POWERS
PYLES
SUTTER &
VERVILLE PC
ATTORNEYS AT LAW

1501 M Street NW | Seventh Floor
Washington, DC 20005-1700
Tel: (202) 466-6550 | Fax: (202) 785-1756

MEMORANDUM

To: **MEDICAL GROUP MANAGEMENT ASSOCIATION**

From: Powers, Pyles, Sutter and Verville, P.C.

Date: April 13, 2011

Re: Accountable Care Organizations: Analysis and Implications

---

The Centers for Medicare and Medicaid Services ("CMS") has now issued proposed rules under the Patient Protection and Affordable Care Act of 2010 ("ACA") to provide a new option for coordinating care for Medicare patients through "Accountable Care Organizations" ("ACOs"). (See April 7, 2011 Federal Register at pp. 19528 *et seq*). Companion rules and policy statements were proposed by several government agencies clarifying the regulatory treatment of ACOs under self-referral, fraud and abuse, anti-trust and tax-exempt organization laws. CMS also unveiled a new ACO website with links to its 429 page proposed rule and related materials (http://www.cms.gov/sharedsavingsprogram/). Comments on the CMS proposal are due June 6, 2011.

The ACA requires CMS to establish a **voluntary** Medicare ACO program by January 1, 2012, using a **shared savings model** to reward integrated or coordinated groups of providers that organize to deliver quality care at a reduced cost, **while continuing to be paid by Medicare on a fee-for-service ("FFS") basis.** The presumed logic of this provision of the ACA is that patients, providers, and the government can all realize some of the advantages of more tightly managed care systems without becoming fully integrated systems or operating under capitated or quasi-capitated payment systems. In short, ACOs are meant to be a hybrid option between Medicare FFS and Medicare managed care payment systems

The ACO option is based, in part, on **prior Medicare demonstration projects** championed by and undertaken with **several large physician group practices**. The ACA, however, allows CMS broad latitude in program design. Furthermore, many decisions made by CMS in establishing the new ACO rules will be exempt from both administrative and judicial review. Thus, medical groups either supportive of or concerned about ACOs should engage now, while there is still time for input to CMS, rather than waiting for final rules to be published later this year or early next.

Set forth below is our detailed analysis of the proposed rule, focusing on issues for public comment, and including potential risks and opportunities for MGMA members.

Overview of Basic Structure: Opportunity or Trap for the Unwary?

The proposed rule provides for two "tracks" for ACOs that lead to a single destination or model over a three year participation period. The two tracks, called the "one-sided" and the "two-sided" models, would be available to **eligible organizations** wishing to contract with CMS as an ACO. These could be "**ACO professionals**" (physicians, physicians' assistants and nurse practitioners and clinical nurse specialists) **in group practices or networks,** hospitals employing ACO professionals, partnerships or joint ventures of hospitals and ACO professionals, and other organizations as CMS deems appropriate (see Fed. Reg. p. 19539).

Eligible organizations must be constituted as a legal entity (corporation, partnership, limited liability company foundation or other entity permitted by state law) to receive shared savings, repay shared losses, and to otherwise implement ACO requirements. The ACO must have a governing body that is composed of ACO provider participants (at least 75% of the governing body), as well as Medicare beneficiary representatives served by the ACO. The ACO must be managed by an individual appointed by the governing body and must have a full-time medical director who is on-site on a regular basis. The ACO must also have a physician-directed quality assurance and process improvement committee, implement evidence-based medical practice or clinical guidelines and processes, and have a compliance plan.

> **NOTE:** An existing **medical group** could be the ACO entity, as could a hospital. Alternatively, medical groups could collaborate with one or more hospitals and other providers to create a new ACO entity for Medicare purposes, without necessarily integrating their operations in other respects. Not all providers serving Medicare patients assigned to the ACO need be participants in the ACO or share in its savings, if any.

Whether an eligible ACO achieves savings in any particular year is determined by comparing the average per capita Medicare costs for "assigned" beneficiaries for the three most recent years prior to the beginning of the ACO agreement (**the "benchmark"**) to the average per capita Medicare costs incurred by those beneficiaries during a year in which the ACO agreement is in effect. Eligible ACOs that achieve savings in any year beyond a threshold percentage **(the "minimum savings rate")** are allowed to share in a percentage of the savings beyond that threshold (**the "sharing rate"**) up to a maximum percentage of the benchmark (**the "sharing cap;"**) (see Fed. Reg. p. 19063). After the initial year, the sharing rate is also affected by how well the ACO scores on 65 quality measures (See "Quality Reporting" below).

> **NOTE:** Because the benchmark is based on the three previous years, beating the benchmark is easier in the first three year ACO contract period, than it would be in a second contract period, when the benchmark to beat is the one the ACO just set by doing a better job of controlling utilization in the first contract period. This has bedeviled various CMS demonstration projects for years, and will likely be a major focus of public comments.

ACOs must agree to accept **at least 5,000 beneficiaries assigned by CMS**. One-sided ACO models have a minimum savings rate that decreases to as low as 2%, thus increasing the sharing rate, as the number of assigned beneficiaries increase. Two-sided ACO models, and one-sided models in their third year, also share in losses that are incurred up to a maximum percentage of the benchmark.

The one-sided model: This model is so-named because, during the first two years, ACOs receive a share of savings but are not subject to sharing in losses. ACOs electing this model can receive savings in years one and two of up to 50% of savings beyond the threshold percentage, depending on quality performance, plus another 0.5%-2.5% if they include Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RRCs) in the ACO and as increasing percentages of the assigned patients use the FQHC or the RHC. In the third year, the one-sided model is subject to the rules that apply to a two-sided model in its first year.

The two-sided model: This model can share in savings and losses beginning in the first year and can receive a higher percentage of savings in the first two years. The two-sided model can share in up to 60% of savings beyond the minimum savings rate, which is a flat 2% of the benchmark regardless of size of the beneficiary population accepted (with a 5,000 beneficiary minimum). It can receive up to another 5% for including a FQHC or an RHC depending on the percentage of its assigned beneficiaries who have at least one visit to one of those facilities. Thus, the two-sided ACO models can receive up to 65% of the savings they achieve in excess of the 2% minimum savings rate. The two-sided model also is liable for all losses (no loss sharing) beyond 2% of the benchmark up to a maximum percentage of the benchmark, which is 5% in year one, 7.5% in year two and 10% in year three (see Fed. Reg. p. 19621). The one-sided model is liable for losses beyond 2% of the benchmark in the third year at a rate of 5% as though it were the first year of the two-sided model. The two-sided model can reduce its liability for losses beyond the 2% threshold down to 35% of the losses by obtaining a perfect score on the quality measures and by including an FQHC or an RHC.

> **NOTE:** As illustrated in the summary above and the table below, the shared savings and loss potential in the two tracks is complicated with several variables. The basis business model (**some might say gamble**) is less complicated. If the ACO can "beat" the benchmark by controlling utilization of services, it gets a share of the savings realized by the government, **but in doing so the ACO participants (physicians and hospitals) receive less fee-for-service payment** than they would if they did a poor job of controlling utilization. At the end of the day, the successful ACO's participants **have less revenue,** collectively, even with the shared savings, not more, so they had better be controlling costs just as they are controlling utilization. An ACO on the two-sided track (and year 3 of the one-sided track) that does a poor job of controlling utilization, pays back a portion of FFS revenues which its participants would keep if they were not participating.
>
> **NOTE:** Conventional wisdom says the easiest savings are found on the hospital and diagnostic services sides of the equation: fewer admits, fewer re-admits, fewer ER visits, fewer MRIs, etc. The same might be true for physician specialty services. But how do

you run a collaborative ACO if some participants, presumably the primary care physician base of the ACO, are clear winners (regular FFS revenues, plus a share of the savings) while their hospital and specialty group partners are clear losers (significantly reduced FFS revenues which cannot be offset by savings)?

The following table summarizes the structure of both options (Table 8, Fed. Reg. p. 19619):

Table 8: Shared Savings Program Overview

Design Element	One-Sided Model (performance years 1 & 2)	Two-Sided Model
Maximum Sharing Rate	52.5 percent	65 percent
Quality Scoring	Sharing rate up to 50 percent based on quality performance.	Sharing rate up to 60 percent based on quality performance
FQHC/RHC Participation Incentives	Up to 2.5 percentage points	Up to 5 percentage points
Minimum Savings Rate	Varies by population	Flat 2 percent regardless of size.
Minimum Loss Rate	None	Flat 2 percent regardless of size
Maximum Sharing Cap	Payment capped at 7.5 percent of ACO's benchmark	Payments capped at 10 percent of ACO's benchmark
Shared Savings	Savings shared once MSR is exceeded; unless exempted, share in savings net of a 2 percent threshold; up to 52.5 percent of net savings up to cap.	Savings shared once MSR is exceeded; up to 65 percent of gross savings up to cap.
Shared Losses	None	First dollar shared losses once the minimum loss rate is exceeded. Cap on the amount of losses to be shared phased in over three years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3. Losses in excess of the annual cap would not be shared. Actual amount of shared losses would be based on final sharing rate that reflects ACO quality performance and any additional incentives for including FQHCs and/or RHCs using the following methodology (1 minus final sharing rate).

Quality Reporting and Performance

ACOs will be required to meet certain quality criteria to participate in shared savings. In the first year, ACOs must report on quality measures and in the remaining two years, ACOs must meet quality performance scores. The quality measures are divided into five domains (or categories): patient/caregiver experience, care coordination, patient safety, preventive health and at-risk population/frail elderly health. Several of the quality measures align with those used in other programs, such as the Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) incentive programs.

Measures will be reported through either claims, patient surveys, **or the group practice reporting option (GPRO)** used for PQRS and the Physician Group Practice demonstration. One of the measures is that at least 50% of the ACO's primary care physicians (PCPs) are meaningful EHR users. A complete list of the measures is in Table 1 of the proposed rule (Fed. Reg. p. 19571-91).

CMS has proposed a "performance score approach" for ACOs to measure quality. Under this approach, CMS will set benchmarks (to be published prior to the start of the ACO program and annually thereafter) for each measure using FFS claims data and Medicare Advantage quality performance rates. An ACO will receive between 0 to 2 points for each quality measure, depending on its performance. If an ACO receives a 90% or better score on a measure, it will receive 2 points for that measure; if an ACO receives less than 90%, it will receive fewer points, down to 0 for an ACO that receives less than 30% for a quality measure. The proposed rule contains a sliding scale table showing the list of potential points and percentages needed to earn that number of points. (Fed. Reg. p. 19595.)

CMS will calculate a percentage score for each domain and average these scores to obtain a final score, so that all domains are weighted equally regardless of the number of measures in the domain. The ACO's final score will determine the percentage of shared savings that it receives. For example, if an ACO's final score is 90%, it will receive 90% of the potential shared savings (or 45% under the one-sided model and 54% under the two-sided model (90% x 50% and 60%, respectively)). In the first year, however, ACOs would obtain all potential savings based solely on reporting fully and accurately. CMS is requesting comments on this performance score approach or a "minimum threshold" approach under which an ACO would receive all potential savings as long as it met minimum quality standards.

> **NOTE:** The quality performance aspect of the proposed ACO program adds another layer of complexity, and may dilute the incentive to participate. As proposed, there is no upside "carrot" no matter how well the ACO performs on quality, just the downside "stick" of losing a portion of the savings that would otherwise go to the ACO because the quality scores are not perfect. Meanwhile, the government still gets the benefit of lower FFS outlays.

CMS is also proposing to coordinate PQRS and ACO reporting requirements, so that ACOs that meet the ACO quality performance measures will automatically be eligible for the PQRS

incentive payment. CMS is also proposing that the ACO publish certain data about itself electronically, including its quality performance scores.

If an ACO fails to meet the minimum attainment level for one or more domains, CMS will issue a warning and has the authority to terminate the ACO in the following year if the ACO continues to fail in one or more quality domains.

How Workable is the ACO Program and Who May Benefit?

Based on the published Regulatory Impact Analysis, CMS expects 1.5 to 4 million Medicare beneficiaries to be assigned to ACOs over the first three years. To put this number in perspective, in 2010, there were approximately 46.5 million Medicare beneficiaries. CMS estimates are based on the assumption that 75-150 ACOs will be established and approved for participation in the program during the first three year period**.**

Significantly, achieving the cost savings anticipated by the proposed rule could pose significant challenges for entities that seek to qualify as ACOs, since **Medicare beneficiaries assigned to ACOs are not precluded from obtaining care from non-ACO providers**, and Medicare beneficiaries must be informed of this by ACO participants. In addition, under the proposed rule, an **ACO will not know the identity of the Medicare patients assigned to it until after care is delivered.** Medicare patients are to be assigned to ACOs retroactively, and an ACO will have only rudimentary demographic information about the Medicare patients for which it is to be held accountable. Thus, it is unclear whether and to what extent the ACO program (if implemented as proposed) will achieve the savings and care integration anticipated by CMS.

While hospital participation in an ACO is not technically required, the administrative and IT requirements imposed on ACOs (and the costs involved in meeting those requirements) implicitly require the involvement of a hospital or another "deep pocket." (**See also "Fraud and Abuse Waivers" below**) The Proposed Rule limits representation of non-providers on the ACOs governing body to 25%, making it appear unlikely that insurance companies would want to play a major role and be the "deep pocket." Hospitals that are not in a position to make significant financial commitments for ACO infrastructure and for the acquisition of physician practices may find the proposition of spearheading the establishment of an ACO program unappealing. However, since a number of the quality measures are those reported by hospitals (e.g. admissions, readmissions, and Hospital Acquired Conditions (HACs), it would appear that ACOs will need the participation of the primary hospital(s) to which the assigned Medicare population is referred.

Likewise, with the requirement that ACOs be in a position to assume financial risk for their assigned population, the capital required for start-up and first year operating expenses may dissuade loosely formed physician networks from making the commitment necessary to participate in the program. In this regard, ACO start-up costs and first year operating costs can be significant, although the existing data suggests that these may vary widely. CMS anticipates that an ACO's **start-up costs and first year operating costs** are likely to be in the range of $1,755,251 based on the experience of the Physician Group Practice demonstration project (the predecessor of ACOs). However, this may be an underestimate: the 10 groups participating in the PGP demonstration project incurred operating and start-up costs that varied substantially

($436,386 to $2,922,820 (first year operating costs); $82,573- $917,398 (start-up costs)). CMS admits that these groups were "uniquely suited" to provide integrated care and had already adopted EHR.

Nonetheless, many in the health care industry have expressed strong interest in the ACO program, at least in concept. The implications of the entry of ACOs into the health care marketplace will vary substantially from area to area, and, at this stage, it is difficult to determine whether the enthusiasm for ACOs that has been evident in recent months will survive the onerous regulatory requirements set forth in the Proposed Rule. On balance, we think medical groups should assume that the ACO program has the **potential to substantially change referral relationships** and financial incentives in those markets where at least one sizeable ACO is formed.

The Role of Primary Care Physicians and Specialists in ACOs

The proposed rule includes significant verbiage lauding primary care physicians, who are viewed by the agency as the "core" participants in the program. Under the governing legislation, an ACO must have at least 5,000 beneficiaries assigned to it, and, under the proposed rule, (and under the governing statute) **the assignment of Medicare beneficiaries to an ACO is based on whether the patient's primary care physician is an ACO participant**. A patient's primary care physician is one from whom the patient receives a plurality of his or her primary care services. "**Primary care physician"** is defined to include only **internal medicine, general practice, family practice and geriatric medicine** physicians. Thus, while medical specialists and non-physician primary care providers (such as nurse practitioners and physicians' assistants) who participate in the Medicare FFS program may participate in an ACO, an ACO must have sufficient primary care physicians to meet the 5000 beneficiary requirement in order to be approved by CMS.

> **NOTE:** This aspect of the program makes it likely that a **large single specialty primary care practice, or a multi-specialty group with a very large primary care base**, is the essential ingredient in forming an ACO. Small specialty practices, or large multi-specialty practices without the primary care base, would appear to be more of a burden than a blessing to an ACO hoping to succeed under this program.

In addition, the clinical quality measures required to be reported by ACO physicians relate primarily to services that are commonly provided by primary care physicians (*e.g.*, patient education regarding smoking cessation, glucose control in diabetics, etc.). It is clear that CMS anticipates that primary care physicians will play a key role in controlling both the quality and cost of services provided to the Medicare beneficiaries assigned to an ACO, functioning as "gatekeepers" in determining access to specialty care, testing and inpatient services. Whether this assumption is a realistic one, in light of the fact that **beneficiaries retain the right to access specialty care outside the ACO**, is a key unanswered question.

It is unclear whether, and to what extent, cardiologists, medical oncologists, and other internal medicine subspecialists will change their CMS specialty designations to "internal medicine" in order to participate in the ACO program as primary care physicians. Nor is it clear whether CMS will allow internal medicine subspecialists to change their specialty designations for this

purpose. There may also be a disincentive to doing so since **primary care physicians can participate in only one ACO, while specialty care providers can participate in more than one**.

Specialists may participate in ACOs as employees, joint venture partners or as providers under contract with the ACO. In those areas where there is more than one ACO, a specialist may be required to institute different patient care protocols and may be required to comply with different pre-authorization or other administrative requirements by each ACO with which he or she contracts or participates. Since a relatively small proportion of Medicare patients generate a substantial proportion of Medicare costs, and since those patients tend to be those with multiple chronic conditions (such as diabetes, asthma, CHF, CAD, and COPD) or expensive acute conditions (such as cancer), it appears likely that ACOs will need the active involvement of at least some specialists to achieve measurable savings.

> **NOTE:** A likely risk to high cost specialty practices is that a primary care based ACO will want to keep the specialists at arm's length, reducing costs of assigned beneficiaries by cutting back on referrals, but keeping the specialists out of the ACO so as not to share resulting savings with them. Another model is to bring them in, but keep the hospitals at arm's length, with the hospitals' loss of FFS revenues being potential gains to both primary and specialty care. In other words, at least in theory, ACOs have the potential to ignite some cut throat behaviour in some local markets.

What is the Likely Impact of ACOs on Medical Groups and other Providers?

At this stage, there are numerous unanswered questions about how ACOs will work and how the health care marketplace will respond to the approach taken by CMS. For that reason, it would be prudent to avoid any hard-and-fast conclusions about the potential impact of the proposed ACO program on MGMA members, particularly given the geographic, organizational, group size and specialty diversity inherent in the MGMA membership.

However, a number of broad observations are worth considering:

- There are three primary ways for an ACO to achieve savings on the care of the assigned Medicare population: (1) Reducing emergency room visits and hospital inpatient admissions; (2) reducing the provision of specialty care for the assigned Medicare patient population; and (3) reducing the provision of imaging and other tests.

- While the proposed rule favors primary care physicians in a number of ways, it appears highly likely that, in order to achieve substantial savings, an ACO likely will have to find ways to reduce the costs of caring for those Medicare beneficiaries assigned to it that have chronic conditions, such as asthma, congestive heart failure, coronary artery disease, and hypertension, as well as other high cost acute conditions, such as cancer care. Technologies and practice protocols that truly reduce the costs of care for Medicare beneficiaries in high cost categories, at least conceptually, should be of interest to ACOs.

- The 65 quality standards include a number of quality measurements intended to discourage admissions for conditions that should be manageable on an ambulatory basis,

such as CHF, COPD, pneumonia, dehydration, and diabetes. Conceptually, then, specialty care that is effective in reducing admissions for these conditions should be of interest to ACOs.

- The quality measures also include a Hospital Acquired Condition (HAC) measure; however, it should be noted that, under CMS' quality reporting program, this measure is already applicable to all hospitals, so the inclusion of this measure in the ACO program may not result in a significant additional incentive for hospitals to reduce HACs.

- While the governing legislation requires ACOs to provide care coordination and specifically mentions the use of telemedicine and remote monitoring as mechanisms through which this may be accomplished, the proposed rule does not require ACOs to utilize remote monitoring or telemedicine or any other specific technology to facilitate care coordination.

Antitrust Risk, Self-Referral, Fraud and Abuse and Tax Considerations:

Antitrust Issues

Contemporaneous with the issuance of the CMS proposed rule on ACOs, the Federal Trade Commission (FTC), together with the Department of Justice (DOJ), issued draft Policy Statements detailing how those agencies would evaluate antitrust issues surrounding formation of ACOs. **Comments on these Policy Statements must be received by May 31, 2011.** The Agencies will use a "**Rule of Reason"** analysis for ACOs that meet the CMS eligibility criteria and will evaluate whether collaboration among ACO participants that are potential competitors is likely to have substantial anti-competitive effects and, if so, whether the collaboration's potential pro-competitive efficiencies are likely to outweigh those effects.

The agencies will assess each ACO for potential anti-competitive impact based on the entity's share of services in each ACO participant's Primary Service Area (PSA). The higher the PSA share, the greater the anti-competitive concerns.

ACOs with a combined **PSA share of 30 percent or less** would qualify for a **"safety zone**" under which they would be presumed unlikely to raise significant competitive concerns. Consequently they would not need to seek review by the FTC/DOJ. To fall within the safety zone, any hospital or ambulatory surgery center participating in the ACO must be non-exclusive to the ACO, regardless of PSA share. To address specialty shortage in rural areas, an ACO could include one physician per specialty from each rural county on a non-exclusive basis and qualify for the safety zone even if this caused it to exceed the 30 percent test. Similarly, inclusion of a rural hospital on a non-exclusive basis could allow one to qualify even if the 30 percent threshold were exceeded.

An ACO whose **PSA share for any service exceeds 50% would be subject to mandatory review** from either the FTC or DOJ and would have to obtain a letter from one of those agencies stating that the arrangement would not be challenged under the antitrust laws.

ACOs outside of the safety zone and below the 50 percent mandatory review threshold could, on a voluntary basis, seek expedited review by the government. In addition, the FTC and DOJ have identified specific types of conduct which ACOs should not engage in if they are to avoid antitrust scrutiny.

The government commits to reviewing and issuing advisory opinions within 90 days for ACOs seeking CMS approval.

Self-Referral and Fraud and Abuse Waivers

Under a separate Federal Register notice published on April 7, 2011, CMS and the HHS Office of Inspector General ("OIG") have requested comment on proposed waivers to the Stark self-referral law, the anti-kickback statute (AKS) and the civil monetary penalty provisions for ACO arrangements (76 Fed. Reg. 19655). The proposed waivers are narrow in scope, **limited to distributions of the shared savings** among the ACO participants, or to entities outside of the ACO but only if closely related to achieving quality and savings goals. Failure to qualify for a waiver does not necessarily mean the arrangement is illegal, but if Stark is implicated, any financial arrangement would need to qualify for an existing Stark exception, and the financial arrangement would need to be analyzed for AKS purposes on its facts and circumstances if outside the very narrow AKS "safe harbors." Any waiver would only last as long as the ACO participates in the Medicare shared savings program.

CMS and OIG are seeking comments on whether to expand the waivers to address ACO start-up costs, operating expenses, and other payments unrelated to shared savings. **The deadline for submitting comments is June 6, 2011.**

> **NOTE:** If CMS estimates with respect to infrastructure and start-up costs are on target, then funding these costs in a newly formed ACO will be a real challenge. If the "deep pocket," whether a hospital or other entity, fronts costs for the benefit of other participants in the ACO, **real regulatory issues will arise** as there is no readily available Stark exception or AKS safe harbor to protect that type of financial arrangement between parties in a referral relationship.

Tax Implications for Non-Profits

In a separate Notice, the IRS is seeking comments on whether it should issue specific guidance to tax-exempt organizations that participate in ACOs. **The deadline for submitting comments to the IRS is May 31, 2011.** Of concern in the IRS notice is 1) whether participation in ACOs could result in private inurement or impermissible private benefit; and 2) whether shared savings from the Medicare program would be subject to unrelated business income tax (UBIT). The IRS states that it would normally expect that shared savings would be derived from activities substantially related to the tax-exempt organization's charitable purpose and thus not subject to UBIT. To avoid risks of private inurement or private benefit the tax-exempt entity would need to ensure that its share of ACO losses is commensurate with its share of economic benefits and both losses and benefits are proportional to the benefits or contributions the tax-exempt entity makes to the ACO.

NOTE: If the "deep pocket" fronting infrastructure and start-up costs for an ACO is a tax-exempt hospital, with subsidies running to for-profit medical groups outside the hospital system, the private inurement issues will be real, and not dissimilar to the Stark and AKS issues noted above.

The IRS is also seeking comments on whether guidance is needed to address circumstances in which a tax-exempt organization participates in non-Medicare shared savings program activities through an ACO (for example, those that involve the private market).

******

FINAL NOTE: Taken together, these ancillary regulatory obstacles present real obstacles to rapid formation of ACOs in many circumstances. Unless the government liberalizes its approach to waivers and safety zones, **as MGMA strongly urged in a CMS/OIG sponsored forum last Fall,** they will increase transaction costs for all, slow down the process, and favor ACOs that are already, or can quickly become, highly integrated systems, at the expense of more loosely formed community collaborations. Under that scenario, the ultimate impact of the ACO program may simply be to further accelerate the growth in large integrated systems which are already pulling so many MGMA members into the orbit of local or regional hospital systems.