

# EMERGING ISSUES IN PHYSICIAN HOSPITAL COLLABORATION STRATEGIES

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# Collaboration

- Why collaborate?
  - Hospitals need to develop a physician relationship strategy.
  - Need for greater hospital-physician alignment in order to pursue common goals while limiting conflicts of interest, lack of trust, or other impediments to success.
  - Increasing financial pressures on both hospitals and physicians due to declining reimbursement.



# Collaboration

- Trends in reimbursement have created substantial incentives for cooperation (i.e. pay-for-performance, accountable care organizations).
- Hospitals and physicians are facing greater regulatory and administrative burdens.
- Both have the need to invest substantial sums to maintain, upgrade and replace medical equipment and information technology, including electronic health record systems.



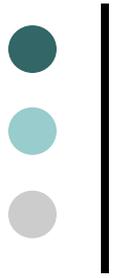
# Goals of Collaboration and Alignment

- Physicians and the hospital help each other comply with quality and safety standards and implement best practices.
- Patient management occurs seamlessly across the continuum from physicians' offices to the hospital.
- Physicians keep patient referrals within the system as much as possible.



# Most Common Physician and Hospital Collaboration Strategies

- Employment
- Physician Practice Acquisition
- Medical Directors
- Compensated On-Call Coverage
- Joint Ventures
- Service Line Co-Management Agreements
- Pay-For-Performance Agreements
- Clinical Integration
- Accountable Care Organizations



# #1 Employment Model



# Physician Employment

- Hospital directly employs physician.
- Re-emergence of employed physician model due to increased cost of private practice (i.e. medical malpractice), increased burden of quality requirements and increased liability for RACs, PPACA Fraud and Abuse and HIPAA/HITECH penalties.
- Physician reasons for desiring employment:
  - Economic conditions and access to capital.
  - Reimbursement not keeping up with expense of running a practice.
  - Don't want to take personal financial risk associated with outside financing.
  - Don't want management and administrative headaches.
  - Generational.
  - Want to practice medicine (not “run a business”).



# Physician Employment

- Hospital reasons for desiring physician employment model:
  - Regulatory environment.
  - Strategy for program development.
  - Need to achieve alignment with physicians on cost, quality and access.
- Hospitals may purchase physician practices and then employ physician or it may directly employ physician to work for existing hospital practice.
- Hospitals no longer employing just primary care physicians. There has been increased employment in specialties such as general surgery, vascular surgery, cardiac surgery and cardiology.



# Employment Agreement Issues

- Critical issues to be addressed in physician employment agreement:
  - Term – Should have a minimum term.
  - Termination – With or without cause.
  - Compensation – Based on fair market value, productivity or quality-based model or some hybrid.
  - Management and control.
  - Post-termination terms – Restrictions on practice location, solicitation of patients and medical records.



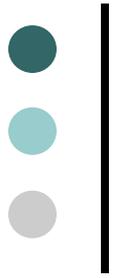
# Issues Associated with Employment Models

- Causes conflict between employed and independent physicians (e.g. turf wars, stealing patients, etc.).
- Independent physician specialists feel they will be shut out of referrals as hospital is able to mandate that employed physicians refer to one another.
- Hospital legally allowed to provide practice support to employed physicians that it cannot provide to independent physicians.
- Physician employment should meet Anti-Kickback Safe Harbor and Stark Law employment exception or fair market value exception.



# Physician Employment

- Properly structured physician employment model will help health systems organize in a manner that is financially sustainable and will provide quality incentives and compensation to attract and retain the best doctors.



# #2

## Practice Acquisition Model



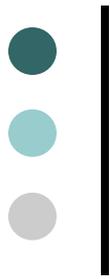
# Practice Acquisition

- Hospital purchases assets or stock of existing physician practice.
- Enter into letter of intent outlining key issues.
- Valuation done to determine fair market value. Should do valuation before deal documents. Usually involves a blend of methods: income, market and cost.
- Asset Purchase
  - Purchase certain designated assets and can exclude liabilities.
  - Can purchase tangible/intangible assets.
  - Purchase done through asset purchase agreement which contains various representations and warranties of seller and buyer.



# Practice Acquisition

- Stock Purchase
  - Purchase shares or stock of physician practice.
  - All assets, liabilities and receivables transferred to buyer.
  - Can assume existing provider numbers, licenses and contracts in most cases.
- Buyer can choose to employ seller.
- Buyer can request seller to be bound by restrictive covenant.
- Good strategy for keeping physicians aligned with hospital or keeping physical location by hospital.
- Way to enter into new market with group of existing physicians.

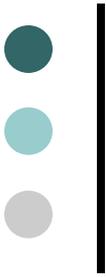


# #3 Medical Directors



# Medical Directors

- Hospital and physician enter into medical director agreement.
- Hospitals compensate physicians who serve as the medical director of a clinical department or service.
- Arrangement allows physicians to assume more institutional leadership and responsibilities.
- Duties must be important for hospital operations and require skills of a physician.
- Medical director's responsibilities should be set forth in a written agreement.
- Compensation should be fair market value.
- Job description should be clear and reviewed annually.
- Medical directorships create and strengthen relationships between physicians and hospitals.



# #4

## Compensated On-Call Coverage



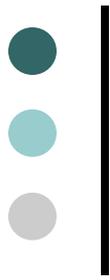
# On-Call Coverage

- Increase in compensated on-call coverage agreements the past few years.
- Must be fair market value compensation, which means compensation is fair market value in an arm's length transaction for actual and necessary items or services, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the parties.
- Relevant OIG Advisory Opinions:
  - OIG Advisory Opinion 07-10 (per diem).
  - OIG Advisory Opinion 09-05 (reimburse on-call physicians for professional services rendered to patients for whom there is no alternative payor source).



# On-Call Coverage

- Compensation must be “set in advance.”
- Structure arrangement consistent with advisory opinions on on-call compensation.
- Most common on-call coverage arrangements:
  - Subspecialty coverage arrangements.
  - Call coverage by employed physicians.
  - Call coverage agreements for multiple hospitals.
  - Per diem call coverage arrangement.
  - Activation fee coverage arrangements.



# #5 Joint Ventures



# Joint Venture Overview

- Joint Ventures (JVs) are business enterprises between hospitals and physicians that are characterized by joint funding, sharing of profits and losses, and control of common resources by the joint venture participants.
- JVs can provide strong alignment between hospitals and physicians by avoiding unnecessary duplication of costs and low utilization of expensive equipment.
- JVs can improve quality and efficiency of medical services by utilizing physicians' medical expertise and hospitals' management expertise.
- Healthcare reform's goal is to integrate physicians and other ancillary services such as an ambulatory surgery center.



# Issues Associated With Joint Ventures

- JVs ability to align hospitals and physicians may be confined to the JVs business.
- JVs ability to grow has become limited due to fraud and abuse laws and reimbursement issues (i.e. prohibition on most under arrangements).



# Joint Venture Regulatory Issues

- JVs must comply with the Stark Act if they provide designated health services to Medicare patients.
- JVs have to comply with the Anti-Kickback Statute (AKS) or should try and meet AKS safe harbor for joint ventures. Failure to meet each element of a safe harbor means the JV is outside the safe harbor and could potentially be subject to federal prosecution.
- Physician investments in JVs should, if possible, come within the safe harbor for investment interests in small entities, which, among other things, limits to 40 percent the equity that may be held by physician investors in a position to make referrals to, furnish services or items to, or generate business for the entity.



# Joint Venture Regulatory Issues

- Joint Venture Ambulatory Surgery Centers (ASCs) should try and meet the ASC safe harbors which includes the following general requirements:
  - At least one-third of each physician investor's medical practice income from all services for previous year were derived from the physician's performance of procedures eligible to be performed within an ASC;
  - Must treat patients receiving benefits under federal healthcare program in nondiscriminatory manner; and
  - Physician-owners must disclose their ownership interests to their patients at the time they are referred to the ASC.
- A physician's ownership interest in a joint venture does not, in most cases, violate the AKS as long as:
  - (1) the return on investment is based on each physician's ownership interest and not their referrals;
  - (2) eligibility to invest does not depend on an agreement to refer;
  - (3) the size of the investment is not based on referrals; and
  - (4) physicians who do not refer are not pressured/required to divest.



# Joint Venture Regulatory Issues

- Federal and state laws regulate the offering of ownership and investment interests in JVs.
- Federal and state laws also contain certain disclosure of ownership requirements to patients.



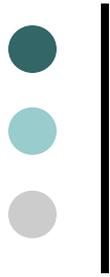
# Joint Venture Tax-Exempt Issues

- Tax-exempt considerations:
  - Further charitable purpose of hospital.
  - No private inurement to insiders.
  - Control of governing board.
  - Income from JV based on contributions of the parties.
  - Hospital should not finance acquisition of interests by physicians.
  - No contribution of existing revenue streams.
  - Reasonable terms for any management agreement.
  - Valuations done by independent appraiser.



# Roles in Joint Ventures

- Documents should set forth who is responsible for certain items, including the following:
  - Anesthesia services
  - Hiring of administrators
  - Staffing
  - Billing
  - Claims Management



# #6

## Co-Management Agreements



# Overview of Management Model

- Service line management agreements are used by hospitals to contract with medical groups to manage and improve the quality and efficiency of a hospital service line (e.g. cardiology).
- Management company can be a JV between hospital and physicians or can be a physician organization.
- Management companies are generally formed as limited liability companies.
- Goal of management model is to align goals of the physicians and hospitals around delivering high quality, efficient and effective healthcare.
- Good option for hospitals and physicians who want greater deal of economic alignment, but who do not want to move to a more fully integrated model.
- Resurgence of management model likely due to elimination of under arrangements and/or contractual joint ventures.



# Purpose of Management Agreements

- Larger number of physicians involved in the management/implementation process.
- Converts physicians' administrative services from an hourly to objectives-based arrangement.
- Incentive for physicians to meet certain goals.



# Management Models

- New joint venture entity (e.g. LLC) is created and has both hospital and physicians as investors.
- New entity is created and has only physicians as investors.
- No new entity formed. Management agreement is entered into between the hospital and an existing group practice.



# Management Agreements

- Hospital enters into a written agreement with a management company that provides for fair market value compensation for the time that the management company dedicates to service line management, development, implementation and oversight.
- Management agreements can provide for bonus payments to management company of pre-determined amounts for meeting specific, mutually agreed upon, and objectively measurable quality improvement and efficiency goals.
- Typically, service line co-management agreements have compensation that consist of both a base fee and a quality-based incentive fee.

# Management Agreements

- Management agreements can contain non-compete provisions.
- Management agreements should contain all services to be performed by management company; the services should not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; the compensation to be paid over the term of the agreement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and the agreement must be in writing for at least one year (i.e. arrangement must satisfy Stark exception for personal services and management agreements).
- Agreement should have appropriate governance structure (i.e. if non-profit hospital involved must conduct business consistent with tax-exempt purpose).
- Duration of agreement should be at least one (1) year.



# Management Agreement Valuation

- AHLA article from January 2011 entitled “Fair Market Value and the Continuing Evolution of Service Line Co-Management Agreements” recommends that the determination of fair market value of compensation for a management agreement includes the following factors:
  - Other arrangements hospital may have with physicians;
  - Other arrangements the hospital may have with the physician(s);
  - The methodology used to track and compensate for the achievement of the day-to-day management tasks;
  - The scope and breadth of the hospital’s service line being managed;
  - The impact of payor mix and sources of revenue; and
  - The integration of designated medical directors and/or a service line administrator.



# Management Agreement Valuation

- If tax-exempt entity is a party to management agreement, it is a good idea to have management company compensation approved in advance by the board.
- Basis for compensation should be well documented.



# Sample Co-Management Agreement Services

- Development of service line.
- Budget process.
- Development of clinical protocols and performance standards.
- Community relations and education.
- Business planning process.
- Satisfaction surveys.
- Physician staffing.
- Scheduling and staffing.
- Assessment of clinical environment and work flow processes.
- Case management activities.
- Credentialing assistance.



# Sample Performance Metrics

- Operational Efficiencies
  - Supply cost
  - Turn-around time
  - On-time starts
- Quality of Service Incentive Compensation
  - Infection rates
  - Mortality rates
  - Patient satisfaction
  - Return to OR
- Clinical quality and patient mix should be monitored throughout the term of the agreement.



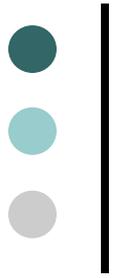
# Compliance Issues

- Key for compensation and bonus structure for achieving quality improvement is that it is fair market value. Good idea to engage a third party appraiser to conduct a valuation to determine fair market value range for scope of activities performed by management company.
- Should also do review of quality metrics that determine reimbursement to ensure that they are appropriate. Incentive payments should only be made for cost reductions where clinical quality is maintained or improved.
- Should review fair market value on a regular basis (e.g. every 2 years).
- Aggregate compensation must be set in advance to meet AKS Personal Services and Management Contracts safe harbor.
- Should be structured to not violate:
  - Civil Monetary Penalty Statute
  - AKS
  - Stark
  - FCA
  - Tax Exemption



# Compliance Issues

- If provider-based facility is managed by management company, then management agreement and structure needs to comply with provider-based status rules.
- Physicians must actively participate in management activities.
- Document activities performed by management company.
- Should have redundant medical director payments eliminated in favor of significantly more comprehensive co-management program.



# #7 Pay-For-Performance



# Pay-For-Performance Overview

- Pay-For-Performance (P4P) creates a financial structure which rewards physicians for their effort to improve service at a specific hospital.
- P4P is also known as “value based purchasing” and this payment model rewards providers for meeting pre-established targets for delivery of healthcare services.
- P4P is different than fee-for-service model where services are unbundled and paid for separately.
- P4P agreement is a contractual relationship between a hospital and a group of physicians who provide services at the hospital. The agreement typically provides that the physicians will receive a negotiated percentage of the P4P rewards the hospital receives in exchange for providing specific quality-related services to the hospital.



# P4P Advisory Opinion

- On 10/14/08 the OIG of HHS approved a P4P agreement for the first time (A0 08-16). This P4P arrangement allowed hospitals to align financially with their medical staffs to drive quality of care improvements at the hospital.
- The approved arrangement consists of a Quality Enhancement Professional Services Agreement (Agreement) between a hospital and a physician-owned professional limited liability corporation (PLLC), which all active staff members in relevant departments can join after they have worked at the hospital for more than one year. Under the Agreement, physicians who participate in the PLLC will commit to practice in compliance with hospital quality targets and will provide specific quality-related services to the hospital in order to improve the quality of care provided to the hospital's patients. These services include:



# P4P Advisory Opinion

- Developing policies and procedures;
  - Reviewing and monitoring quality care in the hospital;
  - Providing care in accordance with hospital quality targets;
  - Ensuring adequate peer review if quality targets are not achieved; and
  - Auditing medical records to track compliance with quality activities.
- 
- In exchange for these services, the hospital will pay the PLLC (which then distributes the payment(s) to the member physicians on a per capita basis) a percentage of the P4P award received by the hospital for achieving specific quality targets established by the payer under a P4P incentive plan. This arrangement permits the physicians to participate in the proceeds received by the hospital for providing high quality care, which benefits the hospital, physicians and patients.



# P4P Rationale

- P4P makes alignment between physicians and hospitals a necessity. High scores in quality are impossible to achieve without cooperation of the medical staff.
- Government also has focus on quality to drive its payment policies.



# P4P Compliance Issues

- All P4P arrangements must comply with federal healthcare fraud and abuse laws.
- Although OIG in Advisory Opinion 08-16 found that the Agreement does raise issues under the CMPL and the Anti-Kickback Statute, the parties included several safeguards designed to reduce the risk of federal healthcare program abuse:
  - First, only physicians who have been members of the hospital's active medical staff for at least one year are eligible to become owners of the PLLC; a requirement intended to reduce the risk of physicians joining the medical staff of the hospital (and moving their patients there) in order to join the PLLC and participate in the potential quality-bonus payments.



# P4P Compliance Issues

- Second, the physician owners of the PLLC receive distributions on a per capita basis; no payments are made to induce patient referrals to the hospital.
- Third, the payments by the hospital to the PLLC are capped, based on historical activity levels of the payer(s) at the hospital (adjusted for inflation) to ensure that physicians are not provided a financial incentive to refer additional patients to the hospital.
- Fourth, the hospital will provide written disclosure of its arrangement with the PLLC to its patients.
- Fifth, the hospital will monitor both the quality of care provided and the volume and case mix of its patients to ensure that the financial rewards of the program do not reduce quality or inappropriately change referral patterns of the physician participants.



# P4P Compliance Issues

- Finally, the quality targets that can be incentivized under the program without raising the need for further analysis by the OIG are limited to those listed by CMS and the Joint Commission in the Specifications Manual for National Hospital Quality Measures, which represents the consensus of the medical community as to the appropriate standard of care.
- For Stark compliance the fair market value, personal services, and indirect compensation exceptions all can be considered when structuring a P4P arrangement.



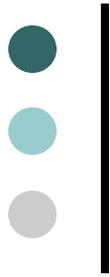
# Tracking P4P

- Some insurance companies have begun to compensate in-network doctors with P4P model.
- P4P metrics/goals include such things as:
  - Accuracy and thoroughness of patient records.
  - Compliance with hospital's risk reduction initiatives.
  - Patient satisfaction scores.
  - The Joint Commission core measures.



# Tracking P4P

- P4P could also have factors which would lead to decrease in physician compensation:
  - Complaints.
  - Re-admissions within 72 hours of discharge resulting from inadequate care.
- Dashboard tracker common tool used to measure metric-based performance.
- Use of outside companies to monitor and measure performance is another common approach.
- CMS may move to implement a P4P system within Medicare 2013.



# #8 Clinical Integration Program



# Clinical Integration Background

- The term “clinical integration” refers to efforts by independent physicians to work more closely together and with their respective hospitals in their care for patients by sharing information, protocols, standards, procedures, and expectations. In a clinical integration model, the physicians remain in private practice, but they voluntarily agree to change their behavior to be more uniform to provide and document compliance with the best practices of care.
- Clinical integration has the potential to create significant benefits for physicians, hospitals and patients by improving quality of care, increasing efficiencies, promoting collaboration among physicians and hospitals, and reducing unnecessary expenses.
- Clinical integration is an economic and legal model whereby integrated providers share the costs of their efforts making care more affordable for all.
- The members of a clinically integrated entity present themselves to the marketplace as a single entity, not individual practices.



# Clinical Integration Background

- As a single entity, the integrated practices can participate in joint venture activity such as payer contracting if it is ancillary to and supportive of their efforts to deliver greater value to consumers.
- Advocate Healthcare has used clinical integration to demonstrate improvements in such areas as: generic prescribing; smoking cessation education; depression screening; asthma outcomes; diabetic care outcomes; coronary artery disease/congestive heart failure outcomes; and childhood immunizations.
- Clinical integration, if not done properly, can trigger FTC and/or DOJ investigation if there is anti-competitive behavior (i.e. competing providers getting together for no other reason than to contract with payers). This is viewed as price collusion and can be illegal.



# Clinical Integration Background

- FTC/DOJ will permit clinical integration if the corroborative activity by the practices is ancillary to the delivery of value to the consumers, as this outweighs the potential harm done through anti-competitive behavior which can be shown by:
  - Focus on improvements in clinical quality and efficiency.
  - Provider participation.
  - Investment of human and financial capital.
  - Data that supports claim of greater value as a clinically integrated entity.
- Such activities support negotiation of joint venture payer contracts.



# Clinical Integration Background

- FTC guidance on clinical integration derived from Advocate agreement:
  - Should include medical management program.
  - Must develop and implement clinical protocols.
  - Should develop a system of performance reporting and benchmarking with peers on a regional and national basis.
  - Must include procedures for taking corrective action when necessary.
  - Should develop methods to managing high-cost and high-risk patients aggressively.
  - Sharing of patient information (EHR is critical).



# Clinical Integration Background

- Key component to clinical integration is greater information sharing across providers.
- Other way to facilitate sharing is development of clinical guidelines/measures to help providers' effectiveness in delivering appropriate care.
- Payment reforms may promote more clinical integration (i.e. replacement of current fee-for-service system with bundled payments).



# Preliminary Integration Issues

- To develop a clinical integration program the following issues must be answered:
  - How much power/decision-making authority will be centralized, and how much will be delegated to a local level?
  - What role will physicians play in decision-making?
  - What checks and balances will exist in the clinical integration model to assure needed physician behavior change and assure that no action will be contrary to the long-term best interests of a hospital?
  - How will the success of clinical integration be measured?
- As a first step key physicians and hospital leaders should be chosen to serve on a task force charged with the responsibility of working through strategic and operational issues regarding clinical integration.



# Structure of Legal Entity

- Initially, the participants must address the type and number of entities that will negotiate contracts with payers and hold the contracts for the providers. This function can be performed within a division of a hospital or through a wholly-owned subsidiary of a system or existing hospital affiliate. The structure can also be a joint venture with an independent physician association or with individual physicians or a combination of both.
- The typical integration models are formed as an independent physician association (IPA) or a physician-hospital organization (PHO).



# Structure of Legal Entity

- An IPA is a single entity formed primarily to represent independent physicians and physician practices in connection with their participation in managed care plans. Traditionally, IPAs are formed to negotiate favorable rates with managed care plans due to the shared risk of the IPA members. IPAs can negotiate capitation contracts with HMOs, but serve as messengers on behalf of individual physicians when negotiating PPO agreements.
- If the IPA is clinically integrated, however, then the IPA is not limited to negotiating PPO contracts on a messenger model basis only. In addition to negotiating rates, IPAs typically administer managed care contracts, manage utilization and track clinical performance.
- Some IPAs provide other services that benefit physician constituents, such as credentialing, negotiating medical care benefits, and arranging for malpractice coverage at discounted levels.



# Structure of Legal Entity

- While an IPA does not integrate the practice of its members, it provides its members with a few of the advantages of an integrated practice.
- A PHO can function similarly to an IPA, but includes hospital services. A PHO is traditionally a joint venture among a hospital and physicians. Physician ownership in a PHO may be through an entity such as an IPA. Like an IPA, the PHO creates limited integration among its members – mainly for the purposes of marketing member services and negotiating with payers. Like an IPA, a PHO markets to managed care payers as a unified network, combining providers into one contracting organization that provides a wide range of care and shares in financial risk.
- Unlike an IPA which generally consists of individual physicians and practices, a PHO is typically organized by a hospital or hospital system and its medical staff. Membership in the PHO may be open to the hospital's entire medical staff or limited to certain physicians who satisfy PHO standards of participation.



# Structure of Legal Entity

- There can be local PHOs and super PHOs. A super PHO is a vehicle used to integrate the activities of the local PHOs and its power is determined by local PHOs.
- A PHO can operate as a division of a hospital or healthcare system or can be a wholly-owned affiliate or subsidiary. A common approach is for the system to own the PHO as a division of a hospital or system, but at the same time appoint physician leaders to serve as 50% of the directors at the governance level of the PHO.



# Structure of Legal Entity

- A PHO and/or IPA can be a corporation or limited liability company and could be either a for-profit or non-profit. Usually organized as a taxable non-profit corporation.
- Participation in a PHO can be exclusive or non-exclusive. Exclusive means that PHO participants may not negotiate or contract with payers on their own. Non-exclusive means PHO members may contract with payers outside the PHO or through the PHO. FTC views non-exclusive arrangements more favorably.



# Structure of PHO

- If a PHO will be a corporation (regardless of whether it will be a for-profit or a non-profit), it will need bylaws.
- The bylaws should address what decisions will be left to the corporation's board of directors and what decisions will be made by the shareholders (if it is a for-profit) or the members (if it is a non-profit).
- The bylaws will also provide guidance with respect to the duties and responsibilities of officers and the conduct of elections and board meetings.
- If the entity will be a for-profit corporation, with more than one shareholder, then a shareholder agreement may be needed to address restrictions on transferring ownership in the corporation.



# Structure of PHO

- No matter how ownership is structured, the governance of the PHO will need to be shared 50/50 with the physicians. Generally speaking, PHO board members consist of 6 or 8 representatives.
- All providers who desire to participate in a PHO will need to enter into written provider agreements.
  - Should be form agreement for primary care physicians, specialty care physicians, ancillary providers and hospital providers.
  - The agreement should address a number of issues important to the business relationship, and should include a description of the authority granted the PHO to negotiate managed care agreements, the duty of providers to deliver services in accordance with those agreements, and a mechanism for reasonable compensation.



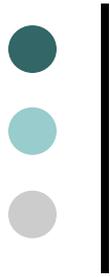
# Clinical Integration Documents

- Checklist of written documents for clinical integration:
  - Business plan for clinical integration, including a 3-year proforma and market assessment.
  - Articles of Incorporation or Articles of Organization for any new entities created, such as an IPA or PHO.
  - Bylaws for separate corporations, or simulated bylaws for a PHO if intended to operate as a separate division of a hospital.
  - Resolutions of the board of directors of PHO.
  - Employee lease agreement between hospital or affiliate and the PHO.
  - Provider agreements with participating providers.
  - Provider agreement with primary care physicians.
  - Provider agreement for ancillary providers.
  - Provider agreement with hospitals.
  - Compensation plan for providers.
  - One year and 3 year clinical integration objectives (i.e. electronic health record system).
  - Agreement between PHO and IPA, if an IPA is created/used.
  - Potential shareholder agreement between hospital and IPA and/or physicians if the PHO is a for-profit joint venture.



# Compliance

- Must comply with:
  - Anti-trust Laws
  - Stark Act
  - Civil Monetary Penalty Laws
  - Anti-Kickback Statute
  - Internal Revenue Code
- An effective clinical integration program can lead hospital down the path of becoming an accountable care organization.



# #9

## Accountable Care Organizations



# ACO Background

- Accountable Care Organizations (ACO) are networks of physicians and hospitals that share responsibility to improve quality of healthcare services and reduce costs for a defined patient population.
- On March 31, 2011 the Department of Health and Human Services (HHS) released proposed new rules to help physicians, hospitals and other providers better coordinate care for Medicare patients through ACOs.
- In the proposed rules, an ACO would agree to manage all of the healthcare needs of a minimum of 5,000 Medicare beneficiaries for at least 3 years.
- ACOs are scheduled to take effect no later than January 2012.
- ACOs make providers jointly accountable for the care of their patients and gives them incentives to cooperate and save money by avoiding unnecessary costs and procedures.



# ACO Background

- HHS estimates ACOs could save Medicare up to \$960 million in the first three years.
- ACOs still keep fee for service but would create savings incentives by offering bonuses when providers keep costs down and meet specific quality benchmarks.
- If an ACO does not save money, then it would just get standard Medicare fees.



# ACO Example

- IPA teams up with hospital to create ACO. Medicare determines a benchmark, that is, what it will cost to treat the average beneficiary in that geographic area per year – let's say \$10,000. The physicians submit their traditional claims to Medicare under RBRVS system while the hospital submits its typical DRG-base claim. Thus, the traditional fee-for-service system remains in place. At the end of the year, Medicare determines if the ACO has provided care for less than \$10,000. If they have, the ACO is entitled to share in the cost savings, and the savings are divided among the providers and hospital.



# Eligibility

- Must have a formal legal structure that will allow it to receive shared savings payments and distribute them among providers.
- Must show it can meet certain quality and reporting standards to be developed by HHS.
- Must agree to a 3-year contract and serve an assigned Medicare patient population of at least 5,000.
- ACOs may include the following types of providers:
  - ACO professionals (i.e. physicians and hospitals meeting statutory definition) in group practice arrangements;
  - Networks of individual practices of ACO professionals;



# Eligibility

- Partnerships or joint venture arrangements between hospitals and ACO professionals;
  - Hospitals employing ACO professionals; and
  - Other Medicare providers and suppliers as determined by the Secretary of HHS.
- Proposed rule requires ACOs to include healthcare providers, suppliers and Medicare beneficiaries on its governing board.



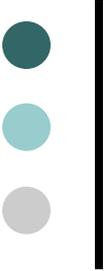
# ACO Savings

- CMS would develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or to be held accountable for losses.
- Amount of shared savings depends on whether the ACO meets or exceeds quality performance standards.
- CMS has proposed a one-sided risk model (sharing of savings only for the first two (2) years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three (3) years).



# ACO Savings

- Proposed rule contains five (5) quality measures that affect patient care:
  - Patient/caregiver experience of care;
  - Care coordination;
  - Patient safety;
  - Preventive medicine; and
  - At risk population/frail elderly health.
- Proposed rule sets out proposed performance standards for aforementioned measures and a proposed scoring methodology, including ACOs from being penalized for treating patients with more complex conditions.
- Department of Justice (DOJ) and Federal Trade Commission (FTC) have issued a proposed Antitrust Policy Statement that proposes to establish different levels of antitrust scrutiny depending on the specific ACO arrangement.
- IRS has issued a proposed policy statement on ACOs.



# Questions?

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