Physician Care: Understanding the Physician’s Role in an Accountable Care Model

Presented by
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• Physician's role in an Accountable Care Organization (ACO)
• Collaboration structures and methodologies to ensure greater accountability
• Independent vs. employed physician’s role
• How to engage both independent and employee physicians as members of an ACO
• Organization of physicians and other institutional health care providers accountable for overall care of traditional fee-for-service Medicare beneficiaries who are assigned by CMS to an ACO
• Promotes accountability for patient population, minimum of 5,000 lives
• Coordinates items and services under Medicare parts A and B
• Encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery
• ACOs that meet quality performance standards will be eligible to receive additional Medicare payments based on risk-adjusted shared savings against historical benchmarks
• Inter- and multi-disciplinary care coordination
• Built on collaboration and shared responsibility/accountability
ACO Requirements

• Each ACO must have:
  – Minimum three-year agreement with HHS
  – Formal legal structure to be able to receive and distribute payments for shared savings to participating providers/suppliers
  – Sufficient number of PCPs
  – Integrated clinical and administrative systems
  – Processes to promote evidence-based medicine, reporting on quality and cost measures and coordination of care
  – Met “patient-centeredness criteria”
Organization of ACOs

- Group practice arrangements
- Networks of individuals and groups
- Joint ventures between groups and hospitals
- Hospitals employing ACO professionals
- Contractual relationships between ACOs and hospitals/groups
- Rural Health Clinics ("RHCs")
- Federally Qualified Health Center ("FQHCs")
- Other models
Long-Term: ACOs created to move from fee-for-service reimbursement to placing risk on providers

Short-Term: Payments will continue to be made under current Medicare programs – continue parts A & B reimbursement

Only participating ACO (and its “participants”) will be eligible to receive payments for shared savings
• Physicians will be core element for all ACOs
• While a physician group that is unaffiliated with a hospital can be certified as an ACO, a hospital without affiliated physicians cannot
• The Final Rule on ACOs (passed in October 2011) makes ACO models more attractive to all providers
Proposed Rule vs. Final Rule

• Significant changes made to attract providers to the program:
  – Decreased financial risk
  – Decreased the number of required quality measures
  – Lowered the thresholds to share in the savings
  – Eliminated the requirement of providers to use EHR
  – Broadened participant eligibility
  – Provided for advanced payment for small or rural ACOs
Proposed Rule vs. Final Rule

• Risk Models:
  – Proposed Rule:
    • Two Models:
      – One-Sided Risk: ACO shares only in potential savings for the first two years; third year ACO shares in savings and losses
      – Two-Sided Risk: ACO shares in savings and losses in all three years
  – Final Rule:
    • Two Models:
      – One-Sided Risk: ACO shares only in potential savings for all three years
      – Two-Sided Risk: ACO shares in savings and losses in all three years (unchanged)

• By eliminating the possibility of sharing in losses in the One-Sided Risk Model, Final Rule encourages ACO participation and experimentation.
Proposed Rule vs. Final Rule

• Fewer Quality Measures:
  – Proposed Rule:
    • 65 measures across 5 domains
  – Final Rule:
    • 33 Measures across 4 domains
      – 7 related to patient/caregiver experience
      – 6 related to care coordination/patient safety
      – 8 related to preventative health
      – 12 related to at-risk populations

• Reduces burden of participation
Proposed Rule vs. Final Rule

• Shared Savings Threshold

Proposed Rule vs. Final Rule

• Shared Savings Threshold (cont.)
  – Proposed Rule:
    • One-Sided Risk Model: shared savings begin at 2%, with some exceptions for small, physician-only and rural ACOs
    • Two-Sided Risk Model: Sharing from first dollar
  – Final Rule:
    • Sharing from first dollar for ALL ACOs in both models once minimum savings rate has been achieved

• Eliminates bias in favor of Two-Sided Risk Model
EHR Requirements

- Proposed Rule:
  - Required at least 50% of an ACO’s primary care physicians be defined as “meaningful users” of Electronic Health Records

- Final Rule:
  - 50% threshold requirement eliminated

Removes this requirement as a barrier to entry
• Advanced Payment Model
  – Provides additional support to physician-owned and rural providers
  – Advance payments would be recovered from any future shared savings achieved by the ACO
  – Under this model, ACOs would receive three types of payments:
    • Upfront fixed payment
    • Upfront payment based on number of its historically-assigned beneficiaries
    • Monthly payment based on number of its historically-assigned beneficiaries
Proposed Rule vs. Final Rule

• Advanced Payment Model (cont.)
  – Model only available to two types of organizations participating in the Shared Savings Program:
    • ACOs that do not include any inpatient facilities AND have less than $50 million in total annual revenue
    • ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than $80 million in total annual revenue
  – ACOs that are co-owned with a health plan will be ineligible, regardless of whether they also fall into one of the above categories
Practice Affiliation Model

SYSTEM PARENT

ACO

HOSPITAL
501(C)(3)

ALLIED PROVIDERS

MEDICAL GROUP
(For-Profit)
Independent vs. Employed Physician

- Physician’s independent involvement in provider-based ACO models
- Hurdles
  - Cost saving requirements
  - Receiving/distributing payments among primary care physicians and specialists
  - Costs of employing EHR and IT requirements
  - Need for central ACO governing body
  - Clinical, administrative and fiscal cooperation between potential competitors
  - Division of profits among physicians and specialists
Independent vs. Employed Physician

• Physician’s involvement in joint venture and hospital-based ACO models as an employee
  – Job responsibilities
  – Distribution of shared savings received by hospital
  – Compensation for ACO-related leadership and management responsibilities
    • Revising employment agreements to comply with Anti-Kickback and Stark Law waivers
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