


Where do Physicians Fit In?

Sorting out the reality from the hype **BY JEREMY N. MILLER, JD AND MICHAEL C. THORNHILL, JD**



IN MARCH 31, the Centers for Medicare and Medicaid Services released its long-awaited proposed rules for Medicare Accountable Care Organizations. The draft rules, which are 429 pages long, implement Section 3022 of the Patient Protection and Affordable Care Act establishing the Medicare Shared Savings Program. The regulations are very complex and indicate just how difficult it will be to get approved by the CMS as an ACO and to meet the requirements to share in any savings. One wag has described the proposed rules as “too much, too late.” Nevertheless, under the law, the first ACOs are to be up and running by Jan. 1, 2012.

Ever since the Affordable Care Act became law, the health care industry has been abuzz with interest in ACOs. Many believe that high-quality, coordinated, patient-centered care for Medicare and private patients is the best hope to rein in spiraling health care costs. Other observers question whether ACOs can significantly reduce Medicare spending—while simultaneously improving quality and patient satisfaction. The results of the CMS’ five year ACO pilot—the Physician Group Practice demonstration project—suggest that while some ACOs would receive very substantial payments, others would not necessarily receive any. Yet, a recent national survey by Health Leaders revealed that 64% of the responding health care organizations plan to create an ACO. At last month’s annual meeting of the California Association of Physician Groups, which includes many of the state’s largest medical groups and IPAs, virtually the entire conference was devoted to ACO-related topics.

The CMS is apparently concerned about wide-spread industry criticism of the proposed ACO rules. In May, it announced three initiatives to encourage greater participation: the “Pioneer ACO Model” designed for organizations that already have significant care coordination processes; the “Advanced Payment ACO Model” to provide up-front funding to providers to form new ACOs; and “Accelerated Development Learning

Sessions” to teach interested providers how to improve care delivery and move toward better coordinated care.

How should physicians, particularly those who are in smaller practices, view this frenzy of interest in ACOs? Are ACOs the flavor of the month or will they radically alter the health care delivery and payment system as managed care has done over the past 25+ years? Should physicians wait on the sidelines and see how things develop or jump in with both feet? If physicians do want to participate in ACOs, can they form their own ACO or partner with someone else (such as a hospital), or will they have to wait to be asked to the dance? For the reasons discussed in this article, the answer to each question is yes, no and maybe.

The Proposed ACO Rules

The proposed ACO rules flesh out in considerable detail what an ACO applicant will have to demonstrate in order to be approved to participate in the Medicare Shared Savings Program. Comments on the draft rules must be submitted by June 6. The final rules are likely to be issued several months later, since the first projects are to begin Jan. 1, 2012 (although this date may be pushed back). To review, the Medicare Shared Savings Program:

“promotes accountability for a patient population, coordinates items and services under [Medicare] parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient services. Under this program, groups of providers and suppliers meeting criteria specified by the Secretary [of the Department of Health and Human Services] may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO). ACOs that meet quality performance standards established by the Secretary are eligible to receive payments of shared savings.” (42 C.F.R. Section 425.2[a]).

It is important to keep in mind that ACO providers and suppliers will continue to

bill Medicare on a fee-for-service basis.

The proposed ACO rules set forth numerous requirements to be eligible to participate as an ACO including:

- The ACO must be a legal entity authorized to conduct business in the state in which it operates.
- The following participants are eligible separately or together to form an ACO: “ACO professionals” (physicians, physician assistants, nurse practitioners, and clinical nurse specialists) in a group practice; networks of individual practices of ACO professionals; partnerships between hospitals and ACO professionals; hospitals employing ACO professionals; and other groups of providers and suppliers recognized by the Secretary.
- The ACO must include a network of Part A and Part B providers and suppliers.
- At least 75% control of the ACOs governing body must be held by ACO participants (including a Medicare beneficiary representative) with each having proportionate control over governing body decision making.
- The ACO must have an adequate number of primary care physicians (internal medicine, general practice, family practice or geriatric medicine) and at least 5,000 assigned Medicare beneficiaries.
- Comply with the following federal laws: Anti-Kickback Statute, Stark Law, False Claims Act, Civil Monetary Penalties, and antitrust (in California the corporate practice of medicine prohibition may also be a concern).
- Enter into a three-year agreement with the CMS.
- Establish mechanisms for repayment of shared losses (in year 3 for the “one-sided” model and all years for the “two-sided” model).

- Be able to define the processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, insure compliance with quality performance standards, and coordinate care.
- Have a full-time senior-level medical director.
- Have infrastructure, such as information technology and electronic health records, to collect and evaluate data and provide feedback to all ACO providers and suppliers.
- Have a compliance plan.
- Be able to demonstrate “patient-centeredness” through patient surveys, evaluation of the health needs of the patients assigned to the ACO, systems to identify high-risk individuals and processes to develop individualized care plans, mechanisms for coordination of care such as enabling technologies and care coordinators, a process to exchange care information when patients transition to another provider or care setting, and a process to share decision-making with the patient.
- Meet 65 quality performance standard measures in five domains: patient/caregiver experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly
- At least 50% of the ACO’s primary care physicians must achieve “meaningful use” of EHR by the second year.
- Unlike with traditional managed care plans, patients are free to seek care from non-ACO providers; they are not even offered PPO-like financial incentives such as reduced coinsurance or deductibles to stay “in network.”
- Primary care physicians can belong to only one ACO; specialists and hospitals can participate in several ACOs.
- A Medicare beneficiary will be assigned to the ACO if the Medicare beneficiary received a plurality of his or her care from a primary care physician participant in the ACO.
- ACO’s and their physician will not know which of their Medicare patients

have been assigned to their ACO until after the first year of the contract. Therefore, as a practical matter, physicians will need to provide “ACO care” to all of their patients.

To qualify for shared savings payments, the ACO must exceed its “minimum savings rate” (as low as 2%), meet the aforementioned quality performance standards by year two, and otherwise maintain its eligibility to participate in the Shared Savings Program. For each year of the contract, the CMS will compute a fixed “benchmark” for the ACO, based on the amount that the CMS would otherwise expect to incur for Part A and B fee-for-service expenditures for the patients assigned to the ACO for that year, and other factors such as beneficiary health characteristics.

For those ACOs that participate under the one-sided model (that is, an ACO not at risk for losses during the first two years), the potential upside would generally be up to 50% of the savings in excess of the ACO’s MSR compared to the ACOs benchmark amount for the year. The MSR can range from 2% to 3.9% depending on the number of beneficiaries assigned to the ACO (the lower the number of assigned beneficiaries, the higher the MSR percentage).

However, in order to receive the full 50% share, beginning in year two, a one-sided model ACO must meet all of the quality performance standards (in the first year the ACO only needs to accurately report its quality data). If, for example, the ACO meets only 80% of the quality performance standards, then it will receive only 40% (80% of 50%) of the shared savings.

ACOs that participate under the “two-sided” model agree to share in savings, *and losses*, from the start. Generally two-sided model ACOs are eligible to receive 60% (or as much as 65%) of gross savings so long as the savings are at least 2% of the benchmark amount for the year, and (after the first year) the ACO meets the quality performance standards. But they are also at risk for losses (i.e., expenditures exceeding the benchmark amount) up to certain limits. Finally, all ACOs will be subject to a 25% withhold to help ensure repayment to Medicare of any losses.

The following examples illustrate the very different results that can arise under the two models. For example, assume a one-sided model (savings only) ACO

has 10,000 Medicare beneficiaries and a benchmark for the year of \$100,000,000. Its MSR would be \$3,000,000 (3% of its benchmark). If the ACO saves the CMS \$5,000,000 for that year, and has no quality-based reduction, its share of the savings would be \$1,000,000 (\$5,000,000 savings—\$3,000,000 MSR x 50%). However, only \$750,000 would be paid to the ACO right away because 25% would be withheld to secure the CMS against possible third year losses.

If this ACO were a two-sided model (savings plus risk), its MSR would be 2%, regardless of the number of Medicare beneficiaries assigned. If the CMS’ savings were less than the MSR (2% of \$100,000,000 or \$2,000,000), the ACO would not share in savings. But if the savings were greater than the MSR (\$5,000,000 exceeds \$2,000,000), the ACO shares in 100% of the savings and at the higher 60% rate (again, assuming no quality measure reductions in its share). Thus, the two-sided model ACO would earn \$3,000,000 (60% of \$5,000,000) or three times what would be earned under the one-sided model (subject to the 25% withhold for possible future losses).

The CMS does not attempt to dictate how the shared savings (or losses) are to be divided among the ACO participants. Obviously, this will be a significant point to be negotiated among the ACO participants, such as a hospital and physicians.

The Physician’s Role

The foregoing requirements would seem to be quite daunting for all but the most sophisticated and managed care-experienced organizations. Our view is supported by several of the CMS’ comments in the proposed rules: First, the CMS estimates, nationwide, that only 75-150 organizations covering 1.5-5 million Medicare beneficiaries (out of a total of 46.5 million in 2010) will be ACO participants initially. The CMS also estimates it will cost approximately \$1.75 million in infrastructure and first year operating costs to develop a functioning ACO. This estimate may be too low. The odds of a collection of small, independent practices (who are not already part of a successful IPA) being able to start an ACO from scratch seem truly daunting. Critics of the proposed rules believe that the complexity and expense to become a Medicare ACO will mean that only large health care systems will be able to do so. Does this mean that physicians will have only a supporting role in the formation,

governance and operation of ACOs? We think it is clear that physician participation and buy-in is central to the ACO model. Simply put, *no ACO* will be able to function without highly involved and effective physicians. The proposed rules are replete with instances where physicians are either to have primacy or share control with other participants, including:

- To state the obvious, only physicians can practice medicine.
- As noted above, three of the four entities eligible to participate as an ACO have physicians (or other ACO professionals) as their sole or co-owners, and not just as participating providers.
- Unless a hospital which employs physicians forms the ACO (a limited possibility in California), physician participants must be on the governing board with “appropriate proportionate control over ...decision making.”
- “Clinical management and oversight must be managed by a full-time senior-level medical director... who is a board-certified physician licensed in the State in which the ACO operates.”
- “A physician-directed quality assurance and process improvement committee must oversee an ongoing action-oriented quality assurance and improvement program.”
- “The ACO must implement evidence-based medical practice or clinical guidelines and processes.”
- An ACO must enough primary care physicians and Medicare beneficiaries assigned to those physicians.
- ACOs will be eligible to receive shared savings only if they meet the CMS’ quality of care performance standards.
- ACOs will be eligible to receive shared savings only if at least 50% of participating primary care physicians achieve “meaningful use” of EHRs by year two.

Should You Form or Join Now?

Physicians need to ask:

- Am I a primary care physician with a significant number of Medicare fee-for-service patients?

- Am I prepared to be legally bound to an ACO for three years?
- If I am a specialist, am I in a specialty which has the potential for significant cost savings in which I might be able to share, such as complex surgery, cancer treatment or management of chronic conditions?
- Is an ACO already formed, or being formed, by my local hospital and other physicians in my service area?
- If I am in a market with a few very large medical organizations am I at risk of losing patients or referrals if I am not ACO-affiliated?
- Will I have an opportunity to play a leadership role in the ACO?
- Can I afford to help capitalize the ACO and share in possible ACO losses?
- Am I a member of a large, multi-specialty medical group? If so, will I have a choice whether to participate?
- Do my physician colleagues and I have the financial resources, time, management and managed care experience to form and operate an ACO? If not, are there potential ACO partners (such as the local hospital) that do?
- Do I buy into the ACO philosophy of coordinated, high-quality, efficient, patient-centered care?

Physicians should also consider whether they need to make a decision any time soon. It is possible that the final regulations will make significant changes. Physicians might also want to wait and see how the early ACO adopters fare.

Alternatives to Joining an ACO

Joining a Medicare ACO is not the only way to participate in the ongoing restructuring of the health care delivery and payment system. Physicians might find it easier to participate in an ACO with private payers where the requirements may not be so burdensome. Several large, established physician organizations such as HealthCare Partners are already participating in ACOs with various combinations of hospital systems and private payers. Both Medicare and private sector payers are implementing a variety of other, cutting-

edge options involving coordinated care and shared savings, including co-management of hospital service lines and departments; bundled payments for acute care episodes; gainsharing for specific procedures such as cardiac catheterization and spinal fusion; hospital-based centers of excellence; and pay-for-performance incentives. Physicians should consider these options as well.

Evaluating a Potential ACO Partner

Among the questions you should consider in evaluating a potential ACO partner are:

- Are your goals shared and realistic?
- Do you trust your potential partner?
- Will control be shared?
- Does your potential partner have the requisite financial and management resources?
- Does your potential partner have significant managed care experience and positive results?
- How will ACO shared savings, and possible losses, be distributed?
- Can your potential partner help attract a network of likeminded physicians and other providers and suppliers?
- Will your potential partner accept primary physician control over clinical matters?

As currently conceived, Medicare ACOs may be feasible only for large health care organizations. This is unfortunate as the majority of physicians practice in smaller groups or solo. Hopefully, the CMS will recognize the need to reduce the barriers to entry so that more physicians can choose to participate and enable Medicare to achieve greater savings. One thing seems clear, however: the Affordable Care Act, in general, and the Shared Savings Program in particular, have generated a tremendous amount of interest in finding innovative ways to achieve the CMS’ triple aim of better care for individuals, better health for populations, and lower growth in health care expenditures.

Jeremy N. Miller and Michael C. Thornhill are attorneys practicing with Miller Health Law Group (www.millerhealthlaw.com) located in Los Angeles. ■