

## **Reimbursing Based on Quality of Care: Federal Government Releases First Look At Accountable Care Organizations**

On June 8, 2010, the Centers for Medicare and Medicaid Services ("CMS") released an initial look at how it intends to implement Congress' mandate to change how healthcare services are reimbursed in this country. The Patient Protection and Affordable Care Act ("PPACA") calls for the creation of "Accountable Care Organizations" or "ACOs", which are groups or networks of physicians and hospitals that voluntarily agree to track quality of care benchmarks and patient outcomes in return for additional reimbursement from the federal government.

### **What is an "Accountable Care Organization"?**

An ACO is a physician group practice; a physician network; a partnership/joint venture between physicians and a hospital; or a group of hospital-employed physicians that agrees to be responsible for tracking the quality, cost and overall care received by Medicare beneficiaries who receive primary care services from providers of the ACO.

Among other statutory requirements, an ACO must:

- Have a formal legal structure to receive and distribute shared savings provided by the federal government;
- Have a sufficient number of primary care professionals treating a sufficient number of Medicare beneficiaries (i.e., 5,000 beneficiaries minimum);
- Agree to participate in the program for not less than 3 years; and
- Have sufficient structure, leadership and administrative processes to track quality and cost data and promote evidenced-based medicine.

### **What Are the Benefits of an ACO?**

If an ACO meets specified quality performance standards for a particular 12 month period, then it will receive a share of any cost savings of actual per capita expenditures for their patient population below a cost cap set by the federal government. This cost cap will be set separately for each ACO. It will reflect the acuity of the ACO's patient population, and it will be adjusted for growth in national per capita expenditures for all Medicare patients.

### **What Are the Quality Benchmarks?**

These are yet to be determined, but CMS intends to publish a proposed rule in the fall of 2010 which will identify these benchmarks.

### **Will ACOs be Penalized for NOT Meeting the Quality Benchmarks?**

No. The ACO will share in any cost savings if the quality benchmarks are met, but will not have their reimbursement cut if they fail to meet these standards.

If you have any questions or concerns about reimbursing based on quality of care, please contact [Bryant Witt](mailto:bcwitt@millermartin.com) at [bcwitt@millermartin.com](mailto:bcwitt@millermartin.com), or any other member of Miller & Martin's [Health Care Practice Group](#).

*The opinions expressed in this bulletin are intended for general guidance only. They are not intended as recommendations for specific situations. As always, readers should consult a qualified attorney for specific legal guidance. Should you need assistance from a Miller & Martin attorney, please call 1-800-275-7303.*

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