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Accountable Care Organizations

By Heman A. Marshall, III, Esq. and Christine F. Underwood, Esq.

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Health Care Group Update

Under the Patient Protection and Affordable Care Act ("PPACA"), no later than January 1, 2012, the Department of Health and Human Services ("HHS") is required to establish a "shared savings program" which promotes "accountability for a patient population and coordinates items and services under [Medicare] Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery." Groups of providers meeting criteria established by HHS, known as accountable care organizations ("ACO's"), will be eligible for certain payments as part of this program.

Who Can Qualify as an ACO?

The following groups of providers and suppliers, if they have established a mechanism for shared governance, are generally eligible to participate as ACO's:

- ACO professionals (i.e., physicians and other professionals recognized under the Medicare program) 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; and
- Such other groups of providers and suppliers as the Secretary deems appropriate.

What are the Criteria?

Once an appropriate structure is established, the ACO must meet the following requirements to be eligible for participation in the shared savings program:

- Be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it;
- Agree to participate in the program for a minimum of three (3) years;
- Have a formal legal structure that would allow the ACO to receive and distribute shared savings payments;
- Include primary care ACO professionals in a sufficient number to manage the Medicare beneficiaries assigned to the ACO (each ACO shall be assigned at least 5,000 Medicare beneficiaries);
- Provide HHS with information regarding its participating professionals to support the assignment of beneficiaries, the implementation of quality and other reporting requirements, and the determination of shared savings payments;
- Have a leadership and management structure that includes clinical and administrative systems;
- Define processes to promote evidence-based medicine, patient involvement, report on quality and cost measures, and coordinate care; and
- Demonstrate to HHS that it meets "patient-centeredness" criteria, such as the use of patient and caregiver assessments or the use of individualized care-plans.

ACO's will also be required to report data to HHS to allow for evaluation of the quality of care furnished by the ACO. Such data may

include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up. HHS may also require additional reporting similar to, or in conjunction with, that associated with the Physician Quality Reporting Initiative ("PQRI") which may include data related to electronic prescribing and electronic health records. ACO's will also be expected to meet certain quality performance standards to be established by HHS.

Should I Consider Forming or Joining an ACO?

On paper, ACO's sound like a beneficial way for physicians and other providers to increase revenue while working to ensure a higher quality of care. In practice, ACO's may do just that, but a lot of questions remain as to how the program will be implemented to ensure benefits to both providers and beneficiaries. Until HHS, and other organizations, provide additional details, providers should proceed cautiously. Some lingering questions remain.

How Will Medicare Beneficiaries Be Assigned to ACO's?

PPACA simply states that HHS shall determine an "appropriate method" to assign beneficiaries to an ACO based on their utilization of primary care services. Significant questions remain as to how beneficiaries will be assigned to ensure fairness to both the beneficiary and the ACO. ACO's will be responsible for meeting certain benchmarks with regard to the care provided, but what if the beneficiary is free to seek care from other than ACO members? What if the beneficiary spends six months of the year in a different geographic location? Clearly, a lot of consideration needs to be given to this issue to determine the most "appropriate method" for assignment of beneficiaries to a particular ACO.

What About Antitrust, Stark, Anti-Kickback and CMP Issues?

Fortunately, these issues are already the topic of discussion. On October 5, 2010, representatives of the Federal Trade Commission ("FTC"), Centers for Medicare and Medicaid Services ("CMS"), and Office of Inspector General ("OIG") co-hosted a workshop on issues associated with ACO's, including those implicated by antitrust, Stark, anti-kickback and civil monetary penalties laws. The workshop provided a forum for providers and other interested parties to express ideas and concerns about how to handle many of these issues. Comments from the workshop indicate that regulators recognize the need for further discussion and flexibility as regards implementation of ACO's.

FTC Chair, John Leibowitz was previously quoted at the AMA Annual Meeting in June as stating, "[i]f you join together to improve patient care and lower costs, not only will we leave you alone, we'll applaud you...and we'll do everything we can to help you put together a plan that avoids antitrust pitfalls." PPACA grants HHS certain authority to waive restrictions under Stark, anti-kickback and civil monetary penalties ("CMP") laws for approved payment arrangements. Further, HHS could create additional statutory exceptions for certain arrangements or draft specific regulatory guidance applicable to ACO's.

Lewis Morris, Chief Counsel for the OIG, has noted that, "[a]s these new models develop in the health care market, the existing fraud and abuse laws will remain important fraud fighting tools. However, some new arrangements may require new approaches to combating fraud, waste, and abuse." While it appears that, on the federal level, regulators are recognizing the need for certain amounts of flexibility as regards ACO's, no such discussions appear to be happening at the state level, which may also be necessary to ensure the successful development of ACO's.

While there is much to still be settled as regards ACO's, it is not too early for providers to gain familiarity with the basic concepts and requirements, make initial assessments as to whether participation in an ACO may be beneficial, and to keep a watchful eye on further developments.

Health Care Group:

Agnis Chakravorty
chakravorty@woodsrogers.com
540.983.7727

Michael Cole
mcole@woodsrogers.com
434.797.8205

H. Allen Glover, Jr.
glover@woodsrogers.com
540.983.7636

Alton L. Knighton, Jr.
knighton@woodsrogers.com
540.983.7632

Heman A. Marshall, III, Chair
marshall@woodsrogers.com
540.983.7654

Thomas T. Palmer
palmer@woodsrogers.com
540.983.7686

Elizabeth G. Perrow
eperrow@woodsrogers.com
540.983.7707

Christopher W. Stevens
cstevens@woodsrogers.com
540.983.7538

Christine F. Underwood
cunderwood@woodsrogers.com
540.983.7512

Dudley F. Woody
woody@woodsrogers.com
540.983.7683