Two Kinds

- Medicare Shared Savings Program ("MSSP")
- "ACO"s that contract with commercial insurers
GENERIC ACO MODEL

- Hospital
- (Physician Groups?)
- ACO, LLC (Nonprofit?)
  - Contract
  - Payors
- Employed Physicians
- PSA?
- Network Physicians?
ACO Entity and Governance

• If a separate legal entity will be formed:
  – Nonprofit or for profit?
  – Tax exempt or taxable?
• Reserved powers of the health system
  – Approval of Board members selected by a nominations committee
  – Amendments to governing documents
  – Sale, merger, dissolution
• Accountability of ACO officers
  – Will the CEO and CFO report to the ACO board or to health system executives (or both)?
  – Selection and removal a possible reserved power of the health system
• Consider impact of peer review and movement of peer review protected information between ACO and health system
Legal Barriers to ACO Integration

Federal:
- Antitrust Law
- Antikickback Statute ("AKS")
- Stark Law
- Civil Monetary Penalties ("CMP")
- Nonprofit/Tax Exemption
Legal Barriers to ACO Integration (cont.)

State:
- Insurance laws
- Managed care laws
- Antikickback laws
- Self-referral laws / “Mini-Stark” laws
- Fee splitting
- Corporate practice of medicine
- Antitrust
- Securities laws
Antitrust

- Competitors prohibited from cooperating to set prices.
- If creating a new, integrated product, arguably not price fixing.
- FTC Antitrust Guidelines -- rules for determining whether integration (financial, clinical) is sufficient.
- 30% non-exclusive, 20% exclusive.
- If a joint venture (due to sufficient integration), a balancing test is still applicable.
Applying the Balancing Tests

- Shared savings
- Capitation
- Bundled payments
AKS Basics

• Intent-based
• Greber test
• Presumptions by regulators
• Managed care
• Special waiver may be available
Stark Basics

• Intent irrelevant
• Non-FMV payment deemed to take into account volume or value
• Managed care exception
• Special waiver may be available
CMP Basics

• Payments to physician to reduce or limit services
Nonprofit / For Profit

• Most hospitals are nonprofit entities under state law.
• Generally, nonprofit entities cannot distribute profits to members, except other nonprofits.
Tax Exemption

• Many hospitals are tax exempt (“501(c)(3)”).
• Prohibited from sharing profits, or paying in a manner that gives rise to private inurement, private benefit, disqualified transactions. Tax consequences for unrelated business income.
• No exemption in law.
• Insurance companies are not permitted to be exempt under 501(m) of the Code.
How Can ACOs Pay?

• Distributing risk may create insurance law problems.

• Payments to independent contractor physicians may create problems under Medicare and tax exemption laws.
Commercial ACO Payments

• Care management / administration
• Quality improvement
• TCOC incentive – shared savings
• Individual cost incentives
• Down-side risk
• Withhold
• Bundled payments
• Capitation
Legal Issues Implicated by Distribution

- Medicare Fraud and Abuse
- Antitrust
- Insurance
- Tax Exemption
State Insurance Laws

• States regulate entities engaged in the business of “insurance”
  – Defined by state statute and case law
  – Assumption of financial risk of loss

• Allocation of risk vs. contract for services: What is the primary purpose of the arrangement?
  – Pricing of own services typically okay.
  – Risk on another’s services, pooling patients to manage risk, fixed payment unrelated to utilization: more likely to = insurance.
TBD: What Risk is Allowed?

- Downstream Risk: many states do not regulate provider organizations when risk is assumed from a licensed insurance carrier.
- Some states regulate such risk bearing organizations under insurance/managed care laws
- Direct contracts with ERISA plans do not shield from insurance/hmo regulation
Applicability of Insurance/HMO/Managed Care Licensing Laws

- Will depend on the state in which the ACO operates
- Multi-state operation?
- May depend on the particular payment structure:
  - Type of payment arrangement
  - Level at which state regulators conclude that the quantity or nature of transferred risk is sufficient to constitute “insurance”
  - Scope of services
How Can ACOs Take Real Risk?

• Meet requirements of insurance laws
  – Financial solvency & capital reserve requirements
  – Compliance with myriad insurance regulations

• Always contract with/via a regulated entity (unless state law says otherwise)
Other State Regulation?

- Third Party Administrator license
- Regulation of indirect provider contracting/network organizations
  - May affect structure of organization
ACO Participation Agreements

• What providers in the ACO network?
  • Eligible provider types, specific providers

• What type of payer arrangements will ACO pursue?
  – Delegation of rights to contract for any and all health services to ACO?
  – Or partial delegation of rights to contract only for incentive arrangements?

• All In vs Opt In
  – By payer? Plan type? Type of incentive arrangement?
ACO Participation Agreements (cont.)

• Exclusive vs. non-exclusive
  – Allow participation by providers in competing ACOs?
  – Larger specialty groups in metropolitan areas may admit patients at hospitals in multiple systems; will they then participate in other ACOs with competing systems?
  – Antitrust considerations
  – State law limitations

• Term and termination
  – Allow termination without cause with advance notice?
  – Continuity of care or payer obligations
  – If a group terminates during the term, would incentives be paid (deficits owed)?
ACO Participation Agreements (cont.)

- Bind to terms of payer agreements
- Attribution of patients/lives
- Clinical management
- Data sharing
- Quality improvement and performance
- Reporting
- IT infrastructure/EHR/interoperability
- Payment
ACO Participation Agreements (cont.)

Ripple effects?

• What impact on reimbursement under the current payer agreements as new incentive arrangements are created?
  – Will health system reimbursement go down or be placed more at risk?
  – Potential antitrust concerns over price fixing

• Effect on physician compensation as new arrangements take effect (e.g., health system pays employed MDs based on wRVUs which are no longer aligned with new payment reforms)
Payer Agreements

• Which ACO network providers are included?
  – All in? Opt-in? Payer discretion?
  – Process for adding or terminating providers
  – Exclusivity requirements

• Agreement with ACO: in addition to or in place of provider network agreements?

• Scope of benefit plans/health insurance products included
Payer Agreements (cont.)

• What membership included? (or eligible)

• Methodology for attribution/assignment
  – Can this be changed?
  – If so, how and when?

• Competition
Payer Agreements (cont.)

• Data sharing & reporting: what, when, how
  – How much
  – Clinical reporting
  – Status updates; performance reports
• Sharing of PHI- HIPAA, state law
• Business Associate Agreements
• IT requirements
Payer Agreements (cont.)

• How much transparency?
  – description of compensation arrangement / methodology
  – description of quality performance measures and requirements
    • How measured
    • How performance on quality measures affects payment(s)

• Other compensation: patient care management fee, administration
Payer Agreements (cont.)

• Term and Termination
  – Impact of early termination on payment
• Process for resolving discrepancies
Should I Form an ACO?

• Expensive
• Little return on investment
• Sufficient population/attributed lives
• Change is hard
Can I Bring Value to an ACO?

- Population health
- Populations with behavioral health conditions
- Care management
- Protocols
- EHR data elements for behavioral health
Should I Join an ACO?

- Access to patients
- Enhanced reimbursement
- Participation in a model that may become more important
- Seat at the table
Questions?