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ACOs DEFINED

Accountable Care Organizations ("ACOs") are groups of doctors, hospitals, and other health care providers, who come together voluntarily to offer coordinated high quality care to Medicare patients. The ACO is characterized by a payment and health care delivery model that requires the provider to be accountable to an assigned group of patients for an established fee. The Centers for Medicare & Medicaid Services ("CMS") states an ACO is "an organization of health care providers that agree to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program . . . ."

The Patient Protection and Affordable Care Act ("PPACA"), also known as Obamacare by many, creates and provides for increased integration between hospitals and physicians that participate in ACOs under the Medicare Shared Savings Program. As of January 2012, PPACA authorized CMS to contract with ACOs, making ACOs a payment option under Medicare. The Department of Health and Human Services also released final regulations for ACOs in October 2011.

ACOs are a relatively new concept and are still gaining prominence under current health care reform. Critical issues that ACOs will confront include the following:

1. Forming the ACO, including without limitation, physician buy-ins, startup costs and overcoming difficulties between physicians and hospital organizations.

2. Implementing the governance and administrative requirements applicable to the ACO and impacts on medical staff issues (i.e., medical staff credentialing).

3. Building technological or administrative capacity needed to achieve the Medicare Shared Savings Program cost and quality goals.

4. Medical staff bylaws and barriers to ACO development.

In summary, there will be numerous regulatory concerns and challenges as providers create ACOs. If you have any questions concerning this topic, please contact the member of our GrayRobinson Health law team with whom you work.

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