Accountable Care Organizations: Scrambling to Get Ready Now

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There's a scramble going on in cities all across the country as physicians, hospitals and other providers organize themselves into "accountable care organizations" in order to capture future financial rewards.

What is an ACO? An accountable care organization (ACO) is essentially a provider network, made up of independent practice groups and hospitals. But while those practice groups and hospitals are legally separate, they are also "clinically integrated," that is, sharing patient care data, establishing common treatment protocols and committed to work toward common quality benchmarks. Internally, an ACO distributes money to individual providers in its network at least in part based on their achievement of quality targets.

To qualify for Medicare purposes, an ACO must provide primary care (and optionally other types of medical care) for a minimum of 5,000 Medicare beneficiaries, for at least three years.

Financial Rewards for ACOs. No later than January 2012, Medicare is required by statute to enter into "shared savings program" contracts with ACOs across the country. Under these programs, ACOs will share in the benefit from the cost savings they achieve for the Medicare program, while still meeting statistical quality objectives. The way an ACO is expected to generate Medicare savings is through better care coordination, fewer procedures and (especially) fewer hospital admissions. The more efficient and high quality the care, the greater the financial reward for individual ACO participants.

Over time, ACOs are expected to become Medicare's preferred contract vehicle. Other private payers like insurance companies likewise may favor contracting with organized ACO networks rather than individual providers.

While it's impossible to predict exact numbers, the financial rewards for participating in a successful ACO could be very large. An important key to that success will be for an ACO to choose its provider partners carefully.

Why hurry? There are a large number of regulatory details that need to be worked out between now and January 2012 concerning ACOs. Those details will directly affect the rewards of ACO participation.

Ordinarily, a lack of regulatory clarity might suggest that delay is appropriate before organizing or joining an ACO. On the other hand, there are competitive pressure reasons not to wait. The 2010 health reform law that created the Medicare shared savings program also appears to limit each physician (or other

provider) to participating in only one shared-savings ACO (see new §1899(b)(4)). This one-ACO rule creates an incentive on the part of an ACO network to get physician practices contractually committed to participating as soon as possible, before they join another ACO. On the other hand, practice groups likewise do not want to wait too long to join an ACO network, lest a desirable ACO network withdraw its invitation to join. Further, ACO networks who are awarded a shared-savings contract in Medicare's initial 2012 round of contracting will likely to hold those contracts for three years. The competitive multi-party negotiating dynamic could be very interesting.

There are many regulatory details still to be worked out with respect to ACOs, including antitrust issues and risks under the federal antikickback statute. But there is little doubt that these details will be resolved favorably by regulators, who are committed to helping ACOs succeed.

ACOs are coming soon, not only for Medicare but also for private payers. Their future impact on the overall health care market prove to be enormous.

Next Steps. Providers and hospitals around the country are already hard at work designing and organizing ACOs, getting ready for January 2012. ACOs need to be legally organized and ready to operate on time to participate in the first round of contracts. Hospital systems in Michigan, including St. John Providence, University of Michigan and Oakwood Healthcare, have disclosed that they are working hard to organize ACOs for the physicians on their medical staffs. But physicians can also organize their own independent ACOs.

As they organize, ACOs will need to decide on a multitude of issues. How will decision making take place within the ACO? Which provider groups should be invited to participate in the ACO, and which should not? Who would contribute most to an ACO's overall quality and efficiency? How will the member groups in an ACO become clinically integrated?

Reciprocally, practice groups need to ask a number of evaluative questions before leaping to join an ACO. Who else is in the ACO that makes it likely that the network will succeed financially? How can a group get out of the ACO if it turns out that the ACO does not function effectively? How are the rights of ACO groups and individual providers protected?

Over the next few months, there will be much activity regarding ACOS. On one hand, Medicare is continuing to clarify the rewards and requirements for ACOs. On the other hand, hospitals and provider groups simultaneously organize themselves to take advantage of this new opportunity. All of the private providers need to carefully consider the contracts they are committing to, and what the long-term implications of those contracts might be.

If you have questions about ACOs or want assistance negotiating the terms of ACO membership, feel free to contact Richard Bouma (rbouma@wnj.com or 616.752.2159) or another attorney in the Warner Norcross & Judd Health Law Group.