For your information

Volume 34 | Issue 98 | December 22, 2011

CMS Releases Final Accountable Care Organization Regulations and Other Guidance

CMS released final regulations on the development of ACOs for Medicare beneficiaries under health care reform. An ACO is a coordinated care model that seeks to improve the quality of health care and better manage cost by changing the incentives of how providers are reimbursed.

Background

As volume-based fee-for-service reimbursement methodologies are increasingly seen as unsustainable, health care payers are moving toward outcomes-based reimbursements. Accountable Care Organizations (ACOs) are emerging as a leading delivery model in the health care marketplace. In the Patient Protection and Affordable Care Act (PPACA), ACOs were specifically designed to help control the cost of care for Medicare beneficiaries while also improving the quality of that care. This delivery and payment model is not restricted to Medicare, and most large commercial payers are also looking to take advantage of coordinated care approaches. Already more than 160 ACOs have been formed in the United States, the majority sponsored by hospital systems.

Under an ACO, hospitals, primary care physicians, specialists, and other health care providers coordinate their activities in an effort to improve the quality and lower the cost of care. For Medicare beneficiaries, the savings are shared by Medicare and the ACO under the Medicare Shared Savings Program (MSSP).

INSIGHT

Although the ACO program under PPACA applies to the Medicare program only, other payers, including employee benefit plans, will have more flexibility to contract with ACOs for private coverage.

The Centers for Medicare & Medicaid Services (CMS) released proposed ACO regulations in March 2011, but those regulations were generally viewed by health care providers as too demanding and onerous.

Volume 34 | Issue 98 | December 22, 2011

MSSP Final Regulations and Advance Payment Model Notice

CMS issued final regulations that address many of the concerns raised in response to proposed regulations. In a separate notice, CMS announced the Advance Payment Model, which is to encourage certain providers to establish ACOs.

Medicare Shared Savings Program

The final regulations establish the MSSP, which is expected to help providers improve their ability to coordinate care for Medicare beneficiaries. Providers that meet certain quality standards will share in any savings with Medicare.

Providers Eligible to Participate. To be eligible to participate in the MSSP, a group of providers and medical suppliers must be accountable for at least 5,000 Medicare beneficiaries. The governing board of the ACO must include both providers and Medicare beneficiaries. Generally, only physicians in a group practice, networks of individual physicians, and hospitals can establish an ACO.

INSIGHT

Final guidance from the Department of Justice and the Federal Trade Commission also eased antitrust concerns that may have kept hospitals and physicians from forming ACOs.

Measuring Quality Improvement. To be eligible for shared savings, an ACO must also meet quality performance standards for:

- Patient and care giver experience,
- Care coordination and patient safety,
- Preventative health, and
- At-risk populations.

In the first year, quality performance will be measured by the level of complete and accurate reporting for all quality measures. In subsequent years, sharing will be based on actual performance on these quality measures.

INSIGHT

To the extent that health care providers succeed in improving quality to meet Medicare standards, these organizational and operational changes should have a spillover beneficial, cost-saving effect for employer-sponsored plans.

Volume 34 | Issue 98 | December 22, 2011

Shared Savings and Losses. Two shared savings models are available to ACOs during their initial agreement period. Under the "one-sided savings model," ACOs share only in any savings. Under the "two-sided shared savings and losses model," the ACO can share in a greater portion of the savings but also must share in any losses.

INSIGHT

Forward-thinking plan sponsors are already looking at payment models that include both risks and rewards for providers. These models should become more common in the future.

Impact on Medicare Beneficiaries. Medicare beneficiaries will be assigned to an ACO if their primary care doctor is part of that ACO. However, unlike most managed care programs, beneficiaries are not limited to providers in the ACO, and they can use any provider. Beneficiaries also can elect not to be included in the ACO.

Advance Payment Model

This model provides additional financial resources to help physician-owned organizations and rural providers establish ACOs. Under this model, selected ACOs will receive three types of payment:

- An upfront, fixed payment,
- An upfront, variable payment, and
- A monthly payment the size of which depends on the number of Medicare beneficiaries historically attributed to the ACO.

Any advance payments are recouped from future savings.

Conclusion

The final regulations address many of the concerns that providers had with the proposed regulations and should help encourage participation in the ACO program. Changes underway in the provider delivery arena will have a direct impact on plan sponsors because many ACOs will also have these delivery and payment models available to plan sponsors.

Buck's consultants are available to assist providers in establishing an ACO, as well as assisting plan sponsors in using ACOs to better manage the cost and quality of health care delivery.

Volume 34 | Issue 98 | December 22, 2011

Buck Can Help

- Establish ACOs and set parameters for charges
- Facilitate negotiations between ACOs and plan sponsors
- Evaluate likely costs and quality improvements from contracts
- Prepare the necessary documents

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This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.
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