remaining true to antitrust and fraud and abuse concerns.

Government leaders have vocalized their excitement about the final rule and the opportunities it provides.

The Key Changes.

CMS identified the following significant changes to the final rule from what was proposed:

- Providers will be able to participate in an ACO and share in savings with Medicare without risk of losing money. ACOs will be able to start sharing in the savings earlier rather than letting Medicare retain all the initial savings.
- The number of quality measures that ACOs will have to meet to qualify for performance bonuses was reduced from 65 to 33.
- The ACOs will also be told up-front which Medicare beneficiaries are likely to be part of their system. Under the earlier rule, ACOs would not know which patients were in the ACO until their contract ended.
- Community health centers and rural health clinics will be allowed to lead ACOs. They were left out of the prior proposal and CMS has reconsidered this.

Unlike the relative vagaries of the proposed rule, the final rule sets specific requirements for documents (from organizational documents to contracts between participants and providers), a compliance program, and data use and access. Providers will have some significant contracting work ahead of them to get an ACO off the ground.

What Does the Final Rule Mean for Providers?

The final rule while making some changes to increase participation in the SSP clarifies that ACOs are just one part of the government’s plan to effectuate health care reform through service and payment model changes. Whether or not ACOs are successful, this final rule is a harbinger of things to come and marks a fundamental change in the way the government views (and pays for) health care. Providers must actively educate themselves on the many reform opportunities with this in mind. Providers should apply for programs that fit with their practice and capabilities because change is coming. Change is inevitable.

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