

# Physician Organizations

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—from a declaration of the American Bar Association

## Physician Involvement in ACOs: An Overview and Real-World Examples

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*“The most significant challenge of becoming accountable is not forming an organization, it is forging one.” ~ Phillip I. Roning<sup>1</sup>*

### Introduction

The unsustainability of the current fee-for-service healthcare delivery model makes inevitable movement toward creation of accountable care organizations (ACOs). Physicians and their organizations stand to thrive in this new era but will need to understand the deep transformational changes required. As counsel to physicians and physician organizations, you can greatly benefit your clients by also understanding the sweeping changes in culture, infrastructure, reporting, and financing, and assist them in navigating the new legal minefield. The purpose of this article is to provide a non-technical overview of ACOs and several concrete examples of early ACOs.

Former Administrator of the Centers for Medicare & Medicaid Services (CMS) Mark McClellan, MD, PhD, described an ACO as follows:

ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.<sup>2</sup>

### ACO Structure

The very label “accountable care organization” tends to convey an impression that an ACO must meet a particular type of organization. In retrospect, it probably should have been called “Accountable Care System.” *It is about function, not form.* The National Committee for Quality Assurance’s (NCQA’s) ACO criteria look to core competencies and infrastructure for implementation but are “agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association).”<sup>3</sup> “While ACO formation and ongoing structural, operational, and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development.”<sup>4</sup>

## Key Legal Issues Affecting ACOs

ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors. Many of these characteristics also happen to raise a number of challenging legal compliance issues for a body of state and federal healthcare law largely premised upon the fee-for-service model. A properly configured ACO should be successful in navigating this legal minefield. For overview purposes, the principal bodies of law affecting ACOs are: antitrust; Anti-Kickback Statute; Stark Law; Civil Monetary Penalties Law; tax; federal and state privacy laws; malpractice; corporate practice of medicine; insurance; intellectual property; state self-referral laws; and state business law.

## The Eight Essential Elements of an ACO

*“[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change.” ~ Gary Edmiston and David Wofford<sup>5</sup>*

### Essential Element No. 1: Culture of Teamwork—Integration

The most important element, yet the one most difficult to attain, is a team-oriented culture with a deeply held, shared commitment to reorganize care to achieve higher quality at lower cost. Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than simply banding together for contracting purposes. Furthermore, physicians tend to be cynical about prior “next best things,” such as health maintenance organizations, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning.

### Essential Element No. 2: Primary Care Physicians

Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, “it seems clear that in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.”<sup>6</sup> This need is logical when you examine the highest impact targets identified for ACOs: (1) prevention and wellness; (2) chronic disease management; (3) reduced hospitalizations; (4) improved care transitions across the current fragmented system; and (5) multi-specialty co-management of complex patients.

### Essential Element No. 3: Adequate Administrative Capabilities

Three essential infrastructure functional capabilities are required for ACOs: (1) performance measurement; (2) financial administration; and (3) clinical direction. For example, qualifying ACOs under the Medicare Shared Savings Program (MSSP) must have a leadership and management structure that includes clinical

and administrative systems that align with the aims of MSSP. The ACO must have an infrastructure capable of promoting evidence-based medicine and beneficiary engagement, reporting on quality and cost metrics, and coordinating care.<sup>7</sup>

### Essential Element No. 4: Adequate Financial Incentives

Three tiers of financial income models are available to ACOs: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.

#### Shared Savings

If quality and patient satisfaction are enhanced or maintained and the ACO realizes savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50%) of those savings is shared by the government with the ACO. To maximize incentives, the savings pool should be divided in proportion to the level of contribution of each ACO participant. If primary care has especially high medical home management responsibility, this responsibility may be accompanied by the addition of a flat per-member/per-month payment.

#### Savings Bonus Plus Penalty

In this model, as with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks but also will be liable for expenses that exceed spending targets. This model is called “symmetric” or “two-sided,” and the bonus potential is increased to balance the accountability or exceeding pre-set goals. Fee for service is retained.

#### Capitation

A range of partial capitation and full capitation models are possible in an ACO. In this model, fee-for-service payments are replaced by flat payments plus potential bonuses and penalties.

### Essential Element No. 5: Health Information Technology and Data

ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It usually will include outcomes and process measures. Nationally accepted benchmarks are emerging. Three categories of data needs exist for an ACO: baseline data, performance measurement data, and data as a clinical tool. The ACO will need the capability to move data across the continuum in a meaningful way, often termed “health information exchange” capability.

### Essential Element No. 6: Best Practices Across the Continuum of Care

Another essential element of a successful ACO is the ability to translate evidence-based medical principles into actionable best practices across the continuum of care for the selected targeted initiative or initiatives.



The five identified high-impact target areas for ACO initiatives are: prevention and wellness; chronic disease (75% of all U.S. healthcare spending, much of it preventable); reduced hospitalizations; care transitions (across our fragmented system); and multi-specialty care coordination of complex patients.

The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today's delivery system, unnecessary spending relating to substandard clinical coordination, aggravated with the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice.<sup>8</sup>

### **Essential Element No. 7: Patient Engagement**

Patient engagement is another essential element. Unfortunately, many of today's healthcare consumers erroneously believe that more is better, especially when they are not "paying" for it—insurance is. It is difficult to accept a compensation model based on input on improved patient population health when that is dramatically affected by a variable outside of physician's control—patient adherence.

### **Essential Element No. 8: Scale-Sufficient Patient Population**

It is okay, even desirable, to start small; to "walk before you run," so to speak. However, potential ACOs often overlook the requirement that an ACO needs to have a minimal critical mass of patients to justify its time and infrastructure investment. The Patient Protection and Affordable Care Act of 2010's (PPACA's) Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to the ACO.

## **Real-World Examples**

So we understand the concept, but what next? How does one decide what to tackle? Will ACOs really work? This article next profiles two examples of ACOs. The first illustrates how specialists, who were not normally associated with ACOs, selected a promising ACO initiative. The second example illustrates the significant potential savings possible for an ACO and its participants. These examples were also chosen to illustrate how neither could exist in a fee-for-service system.

Both examples utilized all eight essential elements. For their location and configuration of specialties, each ACO next selected their targets based on the following criteria:

- a. Greatest and quickest impact by patient population or resource consumption;
- b. Greatest unjustified variation;
- c. Existing best practices, documented success, and outcomes metrics;
- d. Greatest gap between actual and expected/achievable performance;
- e. Greatest interest from clinical champions; and
- f. Readiness of medical community for degree of integration required.

### **Example No. 1: A Specialist-Led ACO Initiative: The Complex Obese Patient Project (COPP)**

The COPP focuses on the obese patient population with at least one chronic condition, using best practices across the continuum from diagnosis to discharge, created by a multi-disciplinary team with the goal of increasing quality, patient satisfaction, and savings for this patient population. It creates: (1) better information at the primary care diagnosis and treatment design phase; (2) better information flow along the entire continuum of care; (3) improved transition from the outpatient to the inpatient setting; (4) improved perioperative processes and outcomes; and (5) improved post-op follow up.

Through COPP, its participating anesthesiologists became aware of new value-adding roles for their specialty in an accountable care model: being the agent for patients transitioning from the medical home to the hospital, navigating the perioperative process while in surgery, and assisting patients returning to the medical home. They realized that their highest opportunity lies with complex patients, who are frequently in and out of the hospital, where fragmentation of care and lack of patient follow-up is particularly poor under a fee-for-service model. In COPP, surgeons, anesthesiologists, and other specialists not normally associated with ACOs found a particularly successful model through which to contribute to better health and lower costs—setting a valuable precedent for other similarly situated, more typically hospital-based specialists.

## Example No. 2: Significant Documented Savings—The Pediatric ACO

One pediatric, ACO-type project, which achieved improved measured quality, may provide some direction on whether savings are really achievable. Beginning at the medical home level, through Community Care of North Carolina (CCNC), care coordination for child and adolescent Medicaid beneficiaries has yielded well-documented results. This model sets up a best practice protocol to direct pediatric patients with complications to the correct specialists, typically at academic medical centers—a radically different referral pattern. CCNC also effectively utilizes care navigators to provide support to patients and enables children to live at home with their families rather than being sent to out-of-state facilities. On December 15, 2011, Milliman Inc., the actuary company, issued a public report on CCNC savings. For children age twenty and under (excluding aged, blind, and disabled), risk-adjusted costs were about 15% less in FY 2010 (\$218.09 per member per month vs. \$185.15) for patients in CCNC. The dollar savings to the Medicaid program were significant: 2007, \$177 million; 2008, \$202 million; 2009, \$261 million; 2010, \$238 million.

Building on this pediatric medical home ACO base and recognizing that: (1) the 5% of children who are chronically ill consume 53% of Medicaid child care costs; (2) referral patterns for these complex patients are not local but statewide (often to different academic medical centers for different needs); and (3) patient engagement is not just with the child but also parents, teachers, and others, CCNC is now sponsoring the Child Health Accountable Care Collaborative of North Carolina (CHACC), a network of medical home pediatricians and academic medical centers. It will transform often-isolated medical homes. The state's

academic medical centers are involved. CHACC will include more than one million children and yield net projected savings of \$105,600,645 over three years, in addition to the previously noted medical home savings levels.

Extending pediatric care along the entire continuum in this manner, while monitoring quality, access, and savings, positions these programs to leverage significant savings.

## Conclusion

Through this simplified overview, one can see past the jargon and confusion often associated with these models that ACOs may be a logical reconfiguration of the way healthcare would be delivered under a true value-based reimbursement model. Understanding the “why” behind ACOs should assist legal counsel in guiding clients successfully. The current system is unsustainable. America is betting big on the ACO alternative and the role of the physician is critical.

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- 3 National Committee for Quality Assurance, *Accountable Care Organization (ACO) Draft 2011 Criteria*, at 7-8.
- 4 Doug Hastings, *Accountable Care News*, December 2010, at 6.
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- 7 76 Fed. Reg. 67976 (Nov. 2, 2011).
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# Measuring Up: Will Your Physician Meet the Thirty-Three Quality-Reporting Metrics Under the CMS Shared Savings Program?

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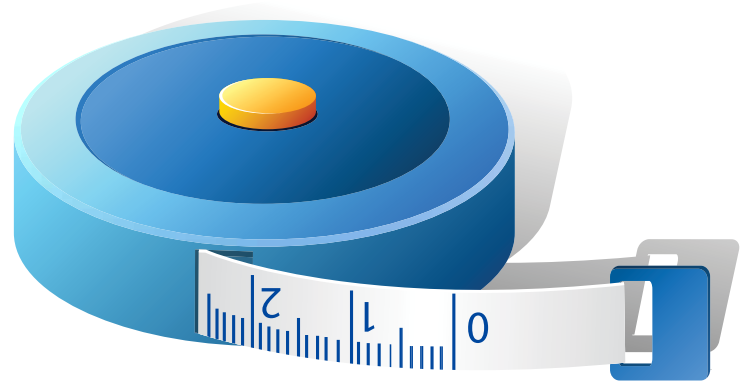
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## Incorporation of Quality Measures Into Healthcare Delivery

As part of the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), the government sought to bend the healthcare cost curve and preserve the viability of the Medicare Trust Fund through the creation of innovative models of care. One solution created under PPACA was the development of accountable care organizations (ACOs) to deliver more-coordinated care for a defined population. The Centers for Medicare & Medicaid Services (CMS) developed the Medicare Shared Savings Program (MSSP) to incentivize ACOs to achieve the triple aim goals of better population health, better individual care, and lower costs per capita.<sup>1</sup> To protect patients against the abuses associated with prior cost-containment efforts, the government developed a methodology that predicated the distribution of cost savings on the achievement of patient satisfaction and quality-of-care scores.<sup>2</sup>

Prior to the passage of healthcare reform, CMS conducted the Physician Group Practice (PGP) Demonstration—which was Medicare’s first physician pay-for-performance initiative. This pilot involved thirty-two quality measures in two different domains.<sup>3</sup> In the PGP demonstration project, CMS established



separate quality payments based on achieving at least one of three benchmarks measured through compliance with Medicare quality standards, achieving a defined level of Medicare Health Effectiveness Data and Information Set outcomes, or demonstrating improvement from one year to the next on certain quality targets.<sup>4</sup> By the fifth year of the program, seven of the participating groups achieved 100% performance on the quality measures, while three others achieved at least 96%.<sup>5</sup> The PGP program served as a precursor for transforming healthcare payment from fee-for-service based to one that utilizes quality of care as its foundation.

## Interim MSSP Rule

In the Interim MSSP rule, CMS outlined sixty-five quality measures in five domains chosen to ensure the delivery of high-quality care.<sup>6</sup> CMS utilized many of the clinical measures from the PGP Demonstration, but also added new standards such as measuring the patient/caregiver experience. Under this measure, patients would be surveyed on questions such as rating their doctor and their ability to access specialist care.<sup>7</sup> Many of the sixty-five measures were deemed to be unnecessarily complex. As an example, the Healthcare-Acquired Condition Composite measure analyzed ten separate conditions such as air embolisms, falls, and trauma with eight additional sub-conditions.<sup>8</sup> Globally, the challenges included the lack of consistency with other CMS-supported quality metrics, meeting the large number of standards, and the absence of true outcome-based measures.<sup>9</sup> Many providers balked at the operational and financial burden of meeting the quality measures and spoke publicly about their unwillingness to participate in the MSSP.

**Figure 1**

Number of Measures Utilized by Year			
Quality Calculation	Year 1	Year 2	Year 3
Pay for Reporting	33/33	8/33	1/33
Pay for Performance	0/33	25/33	32/33

## Final MSSP Rule

On October 20, 2011, CMS issued the Final MSSP Rule. In response to the feedback provided, CMS narrowed the universe of measures from sixty-five to thirty-three and worked to align the standards with those existing in other CMS quality reporting programs.<sup>10</sup> In order to increase participation in the ACO program, CMS agreed to phase-in performance on the quality metrics over a three-year period to allow time for ACOs to adapt their care models. In Year One, an ACO will be responsible for reporting only on the thirty-three measures. In Year Two, an ACO will be required to perform on twenty-five measures and report on the remaining eight measures. In Year Three and beyond, ACOs will be required to perform on all the measures,<sup>11</sup> except the Health Status survey that will continue to be a reporting-only metric.<sup>12</sup> See Figure 1 on page 5.

The final ACO quality measures are based on measures similar to those used in other CMS quality programs, such as the Physician Quality Reporting System (PQRS), and the Electronic Health Record (EHR) Incentive Programs. The measures are also aligned with those developed by nationally recognized organizations such as the National Quality Forum (NQF) and the National Committee on Quality Assurance (NCQA). The final measures also have synergy with value-based purchasing programs and other initiatives such as patient centered medical homes. Finally, research and support for many of the measures is supported by the Agency for Healthcare Research and Quality (AHRQ).<sup>13</sup>

In selecting the final measures, CMS sought to reduce the variability of care delivery while decreasing the cost of care. CMS chose performance standards around four domains with a focus on ambulatory primary care: (1) Patient/Caregiver Experience; (2) Care Coordination and Safety; (3) Preventive Health; and (4) At-Risk Populations.<sup>14</sup> The four domains and the measures associated with each are:

### Patient/Caregiver Experience

The Patient/Caregiver Experience standards focus on the individual patient's relationship with their healthcare provider. In utilizing these measures, CMS sought to promote a relationship that would foster patient engagement in health management.

- a. Timely Care, Appointments, and Information (NQF #5, AHRQ)
- b. Physician Communication (NQF #5, AHRQ)
- c. Patient Rating of Physician (NQF #5, AHRQ)
- d. Access to Specialist (NQF #5, AHRQ)
- e. Health Promotion/Education (NQF #5, AHRQ)
- f. Shared Decision Making (NQF #5, AHRQ)
- g. Health/Functional Status (NQF #6, AHRQ)

### Care Coordination/Patient Safety

The Care Coordination/Patient Safety measures focus on the continuum of care delivery required for successful transition from an acute care setting to a lower acuity environment. In order to

reduce costly hospital admissions/readmissions, CMS included performance standards requiring ACOs to better coordinate care and handle patient hand-offs to prevent these outcomes.

- a. All Conditions Readmissions (NQF #TBD, CMS)
- b. Chronic Obstructive Pulmonary Disease (COPD) Admissions (NQF #275, AHRQ)
- c. Congestive Heart Failure (NQF #277, AHRQ)
- d. Percent of PCPs who qualify for EHR Incentive Payment (CMS)
- e. Medication Reconciliation: Post-Discharge Inpatient Facility (NQF #97, 554, NCQA)
- f. Falls Screening (NQF #101, NCQA)

### Preventive Health

In order to ensure better population health, CMS included various preventative health measures to reward early intervention and help prevent the advancement of disease.

- a. Influenza Immunization (NQF #41)
- b. Pneumococcal Vaccination (NQF # 43, NCQA)
- c. Adult Weight Screening (NQF #421, CMS)
- d. Tobacco Use Assessment/Cessation Intervention (NQF #28)
- e. Depression Screening (NQF #418, CMS)
- f. Colorectal Cancer Screening (NQF #34, NCQA)
- g. Mammography Screening (NQF #31, NCQA)
- h. Blood Pressure Measurement within last two years (NQF #13, CMS)

### At-Risk Populations

In this domain, CMS focused on performance around five disease states that have high incidence rates in the population at large, and specifically, within the Medicare population.

As an example, diabetes affects nearly twenty-six million Americans and has significant associated co-morbidities.<sup>15</sup> In addition, cardiovascular disease affects twenty-seven million Americans while stroke affects more than four million Americans. These conditions require focused care and actively engaged patients.<sup>16</sup> The ability to improve the health of these populations presents a significant opportunity to achieve the goals of the triple aim due to both the prevalence of these disease states and the costs associated with their care.

- a. Diabetes (All-or-Nothing Scoring)
  - i) Hemoglobin A1c (<8%) (NQF #0729)
  - ii) Low Density Lipoprotein <100 (NQF #0729)
  - iii) Blood Pressure <140/90 (NQF #0729)
  - iv) Tobacco Non-Use (NQF #0729)
  - v) Aspirin Use (NQF #0729)

- vi) Diabetes Mellitus: Hemoglobin A1c >9% (NQF #59, NCQA)
- b. Coronary Artery Disease (CAD) (All-or-Nothing Scoring)
  - i) Drug Therapy for Lowering LDL-Cholesterol (NQF #74, CMS composite/AMA-PCPI individual component)
  - ii) ACE-Inhibitor/ARB Therapy (NQF #66, CMS composite)
- c. Hypertension
  - i) Blood Pressure Control (NQF #18, NCQA)
- d. Ischemic vascular disease
  - i) Complete Lipid Profile/LDL Control <100mg/dl (NQF #75, NCQA)
  - ii) Use of Aspirin/Another Antithrombotic (NQF #68, NCQA)
- e. Heart failure
  - i) Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (NQF #83)<sup>17</sup>

## Data Submission

In order to monitor achievement of the quality measures, CMS will utilize a variety of measurement tools to collect and track data during the twelve-month performance period. The seven patient experience measures will be measured via the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) surveys.<sup>18</sup> To ensure consistency of reporting and minimize the subjective nature of these surveys, CMS agreed to contract with selected vendors, at its cost, to administer the surveys during the first two years of the MSSP.<sup>19</sup> The other domains will be measured through the utilization of the Group Practice Reporting Option (GPRO) (twenty-two measures), electronic medical records (two measures), and claims data (three measures).<sup>20</sup> The GPRO tool will assess a random sample of 411 assigned beneficiaries, or 100% of a population.<sup>21</sup>

In order to help fund the infrastructure necessary to support the collection of data, CMS expanded the PQRS incentive payment system to allow providers to participate directly through an

ACO. If the ACO's providers report on the twenty-two measures submitted via the GPRO, they will be eligible to receive the PQRS incentive payment, which equals 0.5% of the ACO provider's total Medicare Part B-allowed charges during the year.<sup>22</sup> The incentive payment is not contingent on the distribution of shared savings.

As organizations assess whether to apply for the MSSP, the challenge of reporting and performing on the quality metrics remains one of the largest financial and operational obstacles to participation. Based on the organizational structure of an ACO, reporting on and meeting the quality metrics will present varying degrees of difficulty. For ACOs that utilize a common information technology (IT) platform, the ability to handle the necessary information may not be as difficult as it will be for organizations that have disparate electronic medical record systems. These organizations face the challenge of mining data from multiple IT systems, creating a common patient identifier, and developing interfaces to share and normalize a patient's data. In order to meet some of these challenges, ACOs should consider a variety of IT strategies, such as developing health information exchanges and data warehouses in order to most effectively centralize medical and administrative data.<sup>23</sup> In addition, ACO providers will need to access disease registries and utilize business analytics to identify patients requiring targeted intervention. The costs associated with implementing these strategies without commensurate financial reward may serve as a potential deterrent to participation in the MSSP.

## Impact on Shared Savings Payments

Regardless of the cost reduction achieved by an ACO, the ACO must also exceed the minimum quality performance standard to receive shared savings distributions. To measure performance on the quality metrics, CMS will utilize a sliding scale scoring methodology with a minimum attainment level of the thirtieth percentile based on Medicare fee-for-service and Medicare Advantage outcomes. CMS will assign a score based on the performance level of the ACO between the ranges of the thirtieth percentile up to the ninetieth percentile. Each domain will be given an equal weighting of 25%.<sup>24</sup> CMS will advise ACO participants of targeted performance levels prior to implementing pay for performance in Year Two of MSSP participation. *See Figure 2 below.*

**Figure 2**<sup>25</sup>

Performance Level	Quality Points	EHR Measure Quality Points
90+ percentile	2.00 points	4 points
80+ percentile	1.85 points	3.7 points
70+ percentile	1.70 points	3.4 points
60+ percentile	1.55 points	3.1 points
50+ percentile	1.40 points	2.8 points
40+ percentile	1.25 points	2.5 points
30+ percentile	1.10 points	2.2 points
<30 percentile	No points	No Points

**Figure 3**

Domain	Maximum Number of Points Available	Assigned Points	Domain Score
Patient/Caregiver Experience	4.0 (one measure - six modules + one individual measure)	4.0	100.0%
Care Coordination/ Patient Safety	14.0 (six measures + double-weighted EHR measure)	12.4	88.6% (12.4/14) = 88.6%
Preventive Health	16.0 (eight measures)	15.0	93.8% 15/16 = 93.8%
At-Risk Populations	14.0 (seven measures, including five components for Diabetes and three for CAD)	11.7	83.6% 11.7/14 = 83.6%
Total	48.0 (twenty-three measures for scoring purposes)	--	--
Final Quality Performance Score (each domain is weighted 25%)			91.5%

For twenty-three of the quality measures, the number of quality points earned will range from a maximum of two points to a minimum of zero. The exceptions include the EHR, diabetes, coronary artery disease, and patient experience survey measures. In order to incentivize the adoption of an IT platform to support coordinated care, CMS doubled the scoring weight for the EHR performance standard. In addition, two of the disease-focused measures, diabetes and coronary artery disease, will be scored on an “all-or-nothing” basis to encourage adoption of best practices around these diseases. As a result, all individual elements within the disease category must be met to receive credit for the measure.<sup>26</sup>

In order to be eligible to receive Shared Savings distributions under the Final MSSP rule, an ACO provider will need to perform on 70% of the measures in each domain. If a provider fails to meet this criterion, they may be placed on a corrective action plan by CMS.<sup>27</sup> To ensure the validity of performance scores, CMS will also monitor attributed patients to ensure that ACO providers do not deselect high-risk patients.<sup>28</sup>

### Sample Calculation

The sample calculation in Figure 3 above depicts the impact of meeting the Final MSSP quality metrics. For example, if an ACO’s performance on the four quality domains generates the performance score shown in Figure 3, then the quality score would impact the Shared Savings distribution calculation as shown in Figure 4 on page 9.

Track One Calculation: Benchmark (\$900) x % Savings Below Benchmark (2.0%) x Quality Score (91.5%) x Sharing Rate (50%) x twelve months x # of assigned beneficiaries (40,000): **\$3,952,800**

Track Two Calculation: Benchmark (\$900) x % Savings Below Benchmark (2.0%) x Quality Score (91.5%) x Sharing Rate (60%) x twelve months x # of assigned beneficiaries (40,000): **\$4,743,360**

### Conclusion

In the Final MSSP Rule, CMS addressed the feedback given by the provider community on the challenges of reporting and performing on sixty-five quality measures. As with many other aspects of the Final MSSP Rule, CMS worked to remove the impediments to ACO participation by creating more-feasible performance standards. While CMS has decreased the number of performance measures, providers will still need to improve their care delivery and create an information technology platform to accurately report and perform as required under the final thirty-three quality standards.

The care delivery redesign will necessitate incorporating two key elements of health reform: better coordinated care and an improved patient experience. A significant portion of the redesign will focus on moving from the current fee-for-service healthcare payment model that is based on autonomy and unit production to one of a collaborative team-based system focused on better patient outcomes. To effectively change the healthcare delivery paradigm, reimbursement must continue to evolve into a system



Figure 4<sup>29</sup>

Shared Savings Payment Calculation		
Assumptions	Track 1	Track 2
Benchmark (Per Member Per Month)	\$900	\$900
Percent Savings Below the Benchmark	2.0%	2.0%
Quality Score	91.5%	91.5%
Sharing Rate	50%	60%
Number of Months	12	12
Number of Beneficiaries Assigned to ACO	40,000	40,000
Calculated Shared Savings Payment from CMS to the ACO	<b>\$3,952,800</b>	<b>\$4,743,360</b>

that rewards physicians for delivering value-based care. This dynamic will create a direct link between quality outcomes and payment for care.

The awarding of shared savings based on meeting cost and quality targets is one of many incentive programs underway to reshape the nation's delivery of healthcare. As part of this transformation, CMS must continue to update its MSSP performance standards to include evolving clinical guidelines that incorporate best practices. This method of reimbursement will reward providers not for the volume of their care, but for the quality of their care.

1 See Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802, 67803 (Nov. 2, 2011) (to be codified at 42 CFR pt. 425) (hereinafter Final Rule).

2 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395–399 (codified as amended at 42 U.S.C. § 1395).

3 *Report to Congress: Physician Group Practice Demonstration Evaluation Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 4, 81 (Sep. 2009), available at [www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_RTC\\_Sept.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_RTC_Sept.pdf). The PGP utilized seven claims-based quality measures and twenty-five medical records-based measures. The claims-based measures were valued at more than four times the medical records-based measures due to the "administrative costs associated with reporting medical record based measures. See *id.* at 39.

4 See *id.* at 39.

5 RTI International, *Physician Group Practice Demonstration: Performance Year 1 - Preliminary Performance Year 5 Summary Results*, CTRS. FOR MEDICARE & MEDICAID SERVS., available at [www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_Summary\\_Results.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Summary_Results.pdf) (only two of the participating groups achieved savings in the first year, only half did so after three years, and the savings achieved by the groups were dramatically different).

6 See Proposed Final Rule, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 19528, 19570–19590 (Apr. 7, 2011) (to be codified at 42 C.F.R. pt. 425) (hereinafter Proposed Final Rule) (the five domains were patient/caregiver experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health).

7 See RTI International & Telligen, *Accountable Care Organization 2012 Program Analysis: Quality Performance Standards Narrative Measure Specifications Final Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 4 (Dec. 12, 2011), available at [www.cms.gov/sharedsavingsprogram/downloads/ACO\\_QualityMeasures.pdf](http://www.cms.gov/sharedsavingsprogram/downloads/ACO_QualityMeasures.pdf).

8 See Proposed Final Rule, *supra* note 6, at 19577.

9 See, e.g., Public Comment on Proposed Final ACO Rule from American Hospital Association to Donald M. Berwick, Adm'r, Ctrs. for Medicare & Medicaid Servs. 18–22 (June 1, 2011), available at [www.aha.org/advocacy-issues/letter/2011/110601-cl-acoprprule.pdf](http://www.aha.org/advocacy-issues/letter/2011/110601-cl-acoprprule.pdf).

10 See Final Rule, *supra* note 1, at 67871. The PGP report also noted that "most PGP participants commented that the additional resources required to collect data for medical-record-based measures were more than expected," but that the cost was expected to decline somewhat in the future after implementation costs have been borne. See *Report to Congress: Physician Group Practice Demonstration First Evaluation Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 4, 81 (Dec. 2006), available at [www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_Final\\_Congress.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Final_Congress.pdf).

11 See RTI International & Telligen, *supra* note 7, at 7–8.

12 See *id.* at 7.

13 See Final Rule, *supra* note 1, at 67873, 67878.

14 *Id.*

15 See *Press Release: Number of Americans with Diabetes Rises to Nearly 26 Million*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 26, 2011), available at [www.cdc.gov/media/releases/2011/p0126\\_diabetes.html](http://www.cdc.gov/media/releases/2011/p0126_diabetes.html).

16 See *Heart Disease and Stroke Prevention: Addressing the Nation's Leading Killers: At A Glance 2011*, CTRS. FOR DISEASE CONTROL AND PREVENTION, available at [www.cdc.gov/chronicdisease/resources/publications/AAG/dhdspl.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdspl.htm) (last visited Mar. 22, 2012).

17 See RTI International & Telligen, *supra* note 7, at 4–6 tbl.1.

18 See Final Rule, *supra* note 1, at 67874.

19 See RTI International & Telligen, *supra* note 7, at 9.

20 See *id.* at 3 (the web system being used is almost identical to the portal in the PQRS Group Practice Reporting Option).

21 See Final Rule, *supra* note 1, at 67893.

22 See *id.* at 67900.

23 Jordan Battani, *Preparing for Accountable Care: The Role of Health IT in Building Capability*, COMPUTER SCIENCES CORP. 2–6 (2011), available at [http://assets1.csc.com/health\\_services/downloads/CSC\\_Preparing\\_for\\_Accountable\\_Care\\_The\\_Role\\_of\\_Health\\_IT\\_in\\_Building\\_Capability.pdf](http://assets1.csc.com/health_services/downloads/CSC_Preparing_for_Accountable_Care_The_Role_of_Health_IT_in_Building_Capability.pdf).

24 See Final Rule, *supra* note 1, at 67899.

25 See *id.* at tbl.3.

26 See RTI International & Telligen, *supra* note 7, at 7–8.

27 See *id.* See also Proposed Final Rule, *supra* note 6, at 19592.

28 See RTI International & Telligen, *supra* note 7, at 7–8.

29 See Final Rule, *supra* note 1, at 67890.

## Avoiding Food Fights: The Value of Good Drafting to ACO Physician Participants

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The Medicare Shared Savings Program (MSSP), which will create Medicare accountable care organizations (ACOs), is predicated on a retrospective reconciliation of expenses incurred as deducted from shared savings earned. The model also measures quality based on specified metrics. One of the principal requirements to participate in the Medicare model is having an entity that is in a position to allocate and distribute Part A and Part B savings earned to the participants. This requirement is very reminiscent of the 1990s world of physician-hospital organizations (PHOs), which often foundered because of disputes as to how dollars would be shared in the few entities that actually got contracts.

Commercial ACOs are following similar formulas. While some, in more sophisticated markets, may be paying percent of premium or global capitation rates, others are paying for bundled payments or episode rates, while still more follow the Medicare model of paying in the ordinary course of business with a reconciliation at the end. Medicare's own bundled payment pilot program<sup>1</sup> offers four different models, any of which might be relevant in a commercial ACO, and two of which would be applicable in an MSSP ACO.<sup>2</sup> Model 2 includes the hospital and physicians in the bundle for an episode of care, and Model 4 is prospective payment for all services provided during a covered hospitalization—physicians included. Both models might be seen in the internal workings of an ACO.

When providers form ACOs, they are taking on new risks and opportunities. The contract with the payor is a critical document. But, just as important to the ACO's viability will be the governance and contractual issues within the ACO. This article is a summary of the highlights of issues to consider in representing physicians, whose enthusiastic engagement is, arguably, the sine qua non of a functional ACO. Other issues will arise depending on the specific context.

### Governance Issues

Depending on the legal mechanism that is used to administer the funds, governance issues might have already been worked out. For example, if there is an existing co-management entity that can be expanded to perform this function within the ACO, that structure might be used. In some small number of communities, PHOs have survived into the present, and they offer a ready vehicle to perform these functions.

No matter the entity though, one of the primary concerns for physicians will be if the directors of the entity, whether a formal, legal Board of Directors or a less-formal group tasked with the

governance function, represent an even number of votes among the physician representatives and others. Physicians often need to feel that the hospital does not have undue control over the allocation of dollars. However, with even numbers of directors, deadlocks are possible.

Supermajority voting is also an issue. While typical supermajority issues in any business would include such matters as dissolution, incurring debt, amending the controlling agreements, approving budgets or change in legal form, in the ACO context other issues might be subjected to supermajority vote requirements. These issues can include any changes in the metrics that drive compensation or allocation of dollars. Adding providers to the ACO or creating new classes of providers might also be subject to supermajorities. In this way, both the hospital entity and the physicians (or other classes of providers as well) would all have to agree with more than a simple majority (e.g., 66% or 75% of each class of directors). Whether a participating provider should be terminated, as well as resolving any appeals of issues that arise, might also be subject to a supermajority vote. Whether to terminate the arrangement surely should be subject to a supermajority vote.

In the MSSP program, the mechanism is all-in or all-out. For the participating hospitals and physicians, all of their compensation from Medicare Parts A and B will flow through the ACO for the beneficiaries assigned to it. In commercial ACOs, contracts may carve out specific product lines, e.g., cardiology or orthopedics or oncologic care. When a commercial ACO is more case-rate or episode-rate driven, additional issues with regard to governance will arise with respect to who should have voting rights. For example, in avoiding readmissions, home health agencies are extremely important. In treatment of pneumonia, physical therapists may not be so important so they might only participate by contract rather than in a governance structure. Where the ACO is episode or case-rate driven, not all physicians need to participate. Rather, the physicians who deliver the care incorporated in the episode would be those to participate in governance.

Decisions must be made regarding whether physicians' voting rights turn on their ownership of shares, by the size of their group (larger groups have more votes), and then, whether they participate as individual groups. These cultural choices do not have one answer. In many of these programs, physicians will be concerned that larger groups will disenfranchise smaller groups. The larger groups will want to be recognized for their larger contributions to results.

### Payment Issues

Depending on the structure of the ACO, participation agreements likely will be required for participating physicians. Much like the independent physician association (IPA) or preferred health organization (PHO) contracts in the mid 1990s, they will establish criteria for continued participation, standards to be maintained, and grounds for termination. In many ways, the most critical issue for the physicians will be the allocation of the earned rewards in a reconciliation-based model. Because most PHOs, not to mention IPAs, never established standards or predicates

for their risk taking in the mid 1990s, they failed in battles over who was entitled to what money, if they got any to share. Truly awful failures occurred when organizations that took downside risk turned to their participating primary care physicians to make up the losses. These issues are essential to confront in the earliest moments of contract drafting.

The next fundamental question is how the dollars are calculated for the shared savings. In the MSSP program, the quality metrics are established by the government. How they are used within the ACO, if at all, is a choice of the participants. In commercial ACOs, quality metrics are either established by the health plan on a take-it-or-leave-it basis or are the subject of negotiation. Where they are negotiated, physicians ought to care that the quality metrics are credible, that the contract provides an unequivocal way of calculating performance, and that they are at risk only for behaviors they can control.

In addition to those fundamental issues, rules either will need to be documented in a contract or an operations manual, addressing what happens if there are disputes among physicians over the right to payment for the same portion of monies. These are the dreaded “attribution” issues. Here again, a range of options exists: for example, if providers cannot agree, none of the providers gets to claim a bonus; or, the one who has the most visits gets the allocation; or they are obligated to work it out among themselves; or the contract provides for an appeals mechanism.

Another critical issue would be the bases for involuntary termination of physicians during the term. Loss of basic qualifications like licensure or staff privileges are obvious. But, in the MSSP program, if a physician were put on pre-payment review by Medicare, this could be a basis for termination. If it were found that physicians were cherry picking (selecting only low-risk patients) or lemon dropping (terminating relationships with complex or highly acute patients), this behavior might be grounds for termination. The big issue for physicians will be termination for failure to comply with standards and where those standards are documented.<sup>3</sup>

## Dispute Resolution

Where real money is at issue, disputes are inevitable. What is and is not subject to an appeals process should be stated clearly in the contracts. For example, if care is episode or case-rate driven, the definition of the case or the episode, which part the provider contracted to render, rules pertaining to how an episode is triggered, broken, or expires ought not be subject to appeal. Matters that might be subject to dispute resolution would be those that are essentially data driven and, therefore, subject to potential errors, such as whether an episode was triggered, attribution of care rendered to specific physicians, whether severity adjustments apply, and the like.

In terms of what kind of dispute resolution process to use, a range of options exists. For example, reconsideration by the initial decision-maker would be one option. Reconsideration by a different internal body whose function is simply to hear appeals would be another. A full fair hearing process or even referral to an external arbitration service are other available options.

Typical issues to address are timeframes for appeals; the scope of evidence permitted to be brought forward; whether attorneys will be involved; whether it is a record review, oral argument, or a face-to-face meeting; and the types of records to be maintained.

All of these points are essential to the credibility to the physicians and their sense of the program's equities.

## Clinical Integration

The viability of any ACO will turn on changed clinical and administrative processes that will produce measured quality and enhanced value. The essence of these changes turns on clinical integration, which has recently been redefined as “*Physicians working together, systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.*”<sup>4</sup> How these changes are implemented and embedded in the operations of the ACO is also significant for contractual relationships among the providers.

The participation agreements must assure that the parties are collaborating in accordance with a meaningful and shared vision. The contracts among the physicians and among the other providers should incorporate standards of behavior that reflect the goals of clinical integration. Much of this would be in the form of standardization—of documentation, use of ancillary personnel, standing orders sets, electronic health records, and more. A useful exercise in the initial creation of an ACO is to have the parties assess their status in moving toward a shared vision. A new self-assessment tool can facilitate that dialogue.<sup>5</sup> In an ACO, these issues are relevant within physician groups, between physicians and hospitals, among otherwise-independent physicians, within the organized medical staff, and within any new ACO entity that is formed to administer the financial gains or allocate downside risk. In many ways, a clear understanding of what it will take in terms of changed physician behavior to achieve the ACO vision can drive the standards that are given force in the participation agreements. This approach is very different from the mid 1990s and should actively involve the participating physicians in its design and articulation.

## Conclusion

The advent of ACOs, whether under Medicare or commercial insurance, represents a host of opportunities but also real pitfalls. Physician counsel should look closely at the internal issues of governance and contracting. Certainty on the front end is far better than vague, immeasurable terms. Fair governance and good contracts can bolster the real collaboration that ACOs require to survive.

1 Bundled Payment Pilot, available at <http://innovations.cms.gov/initiatives/bundled-payments/index.html>.

2 Model 1 is an acute hospital episode only. Model 3 is post-discharge care for thirty days only.

3 See <http://uft-a.com/PDF/ACI-fnl-11-29.pdf>.

4 Gosfield and Reinertsen, “Achieving Clinical Integration With Highly Engaged Physicians” (Nov. 2010), 31 pp. See <http://uft-a.com/PDF/ACI-fnl-11-29.pdf>.

5 See [www.uft-a.com/CISAT.pdf](http://www.uft-a.com/CISAT.pdf).

## Physician Leadership in ACO Governance and Management

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The Medicare Shared Savings Program's (MSSP's) main goal is to reduce healthcare costs by emphasizing a reduction in unnecessary expenditures and implementing redesigned care processes without comprising the quality of patient care.<sup>1</sup> The MSSP aims to achieve this goal by incentivizing the development of accountable care organizations (ACOs). The Center for Medicaid & Medicare Services (CMS) expects an ACO to be a legal entity formed pursuant to state, federal, or tribal law comprised of an eligible group of ACO participants<sup>2</sup> working together to manage care for Medicare fee-for-service beneficiaries. The ACO model's ultimate goal is the efficient and effective provision of quality medical care.<sup>3</sup> The MSSP and ACO regulations call for physicians to play a vital role in the operation and management of an ACO.

CMS regulations indicate that the following participants will play a critical role in an ACO: (1) ACO professionals; (2) group practices; (3) joint ventures between hospitals and "ACO Professionals";<sup>4</sup> (4) hospitals; and (5) other groups of providers of services and suppliers as the Secretary of the U.S. Department of Health and Human Services (Secretary) sees fit.<sup>5</sup> Federally qualified health centers, rural health centers, critical access hospitals, long term care hospitals, skilled nursing facilities, and nursing homes were included in the final rule as eligible participants.<sup>6</sup> As always, the Secretary retains the right to narrow or expand the list of eligible providers.<sup>7</sup>

The MSSP recognizes that the change to quality-driven healthcare requires an institution-wide change; therefore, the MSSP imposes strict governance and operational requirements on ACOs.<sup>8</sup> Participating ACOs must have an accountable governing body responsible for implementing processes aimed at improving the quality of medical care, reporting on quality measures, and coordination amongst ACO members.<sup>9</sup> Additionally, an ACO governing body is responsible for strategic planning,<sup>10</sup> has a fiduciary duty to the ACO,<sup>11</sup> must ensure meaningful representation and participation of ACO members,<sup>12</sup> and must do so without conflicts of interest.<sup>13</sup>

The ideal ACO management structure will align administrative and clinical systems to reduce growth in healthcare expenditures while promoting individual and community health.<sup>14</sup> CMS requires the clinical aspect of the ACO to be managed by a state-licensed physician that is a participant within that ACO and who is physically present at an ACO office or clinical location on a regular basis.<sup>15</sup> In addition to physician involvement as a manager or director of clinical systems, CMS requires each participating doctor to commit to the ACO.<sup>16</sup> Individual ACO provider/suppliers can commit to the ACO by providing a sufficient amount of financial or human investment.<sup>17</sup> Commitment can also be shown by agreeing to abide by mandatory ACO processes and meeting the requisite performance measures.<sup>18</sup> Mandatory ACO

processes include processes that promote evidence-based medicine,<sup>19</sup> promote patient-engagement,<sup>20</sup> develop an internal quality and cost-reporting mechanism that allows for feedback and evaluation of ACO participants,<sup>21</sup> and coordinate care amongst the ACO participants.<sup>22</sup> If we look at the statutory requirements of the MSSP, physicians will have some representation on the governing board and a physician will be in charge of the clinical systems. Whether the regulations adequately ensure physician involvement in ACO management remains unanswered.

Physicians should be well aware that they have potential leverage in ACO participation negotiations. Over the last twenty years, the healthcare industry has moved toward integrated healthcare delivery. This shift has resulted in joint ventures between hospitals and physicians, independent physician ownership of surgical centers, and increased physician-hospital affiliation. From these results physicians can extract information that proves their value in the current industry environment.

Physicians should realize that hospitals need physicians as much as physicians need hospitals—the relationship is symbiotic. Arguably, a hospital could run its own ACO by buying out enough physician practices to cover the spectrum of healthcare (primary care, specialist care, and hospital care); the more likely outcome, however, will be a model based on physician group and hospital partnership. A survey by the American College of Healthcare Executives found that 72% of its members (representing mostly healthcare facilities and systems) were looking to align more closely with physicians.<sup>23</sup> Whether the alignment is promoted by the desire to form a partnership or to outright own the physician practice, hospital wants to integrate. In fact, hospitals may actually need to integrate if they want to form an ACO. The MSSP mandates a minimum of 5,000 beneficiaries for an eligible ACO and the Minimum Savings Rate is tied to the number of beneficiaries served by the ACO.<sup>24</sup> The hospital may not have access to 5,000 beneficiaries without physician group participation.

Second, physicians do not need to join a hospital-run ACO; they can form their own. This physician-only ACO arrangement is incentivized by CMS under the ACO Advanced Payment Model.<sup>25</sup> The Advanced Payment Model is open to: (1) ACOs that do not include inpatient facilities and have less than \$50 million in revenue; and (2) ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than \$80 million in revenue.<sup>26</sup> Of the two ACOs that are eligible for the Advanced Payment Model, the former is a viable option for mid-size medical practices to join. The required lack of inpatient facilities would make it a physician-run ACO in which physicians would occupy critical leadership and management roles. Additionally, the Advanced Payment Model provides such ACOs with upfront payments (recouped through generated shared savings).<sup>27</sup> The upfront payment would help physician-run ACOs with capital that will reduce their individual/practice contributions. Advanced Payment Model ACOs will be allowed to choose between three different advanced payment options.<sup>28</sup> This flexibility would allow physician-only ACOs to pick a payment option that fits their unique circumstances. Eligible ACOs can choose between a fixed upfront payment, a variable upfront payment based upon the number of beneficiaries serviced, and a variable monthly payment based upon

the size of the ACO.<sup>29</sup> A physician-only ACO comprised of small to mid-size physician practices may decide that an upfront payment would reduce their initial capital investment, whereas an ACO comprised of large physician practices might find the consistency of a monthly payment more attractive.

Third, a look at past joint ventures between hospitals and physicians indicates that a strong physician leadership is a successful model to follow. Hospital usurpation of all physician control has been a problem for ambulatory surgical center joint ventures and has proven to be unsuccessful.<sup>30</sup> The Ambulatory Surgical Centers of America (ASCOA), an ambulatory surgical center developer, found that it was critical to let physicians take ownership, literally and figuratively, of ASC joint ventures.<sup>31</sup> In ASCOA-developed ASCs the hospital and the management company retain 51% ownership in the joint venture.<sup>32</sup> The physicians own the remaining 49% and have significant participation on the ASC board.<sup>33</sup> Regent Surgical Health, a surgical center developer and management company, noted that one of its most challenging tasks is to find the perfect balance between satisfying the needs of the hospital and the needs of the physicians.<sup>34</sup> Ultimately, neither the hospital's nor the physicians' needs is greater than the needs of the surgical center.<sup>35</sup> ACO boards will need to implement a similar approach and respect the contributions of each party.

An example of significant physician leadership in an integrated healthcare delivery system is St. John's Clinic, a multi-specialty clinic in southwest Missouri. St. John's Clinic (Clinic) was a member of St. John's Health System (now called Mercy), which is a part of the larger nonprofit Sisters of Mercy Health System.<sup>36</sup> St. John's Clinic decided to improve hospital-physician alignment in the early 1990s by pursuing an integrated healthcare delivery system.<sup>37</sup> The Clinic bought out local and regional practices with hope that it would improve the long-term success of the Clinic; however, within three years of implementing this plan, significant financial and relationship problems emerged.<sup>38</sup> Citing concerns over soaring accounts receivables, the mismanaged central business office, and other business issues, numerous physicians submitted letters of no confidence, which led to a radical change in St. John's organizational structure.<sup>39</sup>

After a long and arduous restructuring process, St. John's emerged with a new organizational and governance structure that empowered physicians by granting them greater authority and accountability in the operations and management of the restructured Clinic.<sup>40</sup> In 2004, St. John's Clinic was named among the top ten clinics nationwide for patient satisfaction and ranked number one for clinics with more than 100 providers.<sup>41</sup>

Physician leadership in the governance and management of ACOs will be a critical element to their success. Similarly, hospitals' capital investment in ACOs will also be critical to ACO success. Even though the ACO regulations mandate physician leadership in the clinical elements of an ACO, ACO participants should work to achieve equity in leadership. As ACO participants sit down to negotiate an ACO formation, they should realize that an ACO that includes all of them will provide the greatest quality care; while hospitals and physicians may be able to form independent ACOs, it may not be the best option for themselves or their patients. Additionally, hospitals should keep in mind the

success of physician-led integrated delivery systems and joint ventures. Physicians, on the other hand, should realize that larger entities such as hospitals will most likely be making significant capital contributions to the ACO. Ultimately, an ACO's success depends on the ability of hospitals and physicians to negotiate an equitable arrangement.

- 1 U.S. Department of Health and Human Services, *Affordable Care Act to Improve Quality of Care for People with Medicare*, HHS Press Release, March 31, 2011, available at [www.hhs.gov/news/press/2011pres/03/20110331a.html](http://www.hhs.gov/news/press/2011pres/03/20110331a.html).
- 2 42 CFR § 425.20.
- 3 *Accountable Care Organizations: Improving Care Coordination for People with Medicare*, (March 31, 2011), available at [www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html](http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html) (last updated November 16, 2011).
- 4 42 CFR § 425.20 defines "ACO Professionals" as physicians, physician assistants, nurse practitioners, or clinical nurses.
- 5 42 CFR § 425.102.
- 6 *Id.* See also 76 Fed. Reg. 19538 (April 7, 2011).
- 7 76 Fed. Reg. 19538 (April 7, 2011).
- 8 42 CFR § 425.106.
- 9 *Id.*
- 10 *Id.* at 106(b).
- 11 *Id.* at 106(b)(3).
- 12 *Id.* at 106(c).
- 13 42 CFR § 425.106(d).
- 14 42 CFR § 425.108(a).
- 15 *Id.* at 108(c).
- 16 42 CFR § 425.108(d).
- 17 *Id.* at 108(d)(1).
- 18 *Id.* at 108(d)(2).
- 19 42 CFR § 425.112(b)(1).
- 20 *Id.* at (b)(2).
- 21 *Id.* at (b)(3).
- 22 *Id.* at (b)(4).
- 23 Victoria Stagg Elliott, *Physicians Have Leverage with Hospitals in Getting Optimal Practice Set-ups*, American Medical News, available at [www.ama-assn.org/amednews/2010/11/15/bisa1115.htm](http://www.ama-assn.org/amednews/2010/11/15/bisa1115.htm) (last modified November 14, 2010).
- 24 42 CFR § 425.604(b).
- 25 U.S. Dept of Health and Human Services, *Advance Payment Accountable Care Organization (ACO) Model*, available at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO\\_Advance\\_Payment\\_Factsheet\\_ICN907403.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf).
- 26 *Id.*
- 27 *Id.*
- 28 *Id.*
- 29 *Id.*
- 30 Rachel Fields, *5 Problems That Hurt a Hospital-Physician ASC Joint Venture—and How to Avoid Them*, Becker's ASC Review, available at [www.beckersasc.com/asc-transactions-and-valuation-issues/5-problems-that-hurt-a-hospital-physician-asc-joint-venture-and-how-to-avoid-them.html](http://www.beckersasc.com/asc-transactions-and-valuation-issues/5-problems-that-hurt-a-hospital-physician-asc-joint-venture-and-how-to-avoid-them.html) (last modified April 28, 2011).
- 31 *Id.*
- 32 *Id.*
- 33 *Id.*
- 34 Mike McKeivitt, *The Management Group's Role in Physician/Hospital Joint Ventures*, available at [www.regentsurgicalhealth.com/Articles/The+Management+Groups+Role+in+Physician+Hospital+Joint+Ventures](http://www.regentsurgicalhealth.com/Articles/The+Management+Groups+Role+in+Physician+Hospital+Joint+Ventures) (last modified February 25, 2011).
- 35 *Id.*
- 36 Michael R. Goler & Donald E. Sorenson, *Physician Governance the Strength Behind St. John's Clinic*, available at [http://findarticles.com/p/articles/mi\\_m0843/is\\_1\\_32/ai\\_n16016098/?tag=content;col1](http://findarticles.com/p/articles/mi_m0843/is_1_32/ai_n16016098/?tag=content;col1).
- 37 *Id.*
- 38 *Id.*
- 39 *Id.*
- 40 *Id.*
- 41 *Id.*

## “Super Group Today, ACO Tomorrow”: How Multispecialty Groups Are Desirable Structures for Future ACO Certification

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The Medicare accountable care organization (ACO) concept<sup>1</sup> is driven by the three industry-wide goals of better care for individuals, better health for populations, and lower growth in Medicare Parts A and B expenditures (Goals). The purpose of the ACO is to solve the troubles of the U.S. healthcare system through focusing on patient-centered, coordinated care.<sup>2</sup> As the parameters of the ACO are developing in practice, some private practitioners are turning to the available group practice model to begin the cooperative restructuring process now. These group practice superstructures are commonly known as a “Super Group.” Super Groups could meet or exceed these general structural Goals in a manner that complies with current laws and regulations, while successfully preparing for ACO participation when ACO becomes an industry norm.

### A Description of a “Super Group”

A Super Group is a memorable term for a large, multi-specialty group practice with a strong primary care foundation. Often times, Super Groups are established through a consolidation of smaller existing group practices that singularly provided high-quality services, have similar cultures, and maintain a common desire to remain independent from committing to a single hospital’s services as an employee or through a professional services agreement. Achieving patient-centered, coordinated care requires that physicians coalesce into larger groups, institutions, or physician organizations with shared goals and patient treatment philosophies. For those averse to uniting with a hospital to achieve these goals, the Super Group offers a viable strategic alternative both prior to and after ACO participation.

As a “Super” provider of healthcare services to its patients, the group provides independent, outcome-determinative, and physician-driven coordinated care for its patients’ healthcare needs, with strong care coordination among its multi-disciplinary team members while decreasing the costs of overhead or administrative services. Physician offices can be the “leanest” of healthcare delivery systems because the individual stands to benefit directly and economically from the elimination of waste or inefficiency. Therefore, physicians have financial incentive for such purposes. Super Groups allow the combined practices to further develop economies of scale by reducing billing, administrative, and dupli-

cate ancillary expenses. As a result, a Super Group’s structure as a group practice is set up to achieve the Goals and become a successful ACO.

For services lacking within the Super Group, such as inpatient services, which are part of the aspect of coordinated care, the Super Group has the ability to look to the marketplace for the highest-quality, lowest-cost provider of those specific services. For example, Hospital One may have the best and most cost-effective cardiology care, while Hospital Two has the highest-quality and most economical urology care. The Super Group would not have exclusivity with a single hospital and, as a result, would have greater freedom and flexibility to utilize what it determines to be the best option to facilitate the Goals.

The Super Group’s basic structure as a group practice is familiar to most physician participants since many already operate under similar concepts in their current smaller scale operations. It has further familiarity because of the compliance of this structure with the current fraud and abuse laws including the federal physician self-referral law (Stark).<sup>3</sup> Super Groups are desirable structures for physicians who want to progress toward the ACO concept but are wary of the new and unfamiliar rules, which will likely need further clarification in the coming months.<sup>4</sup>

### Corporate Similarities Between Stark Group Practice Rule and ACO Rules

Compliance with the Stark group practice rules<sup>5</sup> is necessary so that Super Groups are able to meet many of the exceptions to the Stark law and can provide and bill for designated health services<sup>6</sup> that were referred by their own providers.<sup>7</sup> As discussed below, these factors are similar to requirements for ACO participation. In particular, the group practice rules relating to corporate structure and governance, and the method for distribution of income, are similar to the equivalent requirements for ACO participation as set forth in the ACO Rules.<sup>8</sup>

### Corporate Structure and Governance

The well-known “single legal entity” requirement of the Stark group practice rules is similar to that required of an ACO umbrella organization. As a single legal entity, the Super Group consists of an organizational form recognized by the state.<sup>9</sup> This concept is also a requirement for ACO participation.<sup>10</sup> Due to the consolidation of multiple practices into the single legal entity of the Super Group, this structure eliminates the need to establish a separate ACO-specific governing body of the Super Group. This model is unlike other ACOs, which may be formed with independent participants and therefore are required to have a separate ACO governing board.<sup>11</sup>

Also well known is the “unified business” requirement of the Stark group practice rules,<sup>12</sup> which is similar in many respects to the requirements under the ACO Rules.<sup>13</sup> As a unified business under Stark, the Super Group must have a centralized decision-making body, representative of the Super Group. Compliance with this factor would meet the requirement for ACO participa-

tion, pursuant to which an ACO must “establish and maintain a governing body with adequate authority to execute the statutory functions of an ACO.”<sup>14</sup>

Further, the governing body’s authority under the Stark group practice rules and the ACO Rules is similar in scope. The Super Group’s governing body must have decision-making authority and be able to maintain control over the group’s assets and liabilities, including, but not limited to budgets, compensation, and salaries.<sup>15</sup> Participation as an ACO would require that the Super Group’s governing body provide oversight and strategic direction with accountability for meeting the goals and the ultimate responsibility for the success or failure of the ACO.<sup>16</sup> In other words, the authority of the Super Group’s board to control and to make decisions about the organization as a whole should be expansive so that it can properly carry out the mission of the organization.

A Super Group shares financial risk with its physician participants and is therefore not only a unified business, but also a financially integrated entity favored under the ACO Rules, unlike other ACOs which may incorporate independent practices with less resulting integration. As a result, physician participants in the Super Group have a meaningful commitment to the Super Group’s mission. According to the Center for Medicare & Medicaid Services (CMS), such a commitment can ensure the success of an ACO because it gives each participant a sufficient stake in the organization to motivate the participant to achieve the goals.<sup>17</sup>

In addition, the corporate law fiduciary duties, which govern boards of directors under state laws, are similar to the board fiduciary responsibilities and accountability that is recommended under the ACO Rules.<sup>18</sup> As expressed by CMS in the ACO Rules, this accountability will help achieve the Goals and also impact the ultimate success or failure of the ACO.<sup>19</sup> Because the Super Group represents one cohesive provider rather than a group of independent associations, any concerns relating to conflicts of interest among its Board of Directors may be limited or non-existent. This factor will facilitate achievement of the ACO’s overall mission rather than, for example, the interests of one part of the ACO.<sup>20</sup>

## Distribution of Profits and Shared Savings Payments

For ACO participation, the Super Group must have in place a method for distributing its shared savings payments. Further, this method must comply with the fraud and abuse laws, including the distribution requirements of the Stark group practice rules, or the ACO must receive a waiver from any noncompliance. The well-known rules for distribution of profits and payments under Stark’s group practice rules may also be utilized as a method for distribution of shared savings payments where such payments are made directly to physician members of the Super Group. Under this format the Super Group would have no need to seek a waiver from compliance with the fraud and abuse laws.

The Super Group can be designed to incorporate “Divisions,” grouping physicians together based on practice specialties or service line providers. Such structural protections can not only lessen the identity and cultural loss due to centralized control,

but also can assist with the distribution of profits amongst the physician members of the Divisions. For example, under the group practice rules, a Division with at least five physicians can receive distributions of profit of its own services and therefore its profits would be less subject to the services provided by the Super Group as a whole. An important concept understood by the Super Group in this respect is the protection of cultural practice patterns by having the ability to direct professional fee revenue back to the division or profit center that generated it. This understanding can be applied to ACOs.

## Conclusion

While the healthcare community is grappling with understanding the new structure, realities, and impact of ACOs, the landscape of healthcare services delivery is already changing for some by using the basics of the group practice model. The lawyers are studying the legal impact of the ACO under state and federal laws with the hope that this new concept will spearhead the achievement of better care for individuals, better health for populations, and lower growth in healthcare expenditures. At the same time, others are achieving those results in forming Super Groups, by better utilizing their basic group practice model. In time, this model may be an effective standard of acceptance into the ACO program.

- 1 See 42 U.S.C.A. § 1395jj (2010). The Final Rules implementing this program is located at 76 Fed. Reg. 67802 (November 2, 2011) (ACO Rules).
- 2 See *Making Good on ACOs’ Promise – The Final Rule for the Medicare Shared Savings Program*, Donald M. Berwick, M.D. N Engl J Med 2011; November 10, 2011, available at [www.nejm.org/doi/full/10.1056/NEJMp1111671](http://www.nejm.org/doi/full/10.1056/NEJMp1111671).
- 3 See 42 USCA § 1395nn. Further, any existing state corporate practice of medicine laws would not impact a Super Group, which would have 100% physician ownership and control.
- 4 See, for example, CMS letter dated March 16, 2012, to Medicare Shared Savings Program Applicants clarifying a number of issues in the ACO Rules.
- 5 The “Stark group practice rules” are located at 42 CFR § 411.352.
- 6 Designated health services are a defined set of services applicable to the Stark Law, found at 42 CFR § 411.351.
- 7 As an example, one important exception to Stark that In-Office Ancillary Services exception which a group practice must meet in order to refer internally and bill for ancillary services such as CT scans and laboratory services. See 42 CFR § 411.355 (b).
- 8 76 Fed. Reg. 67802.
- 9 See 42 CFR § 411.352(a).
- 10 See 76 Fed. Reg. 67816 (November 2, 2011).
- 11 See *id.* at 67817.
- 12 See 42 CFR § 411.352(e).
- 13 Under the ACO Rules the composition of the governing body must include representation of the beneficiaries served by the ACO, but allows for some flexibility in this requirement by giving an option to allow alternative innovative ways to involve beneficiaries in ACO governance. See *id.* at 67820. While a Super Group under the group practice rules would not initially comply with this requirement, the composition of the governing body may be modified for ACO purposes, or the Super Group could seek other options.
- 14 *Id.* at 67817.
- 15 See 42 CFR § 411.352 (f)(1)(i).
- 16 See 76 Fed. Reg. 67816 (November 2, 2011).
- 17 See *id.* at 67824-25.
- 18 See *id.* at 67819.
- 19 See *id.* at 67818.
- 20 See *id.* at 67818-19.

## Deciphering ACO Exclusivity Issues for Specialist Physicians

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On November 3, 2011, the Center for Medicare & Medicaid Services (CMS) published the Final Rule setting forth the parameters for accountable care organizations (ACOs) to participate in the Medicare Shared Savings Program (MSSP).<sup>1</sup> One of the concerns of specialist physicians who are interested in joining an ACO is their ability to participate in more than one ACO. In the Final Rule, CMS included provisions that provide flexibility for specialists to participate in multiple ACOs. However, practically speaking, they may not have as much flexibility as the Final Rule appears to provide. This article discusses a practical problem specialist physicians face if they seek to participate in multiple ACOs.

The Final Rule defines an ACO as a legal entity that has a certain Taxpayer Identification Number (TIN), and that is comprised of one or more “ACO participants.”<sup>2</sup> An ACO participant is an individual or group of provider(s)/supplier(s) (e.g., hospitals, physicians, and others involved in patient care) that are identified by a Medicare-enrolled TIN.<sup>3</sup> An ACO provider/supplier is defined as a provider or supplier who is enrolled in the Medicare program and bills on a fee-for-service basis under a billing number assigned to an ACO participant’s TIN.<sup>4</sup>

As part of its application to CMS, a prospective ACO is required to submit a list of its ACO participants and their associated ACO providers/suppliers, and identify those providers/suppliers who are primary care physicians.<sup>5</sup> Further, the ACO participants and the providers/suppliers are, prior to the filing of the ACO application, required to sign agreements or contracts relating to participation in the ACO.<sup>6</sup> Essential to the successful operation of the MSSP is CMS’ ability to gather and analyze claims and other information submitted to CMS by an ACO participant through its billing TIN.<sup>7</sup> This data will be used by CMS to calculate an ACO’s shared savings, assign beneficiaries, benchmark, etc.<sup>8</sup> Consequently, CMS has determined that *all* ACO providers/suppliers associated with each ACO participant TIN must agree to participate in the ACO as a member of that ACO participant.<sup>9</sup> Thus, for example, if a group practice agrees to participate in an ACO, the group practice entity will be designated as an ACO participant and all of the physicians and allied health professionals in the group must agree to participate in that ACO.<sup>10</sup> CMS’ “all or none” approach is one reason why physicians and physician group practices<sup>11</sup> may hesitate before agreeing to become either ACO providers/suppliers or ACO participants.

An ACO participant TIN, and its associated physicians “upon which beneficiary assignment is dependent,” must be exclusive to one ACO.<sup>12</sup> If beneficiary assignment is not dependent on the

ACO participant’s TIN, an ACO participant and its associated physicians may participate in multiple ACOs. Thus, the question of how Medicare beneficiaries will be assigned to an ACO becomes a critical step in determining whether a given ACO participant is able to provide services on behalf of multiple ACOs.

The assignment of a Medicare beneficiary to a particular ACO is a two-step process:

- CMS identifies those beneficiaries who have received at least one primary care service,<sup>13</sup> based on the most recent twelve months (for prospective assignment) or the “performance year” (for final assignment),<sup>14</sup> from a primary care physician who is an ACO provider/supplier in that ACO.<sup>15</sup> ACO assignment of those beneficiaries is made based on a “plurality of care” determination. This means if the allowed charges for the primary care services furnished to a given beneficiary by all the primary care physicians<sup>16</sup> who are ACO providers/suppliers in that ACO exceed the allowed charges for the primary care services furnished by the primary care physicians who are either ACO providers/suppliers in any other ACO, or not affiliated with any ACO and identified by a Medicare-enrolled TIN,<sup>17</sup> he or she is assigned to that ACO.
- For a beneficiary who has not received primary care services from a primary care physician in the previous twelve months, CMS will make a prospective ACO assignment determination based upon the total allowed charges paid by the program to a specialist physician for primary care services rendered to that individual.<sup>18</sup> Again, the plurality of care approach is used. A beneficiary will be assigned to an ACO if the sum of the allowed charges for primary care services furnished to him or her in the most recent performance year by all of the physicians, nurse practitioners, physician assistants, and clinical nurse specialists who are ACO providers/suppliers in that ACO exceeds the sum of the allowed charges for primary care services furnished by either the ACO providers/suppliers in another ACO, or those physicians, nurse practitioners, physician assistants, clinical nurse specialists who are unaffiliated with an ACO and are identified by a Medicare-enrolled TIN.<sup>19</sup>

When the assignment of Medicare beneficiaries to an ACO is determined through Step One, any primary care physicians assigned a beneficiary will cause the ACO participant of which he or she is a member to only be allowed to participate in one ACO. Moreover, even when an ACO participant does not have primary care physicians among its ACO providers/suppliers, if one of its specialist physicians provides the plurality of primary care services in the previous performance year to even one Medicare beneficiary, and that beneficiary does not receive primary care services from any primary care physician, that beneficiary will be assigned to the ACO, and the specialist physician will be treated like a primary care physician in that he or she (and other physicians billing under the ACO participant’s TIN) may only participate in one ACO.

Thus, at first glance, the Final Rule appears to provide physician specialists with the flexibility to belong to multiple ACOs. However, whether intended or not, many specialists may find their options are foreclosed by virtue of the nature of the services other physicians in their ACO participant render, or the services they render as part of their practices. Consider the following scenarios:



## Scenario One

A multi-specialty “group practice”<sup>20</sup> (Group A) which provides “designated health services”<sup>21</sup> (DHS) and which includes primary care physicians and specialists, wants to become a participant in an ACO (ACO One). Group A’s specialists<sup>22</sup> are concerned that participating only in ACO One will harm their stream of referrals from other practices. In this scenario the primary care physicians and the specialists face a dilemma. Because of the primary care physicians, CMS is likely to assign beneficiaries to ACO One, and Group A’s TIN will be exclusively linked to ACO One. In addition, every physician in Group A (primary care physicians and specialists) must agree to participate in ACO One.

One potential resolution would appear to be for Group A to permit its specialists to provide a portion of their services under another TIN. As specialists upon whom beneficiary assignment is not dependent, but for their affiliation with Group A these physicians could be ACO participants and/or ACO providers/suppliers in ACO One as well as other ACOs. Unfortunately, for many group practices this resolution will carry significant potential risk.

CMS and the U.S. Department of Health and Human Services, Office of Inspector General (OIG) recognized that the federal physician self-referral law (Stark Law),<sup>23</sup> the federal illegal remuneration/kick-back prohibition, and the Civil Money Penalties provision<sup>24</sup> could be impediments to the development of ACOs. In order to minimize this likelihood, at the same time the ACO Final Rule was published these agencies promulgated five related waivers in order to provide parties seeking to form and operate ACOs with assurance that their arrangements would not be viewed as violating any of these statutes (Final Waivers).<sup>25</sup> One of them addresses “Compliance with the Physician Self-Referral Law Waiver.”<sup>26</sup> In order to take advantage of this waiver:

... any financial relationship between or among the ACO, its ACO participants, and its ACO providers/suppliers that implicates the [Stark Law must meet three conditions, including]

3. The financial relationship fully complies with the exceptions at 42 C.F.R. 411.355 through 411.357.<sup>27</sup>

Even assuming that the members of Group A are willing to allow its specialists to perform services under a different TIN, that may not result in a satisfactory resolution. The Stark Law prohibits a physician (or an immediate family member of such physician) who has a “financial relationship” with an entity from referring patients to the entity for DHS, unless an exception is available. Many group practices provide DHS by taking advantage of the “in-office ancillary services” exception.<sup>28</sup> In order to satisfy the in-office ancillary services exception, a physician group must, among other requirements, meet the definition of a “group practice.”<sup>29</sup> Satisfying all of the requirements of this definition is not only essential for the group to be able to perform in-office ancillary services, but it gives a group significantly greater flexibility in paying physician incentive and bonus-based compensation.

As noted above, Group A is providing DHS pursuant to the in-office ancillary services exception. In order to take advantage of this exception, Group A must satisfy the Stark Law’s definition of a group

practice.<sup>30</sup> One of the elements of this definition is the so-called 75% test; i.e., “at least 75% of the total patient-care services of the group practice members . . . must be furnished through the group and billed under a billing number (and TIN) assigned to the group . . .”<sup>31</sup> Thus, Group A needs to ensure that any of its members who are permitted to provide services under a different TIN do not cause Group A to fall below the 75% threshold. Depending on the number of physicians who are members of Group A and the proportion of patient-care services furnished under the group’s billing number, it may not be feasible to permit one or more of its specialists to practice part time under a different TIN.

## Scenario Two

Another Stark Law-compliant group practice (Group B) wants to participate in ACOs One, Two, and Three. Group B does not include any primary care physicians. However, one of Group B’s physicians provides primary care services to some Medicare fee-for-service patients. Consequently, there is a risk that at least one Group B physician has provided a Medicare beneficiary the plurality of his or her primary care services over the performance year and during that time, the beneficiary did not receive medical services from either a primary care physician affiliated with an ACO participant, or a physician, nurse practitioner, physician assistant, or clinical nurse specialist who was both unaffiliated with an ACO and identified by a Medicare-enrolled TIN. If that is the case, Group B may be limited to participating in only one ACO.

Because CMS’ beneficiary assignment determination involves a retrospective review of claims data, Group B’s options for ensuring it is able to participate in multiple ACOs appear to be limited. One option may be to develop a mechanism whereby Group B ensures that it is not providing the plurality of a beneficiary’s primary care services; however, without the ability to control which physician a beneficiary elects to see, it is hard for an ACO participant to control where a beneficiary seeks these services. Another option is to make sure all Medicare beneficiaries who receive primary care services from a Group B specialist also receive at least one primary care service annually from a primary care physician who is not affiliated with this group practice. A third option would be to avoid providing those items and services that CMS has defined as primary care for purposes of ACO participation. However, not only would this third option limit the continuity of care provided to Group B’s patients, it also likely would have a significant negative impact on many of these physicians’ incomes.

## Scenario Three

Group B enters into participation agreements with ACO applicants One, Two, and Three. Each applicant is successful and signs an ACO contract with CMS. However, CMS determines that at least one Group B physician has provided one Medicare beneficiary the plurality of his or her primary care services and that beneficiary has not seen a primary care physician during the previous performance year. As a result, Group B’s TIN and all of its physician specialists “upon which beneficiary assignment is dependent” must be exclusive to one ACO.

It is not clear whether CMS or Group B will decide in which ACO Group B will participate. If the decision is made by CMS, this group may find itself a participant in the least attractive of the three options. In either case, Group B will need to terminate its contract with each of the other ACOs, which may have further consequences.

In the Final Rule, CMS tried to clarify when an ACO participant that includes physicians must be exclusive to one ACO. As frequently is the case, the Final Rule raises as many questions as it answers. CMS has recognized this and appears to be attempting to provide the industry with further guidance concerning this and other issues involving the role of TINs in the ACO program. The ACO Memo was the agency's first effort to do so. CMS published another memorandum a week later, giving further guidance on a related issue that is beyond the scope of this article.<sup>32</sup> Hopefully, CMS will be providing additional guidance as the agency continues to encourage the development of ACOs.

1 76 Fed.Reg. 67802.

2 42 C.F.R. § 425.20.

3 *Id.*

4 *Id.*

5 42 C.F.R. § 425.204(c)(5)(i). CMS Memorandum to Medicare Shared Savings Program Applicants, *Additional guidance for Medicare Shared Savings Program Accountable Care Organization (ACO) applicants* (March 16, 2012) (hereinafter referred to as the ACO Memo), at 2.

6 *Id.*

7 *Id.*

8 *Id.*

9 *Id.*

10 *Id.*

11 For purposes of this article, the phrase "group practice" refers to an entity that satisfies the definition of that term found at 42 C.F.R. § 411.352.

12 42 C.F.R. § 425.306(b).

13 "Primary care services" mean the set of services identified by the following HCPCS codes: (1) 99201 through 99215; (2) 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits); (3) Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs. 42 C.F.R. § 425.20.

14 42 C.F.R. § 425.400(a)(2)(ii). CMS explains that the Final Rule provides for "prospective assignment of beneficiaries to ACOs in a preliminary manner at the beginning of a performance year based on the most recent data available. Assignment will be updated quarterly based on the most recent 12 months of data. Final assignment is determined after the end of each performance year based on the data from that year." 76 Fed. Reg. 67867.

15 42 C.F.R. § 425.402(a).

16 "Primary care physician" means a physician who has a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, a physician included in an attestation by the ACO as provided under § 425.404." 42 C.F.R. § 425.20.

17 42 C.F.R. § 425.402(a)(1)(B)(ii).

18 42 C.F.R. § 425.402(B)(2).

19 42 C.F.R. § 425.402(B)(2)(i)-(ii).

20 As defined by the so-called Stark Law, 42 U.S.C. § 1395nn, and its implementing regulations. See 42 C.F.R. 411.352.

21 42 C.F.R. 411.351.

22 For purposes of this Scenario, assume that the specialists do not provide any primary care services. *But see* Scenarios 2 and 3.

23 See 42 USC § 1395nn.

24 42 U.S.C. §§ 1320a-7b(b) and 1320(a)-7a(a)7, respectively.

25 76 Fed. Reg. 67992 (November 2, 2012), Final Waivers in Connection With the Shared Savings Program – Interim Final Rule (the Final Waivers).

26 76 Fed. Reg. 67992 at 68001 (col. 2-3).

27 *Id.*

28 42 C.F.R. § 411.355(b).

29 *Id.*

30 42 C.F.R. § 411.352.

31 42 C.F.R. § 411.352(d).

32 CMS Memorandum to Medicare Shared Savings Program Applicants, *Merger and Acquisitions FAQ* (March 21, 2012).

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# CHICAGO

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- ❖ The role of antitrust in delivery system innovations.

#### Presenters:

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- ❖ Lee B. Sacks, MD, Chief Medical Officer, Advocate Health Care, Chicago, IL
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