As Seen In

Suffolk County Medical Society
Suffolk Academy of Medicine
BULLETIN

Accountable Care Organizations: A Dangerous Regulatory Leap of Faith

By: Douglas M. Nadjari, Esq.

Douglas M. Nadjari

While the general public has focused its present attention upon the controversial requirement that all citizens be required to purchase health insurance, the Patient Protection and Affordable Care Act of 2010 ("the Act") raises potentially dire issues for physicians, physician groups, hospitals and consumers of medical care alike. The most vexing proposal calls for the creation of Accountable Care Organizations ("ACO's"). In general, the Act envisions ACO's as entities comprised of networks of doctors, physician groups and hospitals that somehow share collective responsibility for providing care to Medicare insured patients.[i] Indeed, while member physicians need not be part of the same hospital system, they will be jointly required to manage the full spectrum of the health care needs of its Medicare insured members (a minimum of 5,000) for at least three years.

As a result of this ambitious initiative, the Government estimates that ACO's may save Medicare up to $960 million in the first three years of the program and the offer financial incentives for physicians to "buy in". Proponents say that the ACO model allows successful participants to share in the savings *if* certain medical care quality objectives are achieved; *if* financial savings are demonstrated and *if* the organization implements programs that measure its clinical and cost-saving acumen. Here is another proviso: under existing plans, ACO's meeting benchmarks would not obtain their elusive share of savings for eighteen to twenty-four months after the ACO began investing in the program.

In addition to the very practical concerns with respect to start-up costs and profitability, regulatory landmines abound and the government has done little to explain how it will ameliorate: (1) potential "Stark" law conflicts posed by such arrangements: (2) anti-kickback questions and (3) potentially conflicting anti-trust and not-for-profit status issues that such "conglomerates will inevitably raise.

Under newly proposed federal rules, there are two financial models: the "one sided" model, in which the ACO benefits from the savings it generates (and is not be penalized for having expenditures that exceed benchmarks) and the "two-sided" model in which the ACO reaps a financial benefit from the savings it generates. However, under the two-sided model ACO's *will* be penalized for failing to meet clinical or financial "benchmarks". Nonetheless, the Proposed Rule indicates that all ACO's will be transitioned to the "two-sided" model in the third year of the program. Determining whether one can survive this "sea change" and, if so, which short-term model is viable is a daunting task and, absent further guidance-- one conducted largely in the dark. Nonetheless, with either model, it appears that those unable to reduce cost or meet clinical benchmarks will suffer one fate or another: pay a penalty or simply perish.

In response to those who felt that the existing financial models were financially unrealistic, the Center for Medicare and Medicaid Services announced three new initiatives: (1) Development Learning Sessions (""DLS"), (2) Pioneer ACO Models and (3) Advanced Payment Initiatives. The "DLS" consists of four lectures sponsored by CMS concerning existing ACOs in other jurisdictions. The Advanced Payment Initiative ("API"), will explore whether the government might provide a portion of future shared savings on a more expedited basis in order encourage ACO start-ups. Finally, CMS has proposed what it refers to as a "Pioneer ACO Model" designed to promote the viability of ACO's in rural areas. It would expand the concept to include non-Medicare patients and provide technical support with respect to the implementation of EMR's and other necessary technologies.

Moreover, the success of such programs teeters upon not only the basic economic uncertainties raised herein, but upon a requisite yet illusory "best practice" standards" (and less clinical testing), a new found culture of mutual trust and professional confidence amongst providers that do not even know -- much less trust one another-- all in the absence of any meaningful tort reform.

While the ACO initiative is set to take effect in January 2012, it is it is plagued by uncertainty and five inescapable facts: (1) no ACO's presently operate in New York State and we cannot predict how existing models may work here; (2) they place primary responsibility for patient health and well-being upon the physician who may not know or trust one another; (3) the

extent to which physicians will benefit financially is questionable; (4) there are scant economic incentives to form ACO's that cater to those requiring high cost therapies or patients suffering from morbid conditions commonly found in the very populations ACO's will be called upon to serve and (5) it provides little hope for the survival of solo practitioners or small practice groups that do not wish to be subsumed by large hospital systems.

In the final analysis, the goals are laudable, albeit speculative. Also, looming large over the entire debate is the fact that there are four cases winding their way -- very slowly-- to the U.S. Supreme Court that question whether the entire Patient Protection and Affordable Care Act of 2010 is an improper extension of the Commerce Clause of the Constitution. If the Act is declared unconstitutional the entire statute will fall and statutorily mandated ACO's will fall by the wayside as nothing more than collateral damage. If the statute passes constitutional muster and the pilot programs prove viable, ACO's may be here to stay.

Right now, the medical community is flooded with lawyers and consultants touting ACO's as the inevitable way of the future -- and they may be. In our view, it is simply too early to jump into such an endeavor unless you have a very high tolerance for risk (that cannot be accurately assessed) and access to capital required to form and finance an ACO until you prove to the government that your ACO is worthy of the illusory savings ACO's may offer. The "baby-boomer population continues to grow and there should be ample opportunity to form or join ACO's when the legal, clinical and financial pictures reach "diagnostic quality.

Doug Nadjari is a partner at Ruskin Moscou Faltischek where he is a member of the firm's Health Law Regulatory Department and White-Collar Crime & Investigations Practice Group. Mr. Nadjari's work primarily involves matters of physician discipline, hospital staff proceedings, managed care disputes as well as the defense of physicians and corporations in criminal, administrative and commercial disputes. He is a member of the Nassau County Bar Association, New York State Bar Association, New York State Association of Criminal Defense Attorneys and the New York State Medical Defense Bar Association. He can be reached at (516) 663-6536 or dnadjari@rmfpc.com.

[i] New York's Medicaid Reform Act calls for the creation of ACO's to administer the Medicaid Program and, further, looks to require Medicaid primary care providers to be paid at Medicare established rates.