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Commercial Accountable Care Organizations: Experimentation and Best Practices

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22.1 Introduction

As a companion to federally structured reimbursement programs, such as the Medicare Shared Savings Program (MSSP), established in the Patient Protection and Affordable Care Act (ACA), a variety of risk-sharing, cost-reducing innovations have emerged within the private payer sector. Among them are Commercial Accountable Care Organizations, which are clinically integrated networks of health care providers that receive reimbursement from commercial payers or self-insured employers on a “shared savings” basis (Commercial ACOs). Like their MSSP counterparts, Commercial ACO network participants are typically reimbursed on a fee-for-service basis and can potentially receive a portion of “savings” achieved for a defined patient population over a period of time, usually in twelve month increments. Savings are calculated by comparing current spending to baseline spending for the patient population. Additionally, to be eligible to share in the savings, certain quality and performance measures generally must be attained by the Commercial ACO. Commercial ACOs carry the promise of reducing commercial health care spending and improving quality of patient care while affording participants flexibility in arrangement, ownership and operational design. Unlike their MSSP counterparts, which enjoy federal funding, fraud and abuse waivers and, in some instances, essentially no downside provider risk, the market-driven design of many Commercial ACOs reveal more realistic depictions of the risks and opportunities of shared savings payment arrangements.

The authors wish to express appreciation to Mark Ogunsusi, Squire Sanders Healthcare Fellow, who contributed his time and energy in assisting in the preparation of this chapter.
This chapter will: (1) review the background and trends of Commercial ACOs; (2) spell out key operational considerations and best practices in forming and operating Commercial ACOs; and (3) set forth common business and legal considerations faced by Commercial ACOs.

22.2 Background and Trends of Commercial ACOs

22.2.1 Background of Commercial ACO Analogues

The concept of uniting provider and patient interests has been present for years. Many people have criticized the current fee-for-service system as inefficient and costly, causing providers to receive higher financial benefits for providing more services than may be necessary. Throughout the 1980s and 1990s, health maintenance organizations (HMOs) increased in popularity and were considered to be a potential solution to the costly fee-for-service system. However, patients eventually began to disfavor HMOs due to concerns that HMOs were infringing on patients’ rights to make their own health decisions. Other clinical integration concepts surfaced, capturing early considerations of coordinated health systems with multiple participants. In 2005, the Physician Group Practice Demonstration began, which coordinated ten provider and physician groups in a shared savings program. Participating health care providers continued to receive their usual fee-for-service payment, but they also received bonus payments if their improved coordinated care resulted in slower risk-adjusted health spending growth and improved performance on quality measures.² However, with the increased pressure to lower health care costs and to improve the quality of patient care, the focus started to change from pay for service to pay for performance.

In 2010, the Patient Protection and Affordable Care Act was entered into law. The ACA created the MSSP pursuant to Section 3022, which outlined the concept for “accountable care organizations” and the integration of health care networks to lower costs and increase the quality of care.³ The MSSP allows CMS to enter into agreements with ACOs subject to the rules and regulations created by CMS. Following the creation of the MSSP, the Pioneer ACO program was initiated, allowing CMS to implement and test the MSSP and its criteria. Various chapters in this Handbook provide additional discussion on the scope and introduction of the MSSP, and we will not go into further discussion here.

Since the introduction of the MSSP ACO program, discussions regarding the implementation of Commercial ACOs have increased. Commercial ACOs allow health care providers more flexibility in their formation (e.g., governance and metrics) with less regulatory flexibility and are seen by some to be the most logical step for providers in the rising pay-for-performance tide. Regardless, the concepts of aligning care and decreasing the costs for health care services have been around for some time. The discussion is now shifting to how health care providers improve the quality of care and patient experience through a Commercial ACO.

22.2.2 National Trends and Current Status of Commercial ACOs

Commercial ACOs have evolved over recent years, resulting in various models for participants to consider. As of August 2013, four major Commercial ACO payers were as follows: (1) Aetna (24 ACOs); (2) Blue Cross Blue Shield affiliates (39 ACOs in various states); (3) Cigna (66 ACOs); and (4) UnitedHealthcare (value-based contracts with more than 575 hospitals and 1,100 medical groups). Additionally, Advocate Health Care in Downers Grove, Illinois had one of the largest Commercial ACOs in the country with approximately 380,000 Blue Cross Blue Shield of Illinois enrollees. This recent activity by health care providers is evidence of the current trend of the health care industry to expand into Commercial ACOs. While some in the health care industry are skeptical of success of Commercial ACOs, the trends demonstrate that providers are quickly moving to establish Commercial ACOs. For current examples of Commercial ACOs and activity please refer to the Figures presented in Section 22.2.3.5. For a description of potential stakeholders and controlling entities commonly involved in Commercial ACOs, please refer to Section 22.3.1.

22.3 Comparison of Key Requirements and Flexibility

22.3.1 Risk Sharing Models

Multiple risk sharing models are available for Commercial ACOs. A Commercial ACO may base its shared savings on claims, but it may also allow for benefits to be withheld or it may include increased quality initiatives to be considered. Another option is for the Commercial ACO to calculate gains and losses as determined by specific medical expense target amounts or by splitting the overall performance target amount. Commercial ACOs may also have the risks carried by the Commercial ACO’s primary care providers shift to the provider organization and the administrative functions and risks shift to the Commercial ACO.

No risk sharing model is absolute and the basis for each change is based on the participants involved and the negotiations completed by such potential participants. MSSP ACOs must meet specific savings requirements, which are determined by the track the ACO chooses to follow. Each track has specific calculation requirements and benchmarks that must be met before any shared savings can be paid. Once the track is selected, the participants will need to consider how risk will be allocated, specifically whether one participant will absorb most of the risk or if it will be shared equally. The risk allocation selected will heavily impact whether the MSSP ACO will successfully meet the track requirements. The MSSP ACO tracks are discussed in depth in other chapters of this handbook and will not be discussed in depth here. In contrast, Commercial ACOs are not subject to these tracks and have more flexibility for the allocation of risk in forming a Commercial ACO. For further discussion on Commercial ACOs’ shared savings distributions, please see Section 22.6.1.4 of this Chapter.

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5 Id.
22.3.2 Governance

Potential participants in a Commercial ACO may find themselves grappling with various governance parameters, including such items as the number of board representatives, the allocation of such representatives to provider or specialty groups, election procedures, and quorum requirements.

Commercial ACOs typically have more flexibility than MSSP ACOs for their governance. Specifically, Commercial ACOs may focus governance more on financial contributions from the parties involved rather than from the participants generally. Further, a Commercial ACO may want a completely different and separate governance structure than other current ACOs, both commercial and in the MSSP. The formal designation granted to the governing body of the Commercial ACO depends on the corporate classification of the Commercial ACO (e.g., a corporation typically forms a board of directors and an LLC delegates to members, managers, or committees). Additionally, if an ACO wants to be classified as both commercial and as a participant in the MSSP, it must follow the requirements of the MSSP.

Ideally, the governing board of a Commercial ACO must be structured to help achieve the business purposes of the Commercial ACO, promote the best interest of the organization as a whole, and balance competing interests of critical internal stakeholders such as physicians, and, as applicable, hospitals and health systems. Any Commercial ACO will need strong commitments from all stakeholders, which is more likely to occur if the parties spend the time and energy carefully designing and considering the Commercial ACO’s governance structure. Regardless, Commercial ACOs have flexibility in the formation of its oversight, transparency, fiduciary duties, conflict of interest policies, and the composition and controls of its boards, subject to state and federal laws, as applicable.

22.3.3 Waivers – Patient Compliance

Since the primary goal of a Commercial ACO is coordinated and quality patient care at a reasonable cost, financial incentives and other benefits are encouraged. However, these financial incentives, referrals, and other benefits would typically conflict with the federal and state fraud and abuse regulations. Therefore, the PPACA allows MSSCP ACOs to obtain the following five waivers: the pre-participation waiver, the participation waiver, the shared savings waiver, the compliance with stark law waiver, and the patient incentive waiver. The purpose for these waivers was to allow MSSP ACOs the flexibility to implement and operate successfully while furthering the MSSP program.

The waivers and exemptions do not provide protection for Commercial ACOs or hospitals’ participation in other value-based payment arrangements with private payers. As such, it is critical that participants ensure such commercial arrangements comply with physician self-referral law, anti-kickback statute and civil monetary penalty laws in absence of these regulatory waivers. Participants should also analyze and ensure that the Commercial ACO abides by their respective state laws.

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22.3.4 Reimbursement Incentives

Under the MSSP, an ACO can receive payment for meeting quality metrics and reducing costs. If an MSSP ACO reduces its Medicare expenditures below a benchmark, it is eligible to receive part of the savings from Medicare, the percentages of which depend on which track the ACO is in and on the ACO’s performance score. In the first year, an MSSP ACO can collect on this potential shared savings if it reports on all the required quality measures. In the subsequent second and third years, performance measures then effect the shared savings distribution to the MSSP ACO.

Commercial ACOs typically use a similar payment structure, in which participants are compensated based on Medicare’s fee-for-service rates or productivity and have the opportunity to receive additional payments by achieving certain quality and cost goals. In contrast to an MSSP ACO, a Commercial ACO can create its own set of metrics and thresholds for receiving performance-based payments. It is common for Commercial ACOs to split potential shared savings between the payer and the Commercial ACO equally, as is possible under the MSSP ACO program. As in the MSSP ACO model, the Commercial ACO also independently determines the allocation of shared savings to participants.

Some important factors can aid in the development and consideration for the incentives to be used by Commercial ACOs. For example, Commercial ACO participants should participate in collaborative discussions when negotiating shared savings and incentives. Other factors include assessment of the population being provided with Commercial ACO services and identifying which participant is responsible for what service, which helps to define who should get paid for what services.

Chart/Examples

**Figure A: Potential Structure of a Commercial ACO**

![Diagram showing the structure of a Commercial ACO]

Legend:
- = Ownership
- = Contracts
- = CMS/MSSP only
Figure B: Joint Venture ACO, LLC Structure

Figure C: Example Commercial ACOs and Activity

<table>
<thead>
<tr>
<th>Entity Name</th>
<th>Participants, Players and Activities</th>
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| Cigna (e.g., Granite Healthcare Network) | • Granite Healthcare Network is a partnership among five independent charitable health care organizations in New Hampshire (Concord Hospital, Elliot Health System, LRGHealthcare, Southern New Hampshire Health System and Wentworth-Douglass Hospital); and  
  • Each member is an independent, integrated health care delivery system with primary care doctors, specialists and hospitals.7 |
| Blue Shield of California (e.g., Providence Health and Services) | • Announced in July 2013;  
  • 3-year commercial ACO initiative to provide integrated care to approximately 16,500 Blue Shield HMO members in Los Angeles County;  
  • Includes 3 medical centers (Providence Holy Cross, Providence Tarzana and Providence Saint Joseph); and  
  • Providence Health and Services ACO is Blue Shield’s tenth commercial ACO.8 |

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8 News Release, Blue Shield of California, Blue Shield of California, Providence Health & Services, Facey Medical Foundation, Facey Medical Group to Collaborate on Accountable Care Initiative to Improve Healthcare Coordination and Reduce Costs (July 25, 2013), https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/providence-facey-aco-072513.sp.
### 22.4 Antitrust Issues and Integration

The federal Sherman Act states that “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade among the states or with foreign countries are deemed illegal.”\(^9\) Most states have parallel antitrust provisions, and the Sherman Act is enforced by the U.S. Department of Justice (DOJ), the Federal Trade Commission (FTC), state attorneys general and private plaintiffs.

Even alleged violations of antitrust laws can have serious financial and business consequences. Agreements regarding prices (including timing of prices, elements of prices, and minimum/maximum amount), customers, and/or market allocation, can be viewed as evidence of an illegal agreement in violation of the antitrust laws. Merely sharing such competitively-sensitive information can lead to an inference that the parties have reached an unlawful agreement. Such agreements are typically considered to be *per se* (or automatically) illegal meaning that a plaintiff would only have to prove the existence of the agreement and would not bear the burden of proving anticompetitive effects.

An important exception to *per se* liability is when competitors form joint ventures that create a new product (or service) that they could not otherwise create on their own, and they do so in a way that minimizes any anticompetitive effects. The antitrust laws provide that such legitimate joint ventures are analyzed under a broader, more forgiving, standard called the Rule of Reason that essentially balances the procompetitive and anticompetitive effects of a collaboration against each other.

Competing health care providers that collaborate to provide a new way to deliver health care services must structure their collaborations in a manner that is permitted by this joint venture exception to automatic liability, whether the collaboration is denominated as a Commercial ACO, or in some other fashion. The federal enforcement agencies (the FTC and the Antitrust Division of the US DOJ) have issued various guidelines regarding this joint venture exception and other concerns regarding the formation of a Commercial ACO. These guidelines generally provide that competing providers may be deemed permissible under antitrust laws if: (1) the providers are sufficiently clinically and/or financially integrated; (2) the agreement is reasonably necessary to accomplish the benefits of integration; and (3) the Commercial ACO’s market power is not excessively concentrated in a service area.

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For an in-depth discussion on the antitrust and integration concerns associated with all ACOs, please see Chapter 8 of this handbook. For further discussion regarding Commercial ACOs’ concerns regarding federal fraud and abuse regulations, including the Physician Self-Referral Law, please see Section 22.7 below.

22.5 Structure Options and Considerations

As clinically integrated networks, Commercial ACOs are typically driven by active physician participation and leadership which may be supported by resources from hospitals or other network participants. Although there are many common characteristics across Commercial ACOs, there can be a variety of different participant types, complex governance formats and multifaceted distribution models. Accordingly, it is crucial to understand the potential stakeholders, controlling entities and the common legal structures involved in successful Commercial ACOs.

22.5.1 Potential Stakeholders and Controlling Entities

Commercial ACOs exist in a multitude of structural variations, with participants ranging from providers to commercial payers. Although the details of shared savings distributions are central to the Commercial ACO arrangement, structural components such as the controlling entity and potential stakeholders of the Commercial ACO also characterize the arrangements. In this section, we provide an overview of specific Commercial ACO types including: (1) hospital, health system, or physician network-owned ACOs (Provider ACO); (2) provider joint ventures with commercial payer ACOs (Payer-Provider Joint Venture ACO) and (3) multi-system ACOs (Super ACOs).

22.5.2 Provider ACO

The vast majority of Commercial ACOs are formed by health care providers. Provider ACOs have a multitude of tools, techniques and the skilled workforce necessary to lower medical costs and boost the quality of patient care. Often they provide enhanced efficiency for independent providers through access to infrastructure, economies of scale and best practices. As with all clinically integrated networks, collaborative, coordinated clinical integration initiatives established utilizing evidence-based medicine are essential to the Provider ACO. Such integration efforts require an electronic information infrastructure to share real-time patient information among participating providers and to assess patient outcomes and provider performance. Hospitals are often in a good position to provide such technology to physicians and other network providers. The Provider ACO is most often physician-led, which facilitates the drive towards the adoption of quality care initiatives and cost reduction strategies.

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11 As of February 19, 2013, the majority of ACOs in the U.S., 56%, were sponsored by physician groups, in comparison to hospital systems, 36.5%. David Muhlestein, Continued Growth of Public and Private Accountable Care Organizations, Health Affairs Blog (Feb. 19, 2013), http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/.
22.5.3 Payer-Provider Joint Venture ACO

Payer-Provider Joint Venture ACOs are separate legal entities in which providers and payers are joint owners. In these joint venture arrangements, the parties share in the profits and losses on the basis of ownership. This particular organizational structure is unique to Commercial ACOs as such an arrangement has not been sanctioned under the MSSP. Providers with proven and successful quality care initiatives are more attractive to payers seeking to reduce upward medical cost trends. Payers with population health management capabilities and an electronic information infrastructure are more attractive to providers in a twofold capacity; they offer the prospect of quality-based incentive payments and shared savings, while offering the capability of assisting in the improvement of care through patient data analytics.

22.5.4 Super ACO Arrangements

Super ACOs include multiple health systems, sometimes spanning across several states, and may include large national health insurance companies. They generally involve either: (1) multiple health systems that have partially or fully undergone clinical integration separately; or (2) several large health systems that have come together to form one clinically integrated network. Super ACOs are generally health system-led and have the distinct vantage point of health systems in driving quality care across large patient populations. Participating health systems may form a Super ACO to distribute payment among participants, akin to the Provider ACO discussed supra, or may align with a national payer to formulate a new Commercial ACO product. Establishing or joining a Super ACO provides benefits to participants including: (1) obtaining economies of scale in population health management capabilities, infrastructure, and contracting; (2) enhanced ability to identify and hone in on significant voids in care delivery across participants and patient populations; and (3) stronger competitive footing amidst a rapidly consolidating market.

22.6 Basic Legal Structure and Start-Up

The determination of business form is important to the viability of the Commercial ACO arrangement. Governance flexibility, limited liability for owners and taxation advantages are key considerations.

22.6.1 Limited Liability Company (LLC)

The LLC is the most advantageous and prevalent Commercial ACO business form. LLC members may be a natural person, a corporation, a partnership or another legal association or entity. The LLC is a separate legal entity from its members and ordinarily LLC members are not personally liable for the debts and obligations of the LLC. However, the LLC format may not be available or preferable in all Commercial ACO formation circumstances. For example, federal law disallows insurance companies from forming LLCs and treats such companies as C corporations.

12 Private payers cannot be ACO participants. See 42 C.F.R. § 425.20.
The modern trend is for Provider ACOs to be structured as a single member LLC of a hospital or health system. This insulates non-member participants from the potential risk of capital calls for monetary contributions. The LLC affords a Commercial ACO tremendous latitude to appoint a board of directors that reflects strong physician majority governance, subject to reserved powers of the member. Within the Commercial ACO framework, LLC directors can range from physicians, to advance practice clinicians, to executives from private payers, including self-insured employers, to community members—all of which offer unique perspective into generating innovative practices to reduce medical spending and improve quality of care.

A Commercial ACO structured as a single member LLC is treated as a disregarded pass-through entity of the sole member. An LLC comprised of two or more members is recognized by the IRS as a partnership so taxable profits and losses pass through to the LLC members.

22.6.2 For-Profit Corporation

Corporations are an advantageous business form for a Commercial ACO chiefly due to ease of formation and liability protections afforded to shareholders. The corporation is a separate legal entity from its shareholders and ordinarily shareholders are not personally liable for the debts and obligations of the corporation. However, to maintain separate status from its shareholders, corporations are subject to certain formalities under state law including, without limitation: (1) issuing stock and maintaining a stock register; (2) shareholder election of a board of directors to manage the company; (3) holding an annual meeting; and (4) preparation and filing of an annual report. Because the formalities of a corporation are somewhat restrictive, the corporation is not considered as accommodating for formation of a Commercial ACO as compared to an LLC.

22.7 Commercial ACO Participants

22.7.1 Participants and Their Roles

Each Commercial ACO may vary not only in its structure but also in the participants selected to play a specific role in the Commercial ACO. The subsections below describe some common Commercial ACO participants and their roles.

22.7.2 Physicians and Physician Groups

Every Commercial ACO will need to address the role of its physicians and/or physician groups. Physicians administer and direct a majority of health care services, positioning them to be the best resources to address quality and cost issues. However, physicians and physician groups typically lack the funding or organizational structures to implement a Commercial ACO alone. Because physicians and physician groups play such an important and primary role in the provision of care, they also play a vital role in the formation and implementation of a Commercial ACO. Discussions with the physicians during the development phases of a Commercial ACO are pivotal and must determine how the physicians will share and implement their knowledge regarding the quality and costs of health care services they provide.
22.7.3 Clinically Integrated Networks

A clinically integrated network is similar to a Commercial ACO in that it is a health care collaboration consisting of a group or groups of physicians, hospital, long-term care facilities and/or other health care providers that work jointly to provide health care services. A full discussion on the development of a clinically integrated network is in Chapter _____ of this handbook. A functional clinically integrated network will have clearly defined initiatives and measures to produce quantifiable results. As such, a typical clinically integrated network may include a hospital or a health system and employed, independent/private practice or hospital-based physicians. Together, these providers work to establish the management and infrastructure to operate and govern the network.

22.7.4 Hospitals and Health Systems

Hospitals and health systems typically represent large entities that have the substantial infrastructures and systems to support and implement a Commercial ACO. Specifically, hospitals and health systems have the necessary working capital, staff, facilities, and networks to create and support a Commercial ACO and to provide inpatient care. Because the formation of a Commercial ACO requires many resources, including an electronic health records system large enough to support the patient group, hospital and health systems may be poised to lead the growth in Commercial ACOs. Hospital and health systems play the vital role of providing the infrastructure and guidance to form the Commercial ACO.

22.7.4 Post-Acute Providers

Post-Acute providers include skilled nursing facilities, long term care hospitals, rehabilitation facilities, and home health providers. More Commercial ACOs are often including these post-acute providers in the Commercial ACO arrangement as many patients require some form of post-acute treatment. By incorporating post-acute providers in the coordination of care implemented under the Commercial ACO, patients are not visiting and receiving post-acute care at multiple sites with multiple costs. As such, in order to address costs and quality measures, the Commercial ACO must factor post-acute providers into the implementation of the Commercial ACO.

22.7.5 Payers

Payers in the health care industry represent third parties responsible for the payment of patient services to health care providers. The most commonly recognized payers are health insurers. While payers may lack the medical knowledge or structure, they do maintain and store large amounts of patient and claims data. The expectation for payers to manage this data provides the other participants the necessary information to assess the patient population through risk and utilization assessments. The payers’ management infrastructure for this data may also provide a starting base for the information technology for the Commercial ACO. Further, payers already have provider, billing, and contracting networks in place for the Commercial ACO to consider.

As the number of Commercial ACOs grows, payers can provide a wealth of information to a Commercial ACO about patient populations and needs, risk projections, and the providers with whom they are contracting.

22.7.6 Pharmacies/Pharmacists

Pharmacies and pharmacists are relatively new players to the Commercial ACO market. The Commercial ACO may provide the pharmacies and pharmacists access to health care records and foster communication between all participants in the Commercial ACO network. Despite pharmacists’ contributions to safe and proper medication use, they are an under-utilized participant in Commercial ACO arrangements. Pharmacists are well trained in the administration and prescription of medications. This means they are the best individuals to suggest and advise on proper medication protocols and procedures, eliminating incorrect uses of medication and increasing the health of patients. By including pharmacists in the discussion, they can offer guidance on both positive and negative impacts of medication use for patients.

22.8 Considerations in Joining Commercial ACOs

In view of rapid consolidation in the health care industry, providers must consider whether to join Commercial ACOs. While the considerations for or against joining Commercial ACOs are plentiful, providers are nonetheless being pushed towards more cost-effective care delivery. Influences which impact a provider’s decision to join Commercial ACOs include: (1) declining reimbursement; (2) decreased provider negotiation power in a consolidated payer market; and (3) increased costs associated with operating a medical practice or health care organization, among others. Moreover, access to capital, ability to recruit and ability to integrate with other providers all are factors that tend to encourage providers to consider joining Commercial ACOs as these capabilities will be enhanced by participation in a Commercial ACO arrangement. These benefits notwithstanding, a multitude of other issues must be considered as well.

One of the fundamental concepts shared by all Commercial ACOs is organization-wide shared savings compensation which is inherently tied to the collective performance of Commercial ACO practitioners in addition to the individual practitioner’s performance. Thus, a strong history of physician-led clinical initiatives and successful physician collaboration on an organization-wide basis may indicate a stronger likelihood of generating shared savings. Moreover, demonstrated capacity of a Commercial ACO to galvanize clinicians towards both clinical and financial ends demonstrates a collaborative culture and capability of managing Commercial ACO private payer contracts.

Another fundamental element of Commercial ACOs is the electronic infrastructure needed for clinical data integration and analytics. Central to this requirement is the capability for participating providers to access, evaluate and use real-time clinical data in order to ensure consistency of practice and coordinated care. The interoperability and compatibility of a Commercial ACO’s electronic health record is essential to the Commercial ACO’s ability to generate shared savings and its ability to integrate new providers without sacrificing clinical and financial efficiencies.
Strong administrative leadership is also essential for a successful Commercial ACO. Characteristics of a successful administrative team include: (1) the presence of physicians and other clinicians on the administrative team; (2) non-physician administrative leaders (dyad model); (3) the level of transparency regarding the goals of the administrative team; (4) the strength of communication channels employed by the administrative team; (5) community and intra-organizational views of senior administrators; and (6) a demonstrated attitude towards compliance. Strong management teams will have a strong interest in and ability to recruit quality physicians; a firm understanding of quality clinical best practices; and a strong interest in patient satisfaction. These and many other factors directly affect efficient care delivery and maintaining high standards of quality care.

Acceptance of shared savings programs greatly varies from market to market and implementation of Commercial ACOs’ shared savings concepts are occurring at greatly differing speeds. Providers should assess their market’s readiness for shared savings programs, while seeking to stay ahead of the Commercial ACO curve.

### 22.9 Governance and Key Agreements

As previously discussed in Section 22.3.2, Commercial ACO Governance, the bylaws, operating agreements, and other key components of a Commercial ACO can vary greatly. Provider participation agreements may also vary based on the composition of the Commercial ACO. For an in-depth discussion regarding ACO governance and provider participation and other services agreements, please see Chapters _11_____ and _____ of this Handbook.

#### 22.9.1 Shared Savings Agreements: Key Terms

Shared savings agreements with private payers are the hallmark of Commercial ACOs. The particular terms of such arrangements should be scrutinized by providers as the implications can have large effects on savings returned to such providers.

#### 22.9.2 Benefit Products Included

Many Commercial ACOs utilize an approach similar to Medicare; the Commercial ACO arrangement does not function as a new product and does not alter the payer’s product benefits. Formation of these Commercial ACOs generally require little to no action on the consumer’s behalf. On the other hand, some Commercial ACOs have formed new products that incentivize consumers to select providers within the Commercial ACO’s network. This product model narrows the consumer’s network, while offering lower consumer cost-sharing.

#### 22.9.3 Member Attribution

There are a number of methodologies for attributing members to a Commercial ACO. Two primary methods are (1) prospective attribution; and (2) retrospective, performance year attribution. Although both involve varying methods of tracking patients that utilize the Commercial ACO provider network, studies suggest that retrospective attribution may yield the best financial data for
shared savings determinations, thereby resulting in more accurate and greater savings payments to providers.15

Prospective attribution methodologies attribute members according to historical claims data. This method affords patients and physicians with prior notice of participation in the program. This methodology provides the benefit of immediate performance and cost-savings feedback to drive intra-performance year quality improvement and cost reduction, with periodic assessments. However, this methodology functions under the primary assumption that the majority of assigned members will utilize the same providers in the future as they have as premised on historical claims data. Typically the performance period spans 12 months.

Retrospective attribution methodologies assign patients pursuant to actual provider utilization. At the end of a predefined performance period, claims data is reviewed for participating providers. Patients are then attributed based upon those that actually received a certain amount of participating provider care. This methodology retains the benefit of assessing actual provider performance more accurately. Although this model does not provide prospective notice to providers, and possibly patients, this model incentivizes quality improvement and cost reduction across all patients, not merely the Commercial ACO’s members. However, the methodology does not provide immediate intra-performance year analytics to drive immediate accountable care improvement. Typically the performance period spans 12 months.

Although the particular combination of variations under a retrospective or prospective attribution model depends on the specific payer and providers participating in the Commercial ACO, preliminary studies have indicated that certain attribution methodologies capture the most members. In comparing multiple attribution methodologies, studies indicate that in a group practice environment methodologies attributing patients according to the highest percentage of primary care visits in any care setting, with a tie resulting in attribution to the most recent provider visited, resulted in the highest percentage of members, while capturing the largest portion of high cost services. Furthermore, attributing patients according to visits rather than total dollar amount is preferable, because differences in fee schedules may drive the attribution results, instead of the provider from whom the patient is actually receiving services. Moreover, methods that primarily focus on the majority of office visits or the majority of payments, rather than the plurality, may result in the omission of patients that could benefit the most from greater accountable care and care coordination.

22.9.4 Quality Criteria and Metrics

The Commercial ACO shared savings agreement will delineate certain periods for measurement of performance by providers. Quality metrics and performance measures may be split into different categories, such as inpatient and ambulatory metrics. The actual process of selecting these metrics turns on set clinical initiatives, identified costly care gaps and overarching goals of the payer and the Commercial ACO. The criteria may be based on metrics formulated by participants and metrics

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selected from other sources including: MSSP quality measures, National Quality Forum measures, CMS’ physician quality reporting system, American Medical Association Physician Consortium for Performance Improvement measures, National Committee on Quality Assurance measures (e.g., Healthcare Effectiveness Data and Information Set (known as HEDIS measures)), Patient-Centered Medical Home Standards, and the Patient-Centered Specialty Practice Standard. Commercial ACOs may also utilize mutually agreed upon performance metrics that reach more nuanced practice areas, such as utilization of tests particular to a specific practice specialty premised on independent third-party determined best practices. In any event, the process of selecting measures should be transparent and should involve significant physician input across the care continuum.

Commercial ACOs sometimes develop their own measures in cooperation with the private payer, specific to the nuances of their particular community and patient population. However, the industry custom of using the above mentioned nationally recognized measures instills legitimacy within the entire Commercial ACO arrangement, legitimacy that may be useful if the Commercial ACO wishes to also participate in the MSSP.

22.9.5 Shared Savings Distributions

Many shared savings agreements specify financial cost-reduction target percentages, below which shared savings will not be distributed. Assuming such cost-reduction targets are met and quality metrics are satisfied, Commercial ACOs are generally responsible for determining how shared savings distributions will be allocated among the Commercial ACO participants, although distribution models are sometimes included in the shared savings agreement.

Whether determined by the Commercial ACO or subject to negotiation with a private payer, a strong shared savings distribution model ideally should be: (1) determined considering input from a wide variety of participating providers; (2) relatively simple; and (3) transparent. After overhead costs are subtracted from the total shared savings earned under a payer agreement, two general factors for formulating and distributing shared savings are usually considered: (1) ascertaining individual provider performance according to performance scorecards created to track compliance against established metrics; and (2) allocating shared savings percentage pools by determining the likelihood of provider specialties performing responsibilities and influencing outcomes under constituent parts of Commercial ACO initiatives.

Ascertaining individual provider performance with clinical integration requirements is an essential element of a clinically integrated network generally. Assessment of satisfaction of particular clinical metrics specified in a Commercial ACO payer agreement and conformance to the Commercial ACO’s evidence-based medicine protocols are most often prerequisites to receiving a portion shared savings payments, with the theory being that those who did not contribute to achievement of the shared savings should not benefit from a distribution of shared savings reimbursement.

Commercial ACO shared savings distribution models also typically involve determining shared savings percentage pools for each provider specialty or for groupings of like specialties participating in the Commercial ACO. This determination involves breaking down the Commercial ACO
initiatives into constituent parts and designating expected responsibility levels of provider specialties to undertake a particular subpart of the Commercial ACO quality initiative. The specific percentage of shared savings allocated to a group of providers may be premised on a number of factors that ultimately concern the level of shared savings a provider class is expected to contribute to achieve overall success in cost savings and quality. Considerations in apportioning shared savings percentages include: (1) the overall ability of the provider class to control cost; (2) the general ability of the class to successfully manage care of the patient population and effectuate desired clinical outcomes; and (3) the ability of the provider class to coordinate patient transitions and communicate critical patient information across the care continuum. Consideration should be given not only to how a particular provider directly drives success in certain prospective clinical initiatives, but also to the intended incentive to drive costs down in view of the unique position of certain providers. For instance, post-acute care providers are in strong positions to manage certain chronic conditions, transitional care initiatives and reduce readmissions.

22.10 Regulatory Compliance

Generally, shared savings payments received by a Commercial ACO from private payers do not implicate federal fraud and abuse laws because the individuals covered by the payer agreement are not Medicare or Medicaid beneficiaries. As noted supra Section 1.2.4, clinically integrated networks must work collaboratively across providers who would otherwise be competitors for purposes of state and federal antitrust laws. Indeed, most clinically integrated networks require referrals within the network to better manage the affected patient population in terms of quality of care and cost, unless the network providers cannot provide the necessary medical services or the patient prefers to receive treatment from a provider outside of the clinically integrated network. Commercial ACOs need to be cautious that relationships with physicians and incentives to Commercial ACO patients do not “spillover” into the federal health care programs. Accordingly, understanding the applicability and nuances of the Physician Self-Referral Law (Stark), the Anti-Kickback Statute (AKS) and the Civil Monetary Penalties Law (CMP) is critical to a clinically integrated network to avoid potential civil and criminal liability.

22.10.1 Stark Law

Stark prohibits a physician from making referrals for certain designated health services which may be paid for by Medicare or Medicaid to an entity with which the physician or an immediate family member has a financial relationship, unless an applicable exception applies. A “financial relationship” for the purposes of Stark is defined as: (1) a direct or indirect ownership or investment interest in the entity providing the designated health service which is held by the physician or a member of the physician’s immediate family; or (2) a direct or indirect compensation arrangement between the entity providing the designated health service and the physician or a member or the physician’s immediate family member. As a threshold matter, shared savings received from a private payer and distributed by a Commercial ACO to participating physicians do not directly implicate Stark because referrals made by physicians for the Commercial ACO members are not eligible for payment by Medicare or Medicaid. Notwithstanding, Commercial ACOs may wish to structure their financial arrangements to satisfy a Stark exception.
In the MSSP Waivers Interim Final Rule with Comment\textsuperscript{16} published jointly by the Centers for Medicare and Medicaid and the Office of Inspector General of the U.S. Department of Health and Human Services (OIG), the agencies specifically declined to extend the protections of the Shared Savings Distribution waiver to Commercial ACO arrangements\textsuperscript{17}. The agencies noted that extension of the waiver to similar arrangements under commercial payer plans is not necessary to carry out the MSSP. The agencies indicated that some commercial payer arrangements “may be sensitive to the volume of business generated for downstream providers or suppliers and that this characteristic may have implications for the application of the Physician Self-Referral Law.”\textsuperscript{18} The agencies noted that many Commercial ACO arrangements can be structured to fit a Stark exception for risk-sharing arrangements or other exceptions, such as the indirect compensation exception.

22.10.2 Anti-Kickback Statute

The AKS is a criminal statute that prohibits a party from willfully and knowingly soliciting, receiving, offering, or paying remuneration to another in exchange for referring an individual for an item or service reimbursable under Medicare or Medicaid. As with the Stark law, the threshold question is whether a referral is for an item or service reimbursable under Medicare or Medicaid. While Commercial ACO referrals do not directly implicate the AKS, Commercial ACOs should be mindful that the OIG has frequently cautioned providers about financial arrangements which channel funds for Medicare or Medicaid referrals to referring physicians through arrangements that purport to apply only to non-federal health care business.

In Adv. Op. 13-03, the OIG clarified its historical stance on arrangements that attempt to carve out federal program beneficiaries. Under the proposed arrangement a Medicare-certified laboratory (Parent Laboratory) proposed to form a management company (Management Company) to enter into contractual relationships with physician group laboratories (Physician Laboratory) to provide: (1) a lab suite on an exclusive and full-time basis in a building operated by the Management Company; (2) lab management; (3) certain support services on a shared basis such as a common shipment receiving area, a common business center, and shared waste and custodial services; and (4) personnel, equipment and licenses for use of the Parent Laboratory’s methods of operation as requested by the Physician Laboratory. The Physician Laboratory would commit to provide lab testing only for patients who were not federal program beneficiaries. The Physician Laboratories would use color-coded labels to distinguish private payer specimens and would refer all federal health care programs to another laboratory, potentially including the Parent Laboratory.

In its analysis the OIG indicated that such carve-out arrangements may implicate and violate the AKS “by disguising remuneration for federal health care program business through the payment of amounts purportedly related to non-federal health care program business.” Specifically, the OIG expressed concern that the arrangement would increase the potential that physician owners of the Physician Laboratories would order services from the Parent Laboratory: (1) for reasons of

\textsuperscript{16} 76 Fed. Reg. 67992.
\textsuperscript{17} 76 Fed. Reg. 68006.
\textsuperscript{18} Id.
convenience; (2) to demonstrate commitment to the Parent Laboratory and secure more favorable pricing on private pay services; or (3) simply because the physicians fail to distinguish between the Parent Laboratory and those operated with support from the Management Company. Additionally, the OIG expressed concern that the financial incentives offered under the arrangement would be likely to affect physician decision making with respect to all patients, including federal program beneficiaries, potentially resulting in overutilization of lab services and increased costs to Medicare and Medicaid. Although the AKS is a criminal statute requiring the government to prove “willful and knowing” behavior and Commercial ACO activities should be low risk, Commercial ACOs should be aware of the OIG’s perspective on carve out arrangements.

22.10.3 Civil Monetary Penalties Law

The CMP prohibits: (1) entities or individuals from offering or transferring remuneration to federal program beneficiaries that the entity or individual knows or should know is likely to induce the beneficiary to order or receive Medicare or Medicaid items or services from a particular provider, practitioner or supplier; and (2) hospitals from making a payment, directly or indirectly, to a physician to reduce or limit services to federal program beneficiaries who are under the physician’s direct care. Because the CMPL applies only to Medicare and Medicaid it is not directly implicated in Commercial ACOs. However, in providing care management to Commercial ACO beneficiaries, Commercial ACOs often engage in the types of activities that would potentially implicate the CMP if federal program beneficiaries were affected. For example, Commercial ACOs sometimes provide free items related to management of chronic medical conditions such as blood pressure cuffs to hypertensive patients. Further, where physicians are rewarded for achieving quality metrics under shared savings agreements that potentially limit care to patients, such as reduction in hospital length of stay, the CMP could be implicated if such patients were federal program beneficiaries. Thus, Commercial ACOs must ensure that such care management practices and shared savings incentives do not spill over into the Medicare and Medicaid patient populations.

22.11 Common Pitfalls and Hurdles Once Commercial ACO is Active

22.11.1 Information Technology Glitches

One pivotal element to a Commercial ACO’s coordination of care is strong information technology infrastructure. Because participants in a Commercial ACO are expected to share patient data to streamline the patient’s care, the Commercial ACO must implement a technology system capable to do this. The Commercial ACO will need to address inadequately trained staff in the maintenance of electronic data, which may require a significant amount of time and energy. Such training will impact the success of quality and costs initiatives and improvements in patients’ experience. Without the sharing of some common data on the quality of care being provided, resources being used, and pricing indexes, participants will find it difficult to assess the Commercial ACO’s performance. Additionally, incompatibility among hospital and physician information systems is also an

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impediment to achieving goals of integration under the ACO. Every participant may have different information technology programs in place with different issues that require more time and funds to be align the Commercial ACO’s data sharing capability.

To fight these potential impediments, the Commercial ACO participants should try to address these issues proactively. By carefully discussing and implementing a proper information technology infrastructure, the Commercial ACO will hopefully identify potential issues and resolve them efficiently. Further, participants should designate procedures to be used when future glitches are found to allow for efficient and effective resolution of these issues as well. A complete information technology system will allow the Commercial ACO to properly measure performance and to fix any future technology glitches.

22.11.2 Adjustments to Financial Breakdown

22.11.2.1 Retrospective Beneficiary Attribution Cost Effect and Predictability Hurdles

As described in Section 22.6.1.2, retrospective attribution identifies participating beneficiaries of an ACO at the end of each risk-evaluation period. A potential problem with doing so is that participants must wait for data results, prohibiting immediate intra-performance year analysis. This may impact Commercial ACOs’ ability to efficiently develop a plan of action to address such outcomes. This will further impact budget projections and other analysis.

One way to possibly address this pitfall is to consider multiple attribution models. Participants may also want to run multiple financial scenarios, using various predictions and options to consider how the potential outcomes will differ. This will allow the ACO to have an action plan in place to remedy any issues despite the delay in data.

22.11.2.2 Beneficiary Incentives Gap

Participants in the Commercial ACO will undoubtedly create and incorporate incentives related to the beneficiary metrics. Each ACO will have to develop sufficient information about their participating health care professionals to support beneficiary assignment, to support any shared savings breakdown, and other measurements. Just as other metrics will result in gaps or the need for adjustments, the ACO may experience gaps in its beneficiary incentives or discover current gaps in the infrastructure that will need to be addressed. The ACO should develop the necessary processes to identify the gaps and the remedies to resolve the gaps going forward.

22.11.2.3 Overestimation of Risk Management Capabilities

Organizations naturally and commonly overestimate their abilities. This is arguably amplified when potential profits are involved. While certain participants may have strong capabilities for certain types of care, it is common to assign all the risk to the Commercial ACO itself for managing all patient care and outcomes. This means the participants will need to combine their capabilities with providers that may lack the experience to effectively do so. The participants will need to recognize
that each entity brings various risk management resources and elements to the ACO in order to successfully merge these abilities.

Health care providers can try to prevent this pitfall by preempting the issue as much as possible. The participants in the ACO should discuss their risk management capabilities at length and clearly identify which capabilities are strong and which require further work. By identifying these, the ACO can put certain procedures in place to address the issue going forward.

22.11.2.4 Overestimation of EHR Utilization and Performance Measure Reporting Capabilities

Commercial ACOs will need to collect and manage massive amounts of patient data. Not only does this require a strong information technology infrastructure, it will require the development of policies and procedures for the ACO that allow it to successfully collect and analyze the data. The creation and success of these policies and procedures will take time and be impacted by any issues or gaps in the information technology infrastructure as a result of participants overestimating their abilities. Because the strength of the electronic health records system will impact the reporting capabilities, participants can fight against this issue by clearly identifying the strengths and weaknesses in its technology infrastructure and the reporting capabilities and ways to improve it.

22.11.2.5 Insufficient Performance Integration Beyond Structural Level

Structural and contractual mechanisms may be in place to provide more coordinated care, but Commercial ACOs may lack the infrastructure and management to deliver such coordinated care. Commercial ACO participants will all need to be involved in coordinating the care delivery system to ensure the performance requirements and goals of the Commercial ACO are met. This means that Commercial ACOs will need to consider the necessary funding, staff, management, and resources to reach these goals. By identifying the Commercial ACO’s performance and integration needs, each participant can identify which resources and infrastructure it can immediately provide to the ACO.

22.11.2.6 Insufficient Population Health Management and Surveillance: Patient Outcomes Tracking

Similar to insufficient EHR systems, many ACOs may find that they lack the proper infrastructure to properly monitor and manage the surveillance of their patients’ care and outcomes. Specifically, ACOs may find that they are unable to properly document multiple patients’ records and, as such, it cannot properly manage its patients to make sure the proper care was and is provided. To avoid this issue, an ACO should consider the procedures it currently has and will need in order to sufficiently manage the surveillance and tracking.

ACOs may also face difficulty in engaging patients to administer and manage their own care. For example, patients and family members can provide considerable care on their own, particularly in monitoring chronic illnesses and conditions. As a result, patients and their family members need to play a role in continued care and need to be educated on how to do so successful. Because many health care providers may lack the knowledge and experience relating to this patient involvement, ACOs will need to identify and formulate procedures to address this issue.
22.11.2.7 Insufficient Provider Network Geographical Scope: Impaired Care Continuum

As discussed throughout this Handbook, a primary goal for any Commercial ACO is the continuum of coordinated care for the patients it serves. However, Commercial ACOs will most likely face unforeseen disruptions in the continuum of care and must have procedures in place prior to these disruptions to address them properly. The extent that a payer has a geographic dispersion of membership in an area where the hospital also has strength is important in that the market offered by the payer and the provider should be compatible.20 If such compatibility is weak or inconsistent, then the health care services needed by patients may be interrupted. By identifying where the network may have issues with care continuum and which procedures may be needed, the Commercial ACO can work to avoid an impaired care continuum.

22.11.2.8 Physician Pushback on Standardized Care Management Protocols and Issues with Physician Engagement

Physicians will undoubtedly play a vital role in the Commercial ACO in light of their experience and insight on the delivery of services and ways to improve patient care. To implement this physician insight, the Commercial ACO participants will need to involve the physicians in the development of delivery and performance processes. By engaging the physicians in the development of the Commercial ACO, physicians may provide suggestions regarding patient care, physician performance and incentives, and other initiatives. This process will take time and physicians may decline to participate or resent new processes. This means that the Commercial ACO participants should carefully discuss these processes and come to a uniform agreement on those to be applied. Further, the Commercial ACO participants should clearly identify procedures to address any adjustments that may become necessary to the procedures as the Commercial ACO grows.

22.11.2.9 Disputes Over Interests

Multiple interests will be involved in any formation of a Commercial ACO. Hospitals, health systems, physicians, and others will be concerned with making sure their interests are properly addressed and protected. Because financial incentives are at risk, the Commercial ACO participants need to properly address each participant’s interest in the Commercial ACO’s governance and operations documents. Participants need to formulate a financial infrastructure that identifies each participant’s interests and risks associated with gains and losses of the Commercial ACO. These financial infrastructures must be addressed in the Commercial ACO agreements with participants to foster a successful clinically integrated Commercial ACO. Also, the development of financial models that clearly outline the delegation of interests will allow each participant to understand the financial impact on it as well as the other participants. Failure to address these interests can result in later disputes between the Commercial ACO participants.

Disputes may also occur over the governance structure of the Commercial ACO if the participants have not clearly defined the rights of each participant. As discussed in section 22.3.2 above, all participants must be involved in the negotiation process and discussion regarding the governance structure of the Commercial ACO. This initial negotiation process will result in a clear governance structure, including quality and performance measurements and financial goals of the Commercial ACO. Without this clear governance structure, the participants may find themselves arguing over multiple aspects of the Commercial ACO.

Cultural impacts can also be a source of dispute if the participants fail to accept that its own previous cultures are subject to change. For some participants, they may be used to a certain culture that does not necessarily align with the concept of the Commercial ACO but they are willing to learn and adjust culture to be involved in the Commercial ACO. Commercial ACOs must consider the various cultures being integrated and identify what each culture means to the Commercial ACO. By discussing these cultural strengths and weaknesses, the participants can work to leverage such strengths and neutralize the weaknesses.21

22.12 Mutual Goals and Vision

A common theme for all the pitfalls discussed in this section is recognizing that the Commercial ACO participants will have to rely on each other to successfully implement the Commercial ACO. In the event the Commercial ACO experiences difficulty with electronic health care records or the inability to manage risk, these events will eventually impact other goals of the Commercial ACO if the participants fail to recognize that interdependency is vital to the success of the Commercial ACO as a whole. The participants need to identify and strategize the plan under which the Commercial ACO can and will be successful, which includes addressing all of the items identified in this section (information technology, operations, cultural clashes). By clearly defining the Commercial ACO’s vision and unifying the goals of the Commercial ACO, the process of implementation can move forward.

22.13 Conclusion

The health care industry is currently experiencing multiple changes in the way it delivers and pays for services. Both interest and concern is growing for Commercial ACOs and the many ways in which they may be designed. Various chapters of this Handbook discuss the numerous concerns, regulations, and potential successes that Commercial ACOs are encountering. Flexibility and creativity in the structures and models of Commercial ACOs are allowing for a wide array of participants from all aspects of the health care industry. One thing is certain: more health care providers are asking about Commercial ACOs and considering them as viable options. Only time and results from each Commercial ACO will indicate how successful and popular Commercial ACOs will become compared to the MSSP ACOs and other coordinated care networks from the past.

21 Blue Shield of California, An Accountable Care Organization Pilot, supra note 34, at 3.