Ten Facts That Anesthesiologists Should Know About Medicare Accountable Care Organizations (ACOs)

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1. Medicare Accountable Care Organizations (ACOs) Are A Product Of Federal Healthcare Reform Legislation.

By now, to a greater or lesser extent, most healthcare providers have at least a basic understanding of the recent and broad sweeping federal healthcare reform legislation commonly known as the Patient Protection and Affordable Care Act ("PPACA"). PPACA was enacted on March 23, 2010 and then amended by the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 30, 2010.

One aspect of federal healthcare reform eliciting significant interest among healthcare providers is PPACA's Medicare Shared Savings Program, under which ACOs that meet certain quality performance standards will be eligible to receive Medicare shared savings payments. PPACA requires the Secretary of the United States Department of Health and Human Services (the "Secretary") to establish the Medicare Shared Savings Program no later than January 1, 2012.

2. ACOs Will Be Eligible For Financial Incentives (Enhanced Reimbursement) Based Upon The Quality And Efficiency Of Care Provided To Their Patients.

Under the Medicare Shared Savings Program, physicians and other professionals (including without

limitation physician assistants, nurse practitioners, certified registered nurse anesthetists, clinical social workers and clinical psychologists) manage and coordinate the care of Medicare fee-for-service beneficiaries in a multi-disciplinary manner through ACOs. ACOs that meet certain quality performance criteria, which will be established by the Secretary, will be eligible to participate in the resulting Medicare savings.

The quality performance standards will measure clinical processes and outcomes, patient and caregiver experience, and utilization. As time goes on, the quality performance standards will become increasingly stringent as the Secretary will continuously impose higher standards and/or additional benchmarks that will need to be achieved in order to participate in the shared savings.

It is important to note that the payments through the Medicare Shared Savings Program are enhancements to the otherwise available Medicare reimbursement. The ACO physicians and other professionals will continue to receive payment under part A and part B of the Medicare fee-for-service program in the same manner as they would otherwise. ACOs will not be penalized if quality benchmarks are not attained. That being said, the Secretary will have the ability to terminate ACOs that do not satisfy such quality standards.

3. ACOs Will Not Be Permitted To Directly Choose The Patients For Which They Are Accountable.

PPACA provides that each ACO will be assigned at least five thousand (5,000) Medicare fee-for-service beneficiaries based upon those beneficiaries' utilization of primary care physicians (i.e., beneficiaries that receive services from the ACO's primary care physicians). Assignments will be made through a method that will be determined by the Secretary. ACOs will be prohibited from taking steps to avoid at-risk patients that are likely to negatively impact the ACO's receipt of shared savings.

4. Primary Care Physicians Will Play An Integral Role In Each ACO.

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PPACA promotes the adoption of patient-centered "medical homes" to achieve improved quality of care through coordination of care. As stated above, each ACO will be assigned Medicare fee-for-service beneficiaries based upon those beneficiaries' primary care physicians. Since assignment of patients to an ACO is based upon the primary care physicians participating in the ACO, it is anticipated that, as a practical matter, primary care physicians will be required to have a relationship with only one ACO and will have substantial influence within the their respective ACOs. In contrast, anesthesiologists and other specialists will probably have more flexibility to belong to additional ACOs.

5. Those ACOs That Retain Patients And Refer Patients Within Their ACO Network Will Have The Greatest Opportunity For Success.

It is noteworthy that, although ACOs will be responsible for the care of their assigned beneficiaries, Medicare beneficiaries will be able to choose their healthcare providers even if such providers do not participate in the ACO to which the Medicare beneficiaries are assigned. Thus, ACOs are accountable for achieving quality of care goals without having the ability to necessarily control whether those goals are achieved. There will certainly be an incentive for ACO physicians to refer patients to other physicians within their own ACO. Legal counsel for the ACOs will be challenged to think creatively while acting within a legally defensible framework to structure permissible patient and physician incentives that promote the objectives of the ACOs.

6. ACOs Must Satisfy Numerous Eligibility Requirements In Order To Participate In The Medicare Shared Savings Program.

PPACA mandates that each ACO shall:

- Be willing to be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it;
- Enter an agreement with the Secretary to participate in the Medicare Shared Savings Program for at least three (3) years;
- Have a legal structure that enables it to receive and distribute shared savings;
- Have a sufficient number of primary care professionals for the number of beneficiaries assigned;
- Provide (and have the necessary information technology infrastructure to provide) the Secretary with the information that the Secretary requires in connection with assignment of beneficiaries, implementation of quality standards, and determination of shared savings payments;
- Maintain a management structure that includes clinical and administrative systems;
- Adopt processes to promote evidence based medicine and patient engagement, report on quality and cost measures, and coordinate care; and
- Demonstrate to the Secretary that it meets patient-centered criteria.

As mentioned above, the Secretary will promulgate regulations to refine each of these broad and amorphous requirements. The proposed regulations are expected to be published during Fall 2010.

7. Healthcare Providers Have Substantial Flexibility When Structuring Their ACOs.

PPACA specifically provides that each of the following types of organizations can become an ACO, assuming that they have shared governance and that they satisfy the additional criteria that will be adopted by the Secretary:

- Physicians and other professionals in group practices;
- Physicians and other professionals in networks of practices;
- Partnerships or joint venture arrangements between hospitals and physicians and/or other professionals (e.g., physician – hospital organizations);
- Hospital employing physicians and other professionals; and
- Other groups of providers of services and suppliers as the Secretary determines appropriate.

The various types of models can be conceptualized as highly integrated models (e.g., hospital employment and group practices), models with limited integration (e.g., joint venture, physician organization (PO) and physician hospital organization (PHO) models), and

contractual models (e.g., management services and service line models).

8. The Ability To Efficiently And Effectively Share Information Will Be Key To The Success Of Any ACO.

As a condition of receiving Medicare shared savings payments, ACOs will need to submit information to the Secretary that is necessary to determine the quality of care furnished by the ACO. Each ACO will need to have the information technology and other electronic health record ("EHR") infrastructure in place to maintain, share, retrieve and report meaningful and usable data. It is expected that many ACOs will find that this can be achieved only through the use of health information exchanges. It is interesting to note that this ACO requirement relating to use of EHR dovetails with the Medicare and Medicaid incentive payments that will be available to certain health providers that adopt EHRs and achieve certain specified objectives.

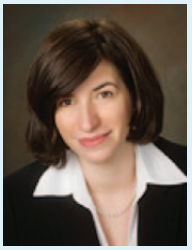
9. ACOs Will Serve As A Catalyst For Further Integration Among Healthcare Providers.

In order to achieve the clinical and administrative coordination and sharing of information that will be necessary to the success of ACOs, physicians, hospitals and other professionals will need to integrate (both clinically and either corporately or contractually) but within the constraints of applicable law. Significant bodies of federal and state law impose numerous barriers to integration among healthcare providers, including without limitation the federal Anti-Kickback Statute, the federal Stark Law, and the federal Civil Monetary Penalty Law (all of which are designed to prevent fraud and abuse with respect to the federal healthcare programs), federal tax exempt laws (prohibiting, for example, impermissible benefits to private individuals), the federal and state patient privacy laws, including without limitation the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") (setting forth standards for the security and privacy of patient information) and the state corporate practice of medicine doctrines (adopted, in part, to preserve the unique attributes of the physician-patient relationship). Furthermore, ACOs will need to be designed with sensitivity towards the federal antitrust laws, which are designed to encourage competition and limit market concentration. Many experts envision progressive changes in many of these substantive areas of the law as governmental authorities attempt to reconcile the tensions created between current legal requirements and the integration required to operate a successful ACO.

10. The Healthcare Community Is Currently Preparing For Future Participation In The Medicare Shared Savings Program Through ACOs.

As of today, there are many uncertainties surrounding the requirements that ACOs will need to satisfy in order to receive payments under the Medicare Shared Savings Program. While the Centers for Medicare & Medicaid Services ("CMS") has published certain ACO guidance on its website titled "Preliminary Questions & Answers" and has held a Special Open Door Forum regarding the Medicare Shared Savings Program, health care providers are anxiously awaiting additional information. Some of our unanswered questions will certainly be addressed during the upcoming ACO workshop that will be hosted on October 5, 2010 by the Federal Trade Commission, the U.S. Department of Health and Human Services' Office of Inspector General and CMS. Furthermore, additional guidance will be provided through CMS's Notice of Proposed Rulemaking regarding this program, which is expected to be published during fall 2010.

Notwithstanding this current state of affairs, many providers are wisely looking beyond the basic contours of the proposed Medicare Shared Savings Program and developing strategies to prepare for its future implications. More specifically, groups of physicians, hospitals, and other providers are developing structures and relationships that will allow them to transform themselves into ACOs upon the commencement of the Medicare Shared Savings Program. This proactive approach is advisable considering the substantial time and monetary resources that will be required in order to effectively organize most ACOs.



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