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CLIENT ADVISORY

Health Reform Act: Should You Form an Accountable Care Organization?

The Patient Protection and Affordable Care Act (the "Act") includes provisions that will allow hospitals, physicians and certain other entities to increase their Medicare reimbursement by establishing "accountable care organizations" ("ACOs"). Section 3022 of the Act contemplates that providers who participate in an ACO would continue to receive their typical Medicare payments, but would also be eligible for bonus payments if the ACO met certain standards for quality and cost savings. Under the Act, the Department of Health and Human Services ("HHS") is required to establish this program by January 1, 2012.

Who can form or join an ACO?

ACOs can be formed or joined by physicians, networks of individual providers, hospitals that employ physicians, and partnerships or joint ventures between hospitals and physicians (e.g. a PHO).

What are the standards for an ACO and how can an ACO improve a provider's Medicare reimbursement?

There are several standards that an ACO must meet in order to qualify for additional Medicare reimbursement. In order to participate in the program, an ACO must enter into an agreement with HHS to be responsible for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO, and must agree to participate in the program for at least 3 years. The ACO must include a sufficient number of primary care providers to care for Medicare beneficiaries assigned to the ACO, and specifically must have at least 5,000 Medicare beneficiaries assigned to it in order to be eligible for the shared savings program. Among other requirements, the ACO must:

(1) have a formal legal structure that allows the ACO to receive and distribute payments for shared savings to its participants;
(2) have in place a leadership and management structure that includes clinical and administrative systems; and
(3) define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.

The Act provides for the Secretary of HHS to establish quality performance standards, and if the ACO meets those criteria and the average per capita Medicare expenditures for the Medicare beneficiaries assigned to the ACO are sufficiently less than projected per capita Medicare expenditures, the ACO would be eligible for a bonus payment. The Act provides for all of these calculations to take into account the individual characteristics of the beneficiaries involved, so that ACOs do not lose potential benefits just because the ACO provides care for at-risk patients. The exact benchmarks for minimum savings and the calculations for bonus payments would depend on future regulations.

Section 10307 of the Act provides that the Secretary of HHS may

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instead offer partial capitation models and other payment models, rather than offering typical Medicare reimbursement and a bonus to ACOs.

Between now and January 1, 2012, HHS is required to issue additional regulations clarifying details for the program. In the interim, hospitals and physicians should continue to consider opportunities for further integration, carefully assess whether establishment of an ACO is worthwhile, and if so, begin the groundwork that will be necessary to participate in the shared savings program in 2012.

If you have any questions or for more information about the Act or ACOs, please contact Jim Daniel, Bill Hall, Mike Newby, or Mark Watson at (866) 967-9604 or by email at: jdaniel@hdjn.com, bhall@hdjn.com, mnewby@hdjn.com, or mwatson@hdjn.com. Additional information about Hancock, Daniel, Johnson & Nagle is available on the firm's website at www.hdjn.com.

Richmond 4701 Cox Road Suite 400 Glen Allen, VA 23060 PO Box 72050 Richmond, VA 23255-2050 O (804) 967-9604	Fairfax 3975 Fair Ridge Road Suite 475 South Fairfax, VA 22033 O (703) 591-3440
Harrisonburg 3210 Peoples Drive Harrisonburg, VA 22801 O (866) 967-9604	Virginia Beach One Columbus Center 283 Constitution Drive Suite 301 Virginia Beach, VA 23462 O (757) 321-6555
Lewisburg, WV 210 West Randolph Street Lewisburg, WV 24901 O (866) 967-9604	Franklin, TN 725 Cool Springs Blvd. Suite 600 Franklin, TN 37067 O (866) 967-9604