ACCOUNTABLE CARE ORGANIZATIONS – PHYSICIAN/HOSPITAL INTEGRATION

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Federal Regulatory Policy Initiatives Impacting Physician/Hospital Integration and the Emergence of Accountable Care Organizations

Upcoming federal regulatory policy initiatives focused on improving health care quality and value will shape future physician/hospital integration projects. The federal government is becoming increasingly committed to enhancing healthcare quality by linking healthcare payment to quality and value and expanding the use of health information technology. Accountable Care Organizations (“ACO’s”), a new model of physician/hospital integration, will enable physicians and hospitals to maximize the opportunities such new federal policy presents.

Quality and Value Initiatives and Pay for Performance Methodology

Until recently, the federal sector has primarily focused its reform efforts on hospital quality reporting. It was the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”), that for the first time linked Medicare payments to the reporting by hospitals of the quality of their services.1 Section 501 of the MMA states: “in a case of a [defined] hospital that does not submit [quality] data to the Secretary . . . with respect to such a fiscal year, the applicable percentage increase . . . shall be reduced by 0.4 percentage points.”2 This imposed a penalty of 0.4 percent on hospitals that fail to report performance as measured by a set of ten quality indicators that are published by the Department of Health and Human Services (“HHS”).3 Interestingly, the

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As I reflect on all that the Section has accomplished this past year, I am writing my last column as your Chair and want to share some thoughts on the state of the Section. I have been honored to work with many dedicated and thoughtful Section leaders and members who participated in so many of the Section’s projects and initiatives. On the staff side, we said farewell to Adam Bielawski in November 2008 and welcomed Simeon Carson as the new Publishing, Technology and Membership Manager in January 2009. Simeon joins our dedicated staff, Administrative Assistant Abbey Palagi, Associate Director Sena Leach and Director Jill Peña.

In this economically challenging time, I am proud of the great strides we made in fulfilling our mission. Through our Interest Groups and deep discounts on programs and publications, the value that Section members receive compares favorably or exceeds any other organization. This past year is an excellent example of how the Section continues to grow as a resource for you to turn to for publications, CLE, and current developments and initiatives in the health law arena.

Publications and Electronic Communications

The Section is proud of its publication program, an area that we continue to grow.

• Practical Guide Series: We added two new publications to this series, Patient Safety Handbook by June Sullivan and Renee Martin and A Practical Guide to Medicare Appeals by Daniel Cody and Kathleen Scully-Hayes. These two books join our first book, HIPAA: A Practical Guide to the Privacy & Security of Health Data, written by June Sullivan. The Publication Committee has been meeting to discuss other topics for the Practical Guide series. If you have expertise in a topic, we hope that you will consider contributing to this series. If you have a suggested topic area for us to consider, let us know that as well.

• The Health Lawyer: For over twenty years, the Section’s flagship publication has provided informative and in-depth articles that focus on a wide range of areas in the health law field. Published bimonthly, The Health Lawyer offers incisive analysis of timely and significant issues.

• ABA Health eSource: Each month, the Section’s monthly e-newsletter has helped keep members informed by publishing original health law articles, delivering the latest information about health law related CLE programs, and providing the most recent health law news and resources.

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The federal government has also used Medicare payments to incent physician quality reporting. The Tax Relief and Health Care Act of 2006 created incentives for physician self-reporting by providing a 1.5 percent increase in reimbursement for physicians under Medicare Part B when they satisfactorily report data on quality measures that are applicable to physicians. Again, HHS was responsible for establishing and publishing those quality measures. Under this Act, the percent reporting was smaller, but still over 80 percent of physicians have reported at least three measures, satisfying the requirement for increased reimbursement.

This legislation created a “Pay for Reporting” paradigm, and it was understood by the healthcare industry that this was just a first step toward healthcare reform. Recently, following in the path blazed by the Bush Administration, there has been careful consideration by the Obama Administration of how to take this reform to the next level, namely, by shifting from simply “Pay for Reporting” to “Pay for Performance.” This system would reward hospitals and physicians for reporting certain quality measures and link payment to the attainment of performance goals. Hospitals and physicians would be challenged to achieve not only better clinical outcomes, but also lower costs. In combination, this will yield increased value.

Payment Reform Initiatives

To finance upcoming healthcare reform initiatives, costs need to be reduced and efficiencies created. To do this, comparative effectiveness research is being conducted to develop favored treatments that will be optimally effective, both clinically and economically. Once again, physician/hospital integration will play a critical role. With both government programs and private plans rewarding selection of the treatment options identified as most clinically and cost effective, hospitals will need to be able to ensure that these treatment options are selected, whenever appropriate. Physician/hospital integration provides hospitals with this sort of input into physicians’ care delivery. Additionally, payment is generally provided based on the cost of the entire hospitalization experience. Yet, absent physician/hospital integration, hospitals have no control over the decisions physicians make that drive hospital costs.

As discussed in more detail below, Accountable Care Organizations (“ACOs”) provide a model for physician/hospital integration to achieve clinically and economically effective care. An ACO is an integrated healthcare delivery system that relies on a network of primary care physicians, one or more hospitals, and sub-specialists to provide care to a defined patient population. Under this model, the hospital and physician networks would be responsible for the quality of care delivered to patients and would receive bonuses for providing high-quality, low-cost care; penalties would be imposed for delivering low-quality, high-cost care.

In an April 2009 Senate Finance Committee proposal for improving patient care and reducing healthcare costs, the Committee endorsed an ACO model in one of its policy options. The proposal references a Medicare PGP Demonstration where multi-specialty groups were provided financial rewards for improving quality and cost efficiency through increased coordination of Part A and Part B Services. The Senate Finance Committee proposal suggests building on this model by producing a shared savings ACO option for 2012. To be eligible for this option, organizations must meet the following minimal requirements:

- Consist of hospitals and physicians;
- Include a legal structure that allows for distribution of bonuses to participating providers;
- Include core contracted specialists;
- Include the primary care physicians of at least 5,000 Medicare beneficiaries;
- Employ joint decision-making;
- Implement a process to promote evidence-based medicine, quality and cost measurement, and coordinated care;
- Assign beneficiaries based on historic prior year PCP; and
- Commit to a minimum two years of participation.

Medicare would establish a spending baseline based on the three most recent years total per beneficiary spending (for both Parts A and B), and CMS would adjust this baseline based on the expected national growth rate. If the participating ACO achieved more than 2 percent in savings, the ACO would be allowed to keep 50 percent of those savings. The other 50 percent of the savings would go to Medicare. This model is currently under consideration in the Senate Finance Committee, and it has great potential to be enacted.

Finally, the draft Kennedy Bill has been recently released to implement President Obama’s healthcare plan. One of the proposals requires all group health plans, not just the federal plans, but private payers as well, to implement...
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a reimbursement structure that provides incentives to: increase quality of care, increase case management and case care coordination, reduce hospital readmissions, and reduce medical errors.\textsuperscript{18}

Physician/hospital integration will facilitate implementation of these payment reform initiatives. Even in the hospital setting, physicians are responsible for treatment decisions and drive clinical outcomes. In fact, according to some studies, doctors are responsible for 80 percent of hospitalization costs. For that reason, hospitals cannot adequately improve care and/or lower costs without having some control over physician decisions. Physician/hospital integration allows hospitals to shape treatment decisions and allows hospitals to align incentive payments with decision-makers, thereby reducing externalization.

Expanding Health Information Technology

A critical part of the current healthcare reform effort centers on advancements in health information technology (“HIT”). Both the Bush and Obama Administrations have looked to the deployment of interoperable electronic health records (“EHR”) to reduce medical errors, reduce costs, and facilitate a comparative analysis of the efficacy of treatment options. Medicare can currently examine claims data, but this does not provide a full picture of quality. In contrast, integration of claims data with searchable EHR will provide a new level of quality analysis.

There are several significant obstacles preventing the successful deployment of HIT. First is the initial start-up cost, which is generally too high for individual physicians and practice groups. Although there have been government program incentives for developing HIT, the government has provided insufficient financial assistance to make such projects feasible. Second, with numerous independent physicians and physician practice groups privileged at any particular hospital, these independent decision-makers are unlikely to all choose the same technology. As a result, the hospital will be less likely to have technology that is interoperable and seamless. This also makes it difficult to coordinate HIT updates. These obstacles have significantly delayed implementation of the universally-endorsed HIT policy objective.

Regulators are attempting to minimize these obstacles to HIT deployment, with special focus on the cost issue. Currently, the approach has focused on easing some of the restrictions under the Anti-Kickback and Stark laws that otherwise prevent hospitals from donating software or hardware to physicians. Since physicians are in a position to refer patients to hospitals, any time a hospital gives something of value (like computers or software) to physicians, issues may arise under the Anti-Kickback Statute or Stark.\textsuperscript{19} Yet, HHS and CMS recognize that hospital donation of HIT will likely enhance patient care.

As a result, the HHS Inspector General promulgated safe harbors to the Anti-Kickback Statute, and CMS promulgated exceptions to the Stark regulations.\textsuperscript{20} This makes it easier for hospitals to provide technology to physicians, but there are limitations. First, hospitals may donate both hardware and software for e-prescribing technology, but hospitals may only donate software for EHR technology.\textsuperscript{21} Additionally, the donee must pay for 15 percent of the hospital’s cost for e-records technology.\textsuperscript{22}

Healthcare providers establishing physician/hospital integration programs will be able to overcome many of these obstacles, even absent regulatory initiatives to promote deployment of HIT. For instance, when an employment relationship binds the hospital and physician, the employment safe harbor will likely bar any potential Anti-Kickback and Stark problems. Additionally, within an integrated hospital system, one decision-maker will make the HIT decisions for the entire integrated system, thus avoiding the problems associated with otherwise multiple, decentralized decision-makers.

Recent Antitrust Developments Impacting Clinical Integration and the Potential of Accountable Care Organizations

In 1996, the Federal Trade Commission (“FTC”) and Department of Justice defined Clinical Integration (“CI”) as,

[An active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.\textsuperscript{23}]

At that time, however, many questions remained as to what precisely this meant. As the market has evolved, the FTC has issued several advisory opinions and consent decrees to Independent Physician Practices (“IPA’s”) and Physician Hospital Organizations (“PHO’s”), and these have begun to clarify the government’s position on CI.\textsuperscript{24} Ultimately, the critical FTC inquiry focuses on whether the CI is sufficient to justify joint contracting.

Recent FTC Guidance on CI

In 2002, the FTC issued an advisory opinion to MedSouth, a physician independent practice association located in Denver, Colorado.\textsuperscript{25} MedSouth proposed establishing a program that would create substantial partial integration of participating physicians’ practices. MedSouth outlined its program’s potential to produce efficiencies, such as higher quality and reduced cost care delivered by network physicians. The key for MedSouth, and for any CI program, is that any collective negotiation of prices must be ancillary
to integration. In other words, the purpose of the model should not be joint contracting, but rather the provision of higher quality, more cost-effective care, with joint contracting being one of many tools used to achieve this goal.

In 2004, San Francisco, California-based Brown & Toland Medical Group and the FTC entered a consent decree regarding a complaint that the FTC filed objecting to the medical group's business model.26 The FTC's consent decree speaks to a “qualified clinically-integrated joint arrangement” where:

[All] physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, these physicians, in order to control costs and ensure the quality of services provided through the arrangement; and any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.27

The critical components of this statement are active participation by the physicians, cost control, and quality assurance, all in the interest of yielding significant efficiencies.

In 2006, Advocate Health Partners and other related organizations constituting more than 2,900 independent Chicago-area physicians entered a consent decree with the FTC that allowed these organizations to not only engage in prospective physician joint contracting, but also to maintain certain prior agreements with payers, including its CI Program.28 One of the critical components of this case was the fact that the comprehensive CI Program was linked to its hospital partners. Accordingly, the trend has begun to move away from IPA and/or physician organization joint negotiations and toward physician integration with hospital partners. This hospital participation is the key to the emerging models and will be necessary under the healthcare reform initiatives being considered today.

Finally, in April 2009, the FTC issued an advisory opinion to TriState Health Partners, a PHO in Hagerstown, Maryland. The advisory opinion approved TriState's proposal to clinically integrate the members of the PHO and contract jointly on a fee-for-service basis.29 Although this advisory opinion was not discussed in advance with the FTC Commissioners, it sets further precedence for integration models.

Practical Guidance for Establishing a CI Program

In light of this series of FTC guidance and also a recent discussion with an FTC Commissioner,30 the authors believe that new models of physician/hospital integration will have several common elements. First, these models will create substantial CI. Second, they will achieve significant clinical and economic efficiencies. These models will aim to contain costs by developing cost-effective, workable care models that reduce administrative and transactional costs. Third, these organizations must strive toward improved quality of care, and this goal should be well documented. Finally, joint negotiation of managed care contracts must be collateral or ancillary to the goal of true CI. This means that joint negotiation will be used to facilitate CI objectives, but the right to engage in joint negotiations is not the goal, in and of itself.

Any integration program must incorporate several essential aspects. First, it should include a medical management program. Second, an integrated program must develop and implement clinical protocols. Third, the program should develop a system of performance reporting and benchmarking with peers on a regional and national basis. Fourth, the system must include procedures for taking corrective action whenever necessary. Specifically, when the program discovers that physicians are not meeting benchmarking goals, those physicians will need to take specified action to ensure that they become compliant with the program’s goals, or they must provide an acceptable reason for not doing so. Additionally, the program should develop methods to manage high-cost and high-risk patients aggressively. This may be achieved by managing episodes of care as part of a disease state management program. Finally, a key to integration will be the sharing of patient information. Health information technology, including EHR and web-based health information technology, will be critical.

In planning an integration program, healthcare providers should consider several factors. First, the program must develop dynamic clinical practice guidelines. Similarly, PHO participants should also continually develop improved practice parameters and protocols that reflect scientific advancements. Additionally, the program ought to utilize state-of-the-art medical devices and drugs in its development of best practices. Finally, in any program, the development of a Pay-for-Performance bonus system, such as the system described above, will be essential.

In its evaluation of integration programs, the FTC will focus on member physician participation. First, physicians will need to demonstrate that they have made a meaningful investment in the organization. This does not necessarily mean that the FTC will require a substantial financial commitment. Rather, physicians may make a modest financial contribution and demonstrate their commitment by serving on a committee or otherwise contributing time and/or services. Second, for purposes of creating substantial CI, it will be important for physicians to participate in all managed care contracts. Yet, the FTC has indicated that physicians should avoid requiring exclusive participation in these managed care contracts.31 Third, when appropriate, member physicians ought to refer to in-network providers. When patients are seen primarily by in-network providers, the integrated program can ensure that

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all patient information is included in the patients’ electronic records and that it facilitates the continuity of care that it is expected to deliver. The FTC will expect physicians to participate in medical management programs and to play significant roles in program committees, working together to develop and share best practices. Ultimately, this concept of significant interaction and cooperation, by and among physician members, is a hallmark of the integration model.

The FTC has not provided much guidance as to whether it will be necessary to form a single, co-owned, legal entity among physicians and hospitals, or whether a contractual relationship between a hospital system and a physician group would suffice. It is unlikely that an integrated health system would be required to form a co-owned legal entity among its physicians and hospitals. If the parties prefer to establish simply a contractual relationship, however, they will need to demonstrate a greater degree of CI than they might under a co-ownership arrangement. Additionally, since the FTC advisory opinions and consent decrees require physicians to comply with clinical protocols and to contribute time, expertise, and money, any contractually based integrated organization will need to create a structure around its participating physicians to facilitate these activities.

Healthcare markets in some states have moved towards what they call “medical staff compacts,” contractual arrangements to achieve enhanced quality and some degree of CI. Such compacts raise important state law questions that will likely vary significantly among jurisdictions. The concept of an organized medical staff as the “contracted entity” may be problematic in some jurisdictions. For this reason, it is expected that structural arrangements, or structural arrangements augmented by contractual arrangements, will be more effective than contractual arrangements alone.

Hospital participation in CI programs will be a focus in the upcoming years. For more than 25 years, disease state management programs have offered to provide managed care plans with hospital and physician services for one rate. The next generation of integration models will continue to do this, but in a much more comprehensive manner. Health systems should be preparing for the possibility of combined DRGs where the hospital and the physician component are integrated and worked into an ACO. As healthcare reform is implemented, these ACOs should be well-prepared and should become the best performers.

Recent Healthcare Market Dynamics and New Models of Physician/Hospital Integration

Healthcare market dynamics are dramatically changing, and as a result, healthcare organization models must change to meet patient healthcare needs to successfully compete in this marketplace. With the economics of medicine today creating significant market tension, hospitals, physicians, and payers are all searching for new ways to respond. To help them meet the market’s evolving demands, healthcare providers will be looking to new integrated models for healthcare delivery.

Evolving Market Demands

Multiple significant economic forces are contributing to the exceptional tension within the current healthcare market. First, employers and payers are demanding greater value and lower costs than ever before. Since many of the traditional methodologies for achieving this have failed, innovative approaches are developing. Beyond the traditional approach of reducing per unit/fee-for-service pricing, there is also a movement towards holding providers accountable for the entire continuum of care with programs such as Prometheus, case rates, and bundled payment. In addition, some employers have implemented changes in benefit design to control their healthcare costs. For example, some employers have offered their employees cash in exchange for attending a set number of diabetic counseling sessions in the hope that this, among other preventative approaches, will avoid the more expensive care associated with later acute illness. Other employers offer to pay greater portions of qualifying employees’ health insurance premiums so long as the employees agree to participate in certain types of testing or health improvement activities.

Second, the economics of private practice are deteriorating. In many markets, payers have achieved high degrees of market consolidation, and as a result, neither physicians nor hospitals have any leverage in negotiations. Limited or no increases, and in some cases decreases, in Medicare fee schedules exacerbate the failure of practice revenue to keep up with expense increases. When physicians previously had been economically challenged, they could add new sources of revenue through ancillary services and joint ventures. However, with rapid changes in those marketplaces, both from a payment perspective and a legislative perspective, physicians currently have fewer options for adding these types of revenue streams. At the same time, physicians are finding it increasingly difficult to reduce expenses. In reality, recent trends may actually add costs, such as those associated with implementing EHR and complying with regulatory requirements.

Third, methods of care delivery are rapidly changing. For many years, the focus of physician-patient interaction has been the traditional office-based setting. Now, the emphasis is on creating medical homes that will manage the care patients receive in a variety of settings. The requirements of a patient-centered
medical home model have been articulated by the National Commission on Quality Assurance (“NCQA”). In early 2008, the NCQA brought together the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association and released a position paper that tried to define a new type of doctor-patient relationship. This relationship would be based on use of electronic records and other electronic resources to provide patients with greater access to their physicians. With the development of e-visits, secure e-mail, on-line patient health records, remote monitoring, and telemedicine, patients can now communicate with their physicians without needing to physically come for an office visit. This will facilitate greater access and better coordination of care, enabling patients and physicians to maintain on-going relationships and become health partners in care.

Recently, the Centers for Medicare and Medicaid Services (“CMS”) has introduced a demonstration project to evaluate the impact and effectiveness of the medical home model, coupled with revised payment structures. Some large employers, including those participating in Bridges to Excellence (an employer-sponsored initiative to measure and improve the quality and cost effectiveness of healthcare) are promoting this model. Healthcare providers will need to carefully plan transitioning their offices into patient-centered medical homes. This planning may include redesigning office facilities and developing “care teams” that will efficiently employ mid-level and other support staff. In California, for example, the patient-centered medical home concept has been utilized by medical groups and IPAs to minimize chronic use of emergency rooms. To do this, care management staff identifies chronic emergency room users, and implements outreach efforts to reduce the need for emergency and other inpatient care.

Finally, physicians are facing a new set of external competitive forces. With dozens of organizations measuring and publishing information about healthcare quality and outcomes, the public has become much more aware of this information than ever before. Although healthcare is not currently greatly influenced by this public reporting, it is clear that it will play a critical role in the future. In order to be successful in a market that is undergoing major cultural and generational shifts, organizations must ensure that the numbers quantifying their quality and outcomes are consistent with the organization’s professed values and expectations. Larger, more structured healthcare organizations that are integrated with physicians are best able to accomplish this. The highest performing groups are those that include both physician-physician and hospital-physician collaboration. Such groups are in the best position to share information and ensure that they achieve the best outcomes.

Currently, much of the focus on quality and outcomes centers on process because that is what can be quantitatively measured. In the future, however, the focus will be on outcomes, and sophisticated data systems will be critical. Physician access to and use of clinical information systems such as EHR is becoming a basic requirement, and more recently, clinical information exchange through data warehouses and disease registries is becoming fundamental. While the economic stimulus package has provided physicians and hospitals with some financial assistance to implement HIT, the amount of assistance pales in comparison to the actual cost of implementation. The real key will be ensuring that organizations have the right types of data, interchanges, and systems in place during this new economy.

Healthcare systems must also appreciate how the human elements of the practice of medicine add further complexity to the challenges faced. To be successful in this changing marketplace, healthcare systems must create a structure that will attract the right physicians with the right talent, and to do this, systems must understand and respond to physicians’ changing motivations.

For example, one study looked at the factors that influence physician relocation decisions. In 1987, hospital facilities were the number one factor in determining market attractiveness to physicians considering relocation. In 2007, the motivations were dramatically different. In 2007, hospitals fell from number one on the list to number twelve, and the new number one motivation for physician relocation was the overall lifestyle available in the area. In general, young physicians want jobs that include benefits and a predictable schedule, retiring physicians want increased options for downsizing their practices, and mid-career physicians want a stable income. Similarly, the premium physicians place on lifestyle has proven to be the number one reason why hospitals are struggling to get physicians for call. The combination of all of these new challenges for hospitals has led to the conclusion that an employment or other integrated model may be necessary for successful physician recruitment. Since physicians’ conceptions of the ideal practice setting will change as they progress through their careers, hospitals will need to create varying employment and other models to retain physicians as their needs change.

Proposed New Models of Physician/Hospital Integration

To be successful in this new economy, healthcare organizations must consider how they can (1) facilitate alignment between physicians and hospitals; (2) develop a compensation or employment model that will align the incentives of productivity, quality, cost, and outcome; (3) ensure physician engagement and leadership within the organization; (4) develop data systems that support data exchange, co-management, and measurement of longitudinal outcomes and costs; and (5) retain an element of flexibility that will allow the model to adapt as the rules of the game continue to change. These organizations must have the flexibility and financial

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wherewithal to manage a transition through multiple payment methodologies, changing incentives, and new care delivery models. Additionally, organized physician entities that are self-governed will drive individual physician performance to meet both group and system-wide goals. Old healthcare organization models may be modified in several ways to achieve these goals.

First, as depicted below, altering the structure and role of independent physicians under old models may provide a successful new model for physician engagement. Under the old hospital model, physicians were either employed by a hospital, employed through a related entity such as a medical foundation, or were independent. The employed physicians and the independent physicians were two entirely separate, sometimes conflicting entities. Under new models, hospitals work with physician organizations that integrate employed physicians as well as independent physicians. This new model reflects a fundamental conceptual shift: before physicians were forced to choose between being employed by the hospital or remaining entirely independent of it. Now, physicians can be integrated with a hospital while still maintaining their independence; yet, all will be jointly accountable for delivering clinical care in a more efficient manner with greater consistency in achieving positive outcomes.

Second, as depicted in the next diagram, PHOs can be seen as the precursor to today’s ACOs. Under the old system, the primary function of IPAs or PHOs was to represent physicians and hospitals (in the case of PHOs) in negotiations with managed care payers to obtain more favorable contracting rates by sharing financial risk. Success and influence of these models are often limited by the number of patients they represent as a percentage of an entire practice, and in many cases, the lack of robust clinical information management systems limited their ability to truly impact overall costs and quality. Under the new system, ACOs can be responsible for negotiating on behalf of the hospital, independent physicians, employed physicians, clinically integrated organizations, and other similar organizations to all payers. Based on the anticipated use of ACOs by CMS as described earlier, the inclusion of traditional Medicare in these models will substantially increase the patient population for which they are responsible.

Third, the role of the physician organization is currently expanding to meet hospital needs. Under the old system, hospitals developed medical directorships, relationships with hospitalists, and on-call arrangements based solely on the hospital’s clinical needs. The medical foundation was, in essence, a separate entity that structured the affiliated medical group for purposes of providing community access to outpatient physician services. Such arrangements are typically fragmented, based on discrete needs, and result in disparate compensation structures and sometimes conflicting expectations. The new models, including ACOs, create a more coordinated approach to serving patient needs – that is, patient-focused systems vs. hospital-focused systems. In doing so, the medical foundation becomes a unifying vehicle to provide a coordinated, clinically integrated physician enterprise to collaborate with the hospital to create systems of care.

Finally, the most significant structural change regarding specific specialty service care delivery models involves creating comprehensive service lines that enable bundling. The old inpatient focused model was based on a view of the physician as a “customer”; creating attractive hospital capabilities to enhance physician participation in and use of hospital facilities. Medical directors were contracted to help improve the quality and efficiency of care, but the focus was on the outcome in the hospital setting. The new model, often labeled as “co-management,” takes the patient’s perspective, integrating and coordinating inpatient and outpatient services to meet the full spectrum of patient needs. It often involves the creation of a new entity that becomes responsible for the management of hospital and physician services within that clinical service line. By creating a management entity that unites hospital and physician interests and maintains an infrastructure to collect and measure the efficiency and quality of care delivered, it can be responsive to evolving payment structures such as bundling or case rates, not to mention achieving better results in public reporting of quality and costs.
Accountable Care Organizations and New Methods for Care Management

The structure and purpose of CI programs for ACO models differ from those of the older managed care models. The primary focus of managed care was controlling costs, while the primary focus for ACO's is enhanced patient care coordination.

Managed care's cost controls included risk contracting (in some parts of the United States) and utilization management (in all parts) with a mixed record of success. In addition, managed care had a patient population that mostly consisted of commercial HMO patients, with Medicare Managed Care coming later. Moreover, the individual physicians participating in PHOs did not often have a large percentage of their patient population participating in HMOs. For this reason, managed care impacted only a small percentage of most physicians' patient populations, yielding little economic incentive for physicians to change the way they practice to make managed care succeed. IT systems were primarily utilized for claims payment and prior authorization to control costs. Information on patient care and financial performance originated with management, and only trickled down to physicians when management decided to share it. However, when managed care organizations contract directly with individual physicians, the physicians typically receive even less information.

The new paradigm of ACO-based integration is focused first on patient care coordination: enabling physicians and hospitals to work better together to achieve quality and cost improvement. The patient population for ACOs will likely initially be from the traditional Medicare program. Physician practices will be impacted more with this population than under managed care. With Medicare hopefully providing financial incentives for improving quality and cost, physicians will have more reason to change their practice to work with the ACO. ACO IT systems will be the platform for integration of the provider efforts on coordination of care and measurement of quality. Information will originate with the physicians providing the care and be shared across all providers within the ACO.

Sharing patient care information among physicians will require a good data warehouse and tools like disease registries. These tools will need to store and share patient information generated by hospitals, primary care and specialist physicians, ancillary providers, pharmacy benefit managers, laboratories, and hopefully the Medicare program. EHRs are an important component, but data warehouses and registries will allow for sharing of information from more sources including among physicians on different EHRs.

An ACO's IT system will allow the ACO to track clinical progress by patient, by physician, and for the organization as a whole. For the patient, shared information will allow physicians to track critical patient data and compare this data to evidence-based guidelines. Shared information will allow physicians treating any patient to have an up-to-date picture of how the patient's condition is progressing, no matter which physician is managing the care at any point in time. It will allow for better coordination when more than one physician is managing the same patient. Episode of care and quality measurement tools will provide feedback on quality and cost, including identifying patients that are outliers and need more active case management by the ACO. The ACO IT should provide report cards to the physicians, showing their progress meeting quality and cost goals.

The patient and physician information will be aggregated in an ACO report card, showing its overall performance. The report card will show the ACO's progress in meeting patient care needs, and show the ACO's progress in improving quality and cost to budget. Ideally, Medicare and other insurers will include a gainsharing provision in its rules to provide successful ACOs with the opportunity to see incentive payments for improving quality and cost.

Yale-New Haven Health System's Path Towards a Medical Foundation Model of Integration

Many of the factors discussed above, in combination with several factors unique to the Connecticut healthcare market, convinced the Yale-New Haven Health System (“System”) that it was time to initiate a physician/hospital integration strategy. As the System worked to develop an integration model, it encountered a variety of obstacles. Ultimately, the System successfully changed Connecticut legislation to permit the pursuit of a medical foundation model of integration, an initial step towards development of an ACO.

As background, the System is an integrated provider, but it essentially consists of three large hospitals. The Yale-New Haven Hospital is 944-bed acute and tertiary care teaching hospital that has been affiliated with Yale School of Medicine since 1826. Bridgeport Hospital is a 425-bed urban teaching hospital. Greenwich Hospital is a 174-bed community teaching hospital. The System's physician strategy has been largely focused at Greenwich and Bridgeport Hospitals and the communities in which they operate.

A confluence of factors within this System's healthcare environment inspired its integration strategy. First, since the wave of mergers and affiliations that consolidated other healthcare markets did not occur in Connecticut, Connecticut continues to have an especially large number of hospitals. Second, Connecticut has many small physician practices and very few large physician groups. IPAs are not prevalent in Connecticut, and as a result, there is very little infrastructure or political base on which to build integrated group practices. Third, like much of the rest of the country, Connecticut has a challenging practice environment, particularly for physicians. Last year, the Connecticut

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Medical Society conducted a physician workforce survey which showed substantial dissatisfaction among physicians. Among the physician respondents, 19 percent were considering a career change, and 10 percent were planning to leave the state in search of greener pastures. Interestingly, the survey also showed that overall, physician satisfaction with their medical careers tended to increase with practice size.

Over the course of the last two years, the System has become increasingly concerned about physician succession planning and the stability of existing practices. The System was convinced that it needed to take action to ameliorate the situation, so it began to look for models that would allow health systems and hospitals to help stabilize physician communities. These models, however, presented federal law problems under the Stark and Anti-kickback statutes, the standard governing tax exemption, and antitrust laws. The System concluded that these laws would make it very difficult to provide capital or other support to community physicians without establishing an affiliated physician practice. Ultimately, the System decided that an ideal model would allow it to work towards establishing an ACO by starting to employ physicians.

Closer scrutiny of such models revealed a variety of state law issues. First, Connecticut law still contained a corporate practice bar, generally prohibiting hospitals from employing physicians. Additionally, Connecticut is a “Certificate of Need” ("CON") state, so hospital initiatives to integrate with physician practices may necessitate a CON.

Attempting to avoid these hurdles, several alternative integration models were explored, but each alternative model posed significant legal issues. First, the System considered the then-prohibited medical foundation model. Next, the System investigated “friendly professional corporations,” tax-exempt medical groups, but federal and state legal issues indicated that this would not provide an ideal vehicle for proceeding with this type of integration model. Ultimately it was determined that the then-prohibited medical foundation model would provide the best means to address the System’s business and legal considerations.

Having greater confidence of success in the potential of the medical foundation model, the System worked to change Connecticut law. Accordingly, a bill was drafted that would allow the organization and operation of medical foundations and would expressly permit hospital or system affiliation. The bill would apply the physician—not the hospital—restrictions on CON. This was critical for ensuring that a new CON would not be needed every time a new physician joined the practice. The bill was introduced in January of 2009. As the System worked toward passage of this bill, its first step was to educate stakeholders, particularly the legislators and the CON authority at the Office of Healthcare Access. It explained what the bill would do and what it would not do, and the audience was relatively receptive. The CON authority was initially concerned that the System was trying to circumvent its regulatory process. In response to this concern, the System added language to the bill that would give the CON authority notice when a medical foundation is organized.

Although the System anticipated opposition from physicians, it did not experience much. This may be due to the fact that it had conversations with the Medical Society prior to introducing the legislation, and it cited the Medical Society’s survey in its testimony to the legislature. The one area of significant concern among physicians centered on how medical foundations would be governed and how control would be divided. In response, the System included a provision in the bill that expressly required that the number of physicians on a medical foundation’s board always be greater than or equal to the number of non-physician hospital administrators on the board.

The System learned a great deal from the healthcare market of the 1990s, and this informed the proposed legislation. It learned in the 1990s that physician organizations are not hospitals and they should not be governed or managed like hospitals. Instead, it expected that physician involvement in government and management would be essential to the success of the medical foundation model, and physician feedback confirmed this expectation. The System also decided that its initiative would be based on the accretion of physician practices and not large-scale acquisitions of practices. Given the current capital market, this decision may be as much a function of practicality as of strategy, but it plans to move forward slowly and is not expecting any large-scale acquisitions. Finally, the System is also implementing productivity-based compensation to align incentives to achieve demonstrably better and more cost-effective care. In early June 2009, the Connecticut legislature passed the bill. Ultimately, the System now feels well positioned in the current healthcare marketplace, regardless of whether comprehensive national healthcare reform occurs.

California Addendum

In response to unique market forces and state laws, California providers have developed CI arrangements that may also serve as models for healthcare providers across the country. For example, health systems in California are refining their Pay for Performance arrangements. Many hospitals have developed service relationships with hospitalists to provide more efficient, cost-effective, high quality care. Hospitalist programs incorporate Pay for Performance, incentivizing physician services to be provided to maximize efficiency and quality. Additionally,
California hospitals are developing more sophisticated medical director relationships, expanding the roles and responsibilities of physicians and making them more accountable for providing cost-effective care. Similarly, hospitals and physicians are increasingly working together toward shared cost and quality objectives through clinical co-management arrangements, medical staff compacts, and professional service arrangements (“PSA’s”).

These developments are partly in response to the significant limitations that California law places on the healthcare market. California is one of the few remaining U.S. jurisdictions prohibiting the corporate practice of medicine. Thus, straightforward hospital/physician employment arrangements are generally precluded. Current legislative initiatives in California offer little or no relief for more direct hospital/physician integration via employment. As an alternative to employment, California permits the establishment of non-profit clinics (i.e., “medical foundations”) through which physicians and hospitals have been integrating for the past several decades. Medical foundations cannot directly employ physicians, but medical foundations can establish professional service agreements with medical groups. Accordingly, when a hospital serves as a member of a medical foundation, the medical foundation links the hospital and medical groups. Medical foundations typically include a contracted network of physicians to supplement clinic based physicians, mimicking the function of an IPA.

In addition to medical foundations, hospital based clinics have been used with increasing popularity over the last decade as physician integration vehicles—especially where there are impediments to establishing the physician component required by California law for a medical foundation (i.e., minimum numbers of physicians and specialists practicing through the clinic on a full-time basis).

ACOs in California are being designed to retain a flexible structure. While federal and State legislative initiatives that allow for a more straightforward business structure for the integration of physicians and hospitals may yet be on the horizon, California providers are using existing structures—medical foundations, hospital based clinics and resurgent joint ventured management services organizations—to provide the structure for advancing CI. In fact, well advised California providers are finding that developments in CI (both from an antitrust perspective and as practically applied) may allow for deployment of existing provider delivery models in new ways that expand the reach of both hospital and physician participants with the possibility of developing greater market share.

Conclusion: Initiating a Clinical Integration and/or Accountable Care Organization Project

While there is no single way to begin a CI and/or ACO project, there are certainly some guiding principles organizations should consider:

- Beginning a dialogue with community physicians. It is critical to keep in mind that the elected medical staff leaders are often not the key opinion leaders among the hospital’s physicians. Thus, the new organization must take the time to identify the true leaders within its medical community, and to open channels of communication, both with these leaders and with the local medical community at large.
- Carefully assessing the organization’s environment, taking inventory of the resources that are available and those which are lacking.
- Involving the organization’s IT department early in the process to assure that it has the data and infrastructure needed to support integration.
- Obtaining competent legal counsel from the start, since state laws vary dramatically.

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Accountable Care Organizations – Physician/Hospital Integration

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Endnotes

2 Id. § 501. 117 Stat. at 2289.
4 Ctrs. For Medicare & Medicaid Servs., U.S. Dep’t of Health and Human Servs., Reporting Hospital Quality Data for Annual Payment Update, http://www.cms.hhs.gov/HospitalQualityProfile/08_HospitalRQDAPU.asp.
8 AHRQ has defined “Pay for Performance” as broadly including any type of performance-based provider payment arrangements including those that target performance on cost measures. AHRQ, Pay for Performance: A Decision Guide for Purchasers, http://www.ahrq.gov/QUAL/p4pguideintro.htm#intro.
See 23 FTC & Dep’t of Justice, 22 42 C.F.R. § 411.357(w)(4).

21 42 C.F.R. § 411.357(v), (w).

20 42 C.F.R. § 411.357.

19 42 U.S.C. § 1395 and 42 U.S.C. § 1320a-

18 Id.,


16 Senate Finance Committee report, supra note 10.

15 Id.

14 Id.

13 Senate Finance Committee report, supra note 10.

12 Senate Finance Committee report, supra note 10.


10, at 17, 18. The Committee notes that currently there are no laws directly addressing the ability of integrated providers to share in the efficiencies that result from joint care of fee-for-service Medicare beneficiaries.

9 See Advocate Health Partners, Agreement Containing Consent Order to Cease and Desist, No. 31-0021 (FTC Dec. 2006); see also Advocate Health Partners, Decision and Order, No. 31-0021 (FTC Dec. 2006).


7 Discussion between Paul DeMuro and an FTC Commissioner in Washington, D.C., on May 6, 2009.


44 The Office of Health Care Access is the state agency designated to issue Certificates of Need.


41 In Connecticut, a CON is defined as “[A] certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, offer a new or different healthcare service or terminated services. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.” Conn. Office of Health Care Access, OHCA: Glossary, http://www.ct.gov/ohca/cwp/view.asp?a=1738 &q=277038#c.


38 Conn. State Med. Soc’y, Connecticut Physicians


36 Id.

35 The NCQA is a private, non-profit accrediting agency designated to issue Certificates of Need.

34 Prometheus is a methodology whereby hospital and physician payments are bundled into case rates, adjusted for severity.

33 Deb Rislow, Leveraging the Present to Build the Future: Executives at a Wisconsin Health Care Network Figured Out How to Fill its Leadership Pipeline; Occupation Overview, HRMagsazine, Mar. 1, 2009; The Hospital-Physician Relationship: Redefining the Rules of Engagement Trustee, Febr. 1, 2005.


30 Discussion between Paul DeMuro and an FTC Commissioner in Washington, D.C., on May 6, 2009.

29 Id.

28 See Advocate Health Partners, Agreement Containing Consent Order to Cease and Desist, No. 31-0021 (FTC Dec. 2006); see also Advocate Health Partners, Decision and Order, No. 31-0021 (FTC Dec. 2006).

27 Id. at 3.


21 42 U.S.C. § 1395 and 42 U.S.C. § 1320a-

20 42 C.F.R. § 411.357.


18 42 U.S.C. § 1395 and 42 U.S.C. § 1320a-


16 Senate Finance Committee report, supra note 10.

15 Id.

14 Id.

13 Senate Finance Committee report, supra note 10.

12 Senate Finance Committee report, supra note 10.


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