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# What to ask if an ACO comes calling



**EVERY MONTH, DERMATOLOGY WORLD** covers legal issues in Legally Speaking. This month's authors, attorneys Daniel F. Shay, Esq. and Alice G. Gosfield, Esq., are health care attorneys at Alice G. Gosfield and Associates, P.C.



**M**any dermatologists are concerned about how to respond if an accountable care organization (ACO) approaches them for participation. What questions should be asked at the outset? What pitfalls lie in the ongoing operation? How do I get out if I do not like it?

A significant aspect of the confusion associated with these questions is the lack of a standard definition of what an ACO is. In the health reform legislation, Medicare is authorized to contract with entities that would have the ability to accept both Part-A and Part-B payment and pay them a portion of any shared savings at the conclusion of a three-year contractual period. The creation of Medicare ACOs is not mandatory. They are not even demonstration projects or pilots. This was simply an opportunity that was made available in the legislation. It is modeled heavily on the Medicare Group Practice Demonstration Project of several years earlier in which, while quality improved, very little by way of shared savings was made available to the participants. (For further reading on this point, see "Lessons from The Group Practice Demonstration Project — A Sobering Reflection." *N Engl J Med* 2011; 365:1659-1661.) There is considerable federal regulation addressing how to qualify as an ACO, as well as regulatory exemptions from Stark, anti-kickback, and antitrust liabilities associated with otherwise disparate and independent providers coming together for this purpose.

But Medicare is not the only game in town. Commercial insurers have now begun to tout their entry into the ACO field. Here, there are no rules of the game nor common definitions. The basic feature is some form of altered payment, typically a shared savings bonus which is available based on measured performance both on quality metrics and financial results. Some of these ACOs are specialty-specific (e.g. a cardiology ACO or an orthopedic ACO), while other insurers expect the participating providers to play for all patients insured by that payer.



The theory behind ACOs is that by putting hospitals, physicians, skilled nursing facilities, and other providers under the same budget, their incentives will be better aligned than they are today, when physicians are paid on a fee-for-service basis and hospitals get paid predominantly based on diagnosis-related groups (DRGs) for inpatient care or Medicare's ambulatory payment classifications (APCs) on the outpatient side. The hope is that the newly interrelated providers will develop infrastructure, processes, and expectations that define a different delivery system. The ACO becomes "accountable" by virtue of the financial risk in not meeting the defined budget as well as, typically, being subjected to quality measurement in order to qualify for additional dollars in shared savings or bonuses.

This article addresses some fundamental questions dermatologists should ask when presented with an ACO opportunity, offers some observations about the contracts that create the ACO, and also addresses some issues that arise under the typical bundled payment models used in ACOs.

### GOVERNANCE AND CULTURE

A fundamental issue in considering whether to participate with an ACO is who sponsors and governs it. Many ACOs are formed as a result of collaboration between a health system and a payer, but data from Leavitt Partners in 2012 showed that physician-led groups were also getting involved. The differences in operations and policy can be substantial, although virtually all ACOs acknowledge the essential role of physicians. They may do so in different ways, however. If the ACO already has a payer contract that is a different proposition from an ACO that is beginning to coalesce in the hopes of getting a payer

contract. Questions to ask include:

- Does the ACO have any contracts already?
- Who owns the ACO?
- Is it for-profit or not-for-profit?
- Who sits on the board?
- What are the operational committees through which the ACO program operates?
- Can you get copies of or access to all of the policies with which you would be expected to comply?

These are questions which will begin to reveal the culture of the organization. If the ACO is just forming, some dermatologists may be interested in getting involved in its development. Asking about those opportunities will matter to some physicians. Physicians who may be in independent practice in the community are sometimes concerned about the extent to which their viewpoint is represented in an ACO which is driven by a health system or a hospital. If this is a concern, ask about what the bylaws or policies say with respect to representation on the board and on significant policymaking committees. Are all the major decision makers from large groups or are slots maintained for independent community-based physicians, too?

The extent to which the ACO can be open and provide mission statements, compacts, or policy documents which state its goals and expectations can matter. Some ACOs are focused around really creating a new culture to deliver care. Others are more oriented solely around the terms of their payer contracts. There is no one answer as to which is a better setting for any dermatologist. That will depend on preferences as well as on how flexible the ACO is. Some may simply say "Here is our agreement. Sign it or not. We'll find

someone else if you don't." Others may be far more welcoming and inclusive.

### CONTRACTUAL ISSUES

ACOs that are not single integrated delivery systems operate through a range of contracts. There is the contract from the payer to the ACO. Then there are the contracts which establish the multiple providers', including physicians', participation with the ACO. These ought to address criteria for initial and continued participation, the payment methodologies and formulae, and when payment is made. This is not very different from the issues that have been associated with joining any network, whether an IPA, a PHO, or even a managed care plan, since the ACO will be making payment to the participants in most instances. That is part of the point. The accountability in accountable care comes from the financial efficiencies of the payment model and quality scoring. Dermatologists should inquire as to whether they will be part of new payment opportunities and if so, what the metrics are against which they will be measured and scored.

The contract should address the bases for termination — by the physician as well as by the ACO. Some ACOs that select their participants very carefully to meet their cultural expectations may not allow without-cause termination without a fairly long notice period, because they have designed their network to have a specific constellation of providers. ACOs that are less discriminating in their choices may allow easier termination without cause.

Dispute resolution should also be addressed in the participation agreement. First there are the basic disputes around termination, payment, and application and adherence to the ACO's articulated standards — whether



practice guidelines, policies, or performance measure thresholds. ACOs are quite variable in the sophistication with which they address these issues. In addition, the fundamental payment incentives that make care more efficient and accountable raise new kinds of disputes than have existed before, as is discussed below. The essence of the ACO incentives is to bundle payment across disparate providers. This requires further inquiry.

#### **BUNDLED PAYMENT**

Bundled payment is the term that is used to describe arrangements where multiple providers who are organizationally separate are held accountable for their delivery of services under a single budget. The Medicare ACO Program is a bundled payment program with a sharing of savings at the end of a three-year period if quality benchmarks are met. As with most bundled payment programs, in Medicare's version providers are paid in the ordinary course of business in accordance with traditional payment models under Medicare Parts A and B.

Most standalone bundled payment programs are focused around episodes of care — one payment for a defined period of time. Where there is an admission involved, the episode usually includes some pre-admission care, the admission, and a period of time (from 30 to 180 days) post-discharge. While episode payments need not be bundled and can be paid to separate providers without shared risk, almost all current bundled payment models are based on episodes of care. Chronic care episodes (e.g. diabetes, asthma, hypertension) extend for a year to coincide with the payment of insurance providers.

Some bundled payment programs, particularly where commercial ACOs

are involved, base their budget for the ACO on prior years' expenditures with the expectation of a reduction. Even if the ACO is specialty-specific rather than having to define specific bundles around condition-based episodes, the payer may say to the ACO, "If you reduce the amount we spent on cardiology services for you last year, you can share in the savings."

For dermatologists, the most critical issue with respect to bundled payment is whether the dermatology services are in the bundle or outside the bundle. Dermatology has not been widely cited as a driver of the increase in health care costs that motivated the creation of ACOs and new payment models. Still, given the overall push for greater value, dermatologists will be expected to demonstrate more efficiency, usually defined as lower costs. In some instances this will be a threshold to be included in the ACO network to begin with. In almost all ACOs, demonstrated efficiency will be required for dermatologists to remain in the ACO.

The disputes that arise under bundled payment can be different from those in traditional fee for service. Usually, if a physician is part of a bundled payment, the definition of what constitutes the bundle (which providers are included), the boundaries of an episode of care, the budget for the bundle, and the rules for when a bundle is triggered, broken, or expired are not subject to dispute resolution because these are what the payer or the ACO has established in designing the system. The rules for severity adjustment of the bundle for more complex patients are also part of the design. But it is important that questions such as whether a specific episode has been launched, whether it is properly severity-adjusted,

the portion of budget that is available to any physician, and the scores which determined if a physician qualified for any upside benefit (e.g., shared savings or a bonus of some kind) should be subject to some kind of review or appeal if the physician disputes the decision of the ACO. This is a potentially critical issue if a dermatologist has the opportunity for additional payment from this model. In some instances, it is possible that dermatologists could share in downside risk as well, but these rules ought to be stated in unequivocal terms in the participation agreement or its supporting policy documents or manuals.

#### **CONCLUSION**

There is no question that ACOs are proliferating around the country. Whether any dermatologist will face the question of whether to join is very market-specific. Once an opportunity is offered, its implications to any practice, how fair it is, and how much risk is at hand are quite variable. Evaluating these opportunities and managing participation in them is a significant contractual issue. Dermatologists should evaluate these opportunities carefully and with sophisticated guidance from experts. *dw*