Part I – Accountable Care Organizations (ACO's): Proposed Regulations

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Section 302 of the Affordable Care Act (ACA) includes provisions related to Medicare payments to providers of services and suppliers that participate in Accountable Care Organizations (ACO's). Providers of services and suppliers who participate in ACO's will continue to receive payments under Parts A and B of the Medicare Program, but will also be eligible for additional payments if they meet certain requirements related to quality of care and cost savings. The Secretary of the U.S. Department of Health and Human Services is required to establish ACO's no later then January 1, 2012.

Proposed regulations to implement these provisions are scheduled to be published in the Federal Register on April 7, 2011. Comments regarding the proposed regulations must be received by the Centers for Medicare and Medicaid Services (CMS) no later than sixty days after the date of publication.

This is the first in a series of articles about ACO's. Future articles will focus on antitrust, kickback and tax issues related to ACO's. We will also address the rights of patients assigned to ACO's to freedom of choice of providers, and what action post-acute providers should take regarding establishment of and participation in ACO's.

Based upon a review of an advance copy of the proposed regulations, they generally provide as follows:

- The ultimate goal of ACO's is to reward better value, outcomes, and innovations instead of just volume.

- The purposes of ACO's are to:
  - Promote accountability for a patient population,
  - Coordinate items and services under Parts A and B of the Medicare Program, and
  - Encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

- A key concept of ACO's is the "three-part aim" that includes:
  - Better care for individuals,
  - Better health for populations, and
  - Lower growth in expenditures.

- Groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for service beneficiaries through ACO's. ACO's that meet quality performance standards established by the Secretary will be eligible to receive payments for "shared savings."

- The following types of providers are eligible to participate in ACO's:
  - ACO professionals in group practice arrangements (ACO professionals include physicians, physicians' assistants (PA's), nurse practitioners (NP's), and clinical nurse specialists.)
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Such other groups of providers of services and suppliers as the Secretary determines appropriate

- Eligible groups of providers of services and suppliers must meet the following requirements in order to participate in ACO's:
  - ACO's must be willing to become accountable for the quality, cost, and overall care of at least 5,000 Medicare fee-for-service (FFS) beneficiaries assigned to it.
  - ACO's must enter into agreements with the Secretary to participate in the program for at least three years.
  - ACO's must have formal legal structures that allow receipt and distribution of payments for shared savings to participating providers of services and suppliers.
  - ACO's must include primary care ACO professionals that are sufficient for the number of Medicare beneficiaries assigned to the ACO, and ACO's must provide the Secretary with information about participating ACO professionals.
  - ACO's must put clinical and administrative systems in place and define processes to promote evidence-based medicine and patient engagement, to report on quality and cost measures, and to coordinate care; such as through the use of telehealth, remote patients monitoring, and other enabling technologies.
  - ACO's must demonstrate to the Secretary that they meet criteria related to "patient-centeredness," such as the use of patient and caregiver assessments and individualized care plans.

- Reports related to quality must address care transitions across health care settings, including post-hospital discharge planning and follow up by ACO professionals.

- ACO's will also be responsible for excess expenditures.

Stay tuned for additional, comprehensive information and analysis of ACO's!