Look Before You Leap: Legal and Practical Obstacles with ACOs

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Coordinated Care and ACOs

Coordinated Care

- **Goal**: ensure that healthcare providers collaborate to make sure patients receive appropriate care at the appropriate time, while avoiding unnecessary duplication of services and preventing medical errors.
- ACOs are only one way of facilitating coordinated care.
- Other CMS Initiatives:
  1. Comprehensive Primary Care Initiative
  2. Bundled Payments for Care Improvements Initiative; and
  3. Community-Based Care Transition Program

What Is An ACO?

Accountable Care Organization (ACO) is a group of doctors, hospital(s), and other health care providers (i.e. DMEs) who voluntarily come together to give coordinated high quality care to their Medicare patients.

ACO participant is an individual/group of providers/suppliers identified by a Tax ID Number (TIN).

- Each member of the ACO may have their own TIN for individual billing

Medicare ACO Models:

1. Pioneer ACO Model
2. Medicare Shared Savings Program
3. Advance Payment ACO Model

ACO Statistics/Models

- As of January 13, 2013, there are 259 ACOs.
  - Most are located in large metropolitan areas
  - Approximately 50% are physician-led with less than 10,000 beneficiaries
  - 4:1 private sector increase

- 2011 survey found of 1700 hospitals found that:
  1. 13% are either participating or planning to participate in an ACO in 2012 and 2013
  2. 56% of hospitals said they were pursuing an ACO contract with a commercial payer of self-insured employer

- May 2012 survey of 206 healthcare organizations found that:
  1. 30.5% are participating in ACOs.

Pioneer ACO Model

Background

- Program designed for early adopters of coordinated care.
- The first performance period began on January 1, 2012.
- **Performance Years 1 and 2**
  - Shared savings + shared losses payment arrangement
- **Performance Year 3**
  - Successful Pioneer ACOs will be eligible to move to a population-based payment model (PMPM)

Status

- Currently, 32 Pioneer ACOs
- No longer accepting applications

Medicare Shared Savings Program

Background

- Program that helps Medicare fee-for-service program providers become an ACO.
- Designed to improve beneficiary outcomes and increase value of care by promoting accountability for the care of Medicare FFS beneficiaries.
- Rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first.

Status

- April 10, 2012 → 27 organizations selected. First performance period began on April 1, 2012.
- July 9, 2012 → 89 organizations selected. Second performance period began on July 1, 2012.
- January 13, 2012 → 106 organizations selected for Third performance period.
- January 2013 → Fourth performance period begins.

Advance Payment ACO Model

Background

- Designed for rural providers.
- Selected organizations receive an advance on the shared savings they are expected to earn.
- Participating ACOs will receive three types of payments:
  - (1) An upfront, fixed payment:
  - (2) An upfront, variable payment: and
  - (3) A monthly payment of varying amount depending on the size of the ACO.

Status

- In summer of 2013, CMS will begin accepting applications for the next round of Advance Payment Model ACOs that begins January 1, 2014.

Forming an ACO Under Shared Savings Program

Requirements

1. Meet all eligibility and program requirements;
2. Serve at least 5,000 Medicare Fee-For-Service patients;
3. Agree to participate in program for at least 3 years; and
4. Establish governing body

Establishing ACO Patients

1. Determined on basis on primary care services
2. Primary care services include:

HCPCS Codes 99201-99215, 99034-99340, 99341-99350, G0402, G0438, and G0439

ACO Payment Under Shared Savings Program

- Until benchmark established, paid under Medicare FFS
- 3-year benchmark to establish ACO performance
- 33 performance standards

<u>One-Sided Model (Track 1)</u>

- Shared savings calculated for each performance year during the term of an ACO's first agreement.
- ACOs not held accountable for losses in Track 1.
- ACOs that wish to continue participating in the Shared Savings Program beyond the first agreement period must do so in Track 2; (two-sided model).
- Under Track 1, the ACO may earn a sharing rate of up to 50 percent based on quality performance.

ACO Payment Under Shared Savings Program

Two-Sided Model (Track 2)

- Under this model, the ACO will be eligible for a higher sharing rate, with a higher performance payment limit, than will be available under the one-sided model.

- Under Track 2, the ACO may earn a sharing rate of up to 60 percent based on quality performance.

Legal and Practical Considerations

Forming ACO

For Profit/Not-For-Profit

- Can newly-created ACO qualify for tax exemption?
- How does ACO maintain tax exempt status when sharing payments among ACO participants?

Relationships Among Providers

- Independent contractors, employees, partnerships, joint ventures, group practice arrangements?
- "Meaningful commitment…to ACO's mission to ensure likely success."

Splitting Shared Savings/Losses

- Equally? Proportional?

Legal and Practical Considerations

Anti-Kickback Statute Stark Law, and CMP Law

Anti-Kickback Statute

- Prohibits kickbacks, rebates and fee splitting among providers.

Stark Law

- Prohibits physician self-referral if physician has financial relationship with provider to whom patient is referred.

Civil Monetary Penalties Law

- Provides civil monetary penalties for direct/indirect payments to beneficiaries to induce beneficiary to order or receive Medicare item from particular provider

Legal and Practical Considerations

Anti-Kickback, Stark Law, and CMP Law Waviers

1. ACO Pre-Participation Waiver

- Applies to startups that predate an ACOs participation agreement with CMS.

2. ACO Participation Waiver

- Applies to ACOs who are already participating in MSSP.

3. Patient Incentive Waiver

- Applies to incentives offered by ACOs to beneficiaries.

4. Shared Savings Distribution Waiver

- Applies to the ACO's distributions or use of the specific savings the ACO earned.

5. Compliance with Stark Law Wavier

Legal and Practical Considerations

Internal Disagreements

- Providers often disagree over how care should be provided.
- Is each provider in the ACO represented equally by the governing body?
- Example: Hospital wants a 64 slice CT scanner, but the nursing home, pharmacy, and DME providers think a 32 slice CT scanner is sufficient..
  - Who decides what kind of scanner to buy?
  - Who pays for it? Do all the providers pay for it equally, even though all might not share equally in the shared savings through the use of the CT scanner?
  - Will ACOs be reticent to try new techniques, therapies, surgeries or drugs because they may be more expensive?
  - Will ACOs only purchase the least expensive diagnostic and therapeutic equipment in order to keep costs down?

Legal and Practical Considerations

Referrals

- Will ancillary care providers and suppliers lose referral sources if they do not join an ACO?
- Should they follow their biggest referral sources to an ACO?
- Example: DME company receives most of its referrals for wheelchairs from Dr. Smith, an orthopedic specialist. If Dr. Smith joins an ACO, he will most likely refer his patients to the DME supplier that serves that ACO.
  - What should the DME company do?
  - What if the DME company's three biggest referral sources for various pieces of equipment join three different ACOs?

Legal and Practical Considerations

Antitrust

1. Joint Price Negotiation

- Section 1 of the Sherman Act, 15 USC § 1, prohibits "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce." As a result, any time that two companies, that work together in the same or overlapping geographic markets, coordinate their pricing or to share confidential information, antitrust concerns rise. This is known as horizontal price fixing.

2. Reduction in Competition

- Section 2 of the Sherman Act, 15 USC § 2 prohibits monopolization, attempted monopolization and conspiracies to monopolize.
- Section 7 of the Clayton Act, 15 USC § 18, prohibits mergers and acquisitions which may lessen competition or tent to create a monopoly.

Legal and Practical Considerations

Antitrust

Statement of Antitrust Enforcement Policy

- FTC and US DOJ want to ensure that ACOs do not facilitate unlawful agreements between competitors (i.e. price-fixing or market allocation).
  - (1) Rule of Reason
  - (2) Antitrust "safety zone" for ACOs with market shares in all the "common services that are less than 30% market share.
- ACOs cannot be a means for individual competitors to act as a single entity.
- Doesn't apply to ACOs that contract with commercial plans that are not part of MSSP.
- Does not prohibit private right of action.
- Horizontal and Vertical Integration Antitrust.

Legal and Practical Considerations

Corporate Practice of Medicine

- Prohibits entities that are not owned and controlled by health care providers to direct health care provisions in the provision of care.
- State laws, not federal.
  - Arkansas, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Ohio, North Carolina, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Washington, West Virginia, Wisconsin
- The CPOM prohibition could conceivably prevent some ACOs from hiring physicians directly.

Legal and Practical Considerations

Liability/Responsibility

- Example #1: Nurse commits HIPAA breach.
  - Although the ACO is ultimately responsible to pay, how are the costs allocated within the ACO?
- Example #2: A physician provider of the ACO is found to have committed malpractice and the ACO must pay out $150,000 in damages.
  - Although the ACO will pay the insurance deductible as a whole, should the physician or physician's group be held internally responsible to pay the deductible?
- Example #3: Physician joins an ACO in year 1; in year 2, physician receives a Medicare ZPIC or RAC audit for claims submitted by the physician before he joined the ACO.
  - Who is going to pay for the cost of the audit(s)?

Legal and Practical Considerations

Liability/Responsibility

- Example #4: Physician joins an ACO in year 1; in year 2, physician receives a Medicare ZPIC or RAC audit for claims submitted by the physician after he joined the ACO?
  - Who is going to pay for the cost of the audits and their potential results?
- Example #5: Hospital bills and receives money from Medicare for a medical procedure on an incorrect patient.
  - Under the Affordable Care Act, a Medicare provider has an obligation to return that reimbursement to Medicare within 60 days after the overpayment has been "identified."
  - If the provider fails to meet that 60-day deadline, the provider becomes liable for substantial penalties under the False Claims Act and also risks exclusion from the Medicare program.
  - If the ACO is fined, is each and every provider responsible for a proportionate share of the cost of the fine?

Legal and Practical Considerations

Under Arrangements

- If a provider is part of ACO, can it provide care "under arrangement" to an ACO?
- An "under arrangement" relationship is traditionally one in which a hospital contracts with a third party to provide a service to the hospital and its patients.
- The hospital bills and collects for the service and pays the third party a fee for providing it.
- Hospitals often enter this type of arrangement with providers that already have specialized services.
- Can an ACO be comprised of the minimum number/type of providers and outsource all the remaining care through "under arrangements," thereby potentially maximizing the shared savings?

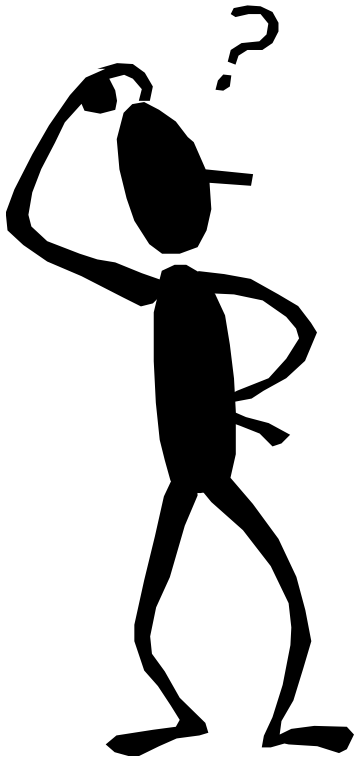
ACOs and Medicaid

- More than 10 states are expanding use of ACOs or coordinated care to their Medicaid populations

- Other states using ACO-style organizations to manage costs (aka "managed Medicaid")
  - Example: Utah and Florida

- In June 2011, Florida shifted Medicaid from FFS to statewide capitated managed care model ("Statewide Medicaid Managed Care" or "SMMC")
  - (1) Managed Medical Assistance; and (2) Long-term Care Managed Care
  - Reform divides Florida into 11 regions
  - AHCA will contract with limited number of MCOs within each region
  - "Achieved Savings Rebate" model.

Questions



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