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HEALTHCARE LAW PRACTICE GROUP NEWS REPORT

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THE ACCOUNTABLE CARE ORGANIZATION:

A Unique Approach to an Age-Old System

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The Department of Health and Senior Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS") released the much anticipated final regulations relating to Accountable Care Organizations ("ACOs") on October 20, 2011. These regulations simplify the language in the original proposal, create more attractive financial incentives for providers who elect to participate in ACOs and pave the way for more flexible entry into ACOs by providers and suppliers wishing to participate in the Medicare Shared Savings Program ("SSP"). The provider community is already taking notice.

By way of background, the Patient Protection and Affordable Care Act, or the health care reform law, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, enacted on March 30, 2010 (collectively, the "Affordable Care Act"), required the Secretary of the Department of Health and Human Services to establish the SSP and to promote the implementation of ACOs in Medicare by no later than January 1, 2012. A critical component of the health care reform system, the ACO is a group of healthcare providers (hospitals, physicians, etc.) who join together to deliver care to a defined patient population and to be "accountable" for advancing patient satisfaction and promoting superior medical care as efficiently as possible. Medicare recipients frequently rely on numerous physicians who work independently; by failing to communicate, these providers duplicate their efforts and require patients to furnish the same information repeatedly and to undergo unnecessary procedures and tests. This fragmented approach ultimately strains the payment system and offers no greater benefit to the patient. By contrast, the ACO requires medical providers to work together to deliver a high level of coordinated patient care, which will eliminate the provision of unnecessary services and produce a cost savings. The Affordable Care Act enables qualifying ACOs to receive a portion of the cost savings as a "bonus," provided that they meet certain benchmarks.

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Initially proposed by the HHS on March 31, 2011, the ACO regulations received significant criticism. The cost to enter an ACO was projected to be exorbitant and the criteria for participation was far too complicated. On balance, the anticipated rewards would not outweigh the costs and providers had no incentive to join the program. Initial interest in joining ACOs dwindled and the program lost momentum before it even started. Rather than moving ahead with ACO formation, providers waited for further direction that would (hopefully) address their concerns. In response to more than 1,300 comments, the final regulations reinvigorate the ACO program by providing for less stringent barriers to entry and performance measures and by offering more considerable financial incentives earlier.

Some of the key components of the final ACO regulations:

- Reduce the number of items necessary to evaluate the quality of care from 65 in the proposal to 33 measures in 4 domains (including patient experience; care coordination and patient safety; preventive health and at-risk populations). The change responds to numerous commenters who insisted that the original quality measures posed such an administrative burden that they discouraged provider participation.

- Create greater flexibility for provider groups to enter into an ACO arrangement by enabling them to select from two different risk models. Providers who select Track 1 for the initial 3-year contract period will not assume any downside risk in program participation and their shared savings percentage will be limited. Providers who select Track 2 (and who presumably have the risk tolerance or financial wherewithal to gamble somewhat) will assume financial risk in exchange for a more significant share of the savings. This is a significant departure from the proposed rule, which required all providers to assume risk immediately upon participation in an ACO.

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- Drastically modify the process for assigning beneficiaries to ACOs. Under the proposed rules, ACO providers ascertained which beneficiaries would participate in an ACO at the end of the performance year. CMS assigned beneficiaries based on where patients received a plurality of their primary care. Providers expressed concerns that they would be unable to effectively coordinate with one another and to develop a meaningful continuum of care, especially for beneficiaries suffering from chronic concerns. By contrast, under the final rule, ACOs will learn which beneficiaries will be assigned to them at the beginning of the year; CMS will deliver quarterly updates. CMS will initially assign beneficiaries based on where they have received services over the past 12 months, either from a primary care physician or from a specialist who renders primary care services. ACOs may provide beneficiaries with marketing and educational materials, which they must provide to the government for initial review within a limited time period. CMS will issue template marketing language.

- Eliminate the requirement that the governing body of an ACO must be proportionally controlled by ACO participants. They instead mandate that the governing body of an ACO must include representation of 75% of the ACO participants and a Medicare beneficiary.

Simultaneous with these final regulations, the Department of Justice and the Federal Trade Commission issued a policy statement providing advice on antitrust issues relative to ACOs and the IRS issued a fact sheet that addresses the participation of tax-exempt organizations in ACOs.

The health care industry anticipates that the momentum toward forming ACOs will increase considerably given these attractive new components. Additional interpretations and guidance will be issued on an ongoing basis. For questions about these guidelines or any aspect of the ACO program, please do not hesitate to contact our Health Care Law attorneys at Schenck, Price, Smith & King, LLP at **973-539-1000**.