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New Entities Will Coordinate Medicare Coverage

Government releases regulations for Accountable Care Organizations

By PAMELA H. DEL NEGRO and MEAGHAN MARY COOPER

The federal government established the Shared Savings Program in the Patient Protection and Affordable Care Act of 2010 to reduce Medicare costs while improving patient care. Under the Shared Savings Program, which is anticipated to begin in 2012, certain health care entities, providers and suppliers that meet specific eligibility criteria may form "Accountable Care Organizations" or "ACOs" to provide and coordinate medical care for Medicare beneficiaries, and potentially share in cost savings. On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS) released proposed regulations governing the formation and operation of ACOs.

Under the proposed regulations, Accountable Care Organization participants are held accountable for the costs and quality of care provided to Medicare beneficiaries assigned to the ACO. If the ACO holds costs below certain benchmarks and satisfies quality standards established by the federal government, it receives a portion of the savings that it generates, in addition to the "fee-for-service" payments that its providers and suppliers receive from Medicare for services rendered. The government estimates that the Shared Savings Program could potentially generate up to $960 million in savings for the Medicare program over three years.

ACO Requirements

The proposed regulations include numerous requirements relating to the ACO's structure, operation and performance. For example, an ACO must be recognized as a legal entity in the state in which it is established, authorized to do business in each state in which it operates, and have its own taxpayer identification number. Its governing body must have broad responsibility for the ACO's operations and include both ACO participants and at least one Medicare beneficiary served by the ACO. Accountable Care Organization participants must have substantial control of the organization's governing body, and each ACO participant must have proportionate control over governing body decision-making.


Pamela H. Del Negro


Meaghan Mary Cooper

ACOs must implement evidence-based guidelines and demonstrate that care is focused on patients and consistent with the federal government's three goals of improved care for individuals, better health for populations, and reduced costs. Examples of "patient-centered" measures include beneficiary surveys, customized plans of care, and open communication with patients about their values and priorities with respect to health care decisions. ACO participants must be subject to performance evaluations and remedial actions, or expulsion, in the event they fail to meet applicable performance guidelines. ACOs will be required to publically report quality performance scores and certain other information required by CMS.

An Accountable Care Organization must have at least 5,000 Medicare beneficiaries assigned to it. Medicare beneficiaries will be assigned to the ACO in which their primary care providers choose to participate. However, a Medicare beneficiary's assignment to a particular ACO will not prohibit him or her from choosing to seek care from a provider unaffiliated with the ACO.

The proposed rule requires that Accountable Care Organizations agree to participate in the Shared Savings Program for at least three years. While primary care physicians can only participate in one ACO

Pamela H. Del Negro and Meaghan Mary Cooper are associates in Robinson & Cole's Health Law Group.

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per three-year period, all other ACO providers and suppliers can participate in more than one ACO during any such period.

Shared Savings Payment

An ACO that keeps costs below applicable benchmarks, and in doing so exceeds a set minimum savings rate while meeting the quality and other requirements of the Shared Savings Program, will qualify to receive a shared savings payment. CMS will establish the benchmark for each ACO by determining the per capita Medicare Part A and B expenditures for beneficiaries who would have been assigned to the ACO in any of the prior three most recent years, adjusted for beneficiary health status and demographics, as well as overall growth trends.

The Centers for Medicare & Medicaid Services has proposed two models for ACO participation, referred to as the "one-sided" model and the "two-sided" model. Under the one-sided model, an ACO is eligible to receive Shared Savings Program payments but is not at risk for any loss if it fails to meet the applicable cost benchmarks and quality requirements. Under the two-sided model, an ACO is eligible to receive a greater share of savings it may generate but is also responsible for sharing losses if its expenditures are above its benchmark.

An ACO may elect to participate under the one-sided model at the outset, but must convert to the two-sided model in its third year of participation, and must continue under the two-sided model thereafter. In the alternative, an ACO may elect to participate under the two-sided model from the start.

Termination From Program

An Accountable Care Organization may voluntarily terminate its participation in the Shared Savings Program, and may be subject to termination by CMS for failure to comply with applicable regulations. CMS may terminate an ACO based on the conduct of the ACO itself or on the conduct of any of its participants, providers, suppliers or contracted parties. For example, an ACO will be subject to termination if it attempts to exclude Medicare beneficiaries with high health care costs. The Centers for Medicare & Medicaid Services has discretion to take certain actions prior to termination, including providing the ACO with a warning notice or imposing a special monitoring plan. A terminated ACO must wait until the original three-year period expires before it reapplies to participate in the Shared Savings Program.

Additional Guidance

In an effort to provide a degree of flexibility for Accountable Care Organizations seeking to establish innovative models envisioned by the Shared Savings Program, several other federal agencies released much-awaited ACO guidance concurrently with CMS's release of the proposed ACO regulations. These include proposed waivers, jointly released by CMS and the Department of Health and Human Services Office of Inspector General, of several fraud and abuse laws that prohibit certain financial arrangements between physicians, hospitals, and other individuals and entities; Internal Revenue Service guidance for tax-exempt organizations participating in ACOs; and a proposed statement of antitrust enforcement policy from the Antitrust Division of the Department of Justice and the Federal Trade Commission describing the application of antitrust law to ACOs. All agencies welcome timely-submitted comments on their proposals. ■