Accountable Care Organizations  
Section 3022 of the Affordable Care Act

[Read the statutory language applicable to this section](http://www.bricker.com/documents/resources/reform/reformbill26.pdf)

[Federal regulations](http://www.bricker.com/services/resource-details.aspx?resourceid=545#regs)

[Federal agency guidance](http://www.bricker.com/services/resource-details.aspx?resourceid=545#agency)

[Bulletins applicable to this section](http://www.bricker.com/services/resource-details.aspx?resourceid=545#bulletins)

Not later than January 1, 2012, the Secretary of HHS is required to establish a shared savings program that promotes accountability for a patient population and coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

Under the shared savings program groups of providers of services and suppliers meeting certain criteria specified by the Secretary of HHS may work together to manage and coordinate care for Medicare fee-for- service beneficiaries through an Accountable Care Organization. Those ACOs that meet quality performance standards established by the Secretary of HHS will be eligible to receive payments or shared savings.

**Eligible Accountable Care Organizations**

The following groups of providers of services and suppliers that have established a mechanism for shared governance are eligible to participate as ACOs

* ACO professionals (physicians and certain defined practitioners) in group practice arrangements
* Networks of individual practices of ACO professionals
* Partnerships or joint venture arrangements between hospitals and ACO professionals
* Hospitals employing ACO professionals
* Such other groups of providers of services and suppliers as the Secretary of HHS determines appropriate.

**Requirements of Accountable Care Organizations**

An ACO must meet the following requirements:

* The ACO must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
* The ACO must enter into an agreement with the Secretary of HHS to participate in the program for not less than a 3-year period (the ‘"agreement period").
* The ACO must have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers.
* The ACO must include primary care ACO professionals that are sufficient for the number of Medicare fee-for- service beneficiaries assigned to the ACO. At a minimum, the ACO is required to have at least 5,000 such beneficiaries assigned to it in order to be eligible to participate in the ACO program.
* The ACO must provide the Secretary of HHS 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, and the determination of payments for shared savings.
* The ACO must have in place a leadership and management structure that includes clinical and administrative systems.
* The ACO must 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.
* The ACO must demonstrate to the Secretary of HHS 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.

**Reporting Requirements**

The Secretary of HHS is required to determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of clinical processes and outcomes; patient and, where practicable, caregiver experience of care; and utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

An ACO will be required to submit data in a form and manner specified by the Secretary of HHS 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.

**Payments and Treatment of Savings**

Under the program ACO participating providers and suppliers payments will continue paid by Medicare in the same manner as they would otherwise be paid except that a participating ACO is eligible to receive payment for shared savings if the ACO meets the quality performance standards established by the Secretary of HHS and the ACO meets the saving requirement described below.

The "savings requirement" requires that for each year of the agreement period, 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 of HHS below an established applicable benchmark.