LEGISLATIVE BRIEF

Health Care Reform: Accountable Care Organizations

The Patient Protection and Affordable Care Act (PPACA) includes provisions directed toward physicians, hospitals and other health care providers with the goal of improving the quality, safety and affordability of health care in the United States. Among other initiatives, PPACA created a Medicare Shared Savings Program to encourage health care providers to better coordinate care for Medicare patients and to establish more accountability for health care costs through the use of Accountable Care Organizations (ACOs). The new savings program is scheduled to be effective on **Jan. 1, 2012**.

On April 7, 2011, the Department of Health and Human Services (HHS) issued proposed regulations on ACOs under the Medicare Shared Savings Program. After receiving comments on the proposed regulations, HHS intends to issue a final rule before the end of 2011.

This Alan Benoy Insurance Services Legislative Brief provides an overview of key aspects of ACOs under PPACA's Medicare Shared Savings Program.

WHAT IS AN ACO?

In general, an ACO is a type of health care payment and delivery model where a network of health care providers shares responsibility for providing care to a group of patients. ACOs are patient-centered organizations, where patients and providers work together to make care decisions. Unlike health maintenance organizations (HMOs), ACO patients are not required to receive their care in-network.

The ACO concept has existed for many years, although interest in ACOs significantly increased after PPACA became law. Under PPACA's Medicare Shared Savings Program, an ACO is a group of providers and suppliers of health care services, including hospitals and physicians, that work together to coordinate and improve care for patients with original Medicare (not Medicare Advantage private health plans). The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of patient care.

An ACO must consist of the following types of providers and suppliers under shared governance:

- ACO professionals in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals; and
- Other Medicare providers and suppliers, as determined by HHS.

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WHAT IS THE PURPOSE OF AN ACO?

ACOs are designed to **improve care** for Medicare patients and **lower health care costs** by encouraging health care providers to work together to treat patients across health care settings. If ACOs save money by providing Medicare beneficiaries with the appropriate care (for example, by improving access to primary care to cut down on emergency room visits), Medicare will share those savings with the ACOs. It is projected that Medicare could potentially save as much as $960 million over three years through the use of ACOs.

WHAT STANDARDS MUST AN ACO MEET TO PARTICIPATE IN THE SAVINGS PROGRAM?

To participate in the Medicare Shared Savings Program, providers must join or form an ACO and apply to HHS. An existing ACO will not be automatically accepted to participate. Although PPACA encourages ACOs through shared savings, participation in ACOs is completely voluntary.

ACOs must meet the following requirements to participate in the Medicare Shared Savings Program:

- Agree to be accountable for the quality, cost and overall care of Medicare beneficiaries;
- Agree to participate in the program for at least a **three-year period**;
- Have a formal legal structure allowing the ACO to receive and distribute payments;
- Include enough primary care ACO professionals for at least **5,000 Medicare beneficiaries**;
- Provide HHS with information on ACO professionals, as appropriate;
- Have leadership and management in place to support clinical and administrative systems;
- Define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care through methods such as telehealth, remote patient monitoring and other enabling technologies; and
- Demonstrate to HHS that it meets patient-centered criteria, such as patient and caregiver assessments and individualized care plans.

HOW DOES THE SHARED SAVINGS PROGRAM WORK?

Under the Medicare Shared Savings Program, Medicare would continue to pay individual health care providers and suppliers in the same manner as they are currently paid under the original Medicare fee-for-service program. HHS will develop benchmarks for ACOs against which performance is measured to assess whether an ACO qualifies to receive shared savings, or will be held accountable for losses. An ACO that attempts to keep costs down by avoiding certain patients can be sanctioned by HHS, and HHS may terminate an ACO agreement if the ACO fails to meet quality performance standards.

Source: Department of Health and Human Services

This Alan Benoy Insurance Services Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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