



RE: Health Law Update: ACOs Allow Providers to Share Medicare Savings With Federal Government

DATE: February 3, 2011

The massive 2010 federal health care reform – the Patient Protection and Affordable Care Act (PPACA) – contains seven pages of amendments to Title XVIII of the Social Security Act by creating the Medicare Shared Savings Program. The purpose of the program is to cut spending in the health care system by contracting with accountable care organizations (ACOs) to make them accountable for the costs and outcomes of patient care. The upside for the participating ACOs is the sharing of any Medicare dollars saved by the ACO for providing health care more efficiently and meeting certain quality performance standards.

Because of the financial incentives offered under the new law, ACOs will likely play a tremendous role in the future of health care. However, the devil is in the details, and details are sparse at this point. The Secretary of the Department of Health and Human Services is charged with promulgating regulations by January 1, 2012. At the present time, we know very little about the specific requirements for ACOs because the precise structural and functional requirements of ACOs have yet to be determined. This memo addresses some of the key points of ACOs that are provided in the PPACA, namely, what they are and how they can participate in the Shared Savings Program.

What is an ACO?

An ACO is a group of health care providers and facilities (doctors, hospitals, clinics, etc.) that contract together for the purpose of assuming responsibility for providing health care to certain patients. Specifically, the PPACA provides that, under the Medicaid Shared Savings Program, “...groups of providers of services and suppliers meeting criteria specified by the Secretary (Health and Human Services) may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization... .” In turn, ACOs that meet certain quality performance standards (which have not yet been established) are eligible to receive payments for shared savings.

Which ACOs are Allowed to Participate in the Shared Savings Program?

The PPACA provides that only certain groups of providers and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program. Those specific groups include:

1. ACO professionals in group practice arrangements. “ACO professional” is defined as a “physician” under Section 1861(r)(1) and a “practitioner” described in Section 1842(b)(18)(C)(i) of the PPACA.
2. Networks of individual practices of ACO professionals.
3. Partnerships or joint venture arrangements between hospitals and ACO professionals.
4. Hospitals employing ACO professionals.
5. Such other groups of providers of services and suppliers as the Secretary determines appropriate.

Subject to the Secretary’s forthcoming regulations, the current eligibility requirement is rather broad. However, once an ACO is formed through a contractual agreement between the eligible parties, there are certain mandatory conditions that ACOs are required to meet before they may participate in the Shared Savings Program. These conditions include the following, which will be supported and expanded by rules established by the Secretary before January 1, 2012:

1. The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
2. The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the “agreement period”).
3. The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers which complies with the “Payments for Shared Savings” subsection (addressed below).
4. The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO. At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it (method to be determined by the Secretary) in order to be eligible to participate in the ACO program.
5. The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements, and the determination of payments for shared savings.

6. The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.
7. The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
8. The ACO shall demonstrate to the Secretary that it meets “patient-centeredness criteria” specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

How will ACOs Be Paid?

Under the program, providers and suppliers will continue to be paid under the original Medicare fee-for-service program (under parts A and B) in the same manner as they would otherwise be made. An ACO participating in the Shared Savings Program will receive an additional bonus payment if 1) the ACO meets quality performance standards established by the Secretary, and 2) the average per capita Medicare expenditures during the agreement period meets certain benchmarks established by the Secretary. The benchmark will be adjusted for patient characteristics. Thereafter, a percent of the difference between the estimated average per capita of Medicare expenditures in a year will be paid to the ACO, and the remainder will be retained by the program. The Secretary will establish limits on the total amount of shared savings that may be paid to an ACO under the program. Even if an ACO is not able to save money through its coordination of care, it will still receive the standard Medicare fees for services rendered to its patients.

Who can ACOs Treat under the Program?

ACOs must treat Medicare fee-for-service beneficiaries in order to participate in the Shared Savings Program. The term “Medicare fee-for-service beneficiary” means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in a MA plan under part C, an eligible organization under section 1876 or a PACE program under section 1894.

Sanctions will be imposed if the Secretary determines that an ACO has taken steps to avoid “patients at risk” in order to reduce the likelihood of increasing costs to the ACO. Additionally, the Secretary may terminate an ACO from the program if it does not meet the quality performance standards to be established by January 2012.

Regulatory Concerns for ACOs

Hospitals and physicians looking to develop an ACO must ensure that their agreement does not violate federal or state anti-kickback statutes (criminal), the Stark Law (civil), tax-exemption laws (for not-for-profit hospitals) and/or anti-trust regulations.

Generally, Stark law prohibits referrals for certain health care services by doctors and other providers to entities in which they have a financial interest. Of course, there are certain

exceptions, such as the "bona fide" employment of physicians. This exception allows entities to employ doctors and pay them as employees while accepting their referrals. Other exceptions include the "personal services" arrangement and the "fair market value" exceptions. While the Stark law does not have a specific exception regarding ACOs, it is possible to structure ACO relationships to meet other existing exceptions under the law.

Yet to be addressed under the new Shared Savings Program is whether federal and state anti-trust laws may apply to ACO arrangements. Since 1996, providers have been allowed to contract together as part of clinical integration arrangements. However, questions remain about whether or not they should be considered "collusive" under anti-trust laws.

In the coming months, the Centers for Medicare and Medicaid Services (CMS) will be releasing regulations outlining the specifics of ACOs under the new law. There is also news that the Federal Trade Commission will be attempting to clarify anti-trust guidelines for ACOs soon. In the meantime, it would be prudent to consider the current prohibitions and other regulatory issues when drafting contractual agreements to establish an ACO. As always, please refer specific questions regarding ACOs, and their role under the new federal health care reform, to any of our attorneys at Smith & Associates.