Proposed Rules Regarding Accountable Care Organizations

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Interested healthcare organizations, physician groups and others have until June 6 to comment on proposed new rules that will guide the creation and oversight of Accountable Care Organizations, or ACOs.

On March 31, the Centers for Medicare and Medicaid Services released its highly anticipated proposed rule regarding the Medicare Shared Savings Program under the Patient Protection and Affordable Care Act. One of the key components of the program is the ACO model of health care delivery. Under the proposed regulations, ACOs are clinically integrated provider organizations that agree to be accountable for achieving savings and quality benchmarks for at least 5,000 Medicare fee-for-service enrollees for three years and to share in savings if these thresholds are met.

To participate, the ACO must be a legal entity under state law, such as a corporation, partnership, limited liability company or a foundation. The proposed rule only permits the following groups to participate in an ACO:
• 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
• Certain critical access hospitals

To qualify, the ACO must be capable of receiving and distributing shared savings; repaying shared losses; and establishing, reporting and ensuring ACO participant and provider compliance with program requirements and quality standards.

CMS proposes that an ACO choose one of two risk models. The one-sided risk model that allows an ACO to pursue fee-for-service Medicare payment and to share in the savings for the first two years, and assume risk for shared losses in the third year. The two-sided risk model requires ACOs to share savings and losses for all three years. Under both models, ACOs will have to exceed a savings benchmark and also perform above certain quality measures in order to receive shared savings payments.

The ACO must have a mechanism for shared governance that allows for “proportionate” control by ACO participants, giving each participant a voice in decision-making process. ACO participants must have at least 75 percent control of the ACO’s governing body. Additionally, the ACO must demonstrate a partnership with community stakeholders and Medicare beneficiaries through representation on its governing board.

ACOs must have a sufficient number of primary care professionals to care for the 5,000 Medicare beneficiaries assigned to it each year. Beneficiaries are assigned on a retrospective basis – based on the primary care physician from whom they receive a plurality of primary care services during the performance year. This means the ACO will not know which beneficiaries it is accountable for until the end of the performance year.

The ACO must demonstrate how it will implement processes to promote evidence-based medicine, patient engagement, and coordination of care, processes to report quality and cost measures, and a number of specific operational requirements designed to promote "patient-centeredness."

Many believe that the proposed regulations provide a framework for ACOs that is cost-prohibitive for most health care providers. Additionally, the potential benefit of shared savings is outweighed by the sheer volume of bureaucratic requirements, lack of beneficiary accountability, and uncertainty with regard to risk. For these reasons, industry stakeholders should provide comments to CMS to address these concerns and to participate in the development of an ACO framework that is attractive to providers.

If you are interested in learning more about ACOs or providing comments to CMS, please contact Cara Jansma at cjansma@wnj.com or 616.752.2193.