Accountable Care Organization Provisions in the *Patient Protection and Affordable Care Act*

The consolidated *Patient Protection and Affordable Care Act*[1] is 974 pages long. Text related to Accountable Care Organizations is found in two sections; the first of these is Section 2706: Pediatric Accountable Care Organization Demonstration Project, which is under Title II, Subtitle I: Improving the Quality of Medicaid for Patients and Providers. Section 2706 runs from page 236 to 237 of the final document. The second of these is Section 3022: Medicare shared savings program, under Title III, Subtitle A, Part 3: Encouraging Development of New Patient Care Models, which runs from page 313 to page 318. Below is a summary of these two key provisions, followed by the text of the sections in their entirety.

Title II, Subtitle I, § 2706 (Pediatric ACO Demonstration Project)

The HHS Secretary shall establish a project that authorizes participating states to recognize pediatric providers that meet specified requirements as ACOs for the purpose of receiving incentive payments. The demonstration shall run from January 1, 2012 until December 31, 2016. States will apply to the Secretary in order to be included, although parameters of this application have yet to be determined.

Project requirements:

1. The Secretary shall establish performance guidelines, in consultation with States and providers, to ensure that the quality of care delivered by a pediatric ACO is commensurate with other pediatric providers;
2. All participating states, in consultation with the Secretary, shall establish an "annual minimal level of savings in expenditures" for covered services needed for the organization to receive an incentive payment; and
3. Providers are required to fulfill a minimum participation period of at least three years.

The incentive payment amounts shall be determined by the HHS Secretary, and may be subject to annual caps.

Title III, Subtitle A, Part III, §3022 (Medicare shared savings program)

By January 1, 2012, the Secretary shall establish a shared savings program to promote accountability for the coordination of items and services under Medicare Parts A and B for a specified population, and to encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under this program, groups of service providers meeting criteria (yet to-be-determined) may work together to manage and coordinate care for Medicare FFS patients through an ACO, and ACOs that meet quality performance standards will be eligible to receive payments from shared savings.

Eligible providers will include professionals in group practices; networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and professionals; hospitals employing professionals; and other entities with the Secretary may deem appropriate. All ACOs must have established a mechanism for shared governance.

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[1] A compilation of the *Patient Protection and Affordable Care Act* (as amended through May 1, 2010), including health-related portions of the *Health Care and Education Reconciliation Act* is available here: http://docs.house.gov/energycommerce/ppacacon.pdf. The attached text is taken from this version of *PPACA.*

Requirements for ACO status:

1. A willingness to become accountable for the quality, cost, and overall care of the Medicare FFS beneficiaries it treats;
2. Entrance into an agreement with the Secretary to participate in the program for not less than 3 years;
3. A formal legal structure that allows the organization to receive and distribute payments for shared savings;
4. The inclusion of primary care professionals that are sufficient for the number of Medicare FFS beneficiaries assigned to the ACO: "At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program";
5. Provision to the Secretary of information regarding the professionals who participate in the ACO (so that the Secretary may decide whether they are sufficient to support the care of the patients assigned), the implementation of quality and other reporting requirements, and the determination of the allocation of shared savings;
6. A leadership and management structure that includes clinical and administrative systems
7. Defined processes that promote evidence-based medicine and patient engagement, reporting on quality and cost measures, and care coordination;
8. Demonstration that the organization meets patient-centeredness criteria.

The Secretary shall determine appropriate measures for assessment of care quality, and providers will be required to submit data on these measures. The Secretary will also determine an appropriate method for assigning Medicare FFS beneficiaries to an ACO based on utilization of primary care services.

Medicare provider payments will continue to be made in the same manner as they have in the past, except that an ACO will be eligible to receive payment for shared savings if it meets quality performance standards, and if its estimated average per capita Medicare expenditures, adjusted for patient characteristics, is "at least the percent specified by the Secretary below the applicable benchmark". Benchmarks will be established for each ACO for every reporting period using its most recent 3 years of per-beneficiary expenditures for Parts A and B, adjusted to account for beneficiary characteristics.

The percent of payment will be determined by the Secretary, as will limits on the total amount of shared savings that can be paid. The Secretary will monitor the avoidance of at-risk patients, and has the power to impose sanctions on ACOs. The agreement between the ACO and the Secretary may also be terminated if the organization fails to meet performance standards.

§3022 was amended by §10307 to allow for the use of partial capitation payments, or any payment model that is determined to improve the quality and efficiency of care while not resulting in additional program expenditures. §10307 also states that the Secretary may give preference for participation to ACOs that are participating in similar pilots with private payers.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2706 [42 U.S.C. 1396a note]. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2707 [42 U.S.C. 1396a note]. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

(1) have attained age 21, but have not attained age 65;

(2) are eligible for medical assistance under such plan; and

(3) require such medical assistance to stabilize an emergency medical condition.

(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) IN GENERAL.—An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

(3) SELECTION.—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.".

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 8002(b), is amended—

(1) in paragraph (81), by striking "and" at the end;

(2) in paragraph (82), by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (82) the following new paragraph:

"(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.".

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking "5-year" each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"SHARED SAVINGS PROGRAM

"SEC. 1899 [42 U.S.C. 1395jjj]. (a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

"(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

"(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

"(b) ELIGIBLE ACOS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance

are eligible to participate as ACOs under the program under this section:

"(A) ACO professionals in group practice arrangements.

"(B) Networks of individual practices of ACO professionals.

"(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

"(D) Hospitals employing ACO professionals.

"(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

"(2) REQUIREMENTS.—An ACO shall meet the following requirements:

"(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

"(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').

"(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

"(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

"(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

"(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

"(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

"(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

"(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

"(i) clinical processes and outcomes;

"(ii) patient and, where practicable, caregiver experience of care; and

"(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

"(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

"(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

"(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

"(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

"(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

"(B) The independence at home medical practice pilot program under section 1866E.

"(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

"(d) PAYMENTS AND TREATMENT OF SAVINGS.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible

to receive payment for shared savings under paragraph (2) if—

"(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

"(ii) the ACO meets the requirement under subparagraph (B)(i).

"(B) SAVINGS REQUIREMENT AND BENCHMARK.—

"(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

"(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

"(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

"(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality per-

formance standards established by the Secretary under subsection (b)(3).

"(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

"(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

"(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(1) the specification of criteria under subsection (a)(1)(B);

"(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

"(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

"(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

"(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

"(6) the termination of an ACO under subsection (d)(4).

"(h) DEFINITIONS.—In this section:

"(1) ACO PROFESSIONAL.—The term 'ACO professional' means—

"(A) a physician (as defined in section 1861(r)(1)); and

"(B) a practitioner described in section 1842(b)(18)(C)(i).

"(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

"(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY.—The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.

[*Subsections (i)-(k) added by section 10307*]

"(i) OPTION TO USE OTHER PAYMENT MODELS.—

"(1) IN GENERAL.—If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

"(2) PARTIAL CAPITATION MODEL.—

"(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may

limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

"(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to an ACO for items and services under this title for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

"(3) OTHER PAYMENT MODELS.—

"(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

"(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

"(j) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

"(k) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—During the period beginning on the date of the enactment of this section and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary.".

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1866C the following new section: **[***As revised by section 10308(b)(1)***]**

"NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

"SEC. 1866D **[**42 U.S.C. 1395cc–4**]**. (a) IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

"(2) DEFINITIONS.—In this section:

"(A) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

"(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and

"(ii) is admitted to a hospital for an applicable condition.

"(B) APPLICABLE CONDITION.—The term 'applicable condition' means 1 or more of 10 conditions selected by the