



Private Payor Participation in Accountable Care Organizations: Limitations, Risks, and Opportunities

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I. Introduction

The Medicare Shared Savings Program (“MSSP”), established by section 3022 of the Patient Protection and Affordable Care Act (“PPACA”)¹ and overseen by the Centers for Medicare & Medicaid Services (“CMS”), provides an opportunity for eligible Medicare providers and suppliers that establish or participate in Accountable Care Organizations (“ACOs”) to share in savings achieved from

coordinating care and lowering healthcare costs through the efficient delivery of Medicare services while meeting quality of care performance standards.

Although the concept of the ACO has flourished as a result of the MSSP, ACOs did not originate in the MSSP. Many health insurers and managed care organizations (collectively, “private payors”) were already experimenting with the concept in the commercial sector before PPACA’s enactment. As a result, private payors with experience in implementing commercial ACO-like structures have shown an interest in partnering with Medicare providers who want to participate in the MSSP.²

Medicare providers may find the idea of partnering with a private payor particularly attractive because private payors not only have commercial-sector experience with collaborative care and cost-saving healthcare delivery models, but also have more monetary and infrastructural resources to invest in and support the development of an ACO. There are regulatory hurdles, however, for these partnerships. This article briefly explores the limitations, risks, and opportunities posed by the legal requirements and regulatory waivers associated with the MSSP that private payors and their potential partners must consider.³

II. Legal Requirements Limiting the Potential Involvement of Private Payors in ACOs

A. Eligible Participants

Under the MSSP regulations, ACOs must be composed of “ACO participants,”⁴ defined as “an individual or group of ACO providers(s)/supplier(s) . . . identified by a Medicare-enrolled TIN [Taxpayer Identification Number], that alone or together with one or more other ACO participants comprise(s) an ACO.”⁵ “ACO provider[s]/supplier[s]” are individuals and entities⁶ that are enrolled in Medicare, bill for items and services furnished to Medicare beneficiaries under a

Medicare billing number assigned to the TIN of an ACO participant, and are “included on the list of ACO providers/suppliers” submitted to CMS as part of the ACO’s MSSP application.⁷ Overall, “under the [MSSP], ACO participants may work together to manage and coordinate care for Medicare . . . beneficiaries,” and “the ACO must become accountable for the quality, cost, and overall care” of the beneficiaries assigned to the ACO, through the implementation of three-year participation agreements with CMS.⁸

Accordingly, based on the applicable regulatory definitions, private payors cannot themselves be ACO participants or ACOs. But private payors may still collaborate with, invest in and contribute to the activities of ACOs and may share in the savings that ACOs achieve. Despite their investments, private payors are, however, limited in the extent to which they may take part in the governance of ACOs.

B. Governing Body Requirements

The MSSP regulations require that 75 percent of the control of each ACO’s governing body be held by ACO participants and that the ACO’s governing body must include a Medicare beneficiary.⁹ These rules directly prevent private payors from having any more than 25 percent control of the ACO’s governing body.¹⁰ Thus, a private payor investing in an ACO will have limited control of the oversight and strategic direction of the ACO and limited ability to hold the ACO management accountable for ACO activities unless the private payor is the manager of the ACO. These limits may be challenging for the private payor to accept. These regulatory limits, however, may be mitigated by the prospect of a return on the investment by sharing in the savings that the ACO achieves and receives from the government.

To offset these regulatory limitations on governing body control, private payors will want to ensure that solid collaborative relationships exist among all members of the ACO governing body and with the ACO’s management. Detailed mission statements as well as policies and procedures may help define how private payors may contribute to the decision-making activities of the ACO’s governing body and ensure that all parties are using complementary processes to achieve the goals of the MSSP.

III. Legal Risks to Private Payors Posed by Participation in the MSSP

Even though they do not qualify as “ACO participants,” private payors may collaborate and contribute to ACOs in multiple ways, such as through financial or technological support. But engaging in these supportive activities and receiving shared savings as a benefit may subject private payors and the ACO’s participants to numerous legal risks in the areas of fraud and abuse, non-profit tax, and applicable state laws and regulations governing the corporate practice of medicine.

A. Fraud and Abuse Laws

Private payors have been able to experiment with a wider range of care coordination models in the commercial sector because federal fraud and abuse laws are generally not applicable to commercial arrangements, but apply to services provided through Medicare, Medicaid or other federal health care programs (“FHCPs”). Because the MSSP is a Medicare-related initiative, an ACO who uses private payor resources may create financial and compensation relationships that

violate the Physician Self-Referral Law (the “Stark Law”),¹¹ the federal Anti-Kickback Statute (“AKS”),¹² the Gainsharing Civil Monetary Penalty (“CMP”),¹³ and/or the Beneficiary Inducements CMP¹⁴ (collectively, the “Fraud and Abuse Laws”). Recognizing this possibility, the Department of Health and Human Services’ Office of Inspector General (“OIG”), in collaboration with CMS, established five waivers within an MSSP interim final rule (“MSSP IFR”)¹⁵ aimed at exempting certain relationships created by the MSSP from some or all of the Fraud and Abuse Laws:

1. an “ACO pre-participation” waiver applicable to start-up arrangements, such as funding and infrastructure-building items, services, and goods provided to ACOs in anticipation of participating in the MSSP;
2. an “ACO participation” waiver applicable to arrangements during the term of the ACO’s participation agreement under the MSSP and for a specified time thereafter;
3. a “shared savings distributions” waiver applicable to distributions and uses of shared savings payments earned pursuant to the MSSP;
4. a “compliance with the Physician Self-Referral Law” waiver of the Gainsharing CMP and the AKS for arrangements among ACO participants or ACO providers/suppliers implicating the Stark Law that meet an existing exception; and
5. a “patient incentive” waiver of the Beneficiary Inducements CMP¹⁶ and the AKS for medically-related incentives offered by ACOs under the MSSP to beneficiaries to encourage preventive care and compliance with treatment regimes.¹⁷

Arguably, if the resulting ACO arrangements comply with the waivers, private payors may provide funding, items, services, or goods to ACOs with reduced enforcement risks to themselves and their partners.¹⁸ The protection afforded by these waivers, however, does not extend to other laws or regulations.

B. Issues for Private Payor/Tax-Exempt ACO Partnerships

For ACOs that involve non-profit or 501(c)(3) entities as participants, it is important for for-profit private payors to ensure that the MSSP’s governing body requirements described above do not pose risks to the tax-exempt status of any of the ACO participants. Additionally, where private payors collaborate in ACOs with tax-exempt entities, private payors must ensure that any funding, items, services, or goods they contribute to the ACO do not endanger their partners’ tax-exempt status.

For example, a notice¹⁹ issued by the Internal Revenue Service (“IRS”) states that “if a tax-exempt organization is a partner [or member] of an ACO treated as a partnership for federal tax purposes, the ACO’s activities will be attributed to the tax-exempt organization for purposes of determining both whether the organization operates exclusively for exempt purposes and whether it is engaged in an unrelated trade or business” subject to the unrelated business income tax (“UBIT”).²⁰ In working with ACOs that involve tax-exempt participants, all parties must ensure that the exempt organization’s participation in the ACO “is structured so as not to result in its net earnings inuring to the benefit of its insiders or in its being operated for the benefit of private parties participating in the ACO,”²¹ such as private payors. Consequently, private payors may have to compromise some of their profit motives to safeguard the tax-exempt status of their ACO partners.

C. Corporate Practice of Medicine

Another barrier that is not fully addressed in the MSSP IFR is the corporate practice of medicine doctrine, which is enforced in a significant number of states based on either statutes or common law principles.²² In short, the doctrine stands for the proposition that corporate entities should not be able to direct the medical decision-making of physicians, and, in certain states, other medical professionals. Depending on the involvement of the private payor and the corporate form of the ACO, a state may determine that certain ACO activities implicate the decision-making of medical professionals and violate the doctrine.

It is fairly clear that, in a number of states, a private payor could not have representatives on the board of an ACO that is a professional corporation or medical practice.²³ The doctrine may also be implicated by MSSP ACOs entering into management or administrative services agreements with private payors for the purpose of using advanced data-sharing or information technology resources. ACOs and private payors must carefully tailor their agreements to ensure that activities implicating medical decision-making activities are segregated from management activities related to the ACO's administration, which may be extremely complicated given the MSSP's goals.

IV. Conclusion

From the outset, the MSSP has been set up to provide opportunities to apply the lessons learned in the commercial sector to transition payment structures within FHCPs away from the fee-for-service models that favor volume of care rather than the value of care for individuals. But there are always risks when entering new territory, and the risks of participating in the MSSP are especially acute for private payors because they cannot be full participants in an ACO. Although the MSSP IFR and IRS Notice available at this time attempt to mitigate the risks of legal enforcement against participants and investing partners in ACOs, the existing waivers and guidance are limited. Until CMS, OIG, or the IRS provide additional guidance, private payors and providers must continue to carefully consider the regulatory limitations and remaining areas of risk before taking part in an ACO-related arrangement under the MSSP.

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- 1 Pub. L. 111–148, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).
 - 2 For example, one-third of the 27 ACOs accepted into the first cycle of the MSSP that began in April 2012 were jointly owned by a subsidiary of a Medicare Advantage and supplemental insurance provider. Seven more ACO joint ventures of that subsidiary were accepted into the program's second cycle that began in July 2012, bringing its grand total to 16. Melanie Evans, "Doc-led ACOs seek to manage costs, quality and hospital relationships," *Modern Healthcare* (Apr. 14, 2012), <http://www.modernhealthcare.com/article/20120414/MAGAZINE/304149950>; Universal American Corp. Reports Second Quarter 2012 Results, Press Release (Jul. 25, 2012) <http://investor.uaac.com/phoenix.zhtml?c=75985&p=irol-newsArticle&ID=1718458&highlight=>.
 - 3 This article limits its analysis to the MSSP, recognizing that private payors may also be involved in the Pioneer ACO program under the supervision of the Centers for Medicare & Medicaid Innovation.
 - 4 42 C.F.R. § 425.102(a).

- 5 42 C.F.R. § 425.20.
- 6 *Id.*
- 7 *Id.*
- 8 42 C.F.R. § 425.100.
- 9 42 C.F.R. § 425.106(c)
- 10 76 Fed. Reg. at 67820.
- 11 42 U.S.C. § 1395nn.
- 12 42 U.S.C. § 1320a-7b(b).
- 13 42 U.S.C. § 1320a-7a(b)(1)-(2).
- 14 42 U.S.C. § 1320a-7a(a)(5).
- 15 76 Fed. Reg. 67992 (Nov. 2, 2011).
- 16 42 U.S.C. § 1320a-7a(a)(5).
- 17 An arrangement need only fall within one waiver in order to receive protection. MSSP IFR at 67994.
- 18 The authors acknowledge that there is some ambiguity in the MSSP IFR regarding whether the pre-participation and the participation waivers contemplate including private payors within their scope. The MSSP IFR states “[t]he participation waiver does not turn on the source of the funds for the arrangement.” *Id.* at 68005. Private payors are not expressly excluded from the scope of the pre-participation waiver, like drug and device manufacturers, distributors, durable medical equipment suppliers, and home health suppliers are, but it is also unclear whether private payor-funded ACO arrangements are, therefore, covered by the waiver. The American Bar Association’s Health Law Section submitted comments to the MSSP IFR on December 28, 2011, which stated that it would be “difficult . . . to attract other providers and suppliers without being able to guarantee that capital investments from outside parties are protected,” but the OIG and CMS have not published further guidance on this issue from the MSSP IFR to date.
- 19 2011-16 I.R.B. 652 (Apr. 18, 2011), available at: <http://www.irs.gov/pub/irs-drop/n-11-20.pdf> (hereafter, “IRS Notice”).
- 20 *Id.*; see also IRS Fact Sheet 2011-11, “Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations” (Oct. 20, 2011).
- 21 IRS Notice.
- 22 For example, Arizona, Arkansas, California, Colorado, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana,

Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Washington, West Virginia, and Wisconsin all have statutes that potentially influence the corporate form and governance of ACOs.

- 23 For example, in New York, a professional corporation must be owned by licensed professionals and all shareholders, directors, and officers must be licensed and currently registered to practice the professional services which the corporation was organized to provide. *See*, N.Y. Bus. Corp. Law § 1503. California may also present a restrictive environment for private payors who want to participate in an ACO, as a provision of its Medical Practice Act states, “[c]orporations and other artificial entities shall have no professional rights, privileges, or powers.” Cal. Bus. Prof. Code § 2400.
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