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Affordable Care Act to improve quality of care for people with Medicare

Proposal for Accountable Care Organizations will help better coordinate care, lower costs

The U.S. Department of Health and Human Services (HHS) today released proposed new rules 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 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.

The proposed new rules will help doctors, hospitals, and other providers form ACOs and are now available for public comment. HHS also announced it will hold a series of open-door forums and listening sessions during the comment period to help the public understand what the Centers for Medicare & Medicaid Services (CMS), the agency administering the ACO program, is proposing to do and to ensure that the public understands how to participate in the formal comment process.

"The Affordable Care Act is putting patients and their doctors in control of their health care," said HHS Secretary Kathleen Sebelius. "For too long, it has been too difficult for health care providers to work together to coordinate and improve the care their patients receive. That has real consequences: patients have gaps in their care, receive duplicative care, or are at increased risk of suffering from medical mistakes. Accountable Care Organizations will improve coordination and communication among doctors and hospitals, improve the quality of the care their patients receive, and help lower costs."

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 saving as much as $960 million over three years for the Medicare program.

Under the proposal, ACOs – teams of doctors, hospitals, and other health care providers and suppliers working together – would coordinate and improve care for patients with Original Medicare (that is, who are not in Medicare Advantage private health plans). To share in savings, ACOs would meet quality standards in five key areas:

- Patient/caregiver care experiences
- Care coordination
- Patient safety
- Preventive health
- At-risk population/frail elderly health.

The proposed rules also include strong protections to ensure patients do not have their care choices limited by an ACO.

If ACOs save money by getting beneficiaries the right care at the right time – for example, by improving access to primary care so that patients can avoid a trip to the emergency room – the ACO can share in those savings with Medicare. ACOs that do not meet quality standards cannot share in program savings, and over time, those who do not generate savings can be held accountable. The new program will be established on January 1, 2012. Before the rule is finalized, CMS will review all comments from the public and may make changes to its proposals based on those comments.

"An ACO will be rewarded for providing better care and investing in the health and lives of patients," said Donald M. Berwick, M.D., CMS Administrator. "ACOs are not just a new way to pay for care but a new model for the organization and delivery of care."

CMS has worked closely with other federal agencies, including the Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Trade Commission (FTC), and Internal Revenue Service (IRS) to ensure that providers and suppliers have the clear and practical guidance they need to form ACOs without running afoul of the fraud and abuse, antitrust, and tax laws. Concurrently with the publication of this proposed rule, the following documents have been issued: a joint CMS and OIG notice and solicitation of public comments on potential waivers of certain fraud and abuse laws in connection with the Medicare Shared Savings Program; a joint FTC and DOJ proposed antitrust policy statement; and an IRS notice requesting comments regarding the need for additional tax guidance for tax-exempt organizations, including tax-exempt hospitals, participating in the Medicare Shared Savings Program.

The proposed rules 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 ACOs.

The proposed rule and joint CMS/OIG notice are posted at: www.ofr.gov/inspection.aspx. For more information, read the fact sheet at www.HealthCare.gov/news/factsheets/accountablecare03312011a.html.

Comments on the proposed rule will be accepted for 60 days. CMS will respond to all comments in a final rule to be issued later this year.

The Proposed Antitrust Policy Statement is posted at: www.ftc.gov/opp/aco/.

The IRS Guidance and Solicitation of Comments will be posted at: http://www.irs.gov/pub/irs-drop/n-11-20.pdf.

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