On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS) published its long-anticipated proposed rule to govern Accountable Care Organization (ACO) participation in the Medicare Shared Savings Program. For health care providers, the Shared Savings Program is a key Medicare initiative to be implemented as a result of federal health care reform legislation adopted in 2010. The Shared Savings Program gives health care providers participating in ACOs an opportunity to receive payments from the Medicare program based on savings achieved as a result of the ACO’s management of Medicare beneficiary care. The recently proposed regulations outline CMS requirements for ACO participation in the Shared Savings Program and the requirements that must be met by the ACO to be eligible for shared savings payments.

Dedicated physician leadership, with the ability to motivate other ACO participants to implement quality and clinical management measures, will be essential to the success of ACOs under the Program. CMS envisions that ACOs will be provider-driven and is requiring significant participation of primary care physicians in every ACO. Primary care physicians should seek to take a leadership role in the formation and operation of ACOs, rather than having the terms of their participation in ACOs dictated to them.

By definition, ACOs are formal legal entities composed of health care providers working together, with shared governance and under one tax identification number, to manage and coordinate health care for Medicare beneficiaries, including coordination of the delivery of items and services under both Medicare Part A and Part B. The expectation is that the coordination of care among the various providers who treat Medicare beneficiaries will result in the transition of beneficiaries between health care providers more efficiently, eliminating duplicative care, resulting in beneficiaries receiving their care in the most appropriate setting, and leading to better overall care and outcomes. ACOs will be required to demonstrate improved quality of care in order to be eligible for payments under the Shared Savings Program.

Only certain providers are eligible to form ACOs under the Program, as follows:

- Physicians, physician assistants, nurse practitioners and/or clinical nurse specialists (hereinafter, “ACO Professionals”) in group practice arrangements;
- Networks of individual practices of ACO Professionals;
- Partnerships or joint venture arrangements between hospitals and ACO Professionals;
- Acute care hospitals employing ACO Professionals; and
- Other providers only as determined by the Secretary of Health and Human Services.

Hospital participation is not required to obtain ACO approval. However, hospitals will want to participate in ACOs. One of the goals of the Shared Savings Program is to reduce or eliminate costly inappropriate and/or preventable inpatient admissions. To counteract the impact of reduced admissions, Hospitals will need to grow their overall market share and may determine to do so through ACO participation.

While CMS considered whether rural health clinics (RAHs), federally qualified health center (FQHCs), and critical access hospitals (CAHs) would be permitted to participate, CMS concluded that the participation of RAHs and FQHCs could only be implemented in collaboration with other providers that are independently eligible to form an ACO and CAHs could only participate if they use
Agreement to become accountable criteria include the following:

(1) Agreement to participate in the Program for at least 3 years - ACO agreements will have a term of at least three years.

(2) Agreement to participate in the Program for at least 3 years - ACO agreements will have a term of at least three years.

(3) A legal structure which allows the ACO to have a term of at least three years. - ACO agreements will have a term of at least three years.

(4) Participation of a sufficient number of primary care providers for the number of Medicare FFS beneficiaries assigned to the ACO - CMS envisions that primary care physicians will be key participants in every ACO. A minimum of 5,000 assigned beneficiaries is required.

(5) Disclosure to the Program of information regarding participating ACO professionals, implementation of quality and reporting requirements, and determination of payments for shared services - The ACO will be required to implement processes to use for reporting on quality and cost measures. These may include adopting data management systems and physician level reminder systems. Indeed, data management systems will likely be a significant start-up cost for many ACOs.

(6) A leadership and management structure that includes both clinical and administrative systems - The ACO participants must share governance and be responsible for at least 75% of the governance of the ACO. Clinical management and oversight must be managed by a senior-level medical director who is a board-certified physician and there must be a physician-directed quality assurance and process improvement committee to oversee an ongoing quality assurance and improvement program.

(7) Defined processes to promote evidence-based medicine, report on quality and cost measures, and coordination of care - Under the current proposal, ACOs will have flexibility to choose the methods by which it will meet these requirements.

(8) Demonstration that the ACO meets specified patient-centeredness criteria, such as the use of patient and caregiver assessments on the use of individualized care plans - Patient-centeredness requires individualized care based on the patient's individualized needs, with beneficiaries informed and encouraged to make choices regarding the care they receive. Under the current proposal, the ACO will be required to have a Medicare beneficiary on its governing board.

Participating ACOs that meet the requirements of the Program and generate program savings, may obtain shared savings payments. Such payments would be in addition to the ordinary reimbursement paid by the Medicare program for the ACO's services. That is, under the current program, payments will continue to be made under Parts A and B of the original Medicare FFS program in the same manner as they would otherwise be made, but participating ACOs are eligible to receive payment for shared savings as well.

ACOs will receive shared savings payments only if the estimated average per capita Medicare expenditures, for Medicare FFS beneficiaries for Parts A and B services under the ACO, adjusted for beneficiary characteristics, are at least a specified percentage below an established benchmark.

CMS proposes to establish benchmarks at the start of the participation agreement based on beneficiaries that received a plurality of their primary care services from primary care physicians participating in the ACO in each of the prior three most recent available years. On the other hand, beneficiaries will be assigned to ACOs retrospectively, at the end of the applicable period, for purposes of determining cost savings, based on where they received their services during the agreement period.

While CMS believes that this approach will provide a relatively accurate reflection of the average population of Medicare FFS beneficiaries that receive their care from the ACO participants during the ACO agreement period, CMS acknowledges that the Medicare FFS population served by the ACO from year to year will change and some of the beneficiaries whose expenditures...
will be included in the benchmark with this approach would not be reflected in the population assigned to the ACO during the years of the ACO agreement period. To be successful under the Program, the ACO will have to treat all Medicare FFS beneficiaries as if they are assigned to the ACO.

CMS also acknowledges that this approach could create an unwanted incentive to seek and/or avoid specific beneficiaries during the ACO agreement period so that average expenditures would more likely be less than those of the historical beneficiaries included in the benchmark. To address this concern CMS proposes to monitor ACO activity. ACOs found to be avoiding certain high risk beneficiaries may be sanctioned and/or terminated from the Program.

CMS has proposed two models for ACO participation in the Shared Savings Program - i.e., a shared savings model (one-sided model) and a shared savings/losses model (two-sided model). Under this proposal, CMS would provide greater rewards in the form of higher sharing rates to ACOs that elect to participate in the two-sided model and accept shared risk for losses under the Program. At the same time, ACOs could enter the Program in the one-sided model and share only in savings in the first two years of participation.

These ACOs will be transitioned to a shared savings/losses model in the third year of participation. For less experienced ACOs, the one-sided model is more appropriate, as it gives the ACO the opportunity to test its ability to achieve savings, and make adjustments, before taking on risk for losses. Ultimately, the proposal outlines an ambitious program and it is unlikely that an ACO will achieve savings until care management becomes fully systemic to its operation.

Implementation of a final ACO rule is currently scheduled to take place on January 1, 2012. However, the proposed rule is subject to public comment and will not be finalized until later this year. Therefore, given the complexity of the rule, CMS may not be in a position to enter any ACO agreements as early as January 1, 2012.

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