How to Build an ACO

Medicare's shared savings program includes specific structural and governance requirements

By Craig H. Smith

While the U.S. Supreme Court is contemplating the constitutionality of the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services is moving forward with implementing one of the ACA's most intriguing offerings: the new Medicare Shared Savings Program for accountable care organizations.

Participating ACOs that meet certain goals over three years can receive additional Medicare reimbursement under a shared savings formula. To participate, however, each ACO entity must have its own tax identification number and be "provider-driven" with an established mechanism for shared governance. CMS began accepting the first round of applications from ACOs in January, and those selected are scheduled to begin participating in the program in April.

But how must these ACOs be structured, and what does shared governance of an ACO really mean? On Oct. 20, CMS issued the final rule that answers these and other important questions.

ACO Structure

Each shared savings program ACO must be an entity established in accordance with state, federal or tribal law and be "capable of: (1) receiving and distributing shared savings; (2) repaying shared losses or other monies determined to be owed to CMS; (3) establishing, reporting and ensuring provider compliance with program requirements; and (4) performing the other ACO functions identified in the statute." In other words, corporations, limited liability companies and partnerships are permissible business structures, provided that the ACO entity has its own tax identification number.

ACO applicants must describe how they will establish and maintain an ongoing quality assurance and improvement program led by an appropriately qualified health care professional.

What is Shared Governance?

An ACO seeking to participate in the shared savings program must have a governing body that is at least 75 percent controlled by direct health care providers such as hospitals, physicians, physician assistants, and other qualifying providers and suppliers. Each ACO also must have at least one Medicare beneficiary representative on its governing body. This leaves open the possibility for less than 25 percent of an ACO's governing body to be represented by non-providers such as health plans, health care technology companies or management firms, or in the case of a nonprofit organization, individual trustees from the community.

Each ACO's operations must "be managed by an executive, officer, manager or general partner whose appointment and removal are under the control of the organization's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes and outcomes." Further, each ACO's clinical management and oversight functions must be managed by a senior-level medical director who is one of the ACO's participating physicians, and that physician must be board-certified and licensed to practice medicine in one of the states in which the ACO operates.

ACO applicants must describe how they will establish and maintain an ongoing quality assurance and improvement program led by an appropriately qualified health care professional. The ACO's quality assurance program need not be physician-led, however, because CMS was persuaded that "many existing and successful quality improvement efforts are not physician-led."

An ACO that cannot meet certain requirements still might be able to participate if it satisfactorily demonstrates to CMS that it has developed "innovative" alternative approaches to assure the ACO will accomplish its mission under the shared savings pro-

gram. For example, an ACO that does not have a Medicare beneficiary on its governing body must satisfy CMS that Medicare beneficiaries nevertheless will have meaningful participation in the ACO's governance — perhaps with significant roles in ACO subcommittees or advisory boards.

Every ACO must adopt a compliance plan, designate a compliance officer (who cannot be the organization's legal counsel) and incorporate operational mechanisms to help the ACO promptly identify and address potential compliance issues.

Governing Body Functions

The ACO's governing body must "provide oversight and strategic direction, holding management accountable" for meeting the ACO's goals. That oversight includes "not only care delivery, but also processes to promote evidence-based medicine, patient engagement, reporting on quality and cost, care coordination, distribution of shared savings, establishing clinical and administrative systems, among other functions." Further, if an ACO wishes to obtain special waivers from potential liability for any particular business arrangement under the Physician Self-Referral Law (i.e., the Stark Law), the federal anti-kickback statute and certain civil monetary penalties, the ACO's governing body must make a bona fide determination that the arrangement for which waiver protection is sought is reasonably related to the purposes of the shared savings program and that the governing body duly authorizes the arrangement.

Large System Participation

CMS has decided that a large health system with one tax identification program for the entire organization will be permitted to participate in an ACO only if all parts of that health system participate. Conversely, large health systems that extend over several states can choose to participate in more than one ACO only if they have multiple tax identification numbers.

Potential Rewards

The health care field has significant experience with many of the governance and compliance requirements CMS expects of shared savings program ACOs. But will ACOs comprising different types of health care providers that provide Medicare beneficiaries with a meaningful role in governance work well together to accomplish the goals of the shared savings program? Those who can do so successfully could see improved patient outcomes and financial rewards for their efforts. **T**

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