The Patient Protection and Affordable Care Act (PPACA) created a shared savings program under the Medicare system that is to commence no later than January 1, 2012. This program is designed to allow incentive payments to organizations that meet the requirements for an ACO in addition to the regular fee-for-service payments.

This provision of the PPACA comes on the heels of many efforts in the private market, both on the health plan side and the provider side, to assemble similar organizations for competitive purposes. Most of these efforts have been spearheaded by hospital systems, and physician providers have been aggressively recruited to join these organizations.

While the Republicans in Congress vow to repeal the PPACA, it is highly unlikely that the entire Act will disappear. Given that the shared savings program and ACOs are revenue raisers in terms of the federal government, the main argument to dismantle this part of the PPACA is the administrative burden that would be added to the health care industry. The shared savings program and ACOs have an excellent chance of being implemented, however, due to the prevailing view that there is much to be addressed and improved upon in the current health care market.

Summary of an ACO

The ACO itself as an organization may take almost any form. The ACO must meet the following statutory requirements:

- “Willing” to become accountable for the quality, cost and overall care of the Medicare beneficiaries assigned to it.
- Must make a commitment for at least three years to CMS for the shared savings program.
- Must have a formal legal structure to allow it to receive and distribute shared saving program payments to participating providers.
Must include sufficient primary care physicians that have at least 5,000 Medicare beneficiaries assigned to it.

Must have a leadership and management structure, as well as policy and procedures, to promote patient-centeredness criteria specified by CMS, including evidence-based medicine, patient engagement, coordinated care and ability to report on quality and cost measures.

Beyond these requirements, CMS will develop quality of care criteria by which it certifies the ACO as being eligible for shared savings program payments. These will include measures of clinical outcomes and other quality performance standards.

The articulated incentive for providers to even be involved in an ACO is receipt of payments under the shared savings program. In order to qualify, the Medicare beneficiaries assigned to the ACO must incur costs that fall below an “applicable benchmark” that is set by CMS.

Considerations in Pursuing Participation in an ACO

1. Cost vs. Benefit. As described above, there will be a whole slew of new requirements, reporting, protocols and structure just to be a qualified ACO. This will not just be at the ACO level but also directly impact participating providers in the ACO. Because CMS has yet to issue regulations, the exact requirements and parameters of controls, reporting and data accumulation requirements are not known. This is likely also to involve some electronic coordination of records from providers through the ACO with other providers. The real dilemma here is that all of this investment, in dollars, staff training and upheaval in operations, is front-end loaded without any assurance of a return on investment.

Not only will ACOs have no way of reliably projecting any extra revenue from being in a shared savings program, but participating providers will, likewise, not know what, if any, share of any such savings it will receive from the ACO.

2. Private Market Pressures. Whether coming from health plans or hospital systems, there is a desperate attempt to formulate new models of delivery of health care. This creates marketing opportunities for health plans in dealing with employer-provided coverage. In turn, this could create a cannibalistic panic among hospital systems just to keep whatever market share they currently have. As to physician providers, they may feel the need to throw their lot into ACOs in order to maintain participation in health plan networks.

3. Political Pressures. As described above, primary care physicians are the initial key element in providing the 5,000 lives to qualify an ACO. Therefore, an ACO, by definition, will have support of primary care physicians who can effectively exert political pressure over the recipients of their referrals. Because many primary care physicians are employed by hospital systems, this pressure may be exerted through hospital staff relationships.

4. Legal Impediments. In many markets, the most likely structure of an ACO will result in exposure for violations of the anti-kickback rules, Stark and anti-trust laws. The federal regulators of these laws (i.e., Federal Trade Commission, CMS and Office of the Inspector General) have sent signals to the marketplace that they will be providing
guidance to allow ACOs to operate without fear of prosecution under these laws. It remains to be seen if this, in fact, will be done and what these exceptions or safe harbors will look like.

**Physician Provider Issues**

Assuming a physician provider, enthusiastically or reluctantly, joins an ACO and is willing to share and disclose data, conform its systems and invest in whatever protocols are required, there will be several key issues that need to be defined and resolved.

1. **Measurement of Incentive Bonuses to Providers.** The ACO itself, in its relationship with not only the Medicare program but also private health plans, needs to have a clear definition of the amount of any incentive payments that it is to receive under those relationships. In addition, the governance of the ACO needs to likewise be clear as to the allocation of these funds to categories of providers within the ACO. If, for example, physicians are allocated a portion as a category, then the allocation within the category for physician providers needs to also be identified.

2. **Who’s Been Naughty and Who’s Been Nice.** The allocation method within an ACO among the providers will need to distinguish those providers that have contributed toward the efficiencies and the generation of those incentive payments versus those providers that have diminished these payments through overutilization and inefficient care. These determinations are likely to be based upon outcome measurements, utilization and analysis of condition of the patients.

   PPACA has a specific provision cautioning ACOs from avoiding sick patients. An ACO may be terminated from the shared savings program (after significant upfront investment to comply in the first instance) if CMS determines that it is attempting to limit care by avoiding sick patients.

   Obviously the development of the necessary criteria for evaluating physician providers for purposes of allocating these payments could be very contentious. Attempts at formulating systems to evaluate outcomes have been ongoing for decades and, for the most part, have been unsuccessful. A physician provider’s willingness to be involved in an ACO, however, needs to include an assessment of how funds that may be received will be allocated.

3. **Flexibility of Commitment.** While the federal rules dictate that an ACO itself must be committed for at least three years to a shared savings program, there currently is no guidance as to the level of commitment of constituent providers within the ACO. Therefore, as all of this is shaking out in the marketplace and with regulators, it may be prudent to make relatively short-term commitments on participation. If, however, the upfront investment in time and dollars to participate is large, and a physician provider is willing to take that step, then a physician provider would not want to be subject to termination from the ACO and would seek a longer term relationship.
Basis for Skepticism

The Medicare and private marketplace are currently pushing toward an ACO-type model with the lure of income to participating providers in excess of what they receive on fee-for-service basis. There is a good chance that this is “fool’s gold” in that thresholds under which the ACO must provide care to generate savings will likely drop if the programs are successful at all. For example, if the threshold in 2012 for a given ACO population of patients is $10 million and the ACO provides care at $8.5 million (with a $1.5 million savings), then it is unlikely that the threshold will remain at $10 million for that population very long.

Rather, the new “standard” will be the $8.5 million which may be difficult, if not impossible, to generate an incentive payment under the shared savings program. It is also possible that once ACOs are established with identified participating providers, that CMS will institute a program of penalizing the ACOs for overutilization. For example, using the illustration described above, if the new threshold is set at the $8.5 million and the providers lose all hope that there is any possibility of future incentive payments, they could easily revert to their old ways and aggregate cost of care would rise to the $10 million level again. It is naïve to think that CMS, now having complete data from the ACO, would tolerate such an increase in cost.

It may be giving Congress too much credit to think that they have created a “bait and switch” to get confirmation of what they always suspected: providers overutilize and milk the system. It is not far-fetched, however, to envision a reduction in reimbursement to match performance levels of ACOs.

Outlook

Give the analysis above, a successful ACO attempt appears daunting. What is relatively certain, however, is that the status quo of the delivery of health care is unlikely to continue. This provides a fertile environment for innovation. ACOs are but the latest byproduct of that.

With regulations yet to be issued putting meat on the bones of the structure and requirements of ACOs and with the “carrot” approach of receiving payments in excess of fee-for-service, there is not yet any clear cut financial incentive for a physician provider to join ACOs to which it is not comfortable. If the ACO concept fizzles out under its own weight, then new models may be proposed as an incentive or may ultimately be required in order to continue participating in government or private health plans. Until that time comes, a physician provider, as well as other providers, may be best served by sitting on the sidelines and watching what develops.

About the Author

Todd I. Freeman, Esq. is a shareholder with Larkin Hoffman Law Firm in Bloomington, Minnesota and has practiced health law for over 30 years. Mr. Freeman has a national practice in healthcare regulatory matters and the structuring of joint ventures. Mr. Freeman is also counsel to the American Association of Accountable Care Associations.

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