

# Accountable Care Organizations: An Opportunity Deserving Consideration?

by

*Chris Was*

## I. Introduction

The 2010 Patient Protection and Affordable Care Act (2010 Reform Act) established a voluntary Medicare Shared Savings Program (Program). On March 31, 2011 the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to implement the Program. To participate in the Program, groups of eligible Medicare providers and suppliers must form an Accountable Care Organization (ACO) approved by CMS. The proposed rule describes the goals of the Program, the requirements for ACOs and the incentive for participation – the opportunity for an ACO to receive a shared savings payment measured against an expenditure benchmark.

Comments on the proposed rule were due by June 6, 2011. Following consideration of comments, CMS will issue a final rule and commence processing applications submitted by organizations seeking to be approved as an ACO. The start date for initial three year contracts between CMS and ACOs is anticipated to be July 1, 2012.

This article will examine key requirements and incentives for ACOs. Following that, Section VI discusses practical considerations to be taken into account by groups evaluating whether to form an ACO.

## II. Program Goals and Objectives – Applying to CMS

The proposed rule articulates a broad "Triple Aim" of the Program. ACOs are expected to advance three principal objectives: (1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures. ACOs will be required to submit applications to CMS to be approved to participate in the Program. As part of the application process, an ACO must describe its plans to achieve "patient-centeredness" criteria, including how the ACO will:

- promote evidence-based medicine
- promote engagement by Medicare beneficiaries
- internally report on quality and cost metrics
- coordinate care

There are additional more specific factors that must be addressed in the application to demonstrate "patient centeredness." Once approved by CMS, and subject to satisfying quality performance standards, the ACO is eligible to receive a shared savings payment.

## III. The Basics – Who Can Form an ACO?

### A. Eligibility Requirements for an ACO

The 2010 Reform Act limits eligibility to form an ACO to certain types of providers and suppliers of Medicare services. The following groups, either separately or in combination, are eligible to participate in ACOs:

- "ACO professionals," defined to include physicians (both primary care and specialists) and other practitioners such as physician assistants, nurse practitioners and clinical nurse specialists, working in group practices
- Networks of individual practices of "ACO professionals"
- Partnerships or joint ventures between hospitals and "ACO professionals"
- Hospitals employing "ACO professionals"
- Providers (including hospitals, skilled nursing facilities, outpatient rehabilitation facilities, home health agencies or hospices that have agreements to participate in Medicare) and suppliers (defined as an entity that bills for items and services furnished to Medicare beneficiaries)
- Critical access hospitals (CAHs) that bill under "Method II" by billing for both facility and professional services.

### 5,000 Primary Care Physician Patients

Each ACO must serve a minimum of 5,000 primary care Medicare patients. The greater the number of Medicare patients served by the ACO, the lower the minimum savings rate (discussed below) that has to be achieved before the ACO can receive shared savings.

Accordingly, the ACO must have a sufficient number of primary care physicians so that 5,000 or more of their primary care Medicare patients are assigned to the ACO. Primary care physicians are required to be exclusive to one ACO. Primary care physicians must have a specialty designation of (1) internal medicine, (2)

general practice, (3) family practice or (4) geriatric medicine (patients of OBGYNs and cardiologists are not counted to qualify the ACO unless they are double board certified to act as one of the primary care designations for the patient). Patients are attributed and assigned to the ACO if they receive most (i.e., a "plurality") of their primary care services from an ACO primary care physician.

Specialist physicians are permitted to participate in ACOs. Patients of specialist physicians who are not patients of an ACO primary care physician are not counted to meet the 5,000 patient requirement. Specialists may participate in multiple ACOs; and an ACO may not require specialists to be exclusive to the ACO (to prevent formation of ACOs with significant market power).

## **B. Key Entity and Governance Requirements**

This section will highlight and summarize some key requirements for the ACO entity and its governance:

### **Entity Requirements**

- An ACO must be a separate legal entity with a federal taxpayer identification number (TIN)
- An ACO can have any legal structure authorized under state law (including corporations, limited liability companies, partnership or other entity); the ACO need not be enrolled in the Medicare Program. All of the participating ACO providers must have a TIN and be enrolled in the Medicare Program.
- An ACO is required to have organizational documents that reflect appropriate ownership and governance of the entity.
- Existing legal entities that otherwise meet the ACO requirements are not required to form a new entity to qualify as an ACO, unless the existing entity engages in substantial non-ACO activities that would make auditing or assessing compliance with Program standards difficult.
- The ACO entity must be authorized and capable of performing the following functions:
  - o receiving and distributing shared savings
  - o repaying shared losses
  - o establishing and reporting quality performance data for ACO participants
  - o performing other ACO functions specified by statute or rule

### **Governance Requirements**

- ACO participants (Medicare enrolled providers/suppliers) must have 75% control of the governing body; each ACO participating provider group must have a representative on the governing body.
- At least one Medicare beneficiary must serve on the governing body.

### **Management**

- ACO operations must be managed by an executive officer appointed by the governing body of the ACO
- The ACO must have a senior-level medical director responsible for clinical management and oversight
- ACO participants must have a commitment to the clinical integration program, either by a meaningful financial investment or human (time and effort) investment.
- The ACO must have a physician directed quality assurance process that holds ACO participating providers accountable.
- The ACO must develop and implement evidence-based medical or clinical guidelines required to be followed by ACO participating providers.

## **IV. The Financial Incentive – Shared Savings (or Losses)**

The proposed rule would not change how providers and suppliers receive payment under the Medicare fee-for-service program. However, an ACO would receive a shared savings payment if the ACO both achieves savings measured against an expenditure benchmark set by CMS and satisfies specific quality performance standards.

CMS proposes two tracks for ACOs participating in the Program. Upon entering the Program, an ACO will choose whether it wishes to assume the risk of shared losses during its first two years of participation. An ACO can choose either Track 1 or Track 2, described below:

Track 1. Track 1 can be chosen for the first two years of participation. This option allows the ACO to share in savings without sharing losses. The following terms of participation apply:

- To qualify for a shared savings payment, the ACO must achieve savings exceeding its "minimum savings rate" (MSR), expressed as a percentage of the predetermined expenditures benchmark. A Track 1 ACO's minimum savings rate varies between 2% and 3.9 percent depending on the number of Medicare beneficiaries assigned (i.e., an ACO with only the minimum of 5,000 Medicare beneficiaries will have a MSR

of 3.9%, while an ACO with 60,000+ Medicare beneficiaries will have a MSR of 2%).

- If savings exceed the MSR, a Track 1 ACO is eligible to share up to 50% of the savings (the "sharing rate"; the sharing rate for Track 1 ACOs that include Rural Health Centers (RHCs) or Federally Qualified Health Centers (FQHCs) is increased up to 52.5%).
- The total savings payment to a Track 1 ACO is limited to 7.5% of the expenditures benchmark.
- In the third year of participation, a Track 1 ACO is transitioned to the Track 2 payment methodology described below, and is held responsible for shared losses.

Track 2. A Track 2 ACO agrees to share in savings and be responsible for shared losses. The Track 2 payment methodology provides greater risks and rewards, as follows:

- To qualify for shared savings, savings must exceed 2% of the expenditures benchmark for the Medicare beneficiaries served by the ACO.
- The "sharing rate" for Track 2 ACOs is up to 60% of savings, dependent upon quality scores (the sharing rate is increased up to 65% for Track 2 ACOs that include RHCs or FQHCs).
- The total savings payment is limited to 10% of the expenditures benchmark.
- A Track 2 ACO's share of losses (expenditures exceeding the benchmark) is limited to 5% in the first year, 7.5% in the second year, and 10% in the third year.
- Track 2 ACOs (and Track 1 ACOs in their 3rd year) must establish a method to repay shared losses to CMS by: obtaining reinsurance; placing funds in escrow; surety bonds; establishing lines of credit.

Terms Applicable to both Track 1 and Track 2. The following key provisions apply to calculation and/or payment of savings to both Track 1 and Track 2 ACOs:

- CMS will predetermine each ACO's expenditure benchmark. In general, the benchmark will be based on Parts A & B expenditures for the Medicare beneficiaries who would have been assigned to the ACO, using the TINs of ACO participants for the 3 years prior to the start of the ACO/CMS agreement. The benchmark will be subject to certain adjustments and updated annually.
- To qualify for the maximum "sharing rate" of savings, ACOs will be evaluated and scored by CMS for performance and using quality measures. ACOs will report data with respect to 65 quality measures categorized into the 5 following "domains":
  - o Better care for individuals
    1. patient/caregiver experience
    2. care coordination
    3. patient safety
  - o Better health for populations
    4. preventive health
    5. care related to "at-risk" populations/frail and elderly (including specified chronic diseases requiring management)
- 25% of shared savings payments will be withheld to assure the capability to repay future shared losses. Withheld savings payments will be returned at the end of each 3-year ACO/CMS agreement period.

## **V. Other Requirements**

ACOs will be subject to various other requirements, either as part of the application process or during their period of participation in the Program, including: in its ACO application to CMS, an ACO must describe how it will achieve various elements of "patient-centeredness"; ACOs are subject to CMS monitoring and evaluation with respect to quality metrics; ACOs will need to implement information technology infrastructure, and assure 50% of ACO primary care physicians are meaningful users of EHR by the second year; and they will need to establish an ACO compliance plan; and submit marketing materials to CMS for prior review.

## **Antitrust Considerations**

The Federal Trade Commission and the Department of Justice has issued guidance regarding ACOs. Some key points are:

- An antitrust "safety zone" is established for ACOs if the collective market share of two or more ACO participating providers for a common service is less than 30% within a "primary service area."
- An ACO with a primary service area market share of greater than 50% for any common service must file for antitrust review and a decision from either the FTC and DOJ that it has no intent to challenge the ACO.
- For ACOs that fall outside the "safety zone," such that collective market share for the common service is between 30% and 50%, the ACO is not required to seek agency review. Five types of conduct are identified to avoid antitrust enforcement.

## **VI. Practical Considerations**

In evaluating whether to form or join an ACO, identified below are some considerations to be taken into account:

- **Legal Structure.** The CMS proposed rule grants a great deal of flexibility with respect to the legal structure of an ACO. Certainly an entity choice that could make sense in many circumstances is a board-managed limited liability company. With respect to participation by tax exempt hospitals in an ACO that includes for-profit participants, the IRS has issued guidance that neither the private benefit rule nor the prohibition against private investment will be violated if CMS accepts the ACO into the Program, and certain other operating conditions are met.
- **Participation by Non-ACO Medical Providers/Suppliers.** It may be necessary from a perspective of raising capital and providing management expertise to involve ACO participants that are not providers of medical services. However, as noted, 75% of the governing board must be controlled by ACO providers of medical services. This may restrict the ability of ACOs to attract investment by non-ACO providers. Similarly, the requirement that each ACO participating provider group be represented on the governing board may prove cumbersome.
- **Access to Capital and Other Resources.** Clearly there will be start-up costs associated with formation of an ACO: in most cases a new legal entity will need to be established; it may be necessary to engage consultants to assist with preparation of the application to CMS; various clinical and patient care protocols will need to be developed to govern ACO participants; investment in EHR technology, administrative and clinical information systems may be necessary, keeping in mind the requirement that a minimum of 50% of ACO primary care physicians must be meaningful users of EHR by the second year.
- **Management.** The ACO may need to contract for experienced executive management to operate the ACO.
- **Existing Entities.** CMS makes clear that existing provider organizations can qualify as ACOs, even if they engage in non-ACO operations, provided that the non-ACO operations do not create problems auditing or assessing compliance with the Program's objectives and requirements.
- **Distribution of Shared Savings Methodology.** Not addressed by CMS in the proposed rule is a methodology by which shared savings are distributed among ACO participants. However, the methodology for distribution of shared savings payments adopted by an ACO must be addressed in its application to CMS, and clearly this significant issue will be at the forefront upon formation of the ACO.
- **Cost/Benefit Analysis.** Ultimately organizations considering forming an ACO will need to estimate the initial "set-up" costs and ongoing operational costs, and compare those costs to the potential for a shared savings payment. The proposed CMS benchmark of Parts A and B expenditures for beneficiaries who would have been assigned to the ACO in the 3 prior years must be estimated. In general, the potential shared savings payment would be projected by: (1) deducting actual Parts A and B expenditures for the same population during an ACO-managed period of measurement from the benchmark; (2) further deducting 2% of the benchmark (the MSR) to yield "savings"; and (3) multiplying the "savings" by the applicable shared savings rate (ranging from 50% to 65%) to yield the potential for a "shared savings payment." All necessary data to estimate the potential for savings may not be readily available.

If you have any questions, please feel free to contact Chris Was at 615-744-8527 or [cwas@millermartin.com](mailto:cwas@millermartin.com), Teresa Culver at 615-744-8406 or [tculver@millermartin.com](mailto:tculver@millermartin.com), Jim Porter at 744-8523 or [jporter@millermartin.com](mailto:jporter@millermartin.com), Ward Nelson at 423-785-8250 or [wnelson@millermartin.com](mailto:wnelson@millermartin.com), Christie Burbank at 423-785-8307 or [cburbank@millermartin.com](mailto:cburbank@millermartin.com), or any other member of Miller & Martin's Health Care Practice Group.