

# HEALTH REFORM IMPACT

## What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### The ABCs of ACOs

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#### *Introduction*

In fewer than 21 months, a new program that has the potential to transform the current healthcare delivery system will take effect. Section 3022 of the Patient Protection and Affordable Care Act (“PPACA”) requires the creation of the Medicare “shared savings program,” which allows qualified groups of providers and suppliers to work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (ACO). ACOs that meet quality performance standards established by the Secretary will be eligible to receive payments for shared savings. The Secretary of Health and Human Services (the “Secretary”) must establish the shared savings program no later than January 1, 2012.

PPACA does not provide many details on forming ACOs or on what requirements will apply to ACOs. Obviously, implementing regulations will greatly impact the structure and function of ACOs and the benefits of establishing an ACO. For now, PPACA provides guidance on (1) what types of entities can form an ACO, and (2) what requirements must be met to receive payments.

#### *Details<sup>1</sup>*

The following groups of providers that have established a mechanism for shared governance are eligible to participate as ACOs: (1) “ACO professionals” (defined as physicians, physician assistants, nurse practitioners or clinical nurse specialists) in group practice arrangements; (2) networks of individual practices of ACO professionals; (3) partnerships or joint venture arrangements between hospitals and ACO professionals; (4) hospitals employing ACO professionals; and (5) other groups of providers of services and suppliers as the Secretary determines appropriate.

Each ACO must (1) become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it, (2) enter a three-year agreement to participate, (3) have a formal legal structure to receive and distribute shared savings payments, (4) have a sufficient

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<sup>1</sup> Portions of this section of our alert will also appear in an upcoming Member Briefing of the Regulation, Accreditation, and Payment (RAP) practice group of the American Health Lawyers Association.

number of primary care ACO professionals, (5) have a sufficient number of necessary ACO professionals, (6) have in place a leadership and management structure that includes clinical and administrative systems, (7) have defined processes to promote evidence-based medicine and patient engagement, to report on quality and cost measures, and to coordinate care, and (8) demonstrate that it meets patient-centeredness criteria specified by the Secretary.

The Secretary must establish quality performance standards for ACOs and over time will specify higher standards, new measures, or both in order to improve quality of care. The Secretary must also establish a method to assign fee-for-service beneficiaries to ACOs.

Participants will receive standard Part A and Part B payments, except that they may receive additional payments in the form of shared savings if the estimated average per capita Medicare expenditure under the ACO for Medicare fee-for-service beneficiaries is a specified percentage of a benchmark established by the Secretary using the most recent available three years of per-beneficiary expenditures (note that, under Section 10307, the Secretary has authority to develop alternative payment models, such as partial capitation models).

To combat potential abuse, the Secretary may apply sanctions if it determines an ACO has taken steps to avoid high-risk patients. Providers who participate in the ACO program may not receive payments under other Medicare shared savings programs. Additionally, under Section 10307 of PPACA, the Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

Finally, under Section 2706 of the PPACA, the Secretary must also establish the Pediatric Accountable Care Organization Demonstration Project no later than January 1, 2012, to authorize a participating state to allow pediatric medical providers that meet specified requirements to be recognized as an ACO for purposes of receiving incentive payments in the same manner as an ACO under Section 3022.

### *Implications*

Section 3022 does not create safe harbors or exceptions that address how ACOs will comply with the Anti-kickback Statute, the Stark Law, antitrust laws, the Civil Monetary Penalty Law prohibition on direct or indirect payments to physicians to reduce or limit services (which has been interpreted by the OIG to prohibit even payments that encourage physicians to reduce medically *unnecessary* care), or other restrictions. However, Section 3022 expressly permits the Secretary to waive requirements of the Anti-kickback Statute (and other provisions found at 42 USC § 1320a-7b), the Civil Monetary Penalties Law, and Title XVIII of the Social Security Act (which governs the Medicare program), including provisions of the Stark Law.

Although ACOs under federal law are a new concept, they have been discussed by various value-based purchasing advocates and the Medicare Payment Advisory Commission (MedPAC) prior to the enactment of PPACA. Some commentators have predicted that this new legislation will spur the private sector to develop programs promoting clinical integration using the federal definition of an ACO. Stay tuned for additional details regarding ACOs, including the resolution of key questions, such as how clinically integrated an organization must be to be to qualify as an ACO. If you have any questions about this alert, please contact any of the attorneys in our Healthcare Practice Group listed below.

Also, please [click here](#) to visit our special web page for Health Reform IMPACT.

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