

Avoiding Food Fights: The Value of Good Drafting to ACO Physician Participants

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The Medicare Shared Savings Program (MSSP), which will create Medicare accountable care organizations (ACOs), is predicated on a retrospective reconciliation of expenses incurred as deducted from shared savings earned. The model also measures quality based on specified metrics. One of the principal requirements to participate in the Medicare model is having an entity that is in a position to allocate and distribute Part A and Part B savings earned to the participants. This requirement is very reminiscent of the 1990s world of physician-hospital organizations (PHOs), which often foundered because of disputes as to how dollars would be shared in the few entities that actually got contracts.

Commercial ACOs are following similar formulas. While some, in more sophisticated markets, may be paying percent of premium or global capitation rates, others are paying for bundled payments or episode rates, while still more follow the Medicare model of paying in the ordinary course of business with a reconciliation at the end. Medicare's own bundled payment pilot program¹ offers four different models, any of which might be relevant in a commercial ACO, and two of which would be applicable in an MSSP ACO.² Model 2 includes the hospital and physicians in the bundle for an episode of care, and Model 4 is prospective payment for all services provided during a covered hospitalization—physicians included. Both models might be seen in the internal workings of an ACO.

When providers form ACOs, they are taking on new risks and opportunities. The contract with the payor is a critical document. But, just as important to the ACO's viability will be the governance and contractual issues within the ACO. This article is a summary of the highlights of issues to consider in representing physicians, whose enthusiastic engagement is, arguably, the sine qua non of a functional ACO. Other issues will arise depending on the specific context.

Governance Issues

Depending on the legal mechanism that is used to administer the funds, governance issues might have already been worked out. For example, if there is an existing co-management entity that can be expanded to perform this function within the ACO, that structure might be used. In some small number of communities, PHOs have survived into the present, and they offer a ready vehicle to perform these functions.

No matter the entity though, one of the primary concerns for physicians will be if the directors of the entity, whether a formal, legal Board of Directors or a less-formal group tasked with the

governance function, represent an even number of votes among the physician representatives and others. Physicians often need to feel that the hospital does not have undue control over the allocation of dollars. However, with even numbers of directors, deadlocks are possible.

Supermajority voting is also an issue. While typical supermajority issues in any business would include such matters as dissolution, incurring debt, amending the controlling agreements, approving budgets or change in legal form, in the ACO context other issues might be subjected to supermajority vote requirements. These issues can include any changes in the metrics that drive compensation or allocation of dollars. Adding providers to the ACO or creating new classes of providers might also be subject to supermajorities. In this way, both the hospital entity and the physicians (or other classes of providers as well) would all have to agree with more than a simple majority (e.g., 66% or 75% of each class of directors). Whether a participating provider should be terminated, as well as resolving any appeals of issues that arise, might also be subject to a supermajority vote. Whether to terminate the arrangement surely should be subject to a supermajority vote.

In the MSSP program, the mechanism is all-in or all-out. For the participating hospitals and physicians, all of their compensation from Medicare Parts A and B will flow through the ACO for the beneficiaries assigned to it. In commercial ACOs, contracts may carve out specific product lines, e.g., cardiology or orthopedics or oncologic care. When a commercial ACO is more case-rate or episode-rate driven, additional issues with regard to governance will arise with respect to who should have voting rights. For example, in avoiding readmissions, home health agencies are extremely important. In treatment of pneumonia, physical therapists may not be so important so they might only participate by contract rather than in a governance structure. Where the ACO is episode or case-rate driven, not all physicians need to participate. Rather, the physicians who deliver the care incorporated in the episode would be those to participate in governance.

Decisions must be made regarding whether physicians' voting rights turn on their ownership of shares, by the size of their group (larger groups have more votes), and then, whether they participate as individual groups. These cultural choices do not have one answer. In many of these programs, physicians will be concerned that larger groups will disenfranchise smaller groups. The larger groups will want to be recognized for their larger contributions to results.

Payment Issues

Depending on the structure of the ACO, participation agreements likely will be required for participating physicians. Much like the independent physician association (IPA) or preferred health organization (PHO) contracts in the mid 1990s, they will establish criteria for continued participation, standards to be maintained, and grounds for termination. In many ways, the most critical issue for the physicians will be the allocation of the earned rewards in a reconciliation-based model. Because most PHOs, not to mention IPAs, never established standards or predicates

for their risk taking in the mid 1990s, they failed in battles over who was entitled to what money, if they got any to share. Truly awful failures occurred when organizations that took downside risk turned to their participating primary care physicians to make up the losses. These issues are essential to confront in the earliest moments of contract drafting.

The next fundamental question is how the dollars are calculated for the shared savings. In the MSSP program, the quality metrics are established by the government. How they are used within the ACO, if at all, is a choice of the participants. In commercial ACOs, quality metrics are either established by the health plan on a take-it-or-leave-it basis or are the subject of negotiation. Where they are negotiated, physicians ought to care that the quality metrics are credible, that the contract provides an unequivocal way of calculating performance, and that they are at risk only for behaviors they can control.

In addition to those fundamental issues, rules either will need to be documented in a contract or an operations manual, addressing what happens if there are disputes among physicians over the right to payment for the same portion of monies. These are the dreaded "attribution" issues. Here again, a range of options exists: for example, if providers cannot agree, none of the providers gets to claim a bonus; or, the one who has the most visits gets the allocation; or they are obligated to work it out among themselves; or the contract provides for an appeals mechanism.

Another critical issue would be the bases for involuntary termination of physicians during the term. Loss of basic qualifications like licensure or staff privileges are obvious. But, in the MSSP program, if a physician were put on pre-payment review by Medicare, this could be a basis for termination. If it were found that physicians were cherry picking (selecting only low-risk patients) or lemon dropping (terminating relationships with complex or highly acute patients), this behavior might be grounds for termination. The big issue for physicians will be termination for failure to comply with standards and where those standards are documented.³

Dispute Resolution

Where real money is at issue, disputes are inevitable. What is and is not subject to an appeals process should be stated clearly in the contracts. For example, if care is episode or case-rate driven, the definition of the case or the episode, which part the provider contracted to render, rules pertaining to how an episode is triggered, broken, or expires ought not be subject to appeal. Matters that might be subject to dispute resolution would be those that are essentially data driven and, therefore, subject to potential errors, such as whether an episode was triggered, attribution of care rendered to specific physicians, whether severity adjustments apply, and the like.

In terms of what kind of dispute resolution process to use, a range of options exists. For example, reconsideration by the initial decision-maker would be one option. Reconsideration by a different internal body whose function is simply to hear appeals would be another. A full fair hearing process or even referral to an external arbitration service are other available options.

Typical issues to address are timeframes for appeals; the scope of evidence permitted to be brought forward; whether attorneys will be involved; whether it is a record review, oral argument, or a face-to-face meeting; and the types of records to be maintained.

All of these points are essential to the credibility to the physicians and their sense of the program's equities.

Clinical Integration

The viability of any ACO will turn on changed clinical and administrative processes that will produce measured quality and enhanced value. The essence of these changes turns on clinical integration, which has recently been redefined as "*Physicians working together, systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.*"⁴ How these changes are implemented and embedded in the operations of the ACO is also significant for contractual relationships among the providers.

The participation agreements must assure that the parties are collaborating in accordance with a meaningful and shared vision. The contracts among the physicians and among the other providers should incorporate standards of behavior that reflect the goals of clinical integration. Much of this would be in the form of standardization—of documentation, use of ancillary personnel, standing orders sets, electronic health records, and more. A useful exercise in the initial creation of an ACO is to have the parties assess their status in moving toward a shared vision. A new self-assessment tool can facilitate that dialogue.⁵ In an ACO, these issues are relevant within physician groups, between physicians and hospitals, among otherwise-independent physicians, within the organized medical staff, and within any new ACO entity that is formed to administer the financial gains or allocate downside risk. In many ways, a clear understanding of what it will take in terms of changed physician behavior to achieve the ACO vision can drive the standards that are given force in the participation agreements. This approach is very different from the mid 1990s and should actively involve the participating physicians in its design and articulation.

Conclusion

The advent of ACOs, whether under Medicare or commercial insurance, represents a host of opportunities but also real pitfalls. Physician counsel should look closely at the internal issues of governance and contracting. Certainty on the front end is far better than vague, immeasurable terms. Fair governance and good contracts can bolster the real collaboration that ACOs require to survive.

1 Bundled Payment Pilot, available at <http://innovations.cms.gov/initiatives/bundled-payments/index.html>.

2 Model 1 is an acute hospital episode only. Model 3 is post-discharge care for thirty days only.

3 See <http://uft-a.com/PDF/ACI-fnl-11-29.pdf>.

4 Gosfield and Reinertsen, "Achieving Clinical Integration With Highly Engaged Physicians" (Nov. 2010), 31 pp. See <http://uft-a.com/PDF/ACI-fnl-11-29.pdf>.

5 See www.uft-a.com/CISAT.pdf.