REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-15

Subject: Physician Access to ACO Participation

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At the 2014 Annual Meeting, the House of Delegates adopted Policy D-160.930, which calls on the American Medical Association (AMA) to study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. be excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention.

The following report, which is presented for the information of the House, provides background on different types of ACOs and addresses the issues raised in Policy D-160.930.

BACKGROUND

The ACO concept encompasses both a care delivery model and a provider payment model. ACOs are characterized by groups of providers who work together to provide coordinated care to a defined set of patients, and who agree to be held collectively responsible for the quality and cost of that care. As a payment model, ACOs are legal entities that enable clinically integrated provider groups to enter into contracts with third party payers that allow the providers to share in the savings, or losses, associated with the care provided to a specific patient population. The savings accrued or losses incurred by an ACO are determined by its performance relative to quality benchmarks and risk adjusted spending targets established by the payers for a defined performance period. Base payment arrangements for ACOs and their participating providers could include fee-for-service or some form of capitated payments.

There is no single set of rules or characteristics that govern the formation or operation of an ACO. Broadly speaking, all ACOs are provider-led entities organized around the goals of improving patient outcomes, improving the experience of care, and lowering costs. The scope of these goals and how they are achieved varies, however, and may depend on the requirements and expectations of the payer or payers with whom an ACO contracts.

Leavitt Partners, a health care consulting firm, uses the concepts of integration, differentiation, and centralization to describe broad categories of ACOs.[1] Integration refers to the services the ACO directly provides to its patient population (e.g., outpatient, inpatient, or "full spectrum," which includes ambulatory and hospital care, along with other services such as post-acute care). Differentiation refers to the range of services that the ACO accepts responsibility for, either by providing the services directly, or by contracting with other providers. Centralization refers to the ownership of the ACO, specifically whether it is owned by a single entity or is a partnership among multiple owners. Using these concepts, Leavitt Partners describes the following six distinct types of ACOs:

- Independent Physician Group ACO: Single ownership, representing smaller physician groups that accept responsibility for providing outpatient care (generally limited to primary care) directly to their patient population.

- Physician Group Alliance ACO: Joint ownership between two or more multi-specialty physician groups that accept responsibility for providing outpatient care directly to their patient populations.

- Expanded Physician Group ACO: May include single or multiple owners, but characterized by providing outpatient care directly to their patient population and contracting with other providers to provide hospital or other services.

- Independent Hospital ACO: Single ownership that directly provides inpatient care. Outpatient services may be provided directly if owner is an integrated health system or physician-hospital organization, or may contract with other providers.

- Hospital Alliance ACO: Multiple owners with at least one owner providing direct inpatient services. Participants in this type of ACO tend to be smaller hospitals or hospital systems or small physician groups, particularly in rural areas.

- Full Spectrum Integrated ACO: May include single or multiple owners, but characterized by providing all aspects of care directly to patients.

Leavitt Partners' ACO taxonomy is useful for understanding the variety of organizational structures that are commonly used to help ACOs achieve their goal of better care at a lower cost, and underscores the diversity that exists in the ACO marketplace.

MEDICARE AND PRIVATE PAYER ACOS

The Centers for Medicare & Medicaid Services (CMS) offers three ACO contracting opportunities for Medicare providers. The Pioneer ACO program is administered by the Center for Medicare and Medicaid Innovation (the Innovation Center), and was designed to support provider systems that already had experience delivering integrated care to patient populations. Only 19 ACOs participate in this program. The Medicare Shared Savings Program (MSSP) is a much larger program, established by the Affordable Care Act (ACA) in order to encourage the development of ACOs to provide care for Medicare beneficiaries. Although all ACOs participating in the MSSP must meet certain requirements, the ACA and subsequent regulations allow considerable flexibility with respect to the specific composition and governance structure of an eligible ACO. More than 405 MSSP ACOs serving more than seven million beneficiaries have been established since passage of the ACA.[2]

In March 2015, the Innovation Center announced that it would accept applications for provider groups interested in participating in the Next Generation ACO Model. Participating ACOs will assume greater financial risks and have the potential to earn greater financial rewards than Pioneer ACO or MSSP participants. The Next Generation ACO Model will use a different benchmark methodology to determine ACO performance, and includes new tools that facilitate increased patient engagement and care coordination. According to CMS, the new model is intended to test whether increased financial incentives and patient engagement tools result in better health outcomes and lower costs for Medicare fee-for-service beneficiaries.[3]

Being an ACO is not synonymous with participating in a Medicare ACO initiative. Many other ACOs have been formed or are operating under contracts with private payers. Estimates of the total number of ACOs in the US vary, largely because there is no central list of non-Medicare ACOs and it can be difficult to identify ACO contracts with private payers. Leavitt Partners estimates that there are more than 600 ACOs operating across the US.[4] The majority of ACOs contract with public payers, but several private insurers, including Cigna, Aetna and UnitedHealthcare, have contracts with ACOs, as do a small number of self-insured employers. Leavitt estimates there are approximately 20.5 million patients enrolled in ACOs across the country. Oliver Wyman, another health care consultancy, estimates that more than two-thirds of Americans live in an area where an ACO is in operation.[5]

ACO NETWORK DEVELOPMENT AND CONTRACTING

The focus of Policy D-160.930 is on strategies ACOs use to include or exclude physicians from participation in the ACO. Unlike a managed care or provider network developed by an insurer, the composition and membership of an ACO is determined by providers. As provider-led entities, ACO leaders determine the particular goals and priorities they want their ACO to achieve, and then recruit and secure contracts with physicians and other providers who can help achieve those goals.

ACO networks are designed to meet the quality and cost transformation goals of the ACO. Participating physicians and other providers must be able to demonstrate a commitment to the clinical and financial goals identified by the ACO, and a willingness to transform clinical practices and participate in data collection and sharing efforts that support the goals of the ACO. In many cases, ACO networks may be developed based on existing formal or informal professional relationships between providers in a local community.

Local trends among payers offering risk-based contracting arrangements are likely to influence some decisions with respect to how physicians or physician groups are selected to participate in ACO networks. Contracts with payers will help determine the scope of services for which the ACO is responsible, specific cost and quality targets, reporting requirements, shared savings arrangements, and definitions of total quality of care. ACO leaders are likely to consider whether the inclusion of a physician or practice would contribute to the ability of an ACO to negotiate a strong payer contract and to successfully meet the terms of the contract.

For example, under current MSSP regulations, beneficiaries are retrospectively assigned to a Medicare ACO based on the patient receiving a "plurality" of primary care services from physicians within that ACO. Although CMS does not define the types of providers or services that must be included in an ACO, using primary care services as the basis of patient assignment requires that, at a minimum, an ACO include providers qualified to provide primary care services. Medicare ACOs must also agree to accept responsibility for at least 5,000 Medicare beneficiaries. Accordingly, groups wishing to form a Medicare ACO must ensure sufficient capacity among participants to care for and report data on a 5,000 member patient panel.

MSSP RULES REGARDING ACO PARTICIPATION

Publicly available information about specific contracting arrangements between physicians and ACOs is extremely limited, especially for ACOs that contract with private payers. The current rules governing the MSSP provide limited guidance regarding physician selection and deselection processes. Per the ACA, an ACO can be comprised of one or multiple types of providers or groups of providers, including group practices, networks of individual physicians and hospitals. ACOs must submit an application to CMS to participate in the MSSP, which includes several questions

and attestations about provider participation and processes for ensuring accountability for the quality, cost and overall care of patients.[6] Prior to applying for MSSP participation, an ACO must secure individual agreements with all entities (defined as "participants" by CMS, and identified by a single Tax Identification Number [TIN]) confirming their participation in the ACO and agreeing to comply with the regulations governing the MSSP. Since CMS currently uses Medicare-enrolled TINs to identify ACO participants, all providers who bill under a single TIN are considered part of the ACO. Accordingly, CMS also requires that ACOs ensure that all individual providers billing through the TIN have agreed to participate in the MSSP program and follow the program regulations. Individual physicians who are associated with a TIN that has a Medicare ACO contract cannot opt out of ACO participation, and cannot participate in more than one ACO that has a TIN number used to bill for primary care services. Entities that are unable to secure such agreements with all providers billing under a single TIN may not form a Medicare ACO.

The MSSP application also requires that ACOs specify "remedial measures that will apply to ACO participants and providers/suppliers who do not follow the requirements of their agreements with the ACO." ACO applicants are required to:

> submit a narrative describing how [the] ACO will require ACO participants and providers/suppliers to comply with and implement a quality assurance and improvement program including, but not limited to…processes to promote evidence-based medicine, beneficiary engagement, coordination of care, and internal reporting on cost and quality. Please include a description of remedial processes and penalties (including the potential for expulsion) that would apply for non-compliance.

Expelling a physician from a Medicare ACO would require severing the relationship between the physician and the TIN, or terminating the ACO agreement with the entire entity represented by the TIN, because all physicians billing under a single TIN are considered part of an ACO under current MSSP rules.

While not directly related to the processes by which physicians are selected to join an ACO, CMS' current method of beneficiary assignment may result in physicians being *de facto* excluded from participation in an ACO. Under MSSP rules, physicians that bill primarily for primary care services cannot participate in more than one ACO. This is because, as noted, beneficiary assignment is based on CMS' determination that a physician has provided a plurality of primary care services to a beneficiary during the benchmark period. According to current MSSP rules, non-primary care specialists are allowed to participate in more than one ACO, but CMS' beneficiary assignment methodology often makes this impractical or even impossible. CMS' decision to link providers and ACOs by TIN limits the flexibility of specialist physicians who wish to participate in more than one ACO by necessitating that they bill under a different TIN if they want to participate in multiple ACOs. In addition, in some cases, CMS has attributed non-primary care specialists' patients to ACOs based on office visits with those specialists, forcing ACO exclusivity.

In December 2014, CMS published a proposed rule that, once finalized, will change some of the regulations governing the MSSP ACOs. One of the new policy proposals, which the AMA supported, designates a list a specialties that will never be included in the beneficiary assignment process, thus allowing these specialist physicians, such as surgeons, to be involved with multiple ACOs. The AMA comments on the proposed rule also encouraged CMS to provide flexibility for specialist physicians who want to participate in more than one ACO by examining the possibility of using a combination of TIN and National Provider Identifier, instead of TIN alone, so that specialty and subspecialty physicians who provide some primary care services could choose on an individual basis whether or not to have these services included in the ACO beneficiary assignment process.[7]

PATIENT ACCESS TO CARE

Although it is to an ACO's advantage to directly or indirectly control all aspects of patient care, receiving care from an ACO does not, per se, limit a patient's ability to seek care outside the ACO. MSSP ACOs are expressly prohibited from restricting patient access to care outside the ACO, which has resulted in some MSSP ACO participants expressing concern about being held responsible for ACO-assigned patients who choose to receive care outside of the ACO. As noted, the Next Generation ACO Model includes components that are specifically intended to strengthen a beneficiary's engagement with an ACO, including allowing patients to confirm their relationship with ACO providers, and establishing incentives for patients to receive care from the ACO. Regardless of these incentives, however, beneficiaries retain access to their choice of services and providers under the original fee-for-service Medicare rules.[8]

The ACA and subsequent regulations ensure that Medicare beneficiaries have access to any physician who treats Medicare patients, regardless of whether the care is provided within or outside of an established ACO. Current MSSP rules assign patients to ACOs retrospectively based on whether the patient receives primary care services from a physician who participates in an ACO. However, even when patients are assigned to an ACO, they retain the right to seek care from any physician who treats Medicare patients. In the December 2014 proposed rule, CMS proposed, and the AMA supported, establishing a process to allow patients to voluntarily align with an ACO.

It is to the ACO's advantage to encourage participating providers to refer patients to other providers within an ACO when appropriate, or to establish relationships with individual physicians or entities that provide care to its patient population but are not participants in its ACO network. MSSP ACOs are held accountable for the total cost of care for their attributed patient populations, whether ACO participating providers deliver that care or not. In addition to contracts with ACO participant providers, MSSP ACOs can also contract with physicians or facilities as "other entities," a designation that compels the contracted provider to comply with MSSP program rules and potentially qualify for shared savings, but does not require exclusive affiliation with one ACO.

It is unclear how private payers are integrating ACO contract arrangements with their plan offerings and benefit design structures. At this point, it is likely that plan offerings that involve receiving care from an ACO are being developed separately from broader plan network development strategies. Because there are still relatively few ACO-type contract arrangements with private payers, plan enrollees may have the option of receiving care from an ACO-affiliated provider where available, but retain access to the full panel of network providers. Private payers could potentially design plans that include incentives for patients to seek care from an ACO and within a single ACO network, as long as the network of physicians participating in the ACO satisfies established network adequacy requirements.

AMA POLICY AND RESOURCES

Policy D-385.963 encourages physicians "to make informed decisions before starting, joining, or affiliating with an ACO." The AMA has developed multiple resources to assist physicians with evaluating their options related to participation in ACOs or other practice arrangements. "Competing in the Marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration, third edition" describes a range of integration possibilities that address the desire of many physicians to retain some level of autonomy while also acknowledging the realities of today's marketplace.[9] "ACOs and other options: A 'How to' Manual for Physicians Navigating a Post-Health Reform World," provides a

detailed overview of the various options physicians have in the changing environment, including the benefits and challenges associated with establishing or participating in physician and other health care provider collaboratives.[10] In addition, AMA comment letters, papers prepared by the AMA Innovators Committee, and other delivery reform resources are available on the AMA website at www.ama-assn.org/go/paymentpathways .

DISCUSSION

The vast majority of ACOs have physicians in leadership positions. According to the National Survey of Accountable Care Organizations, conducted by the Dartmouth Institute for Health Policy and Clinical Practice, 51 percent of ACOs are physician-led, and an additional 33 percent are jointly led by physicians and hospitals. In addition, 78 percent of ACOs have a majority of physicians on their governing boards, and 40 percent of ACOs are physician-owned.[11]

ACO contracting at the physician level is primarily a business decision made by ACO leaders based on the clinical and business goals of the particular ACO. Because ACOs are by definition collectively responsible for the care of their patients, it is in the best interest of all ACO participants to ensure that participation is limited to individuals or entities that can further the goals of the ACO. It is also in the best interest of the ACO to retain physicians who support the organizational goals and are willing to commit to the success of the ACO over the long term.

As with any other type of contracting arrangement, it is important that ACOs be transparent in their contracts with individual physicians, and that physicians carefully review ACO contracts to ensure there are clear guidelines with respect to how physician performance will be evaluated, and the circumstances under which a physician may be removed from an ACO panel.

The Council believes that it is likely that the trend of the rapid growth of ACO formation will continue. The ability of an ACO to attract and retain physicians who contribute effectively to the clinical and cost goals of the ACO will be critical to its success. It is possible that ACO markets may evolve such that competition among ACOs for physician members could have a positive impact on physician recruitment and retention.

Given that the ACO concept is evolving, the Council believes that our AMA should continue to encourage flexibility and innovation in the design and development of ACOs supported by both public and private payers. Ensuring that patients have access to high quality, appropriate and timely physician-led care remains a priority for this Council, and for our AMA. Ensuring professional satisfaction and practice sustainability is one of our AMA's core focus areas, and efforts to identify and support current and emerging payment and care delivery models that work best for physicians across a variety of practice settings are ongoing. As the number of ACOs increases, it will be important for our AMA to continue to monitor the impact of ACOs on the ability of physicians to provide the best care for their patients.

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