ABA Health Law Section | Business & Transactions Interest Group | BUSINESS WIRE

Volume 1 No. 2
Spring 2016

Practical Guidance for Evaluating Physician Participation in ACOs

Albert Lin and Kris Kwolek, Husch Blackwell, Austin, TX

Providing clients with guidance regarding participation in an accountable care organization ("ACO") can be complicated because regulators, legislators, lawyers and business people have been hard at work developing legal and operational models to address differing needs and goals. This means that a physician client's idea of what it means to join an ACO may differ from a hospital client's idea of what comprises an ACO, and both ideas may differ from how Medicare defines an ACO. Due to the wide variety of arrangements, it is impossible for this article to address all potential nuances of an ACO arrangement, but, as a practical matter, there are several significant issues to consider when evaluating physician participation in an ACO.

Notwithstanding the complexities, the Medscape Physician Compensation Report 2016 ("Medscape Report"), released on April 1, 2016,[1] provides an encouraging update on the progress of the ACO as a critical element of developing improvement of health care. While the ultimate ACO goals of improving patient care and decreasing costs by encouraging the use of quality metrics is still debated, the Medscape Report shows increasing physician participation in ACOs, with 31% of surveyed specialists and 39% of primary care physicians reporting their participation or intention to participate in ACOs.[2] Further, as of January 1, 2015 Medicare data reflects over 434 ACOs serving 7.7 million beneficiaries.[3]

The variety of ACO types results in just as many legal structures being created. Given the complexity of the topic, this article hopes to provide a generalist's overview to assist counsel in approaching a client's questions in evaluating physician participation in ACOs.

A. ACO Types.

The broad variety of ACOs and the terminology can be overwhelming. The basic versions that the practitioner will most likely encounter, and their "subclasses" include the following:

a. Medicare ACOs. Medicare ACOs are born out of the Patient Protection and Affordable Care Act ("PPACA") through the implementation of the CMS Innovation Center. Medicare ACOs must meet specific regulatory requirements and obtain approval from Medicare. These ACOs utilize metrics developed by Medicare and apply to care provided to a patient pool consisting of Medicare beneficiaries. Within Medicare ACOs, there are currently several types - the Pioneer ACO Model, the MSSP ACO, the Advanced Payment Program, the ACO Investment Model, the Comprehensive ESRD Care Model, and the Next Generation ACO Model. All are currently outlined on the CMS website.[4] These ACOs enter into agreements with CMS for a fixed period and follow specific CMS rules and metrics. They have some potential advantages such as waivers of federal anti-kickback and physician self-referral laws to allow innovative arrangements that may otherwise be prohibited and antitrust guidance describing arrangements that should avoid antitrust scrutiny. Due to the CMS regulatory environment, it is possible that a Medicare ACO may provide more certainty regarding the rights and obligations of a physician relative to a commercial ACO.

b. Commercial ACOs. These are entities that look to the Medicare ACO model for some aspects of operation, but are not approved by Medicare and do not receive incentive payments from Medicare. Rather, commercial payors, such as Aetna, Blue Cross Blue Shield or United Health Care, may negotiate with an entity to make additional payments for provider compliance with care metrics or best practices. For example, a health plan may make a per-member, per-month payment to the entity if the entity performs certain care coordination activities. This payment would be in addition to the provider's individual fee-for-service payment. A drawback to the relatively unregulated space of commercial ACOs is that the metrics or data used for an ACO agreement with one health plan may differ from those required from another health plan. Also, the large variety of corporate structures and revenue models mean close scrutiny is required for a physician to understand exactly what rights and obligations exist.

B. Understanding Physician Benefits and Costs.

The most common benefit of an ACO sought by physicians is additional revenue. ACO payments are generally in addition to Medicare or other health plan fee-for-service payments otherwise made to providers, and can thereby create significant financial incentives for meeting the performance metrics.[5] Of course, it is important to recognize that participation in an ACO does not guarantee additional payments.

[1] Available at http://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=1.

[2] Id. at Slide 18.

[3] CMS Welcomes New Medicare Shared Savings Program (Shared Savings Program) Participants, Centers for Medicare & Medicaid Services (Jan. 11, 2016).

[4] *See* https://innovation.cms.gov/initiatives/aco/.

[5] The MSSP performance metrics can be downloaded at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html.

Volume 1 No. 2
Spring 2016

As mentioned above, another benefit of ACOs, exclusive to Medicare ACOs, is the waiver of the application of federal anti-kickback and physician self-referral laws to Medicare ACO arrangements. Given the potentially significant costs associated with federal regulatory enforcement actions, structuring healthcare operations within a Medicare ACO model may provide substantial benefits if the criteria of the waivers may be met.

To gain the benefits of an ACO participants must consider the costs arising from participation such as those associated with improved care coordination, additional patient engagement, and better medical records technology, all of which require capital investment and fundamental changes in the way physicians practice. Costs of ACO startups vary extensively but reports show the average start-up costs to be $2,000,000, with a range from $300,000 to $6,700,000, based on patient population.[6] Costs spread among ACO participants can be significant. In addition, involvement in an ACO will come at a loss of some autonomy. Physicians should be advised to consider the immediate and projected costs and ask questions of the ACO leadership, which may not always be detailed in a typical prospectus when given an opportunity to join an ACO. Indeed, the nature of an ACO is not strictly that of a passive investment, explaining the rarity of formal offering documents. The physician should consider the initial investment, the obligations of continuing capital contributions if necessary, and the likelihood of achieving shared savings distributions.

C. Corporate and Tax Structures.

An ACO can take a wide variety of forms, with Medicare ACOs requiring compliance with PPACA's requirements (commercial ACOs may take into account similar requirements). These requirements include, with respect to the providers of services and suppliers that may make up a Medicare ACO, a "mechanism for shared governance." There must be a formal structure that allows the Medicare ACO to receive and distribute shared savings payments to the participating providers, which usually calls for a new or existing legal entity to serve as the Medicare ACO. Within a legal entity such as a limited liability company or corporation, governance may be set up in the form of classes of managers or directors. There are pros and cons of each structure, with LLCs having more general flexibility in design and membership composition; moreover, ACOs that are hospital-driven may consider the nonprofit corporation form. Physicians should be aware of the exact legal structure and their stake in the ACO.

It is equally critical that the ACO consider current and future cash flows from CMS and from commercial payors for proper tax planning (and the physician should inquire as to how shared savings payments are to be distributed, whether as compensation, partnership distributions, or corporate dividends). ACOs differ widely in this respect. Physicians should advise their own tax advisors of their pending ACO participation and permit their tax advisors to review and comment on the documentation; the earlier such information is provided, the better the tax advisors can plan for the tax burden associated with future shared savings payments.

D. Membership (Network) / Management Considerations.

Medicare ACOs are permitted to have providers of services and suppliers participate, which can include physicians in group practice arrangements, networks of individual physicians, partnerships or joint venture arrangements of hospitals, hospitals, critical access hospitals, rural health clinics, federally-qualified health centers, and other providers of services and supplies deemed appropriate by CMS. Commercial ACOs may, as a practical matter, mirror this scope of membership but have no regulatory requirements. Colloquially, the Medicare ACO members will be either "ACO participants," which are the providers and suppliers that bill Medicare (or insurance companies) directly under the Medicare ACO participant's taxpayer identification number ("TIN"), and "ACO providers/suppliers," which are providers and supplier that bill under a Medicare ACO participants' TIN. For example, some physicians who bill directly are the "ACO participants;" physicians who work for a group practice and bill under the group practice's TIN are the "ACO provider/suppliers."

Medicare ACOs are required to have enough primary care physicians to serve at least 5,000 Medicare beneficiaries; commercial ACOs have no such mandate but as a practical matter need sufficient network coverage to be viable. The physicians should consider, particularly in the case of commercial ACOs, whether the ACO membership (i.e. provider network) is broad enough to function effectively in the desired market. For example, the ability to keep patients within the ACO network and avoid having patients seek services outside of ACO network, can increase the odds of the ACO generating shared savings and improving quality.

A key requirement for the Medicare ACO is the requirement that at least 75% of its governing body consist of ACO participants. Within the governing body, Medicare ACOs are subject to additional requirements, such as demonstrated qualifications by the management team to have experience with payor initiatives, to have board licensed senior medical director to provide clinical management and oversight, and to have physician-directed quality assurance and process improvement committees. A Medicare beneficiary must also serve on the governing body of a Medicare ACO. And there must be a written conflicts of interest policy in place. Commercial ACOs will incorporate

[6] National ACO Survey (Nov. 2013), available at https://www.naacos.com/pdf/ACOSurveyFinal012114..pdf.

Volume 1 No. 2
Spring 2016

similar concepts. The physician evaluating ACO participation should be cognizant of the more complex governance structure, as well as consider active participation.

E. Methodology of Distribution of Shared Savings.

While Medicare ACO rules require a formal mechanism for the distribution of shared savings among Medicare ACO participants and providers/suppliers, the actual design is left to entity governance. The same is the case with commercial ACOs – there is just no regulatory oversight as is the case with a Medicare ACO. There is a wealth of whitepaper material describing payment methodologies, a particularly comprehensive one from the Commonwealth Fund, for example.[7] Physicians should identify the number and composition of the ACO network, and understand how shared savings payments are distributed within each class of members. The methods vary widely. Physicians should at least consider whether the distribution methodology is meaningful, fair, management and transparent. Specific questions might entail whether the ACO discloses (i) how much of shared savings are maintained for operations and capital expenditures, (ii) whether there is a division of distribution between classes such as hospitals, physicians, and provider/suppliers, and what the division is within each class; (iii) whether the division is based on patients, RVUs, visits, or some other measure; (iv) whether there is a difference in distribution based on specialty; and (vi) whether the distribution is made at the organization or individual level? Also important is whether the ACO imposes any take-back or claw-back provisions that would impose repayment obligations on a provider that fails to meet criteria or if the ACO overall fails to achieve its goals.

F. Conclusion.

Evaluating physician participation in an ACO will be difficult for practitioners new to the model; however, ACOs continue the upward trend and the business and transactional attorney should be familiar of the unique facets of this relatively new model of health care networks.

[7] Balit and Hughes, Key Design Elements of Shared Savings Payment Arrangements Issue Brief (Commonwealth Fund, Aug. 2011), available at <http://www.commonwealthfund.org/>.

Recent Federal Guidance Regarding Certificates of Need

Robert H. Schwartz, Butzel Long, Bloomfield Hills, MI

On January 11, 2016 the Federal Trade Commission (FTC) and the Antitrust Division of the U.S. Department of Justice (DOJ) issued a joint statement on Certificate of Need (CON) Laws and South Carolina House Bill 3250.

Background

The Joint Statement noted that originally state CON laws had laudable goals of reducing health care costs and improving access to care. It is worth remembering that CON laws had their germination under the National Health Planning and Resources Development Act of 1974 where states were required to pass CON legislation to avoid losing certain federal funding. The Joint Statement further noted that after years of experience the CON laws can apparently have the effect of undermining the very goals the laws were intended to achieve.

The Joint Statement states that the CON laws have created barriers to entry and expansion and limit consumer choice. Incumbent firms - those with existing CONs - seek to thwart or delay entry into the market or expansion by others; and finally citing the Phoebe Putney Case, the CON laws "… can deny consumers the benefit of an effective remedy following the consummation of our anti-competitive merger." Finally the Joint Statement concludes that the evidence does not support that CON laws succeeded in controlling costs or improving quality. The recommendation by the FTC and DOJ is that South Carolina consider repealing its CON laws. There is a minority opinion that takes a different view.

The Joint Statement was not the first review of CON laws' impact on competition. In 2004, the DOJ and FTC released a report on health care competition issues including CON laws. Further the DOJ and FTC in that review of particular CON laws has encouraged states to consider their competitive impact.

The Joint Statement makes specific reference to South Carolina's CON Program and House Bill 3250. The South Carolina House Bill would repeal South Carolina's existing CON program effective as of January 1, 2018. The Joint Statement reviews the impact of CON laws such as South Carolina's CON law. The Joint Statement notes that CON laws like South Carolina's raise the cost of entry and expansion; remove, reduce or delay competitive pressure; and prohibit entry or expansion outright upon the denial of a CON. The Joint Statement encourages South Carolina to consider the