



Public Health Law

Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Accountable Care Issue Brief: Basic Principles and Related Law

Public health and health care are engaging in new ways to approach health system transformation. One such method is “accountable care,” the coordinated provision of patient services by healthcare providers and facilities with the goals of improving patient and system outcomes and avoiding inefficiencies.¹ Accountable care frameworks are based on risk and reward, with providers and facilities agreeing to share the financial risk for a population in return for the opportunity to access rewards upon meeting healthcare quality and cost goals. Federal and state laws have established a variety of programs to incentivize the formation and success of legal entities that engage in accountable care. This issue brief outlines three legal mechanisms under which providers and facilities may form and operate accountable care entities.

Private Contracts Connecting Providers and Facilities

Private payers and providers led the shift toward accountable care frameworks by championing concepts of “care coordination” and “integrated networks of care.” Providers and facilities have incorporated these principles into existing contracts and employment relationships or developed new versions to fit the changing health system. The following list includes examples of private, contract-based provider and facility delivery systems that sought to lower costs while improving quality and patient care:

- Patient-centered medical homes (PCMHs) that evolved in the 1990s sought to improve primary care delivery;²
- Medicare Health Quality and Physician Group Practice demonstrations authorized beginning in 2005 espoused care coordination;³

¹ Elliott S. Fisher et al., *A Framework for Evaluating the Formation, Implementation, and Performance of Accountable Care Organizations*, 31 HEALTH AFF. 11, 2368 (2012).

² See, e.g., Leighton Ku et al., *Promoting the Integration and Coordination of Safety-Net Health Care Providers Under Health Reform: Key Issues*, THE COMMONWEALTH FUND (Oct. 2011), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Oct/1552_Ku_promoting_in_tegration_safetynet_providers_under_reform_ib_v2.pdf.

³ *Id.*



- Large multi-specialty medical group practices that contracted with health plans in the early 2000s began to define quality metrics, improve health information technology and exchange, and shift culture toward accountability and transparency;⁴
- Integrated delivery systems, commonly owned by physicians and potentially an insurance plan, emphasized lowering costs for covered populations while maintaining satisfaction and outcomes since 2001;⁵
- Blue Cross and Blue Shield of Massachusetts's Alternative Quality Contract program, incentivized through 2005 health system transformation laws in Massachusetts, provided medical groups a "global budget" with up-front funds and financial incentives to improve quality and cost, although administered through health management organizations;⁶ and
- The Premier, Inc. healthcare alliance launched the Accountable Care Implementation Collaborative in May 2010 to develop capabilities for private organizations to improve medical homes, data management, and patient satisfaction.⁷

Medicare Accountable Care Organizations Designed to Improve Healthcare Quality

In contrast to the variability of private sector accountable care entities, federal law provides numerous, specific standards for accountable care organizations (ACOs). Section 3022 of the Patient Protection and Affordable Care Act of 2010 (ACA) established the Medicare Shared Savings Program (MSSP), which authorizes reimbursements to "approved ACOs," new legal entities recognized and incorporated under applicable federal, state, or tribal law and authorized to conduct business in every state of operation.⁸ Because ACOs can receive Medicare reimbursement for providing care, they must meet strict requirements for approval. ACOs must 1) become accountable for the quality, cost, and overall care of the assigned population; 2) include enough primary care ACO professionals to serve a minimum of 5,000 beneficiaries; 3) provide information on participating professionals; 4) define processes for and report on care; and 5) demonstrate that they meet patient-centeredness criteria.⁹

An ACO must be formed by one or more eligible participants who work together to manage and coordinate care for Medicare fee-for-service beneficiaries.¹⁰ The total amount of shared savings will

⁴ Paul DeMuro, *Accountable Care*, 24 THE HEALTH LAWYER 6, 5–8 (Aug. 2012) (discussing early accountable care developments at the Mayo Clinic, Kaiser Permanente, and Group Health Cooperative of Puget Sound, among other provider arrangements).

⁵ *Id.*

⁶ Zirui Song et al., *The "Alternative Quality Contract," Based on a Global Budget, Lowered Medical Spending and Improved Quality*, 31 HEALTH AFF. 8, 1886 (2012); Robert Mechanic et al., *Medical Group Responses to Global Payment: Early Lessons from the "Alternative Quality Contract" in Massachusetts*, 30 HEALTH AFFAIRS 9, 1735 (2011) (comparing the state program targeted to health maintenance organizations to federal authorizations for new accountable care organizations).

⁷ Susan DeVore & R. Wesley Champion, *Driving Population Health Through Accountable Care Organizations*, 30 HEALTH AFF. 1, 41 (2011).

⁸ Medicare Shared Savings Program, 76 Fed. Reg. 67,802 (Nov. 2, 2011); 42 C.F.R. § 425.104 (2012) (specifying that ACOs will be identified by a taxpayer identification number).

⁹ *Id.*

¹⁰ 42 C.F.R. §§ 425.100, 425.102 (2012) (designating the following groups of service providers and suppliers as eligible participants: ACO professionals in group practices, including physicians, physician assistants, nurse practitioners, and clinical nurse specialists; networks of individual ACO professionals; partnerships or joint ventures between hospitals and ACO professionals; hospitals employing ACO professionals; critical access hospitals; rural health clinics; and federally qualified health centers). Other providers, such as long-term care hospitals, home

depend on meeting quality performance standards, creating an incentive for the ACO to improve the quality of care for the population covered.¹¹ ACOs must maintain a three-year contract with the Secretary of Health and Human Services as well as a Data Use Agreement with MSSP, while complying with the Health Insurance Portability and Accountability Act of 1996 and other statutory, regulatory, and contractual requirements.¹²

The types of ACOs authorized for reimbursement with different levels of risk and savings are categorized as:

- **MSSP Track 1**, allowing an ACO to share with Medicare up to 50% of its savings once it spends less than a benchmark established by the population's use of primary care services at the end of each year;¹³
- **MSSP Track 2**, requiring the ACO to assume risk, allowing it to share in a greater portion of any savings, but also to share in any losses incurred if it fails to meet its benchmark;¹⁴
- **MSSP Advanced Payment Model**, providing ACOs that serve rural populations or significant Medicaid beneficiaries (characterized by low annual revenues and with limited inpatient facilities) up-front capital, but requiring the repayment of costs that are not recouped;¹⁵ and
- **Pediatric ACOs**, authorized as demonstration projects under section 2706 of the ACA for states to incorporate into Medicaid or Children's Health Insurance Programs (CHIP) (described further below).¹⁶

Medicaid and Accountable Care to Reach Vulnerable Populations

Since 2010, state laws have incorporated accountable care principles to Medicaid programs to align incentives and improve costs in parallel with federal Medicare reforms. Although risk-based managed care organizations or fee-for-service primary care case management programs still dominate the Medicaid payment model, states are adding accountable care strategies and PCMHs to their managed care programs to improve quality, effectiveness, cost containment, and health outcomes.¹⁷ Many new

health agencies, and skilled nursing facilities, may participate in the program through collaborations with ACOs formed by eligible entities. 42 C.F.R. § 425.102 (2012).

¹¹ Centers for Medicare & Medicaid Services, Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program (Nov. 2012), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf.

¹² 42 C.F.R. §§ 425.708, 425.710 (2012) (prohibiting the program from sharing any identifiable claims data relating to treatment for alcohol and substance abuse).

¹³ 42 C.F.R. § 425.604 (2012).

¹⁴ *Id.*

¹⁵ CENTERS FOR MEDICARE & MEDICAID SERVICES, ADVANCE PAYMENT ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL (Nov. 2012), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf (detailing the obligations of the ACO to repay costs that are not recouped in contract provisions).

¹⁶ Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

¹⁷ KAISER COMMISSION ON MEDICAID AND THE UNINSURED, EMERGING MEDICAID ACCOUNTABLE CARE ORGANIZATIONS: THE ROLE OF MANAGED CARE (May 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8319.pdf>; Leighton Ku, *supra* note 2, at 7 (stating that capitated managed care plans encourage efficiency in order to keep savings and reduce risk for expenditures that exceed premiums, undertaking activities such as disease management and care coordination, and that primary care case management also places responsibility on providers, who are paid through fee-for-service payments and per-member-per-month fees that incentivize

strategies are approved in demonstration projects through waivers authorized under section 1115A of the Social Security Act, which establishes the Center for Medicare & Medicaid Innovation to test methodologies for service delivery and payment for Medicare, Medicaid, and CHIP.¹⁸

State accountable care strategies vary widely, likely due to “individual states’ history and experience with managed care, other delivery arrangements within Medicaid, and challenges inherent in serving low-income and chronically ill populations.”¹⁹ For example, Medicaid accountable care entities could operate

- Like an insurer, alongside managed care organizations;²⁰
- Within capitated managed care plans as a single healthcare provider;²¹
- As subcontractors that participate in shared savings with other healthcare entities, blending the first two strategies;²² or
- As pediatric ACOs approved under Medicaid or CHIP for five-year demonstration projects, with discretion left to states to determine the scope and specific measures of the projects.²³

decreased use through providing mental health integration or chronic obstructive pulmonary disease, for example).

¹⁸ Section 1115A of the Social Security Act, as added by section 3021(a) of the ACA, Pub. L. No. 111-148, 124 Stat. 119; *see also* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS (June 2011), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf>.

¹⁹ *Id.*

²⁰ Leighton Ku et al., *supra* note 2, at 7; *see also* MISS. CODE ANN. § 43-13-117 (2012) (authorizing the implementation of an accountable care program, among other options, as an organization paid on a capitated basis under a managed care program or coordinated care program subject to Medicaid approval before the repeal on July 1, 2013); N.H. REV. STAT. ANN. § 126-A:5 (2011) (authorizing an accountable care organization as one model for Medicaid managed care).

²¹ Leighton Ku et al., *supra* note 2, at 7 (raising a potential problem where mandatory managed care could assign patients on a prospective basis, locking them in to a Medicaid ACO and thereby restricting their choice of providers); *but see* 10 COLO. CODE REGS. § 2505-10:8.205, as amended by 2012 Colo. Reg. Text 278321 (2012) (including an accountable care collaborative demonstration project allowing primary care providers and regional care collaborative organizations to receive fee-for-service payments and capitated per-member-per-month fees as an enhanced medical home model); *see also* MONT. CODE ANN. §§ 33-31-102, 33-31-201 (2011) (defining an accountable care organization as a group of providers that are “willing and able of accepting accountability for the total cost and quality of care for a defined population and allowing the requirements for health maintenance organizations to be waived for organizations approved as Medicare ACOs); N.Y. PUB. HEALTH LAW §§ 2816, 2999-p, 2999-q (McKinney 2011) (including an accountable care organization of health care providers within the definition of health care providers and allowing certification of accountable care organizations to deliver health services and participate in Medicare); TEX. ADMIN. CODE tit. 1, § 371.1607 (2012) (regulating an accountable care organization as a “person” furnishing Medicaid or other services); UTAH CODE ANN. 1953 § 26-18-408 (2013) (authorizing accountable care plans to be administered by an accountable care organization through a risk-based delivery service model).

²² Leighton Ku et al., *supra* note 2, at 8; *see also* N.J. STAT. ANN. § 30:4D-8.3 (West 2011) (establishing a demonstration project that allows nonprofit corporations to become certified as Medicaid ACOs and include the state health department, managed care organizations, and other facilities and providers as participants); OR. REV. STAT. ANN. § 414.625 (West 2012) (incorporating demonstration projects of “coordinated” care organizations into the state Medicaid program); WASH. REV. CODE ANN. § 70.54.420 (West 2010) (establishing pilot projects for accountable care organizations comprised of healthcare provider or healthcare delivery system networks, including PCMHs).

The focus on improving population health through accountable care also differs across state laws:

- Some states require participation in Medicare accountable care entities from public health agencies and representatives to emphasize population health measures;²⁴
- Other states focus entirely on cost outcomes and quality measurements without reference to health outcomes;²⁵ and
- Most frequently, state laws identify health conditions or problems that accountable care entities must tackle, but do not require involvement by specific public health partners or specify the method by which those issues must be addressed.²⁶

Developing Evidence by Evaluating Accountable Care

While opportunities to experiment with new healthcare delivery frameworks appear to be expanding under federal and state laws, as of this writing, limited data are available on the relationship between accountable care and population health.²⁷ However, much attention has been paid to the measures and impacts that will be studied and evaluated over time.

Examples of existing and proposed evaluations of process measures²⁸ and impacts include:

- The Alternative Quality Contract performance measures in Massachusetts, including primary care-oriented measures such as aggregate and individual measures in chronic care management, adult preventive care, and pediatric care;²⁹
- New types of contracts for accountable care entities that collect data on cost, quality performance, the population served, electronic health record use, quality improvement processes, care management processes, and training programs;³⁰
- Health system transformation effects on individuals covered under an accountable care contract, individuals cared for by the providers outside of the contract, and the community as a whole;³¹ and

²³ ACA, Pub. L. No. 111-148, 124 Stat. 119; *see also* N.H. REV. STAT. ANN. § 126-A:3 (2011) (authorizing the submission of a state plan amendment to administer CHIP through an accountable care organization or other model to be chosen based on the best evidence available).

²⁴ *See, e.g.*, 20 ILL. COMP. STAT. ANN. 1340/25 (West 2011) (including mental health and substance abuse services); N.J. CODE ANN. § 30:4D-8.3 (2011) (including primary care, behavioral health, and dental, pharmacy, and other services); and OR. REV. STAT. ANN. § 414.625 (West 2012) (including chronic conditions, mental illness or chemical dependency, appropriate preventive, health, remedial, and supportive care and services).

²⁵ *See, e.g.*, WASH. REV. CODE. ANN. § 70.54.420 (West 2010) (requiring patient experience data).

²⁶ *See, e.g.*, COLO. REV. STAT. ANN. § 25.5-4-418 (West 2011) (including physical, oral, and behavioral health care services).

²⁷ Elliott S. Fisher et al., *A Framework for Evaluating the Formation, Implementation, and Performance of Accountable Care Organizations*, 31 HEALTH AFF. 11, 2368 (2012).

²⁸ *Id.* at 2370 (including federal, state, and local context, provider and payer readiness to adopt an accountable care framework and contract structures, implementation activities undertaken, and intermediate outcomes).

²⁹ Zirui Song et al., *supra* note 10, at 1887.

³⁰ Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 7, 1295, 1297–98 (2010) (including organizations such as physician-hospital organizations that function within a hospital's medical staff, independent practice associations that have become organized networks of physician practices, and "virtual" physician organizations comprised of small, independent physician practices).

- Medicaid programs that measure performance against quality and cost benchmarks for vulnerable populations, particularly those with complex medical problems or social disadvantages, to determine whether accountable care entities can serve unique needs.³²

Establishing the metrics used to measure population health measures for the accountable care framework will allow future research to investigate whether accountable care mechanisms will be effective in improving public health outcomes.

Resources Available

The CDC's [Health System Transformation webpage](#) offers resources from various organizations that can be used to inform accountable care initiatives and evidence-based practice.

For additional information about this issue, please email phlawprogram@cdc.gov.

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³¹ *Id.* at 2371.

³² Valerie A. Lewis et al., *The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles*, 31 HEALTH AFF. 8, 1778–81 (2012).