Regulatory Review: Ten Facts You Should Know About Medicare ACOs

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1. Medicare Accountable Care Organizations (ACOs) are a prodct of federal healthcare reform legislation.

By now, most healthcare providers have at least a basic understanding of the recent and broad sweeping federal healthcare reform legislation commonly known as the Patient Protection and Affordable Care Act (PPACA), which was enacted on March 23, 2010. One aspect of PPACA eliciting significant interest among healthcare providers is the Medicare Shared Savings Program, under which ACOs that meet certain quality performance standards will be eligible to receive Medicare shared savings payments. PPACA requires the Secretary of the United States Department of Health and Human Services (HHS) to establish the Medicare Shared Savings Program no later than January 1, 2012.

2. ACOs will be eligible for financial incentives (enhanced reimbursement) based upon the quality and efficiency of care provided to their patients.

Under the Medicare Shared Savings Program, physicians and other professionals manage and coordinate the care of Medicare fee-for-service beneficiaries in a multi-disciplinary manner through ACOs. ACOs that meet certain quality performance criteria will be eligible to participate in the resulting Medicare savings. The ACO physicians and other professionals will continue to receive payment under Part A and Part B of the Medicare fee-for-service program in the same manner as they would otherwise. ACOs will not be penalized if quality benchmarks are not attained.

3. ACOs will not be permitted to directly choose the patients for which they are accountable.

PPACA provides that each ACO will be assigned at least 5000 Medicare fee-for-service beneficiaries based upon those beneficiaries' utilization of primary care physicians.

4. Primary care physicians will play an integral role in each ACO.

Since assignment of patients to an ACO is based upon the primary care physicians participating in the ACO, it is anticipated that, as a practical matter, primary care physicians will be required to have a relationship with only one ACO and will have substantial influence within the their respective ACOs.

5. Those ACOs that retain patients and refer patients within their ACO network will have the greatest opportunity for success.

Although ACOs will be responsible for the care of their assigned beneficiaries, Medicare beneficiaries will be able to choose their healthcare providers even if such providers do not participate in the ACO to which the Medicare beneficiaries are assigned. There will certainly be an incentive for ACO physicians to refer patients to other physicians within their own ACO.

6. ACOs must satisfy numerous eligibility requirements in order to participate in the Medicare Shared Savings Program.

Each ACO will need to satisfy numerous requirements, including, without limitation: (a) being willing to be accountable for the quality, cost, and overall care of Medicare beneficiaries; (b) contractually committing to participate in the Medicare Shared Savings Program for at least three years; (c) maintaining a management structure that includes clinical and administrative systems; and (d) adopting processes to promote evidence based medicine and patient engagement, report on quality and cost measures, and coordinate care.

7. Healthcare providers have substantial flexibility when structuring their ACOs.

PPACA provides that numerous types of organizations can become ACOs. The various types of models include, without limitation, hospital employment models, group practices, joint ventures, physician organizations, physician hospital organizations, management services arrangements, and service line models.

8. The ability to efficiently and effectively share information will be key to the success of any ACO.

As a condition of receiving Medicare shared savings payments,

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ACOs will need to submit information to the Secretary of HHS that is necessary to determine the quality of care furnished by the ACO. Each ACO will need to have the information technology and other electronic health record infrastructure in place to maintain, share, retrieve, and report meaningful and usable data.

9. ACOs will serve as a catalyst for further integration among healthcare providers.

In order to achieve the clinical and administrative coordination and sharing of information that will be necessary to the success of ACOs, physicians, hospitals, and other professionals will need to integrate, but within the constraints of applicable law, including the federal Anti-Kickback, Stark, and Civil Monetary Penalty laws, federal tax exempt laws and federal and state privacy laws, federal anti-trust laws, and the state corporate practice of medicine doctrines.

10. The healthcare community is currently preparing for future participation in the Medicare Shared Savings Program through ACOs.

As of today, there are many uncertainties surrounding the requirements that ACOs will need to satisfy in order to receive payments under the Medicare Shared Savings Program. Notwithstanding this current state of affairs, many providers are wisely looking beyond the basic contours of the proposed Medicare Shared Savings Program and developing strategies to prepare for its future implications.