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Accountable Care Organizations:
How Healthcare Reform Will Transform
Hospital-Physician Relations

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Agenda

- The state of hospital-physician relations before PPACA
- Direct employment of physicians by hospitals
- Alternative physician employment/ affiliation models
- Accountable Care Organizations (ACOs) – A New Way for Medicare to Contract with Providers
- Transforming existing models into ACOs
- Ownership, governance and operation of ACOs
- Key challenges to ACO development
- How the medical home concept may shape ACOs
- Legal hurdles to ACO development
The State of Hospital-Physician Integration
Before PPACA – the Healthcare Reform Act

• For decades, the industry has been seeking a new paradigm for delivering better-coordinated, safer and more affordable care

• Bona fide collaborative efforts to achieve efficiency, connectivity and quality do exist, but they are not yet the norm

• Traditional hospital-physician relationships were designed for a payment system that rewarded greater volumes of service

• In contrast, the post-Reform era will be based upon payment models that reward those who create value for patients and payers, encourage innovation and accountability
Traditional Drivers of Hospital - Physician Integration

• Growing volumes and increasing market share have been the primary reasons
  • 51% of hospitals say they employ doctors to further growth of their business
  • 42% say they employ doctors to stabilize their ability to serve patients
  • Only 7% say they employ doctors to transform how healthcare is delivered
# The Spectrum of Physician-Hospital Relationships

*Source: EthosPartners © 2010*

<table>
<thead>
<tr>
<th>Range of Affiliation Models</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
<th>Model 7</th>
<th>Model 8</th>
<th>Model 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>Traditional</td>
<td>Physician Recruitment</td>
<td>Medical Directors &amp; Personal Service Agreements</td>
<td>Management Service Organization</td>
<td>Center of Excellence</td>
<td>Joint Payer Contracting</td>
<td>Joint Ventures</td>
<td>Co-Management Agreement</td>
<td>Physician Employment</td>
</tr>
<tr>
<td>Projected Utilization Next 24-36 Months</td>
<td>No Growth</td>
<td>Slight Growth</td>
<td>No Growth</td>
<td>Decrease</td>
<td>Slight Increase</td>
<td>Decrease</td>
<td>Steady Growth</td>
<td>Steady Growth</td>
<td>High Growth</td>
</tr>
<tr>
<td>Additional Comments &amp; Rationale</td>
<td>Increasing recognition of need to rebuild physician relations programs</td>
<td>Limited per Stark and other regulations</td>
<td>Slight decrease in number of physicians, increase in pay, and accountability</td>
<td>Practices will continue to evaluate whether to seek practice support due to financial pressures</td>
<td>Typically focused upon favored margin services</td>
<td>Dependent upon extent of clinical integration</td>
<td>Continues to increase despite initial resistance from hospitals and systems</td>
<td>Continued increase due to focus on quality and efficiency</td>
<td>Increasing physician employment integration in multiple forms</td>
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</tbody>
</table>
Why Is Hospital Employment an Attractive Alternative to Physicians?

- Changing demographics of the medical profession
- Economic pressures
- Income security and freedom from administrative burdens outweigh loss of autonomy
- Hospitals are beginning to see physicians as partners not customers
- However, physicians are only willing to affiliate with a health system that gives them a meaningful stake in governance and the ability to produce high quality care as well as strong financial results
The Appeal of the Employer-Employee Relationship

• In today’s regulatory environment where all payments by hospitals to physicians has the potential of being challenged, the AKS employment safe harbor and its equivalent under Stark offer legal protection that makes affiliation simpler and less uncertain.

• But it is important to note that employment is not the same as integration. Many hospital-employed physicians continue to function as they did in private practice.
Employment Gives Hospitals Latitude to Do Things With Physicians That Otherwise Would Be Legally Difficult If Not Impossible

- Require referrals to hospital’s facilities, not to competitors, except where patient needs dictate
- Require adherence to clinical guidelines
- Where applicable, bill as provider-based practices
- Make major investments in EMR technology
- Avoid some of the more difficult regulatory requirements governing hospital-physician relationships
Alternatives to Hospital Employment of Physicians

• Physicians who would otherwise shun direct employment by hospitals have become willing to join physician-centric alternatives

• Models such as the Physician Enterprise and Leased Practice have changed the way hospitals and physicians see each other

• These alternatives move hospitals away from the traditional “feed the beast” paradigm to the management of a cohesive system of clinicians whose overriding goal is to coordinate care for the patient
Professional Services Agreements — Clinical Co-Management Agreements

- PSAs and CCMs are rapidly taking the place of what previously were known as “medical directorships”
- Useful in building programs and service lines around key doctors
- Ensure that the best physicians provide leadership in the development and enforcement of clinical guidelines
- Regardless of form, they are intended to increase the physician’s sense of connection with the hospital and its programs
- There is regulatory risk in PSAs and CCMs if their true purpose is to pay for referrals
Other Pre-Reform Models

- Physician-Hospital Organizations
- Independent Practice Associations
- Multi-Specialty Groups owned by hospitals or systems
- Management Service Organizations
- Medical Foundations
- Clinical Institutes
- Joint Ventures
ACOs – A New Way for Medicare to Contract with Providers

- PPACA directs DHHS to select and foster innovative payment and care delivery models that reduce Medicare expenditures while preserving or enhancing quality of care.

- Sec. 3021 of PPACA requires that deference be given to models that improve coordination, quality and efficiency. Two of those models are ACOs and Medical Homes.

- ACOs seek to control costs and improve quality by making incentive payments to multi-provider networks that meet certain targets.

- Medical Homes seek to improve care coordination and outcomes by payments to one’s personal physician.
What Is Required To Transform Existing Arrangements into Accountable Care Organizations (ACOs)?

• Time – even if you think that PPACA may never be implemented as enacted, there’s an incredible amount of work to do to get ready for industry-driven reforms.

• Begin by considering the core PPACA principles:
  – Accountability for a defined population
  – Infrastructure that promotes quality and efficiency
  – Adequate number of primary care providers
  – Legal structure that allows risk and incentive sharing
  – Patient-centered processes of care
  – Ability to report quality measurements
  – Ability to function under targeted levels of cost and growth
What Is Required to Transform Existing Models Into ACOs?

• Creating or restructuring organizations that can receive and administer new forms of payment, e.g., “bundles”

• Problems with most existing hospital-physician models:
  – Directing contracting: not easily scalable, sense of loyalty is lacking, hard to administer
  – Physician-hospital organizations: provider loyalty still uncertain; uneven quality because poor performers are often included
  – Employment: substantial capital commitment, not acceptable to some physicians, may be unnecessary in many cases
  – Most existing models still lack the necessary level of clinical integration to function as ACOs
What Is Required to Transform Existing Models Into ACOs?

• Assuming that a significant number of physicians will remain independent practitioners, how can an organization cause employed and non-employed physicians to work together?
  – Common interests/ common fears
  – Need for the resources of a larger organization
  – Need for performance improvement infrastructure
  – Interdependency of the various specialties
  – May be no other way to get paid in the post-Reform environment
What Is Required to Transform Existing Models Into ACOs?

- At a minimum, the new organizational structure must support:
  - **Performance improvement**: mechanisms to monitor and manage resource consumption and cost; mechanisms to monitor and manage quality, outcomes and patient satisfaction
  - **Selectivity**: only providers who are committed to performance improvement are invited; requires more than traditional credentialing
  - **Investment**: both monetary and human capital required in large amounts over time; ability to demonstrate to stakeholders that this investment is paying dividends
What Is Required to Transform Existing Models Into ACOs?

- Clinical transformation that reduces demand must be offset by the creation of value recognized and rewarded by payers
- The ACO must avoid taking on risk too soon, i.e., before its systems can manage that risk
- The ACO should start with pilot populations (e.g., a hospital’s own self-insured employees) before opening up to the general public
- The ACO should design a payer contracting strategy that creates value for purchasers, rather than use market position to leverage negotiations
ACOs and Financial Risk

Tier 3
Financial Risk: High
Mode of Payment: Full or partial capitalization and extensive bundled payments
Additional Incentives: Highest level of shared savings and bonuses if per beneficiary spending is below agreed-upon target, but greatest amount of risk if spending is above agreed-upon target.

Tier 2
Financial Risk: Moderate
Mode of Payment: Fee-for-service, partial capitation, some bundled payments
Additional Incentives: More shared savings and bonuses if per beneficiary spending is below agreed-upon target, but also some risk if spending is above agreed-upon target

Tier 1
Financial Risk: Low
Mode of Payment: Fee-for-service
Additional Incentives: Some shared savings and bonuses if per beneficiary spending is below agreed-upon target.

Who Should Own the ACO?

• Build it, buy it, rent it?

• **Advantages of ownership**
  – Easier to set standards
  – Simplifies flow of funds
  – Facilitates cross-subsidization of risk

**Disadvantages of ownership**

– Require capital
– Centralization limits innovation
– Network still may be “porous”
Who Should Own the ACO?

- **Advantages of partnership**
  - Less capital outlay
  - Builds stronger alliance of best providers
  - Allows for innovation and sharing

**Disadvantages of partnership**
- Cultural differences
- Conflict over standards and accountability
- Harder to share risk and funding obligations

**The role of provider-owned health plans**
- Better means of complying with state insurance requirements?
How Should the ACO Be Governed?

- The importance of effective board leadership and oversight cannot be overstated
- ACO boards may need to become involved in some matters that were traditionally left to management
- Managing performance risk and reward can only be accomplished through shared governance
- If the ACO is an owned subsidiary of a tax-exempt system, balancing the private interests of physicians with the public’s interest in accountability will be reflected in:
  - Board composition
  - Reserved powers
  - Oversight functions of the board
How Should the ACO Be Governed?

• The Importance of Committees
  – **Clinical Leadership Committee**: sets key care-process steps
  – **Clinical Operations Committee**: sets e-guidelines to promote integrated workflow
  – **Steering Committee**: monitors adherence to guidelines, communicates with system
  – **Finance Committee**: determines physician compensation based upon performance based metrics, sets prices
How Should the ACO Be Operated?

- Ensuring a proper mix of providers
- Incorporating the Medical Home model as appropriate
- Including providers recognized by PPACA but often outside the traditional integrated delivery system
  - Post-acute care providers
  - Federally qualified health centers
  - Community based collaborative care networks
- The objective: safer, more efficient, timely and equitable care; patient at the center
How Should the ACO Be Operated?

Five key elements of successful ACO operations:
- Selective, scalable provider membership
- Delivery of evidence-based care
- Infrastructure for coordination/collaboration
- Transparent performance measurement
- Meaningful performance-based incentives/disincentives
Key Challenges to ACO Development

• Physician Buy-In
• Patient Acceptance
• Payment Uncertainty
• High Cost of Building the ACO Infrastructure
• What Will Become of the Voluntary Hospital Medical Staff?
The Role of Medical Homes

- ACOs and medical homes are not competing models
- Medical homes may be the best means of placing the patient at the center of the transformed delivery system
- Medical homes will be charged with ensuring a continuous, comprehensive series of care encounters coordinated by a team of primary care providers
The Role of Medical Homes

- Medical homes will:
  - Take responsibility for arranging care delivered by others in the ACO
  - Continuously communicating with patients
  - Supporting self-management, proactive patient monitoring, coordination of family and community resources
  - Integrating clinically useful patient data
  - Applying evidence based guidelines as they become available
The Role of Medical Homes

The objectives of medical homes are not inconsistent with the objectives of an ACO:

- Reducing patient disparities
- Preventing hospitalizations
- Preventing readmissions
- Reducing ER visits
- Improving health outcomes
- Improving patient satisfaction
- Reducing duplication and waste
- Reducing expenditures
Legal Hurdles to ACO Development

• Existing Stark, Anti-Kickback and Civil Monetary Penalty rules were not designed for the post-Reform environment and will need significant revision for Accountable Care to take root.

• Issues of FMV and commercial reasonableness will remain central to fraud and abuse analysis but evolving notions of self-referral and self-interest must be recalibrated for these new payment and delivery models.

• Physician compensation in the new system must include a plan for distributing incentive payments and shared savings. Current regulations remain at odds with this financial concept.
Legal Hurdles to ACO Development

• In particular, how should gain sharing, pay for performance and other risk/reward sharing be interpreted under CMP law and applicable sections of the Internal Revenue Code?

• Can employed physicians be paid a percentage of a hospital’s Medicare cost savings under applicable Stark exceptions without a volume/value problem?

• The Stark employment exception is limited to compensation paid for “identifiable services” – does that include changing physician behavior/performance?
Legal Hurdles to ACO Development

• IRS rules and guidance have traditionally been premised on the assumption that hospitals were usually tax-exempt and physicians and other independent providers were usually taxable. If non-profit community health systems continue to employ an increasing number of practitioners, will those rules remain relevant?

• Will increased importance on community benefit and transparency keep some needed physicians from participating in ACOs?
Legal Hurdles to ACO Development

- Although ACOs potentially interject a new level of competition into the marketplace, they can only function if providers are allowed to cooperate in ways that historically raised serious antitrust questions.

- Because ACOs are to be built upon a foundation of clinical and financial integration, one might expect that reasonable application of joint venture antitrust analysis will not impede ACO development.

- However, collective actions by competitors that exclude some providers, tie one good or service to another, and establish uniformity in price and other terms will draw scrutiny, particularly if ACOs achieve market dominance.
Legal Hurdles to ACO Development

- Other legal issues include:
  - Corporate practice of medicine
  - Prohibitions against fee-splitting
  - State insurance laws, especially those that regulate risk bearing networks or permit “any willing provider” to participate in a health plan
  - Certificate of need (possibly)
  - Patient privacy and data security laws
  - Federal preemption issues
Assessing Organizational Readiness

• Review your client’s readiness for change:
  – Client’s priorities now and in the coming months
  – Existing infrastructure, especially IT interconnectivity and current data on physicians
  – Potential for clinical performance improvement
  – Degree to which physicians are genuinely interested in integration
  – Support of payers in your region
  – The relative absence of state law barriers
Final Comments

• Physician leadership is essential

• Bona fide reform requires a shared commitment to the needs of patient and to continual innovation and quality improvement

• This will demand a level of cooperation that has never before been expected of health care providers

• As lawyers, we have a crucial role to play in bringing about this transformation no matter what our lawmakers and regulators do