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The Law and Its Implications

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Toward Accountable Care: How Healthcare Reform Will Shape Provider Integration

Peter A. Pavarini, Esq.
Squire, Sanders & Dempsey L.L.P.
41 South High St., Suite 2000
Columbus, Ohio 43215
614-365-2712
ppavarini@ssd.com

Agenda

- The state of hospital-physician integration before Reform
- Direct employment of physicians by hospitals
- Alternative physician employment models
- PSAs and clinical co-management agreements
- Other pre-Reform models
- Which providers will succeed under accountable care?
- 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 at least two decades, the industry has been seeking a new paradigm for delivering bettercoordinated, 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



Why Is the Employment of Physicians By Hospitals Back in Vogue?

- 1990s employment was mostly a response to managed care
- Changing demographics of the medical profession and economic pressures have created a different environment in the 2000s and made hospital employment an attractive alternative
- Hospitals are beginning to see physicians as partners not customers
- Physicians are only willing to join a model that gives them a meaningful stake in governance and the ability to produce high quality care and strong financial results
- Alignment has become an offensive strategy, not merely a defensive one



The Employment Model 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



Alternative Physician Employment Models

- 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



Who Will Succeed Under Accountable Care?

- The Medicare PPS program provides some indication of who will be the winners and losers under Accountable Care
- All providers have an opportunity to improve
- But not all will achieve optimal performance
- Self-interested pockets of resistance will impede the transformation that is required
- Winners already have collaborative processes in place
- Losers will need to make greater changes than they can afford or care to make
- Internal factors v. external factors



What Is Required To Transform Existing Models into ACOs?

- Time and there's less of it than most people think
- Build upon prior integration efforts if you have them and if they have proven effective
- Consider the core PPACA principles:
 - Accountability for a defined population
 - Infrastructure that promotes quality and efficiency
 - Adequate 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 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



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?

- One Example the Geisinger Model
 - Clinical Leadership Committee: sets key careprocess 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?



How the Medical Home Concept Fits In

- 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



How the Medical Home Concept Fits In

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

How the Medical Home Concept Fits In

- 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



- Existing Stark, Anti-Kickback and CMP 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
- The centerpiece of ACO compensation must be a plan for distributing incentive payments and shared savings (i.e., gainsharing). Although legal developments have been trending in ways that favor these concepts, there remains a gap between existing law and the ACO financial model



- In particular, how should gainsharing, 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?



- 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?



- 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 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 former 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



- 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

- As previously noted, every organization starts from a different place, but all have some potential to improve
- Readiness for change may be evaluated by:
 - Organization's priorities now and in the coming months
 - Existing infrastructure, especially IT interconnectivity and current data on physicians
 - Potential for clinical performance improvement
 - Degree that physicians are genuinely interested
 - Support from payers other than federal programs
 - The relative absence of state law barriers



Final Comments

- Physician leadership is essential
- Accountable care is really a shared commitment to the needs of patients and to continual innovation/ improvement
- This requires a level of cooperation that has never before been expected from providers
- Why have federal policy makers been so enamored with the large non-profit clinic models like Geisinger, Mayo and Cleveland Clinic? Is this everyone's future?