An important consideration for many physicians and their practice entities is whether their participation in an accountable care organization (ACO) regulated by the Centers for Medicare & Medicaid Services (CMS) will limit their ability to join other federally regulated ACOs. The Medicare Shared Savings Program (MSSP) physician exclusivity restriction prevents physician practices from being included as participants in more than one MSSP ACO if they bill Medicare under any of the Healthcare Common Procedure Coding System (HCPCS) codes listed in the expansive MSSP definition of “primary care services,” which includes evaluation and management (E&M) codes commonly billed not only by primary care physicians but also by physicians in various specialties. Physicians and physician practices, however, have flexibility to structure relationships with more than one ACO. This Executive Summary describes exclusivity principles and some related complications for physician practices and ACOs, as well as several alternative approaches to affiliate with multiple ACOs.
MSSP Regulations

Each ACO must have a unique patient population so CMS can perform program operations, such as beneficiary assignment, benchmarking, sampling for quality reporting, and performance evaluation. Physician exclusivity and Medicare beneficiary assignment to a particular ACO are based on “primary care services” furnished to Medicare beneficiaries under the federal taxpayer identification number (TIN) or related CMS Certification Number (CCN)¹ of an ACO participant. The MSSP regulations set forth the physician exclusivity restriction at 42 C.F.R. § 425.306(b), which states:

Each ACO participant TIN upon which beneficiary assignment is dependent must be exclusive to one Medicare Shared Savings Program ACO for purposes of Medicare beneficiary assignment. ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive to one Medicare Shared Savings Program ACO.

The MSSP regulations define an “ACO participant” as an individual or group of ACO provider(s)/supplier(s) that: (1) is identified by a Medicare-enrolled TIN; (2) alone or with other ACO participants comprises an ACO; and (3) is included on the list of ACO participants submitted by the ACO to CMS during the ACO application process.² The physician exclusivity restriction potentially applies to any ACO participant that bills Medicare for services that fall within the MSSP “primary care services” definition. Exclusivity potentially extends across a wide range of medical practice settings, including group and solo physician practices, as well as federally qualified health centers (FQHCs), rural health centers (RHCs), hospital affiliates, and health systems. For simplicity, this Executive Summary uses the term “physician practice” in a broad sense to include any health care provider or supplier that directly or indirectly employs or otherwise retains the services of physicians, physician assistants (PAs), nurse practitioners (NPs), or clinical nurse specialists (CNSs) and bills for their services.

Assignment is a process that CMS uses to identify those beneficiaries who have received a sufficient level of primary care services from physicians (and in some cases

¹ The ACO FAQs note that CMS uses the CCNs of FQHCs, RHCs, and Method II Critical Access Hospitals to assign beneficiaries to an ACO, and uses TINs for all other types of providers.
² 42 C.F.R. § 425.20.
PAs, NPs, and CNSs) within an ACO to justify designating the ACO as primarily responsible for the patient’s care and allowing the ACO to share in any savings relating to those beneficiaries. Assignment is determined under a two-step process that focuses on whether physicians affiliated with a particular ACO furnish a plurality (based on Medicare-allowed charges) of primary care services for the beneficiary. A beneficiary who sees a primary care physician who is affiliated with an ACO will be assigned to the ACO under Step 1 if the Medicare-allowed charges for primary care services furnished to the beneficiary by the ACO’s primary care physicians exceed the Medicare-allowed charges for primary care services of primary care physicians who are affiliated with any other ACO or are not affiliated with any other ACO. If a Medicare beneficiary receives services that are billed under any of the HCPCS codes that are included within the definition of primary care services, but does not see a primary care physician, then assignment of that patient will be determined under Step 2, which is similar to Step 1 except that the plurality determination is based on Medicare-allowed charges for primary care services of physician specialists, NPs, PAs, and CNSs, rather than primary care physicians.

It is important to keep in mind that the definition of “primary care services” under the MSSP regulations is broader than common usage would suggest. The definition section of the MSSP regulations defines primary care services as all services within any of the following HCPCS codes:

- 99201–99215 (office or outpatient E&M visits);
- 99304–99340 (E&M services in a nursing or similar facility);
- 99341–99350 (E&M services in the home);
- G0402 (welcome to Medicare visit);
- G0438 and G0439 (annual wellness visits); and
- Revenue center codes 0521, 0522, 0524, and 0525 for FQHCs and RHCs.

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3 42 C.F.R. § 425.402(a).
4 The regulations, at 42 C.F.R. § 425.20, define “primary care physician” as a physician who has a primary care specialty designation of internal medicine, general practice, family practice, or geriatric medicine. For services furnished within a FQHC or RHC, this definition applies to all physicians included in the ACO’s attestation of physicians who directly provide primary care services in the FQHC or RHC.
5 42 C.F.R. § 425.20.
Notwithstanding the “primary care” label, the codes for primary care services are not unique to primary care. In fact, some of the E&M codes within the definition apply to services of a wide range of primary care physicians and specialist physicians who sometimes furnish E&M services in office, outpatient, home, or nursing facility settings.

The text of the exclusivity regulation and related CMS commentary in the preamble to the final MSSP rule do not explain how to determine whether beneficiary assignment is dependent on an ACO participant TIN and therefore triggers the exclusivity restriction. Under a literal reading, 42 C.F.R. § 425.306(b) could be construed to require exclusivity only if Medicare beneficiaries are actually assigned to an ACO based on primary care services billed to Medicare by the ACO participant. The ACO Frequently Asked Questions (ACO FAQs) reject this literal reading and broadly apply the exclusivity restriction.

**CMS FAQ Guidance on Exclusivity**

CMS updated its ACO FAQs\(^6\) in early spring of 2013 by adding 13 questions and answers that provide important guidance on the ability of physician practices to participate in multiple ACOs. CMS applies the exclusivity restriction to any ACO participant that bills Medicare for services under any of the billing codes that fall within the definition of primary care services, in which case the participant’s TIN (or CCN, in the case of FQHCs, RHCs, and Method 2 critical access hospitals) is not allowed to appear on the participant lists for multiple ACOs.

Although CMS broadly interprets the scope of the exclusivity restriction with regard to participation, the ACO FAQs recognize that physicians and physician practices have flexibility to avoid exclusivity either by using separate TINs or by affiliating with ACOs as “other individuals or entities performing functions or services related to ACO activities” (“other entities” for short), rather than as ACO participants. These alternative approaches are discussed below.

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\(^6\) Available at [www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/sharedsavingsprogram/faq.html](http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/sharedsavingsprogram/faq.html).
Exclusivity Concerns for Physicians and ACOs

The physician exclusivity restriction presents significant planning challenges for physicians, physician practices, and ACOs. Some potential concerns are noted below.

There is no minimum primary care service threshold for exclusivity. Furthermore, all physicians, PAs, NPs, and CNSs billing under a TIN are interdependent. Consequently, even a single claim for primary care services of a physician, PA, NP, or CNS for primary care services would cause the entire TIN (and all physicians, whether specialists or primary care physicians, whose services are billed under the TIN) to become subject to exclusivity.

Exclusivity can trigger conflicts within physician practices based on factors such as specialty (or subspecialty), geography, referral and working relationships with health systems and other health care providers, and strategic vision. In a multispecialty practice, the interests of primary care physicians and specialists may clash. For example, primary care physicians may favor participation in the local ACO, while specialists may have an interest in drawing from a wider geographic base and maintaining relationships that may be dispersed among separate ACOs. Both single-specialty and multispecialty physician practices that are located within geographic areas served (or potentially served) by multiple ACOs may face potential turf battles relating to exclusivity, particularly if the group’s offices are spread across a large metropolitan area and its physicians within each office or division maintain strong community relationships and some level of management control over the local affairs of the division.

Specialists may face the prospect of inadvertent exclusivity, particularly if they entered into participation agreements when it was commonly believed that only primary care physicians, and not specialists, were required to be exclusive to a single ACO. The view that specialists were not subject to exclusivity was consistent with the proposed MSSP regulations, but not the final rule as interpreted in the ACO FAQs and implemented by CMS.

ACOs may clash over exclusivity issues. Potential issues of contention include shortages of certain specialty physicians or of primary care physicians, alignment
objectives, and strategic objectives. Some ACOs have been unable to satisfy the 5,000-assigned beneficiary threshold because of the exclusivity restriction and have, therefore, not qualified for participation in the MSSP.

**Non-participating ACO Physician (“Other Entity”) Alternative**

The flexibility to create roles in ACOs as other entities, rather than as ACO participants, provides ACOs and physicians with a mechanism to essentially opt out of the assignment process and the exclusivity restriction. For example, a physician practice that wishes to avoid exclusivity could establish contractual relationships with multiple ACOs without being a participant in any ACO, or could be a participant in one ACO and contract on an other entity basis with other ACOs. These other entity arrangements can apply to primary care physicians as well as specialists.

The rights and obligations of an other entity and its physicians are determined by the contract between the ACO and the physician practice and may include terms that correspond closely to the rights and obligations of ACO participants. In particular, the ACO FAQs recognize that a contract can be structured to allow an other entity to share in savings relating to the ACO’s participation in the MSSP. ACOs must obtain the agreement of other entities to comply with MSSP rules and the ACO’s participation agreement with CMS,\(^7\) as well as other applicable law,\(^8\) to satisfy MSSP record-keeping requirements, and to allow CMS to audit and inspect related records.\(^9\) In addition, CMS recommends that the agreement between an ACO and an other entity allow the ACO to terminate the agreement if the other entity fails to comply with MSSP rules.\(^10\)

Other entity arrangements are subject to some limitations that do not apply to participants. Physician practices that affiliate with ACOs as other entities do not appear on lists of ACO participants, do not qualify for Physician Quality Reporting System (PQRS) incentives or avoid PQRS adjustments through ACO quality reporting, and are not included in determining beneficiary assignment to ACOs.

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\(^8\) 42 C.F.R. § 425.208.
\(^9\) 42 C.F.R. § 425.314.
\(^10\) See ACO FAQs.
Strategies regarding potential other entity relationships can vary from ACO to ACO. Some common issues for ACOs include: whether to enter into other entity relationships; distinctions between ACO participants and other entities, including the right to a portion of shared savings; and impact on beneficiary assignment, alignment, and competitive dynamics.

Participating in multiple ACOs, whether as an other entity or through the use of separate TINs, may present various practical challenges for physician practices. For example, each physician practice will need to coordinate its compliance with the contracts, policies, procedures, and other requirements of all of its ACO affiliations. Compatibility of electronic health record systems also may be an issue.

ACO leadership and participating physicians may view participation as a sign of commitment to the ACO and non-participation as reflecting lack of commitment. Physician practices and ACO leadership therefore may need to explain the role and contributions of non-participating physicians, as well as the reasons for other entity status.

Another potential tradeoff relates to the Final Waivers in Connection with the Shared Savings Program,11 which waive the application of Section 1877 of the Social Security Act (Stark Law),12 Section 1128B(b) of the Social Security Act (Anti-Kickback Statute),13 and civil monetary penalty (CMP) gainsharing and beneficiary inducement prohibitions if the waiver requirements are satisfied. Other entity arrangements can be structured to satisfy the shared savings distribution waiver, but not the broader ACO participation waiver and the other three waivers. In some cases, other entity arrangements therefore may warrant additional consideration of fraud and abuse issues.

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13 42 U.S.C. § 1320a-7b(b).
Use of Separate TINs

As recognized in the ACO FAQs and the CMS commentary to the final MSSP regulations, exclusivity applies to the TIN of an ACO participant, and not to the National Provider Identifier (NPI) of a physician or other practitioner. Billing under multiple TINs therefore offers an alternative approach to avoiding exclusivity. Examples of separate TIN approaches for a group practice physician who desires to participate in multiple ACOs include participating under her Social Security Number (SSN), through a separate group (whether as employee or independent contractor), or through employee leasing arrangements or other professional service agreements under which a separate entity bills for her services.

A physician who wishes to participate individually can do so under his SSN, but must be individually enrolled in Medicare. This takes some time and therefore requires advance planning to enroll under the Provider Enrollment, Chain, and Ownership System (PECOS). While a physician’s SSN must be exclusive to a single ACO if he participates individually and bills Medicare for primary care services under the SSN, individual participation would not preclude the physician from furnishing primary care or other patient care services through a physician practice that participates in another ACO.

An open issue is whether a physician or entity is allowed to participate in an ACO under a Medicare-enrolled TIN if services are not billed under the TIN. The definition of “ACO provider/supplier” includes a requirement that the provider or supplier bills Medicare under a Medicare billing number assigned to the TIN of an ACO participant. This suggests that a physician participating under the participant’s TIN, or his SSN, without billing Medicare under the TIN or SSN, could be construed as inconsistent with the MSSP definitions of ACO provider/supplier and, in turn, ACO participant. Furthermore, the ACO FAQs appear to contemplate that participants are expected to bill under the Medicare-enrolled TIN. On the other hand, neither the MSSP regulations nor public

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15 An SSN is a TIN.
16 42 C.F.R. § 425.20 (definition of “ACO provider/supplier”).
guidance from CMS appear to expressly require billing under the TIN. Uncertainty likely will remain unless and until CMS provides guidance on this issue.

While the use of separate TINs can work in some circumstances for primary care physicians as well as specialists, arrangements involving the use of multiple TINs run some risk of jeopardizing the ability of physician practices and their physicians to comply with legal requirements and contractual obligations, and so may need to be carefully structured. For example, physician practices whose physicians split their time between several entities may find it more difficult to satisfy the Stark Law “group practice” definition\(^\text{17}\) (particularly the requirement that at least at least 75% of the patient care services of the group’s member physicians be furnished through the group and billed under a billing number assigned to the group) and the supervision and billing elements of the Stark Law in-office ancillary services exception,\(^\text{18}\) and to avoid the reimbursement restrictions of the Anti-Markup Rule.\(^\text{19}\)

Furthermore, billing through separate physician practices can create logistical challenges for staff members and billing companies. For example, if a physician bills under separate TINs within a single office, it may be difficult for the office staff to ensure that records and billing reflect the appropriate provider for each patient. An additional concern is that the use of separate TINs may require written consent by third parties to avoid breaching contractual or fiduciary obligations.

**Conclusion**

Physicians and physician practices who desire to participate in multiple ACOs may wish to evaluate whether any current or contemplated ACO arrangements will trigger exclusivity. If so, the physician practice may look into structuring (or restructuring) its arrangements to avoid the exclusivity restriction through other entity arrangements or

\(^{17}\) 42 C.F.R. § 411.352.

\(^{18}\) 42 C.F.R. § 411.355(b).

\(^{19}\) 42 C.F.R. § 414.50.
the use of separate TINs. ACOs also should develop strategies to address physician exclusivity issues.