A Publication of the American Health Lawyers Association
In-House Counsel Practice Group

Volume 16 • Issue 3 • December 2010

In-House Counselor

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AMERICAN HEALTH LAWYERS ASSOCIATION

Successful Achievement of Physician/Hospital Alignment Strategic Goals

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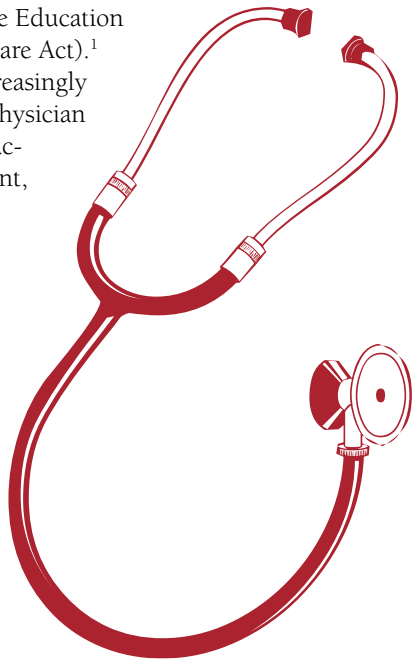
The first step in a successful physician/hospital alignment strategy is to develop a plan to achieve the goals of improved quality and controlled overall cost. Deciding on a structure is often much easier after the plan is developed. In other words, form follows function.

Improving physician/hospital alignment is at or near the top of virtually every hospital and health system's strategic plan. There are many different ideas of what alignment is and how it can be implemented. Some of the more innovative strategies for alignment that are receiving a great deal of attention include clinical service line co-management agreements, multi-provider clinically integrated networks (including Accountable Care Organizations (ACOs), medical homes, integrated delivery systems, on-call arrangements, and payor contracting strategies). ACOs will be implemented under the healthcare reform law, the Patient Protection and Affordable Care Act, as amended by the Health Care Education and Reconciliation Act of 2010 (Affordable Care Act).[1] Other more traditional strategies that are increasingly being used include physician employment, physician practice acquisition, medical services and practice support agreements, physician recruitment, hospital assistance with physician liability insurance, and joint ventures.



Many articles written about ACOs focus on structure, legal requirements, and legal and operational impediments that create great complexity. This article takes a different approach. The article first discusses the elements of a plan to achieve the goals of improved quality and controlled overall cost—the twin goals of every ACO. Once the plan for achieving these goals is developed, it is easier to develop a workable structure for the benefit of patients, providers, and employers.

The reason for hospital and health system emphasis on improving alignment with physicians is clear. The demands coming from many sources for higher quality and more cost control require physician participation among themselves and with other providers on a much more coordinated basis. Past efforts to accomplish this include gainsharing, which was the subject of several favorable advisory letters from the U.S. Department of Health and Human Services (HHS) Office of Inspector General.[2] The gainsharing discussed in these letters, in the opinion of many, did not create sufficient incentives to result in the type of close physician/hospital cooperation that is necessary to achieve truly effective quality improvements and cost reductions.

Clinical service line co-management agreements are a strategy that has achieved better results than gainsharing. The agreements give a large role to physicians to manage a specific clinical service line and usually result in substantial payments to the physicians for their substantial effort. Substantial payments, including sizeable performance bonuses for achieving metrics determined in advance, have been found by expert valuators to be within the range of fair market value and to be commercially reasonable. These agreements can be very effective in improving quality in specific service lines. They can also help control overall costs to a degree. These agreements result in a greater alignment than gainsharing, but are not as wide-reaching as many ACOs.

The strategy that appears to most effectively meet the quality and cost goals involves the creation and operation of multi-provider clinically integrated networks (Networks). A successful Network is typically led by physicians with strong authority and ability to coordinate the care provided by all of the various providers in the Network.

A lot of attention is being focused on Networks that will meet the Affordable Care Act definition of ACOs. The term ACO was first used in the Affordable Care Act, but the concept is not new. Healthcare providers have been working for years to develop Networks. The goals of these Networks is to develop a highly integrated approach led by physicians and including other providers in the Network, whereby each provider receives information and direction that is consistent with coordinated medical and disease management plans such that patient quality is significantly increased and overall healthcare costs are reduced.

Networks that have achieved a high level of clinical integration have been described in great detail in recent Federal Trade Commission (FTC) advisory opinions.[3] FTC carefully reviews situations where Networks collectively negotiate payor agreements on behalf of all of their provider members. In general, if a Network is sufficiently clinically (or financially) organized and it achieves significant quality improvement and cost reductions, FTC may in some circumstances decide not to challenge collective negotiation of payor contracts. The circumstances include whether the Network is in fact non-exclusive, the market concentration of the Network, and whether the collective negotiation of payor agreements is necessary and ancillary to the achievement of the quality and cost goals. The inquiry is highly fact intensive, and the many advisory opinions, both favorable and unfavorable, are a good source of information on FTC's views on clinical integration.

The quality and cost goals that are essential to favorable FTC treatment are also the goals that will lead to Network success in the marketplace. These twin goals are also the primary goals set for ACOs in the Affordable Care Act.

ACOs themselves are a creature of the Affordable Care Act but are not a major factor in the industry as of yet. An ACO is required for providers to participate in the voluntary Medicare shared savings program.[4] In addition, an ACO is required for participation in a Medicaid pediatric demonstration project in which a state may allow pediatric medical providers to be recognized as an ACO for purposes of receiving Medicaid incentive payments similar to payments under the Medicare shared savings plan.[5] There are several other concepts in the Affordable Care Act that involve pilot programs and demonstration projects that will test accountable care concepts. For example, one such program tests bundled payments with respect to particular episodes of care. This payment methodology may play a significant role as ACOs and Networks are implemented in the future.[6]

The starting point for the development of a successful Network, including ACOs, involves the development of a plan for an infrastructure that will provide the information essential to achieve clinical integration that will accomplish the quality and cost goals.

Description of the Environment That Defines an ACO's Necessary Infrastructure

To achieve the goals of several other provisions of the Affordable Care Act, it will be useful or necessary for an ACO to be used. For several years, providers have been creating Networks that are clinically and/or financially integrated for purposes of responding to non-ACO market pressures and to achieve quality improvement and cost-control goals demanded by managed care payors, employers, consumers, business coalitions, and states and other governmental entities. While financial integration will result from many payment arrangements, it is likely that more than financial integration is needed for an ACO to be successful.

Strategic Rationale for the Infrastructure Required by an Effective, Clinically Integrated ACO

An ACO maximizes its chances of achieving its quality and cost goals if its focus is on primary care-centered individualized health supervision, which includes a personal physician for each patient who leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Quality and safety are enhanced by a care-planning process, evidence-based medicine, clinical decision support tools, performance measurement, active participation of patients in decision-making, and centralized, comprehensive information technology

Physicians, often in collaboration with a hospital or health system, will comprise the ACO leadership. The physicians may be a single group practice, but in most cases they are a number of unrelated group practices and also include hospital-employed physicians. The first step of Network formation is for the physicians to develop active and ongoing clinical initiatives that are designed to control costs and improve the quality of healthcare services. Results will be measured so as to evaluate and remediate provider performance.

An effective ACO requires a technology system that relies on patient population management, evidence-based medicine, a predictive model for patient health status, patient health risk profiling, patient management (particularly regarding laboratory and pharmacological services and items), and metabolic management (System Requirements). However, the technology system does not have to be, and in many circumstances is not, electronic health records (EHRs). EHRs may not provide the type of data that informs all providers of the disease and medical management program for each patient.

The technology system must have access to the complete recent medical history of each patient in the ACO's patient population and real-time medical treatment provided for each patient. The best source for obtaining patients' medical history is by directly accessing the third-party administrator or other claims-processing entities through which all of the patients' medical claims flow. This data provides real-time access to patient's medical records and medical conditions. Access to the medical history data and current medical claims results in a complete history of the nature of medical claims, clinical laboratory values, biometric values, prescription drug claims, and provider cost related to each patient.

The technology must have analytical algorithms that enable it to analyze the medical history and current medical treatment in a manner that supports each of the System Requirements. Further, the ACO must either have an in-house staff that understands how to apply the data and analysis resulting from the technology system, or the ACO must contract with a vendor for such capable staff. By engaging both the patient and his or her providers, an individual care management program will be designed in a manner that will modify behavior, use specialists intelligently, and use advanced care where appropriate.

To be successful, a strategic plan to develop an ACO requires the full commitment of governing boards, CEOs, senior management, and physician leadership. An ACO's strategy must be to transform the way the participating providers deliver healthcare by elevating the following to the highest level of importance:

- Refocus the providers on quality and cost goals;
- Improve quality and patient satisfaction and reduce overall healthcare cost;
- Develop quality standards the providers can manage and measure; and
- Change the reimbursement system so that all providers share equitably in the payments and cost savings.

There are many attributes of the infrastructure of a clinically integrated ACO that can be derived primarily from antitrust guidance discussed above. A few elements of this guidance bear emphasizing:

- The ACO will create a broad network of both primary care physicians and specialists to provide "seamless" care. There will be a significant amount of "interdependence" among physicians, which is the keystone of any clinical integration program.

- The ACO will have a strong internal referral system.
- Physicians will make a high degree of investment in the ACO, in terms of time, effort, and/or money. This is necessary to achieve physician leadership of the ACO and its critical activities.
- The ACO will promote physician collaboration through protocols, benchmarks, and performance and compliance monitoring that physicians will develop and implement.
- The ACO will implement review processes to identify physicians who are not complying with the ACO programs. Policies will be adopted to enforce compliance with ACO programs, including expulsion from the ACO, if necessary.
- The ACO will ensure that all physicians are working toward the same quality and financial goals.
- Under some programs, such as Medicare's shared savings program, the ACO will receive a payment to cover, in whole or in part, services provided by its member providers. Under the Medicare shared savings program, fee-for-service payments will be made directly to the providers rendering the services. In addition, a shared savings payment will be made to the ACO if it qualifies for the payment.
- An ACO likely will make different payment arrangements with private payors.
- An ACO will need to establish the same quality and cost goals for all patients, regardless of payor source. It is not realistic for providers to treat patients differently depending on their source of payment.
- The ACO will be able to demonstrate the necessity of joint contracting to achievement of its intended efficiencies, particularly if the ACO is negotiating contracts with payors where there is not substantial financial integration under such contract.

A structure can more easily be developed after the plan for achieving the ACO's goals, as discussed above, are finalized. Following are some potential structure options:

- *Medical Home*—A medical home can be a legal entity or a contractual relationship between physicians that contains the physicians who will be involved in the development and operation of the ACO. Once the medical home is structured, it will either include other non-physician providers as owners or on a contractual basis. The legal documents will set forth the operational protocols that are designed to achieve the quality and cost goals, authority regarding entering into contracts with payors and employers, and methodology for allocating payments among providers.
- *Integrated Delivery System (IDS)*—Many systems have created an IDS in the past, which are entities that include a variety of different providers. The entity itself could serve as a starting point for developing an ACO, but substantial changes would need to be made to grant the necessary authority and responsibility required of an ACO.
- *Existing PHO*—An existing PHO might contain many of the physicians and providers needed of an ACO, but much restructuring would be required to grant the authority and responsibility for ACO operation to the appropriate entities.

There are many other structures that can be used for an ACO and a Network. The three above are only examples. They illustrate how the development of a plan to achieve the twin goals of higher quality and controlled cost will go a long way to helping decide how the necessary authority and responsibility should be delegated.

ACOs will not be developed under the Affordable Care Act until further regulations are promulgated by the HHS Secretary, by January 1, 2012. However, Networks already exist that have actual results that demonstrate that their clinical integration is achieving quality improvements and overall cost reductions. Such effective Networks may have a profound effect on private payor contracts and may also lead to direct contracting between the Network and employers. An effective Network can negotiate a different payment methodology that better suits the services provided by a Network, such as capitation, sharing the medical loss ratio, and bundled payments. An effective Network can also approach an area employer and propose a direct contracting relationship. There are many legal and regulatory issues that will require attention, but the ability to direct contract may well be worth the cost of dealing with these issues.

In conclusion, it appears that Networks will be developed in many areas and will cause a substantial change in healthcare provision and payment. However, in any area where a Network has not been created, providers may continue to receive payments under the existing system, perhaps at lower rates.

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1 Public Laws 111-148 and 111-152 (2010).
2 *See* OIG Advisory Opinion 09-06.
3 *See* TriState Health Partners Inc. Advisory Opinion, April 13, 2009; Greater Rochester Independent Practice Association Inc. Advisory Opinion, September 17, 2007.
4 ACA § 3022(i)(3); Section 1899(i) of Title XVIII of the Social Security Act.
5 ACA § 2706; Section 1899 of Title XIX of the Social Security Act.
6 Section 3023 of ACA.