



Southern California HFMA Educational Program #3

**Accountable Care Organizations (ACOs)
and
Physician Hospital Integration Under
Healthcare Reform**

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Paul R. DeMuro
Partner
Latham & Watkins LLP
355 South Grand Avenue
Los Angeles, CA
213.891.7330
paul.demuro@lw.com



Healthcare Reform and the Dynamics of the Marketplace Moving Toward ACOs and Clinical Integration

Selected Components Of Healthcare Reform

- Ensuring Quality Of Care By Developing Guidelines For Use By Health Insurers To Report Information On Initiatives And Programs That Improve Health Outcomes Through The Use Of Care Coordination And Chronic Disease Management, Prevent Hospital Readmissions And Improve Patient Safety, And Promote Wellness And Health
- Shared Responsibility For Healthcare



Improving The Quality Of Medicaid For Patients And Providers — A Precursor Of What Is To Come?

- **Adult Health Quality Measures—To Be Developed And Reported On**
- **Payment Adjustment For Health Care-Acquired Conditions—Prohibits Payment For Certain Services Related To A Health-Care Acquired Condition**
- **State Option To Provide Health Homes For Enrollees With Chronic Conditions—Medical Homes**



Improving The Quality Of Medicaid For Patients And Providers — A Precursor Of What Is To Come?

- **Demonstration Project To Evaluate Integrated Care Around A Hospitalization—Episodes Of Care**
- **Medicaid Global Payment System Demonstration Project—Combined Hospital And Physician DRGs**
- **Pediatric Accountable Care Organization Demonstration Project—ACOs**
- **Medicaid Emergency Psychiatric Demonstration Project**



Improving The Quality And Efficiency Of Health Care

- Hospital Value-Based Purchasing
- Improvements To The Physician Quality Reporting Initiative
- Improvements To The Physician Feedback Program—Compare The Per Capita Utilization Of Physician And Physician Groups To Others Similarly Situated. These Will Be Risk-Adjusted And Standardized
- Payment Adjustment For Conditions Acquired In Hospitals—Payment Penalty For The Hospitals In The Top 25th Percentile



National Strategy To Improve Health Care Quality

- Interagency Working Group On Health Care Quality
- Quality Measure Development At AHRQ And CMS
- Quality Measurement
- Data Collection And Public Reporting



Encouraging Development Of New Patient Care Models

- Establishment Of Center For Medicare And Medicaid Innovation Within CMS
- Medicare Shared Savings Program—Rewards ACOs That Take Responsibility For The Costs And Quality Of Care Received By Their Patient Panel Over Time
- National Pilot Program on Payment Bundling



Encouraging Development Of New Patient Care Models

- Independence At Home Demonstration Project
- Hospital Readmissions Reduction Program
- Community-Based Care Transition Program
- Extension Of Gainsharing Demonstration



Health Care Quality Improvements

- Health Care Delivery System Research And Quality Improvement Technical Assistance
- Grants Or Contracts To Establish Community Health Teams To Support The Patient-Centered Medical Home
- Grants To Implement Medication Management Services In Treatment Of Chronic Disease
- Design And Implementation Of Regionalized Systems For Emergency Care
- Program To Facilitate Shared Decision Making— Help Patients Understand Their Treatment Options



Marketplace Dynamics

- Most Hospital's Financial Reserves Are Down From Their High Points
 - Meeting Debt Covenants Can Be More Difficult
- Bad Debts And Charity Care Are On The Rise
- Less Elective Procedures
- Expenses Continue To Rise
- Managed Care Contract Relationships Are Increasingly Strained



Physicians Are Specifically Experiencing/Facing

- Joint Ventures Which Are Losing Money
- Financial Problems Due To Stagnant Or Decreasing Reimbursements, Physician Defections And Many Physician Groups Are Imploding
- Greater Difficulty In Recruiting New Physicians And Significant Regulatory Hurdles In Seeking Hospital Assistance In Doing So
- Vendors In Financial Distress



Physicians Are Specifically Experiencing/Facing

- Greater Difficulty In Making Infrastructure/Capital Investments, Particularly In The IT Area, For Electronic Health Record Development And Implementation.
- Greater Consolidation In The Hospital And Physician Sectors
- Greater Need To Become Integrated And/Or Become Participants In Integrated Delivery Systems Which Can Become ACOs



Physicians Are Specifically Experiencing/Facing

- A Serious Lack Of Primary Care Capability, Particularly With The Prospect Of Another 45 To 46 Million Individuals Being Added To The Insurance Roles
- A Movement Toward Patient-Centered Medical Home Models
- Greater Use Of Technology In The Delivery Of Care
- Increasing Focus On Quality, Outcomes And Cost



The Need For Greater Clinical Integration

- To Be Able To Share Revenues
- Implement Appropriate Cost Savings And Quality Initiatives
- Effectively Contract With Managed Care Plans



The Need For Greater Clinical Integration

- To Be Prepared For The Above Tenets Of Healthcare Reform
- To Be A Survivor Not A Cast-A-Way
- For The Onslaught Of 45 To 46 Million Additional People Attempting To Access The Healthcare System



Accountable Care Organization— Description/Definition

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.

Antitrust Considerations, Including Avoiding The Market Power Trap and Achieving Legitimate Financial or Clinical Integration

- Legal Background – Physician Collective Negotiations
 - Early 1980s – Supreme Court Made Clear In *Arizona v. Maricopa County Medical Society*:
 - Physicians In Independent Practices Are Supposed To Compete
 - When They Do Not, By Collectively Setting Prices For Individual Services, They Can Be Guilty Of Price Fixing
- FTC And DOJ Have Conducted Hundreds Of Investigations In Past 25 Years



Application Of Well-Established Joint Venture Analysis To Specific Circumstances Of Physician Markets

Not Some Secret Formula; Follows *Polygram Holding* ("Three Tenors")

- Is The Restraint Inherently Suspect?
- Is The Justification For The Restraint?
- Legally Cognizable?
- Economically Plausible?
- Reasonably Necessary?
- Are anticompetitive effects likely?



Question Is Whether There Is A Meaningful Prospect Of:

- Improving Efficiency/Reducing Costs On The Delivery Of Care
- Improving Quality Of Care

Hardest Issue: Joint Negotiations Must Be "Reasonably Necessary" To Achieving Efficiency Goals.



Financial Integration

Capitated Contracts

- Meet The “Reasonably Necessary” Standard
- Sham Concern
- Do Stop/Loss Or Outlier Fee-For-Service Provisions Defeat Capitated Structure?
- No Enforcement Yet On This Point

Withholds/Bonuses/P4P

- Variation In Physician Pay Must Have Sufficient Magnitude Typical Benchmark Is 15% *SHO* (Advisory Opinion): 5% Not Sufficient
- Thresholds Must Be Relevant To Physician Behavior *New Millennium Orthopaedics* (Cincinnati)
- "Reasonably Necessary" Requirement Applies. Do The Incentives Require The IPA To Practice In A More Collaborative Manner?



Clinical Integration

- Concept Is Dynamic, Not Static
- Concept Is "Clinical Integration," Not "Clinical Programs." Do The Clinical Programs Require The Physicians To Practice In A More Collaborative Manner?
- Clinical Integration Does Not Automatically Confer The Right To Negotiate Contracts With Health Plans On A Joint Basis. Joint Negotiations Must Be Ancillary To A Clinical Integration Program



Relevant In One Litigated Case: *NTSP* (Public Casalino Report)

- Clinical Guidelines With Electronic Reminders
- Nurse Case Management Programs/Disease Management Programs
- Registries For Patients With Chronic Diseases
- Physician Performance Peer Reviews For Efficiency And Quality



Relevant In One Litigated Case: *NTSP* (Public Casalino Report)

- Patient Education
- Common System Of Electronic Medical Records
- Rejection Of Organizational Culture/Teamwork/Spillover Effects



Relevant In Three Opinion Letters: *SHO; GRIPA; Tri-State*

- Clinical Protocols
- Primary Care/Specialists Physician Referral Patterns

Legal Joint Conduct Without Integration - Messenger Model

- Traditional Messenger Model
- Reverse Messenger Model
- Market Power Analysis
 - Applies To All Organizations
 - Clinical Or Financial Integration Not A Justification For Market Power
 - Staff-Model Medical Groups Not Exempt
 - Safety Zones
 - Exclusive/Non-Exclusive Distinction
 - Non-Exclusive Standard. Less Than 30% Of Physicians, But At Least One Physician, For Each Medical Specialty



Legal Joint Conduct Without Integration - Messenger Model

- Rule Of Reason
 - Product Market Definition
 - Geographic Market Definition
 - Measuring Market Share
 - Anticompetitive Effects
 - Entry Conditions



New and Evolving Models of Physician/Hospital Integration

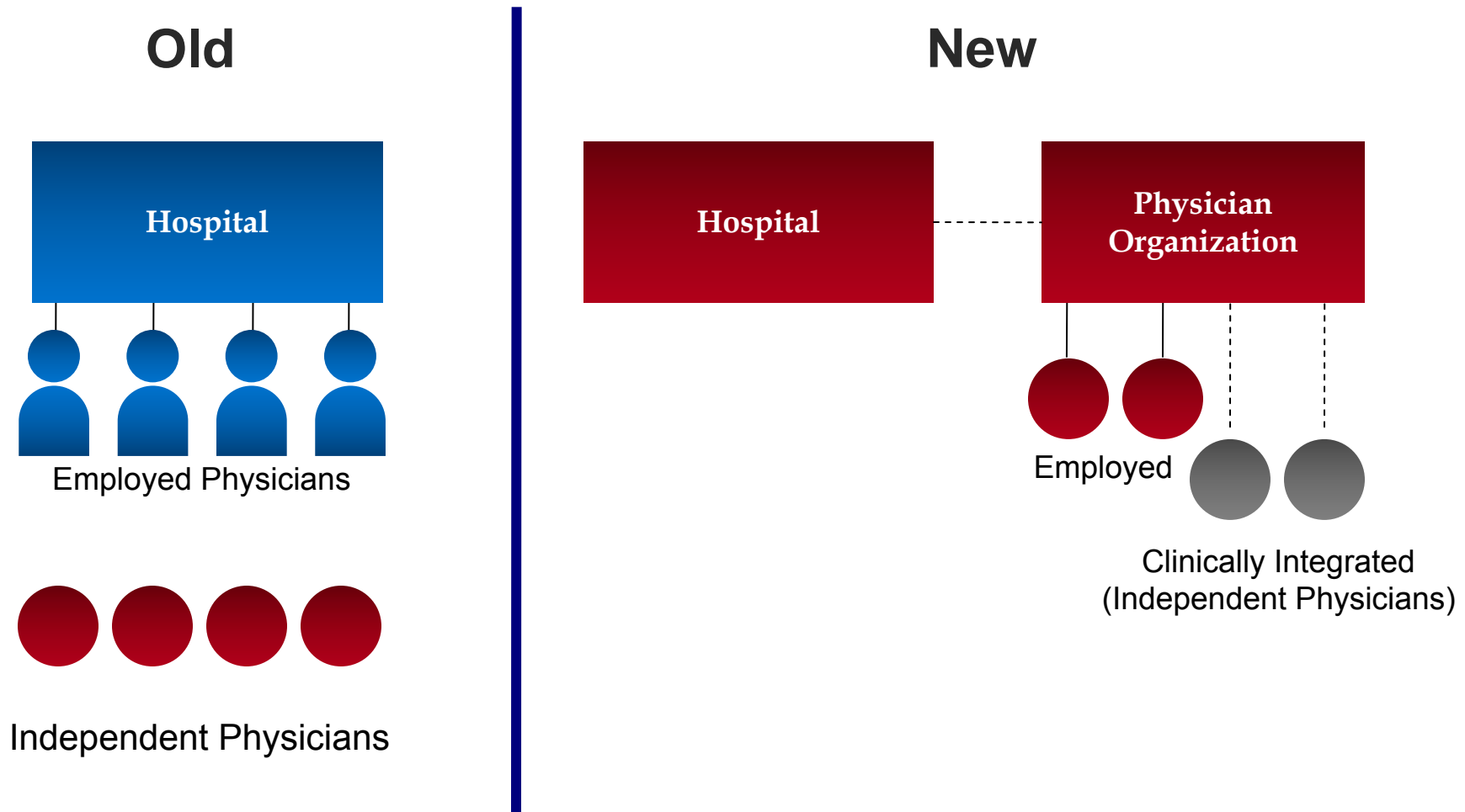
- Facilitate alignment between physicians and hospitals;
- Develop a compensation or employment model that will align the incentives of productivity, quality, cost and outcome;
- Ensure physician engagement and leadership within the organization;
- Develop data systems that support data exchange, co-management, and measurement of longitudinal outcomes and costs; and
- Retain an element of flexibility that will allow the model to adapt as the rules of the game continue to change



Proposed New Models Of Physician/Hospital Integration

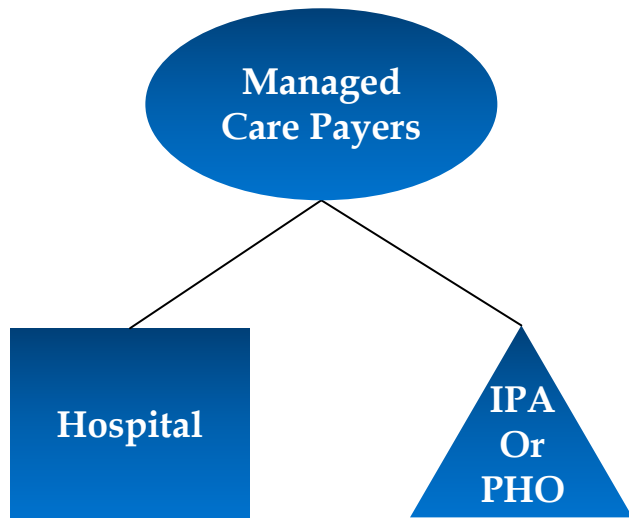
These organizations must have the flexibility and financial wherewithal to manage a transition through multiple payment methodologies, changing incentives, and new care delivery models. Additionally, organized physician entities that are self-governed will drive individual physician performance to meet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

Employment Model: Add Structure and Options for Independents

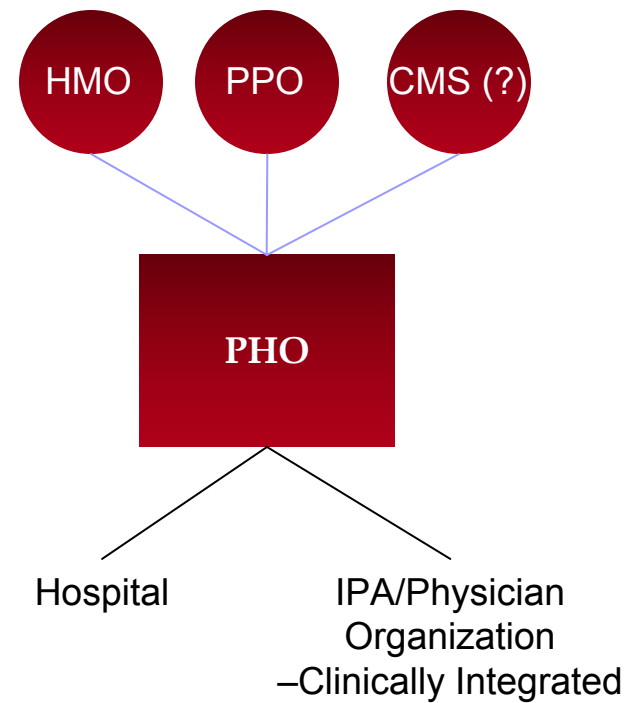


PHO: Precursor to ACO

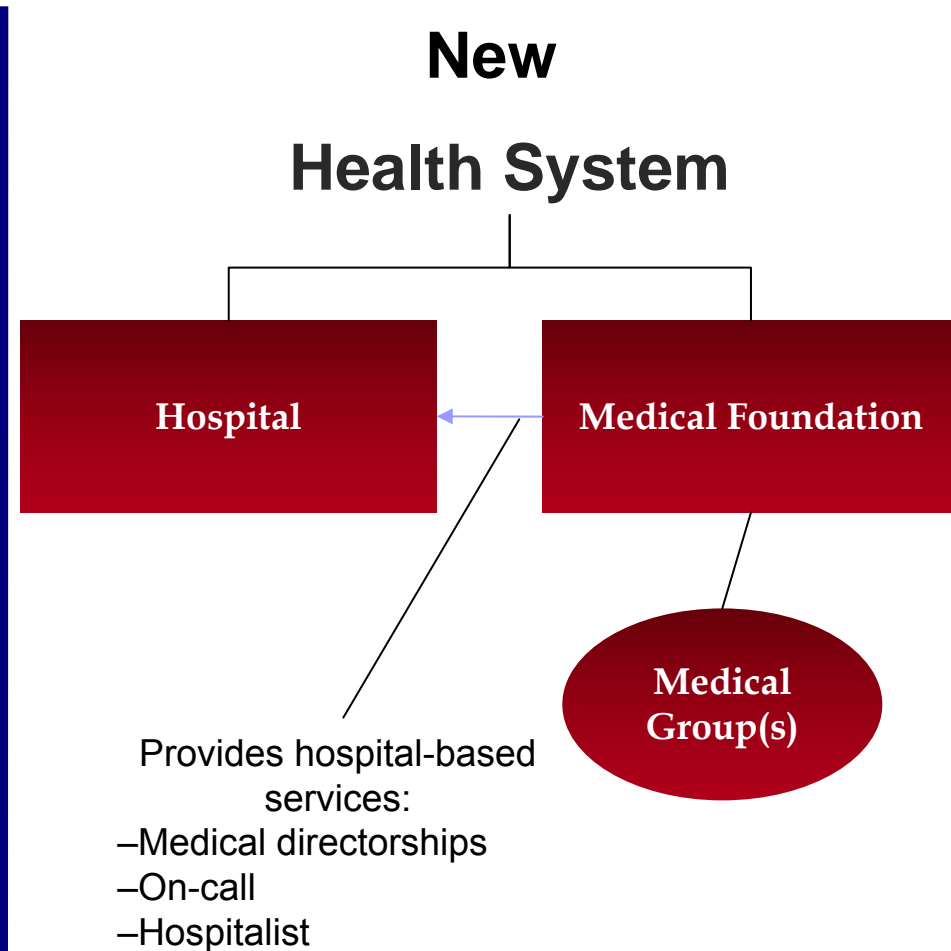
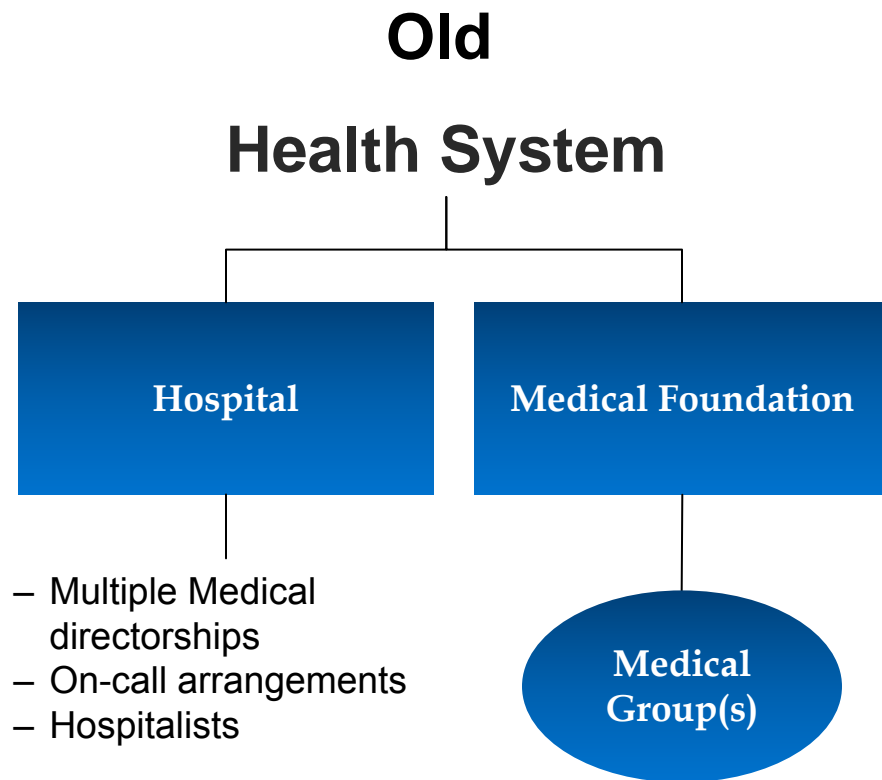
Old



New

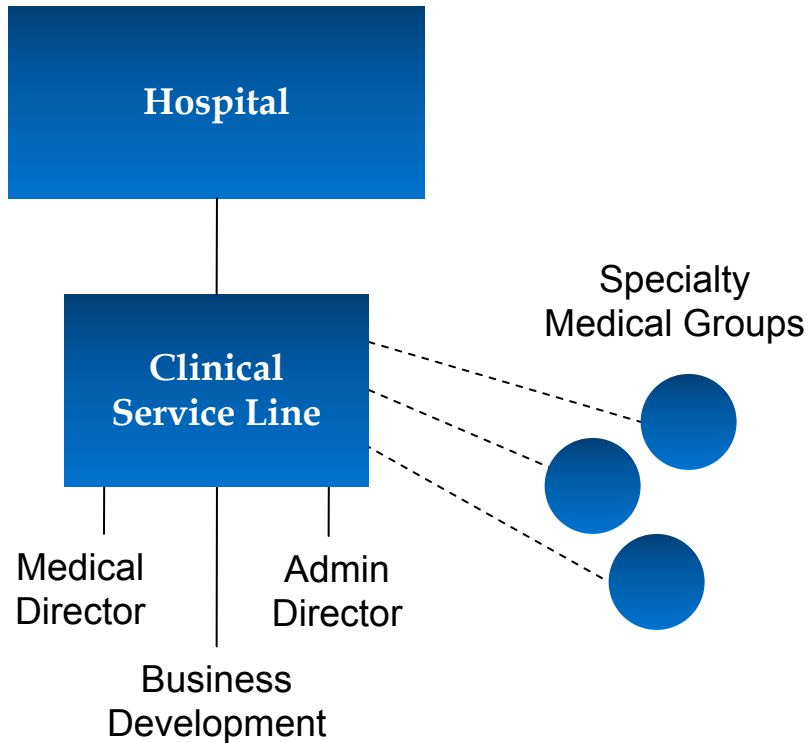


Expanding the Role of the Physician Organization – Meeting Hosp Needs

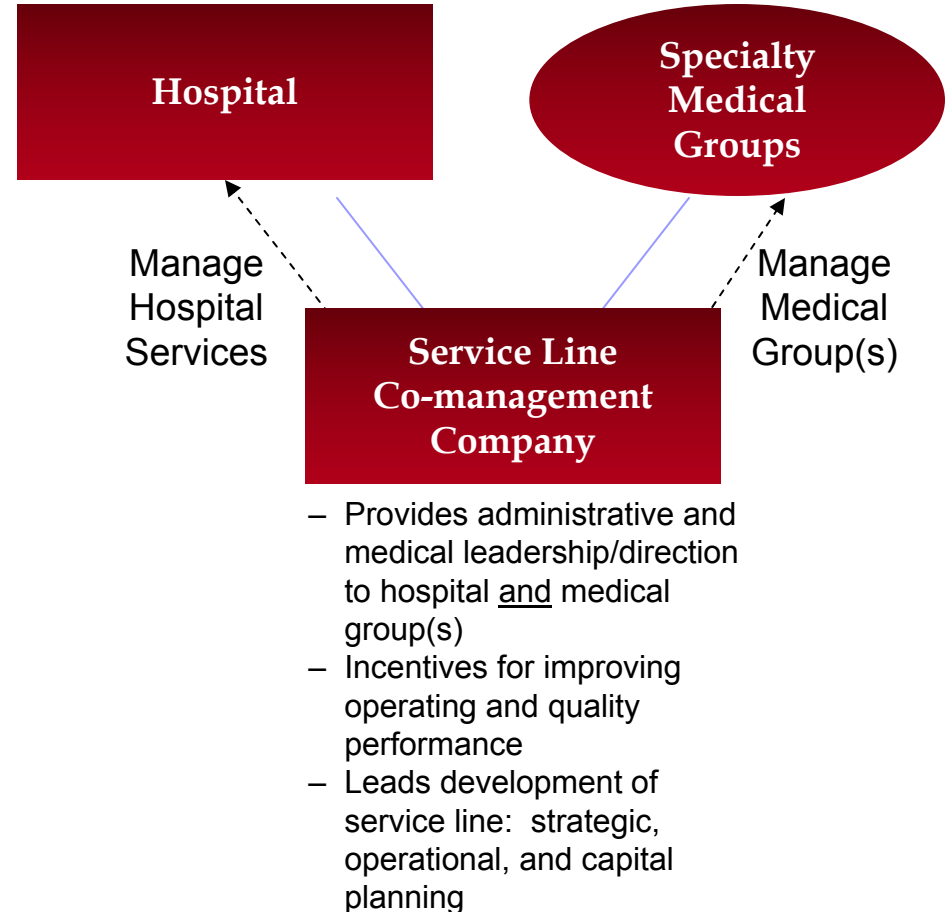


Comprehensive Service Line Management – Enabling Bundling

OLD



NEW





Accountable Care Organizations and New Methods for Care Management

- Primary focus of managed care was controlling costs, while the primary focus for ACO's is enhanced patient care coordination
- 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. 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



Accountable Care Organizations and New Methods for Care Management

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.



Initiating A Clinical Integration And/Or ACO Project

New Models for Physician/Hospital Integration Common Elements

- These models will create substantial Clinical Integration
- They will achieve significant clinical and economic efficiencies
- Joint negotiation of managed care contracts must be collateral or ancillary to the goal of true Clinical Integration



New Mandate For Physician/Hospital Integration—Essential Aspects

New Models for Physician/Hospital Integration Common Elements

- A medical management program.
- Must develop and implement clinical protocols.
- Develop a system of performance reporting and benchmarking with peers on a regional and national basis.



New Mandate For Physician/Hospital Integration—Essential Aspects

New Models for Physician/Hospital Integration Common Elements

- Must include procedures for taking corrective action whenever necessary
- Should develop methods to manage high-cost and high-risk patients aggressively
- The sharing of patient information



What An Integration Program and Healthcare Providers Should Consider:

- The program must develop dynamic clinical practice guidelines.
- Participants also should continually develop improved practice parameters and protocols that reflect scientific advancements.
- The program ought to utilize state-of-the art medical devices and drugs in its development of best practices.
- The development of a Pay-for-Performance bonus system will be essential.



The FTCs Evaluation of Integration Programs

- The FTC will focus on member physician participation such that the physicians will need to demonstrate that they have made a meaningful investment in the organization.
- For purposes of creating substantial Clinical Integration, it will be important for physicians to participate in all managed care contracts.
- When appropriate, member physicians ought to refer to in network providers.
- Physicians should participate in medical management programs and to play significant roles in program committees



Conclusion

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

- Beginning a dialogue with community physicians
- Consider all potential stakeholders and seek their input.
- Ensure that the required degree of collaboration among providers and others is available, along with the required size, e.g., there may be a need for providers to “network”.




Conclusion

- 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.
- Ensure that sufficient resources, e.g., financial, expertise, time and infrastructure are available.



Questions ???



Portions of this PowerPoint are adapted from the Section-by-Section Analysis of The Patient Protection and Affordable Care Acts prepared by Responsible Reform for the Middle Class, and also adapted from B. Aseityne, P. DeMuro, L. Jacobs, P. Katz, D. Meron, D. Settelmayer, B. Silverstein, and J. Marder, “Accountable Care Organizations-Physician/Hospital Integration,” *The Health Lawyer*, Vol. 21, No. 6 (August 2009).