The Regulations are coming! Ten things that we already know about Accountable Care Organizations.

If the rumors are true, tomorrow the Centers for Medicare and Medicaid Services, the Office of the Inspector General and the Federal Trade Commission will be releasing voluminous regulations governing the formation of Accountable Care Organizations ("ACO") and the Medicare Shared Savings Program. But before we receive all the minutiae of the regulations, we wanted to provide a brief overview of what is already known about ACOs.

1. The purposes of ACOs are to: (1) facilitate coordination and cooperation, (2) improve the quality of care and (3) reduce unnecessary costs.
2. ACOs were created by the Affordable Care Act, which was signed by President Obama approximately one year ago.
3. In order to be an ACO, providers will have to develop a formal legal structure to receive and distribute the shared savings that are at the heart of the ACO program.
4. ACOs will have to affiliate with enough primary care providers for a minimum of 5,000 beneficiaries and will need to agree to participate in the program for a minimum of three years.
5. As this system will be based on data and evidenced-based medicine, ACOs will be required to have processes in place to "(a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures" and " (c) coordinate care."
6. ACOs must be able to demonstrate patient-centered criteria. However, we will have to wait for the regulations to determine how CMS defines "patient-centeredness".

7. Patient experience will be one of the quality measures included in the program, along with patient outcomes and utilization.
8. ACOs will be able to be formed using a variety of different business models. The statute specifies the group practices, networks of practices, joint ventures between hospitals and physicians and hospitals employing physicians will all be acceptable and it is possible, through the regulations, that the Secretary will bless other business models. In crafting a business model, state-specific issues (such as corporate practice of medicine and possibly insurance regulations) will likely play a role.
9. ACOs will have to be structured to comply with the Stark law, the Anti-Kickback Statute, existing Medicare rules as well as state fraud & abuse laws (corporate practice of medicine, fee-splitting, etc.) While there may be some new exceptions and safe harbors created, ACOs are not going to be given carte blanche to disregard existing fraud and abuse laws.
10. The anticipated start date of the program is January 1, 2012 and providers that are appropriately structured can enroll in ACOs after that date.

It is important for providers to understand that significant time and money will go into establishing an ACO and there is no guarantee that the shared savings will lead to a recoupment of these start-up costs. However, ACOs, along with several other new payment models that will be tested as part of the Affordable Care Act, may allow providers to share in savings achieved through coordination of care and increased use of quality data.

Please stay tuned for future articles and blog entries about Affordable Care Organizations once the regulations are published. If you have any questions regarding Affordable Care Organizations, please contact Andrew Wachler, Amy Fehn or Alicia Chandler.