

HEALTH LAW UPDATE

June 10, 2010

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CMS SHARES THOUGHTS ON ACOs AND SHARED SAVINGS PROGRAMS

PPACA established several demonstration programs to test and evaluate new Medicare healthcare delivery and payment models. This effort is designed to not only improve care coordination and quality, but also to reduce the rate of healthcare spending growth. These demonstration projects, which are part of the Shared Savings section of PPACA, include bundled payments, accountable care organizations (ACOs) and the patient-centered medical home. In addition to the delivery models specifically identified, PPACA also established a new Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) that can test other care models -- giving the U.S. Department of Health and Human Services (HHS) the authority to expand the scope and duration of the new models, including the authority to implement them nationwide.

An ACO is an organization of healthcare providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries enrolled in the traditional fee-for-service program who are assigned to it. CMS recently issued a [Q&A addressing ACOs](#). The Q&A generally reiterates PPACA with respect to how an organization can qualify as an ACO. However, the Q&A also clarifies several points not addressed in the statute. These include:

- Medicare beneficiaries will not have access reduced by ACOs. CMS stated that for purposes of an ACO "assigned" means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services and that it will not affect their guaranteed benefits or choice of doctor.
- Regulations will be proposed in the fall.
- ACOs meeting specified quality performance standards will be eligible to receive a share of the savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary of HHS and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.
- ACOs will not be penalized if quality targets are not achieved.

Baker Hostetler is currently working with several clients on the development of ACOs and on various integration strategies that may be used in developing an ACO in the future. Over the next several issues of the *Health Law Update*, we will take a closer look at each of the shared savings opportunities and how healthcare providers can be best positioned to maximize opportunities under the shared savings programs.

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