

## ACOs, CO-OPs and other options: A “how-to” manual for physicians navigating a post-health reform world

The current environment presents opportunities and risks. This manual is designed to help you maximize the likelihood of successfully navigating the new post-health reform world, while minimizing the risk of failure.

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## Preface

**Catherine I. Hanson**

Physicians throughout the country are trying to figure out how to respond to health system reform and increasingly incessant demands for health care cost-containment. Because so much remains uncertain—from the content of the proposed accountable care organization (ACO) regulations, to the response of employers and consumers to new health plan options—the choices can indeed seem daunting.

The current situation presents enormous opportunity and enormous risk. The goal of this manual is to help physicians maximize the likelihood of success, while minimizing the risk of failure, whatever the road they decide to take. The chapters in this manual were written by seasoned, expert physician practice consultants who have taken the learnings of the past and translated them into valuable knowledge for the future.

Indeed, while there are undeniably new aspects to it, the current situation is not entirely unprecedented. There was a similar flurry of hospital purchases of physician practices and physician consolidations in the early 1990s. While some of the systems that were created during that period have continued to flourish, many others failed. In California alone, 147 physician organizations serving 4.1 million patients closed or went bankrupt between 1998 and 2002.<sup>1</sup> The profound financial and personal hardship this imposed on these physicians, their families and their patients should not be minimized. Life savings were lost, marriages were destroyed and long-standing patient-physician relationships were severed.

But physicians do not have to repeat the mistakes of the past—they can learn from them. Physicians can analyze their present situation to determine whether it even makes sense for them to make a change. If they conclude that change is advisable, they can consider the whole gamut of options available. And if they conclude that moving to an integrated delivery system makes sense, physicians can evaluate the likelihood that any particular system is likely to be successful. In its December 2010 publication entitled “Accountable Care Organizations: Avoiding Pitfalls of the Past,” the California Health Care Foundation laid out six requisites for a successful ACO, which it created in light of past failures:

- A shared strategic vision that identifies the longer-term goals of the ACO within the context of community health needs, provider capabilities, and state and federal health policy.
- An organizational structure that supports the ACO’s strategy through shared hospital-physician leadership; transparent decision making; and clarity surrounding participants’ roles.

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<sup>1</sup>Cattaneo & Stroud, Inc., 2010: List of Closed Medical Groups

- Alignment of provider financial incentives consistent with the ACO’s strategic goals and addressing the issues of cost, access, quality and choice.
- Appropriate clinical and organizational infrastructure, including coordination of medical care, financial systems and information technologies.
- Sufficient capital and clinical/financial management capabilities to support the assumption of risk and a plan to transition from lower-risk payment models such as shared savings to higher-risk models such as partial or complete capitation.
- Trusting, respectful relationships among ACO participants, and clear channels of communication.

Physicians do not need to—and should not—rely on the assurances of fast-talking consultants; they can ask the hard questions and make their own assessments of the extent to which any proposed venture meets these necessary criteria.

Nor will this manual be static. As the government’s regulations and other guidance are finalized, these articles will be updated to reflect those developments. Additional chapters will also be added to expand the scope of the issues covered by this manual. The American Medical Association (AMA) welcomes questions and suggestions from its members for new chapters or other tools to assist them in their efforts to improve the quality and efficiency of the care they provide to their patients in this changing environment—just e-mail Henry Allen at [henry.allen@ama-assn.org](mailto:henry.allen@ama-assn.org) or Wes Cleveland at [wes.cleveland@ama-assn.org](mailto:wes.cleveland@ama-assn.org).

Finally, the AMA has been and will remain actively engaged in advocating for physician interests in connection with ACOs and other delivery system reforms. For example, in its Dec. 2, 2010, letter to Donald Berwick M.D., Administrator of the Centers for Medicare and Medicaid Services (CMS), the AMA made numerous recommendations designed to maximize the opportunities for physician-led ACOs, such as urging the creation of explicit safe harbors from antitrust enforcement; urging waivers of the Civil Monetary Penalty statute, the Anti-Kickback statute and the Ethics in Patient Referrals (Stark) statute; and to opposing the mandate that ACOs implement a full electronic health record. Visit [www.ama-assn.org/go/ACO](http://www.ama-assn.org/go/ACO) for up-to-date information on AMA’s efforts in this area as well as the latest on the government’s ACO guidance. In 2010, the AMA also developed a comprehensive member benefit entitled “Pathways for Physician Success under Healthcare Payment and Delivery Reforms.” This benefit is an important resource for any physician considering entering into arrangements involving ACOs, payment bundling, medical homes and gainsharing. AMA members can visit [www.ama-assn.org/go/paymentpathways](http://www.ama-assn.org/go/paymentpathways) to access this resource.

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## Introduction: Complex environment—difficult choices

**David W. Hilgers**

### **Hypothetical**

You are a member of a six-person family medicine practice in a city with a population of one million people in the midwest. Your practice is very busy, with most commercial patients coming from three major insurance payers in the city. About 60 percent of your practice is commercial and the remainder is largely Medicare. You have very little negotiating leverage with the insurance companies, and as a consequence, your reimbursement has been declining on a regular basis. Recently, you did receive an increase in Medicare payment rates, but it has not resulted in a significant improvement in your practice revenue. Nevertheless, on the whole, it is a comfortable practice with adequate income at present, but you are concerned about the future.

Your city is dominated by two hospital systems: one is a for-profit and one is a nonprofit. Recently, one of your member physicians was approached by the nonprofit hospital, seeking to employ the practice as part of the hospital's effort to form a state-wide accountable care organization (ACO) with other nonprofits in the state to serve Medicare patients. The members of your group are very conflicted as to the correct direction, and a number of physicians feel that they have little choice but to accept the hospital's proposal. You have been assigned to seek advice on what would be the best choice.

The hypothetical above is just one example of the hard choices physicians are having to face in today's very complicated health care world. This physician guidance from the American Medical Association (AMA) will, hopefully, give physicians facing these choices some insight regarding the complex factors influencing their practice and the options that may be available to them for negotiating a viable path through the environment.

### **Physician environment**

Why are physicians having to make these difficult choices? What in the environment is creating all of these enormous pressures requiring physicians to do something other than simply practice medicine? Unfortunately, the answer is very clear but daunting: the uncontrolled rising cost of health care. Although there are other issues that have some impact on the changes that are occurring, this unrelieved increase in the cost of health care is by far the largest factor forcing change. Just a few facts illustrate the significance of this intractable problem.

- In 2008, health care expenditures in the U.S. exceeded \$2.3 trillion with costs per resident at \$7,631 per year.<sup>1</sup>
- In 2009, the percentage of gross domestic product (GDP) spent on health care was 17.3 percent. In 2008, it was 16.2 percent, making the increase to 17.3 percent in 2009 the largest one-year increase since 1960.<sup>2</sup> The country closest to the United States in health care expenditures is Germany, where 11.1 percent of its GDP is spent on health care.<sup>3</sup>
- The cost of Medicaid grew an estimated 9.9 percent in 2009. The cost of Medicare grew an estimated 8.1 percent in 2009.<sup>4</sup>
- Despite all the spending in health care, quality—as tested by infant mortality and life expectancy—in the United States fares worse than most developed nations.<sup>5</sup>
- Only 45 percent of primary care physicians in the United States have electronic medical records. In Australia, Italy, New Zealand, the United Kingdom, the Netherlands and Sweden, more than 90 percent of primary care physicians have this technology.<sup>6</sup>
- The average annual health insurance premium in 2009 for a family was \$13,027, an increase of more than 54 percent since 2000.<sup>7</sup>

These rising costs are insupportable by the state or federal governments, the employers who pay the premiums, or the patients who pay the co-insurance particularly when the United States fares so poorly on international public health scorecards. Although the implications of this increasing pressure on the economy are complex and far-reaching, it is safe to say that all of the following environmental factors causing physicians to consider changes are driven largely by this inexorable cost pressure on the economy.

## 1. Declining reimbursement

Physician reimbursement has been declining in the United States for years. From 1995 to 2003, a physician's net income adjusted for inflation declined 7 percent.<sup>8</sup> From 1995 to 2008, physician reimbursement declined an even greater 25 percent.<sup>9</sup> There are a number of factors driving this decline:

**(a) Pressure to slow cost increases.** Both insurers and Medicare are constantly trying to slow health care inflation. An easy target is physician reimbursement. Consequently, all payers are continuously using reductions in physician fees to hold costs down.

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<sup>1</sup> "U.S. Health Care Costs," [www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx](http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx).

<sup>2</sup> Truffer CJ, Keehan S, Smith S, Cylus J, Sisko A, Poisal JA, et al. "Health spending projections through 2019: the recession's impact continues," *Health Affairs* (Millwood). 2010; 29(3): 522–9.

<sup>3</sup> *Ibid.*

<sup>4</sup> Truffer CJ, Keehan S, Smith S, Cylus J, Sisko A, Poisal JA, et al. "Health spending projections through 2019: the recession's impact continues," *Health Affairs* (Millwood). 2010; 29(3): 522–9.

<sup>5</sup> Burns, "America Health Care Quality Since 1994: The Unacceptable Status Quo," Center for America Progress, January 8, 2009.

<sup>6</sup> Schoen, Osborn, Doty, Squires, Peugh, Applebaum, "A Survey of Primary Care Physicians in 11 Countries," *Health Affairs* Web Exclusive, Nov. 5, 2009.

<sup>7</sup> *Cost of Family Coverage Provided by Employers 1.5 Times More in 2009 Than in 2000*. AHRQ News and Numbers, July 21, 2010. Agency for Healthcare Research and Quality, Rockville, MD. [www.ahrq.gov/news/nn/nn072110.htm](http://www.ahrq.gov/news/nn/nn072110.htm).

<sup>8</sup> Center for Studying Health System Change, June 23, 2006, *Losing Ground: Physician Income 1995-2003*.

<sup>9</sup> JAMA, *Trends in the Work Hours of Physicians in the United States*, Feb. 24, 2010.

**(b) Lack of negotiation leverage.** The enforcement agencies' present interpretation of the antitrust laws hinders independent practices' ability to jointly negotiate with health insurers. Since most physicians practice in independent, smaller groups, they cannot unite to negotiate for higher fees, unless the physicians (1) share substantial financial risk for health care services (e.g., via capitation) or (2) are clinically integrated. Unfortunately, delivery models involving physicians' assumption of such financial risk have fallen out of favor with many purchasers of physician services. At the same time, as currently interpreted by the U.S. Department of Justice and the Federal Trade Commission, the standard of clinical integration sufficient to justify joint price negotiations is too demanding. Consequently, most physicians have very little ability to negotiate higher rates with health insurers. Instead, the health insurers have been able to reduce the rates paid in order to keep their health care costs lower. In some markets, large groups can negotiate higher rates, but this is not the common experience for most physicians.

**(c) The increasing cost of medical groups.** The costs of operating a medical group have continually increased. Everything from rent to labor to malpractice costs have continued to go up.<sup>10</sup> Thus, physicians are caught between decreasing reimbursement and increasing costs.

**(d) Restrictions on revenue diversification.** In order to make up for these decreased fees and the rising cost of practice, physicians have increasingly relied on ancillary service income to supplement their traditional fee-for-service income. However, due to the focus of the federal government (and increasingly, state governments) on concerns regarding kickbacks to physicians, the government regulatory apparatus has concentrated on restricting this ancillary income as much as possible. It is very easy to recite numerous examples of this policy, but a few will suffice.

- Doctors have in some cases tried to supplement their declining practice revenue by jointly owning imaging centers. Several groups can support an imaging facility whereas one small practice does not have the necessary volume of patients. Regulators have seen these types of imaging joint ventures as an attempt to generate money from referrals and consequently have attempted to limit the availability of physicians to form these shared centers. Recently, federal regulators have effectively eliminated the ability to share imaging centers by prohibiting "per click" leases and preventing doctors from charging Medicare more than it costs the physicians to deliver such imaging services through the anti-markup prohibition. These changes were specifically designed to eliminate shared imaging centers.
- Doctors have sought to supplement their income with ownership in ambulatory surgery centers (ASC) and hospitals. Medicare has substantially reduced ASC reimbursement for non-hospital owned ASCs.<sup>11</sup> And in 2010, the Patient Protection and Affordable Care Act (ACA) outlawed the ownership of hospitals by physicians if those hospitals were not owned by physicians on Mar. 23, 2010.

An objective look at the regulatory direction of both state and federal governments demonstrates a consistent pattern to reduce or eliminate the ability of physicians to obtain any revenue from services other than those that they perform as physicians.

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<sup>10</sup> "Medical Group Practice Cost Increases Outpace Revenues," MGMA, October 20, 2009, [MGMA.com/pres/default.aspx?id=22678](http://MGMA.com/pres/default.aspx?id=22678).

<sup>11</sup> Medicare and private payers have created a compensation model that reimburses hospital-based outpatient surgical services at a greater rate than outpatient surgical services not owned by hospitals. The justification for this differential is the need of hospitals to support greater infrastructure that stand above out-patient centers since hospitals provide a wide range of services and provide care to uninsured patients.

**(e) Increasing competition.** The new growth of hospital-owned practices has created competition for traditional physician practices. Larger delivery systems have substantial access to capital and resources, which allows those systems to build new facilities with new equipment in close proximity to existing physician practices. Essentially, these hospital-owned groups are competing aggressively for the dwindling numbers of commercial patients.

## **2. Change in culture**

In addition to the oppressive financial pressures faced by physicians, there are lifestyle pressures as well. The growing regulatory demands of governmental and insurance programs require that physicians spend ever-increasing amounts of time dealing with administrative issues. The list goes on forever, but privacy and confidentiality, patient consent, billing, occupational safety, retirement plan, employment discrimination, fraud and abuse, and electronic health records issues are just some of the areas of regulation requiring administrative oversight. These are not insignificant, trivial concerns. If a physician has a problem with fraud and abuse or Health Insurance Portability and Accountability Act (HIPAA) compliance, the fines can be enormous, and some of the violations are subject to criminal charges. The same can be said of Occupational Safety and Health Administration and environmental issues. Consequently, in addition to practicing medicine, physicians must operate a very complex business overrun with regulatory requirements. The present-day physician must spend a substantial part of his or her time overseeing these administrative requirements or spend a substantial amount of his or her income in paying others to do this oversight. The practice of Marcus Welby is a mythological vestige of the past.

Meanwhile, the younger physicians now coming out of medical schools are much less interested in long hours and greater responsibilities. Instead, many younger physicians value increased time off, reduced administrative responsibilities and less leadership responsibility. This change in the goals of physicians creates new economic pressures on medical practices as they must adjust to this more relaxed attitude toward work in the practice.

This combination of factors inevitably leads the present physician leadership of many smaller practices to seriously evaluate their choices. The retirement accounts of many physician practice leaders have been decimated by the recession and financial crisis. Physician leaders also face enormous potential liability from regulatory compliance issues, while professional liability is an ever-present threat. Finally, some new employees do not appear to share the same desire to take on major practice responsibilities. Thus, these cultural changes are a significant factor in pressuring physicians to make difficult choices.

## **3. The development of integrated systems**

Historically, physicians have operated a cottage industry populated by thousands of solo practices or small groups. In 1991-1997, 40.7 percent of physician practices were solo or two-physician practices. At that time, 61.6 percent of physicians owned an interest in their practice.<sup>12</sup> Only 16 percent of physicians practiced in groups with more than six physicians, and 10.7 percent practiced with hospitals.<sup>13</sup>

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<sup>12</sup> “Proportion of Physicians in Solo/Two Physician Practice Groups,” Center for Studying Health System Change, Aug. 16, 2007; <http://hschange.org/CONTENT/942/?/PRINT=1>

<sup>13</sup> Liehafer and Crossman HSC Community Tracking Study Physician Survey, Tracking Report 18, August 2007.

By 2008, the number of physicians in solo or two-person practices had declined to 32.5 percent, while 21.8 percent of physicians practiced in private practices with more than six physicians.<sup>14</sup> More than 60,000 physicians were employed by hospitals in 2008, approximately twice the number that were employed in 2001. A survey of residents in 2008 indicated that 22 percent of residents expected to be employed by hospitals, as opposed to 2003, when 5 percent did.<sup>15</sup>

This trend has been predicted for years. It is no secret that many of the most respected health care economists in the United States believe that integrated systems are the best structure to reduce health care costs. Influential policymakers such as Alain Enthoven and Uwe Reinhardt strongly advocate integrated delivery systems as a solution to the health care cost issue.

It is also of little dispute that the federal regulatory policy in the past has been designed to push physician groups into integrated systems. As discussed earlier, so many of the regulatory moves to limit ancillary services available to physicians have developed loopholes or exceptions for hospital-owned groups. Thus, there is no compliance issue with a physician-employee of a hospital referring a patient to the hospital for imaging. However, if the physician referred the patient to a shared imaging center, this could result in a violation of federal law.

Quality payment programs are another example of this policy to promote integrated, large systems. Medicare has initiated a program to pay additional moneys to physicians who meet certain quality standards. In August 2009, the Centers for Medicare and Medicaid Services announced that physicians in five of the 10 groups participating in the Physician Group Practice Demonstration (PGPD) earned \$25.3 million in incentive payments.<sup>16</sup> It would be virtually impossible for smaller groups practicing in isolation to achieve the types of benchmarks or target performance on the 27 quality markers for patients with diabetes, coronary heart disease and congestive heart failure that were used to judge the performance of the large groups that participated in the PGPD. As these types of quality payments proliferate, under the current regulatory regime, it appears that only large fully integrated groups, or (perhaps) financially or clinically integrated provider organizations, will be able to access those payments.

Another factor driving integration is current antitrust enforcement policy, which allows clinically or financially integrated provider systems of networks to negotiate with plans, whereas physician groups operating without the requisite level of integration cannot.

Finally, the push to acquire and implement electronic health records also appears to favor larger systems. The cost of electronic health records may be out of reach for many small physician groups, notwithstanding Medicare or Medicaid “meaningful use” incentives.

#### **4. Health care reform**

The culmination of this inexorable governmental and policy push toward integrated delivery systems is reflected in the ACA. The ACA calls for the development of multiple pilot projects, virtually all designed for integrated systems. These pilot projects encourage episodic payment systems such as bundling, capitation and quality payments, as well as medical homes and other collaborative programs. In addition to these pilot projects, there is a specific statutory provision authorizing the creation of accountable care organizations (ACOs). These are, by definition, integrated delivery systems requiring one entity utilizing participation from providers of all types

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<sup>14</sup> *Ibid*; 13 HSC 2008 Health Tracking Physician Survey, Data Bulletin No. 35, September 2009, <http://hschange.org/CONTENT/1078/?PRINT=1>

<sup>15</sup> Marriott, Hawkins & Associates, Inc., 2008 Survey of First Year Medical Students.

<sup>16</sup> “Medicare Demonstrations Show Paying for Quality Health Care Pays Off,” *Medicare News*, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Aug. 17, 2009.

necessary to deliver complete health care services to Medicare patients. ACOs, if successful, will receive a percent of any cost savings generated by the ACO in caring for the Medicare population assigned to the ACO, notwithstanding the long-standing federal gainsharing prohibition.

In the build-up and aftermath of health care reform, it is apparent that the development of integrated delivery systems are a goal of the federal government, and that, as a consequence, such systems will continue to develop and become a large part of the health care delivery system.

## **5. Lack of capital**

Given this impetus for the development of large, integrated delivery systems, many physicians would like to participate as equal partners in the development of these systems. However, the infrastructure essential to the development of these systems requires substantial financial resources. Unfortunately, physician practices have not been structured to develop capital resources or to serve as vehicles for raising capital. Hospitals and insurance companies typically are the only types of players in the health care market that have access to the capital that is needed to develop these integrated delivery systems. Consequently, as physicians are pressured to move into larger systems, it can be very difficult for them to self-finance this growth.

## **6. Shortage of physicians**

The number of physicians per capita will decrease in the United States because physician production has not kept pace with population growth. Further, the number of elderly will double because of baby boomers and longer life spans. In addition to more elderly, medical successes across the life span have resulted in more people living with serious and chronic illnesses (e.g., cancer survivors, AIDS patients). Finally, even the best prevention will not eliminate disease but only delay it. Indeed, this shortage is already becoming apparent, particularly in primary care. Presently, the U.S. has 352,908 primary care physicians and the Association of American Medical Colleges estimates that 45,000 more will be needed by 2020.<sup>17</sup> Cardiologists, radiologists and anesthesiologists are all also in short supply.<sup>18</sup>

This physician shortage should be a countervailing factor in the continual decline of physician income. Logically, if physicians are in short supply, there should be an increase in the compensation payable to them in order to attract physicians. So far, because of the highly regulated Medicare fee structure, this rebound in physician income has not occurred. However, it is hard to believe that incomes can continue to decline in the face of severe shortages. Paraprofessionals may be utilized to plug some of the gaps, but they cannot substitute for physicians in most situations due to the vast differences in education and training. In any event, the shortages are so great it seems impossible for it not to have a positive impact on physician incomes.

When one steps back and surveys the environment in which physicians are operating, it is fair to state that physicians are facing one of the most complex situations ever seen by any professional group. In the face of these pressures, it is hard for physicians to conclude that they should stand pat. On the other hand, the correct choice does not seem all that clear either. Nevertheless, common wisdom would indicate that the trends described above are going to continue. Smaller practices will likely be at a disadvantage in almost everything, from reimbursement to cost to capital to hiring. The entities capable of creating the administrative and logistical infrastructure to develop integrated delivery systems will likely become increasingly dominant in the market.

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<sup>17</sup> Sataline & Wang, "Medical Schools Can't Keep Up," *The Wall Street Journal Digital Network*, April 12, 2010.

<sup>18</sup> Merritt, Hawkins & Associates, Survey of 280 Hospitals, 2002.

Those organizations able to deliver large numbers of physicians to these integrated delivery systems will be at an advantage. On the other hand, the existing and growing shortage of physicians should put many physicians in an advantageous position. For example, ACOs must have primary care capacity under the reform bill. Primary care physicians are at a premium. Their numbers are small and are diminishing. This should mean that they will be able to demand greater income and more benefits from ACOs and other integrated delivery systems. Similarly, other specialties may find themselves in the same position in a short period of time. Cardiologists are becoming rare. Neurosurgeons are always in demand.

Understanding that all of these factors complicate physician decision making, it is useful to at least examine some of the options available to physicians at this point.

## Options

There are so many possible scenarios. The hypothetical at the start of this chapter is only one. The situation will be much different for a physician in a small rural area or specialists in a large single-specialty group. A large multi-specialty group will also have a different situation. Much will depend on the number of hospitals in the physician's locale. The possible circumstances are virtually endless. However, as a prelude to the rest of this Physician Guidance, the following is a list of some of the options available to physicians, which will be expanded upon in later chapters.

- 1. Don't do anything.** This is certainly a possibility for some physicians in unique situations. For example, physicians specializing in in vitro fertilization may be able to continue to practice as they have been because of their unique market, which is driven by patient choice. Other physicians may prefer to continue on in small practices. A larger specialty group that has not seen substantial reductions in compensation may be able to watch and wait. A large multi-specialty group may have enough leverage in a particular market to stay independent while demanding support from integrated delivery systems.
- 2. Stand pat but attempt to grow the practice.** One fact that seems to be clear even in the muddled situation that we face is that larger will often be better. Consequently, a smaller group of physicians that is not under immediate financial pressure can continue its present course but attempt to grow by adding physicians or merging groups. Whatever the payer—insurance company, ACO, medical home, Medicare, Medicaid—there will be a need for physicians to provide the services. If the medical group is of substantial size and can deliver a substantial number of physicians to the payer, the group will generally be in a better position to negotiate rates and document its quality. This larger size will allow the group to be more flexible as it adapts to whatever may come in the future.
- 3. Employment by hospitals.** This may be a way for many physicians to eliminate substantial administrative responsibilities while aligning with the hospital system that can provide the infrastructure to be able to compete in a world increasingly dominated by integrated delivery systems.
- 4. Form large clinically integrated practice associations that can negotiate as one.** As such, these large clinically integrated systems may be able to provide substantial numbers of physicians to the various integrated delivery systems, such as ACOs or hospital-integrated systems. By doing so, the individual physician groups could remain largely independent and negotiate as one to seek better positions in these integrated delivery systems, both in terms of control and reimbursement.
- 5. Changing to a concierge or direct practice.** This method of practice will, in all likelihood, still be viable after the insurance reform provisions of the ACA take effect. People may be

willing to pay for personalized care beyond their insurance premium. As long as this type of practice methodology is not outlawed, it certainly may remain a viable option.

6. **Partnering with hospitals.** Physician groups may be able to develop service-line management companies by which they can retain some independence but receive compensation from the hospitals for providing management services of a specific service line within the hospital. Another example is to utilize the medical staff relationship with the hospital to try to develop a partnering structure for ACOs or integrated delivery systems. This will be dependent upon the attitude of the local hospital.
7. **Partnering with health insurers.** Physicians may also want to consider arrangements with health insurers to obtain the capital and data necessary to operate an ACO. This scenario may allow physicians to reduce hospitalizations without the potential pushback of a hospital partner. However, the success of such a venture will depend on the willingness of the health insurer to cede significant control to the physician group.
8. **Insurance CO-OPs may be a possibility.** The ACA authorizes the creation of insurance CO-OPs that might compete in providing insurance through the health insurance exchanges that the ACA mandates must be operational by Jan. 14, 2014. Physicians may be able to create such an insurance company at a minimum cost because of the subsidies available through the ACA. This would allow them to have greater control over the insurance company with which they would affiliate.

In analyzing and evaluating these various options, physicians will have to be very objective and candid about their situation in the market.

- If you are a solo practice in a large city, you will have to recognize that your ability to continue in that practice will likely depend on your willingness to take reduced income or switch to a concierge-type practice. However, your ability to secure a beneficial employment agreement with the hospital may be limited as well, depending on your specialty.
- On the other hand, if you are a small practitioner in a small town, your importance to the local hospital may give you the clout to secure a strong relationship with the hospital, potentially without becoming a hospital employee. If that hospital is going to be able to deal with integrated delivery systems or insurance companies, it is going to need your allegiance and support. The hospital may threaten to bring in a competing doctor, but that may not be a real threat given the shortage of physicians.
- If you are in a position where you might be able to develop a large clinically integrated organization, you must understand that that is going to cost substantial amounts of money, time and resources. It is not something that can be undertaken lightly. Therefore, if you want to commit to developing such an organization, you must make sure that the resources are available to help you complete your efforts.
- You may be a substantial multi-specialty group. In that case, you may want to consider potential hospital partners that recognize your value. You may be able to develop a relationship with a hospital partner that allows you to maintain a substantial amount of your autonomy while giving the hospital what it needs with your participation in its integrated delivery system. Alternatively, there may be a health insurer that is interested in affiliating with you and providing significant capital and technological resources.
- You may be part of a health care delivery system with a strong community focus. In that case, you may want to consider creating a non-profit health insurance plan made possible by the CO-OP provisions of the ACA. Again, this is not an alternative to be taken lightly, but

the ACA itself provides a source of potential funding for such efforts, and such a CO-OP could provide a welcome dose of competition to some overly concentrated markets.

In making an assessment of options, it is very important to be extremely realistic about your group's strengths and weaknesses. These are some of the questions that need to be asked:

1. Is your group on sound financial footing, and can you continue to sustain reasonable incomes over the next five to six years?
2. Is your group going to invest in some of the infrastructure—both technological and human—that will be needed to compete with more sophisticated integrated delivery systems?
3. Does your group have strong and deep leadership with cohesion among the members? If you don't have both of those characteristics, staying the course may be difficult.
4. Who are the realistic partners you might work with, and how trustworthy are they? There are differences between hospitals and medical groups in their reliability and credibility. When you can, it is better to partner with a reliable party rather than one who offers more money at the outset but cannot be counted on to stay the course.
5. What is your bargaining position in the community? Are you well-thought of, and do you bring sufficient capacity to give you substantial leverage? If not, it is important to evaluate what kind of leverage you might have and how you might strengthen it.
6. Is your group prepared to spend the time and resources it will take to carve out a strong position in any joint venture such that the group or the physicians in it will have a substantial say in that new, combined organization? It will take time and money to put your group in a position where it will have a substantial say in any organization, be it an ACO or integrated delivery system. If the group doesn't want to spend that time and money, it is probably best not to reach too high for a leadership position.
7. What is your plan for the future? Are you close to retirement or in the prime of practice? If the former, you may want to try to obtain the best money deal possible. If the latter, you may want to choose a partner for the long-term. This difference in perspective can create difficulties between members of the same practice when making group decisions.

As indicated earlier, the scenarios can go on ad infinitum. The choices are difficult and the clear answers few. Hopefully, this "how-to" manual will give you some idea on how to deal with your specific circumstances.

## Chapter 1: Accountable care organizations—overview

Sidney S. Welch

### I. What are ACOs?

#### A. History and background

Drs. Elliott Fisher and Glenn Hackbarth first coined the term “accountable care organization” (ACO) at a 2006 Medicare Payment Advisory Committee (MedPAC) meeting.<sup>1</sup> Subsequent input, such as Drs. Stephen Shortell and Lawrence Casalino’s 2007 paper, “Accountable Care Systems for Comprehensive Health,”<sup>2</sup> and the passage of the Patient Protection and Affordable Care Act of 2010 (ACA),<sup>3</sup> has refined this concept. Generally speaking, the ACA defines an ACO to be an organization of physicians and other health care providers held accountable for the overall quality and cost of care delivered to a defined population of traditional fee-for-service Medicare beneficiaries who are assigned by the Centers for Medicare and Medicaid Services (CMS) to an ACO.<sup>4</sup> The theory behind the ACO concept is that effective delivery of and coordination of care (and thus cost savings) is difficult to achieve without integration among the providers that deliver patient care. Therefore, ACOs are incented, in the form of “shared savings,” to manage care in a manner that results in cost savings.<sup>5</sup> The ACO also holds providers accountable for clinical outcomes by required clinical outcomes reporting and other performance measures.<sup>6</sup> While extremely similar to the players in the alphabet soup of managed care players in the 1990s—the independent physician associations (IPAs), the physician-hospital organizations (PHOs), and the healthcare maintenance organizations (HMOs)—ACOs differ significantly: 1) the accountability rests with the providers, rather than the health insurers; 2) no health plan intermediary is required to contract with the provider organization; 3) ACOs have great flexibility in their provider composition; and 4) ACOs allow for payment under a fee-for-service arrangement.

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<sup>1</sup> Jordon T. Cohen, *A Guide to Accountable Care Organizations, and Their Role in the Senate’s Health Reform Bill*, March 11, 2010, [www.healthreformwatch.com/2010/03/11/a-guide-to-accountable-care-organizations-and-their-role-in-the-senates-health-reform-bill](http://www.healthreformwatch.com/2010/03/11/a-guide-to-accountable-care-organizations-and-their-role-in-the-senates-health-reform-bill)

<sup>2</sup> Stephen M. Shortell and Lawrence P. Casalino, *Accountable Care Systems for Comprehensive Health Care Reform*, March 2007, [www.rwjf.org/files/research/accountablecaresystemsforcomprehensivehealthcarereform.pdf](http://www.rwjf.org/files/research/accountablecaresystemsforcomprehensivehealthcarereform.pdf)

<sup>3</sup> Patient Protection and Affordable Care Act of 2010 (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>4</sup> ACA § 3022.

<sup>5</sup> *Infra* at 2.

<sup>6</sup> See generally Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, & Jonathan S. Skinner, “Fostering Accountable Health Care: Moving Forward In Medicare,” 28 *Health Affairs* at 219–w231 (2009), [www.dartmouth.edu/~jskinner/documents/FisherESFostering.pdf](http://www.dartmouth.edu/~jskinner/documents/FisherESFostering.pdf).

The government's support, if not directive, of the push to clinical integration is fairly evident and includes, but is certainly not limited to, ACOs. For example, Medicare's quality measurement efforts have paid out "quality" payments to doctors to the tune of \$16.7 million to 10 groups.<sup>7</sup> Similarly, Medicare has paid out \$25 million to 250 hospitals in 2008 for quality reporting initiatives.<sup>8</sup> Another manifestation of this direction has been the Acute Care Episodes Demonstration Project (also referred to as the Bundled Payment Demonstration Project), wherein CMS makes a single payment for both Part A and Part B Medicare services furnished during an inpatient stay.<sup>9</sup> Under the Demonstration Project, CMS selected 28 cardiac and nine orthopedic inpatient surgical sets of procedures.<sup>10</sup> In addition, CMS indications have been that it may liberalize regulatory restrictions on gainsharing payments, including, but not limited to, the shared savings program for ACOs in the near future. And the market has responded to this push even prior to implementation of the ACO provisions of the ACA. The past three years, at least, have been hallmarked by local and national hospital acquisition and employment of physicians. Much of this trending is positioning hospitals, and potentially their affiliated physicians, to take advantage of government directives and incentives encouraging clinical integration and associated quality and cost accountability.

## **B. The Affordable Care Act**

Under the ACA, which became law on Mar. 23, 2010, the ACO concept got heightened attention. The ACA established an ACO program for Medicare, which is scheduled to begin in January 2012.<sup>11</sup> While this model gives a Medicare option, many anticipate that third party payers likely will follow suit and create a shared-savings program for ACOs interested in extending their reach into the commercial managed care market. In fact, the ACA allows for preferential participation in the Medicare ACO program for organizations that have ACO arrangements with third-party payers.<sup>12</sup>

Many of the specifics of this new Shared Savings Program are left to the discretion of the Secretary of the Department of Health and Human Services (HHS). After obtaining stakeholder input,<sup>13</sup> CMS published its proposed ACO regulations.<sup>14</sup>

## **C. American Medical Association ACO policy**

At its 2010 Interim Annual Meeting held on Nov. 11, 2010, the American Medical Association's (AMA) House of Delegates adopted principles for ACOs, which include the following:

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<sup>7</sup> [www.cms.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap\\_OEA\\_1-16\\_508.pdf](http://www.cms.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf) at 16.

<sup>8</sup> *Id.* at 8.

<sup>9</sup> [www.cms.gov/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf)

<sup>10</sup> *Id.*

<sup>11</sup> ACA, Pub. L. No. 111-148, Sec. 3022.

<sup>12</sup> ACA, Pub. L. No. 111-148 (2010).

<sup>13</sup> See for example 75 Fed. Reg. 70165 (Nov. 17, 2010), available at:

<http://edocket.access.gpo.gov/2010/pdf/2010-28996.pdf> Specifically, CMS asked for input on (1) policies/standards to ensure that solo and small practice providers have the opportunity to actively participate in the ACO models and Medicare Shared Savings Program; (2) payment models, financing mechanisms and other systems that it might consider to address the issue of limited access to capital and other resources to fund shared-savings activities for small practices; (3) how CMS should develop patient attribution models for the ACO and Shared Savings Programs (i.e., should they be attributed before the start or at the end of the performance period); (4) how beneficiary and caregiver care should be assessed; (5) the aspects of patient-centeredness that it should consider and how it should be evaluated; (6) the quality measures the Secretary should use to determine performance for purposes of the Shared Savings Program; and (7) the additional payment models CMS should consider.

<sup>14</sup> 76 Fed. Reg. 19528 (April 7, 2011), available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=I9OuVL/1/2/0&WAISaction=retrieve>

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1. the guiding principle that the goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care;
2. ACOs must be physician led (to ensure that medical decisions are based on patients' versus commercial interests) and encourage an environment of collaboration among physicians;
3. physician and patient participation should be voluntary;
4. the ACO's savings and revenues should be retained for patient care services and distributed to the ACO participants;
5. waivers and safe harbors should be created to give flexibility to the patient referral and antitrust laws necessary to allow physicians to form or participate in ACOs without being employed by the hospitals or ACOs;
6. additional resources should be provided to encourage ACO development in the form of financing up-front costs of creating an ACO;
7. ACO spending benchmarking should be adjusted for difference in geographic practice costs and risk adjusted for individual patient risk factors, and ACOs spending less than the national average per Medicare beneficiary should be provided an additional bonus payment so that organizations that have already achieved significant efficiencies are incented to participate;
8. the quality performance standards established by the Secretary must be consistent with the AMA's principles for quality reporting;
9. an ACO must be afforded due process before it is terminated from Medicare for failing to meet quality performance standards;
10. the ACO should be allowed to use different payment models, and any capitation payments must be risk-adjusted;
11. the Consumer Assessment of Healthcare Providers and Systems Patient Satisfaction Survey should be used to determine whether an ACO meets the required patient-centeredness criteria;
12. Medicare must ensure that electronic health record systems are interoperable; and
13. if an ACO bears risk, it must abide by financial solvency standards for risk-bearing organizations.<sup>15</sup>

## **II. Legal issues**

### **A. The Affordable Care Act**

The ACA set the following specific requirements for ACOs to serve the Medicare program. Under these requirements, an ACO must: (1) have a sufficient amount of primary care physicians to serve at least five thousand Medicare beneficiaries; (2) agree to a three (3) year participation in the program; (3) have a formal legal structure; (4) have defined processes to promote evidence-based medicine; (5) have a mechanism of shared governance and a leadership management structure; and (6) have a health information infrastructure to enable community-

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<sup>15</sup> Victoria Stagg Elliot, AMA meeting: Delegates approve guidelines for ACOs, AMEDNEWS, Nov. 22, 2010, [www.ama-assn.org/amednews/2010/11/22/prsi1122.htm](http://www.ama-assn.org/amednews/2010/11/22/prsi1122.htm)  
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wide care assessment and coordination, including functional integrated electronic health records (EHR).<sup>16</sup> Each ACO must also have a formal legal structure that will allow it to receive shared savings payments and distribute them among providers, and it must show that it can meet quality and reporting standards to be developed by HHS.<sup>17</sup>

CMS will provide incentives for high quality care and overall cost savings generated by ACOs, which are described as a “Shared Savings Program.” By Jan. 1, 2012, the Secretary of HHS must establish a Shared Savings Program that: (1) promotes accountability for a patient population; (2) coordinates items and services under Medicare parts A and B; and (3) encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under this program, which does not specify how beneficiaries will be assigned to each ACO, the ACO (as opposed to the participating providers) will be eligible to receive additional payments from Medicare when certain performance guidelines are met and cost-savings targets are achieved. The amount of the additional payment will be a percentage of the difference between the estimated per capita Medicare expenditures for patients assigned to the ACO and the cost-savings per capita Medicare expenditures threshold.<sup>18</sup> The manner of distribution of the shared savings by the ACO to its participants is not specified and likely will be left to each ACO.

One of the other items created by the ACA was legislative direction to the Secretary of HHS to create and begin operation of the Center for Medicare and Medicaid Innovation (CMI) no later than Jan. 1, 2011.<sup>19</sup> The ACA charges the CMI with testing innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care. In selecting such models, HHS must give preference to models that also improve the coordination, quality and efficiency of health care services furnished to Medicare or Medicaid beneficiaries or beneficiaries of both programs. The ACA also gives HHS the authority to waive certain laws, such as the Anti-Kickback statute and Stark law, while testing payment models.

## **B. Antitrust**

There are antitrust ramifications in forming and operating an ACO. The ramifications are discussed in the chapter entitled “Managing antitrust risks associated with ACOs.” (In April 2011, the Federal Trade Commission (FTC) and the Department of Justice issued a Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, which is discussed in detail in that chapter).<sup>20</sup>

## **C. Anti-Kickback Statute/Stark**

An ACO and its activities also potentially implicate the federal physician self-referral law,<sup>21</sup> commonly known as “Stark,” and the federal Anti-Kickback Statute.<sup>22</sup> Stark, a civil statute with civil penalties, generally prohibits a physician, and his or her immediate family members, from making a “referral” to an “entity” for the furnishing of “designated health services” if the physician has a “financial relationship” with the entity. Stark may be implicated by an ACO arrangement in which the ACO’s members include physicians and hospitals and in which the

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<sup>16</sup> ACA, Pub. L. No. 111-148, sec. 3022 (2010).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> 76 Fed. Reg. 21894 (April 19, 2011) available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=I9OuVL/0/2/0&WAISaction=retrieve>

<sup>21</sup> 42 U.S.C. § 1395nn (a)(1)(A).

<sup>22</sup> 42 U.S.C. § 1320a-7(b).

physicians may refer Medicare/Medicaid/CHAMPUS beneficiaries to the hospital for designated health services, including, but not limited to, inpatient and outpatient hospital services. If the ACO arrangement calls for shared savings or any other payments to be made to participating physicians from the hospital, the “financial relationship” necessary to implicate the statute is present. CMS did propose an exception to Stark in July 2008 for certain shared savings arrangements that meet 16 requirements.<sup>23</sup> In its current form, the proposed exception is not flexible enough to permit many ACO arrangements to pass muster under the Stark law.

The Anti-Kickback Statute, a criminal statute with criminal penalties, makes it a crime for anyone to knowingly and willfully induce/pay or solicit/receive remuneration for the referral of patients for items or services reimbursed under Medicare, Medicaid, or CHAMPUS.<sup>24</sup> Because most ACO arrangements will involve an exchange of remuneration among parties who are in a position to refer patients for items or services reimbursed under Medicare, Medicaid, or CHAMPUS and no safe harbor currently exists under the Anti-Kickback Statute for ACO arrangements, the arrangement likely will implicate the Anti-Kickback Statute. Unlike Stark, under the Anti-Kickback Statute, if an arrangement does not fall within a safe harbor it will not automatically violate the statute. It will, however, invite scrutiny from the enforcement agencies to examine the parties’ intent to determine whether any one purpose of the arrangement was to solicit, receive, induce or pay for the referrals of patients covered under Medicare, Medicaid, or CHAMPUS. As this scrutiny usually is not desired, participants are hopeful that a safe harbor may be adopted for ACOs under the Anti-Kickback Statute.

At an Oct. 5, 2010 workshop hosted by CMS, the FTC, and the Office of Inspector General (OIG), participants from the private sector and representatives of the government focused on the implications of the Anti-Kickback Statute, Stark, and civil monetary penalty laws (CMP) for ACOs, the scope of any proposed waiver of the Anti-Kickback, Stark and CMP laws, and the different types of financial arrangements that need waiver protection. The participants did not reach consensus as to the form of any waivers, safeguards, or future action to encourage innovation other than a clear indication that guidance is needed and that the government faces challenges in drafting the same.

In April 2011, CMS and the OIG issued a proposal regarding how the application of the Anti-Kickback Statute, Stark, and civil monetary penalty laws might be waived in the context of ACOs.<sup>25</sup>

### **III. Practical issues**

The ACA gives the participants great discretion in the formation and operation of their ACO, which has benefits and challenges on a practical front.

#### **A. Who are members?**

Group practices, independent practice associations or other networks of individual practitioners, and additional groups defined by HHS can participate as ACOs. Although the ACA also permits hospitals to form ACOs, and hospitals are actively pursuing this option, an ACO need not include a hospital. However, because the stated goal for ACOs is to deliver coordinated and efficient care, a hospital may be a critical component for an ACO. This fact, however, does not preclude physician-only or physician-driven ACOs. Regardless of the ACO’s structure,

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<sup>23</sup> 73 Fed. Reg. 38502 (July 7, 2008).

<sup>24</sup> 42 U.S.C. § 1320a-7(b).

<sup>25</sup> 76 Fed. Reg. 19655 (April 7, 2001) available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=I9OuVL/4/2/0&WAISaction=retrieve>  
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physician leadership and participation are keys to an ACO's success since physician decisions contribute greatly to health care utilization and cost. Therefore, physician participation is critical to achieve shared savings.

ACO organizers may make membership decisions based on existing structures, networks, and resources in their community. In addition to physician/hospital constituency decisions, organizers will need to consider the primary care/specialty care physician balance. Primary care physicians clearly will play a central role in ACOs in coordinating the care delivery.<sup>26</sup> As such, these physicians would be well-served to take a leadership role in the ACO to ensure their vantage points are incorporated into the ACO organization and management. Specialists, on the other hand, are not required to be part of the ACO but will continue to play an important role in coordinated care of the patient. The ACO will need to determine the role for specialists--whether more integrally involved in the coordinated care<sup>27</sup> or hearkening to managed care days, as argued by some, more as a resource to be rationed.<sup>28</sup>

## **B. What does the structure look like?**

Not only in its membership but also in its structure, an ACO is not a one-size-fits-all proposition but must account for the community dynamic, resources, and needs. While the ACA requires ACOs to have a formal legal structure in order to participate in the Shared Savings Program,<sup>29</sup> the ideal legal structure depends on many factors, including the ACO's goals, the quantity and quality of available participants, cultural differences of participants, and financial resources. For example, in some communities, provider organizations (such as medical groups, IPAs and PHOs) already exist that will be able to be adapted into an ACO context. Others may be able to use existing medical staffs and/or employed physicians to build an ACO. Each ACO will include different participants to meet the goals, needs, and culture of its beneficiaries and communities.

Part of the beauty of the ACA's ACO provisions is that they give each ACO great flexibility in establishing its structure. This flexibility gives participants and interested parties the ability to develop models that meet their particular needs, creating a greater likelihood of success. Potential participants and organizers should avail themselves of this flexibility and take the opportunity to assess specific needs, as well as the governance and tax ramifications, that best fit the mission and strategic plan of the ACO.<sup>30</sup>

As a general proposition, five different ACO models have been described: the multi-specialty group practice model; the hospital medical staff organization; the physician hospital organization (PHO); the interdependent practice organization; and the health plan-provider organization.<sup>31</sup> The multi-specialty group practice model consists of a multi-specialty group with contractual or

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<sup>26</sup> See Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Reform (September 7, 2009), [www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf](http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf) (recognizing that the "mechanisms to reducing and slowing healthcare expenditures are prevention early diagnosis, chronic disease management, and other tools—tools which are delivered primarily through primary care.").

<sup>27</sup> *Accountable Care Organizations: Principles*; American Medical Group Association (May 28, 2010) [www.amga.org/AboutAMGA/ACO/principles\\_aco.asp](http://www.amga.org/AboutAMGA/ACO/principles_aco.asp).

<sup>28</sup> Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform (Sep. 7, 2009) [www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf](http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf).

<sup>29</sup> ACA, Pub. L. No. 111-148.

<sup>30</sup> Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, October 2009, [www.urban.org/uploadedpdf/411975\\_accountable\\_care\\_orgs.pdf](http://www.urban.org/uploadedpdf/411975_accountable_care_orgs.pdf)

<sup>31</sup> Stephen M. Shortell and Lawrence P. Casalino, *Accountable Care Systems for Comprehensive Health Care Reform*, Mar. 2007, [www.rwjf.org/files/research/accountablecaresystemsforcomprehensivehealthcarereform.pdf](http://www.rwjf.org/files/research/accountablecaresystemsforcomprehensivehealthcarereform.pdf)

other relationships with hospitals and health plans. Examples of these models would include the Mayo, Marshfield and Palo Alto Medical Clinics to name only a few. Perhaps due to its ability to deliver coordinated care to a defined group of patients, greater resources, and economies of scale, this model has advantages in caring for patients and episodes of illness over time, particularly in a bundled payment or capitated arrangement. However, its weaknesses may include size, bureaucracy, expense, and specialists/primary care dissent.

Hospital medical staff organizations (often referred to as the extended medical staff ACO model) utilize a hospital or health system's medical staff as the accountable physician component of the ACO, which gives the potential to manage chronic illnesses and acute episodes of hospitalizations. Downsides include the potential history of medical staff/hospital tension, legal obstacles to gainsharing, and the absence of financial incentives for physicians and hospitals to work together, as reflected in current payment mechanisms.

The PHO model can utilize existing PHOs put together in the United States, mostly in the 1990s. This model may offer the benefit of using an existing PHO structure and the possibility to manage care across the continuum of delivery. However, it does not necessarily involve all physicians on the medical staff but rather those that want to or the hospital chooses to have participate, which may help control costs but may lead to dissension among the medical staff, including potential challenges under state "any willing provider" and antitrust laws.

The independent practice organization (IPA) offers a possible structure for physicians who practice in smaller or more independent practices. Like an IPA, this model allows loosely organized collections of relatively small physician practices with strong leadership and governance and ample patient volume to establish an ACO. However, the looser affiliation may create antitrust challenges and/or make it difficult for the organization to achieve shared savings from coordinated care.

Last of all, the health plan-provider organization is a partnership between a health plan and a physician practice, giving greater access to disease management technologies, electronic technology, and financial resources. Kaiser-Permanente and Intermountain Health Plan are two well-known examples. However, this model is limited by the significant distrust that permeates most health plan-physician relationships.

These examples are just a few that we have seen and will see in months to come as participants adapt structures to meet their specific needs.

### **C. Who controls/leads?**

Another important issue for an ACO is who will provide leadership for the organization. The ACA requires that ACOs have a leadership and management structure for their clinical and administrative functions.<sup>32</sup> This leadership will have to be culled from and work with the often-present strained dynamic between physicians and hospitals. This interdependent relationship may be summed up best by the Kaiser Institute's description: "from the hospital's perspective, physicians exist to work with the hospital to achieve its goals. In contrast, from the physician's perspective, the hospital exists to help the physicians meet the goals for their patients and advance the physician's professional practice."<sup>33</sup> This issue can be difficult to resolve against a backdrop of mistrust and battles over control. Regardless, because one of the major goals of any

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<sup>32</sup> ACA, Publ. L. No. 111-148.

<sup>33</sup> Francis J. Crosson & Laura A. Tollen, *Partners In Health: How Physicians and Hospitals Can Be Accountable Together*, Chapter 3, p. 50 (Kaiser Institute, 2010). Francis J. Crosson & Laura A. Tollen, *Partners In Health: How Physicians and Hospitals Can Be Accountable Together*, Chapter 3, p. 50 (Kaiser Institute, 2010).  
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ACO is accountability of clinical care, physicians **must** take, and hospitals, if involved, **must** offer physicians a leadership role and active participation in the development and operation of the ACO. Hospitals contemplating ACOs should not get too far down the path of development without physician involvement and participation in the planning process. Nor should physicians wait for an invitation from the hospital to get involved. They need to be thinking about opportunities for their practices, how their practice might work in an ACO context, and where they might be best positioned in the changing health care market.

Although leadership and control decisions will also be unique to each situation, generally, shared governance is critical to building a successful integrated system. Generally, a governing board should (i) be able to provide diversity of experience and opinions, (ii) require individual responsibility and interactive discussions, and (iii) allow for efficient decision-making. To the extent that both hospitals and physicians are to participate in the governance of the ACO entity, the board should reflect a balanced constituency of participating provider groups and hospital(s). For those situations in which trust is a potential obstacle to collaboration and the ACO's success, strong physician leadership represented as a majority will be necessary to establish the trust necessary to promote and achieve the ACO's collaborative efforts. ACO leadership must recognize the importance of understanding all ACO constituents' needs and reconciling conflicting interests. The ACO's long term success is dependent upon collaboration among its participants to achieve its goals.

Finally, leadership, and particularly physician leadership, is a critical issue for ACOs, given their goal of accountability of care. In order to recognize this goal, the ACOs will be focused on developing clinical protocols and guidelines, gathering clinical data, establishing clinical performance indicators and measures, and building reporting mechanisms, all of which will require strong physician participation and leaders. Rather than allowing a few physicians to drive these efforts, the ACO should educate and vest as many participating physicians as feasible with an ownership interest in these deliverables to ensure the future success of the organization.

#### **D. Size**

An ACO will need to determine its optimal size and scope. An ACO must have the scale required by the ACA (e.g., the ACO must have a sufficient number of primary care physicians sufficient to treat at least 5,000 Medicare beneficiaries). In addition, ACO size may be dictated by the need to support the administrative and technological infrastructure to satisfy federal ACO performance requirements. The ACO will need to develop protocols, collect quality reporting information, establish mechanisms to monitor and coordinate utilization and ensure quality and efficiency of care, work with payers, and incentivize providers.<sup>34</sup>

#### **IV. Viability**

Not surprisingly, in light of these financial incentives for achieving quality measures, many industry players have recognized that quality is difficult, if not impossible, to achieve without involving all relevant health care providers. The result has been a number of collaborative activities between physicians and other providers, usually hospitals. Arguably, ACOs naturally lend themselves to physician-centric organizations since physicians' decisions regarding health care resource allocation make up a major portion of the overall health care costs and have the greatest potential for cost savings in the delivery of health care. To date, many of the ACOs in existence or underway are hospital-driven, generally due to capital, finance, organizational and personnel reasons, and possibly a desire by these hospitals for control in the event ACOs are truly successful in reducing costs associated with inpatient care by wellness and other preventive

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<sup>34</sup> Pub L. No. 1111-148, § 3022 (2010).

measures. This latter factor offers great potential for physicians to take the initiative and lead in these organizations.

Critics have made a number of arguments against the long-term viability of ACOs. These arguments include the fact that previous managed care attempts failed miserably because they were poorly executed and employers and patients preferred open panels managed by health insurers rather than closed panels managed by providers.<sup>35</sup> However, these arguments ignore the fact that the ACA's ACO concept involves a shared savings model that does not restrict patient choice or require providers to take financial risks. Others argue that the dynamic between hospitals and physicians will not be adequately incented by the shared savings payment model, particularly in which both parties often benefit from maximizing the volume of services they provide and, therefore, the revenue they receive.<sup>36</sup> Additionally, what incentive do the hospitals have to participate when an ultimately successful ACO will keep patients out of the hospital, meaning less charges and revenues for the hospital?<sup>37</sup> Regardless of the strength of these arguments, physicians certainly need to be well-positioned for future markets, and exploration of physician-driven ACOs may be one opportunity to take the lead.

Additional challenges include issues of control, money, and time investment.<sup>38</sup> Understandably, many physicians are concerned with hospital integration efforts (in the form of practice acquisition and employment) as a means to exert control over physician practices. While the possibility (and reality) of this abuse certainly exists, many hospitals are merely taking the time to position themselves in the marketplace, which has resulted in them taking the lead on the integration front. Physicians can avoid being supplanted in this process if they get involved in the ACO leadership early on and if both parties recognize the need for a collaborative effort.<sup>39</sup>

The significant financial investment required for an ACO's formation and operation requires deep pockets, significantly more so than is usually available to physician participants, which also explains why it has been more common to see hospitals taking the lead on the ACO front. CMS may have recognized the need to even the playing field. CMS has asked for specific input to the ACO regulations with a call for specific information on "financing mechanisms, and other systems that it might consider to address the issue of limited access to capital and other resources to fund shared savings activities for small practices."<sup>40</sup>

Of equal importance is the time commitment that formation and operation of an ACO will require of its participants. On the clinical side alone, the decision-making, analysis of current systems, and development of protocols, guidelines, and processes will require a substantial commitment of resources and time. In an environment where time is money and physicians are compensated for medical services they deliver, they may be reluctant to sacrifice this patient care

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<sup>35</sup> Jeff Goldsmith, *The Accountable Care Organization: Not Ready for Prime Time*, available at

<http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/>

<sup>36</sup> Marsha Gold, *Accountable Care Organizations: Will They Deliver?*, Mathematical Policy Research, Inc. MCPP Healthcare Consulting (May 14, 2010),

[www.mathematica-mpr.com/publications/pdfs/health/account\\_care\\_orgs\\_brief.pdf](http://www.mathematica-mpr.com/publications/pdfs/health/account_care_orgs_brief.pdf)

<sup>37</sup> Joe Carlson, *ACOs: A mystery of biblical proportion*, ModernHealthCare.com (Aug. 9, 2010),

[www.modernhealthcare.com/article/20100809/NEWS/308099959#](http://www.modernhealthcare.com/article/20100809/NEWS/308099959#).

<sup>38</sup> *Supra* at endnote 28.

<sup>39</sup> For a discussion on physician-controlled ACOs, see Robert Kocher, M.D. and Nikhil R. Sahni, B.S., *Physicians versus Hospitals as Leaders of Accountable Care Organizations*, The New England Journal of Medicine—Health Policy and Reform (Nov. 10, 2010) <http://healthpolicyandreform.nejm.org>.

<sup>40</sup> See Recordings and Transcripts, Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback and Civil Monetary Penalty (CMP) Laws, [www.cms.gov/PhysicianFeeSched/downloads/10-5-10ACO-WorkshopPMSessionTranscript.pdf](http://www.cms.gov/PhysicianFeeSched/downloads/10-5-10ACO-WorkshopPMSessionTranscript.pdf).

time to work on an ACO. However, if they do not make time and are not supported to make time, they may be left out of some of the models of health care for the future.

## Chapter 2: Accountable care organization governance issues

**Stephen M. Fatum and Robert M. Martin**

Physicians considering whether to join or form accountable care organizations (ACOs) need to pay close attention to how participants in the ACO will exercise power and divide money. The governing body and bylaws of the ACO should address these matters.

This chapter discusses these issues within the specific context of ACOs that are formed through a physician-hospital partnership, since that is where much of the policy and legal discussions outside of organized medicine currently appear to be focused. Accordingly, this chapter focuses on ways in which ACO governance authority may be allocated between representatives of physicians and lay entities like hospitals when physicians and those entities partner to form and operate an ACO. Notwithstanding this focus, nothing in this chapter is intended to suggest that physicians must partner with a hospital or other non-physician entity when creating an ACO. Physicians are free to form ACOs with organizations other than hospitals and may create ACOs that are entirely physician-owned and operated. For example, an independent practice association (IPA) that obtains the requisite capital from potential lenders or grantors such as banks or the Center of Medicare Innovation may assume a primary leadership role in ACO creation and operation without the necessity of partnering with a hospital or other lay entity. Nevertheless, much of the information in this chapter concerning the governance issues that need to be considered when developing an ACO will be applicable not just in physician-hospital contexts, but whenever physicians collaborate with other entities to form an ACO.

Organizations such as fully integrated medical groups or physician-only networks with primary care physicians taking care of at least 5,000 Medicare beneficiaries will be eligible to be designated as a qualified ACO without any hospital ownership of the ACO or any hospital control over the ACO's governing body (e.g., no right to appoint a member of the ACO's board). In this type of model, the ACO would enter into agreements with hospital(s) whereby those hospitals would provide hospital services to the ACO's Medicare beneficiaries as specified in those contracts.

Nonetheless, the assumption in the industry is that many ACOs will be structured and operated as joint ventures with physicians and hospitals working collaboratively at the governance level. This assumption is based upon the health care industry's past experience with physician hospital organizations (PHOs), the projected capital requirements needed to fund investment in information systems and information technology to be competitive, and the enlightened self-interest of hospitals to align their financial interests with physicians even though they may receive little, if any, financial investment from the physicians. There appears to be little dispute that collaboration will be critical to the success of any ACO committed to improving the quality

of care and reducing total costs. Some believe that a joint venture offers the best foundation for such collaboration.

Many consultants and legal advisors for hospitals are promoting an ACO model whereby the ACO operates as a wholly-owned affiliate of the hospital. In this model, hospitals intend to share some decision-making authority with physicians. This model may offer hospitals tax benefits and more flexibility with respect to how they may transfer funds to the ACO. Legal requirements, including those applicable to tax-exempt organizations under the Internal Revenue Code which apply to the vast majority of hospitals in the country, determine the extent of this flexibility, the tax benefits available and how much decision-making authority can be shared with physicians. The challenge with such a model is whether it will maximize physician engagement and produce the best possible outcome for the community.

Even though ACOs may be viewed as a new type of venture, it is reasonable for physician and hospital leaders to believe that ACOs have much in common with PHOs that were prevalent in the 1980s and 1990s. Historically, PHOs were joint ventures that assumed financial risk for the care of patients. PHOs entered into agreements with managed care organizations (e.g., health maintenance organizations [HMOs]), which compensated physicians and hospitals for their services in a number of different ways, including discounted fee schedules and capitation. “Capitation” refers to a fixed payment per member per month for covered services without regard to actual costs incurred by the providers for such member. Capitation placed PHOs at tremendous financial risk. Unlike PHOs, ACOs, at least initially, will not receive capitation from Medicare as a payer. Thus, ACOs will bear no financial downside risk for the cost of services rendered to Medicare beneficiaries. This one distinction between PHOs and ACOs is enormous from a financial perspective. Nonetheless, PHOs and ACOs share fundamentally the same goal of ensuring patients receive the right care at the right time by the right provider in the right setting to produce the best possible outcome for patients day after day. Given the need for hospital and physician collaboration at the governance level to achieve this shared goal, ACOs would do well to learn from the experiences of PHOs and their successes and failures at the governing body level.

### **Key concepts**

The term “governing body” refers to a designated group of individuals ultimately responsible for setting the ACO’s vision, approving its strategic and business plans, overseeing the implementation of the plans, approving annual budgets, monitoring financial and operational performance of the ACO, and—perhaps most importantly—holding its chief executive officer and his/her management team accountable for the performance of the ACO. If the ACO is a corporation, whether a for-profit with shareholders or not-for-profit with members, the governing body is almost always referred to as the “board of directors.” If the ACO is a limited liability company or partnership, then another name might be used for the governing body, such as “management committee.” For purposes of this chapter, an ACO will be regarded as a corporation, and its governing body, without regard to the form of legal entity selected, will be referred to as the “Governing Board” or “Board.”

The term “bylaws” refers to a document approved by the Governing Board that addresses a wide range of fundamental issues related to how a corporation conducts its affairs. Bylaws are analogous to the official rules of a game that players can appeal to when there is a question about proper process and who has authority to do what. Bylaws address such matters as the size of the board, qualifications of individuals to serve as directors, authority granted to officers and votes needed before an action is deemed binding upon the business. Bylaws must comply with the applicable law of the state in which the ACO is organized. Most state laws grant very broad

discretion to the drafters of the bylaws to determine what procedures should be followed, what checks and balances should be adopted, and how much authority should be granted owners, directors, officers and committees. The bylaws are not final until approved in a manner specified in the bylaws, which is usually by vote of at least a majority of the Governing Board. The Patient Protection and Affordable Care Act (ACA) neither establishes standards for bylaws nor advice on or how to structure the governance function of ACOs.

While generic bylaws and other governance documents can work for many business enterprises, they are unwise for an ACO. Ideally, the Governing Board of the ACO must be structured to help achieve the business purposes of the ACO, promote the best interest of the organization as a whole, and balance competing interests of critical internal stakeholders such as primary care physicians, specialty care physicians, and, as applicable, hospitals and health systems. At a very practical level, however, successful ACOs will need to earn the buy-in and trust of these key stakeholders. Buy-in is more likely to be accomplished if leaders invest time and money into the design of a governing structure that addresses the unique financial, market, legal, operational, strategic and political considerations of the ACO, as well as concerns and fears of the ACO's critical stakeholders.

The temptation will be for stakeholders and others with a vested self-interest in the performance of the ACO to exert as much influence as possible on the direction and function of the ACO. Some of these efforts will be obvious, and yet other efforts will be subtle. Sophisticated legal, financial and business advisors with potential biases and conflicts of interest may tilt a conversation in one direction over another by promoting, implicitly or explicitly, one option over another, minimizing the risk of a particular option under consideration by the Governing Board, or omitting entirely the discussion of viable options. Sometimes people argue for generic bylaws to save legal costs when they believe the generic bylaws will give them more influence than if the bylaws were tailored to the unique needs of each particular ACO after thoughtful dialogue about issues important to all stakeholders. Obtaining competent and experienced independent counsel who is not more loyal to one stakeholder over another may be critical in obtaining objective advice on structuring the governance function to address all the needs of the ACO. While it is unfortunate that some leaders may be promoting their own self-interests at the expense of the best interests of the whole organization, it would be even more unfortunate if other leaders did not acknowledge this risk, find ways to manage it, and then take prompt action to communicate decisively and unequivocally that self-promotion at the expense of the good of the whole organization will not be tolerated. Attending meetings unprepared, approving Governing Board resolutions not properly explained or understood, and not asking good questions of the right people at the right time would create the type of environment that would invite the type of behavior that will undermine the goal of collaboration of all critical stakeholders.

No one disputes that Governing Board members, including physician board members, will need to be engaged in the business and goals of the ACO for it to be successful. Some governance structures promote engagement more than other structures by the way they select, develop and train future leaders of the organization. These leaders, like good coaches, make all the difference. Good coaches expect the best of their players, set clear and high standards, and hold their players accountable for their performance. Board members should do the same for their management team and their providers. Good coaches command respect not only by virtue of their title but their vision, character and commitment to excellence. Board members should do the same. Good coaches walk the talk not only on but also off the field. Leaders of ACOs should walk the talk not only in the boardroom but also in the parking lot. Good coaches expect their players to put on their A-game on the field, and their players live up to their expectations. Board members should

expect the same of their management team and providers, and they will live up to their expectations.

No area of decision-making better illustrates the need for a strong governing structure with actual and perceived integrity than the subject of how money will be divided by and among hospital(s), different physician specialties and others involved in providing care to patients (sometimes collectively referred to as providers). This is particularly true for the governance of ACOs because the federal government will not direct how savings should be shared. Governing Boards will have very few good precedents, if any, for fairly sharing the revenue derived from reducing expenses for the Medicare program in the manner proposed by the ACA.

Arguably, the job of the board of a PHO to share revenues fairly was easier when the reimbursement was based upon a discounted fee schedule. This system of reimbursement still rewarded productivity as measured by billed charges or Relative Value Units (RVUs). Even in the case of capitation models, when the boards rewarded providers whose costs were below budget for a defined population, the metrics for reimbursement were frequently based upon actual or projected units of service or, in the alternative, shared pro rata with little or no connection to value created.

In contrast, under the ACA, revenue for the ACO will be generated by delivering the same or higher level of care for less total costs per assigned beneficiary than a national average of peers. Ideally, there will be savings to share. As a practical matter, many ACOs may have very little or no savings to share with their providers. Assuming there are meaningful savings, then one would hope they will be shared primarily with those responsible for creating the value. Unfortunately, providers will have difficulty demonstrating their role in creating the savings. Some providers will overstate their contributions and have little evidence to back up their beliefs. The Governing Board will need to address the claims of the providers in a manner that preserves credibility and long-term viability of the ACO, even when the Board itself may not know or be able to demonstrate with sufficient precision how to fairly distribute the revenue generated from such savings.

The governance structure and bylaws of the ACO should build in sufficient flexibility to allow the ACO to evolve and respond to changes in the marketplace and government reimbursement. Commercial payers may want to explore alternative payment methods. More employers may want to engage in direct contracts to manage certain types of diseases. The government may be less interested in shared payments and more interested in bundled payments. An ACO focused on creating value for payers should be able to adapt to these types of changes.

Hospitals and physicians who suffer the most financially from the changes championed by the ACO leadership will likely put pressure on the Governing Board to approve an ACO compensation plan that preserves the status quo by protecting those hospitals and physicians from big drops in income. This pressure will be real and yet will need to be managed to be fair to all the stakeholders who made decisions, changed behaviors, took risks and created value for Medicare beneficiaries and Medicare as a payer.

Given the ACO payment methodology of sharing cost savings, providers will be more dependent on each other to receive any savings from participation in the ACO. In particular, providers who create cost savings may receive nothing for their efforts if other providers in the same ACO add costs for the care of their patients. As a consequence, there is a strong likelihood that some providers may point fingers at each other if some providers change their behavior to adapt to accountable care, and the other providers choose not to change their behaviors. For example, some physicians may adopt evidence-based, best practices for their specialty, and other

physicians may act as though evidence-based medicine is appropriate for others but not them. Similarly, hospital leadership may resist aggressive efforts to avoid hospitalizations or move services from the hospital outpatient department to less expensive outpatient facilities.

No one can predict with confidence how the delivery of health care in the United States will evolve over time, but given the magnitude of the economic pressure Medicare and Medicaid place on national and state budgets, there can be little doubt that there will continue to be major changes in reimbursement to control costs as best as possible. Organizations with governance structures that promote and empower leaders to anticipate and prepare for the problems of the future will be much more likely to survive and thrive in the future. There are some who believe that the way to be competitive in the future will be to continue to do the same things they have always done to be successful but instead simply do them faster or more efficiently. Others would say that this mindset is analogous to the businesses that made horse buggies and whips when automobiles were first manufactured. If you simply do what you have already done and do not adapt to the changes in the marketplace, then you will go out of business. For example, if the manufacturers of horse and buggies had defined themselves as being in the business of transportation as opposed to merely business of horse and buggies, they may have been able to adapt and survive. Instead they remained fixated on what they knew and not what the market demanded. Similarly, there are those who believe physicians and hospitals may no longer be in the business of just treating people who are ill on an encounter-by-encounter basis but rather in the business of keeping individuals and communities healthy. Leaders of the ACO will need to make the difficult distinction for its providers between what is a temporary change (such as eight track tapes in the 70s) and what is permanent change (such as the Internet). They will also need to make strategic decisions about what to change, how to change, when to change and how much to change. The governing structure needs to attract and support leaders who are best prepared and most committed to do this difficult work on behalf of the providers they represent.

The burden will be on the members of the board to use their best judgment to assess how to motivate and reward providers with incentives to better manage the care of Medicare beneficiaries. Most providers will be very wary of changing their behavior to lower total costs for Medicare if they know they will receive less reimbursement for their services with only a theoretical possibility of payment for the small share of savings, if any, generated for the Medicare program by the actions of the ACO and its providers.

Due to these and other pressures, it will be imperative for the parties to create a governing structure that is as balanced, fair, representative and independent as possible when addressing these vexing issues in a manner that is politically sensitive, financially prudent and responsibly transparent. Since the rank and file providers will have little or no knowledge of the full deliberation that occurs in meetings of the Board, it will be even more important to design a structure that builds confidence by the stakeholders that deliberations will be robust, all concerns will be considered and decisions will be made for the best interest of high quality patient care and the best interest of the organization as a whole and over time. The structure and process directed by the bylaws will also need to address the preconceptions and biases of participating providers as a matter of substance as well as appearance.

If critical stakeholders do not place their trust in the integrity of the governing structure and the process for making decisions, then the organization will likely fail when it invariably hits the bumps in the road associated with any new enterprise. Well-designed bylaws are analogous to the Constitution. They anticipate human nature and therefore contain checks and balances on the use of power and offer stability and consistency even during times of difficulty. They both are intended to inspire trust in the deliberative process. Providers who do not have such trust will likely vote with their feet and withdraw from future ACO participation if they feel that decisions

promote the agenda of one stakeholder over another or the Governing Board is not advancing an agenda in a meaningful manner that promotes the goals of creating value, namely higher quality care, lower costs for payers and improved levels of patient services. Perhaps even more troubling will be physicians who respond to what they perceive as biased decisions by participating in the process in name only and refusing to engage in any meaningful manner in the important work of driving desirable change that will improve outcomes for patient care.

Lawyers and their clients have many tools available to help hospitals and physicians achieve their goals of collaboration while also addressing practical and financial concerns in a legally compliant manner. This chapter will focus on three key tools: reserve powers, bylaws and management agreements. The chapter will not address fiduciary duties (such as the duty of care or duty of loyalty) or best practices for Governing Boards (such as the importance of constructive partnerships between Governing Boards and their chief executive officers and the role of boards in offering strategic oversight without engaging in management or day-to-day operations).

## **I. Reserve powers**

Issues of governance are rarely addressed in a vacuum. In the vast majority of times, an overarching concern relates to the money investment necessary to capitalize and operate an enterprise, especially during the first few years. The questions frequently relate to: how much money is needed; what the options to finance the enterprise are; who has the money to invest; who is willing to take the risk that they may lose their entire investment; who is prepared to wait months or years for a return on their investment; and who will have the deep pockets in the future when the organization needs to invest in the latest advancements in information systems/information technology. Historically, individual physicians are reluctant to make significant capital investments. As a consequence, hospitals (and when applicable larger medical groups) often find themselves stepping into the void and contributing either all the capital or most of the capital.

Conventional wisdom might suggest that the need for capital will steer physicians to lean more on their hospital partners. However, physicians would be well served to evaluate other options because it may be that the needs for capital can be satisfied in ways other than through upfront capital investments. For example, if the ACO is a not-for-profit, the physician leadership may require a minimum initiation fee such as \$1,000 from each physician member and then a relatively modest annual dues fee from each of its physician members. The hospital partner could then be asked to match their contributions. Capital needs in excess of this revenue might be financed through management agreements discussed below and long term equipment leases. Some ACOs might be well served to think of alternative revenue streams unrelated to Medicare that could produce a profit to be used to finance the cost of operating the ACO. For example, incentive payments for investment in health information technology are available pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act and may deserve consideration. For more information on the HITECH Act incentives, see the chapter entitled **“Guidance on EHR incentive payments.”**

Everyone seems to recognize that physician “buy-in” will be a critical factor for the ACO to be successful. To receive the benefit of physician “buy-in,” hospitals may be willing to allow physicians to serve on the Governing Body in a manner disproportionate to their capital investment. In most hospital and physician ventures, the board is composed of equal numbers of representatives of hospitals and physicians even when the hospital contributes all or most of the capital. These physician board members exercise the same rights and duties as all the other directors.

As much as hospital executives may desire physician leaders to serve on the Board of the ACO, even one that is wholly-owned by the hospital, these executives face a number of financial and legal considerations that limit their ability to cede control disproportionate to physician investment.

For those ACOs in which the physicians will contribute less capital than their hospital partners, the most common way for the hospital partner to share control with physicians is for the Board of the ACO to grant certain reserve powers to the board of directors of the hospital/health system providing the funds. These reserve powers can achieve many goals, including protecting the value of the hospital's investment, engaging physicians in the deliberative decision-making process in a meaningful manner, striking a delicate balance between competing priorities and addressing compliance concerns with various laws related to tax exempt organizations and referral relationships between physicians and the hospitals. However, the functions of the Governing Board of the ACO and its bylaws do not change. Specifically, matters still require deliberations by the ACO's Board and approval in accordance with its bylaws. What is different is that the ACO Board would no longer have the final say on all matters. Instead, certain expressly stated actions of the Governing Board of the ACO will not be final until the hospital with the reserve powers approves the action.

There is no "one size that fits all" when it comes to reserve powers. They are crafted and negotiated based upon a number of unique circumstances. Topics sometimes covered by reserve powers include:

- Approval of amendments to the articles of incorporation or bylaws;
- Approval of mergers and acquisitions;
- Approval of capital and operating budgets;
- Approval of incurrence of debt; and
- Approval of non-budgeted expenses above certain thresholds.

There are many important nuances to be aware of when negotiating and drafting reserve powers. For example, there is the question of who speaks for the hospital: the CEO of the hospital or the board of the hospital. One might think that the CEO and board for all practical purposes are one in the same, but those who are more politically savvy will recognize the distinction as critical in how decisions are made. In another example, a hospital may want a reserve power that grants the hospital board the power to approve the appointment of the president of the ACO, and the ACO Board may insist on the right to have the authority to remove the ACO president without approval of the hospital's board. While reserve powers usually result in the sharing of power in a few key areas, it is possible that some drafters without proper oversight may craft reserve powers in such a manner as to grant the hospital not only the authority to approve or disapprove an action approved by the ACO Board but also the authority of the hospital to initiate an action unilaterally in certain circumstances without approval by the ACO's Board. The differences between the two approaches and the implications for the operation of the ACO would be profound.

Power is a funny thing. The presence of a person or entity with power affects the dialogue and recommendations about how to proceed even without the power being exercised. An analogy would be the flow of traffic. Cars slow down when drivers see policemen on the road. Policemen do not have to put on their sirens or pull people over to affect the speed of traffic. Drivers know better than to test a police officer by going in excess of the speed limit. They modify their behavior voluntarily. In a similar manner, the board of an organization that is a hospital affiliate

that has granted reserve powers to the hospital rarely takes actions the hospital affiliate's board believes will not pass the hospital board. The mere presence of hospital reserve powers, therefore, becomes a deterrent to actions that the hospital affiliate might consider taking but that the hospital board would likely find objectionable, without the hospital board ever having to take a position that might be viewed as controversial or confrontational. From the other perspective, for political and practical reasons, a typical hospital board will almost certainly accept the action of an ACO's Board unless the hospital board believes the ACO Board's actions were truly objectionable. Most hospital boards with reserve powers give the benefit of the doubt to their affiliate boards and defer to the greater knowledge of their affiliates' board members on any given subject that is of interest to them.

The net result is that reserve powers are an effective way for hospitals and physicians to align their goals in a legally compliant manner.

- The hospital can contribute most, if not all, the capital.
- Physicians can engage in positions of power.
- Hospitals can protect their charitable assets that are used to make investment.
- Hospitals can comply with various regulatory laws, including the Internal Revenue Service's requirements for tax-exempt organizations.

## **II. Bylaws**

The bylaws play a very important role in building trust between the physicians and hospital(s). A very good way to build trust is to acknowledge conflicts of interest and build into the bylaws structure different types of checks and balances on how power is exercised. The bylaws will not eliminate economic self-interest and historical patterns of competition, but if they are designed properly, they will promote thinking about the best interest of the entire organization and its overall mission. The bylaws can also reduce the risk of one constituent gaining too much power at the expense of other important constituents. A well drafted set of bylaws for an ACO will address the following types of questions.

### **1. What can be done to ensure that the ACO's Board is fairly representative of critical stakeholders?**

The ACO's bylaws can be drafted in such a manner as to ensure appropriate representation of key stakeholders. For example, the bylaws might require half the members of the Board to be physicians. The bylaws might also require that half of the physicians must be primary care physicians, and the other half must be specialists. In its proposed ACO regulations, published by the Centers for Medicare and Medicaid Services (CMS) in April 2011, CMS stated that 75 percent of the ACO's Board must be selected by the ACO's providers. Further, and perhaps with a lack of clarity that hopefully will be provided by CMS its final ACO rule, each ACO participant must choose an appropriate Board representative from within its organization, and each ACO participant must have appropriate proportionate control over ACO decision making.\*

The bylaws will also address how the directors are selected and whether there are any special eligibility requirements to assure fair representation. For political and financial reasons, the bylaws may designate certain Board seats for representatives of groups identified by name or by other defining characteristics (e.g., size of the represented group). The bylaws may also provide

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\* 76 Fed. Reg. 19528 (April 7, 2011) available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=K1skta/1/2/0&WAISaction=retrieve>

for a nominating committee that screens candidates for the ACO's Board. A nominating committee can be a good way to make sure that individuals who might be disruptive are never elected. The risk is that those who control the nominating committee can use their power to block qualified individuals who may be viewed as threats to the prevailing thinking of the organization.

There is a strong bias by hospital and physician leaders to select physicians to represent the perspective of physicians. Physicians, however, may be well served to consider non-physicians to represent them. The issues should be: who will be the most effective leader who can articulate the concerns of physicians in a compelling manner? Related questions should include the following:

1. Who has the trust of the physicians?
2. Who has good business experience?
3. Who has the time to prepare for important meetings?
4. Who knows how to work the politics of an organization to get things done?

For example, it may make more sense for physicians to consider electing the chief executive officer of a respected medical group to serve on the ACO Board in a seat elected by physicians.

The answer to these questions often drives the answer to the question about how many directors should serve on the ACO's Board. Experts on the subject of effective board governance often recommend smaller boards of between five and nine directors. When boards get much larger than this range, in order to be as representative as possible of their core constituents, experts frequently recommend the creation of executive committees that meet more often than the board and engage in much more in-depth discussion of issues important to the organization.

## **2. What can be done to ensure that the ACO's Board's voting is truly representative of the will of all the critical stakeholders?**

Ordinarily, a matter approved by the majority of all the directors is binding upon an organization. For an ACO, however, it may be better to approve bylaws that authorize class voting. Most PHOs have one class of directors representing the physicians and another class representing the hospital. For an action to be binding upon the PHO, a majority of each class of directors has to approve the action. This effectively gives each class the opportunity to block an action it opposed. Nothing would preclude the bylaws from specifying that there are more than two classes of directors if that would help achieve strategic objectives.

## **3. What can be done to give maximum protection to the critical stakeholders that their voices will be heard?**

Sometimes a majority of votes, even a majority of a particular class, is not sufficient protection against unintended consequences. Bylaws can identify matters so important to critical stakeholders that they require what is called a supermajority vote for approval.

The term "supermajority" means that more than 50 percent of the directors, or class of directors, must approve an action before it is binding upon an organization. Supermajority frequently refers to 60 percent, 66 <sup>2</sup>/<sub>3</sub> percent or 75 percent of all the directors on the board or all the directors within each class of directors on the board.

Supermajority voting provisions need to be analyzed carefully in the context of the size of the board or the classes of directors. These provisions can be written in such a manner so that one dissident director can hold the entire board hostage to his or her personal agenda. To illustrate,

let's assume the board has eight directors with two classes of four directors each. If the bylaws require a supermajority vote of  $\frac{3}{4}$  of the directors in each class, then three of the four directors in a class could approve an action. This may seem reasonable, but what if the size of the board were changed to six directors with two classes of three directors? A 75 percent vote would mean that all six of the directors would have to agree to an action before it could pass. This is because 75 percent of three directors is more than two of the three directors. The net effect would be that any one director could vote "No" to block an initiative that the five other directors supported. The point of this illustration is to demonstrate the importance of identifying hypothetical voting combinations based upon size of board and supermajority voting requirements that anticipate and address potential problems before they occur.

#### **4. How does an organization make sure that its best people serve as its directors?**

To attract the best people to serve, the board needs to: (i) have real power to influence the direction of the organization as opposed to being a rubber stamp at meetings in which the board has little or no purpose or power; (ii) compensate individuals for their time commitment with a fair stipend for meeting preparation and attendance; and (iii) solicit, cultivate and train (send for training) leaders who reinforce a culture of inquiry and respect for thoughtful opinions, even those contrary to the view of the majority.

#### **5. How does the board know that the information it receives is accurate, complete, timely and relevant to its deliberations?**

The management team is responsible for the information supplied the board. The board needs to hold the management team accountable. This is best done by board members asking probing questions in a thoughtful and respectful manner. When the answers are not satisfactory, then the board members have several options, including hiring a third party to validate information.

The integrity of the decision-making process is reinforced if the board properly fulfills its role by setting high expectations for the management team and holding it accountable. For example, the board can ask its management team to communicate with the board in the same manner that physicians help patients make informed decisions about their health care by presenting options, reviewing the risks and benefits of each option, and making sure that the patient's questions are answered to his or her satisfaction. The bylaws can address the expectations of the chief executive officer and board members in the description of the roles and responsibilities of officers and directors.

#### **6. Why is a quorum important?**

A quorum refers to the minimum number of directors needed to start and continue a meeting of the board. When there is no quorum, there can be no voting that is binding. State statutes will provide a minimum number of directors needed for a quorum. Most bylaws require a quorum that is more than the minimum set forth in state statutes. Generally speaking, having a quorum is not a major point of contention, especially if voting requires the approval of more directors than the state law minimum for a quorum. A quorum is important because it ensures that there will be a sufficient number of directors present to participate in and benefit from the discussion of matters important to the organization before voting.

Generic bylaws provide for a quorum of the board if a majority of directors are present at a meeting. Generic bylaws would state that a majority of votes where a quorum is present would be binding on the organization. That sounds fine until one thinks through the hypotheticals. If a board consisted of nine directors, then a quorum would consist of five directors. A majority of five would be three. So three directors in a generic set of bylaws could vote to approve an action

binding upon the organization as a whole. Usually bylaws with class voting and/or supermajority voting requirements eliminate the risk of a few directors having too much power, as illustrated in this example.

## **7. How may the bylaws be amended?**

As hard as individuals may struggle to create the right set of bylaws, all the work would be for naught if the bylaws could be amended relatively easily and quickly. When there are power struggles, one side or another may try to amend the bylaws to fit a particular agenda or vision for the organization. The best way to protect against this risk is to require a supermajority vote of directors by class as well as a requirement that all changes be shared in writing at least several days in advance of board meetings to avoid last-minute surprises. Some organizations' bylaws may even require that changes in the bylaws have the approval of shareholders of a for-profit corporation, or members of a not-for-profit corporation, as an added level of protection against the unpredictable. To the extent the hospital board has reserve powers applicable to bylaws amendments, the implications of those powers will also need to be carefully considered.

The temptation for many physicians is to believe that bylaws are written in stone. They are not. Bylaws are intended to assist an organization function in a fair, consistent and responsible manner to achieve a shared vision. State laws grant each business the flexibility to tailor its bylaws to meet its unique needs.

## **8. What can be done to improve transparency in a responsible manner?**

Experience demonstrates the value of transparency to hold accountable not only providers but also their leaders. At the governance level, transparency can be achieved by the bylaws addressing subjects such as how often will there be meetings with physician members, clarifying who has authority to set agendas for these physician meetings, specifying what information must be shared and what information may be shared with physician members, and who has authority to request and receive reports summarizing key indicators of ACO performance. Physicians must have a clear understanding regarding when, and how, information will be shared. Some bylaws may advance the benefits of transparency by requiring boards to post minutes in a manner that members can easily access if they wish.

## **III. Management agreements**

One of the most critical decisions the Board of an ACO will address is whether to employ its own management team or contract with another organization to provide this service (sometimes referred to as "outsourcing"). A potential benefit for an ACO outsourcing the management function is the ability to recruit and retain higher-quality and more experienced staff to run the ACO than would otherwise be available. Some may see a benefit in avoiding the headaches often associated with hiring and managing one's own staff when that burden can be off-loaded to another organization. Another benefit is that the physicians may need to invest less capital to get the enterprise started if the management agreement requires the management company to provide the ACO with capital assets that are amortized over time.

If the ACO wants to consider outsourcing, then it next needs to address whether to work with an independent management company or one owned by its hospital partner. Frequently, hospitals will want a physician-hospital joint venture to use its hospital-owned management company. A hospital is legally permitted to offer these services directly or through a wholly-owned subsidiary, but the hospital must be able to demonstrate that transactions between the management company and ACO are fair market value. If the ACO is a wholly-owned hospital

affiliate, the hospital may be able to justify an arrangement that does not break even if the ACO can demonstrate that the arrangement improves the health of the community.

An independent management company will ordinarily charge the maximum amount it believes the ACO would be willing to pay. Ordinarily joint ventures find hospital management companies to be less costly because even within the range of fair market value, hospitals are likely to be more flexible in working with the ACO around issues related to cash flow (such as paying at the end of the month as opposed to the first of the month) than are for-profit management companies. Hospitals will also be less likely to measure profit in terms of maximizing financial return at the management company level and more likely to find a return on their investment in the performance of the ACO, the level of satisfaction of the physicians and most importantly the effectiveness of the ACO in carrying out its mission to improve the health of the community it serves.

From a physician's perspective, the issue of a hospital-owned management function will probably be the price physicians will pay for partnering with a hospital to create an ACO. The real price may not be measured in terms of greater or lower management fees but rather the quality, independence and accountability of the management function.

The ability of a board to function effectively is dependent upon the accuracy, relevancy, timeliness, accessibility and completeness of the information that the management team presents to the board to facilitate discussion and evaluate management recommendations. The management agreement can be a subtle but very effective way for a hospital to assert substantial influence over an ACO through its continual flow of information. There is an inherent conflict of interest that has to be managed with respect to whether the leaders of a hospital-owned management company feel more accountability to (i) their client (i.e., the ACO) or (ii) the hospital. This is particularly true in the context of an ACO in which a significant portion of savings could be physician pre-hospitalization interventions and alternative therapies that avoid expensive hospitalizations as well as a shift away from hospital outpatient services to less costly alternatives.

These types of issues can usually be managed successfully if the parties anticipate them and use a certain degree of creativity and innovation in the drafting of the management agreement to address these real concerns. Denying or ignoring these potential conflicts can be a source of great tension.

For example, a critical question is who has the authority to hire, fire, evaluate and set compensation and bonuses for the person acting as the CEO of the ACO, even if the CEO is employed by the hospital management company. This authority could be vested in the hospital or the Board of the ACO. For many organizations, this single distinction could lead to very different results for the ACO. The ultimate tool to assure the ACO that the management company and its employees will put the interest of the ACO first would be for physicians to insist on the right to terminate the management agreement with or without cause at any time with a negotiated number of days of notice. Another approach would be for the ACO to have the option to directly employ the key management employees.

Some business owners will say one should never hire someone you cannot fire. If the management company is independent of the hospital, the presumption is that the ACO would exercise its rights to terminate the management agreement for poor performance. The same may not be true if the management company is owned by the hospital. If the hospital-owned management company fails to meet the ACO's expectations, it may be difficult for the physicians and the hospital to have an objective conversation about the management company's

performance. Note that if there are two classes of directors and each class must approve an action to terminate the management agreement, the Board could not terminate the hospital as the management company without the approval of the hospital representatives on the board of the ACO. For this reason, the physicians may want to write into the management agreement a provision stating that the agreement can be terminated simply by a supermajority of the ACO's directors who were selected by the physicians, without regard to the voting of the representatives of the hospitals.

Physicians would be well served to develop contingency plans in anticipation of problems in how the management company may function. For example, the ACO may choose initially to outsource the management function but build in an option to terminate the management agreement upon occurrence of certain conditions. If the ACO is not satisfied, then the ACO could assemble its own management team with mostly, if not entirely, new individuals.

#### **IV. Conclusion**

The challenges facing ACOs will be enormous. Physician and hospital leaders of the ACO will need to articulate a compelling case for where the ACO is going and why; build organizational momentum around a new operational model; transform their cultures to be grounded in collaboration in every aspect of the ACO's operations; and develop financial models that lead to a path of viability. Given the enormous conflict between rewards for productivity and rewards for managing total costs, the creation of such a financial pathway to success will be treacherous. Next, leaders will be challenged with assembling a delivery system that is committed to achieving best outcomes through the use of best practices and evidence-based medicine.

The starting point for an ACO to even have a chance to tackle these challenges will be for hospital and physician leaders to develop a business model grounded in the spirit of physician and hospital collaboration.

The source and model of collaboration needs to start at the very top of the ACO, namely, its Governing Board. These leaders have an opportunity to demonstrate collaboration in how they structure the ACO, how they agree power should be exercised, and how they plan to share potential revenue from Medicare cost savings. If done with care, respect for the critical stakeholders and attention to important details, physicians will feel engaged, empowered and accountable. If done with appropriate dialogue and informed decision-making, the ACO will gain the trust of all its critical stakeholders. The culture will not be one of "top down" or "own and control" but rather a combination of "bottom up" culture of personal responsibility and continuous improvement and "top-down" culture of shared leadership, strategic thinking and accountability.

There is no one model for physician/hospital governance that will work equally well for all ACOs. And yet there are common questions that physician and hospital leaders should take into consideration when designing the governing structure and bylaws that will help the ACO be successful over the long term.

- Will physicians "buy in" to the model?
- Will the model inspire trust and confidence in the ACO leadership team?
- Will there be appropriate accountability for ACO leaders?
- Will the ACO be transparent?

- Does the structure strike the right balance between sufficient checks and balances on the use of power and the authority to make decisive strategic decisions when the conditions warrant such action?
- Is there enough power vested in the Governing Board to make the difficult decisions (e.g. terminating providers who do not comply with ACO standards developed by peers or terminating the hospital's management company for poor performance) needed to achieve the overall mission of creating value for patients through higher quality care, lower costs and better service?
- Will the model attract and retain the best and brightest leaders within the ACO to serve as members of the Governing Board?
- Will all critical stakeholders feel like their voice will be heard before decisions are made?
- Will high quality executives want to work for the ACO?
- Does the model anticipate and manage potential conflicts of interest?
- Does the model promote excellent communication at all levels of the ACO?
- Will the ACO's structure lead to a cultural transformation needed to respond to market changes in a competitive manner?
- Is the foundation of the ACO governing structure designed in such a manner that the ACO can (i) evolve over time, (ii) respond competitively to new forms of reimbursement beyond just shared savings and (iii) attract commercial payers as opposed to Medicare alone?

To paraphrase President Harry Truman, whether an ACO succeeds or fails, the buck stops with the Governing Board of the ACO. Physician and hospital leaders should acknowledge this responsibility and devote appropriate attention to design, and redesign over time, the governance model and bylaws that will help them best address these common questions.

## Chapter 3: Partnering with hospitals to create an accountable care organization

Elias Matsakis

There are many opportunities for physicians and hospitals to affiliate and clinically integrate so as to enable both parties to improve their service delivery and positively impact their financial viability. The accountable care organization (ACO) concept requires, at a minimum, enforceable contractual clinical integration. In many cases ACOs may involve complete integration in which both the physician and hospital services are provided by one or more entities under common control.<sup>1</sup> There is no single approach to partnering with a hospital or hospital health system that is uniformly applicable or recommended. Physicians should however consider the following in developing the strategy and approach to creating a mutually beneficial relationship with the hospitals in their market.

### What do hospitals hope to achieve through clinical integration?

While individual hospital objectives will likely be influenced by their specific circumstances, all hospital providers face the following challenges, which can be ameliorated by effective partnering with physicians.

- Need for physician cooperation to manage inpatient quality—avoidance of never events.
- Need for physician cooperation to minimize length of stay and unnecessary costs.
- Need for interoperable electronic health records (EHR).
- Need to **demonstrate, not just provide**, quality patient care and address pay-for-performance mandates.
- Need to address reduced demand, higher volumes of Medicaid and uninsured patients, and more significant numbers of tertiary cases in hospitals.
- Need to offset lower reimbursements by taking advantage of opportunities to negotiate for increased payments based on quality/efficiency metrics.
- Need for alignment with physicians to effectuate bundling arrangements or shared savings programs that will become applicable to ACOs.
- Desire to develop synergies with respect to ancillaries and overhead.

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<sup>1</sup> Section 3022 of the Patient Protection and Affordable Care Act of 2010 (“ACA”), Pub. L. No. 111-148, 124 Stat. 119 contains the Medicare program’s statutory ACO requirements.

## **Evaluating your hospital partner**

Hospitals and health systems vary significantly in their financial strength, market position, medical staff composition, compliance programs, payer mix, service offerings, technology investments, management quality and style, information technology, and technological infrastructure—and perhaps most importantly, **their willingness and effectiveness in partnering with their physicians.** The vast majority of hospitals are not-for-profit or public entities that are subject to significant constraints in dealing with and compensating their physician employees and affiliates. All hospitals have unique management and board dynamics that both color the willingness to partner with physicians and determine the extent to which they would internalize as a core value strong physician governance.

**Appendix 1** sets forth a checklist that is useful in evaluating a hospital as a potential ACO or as a more complete integration partner. In the end, the proper leveraging of the combined strengths of the physician participants in an ACO to create a delivery system that is perceived as the leader in quality will be essential. To achieve that goal, ACOs must meaningfully produce and fairly allocate shared savings revenues over a specific episode of care or population. Since the object of the integration is to produce better quality for less cost through the effective use of technology, significant coordination of care, avoidance of duplication or unnecessary expenses and strong patient satisfaction, the checklist is an important first step to determining whether the investment of time and resources in partnering with the hospital can realistically produce a better patient treatment paradigm.

## **Setting the agenda**

Physicians should frame or help frame the agenda for all clinical integration discussions. The physician interests can best be represented to the extent that physicians can identify physician leaders with the temperament, professional reputation and passion to improve quality and who enjoy the respect of their peers, hospital senior management and members of the hospital's board. As with any partnership, however limited or comprehensive, establishing a set of mutual goals and confirming a shared set of values are essential first steps in designing the collaboration. Because of the differential in resources, physicians are well served to negotiate up-front access to their own strong professional advisors who can enable the physicians to organize their resources in a way to maximize both the physician contribution and the value received for that contribution.

The agenda can fall into one of two alternative approaches to integration.

### **1. Maximize synergies/maintain independence.**

Under this approach the first step is for the physicians to explore all potential less integrated models for partnering with a hospital as a way of building trust, improving both parties' bottom lines, and achieving clinical coordination. This initial step will set the stage for a future joint venture ACO and possible full integration later. To pursue this strategy, key physician groups that will participate and set specific goals and objectives for win-win affiliations must be identified at the outset.

### **2. Cashing out and designing a health system.**

Alternatively, physicians may wish to explore the economics, future synergies and governance opportunities of actually combining the strengths of the hospital and the physicians into a new integrated delivery system. Pursuing this strategy, physicians should determine how much near term cash they may realize by affiliating with the hospital, what income guarantees are available,

and the value of aligning early with the hospital to gain first-mover advantage in the design of the new organization.

Attached as Appendices 2 and 3 are two sample issues listings. [Appendix 2](#) sets forth the issues appropriate for testing the waters of partial integration. [Appendix 3](#) outlines issues to be addressed in connection with a more complete integration. The agendas are illustrative and physicians should rely on their professional advisors to frame the discussion. Often times, the initial discussions are highly informal or are initiated by a hospital consultant or a formal presentation by hospital management. In either event, the critical first step is to organize the physician leadership to develop consensus positions and an approach to sharing the cost of the negotiations, including retention of professional advisors who will focus on the physicians' best interests.

### **Alternative ACO structures**

It is likely that ACOs will be established under one of the following structures:

- An arrangement in which the physician-owned entity contracts with hospital and skilled nursing providers to furnish the required services, and payments are distributed pursuant to these contractual arrangements;
- A joint venture entity in which (at least) the hospital and physician providers are members and participate in the governance of the ACO with payments distributed under contractual arrangements and through distributions to members;
- An integrated delivery system with physicians generally employed within the system and potentially having additional independent contractor arrangements with physicians and other health providers;
- A hospital or health system with physician participation via contract; and
- A hospital or physician-owned entity joint venture with a health insurer.

Each structure will raise complex antitrust, tax exemption, fraud and abuse, and contractual issues. Existing antitrust guidance and safe harbors under the self-referral and anti-kickback prohibitions are in most cases insufficient to provide the requisite legal certainty to the participants in structuring the transaction. Representatives of both the American Medical Association (AMA) and the American Hospital Association have requested that regulations implementing the ACO provisions of the Affordable Care Act (ACA) expand existing or create new safe harbors that will ameliorate fears stemming from a lack of clarity concerning liability protection for those who seek to lawfully develop and operate ACOs. The final implementing regulations may dictate which of the above models would be easiest to launch and execute.

Subject to this future regulatory guidance, generally physician interest would be served under models in which physicians have equity in, if not control of, the ACO and strong governance rights. The shared savings objectives will require significant coordination both among and between the physician primary care and specialist physicians. In addition, physicians will need to assist hospitals in all aspects of their clinical operations. The investment of time, money and resources will need to be funded, and ACOs will need to identify ways to lawfully incentivize physicians in the process and hold them accountable for achieving the required quality and savings.

## **Where will the savings come from?**

In negotiating with hospitals, physicians need to understand where the expected savings will come from, as the design of the ACO will need to place the right decision makers with the right authority in a position to both implement and obtain the buy-in for change. The enormity of the clinical tasks are strong arguments for physicians to request that the ACO and/or any more fully integrated delivery system be physician led and physician driven. The quid pro quo for this approach is the physicians' ability to communicate their willingness to change historical behaviors to patterns which can demonstrably reduce cost while still maintaining and improving quality and patient outcomes.

A significant portion of savings will come from physician pre-hospitalization interventions and alternative therapies that avoid expensive hospitalizations. The tension between a hospital's need to "fill beds" and an ACO's obligation to limit avoidable hospitalizations will be an ongoing operational challenge. Similarly, use of less expensive outpatient facilities by the ACO may also adversely affect demand for hospital outpatient services. The changes will likely affect the relationship between primary care and specialty physicians as the ACO addresses the management of diagnostic testing and less invasive procedures. As to each of these tensions, all involved providers will need a stake in the clinical decision making for there to be the requisite buy-in. All the foregoing will require coordination, consensus, compromise and commitment.

Other savings will come from improved coordination in the discharge and rehabilitation of patients so as to minimize readmissions and lengths of stay at skilled nursing facilities and ensuring that the patients comply with their post-discharge instructions. Coordination of the inpatient diagnostics with prior medical history through access to interoperable EHR and timely evaluation of payments might also minimize duplicate testing and length of stay. Negotiation for discounts on expensive medical devices has also been shown to be an effective strategy for reducing costs.

## **Clinical integration initiatives that have been successful in current practice**

Many currently successful hospital-physician arrangements have elements that should be considered as part of structuring a hospital-physician ACO arrangement. These could be negotiated independent of or in connection with discussions targeting ACO formation. Hospitals and physicians have successfully collaborated to create efficiencies and improve quality in a number of ways:

- Provider-based joint ventures.
- Service line management agreements.
- Other management services organization (MSO) arrangements and EHR connectivity arrangements.
- Gainsharing arrangements.

## **Provider-based joint ventures**

In order to create physician alignment, standardize training and protocols, develop or expand outpatient capabilities, drive efficiencies and facilitate EHR interoperability, many hospitals have contracted with physician entities to form provider-based joint ventures or to have physician entities manage outpatient departments. Typically, these provider-based arrangements are structured such that:

- The physician organization manages the hospital outpatient department.

- In compliance with the Stark law, the physician entity can provide supplies and personnel at fair market value or equipment at fair market value, but not both supplies and personnel AND equipment. In addition, “per click” lease arrangements are now prohibited.
- The arrangement is operated as part of a hospital department with demonstrated clinical integration, clinical reporting and financially included as part of a hospital department.
- The hospital must own or lease the facility and bill for the services provided in that facility.

### **Service line management agreements**

Hospitals desiring to create “centers of excellence” and to create a fully integrated continuum of care have entered into service line management agreements in which physician entities and their designated administrators assume responsibility for an entire line such as orthopedics. These service line agreements generally offer specialists the opportunity to clinically impact the inpatient or outpatient service and benefit from the improved quality, efficiency and effectiveness of the service along a single specialty. The model can be structured to enable the physician entity to retain a portion of savings with respect to supplies and can contain gainsharing provisions subject to meeting criteria that would be amenable to a favorable advisory opinion by the U.S. Department of Health and Human Services Office of the Inspector General (OIG). Gainsharing arrangements must meet strict Medicare requirements to enable physicians to benefit from reduced costs.

As ACO regulations are promulgated, the ACO might serve as an appropriate entity for this type of arrangement with appropriate control and lawful incentives and accountability vesting in the physician leadership. In those circumstances in which hospitals are unionized, implementation will generally require a favorable modification to the collective bargaining agreement as inevitably the changes in staffing, cross-training, work rules and reporting responsibilities are likely to be outside the hospital’s ability to impose unilaterally.

### **Other MSO arrangements and EHR connectivity arrangements**

The ability to leverage compatible EHRs is at the cornerstone of the ACO paradigm. Historically, hospitals and large group practices and other physician groups have loosely affiliated via use of MSOs in order to provide savings to independent physician practices via scale. To the extent that the ACO will be involving a large number of independent physician practices, a significant discussion topic will be the management and information systems which will be offered to clinically integrate the group. Hospitals often have a large number of employed physicians. Determining which EHR system, billing system and other practice management systems will be utilized is a significant upfront decision that could materially shape both the complement of physicians willing to join, the expense burden or savings generated, and the ability of the ACO to have the infrastructure necessary to meet the ACO requirements for patient connectivity and demonstrable outcomes.

### **Gain-sharing**

Central to the ACO concept will be shared savings either across a given population or an episode of care. Recent OIG advisory opinions have permitted hospitals and physicians to share quality incentives and cost savings. Generally the criteria for sharing quality incentives include credible medical support that the criteria have potential to improve, and are unlikely to adversely affect, patient care. Financial incentives are tied to meeting quality targets with quality measures meeting Centers for Medicare and Medicaid Services (CMS) and Joint Commission standards, and there are no incentives for physicians to apply a specific standard when doing so would be medically inappropriate. The quality targets must be reasonably related to the hospital’s practices

and patient populations. Transparency and notification to patients are also critical elements to protect against underutilization or improper patient steering. Gainsharing arrangements that have been approved by the OIG also include fair market value reviews, continued monitoring to avoid underutilization, per capita distributions to participants irrespective of case or procedure volume, and limited duration (typically less than three years). The legal standards will vary depending on whether the ACO employs or contracts with physicians. Identification of potential gainsharing arrangements on the front end might create the win-win opportunities for collaboration to help offset the start-up costs of ACO development.

### **Launching an insurance CO-OP**

The health reform legislation has authorized \$6 billion for the creation of new risk-adjusted CO-OPs.<sup>2</sup> Because many hospitals and health systems self-insure and have major employers on their governing boards, physicians should also consider partnering with their hospitals in the formation of an insurance CO-OP. Depending on the historical data available from these natural constituencies, it may be possible to form a CO-OP that could provide competitive benefits that complement and reward the same efficiencies, quality and patient connectivity that underlie the ACO criteria. The health reform legislation's sponsorship of CO-OPs is intended to increase competition at the payer level and expand consumer choice, while at the same time enabling the ACO to obtain reimbursement outside traditional fee for service or capitation parameters. See the chapter entitled **"CO-OPs and accountable care"** for further information.

### **Conclusion**

The ACO concept presupposes significant physician leadership in structuring the necessary clinical integration and launching the requisite innovations. Hospitals generally have a superior set of financial and administrative resources that to date have been used to capture market share and to propose arrangements in which physicians become employed either by the hospital or via an affiliated group practice as part of a single system. These arrangements often co-exist with a strong independent medical staff. In negotiating ACO arrangements with hospitals, physicians must not abdicate their responsibility to drive a patient-centered agenda. Creating a group of physician providers whose professional reputations would enable them to serve as natural leaders is the critical first step. Investing in independent legal and financial advice is the essential next step for the physician representatives to both remain legally compliant and implement a viable ACO.

Independent of the Medicare incentives surrounding ACOs, the clinical integration inherent in the ACO may provide significant opportunities for the physicians and their hospital affiliate to structure managed care programs and incentives that could finance some of the infrastructure and reward the participants for demonstrable quality and efficiency achievements. Physicians must determine whether their community would best be served by a complete integration or by a partial integration targeting specific services and patient populations such that their professional futures are not fully and finally dependent upon the success of the complete integration.

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<sup>2</sup> 42 U.S.C. § 18042(b)(2)(D)

## Chapter 3 Appendix 1: Assessing your hospital as an ACO partner

### **I. Compatibility and alignment**

- A. History of successful partnering with physicians on clinical and financial initiatives
- B. Openness to physician-driven leadership
- C. Degree of current interdependence
- D. Responsiveness to physician initiatives
- E. Open communication concerning strategic and administrative initiatives
- F. Compatible leadership styles
- G. Compatible and positive market perception of quality
- H. Compatible EHR
- I. Compatible benefits, cost and staffing ratios
- J. Significant medical staff presence and strategic plan that values physician service capabilities and outpatient services

### **II. Financial strengths**

- A. Strong balance sheet with significant cash balances
- B. Low debt to equity ratio
- C. Leadership in regional market
- D. Positive net margin
- E. Success in outpatient service ventures
- F. Excellent facilities
- G. Excellent primary care base

### **III. Management strengths**

- A. Trusted and effective CEO and senior management team
- B. Efficient and effective operations

- C. Demonstrative ability to recruit and retain primary care and specialty physicians
- D. Strong culture of compliance
- E. Strong communication skills and track record of good decision making
- F. Excellent clinical managers and medical staff leadership
- G. Ability to retain quality administrators
- H. Ability to demonstrate and be compensated for quality with third-party payers
- I. Independence and quality of the hospital's board—strength of independent directors or trustees
- J. Free standing or part of a hospital system
- K. Track record of successful innovation and support of physician practices and professional development
- L. Excellent patient satisfaction results and clinical outcomes and effective use of technology

#### **IV. Perceived synergies**

- A. Potential for expense savings due to improved purchasing, economy to scale, enhanced employee benefits and elimination of duplication
- B. Improved margins through more efficient use and consolidation of ancillary services
- C. Opportunity to expand market share
- D. Efficient access to capital
- E. Increased collaboration with hospital-employed physicians
- F. Learning curve savings on EHR, quality measurement systems and practice integration
- G. Assistance in recruiting new physicians
- H. First in advantage for building centers of excellence and leveraging best practices

#### **V. Other considerations**

- A. Potential to access new software and benefit from compliance, manage care contracting, capital markets and reimbursement expertise
- B. Effect on current referral sources both within the hospital and outside the hospital's medical staff and physician groups and on the physicians' relationship with other hospitals, health systems or outpatient providers. Costs and risks associated with antitrust, regulatory compliance, licensing and state prohibitions with respect to corporate practice of medicine
- C. Cost of integration
- D. Challenges in integrating administrative and clinical teams
- E. Receptivity of independent medical staff and currently employed physicians

## Chapter 3 Appendix 2: Issues listing as to partial integration

### **I. Mutual objectives**

- A. Define scope
- B. Benefit to patients and payers
- C. Participant objectives
- D. Identification of perceived synergies

### **II. Nature of relationship**

- A. Contractual (i.e., no unified entity)
- B. Special purpose entity (limited liability company, limited partnership, limited liability partnership, joint venture)
- C. For profit or not-for-profit

### **III. Respective roles and responsibilities**

- A. Allocation of administrative and management responsibility
- B. Services to be provided
- C. Extent of capital required
- D. Allocation of risk
- E. Respective financial commitments
- F. Management authority and reporting

### **IV. Compensation and performance expectations**

- A. Compensation for services
- B. Valuation of assets contributed
- C. Financial incentives
- D. Performance metrics
- E. Process for selection and expense sharing for selecting consultants and appraisers

## **V. Governance**

- A. Composition of governing body
- B. Retained and reserved powers
- C. Negative control and supermajority requirements
- D. Deadlock resolution

## **VI. Scope**

- A. Exclusive or nonexclusive
- B. Limited service line non-compete
- C. Types of services covered
- D. Geographic

## **VII. Term**

- A. Duration, options to extend
- B. Termination without cause
- C. Termination with cause
- D. Termination with respect to changes in law
- E. Unwind provisions

## **VIII. Business plan and other issues**

- A. Location of service
- B. Method of clinical integration
- C. Enforcement of quality and other metrics
- D. Dispute resolution
- E. Transaction timeline
- F. Financing or lease of premises/capital/or shared IT
- G. Naming rights/professional liability and other insurance and indemnifications
- H. Revenue and expense allocations/pass through or marked
- I. Employees and benefits leased from one participant or jointly contracted

## Chapter 3 Appendix 3: Issues listing as to full integration

### **I. Mutual objectives**

- A. Benefits to be achieved through complete integration
- B. Identification of benefits to patients and payers
- C. Identification of perceived synergies
- D. Participant objectives

### **II. Nature of relationship**

- A. Creation of health system with significant physician governance and affiliated physician service organization
- B. Creation of physician division within a hospital or health care system
- C. Exclusive professional services arrangement
- D. For profit or not-for-profit
- E. Separation of functions via a management services organization/physician management company
- F. Ancillary agreements (lease, management, professional services, funding, asset or stock purchase or sale)

### **III. Transaction timeline**

- A. Establishment of a negotiating team
- B. Selection of professional advisors
- C. Due diligence timetable
- D. Regulatory and antitrust analyses
- E. Valuation process
- F. Required consents and license transfers
- G. Required financing
- H. Establishment of regular meetings and reporting

#### **IV. Governance**

- A. Extent and determination of the manner of selection of physician representation on governing body and any affiliated physician service organization
- B. Retained or reserved powers to health system or physicians
- C. Negative control and supermajority requirements
- D. Deadlock resolution
- E. Amendment of governance documents
- F. Administrative reporting and physician rights with respect to various aspects of the practice
- G. Service line and outpatient management agreements
- H. Opportunities for physician administrators/medical directorships and clarification of the physician managers' role with respect to hospital operations and relationship to hospital medical staff department chairs
- I. Requirement that all hospital-based physicians employed by or recruited by the integrated health system do so as part of the physician division within the system, and clarification of the physician division's relationship with hospital-based physicians and hospital-employed physicians
- J. Physician governance—by specialty or through a single multi-specialty board
- K. Decisions in which physicians recommend and decisions in which physicians control
- L. Role and reporting responsibility of the medical director and any physician CEO or physician group administrator

#### **V. Physician employment agreement terms**

- A. Term
- B. Compensation plan/guaranty/productivity measurements/treatment of midlevel providers/expense allocations and support
- C. Non-compete, if any
- D. Compensation and expectation for administrative services and for start-up clinical initiatives or market expansion
- E. Termination and unwind provisions and definitions of for cause, for good reason and without cause
- F. Professional liability coverage/tail insurance issues
- G. Dispute resolution
- H. Practice support and location
- I. Quality and efficiency benchmark development process and incentives
- J. Rights on termination/dispute resolution
- K. Permissible outside activities

L. Other medical staff memberships/call requirements

M. Severance and employee benefits

## **VI. Valuation**

A. Valuation of assets, service lines, and human resources contributed or acquired

B. Valuation of compensation as within fair market value

C. Valuation of any service line management or other compensation as within fair market value

D. Process for selection and expense sharing for selecting consultants, appraisers and professional advisors

## **VII. Business plan issues**

A. Budget development and approvals

B. Recruitment plan

C. Retention of key physician administrators and reporting responsibilities and rationalization of existing staff, facilities, departments and ancillaries

D. New facilities

E. License transfers, regulatory approvals

F. Strategic direction

G. Compatibility of strategic goals to incentives in the compensation plan

H. Name

I. Confidentiality and communications

J. Integration and communication protocols and standardization of practices

K. Development of centers of excellence and clinical protocols

L. Receptivity and inclusion of independent medical staff and existing employed physicians

## Chapter 4: Partnering with health insurers to create an accountable care organization

Wes Cleveland

### I. Introduction

#### A. Payment based on quality and resource use

Physicians today find themselves facing an ever-increasing push to adapt to new payment methodologies. In many markets, both commercial and public payers have historically paid physicians strictly on a fee-for-service basis. Yet there is a concerted push in both public and private sectors to replace fee-for-service payment mechanisms with methods of payment that are based, at least in part, on the quality of those services as judged according to specific quality measures as well as physicians' cost-effectiveness.<sup>1</sup>

The accountable care organization (ACO) is an example of an emerging health care delivery model that will receive payment utilizing the concepts of cost-reduction and quality. As authorized by the Patient Protection and Affordable Care Act (ACA), participants in a Medicare-certified ACO will receive standard Medicare fee-for-service payments for caring for a defined population of Medicare beneficiaries. The ACO may also be paid a percentage of the difference between the costs that Medicare estimates will be needed to care for that population and the Medicare resources the ACO actually utilizes in treating that population, so long as the ACO also satisfies certain quality measures.<sup>2</sup>

This push for new payment models is not confined to fee-for-service payment methodologies. There is, for example, a renewed desire to explore payment mechanisms based on physician and provider assumption of risk, in which physicians or providers are at least partly at financial risk for caring for a defined patient population. The ACO again provides an example here as the ACA permits ACOs to utilize partial capitation.<sup>3</sup> The Medicare Payment Advisory Commission has also recommended that the Medicare ACO concept be "strengthened" by implementing a "two-sided" ACO risk model in which, in addition to sharing in a percentage of Medicare cost

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<sup>1</sup> One source of such quality measures is the Physician Consortium for Performance Improvement (PCPI). The PCPI is comprised of more than 170 national medical specialty societies, state medical societies, the American Board of Medical Specialties and member boards, Council of Medical Specialty Societies, health care professional organizations, federal agencies, individual members and others interested in improving the quality and efficiency of patient care. The PCPI has developed 266 quality measures, which may be accessed at [www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml](http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml).

<sup>2</sup> See 42 U.S.C. § 1395jjj(b)(2)

<sup>3</sup> See 42 U.S.C. § 1395jjj(i)(2)

savings, ACO participants would also be at risk for a percentage of health care spending that exceeds specific benchmarks.<sup>4</sup>

## **B. Infrastructure**

A robust infrastructure will likely be essential to thrive, if not survive, in an environment utilizing payment systems based on quality and cost-effectiveness predominate. This infrastructure will require substantial financial investment to develop and maintain, and will also have to possess considerable technological sophistication. In the long run, interoperable electronic health records (EHR) will likely play a large part in the infrastructure, although the American Medical Association (AMA) is advocating for flexibility to allow ACOs to start with patient registries and other less costly information systems in the short run. Prompt information sharing among a wide range of physicians and health care providers through an EHR system may significantly reduce costs by eliminating duplicate tests and reducing errors. Close cooperation and information sharing between physicians is likely to lead to increased patient satisfaction, which appears to be a Medicare ACO requirement.<sup>5</sup>

Aside from interoperable EHR systems, the infrastructure must have the capacity to demonstrate to public and private purchasers that the ACO can deliver quality and cost-effective services. This end will be greatly served if physicians and health care providers have ready access to the ACO's quality and/or cost-effectiveness metrics and stay apprised of new "best practices" so that physicians and providers will be able to further increase quality and efficiency. Just as important, systems must exist that can hold collaborating physicians and providers accountable to these metrics. Physicians and providers must also regularly be given useful information concerning their performance based on those metrics, and receive professional assistance when those metrics are not satisfied due to circumstances within the physicians' control.

## **C. Access to resources**

Developing and maintaining this type of infrastructure will be expensive. Although physicians are being increasingly pressured to integrate, large numbers of physicians still practice alone or in groups of fewer than five.<sup>6</sup> These physicians will most likely not have access to the financial resources necessary to develop and maintain the requisite internal systems. This may be true notwithstanding publicly available incentives. For example, physicians may receive up to \$44,000 from Medicare or \$63,750 from Medicaid if they can demonstrate "meaningful use" of EHR.<sup>7</sup> However, there is concern in the physician community that satisfying the requirements of meaningful use itself will pose significant financial and technical challenges, especially for physicians operating in solo and small practices. Additionally, these incentives will likely not be sufficient in many cases to cover all of the other costs associated with EHR (e.g., on-going maintenance of the EHR system and lost productivity during implementation of, and training concerning, the EHR system). According to a recent survey by CDW reported Dec. 13, 2010, the total costs of EHR implementation run as high as \$120,000 per physician ([www.cdw.com](http://www.cdw.com)). In 2009 PricewaterhouseCoopers issued a report entitled "Rock and a Hard Place: An analysis of the \$36 billion impact from Health IT stimulus funding," which concluded that the full cost of EHR implementation for a three-physician practice ranged from \$173,750 to \$296,000. ([www.pwc.com](http://www.pwc.com)).

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<sup>4</sup> See Nov. 22, 2010, letter from MedPAC to Dr. Donald M. Berwick, Administrator, Centers for Medicare and Medicaid Services. The letter can be accessed at

[www.medpac.gov/documents/11222010\\_ACO\\_COMMENT\\_MedPAC.pdf](http://www.medpac.gov/documents/11222010_ACO_COMMENT_MedPAC.pdf)

<sup>5</sup> See 42 U.S.C. § 1395jj(b)(3)(A)(ii)

<sup>6</sup> See the chapter entitled "**Introduction: Complex environment—difficult choices**"

<sup>7</sup> For additional information, see the chapter entitled "**Guidance on earning EHR incentive payments**"

However, through collaborative endeavors with other physicians or nonphysician partners, physicians may be able to develop either the necessary systems themselves or have access to such systems. Health insurers represent one type of organization with which physicians may partner to make such systems-development possible. This chapter discusses some of the issues facing physicians when considering whether or not to partner with a health insurer to create an ACO.

## **II. Partnering with health insurers**

### **A. Threshold challenge**

There is a key threshold issue that must be considered prior to discussions concerning physician-health insurer ACO collaboration, namely, the health insurer's relationship to its competitors in connection with the ACO. The nature of this relationship may in and of itself determine whether or not collaborating with the health insurer is an attractive possibility. For example, the health insurer may take the position that the ACO may not contract or otherwise partner with other health insurers or payers. If so, that fact alone may discourage the physician from further consideration. On the other hand, the health insurer's cooperative relationship with its competitors may result in benefits that could encourage physician collaboration. Activities undertaken by the Integrated Healthcare Association (IHA) may provide an example here. Through the IHA, major California health plans, with input from physician medical group leadership, adopted a uniform set of quality performance measures that apply across those health plans. The plans also aggregate their data in an effort to provide reliable performance evaluations. Similar standardization of performance metrics utilized by multiple health insurers contracting with the ACO might increase the likelihood of physician collaboration. Another example might involve an ACO that is jointly-funded by health insurers in a manner analogous to some primary-care medical home models. For example, in May 2009, WellPoint, United Healthcare, CIGNA, Aetna, Humana and Colorado's Medicaid program launched a patient-centered medical home pilot program. Physicians are paid both on a fee-for-service basis and with a per-member, per-month fee set by individual health insurers. The health insurers use the same measures to track patient outcomes and determine physician performance. Similar joint financing and coordination of performance metrics in the context of an ACO might go a long way to foster serious physician consideration of an ACO collaborative.

### **B. Subsequent considerations influencing the decision to collaborate**

Even if a health insurer's relationship to competing health insurers is structured in a manner that may initially encourage more than a cursory physician consideration of possible ACO collaboration, significant challenges may still exist. Because of their prior experiences with health insurers, some physicians may not be sanguine about the possibility of a win-win ACO collaborative with a health insurer. Many physicians have had to shoulder the disadvantageous terms of take-it-or-leave-it contracts, cope with black box payment rules and fight unresponsive bureaucracies to provide their patients the care they need. Many physicians' practices continue to be plagued by avoidable administrative inefficiencies and lack of transparency that diverts valuable time and resources from patient care. In some cases, physicians have had to resort to litigation in an effort to rectify these and other negative effects of dealing with health insurers. This history is likely to jade some physicians' view of potential health insurer ACO collaboration.

At the same time, the advent of new payment mechanisms may encourage the development of new health insurance business models that may treat collaborating physicians as real partners. For example, organizations on the health-insurer side of the equation have at least stated that

“strong physician buy-in” is a necessary condition for ACO success.<sup>8</sup> Health insurers may also have to be more cognizant of the quality of physician relations given that the ACA may require evidence of satisfactory provider experience as a condition of ACO certification.<sup>9</sup> There are also existing models, such as the relationship between Rocky Mountain Health Plans and Mesa County Physicians, IPA, Inc., in Grand Junction, Colorado, which illustrates how physicians and health insurers might be able to work together in a way that benefits both parties and the community as a whole.

Although it is too early to tell what effect, if any, the advent of ACOs will have on physician-health insurer interactions, it is likely that some physicians will be presented with opportunities to collaborate with health insurers in ACO formation. With this probability in mind, the next section discusses the potential value that health insurers might provide physicians in terms of an ACO partnership.

### **III. Possible advantages of partnering with a health insurer**

#### **A. Existing physician frameworks amenable to collaboration**

Physicians may in varying degrees already be participating in organizations that may provide a ready foundation for an ACO collaborative with a health insurer. Independent practice associations (IPAs) have existed in many health care markets for decades and may provide physicians with a useful foundation for collaboration. (In some cases, IPAs may also be used as the underlying structure to create an ACO comprised solely of physicians.) Some IPAs have developed the type of infrastructure described above. But even if an IPA has not reached this stage of development, an IPA may provide a legal and organizational framework to support the development of internal systems that would be able to interface and make efficient use of the data that health insurers may be willing to share with physicians.

#### **B. Financial resources**

Health insurers have financial resources that many physician practices may not possess. Some health insurers appear willing to assist physicians in infrastructure development. For example, at an Aug. 5, 2010, meeting, representatives from WellPoint, Aetna, UnitedHealth Group and Highmark stated that their companies would offer financial incentives to those who made meaningful use (as defined by the Centers for Medicare and Medicaid Services [CMS] of an EHR or satisfied similar requirements.<sup>10</sup> Assistance may not be limited to the availability of financial incentives for EHR adoption. For example, in September 2010, CIGNA and Piedmont Physicians Group in Atlanta announced that they had created an ACO pilot project.<sup>11</sup> As part of the ACO, Piedmont Physicians Group employs a registered nurse funded by CIGNA. The nurse is tasked to coordinate clinical care to help patients with chronic conditions manage their conditions.

#### **C. Systems that may be able to facilitate the application of quality and cost-effectiveness measures**

Many health insurers purport to evaluate physician performance based on quality and/or cost-effectiveness. There are well-founded concerns in the physician community concerning the

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<sup>8</sup> See “Creating an Accountable Care Organization,” which can be accessed on the Ingenix Consulting Web site at [www.ingenixconsulting.com/HealthCareInsights/HealthPlanSolutions/insightPOV\\_13/](http://www.ingenixconsulting.com/HealthCareInsights/HealthPlanSolutions/insightPOV_13/).

<sup>9</sup> 42 U.S.C. § 1395jj(b)(3)(A)(ii)

<sup>10</sup> Four Private Health Payers Unveil Plans To Offer Providers Meaningful Use Incentives, BNA Health Care Daily Report, Aug. 6, 2010

<sup>11</sup> [www.piedmontphysicians.org/wtn/Page.asp?PageID=WTN000066](http://www.piedmontphysicians.org/wtn/Page.asp?PageID=WTN000066)

fairness of these programs. At the same time, any physician interested in participating in an ACO should expect to be evaluated on both quality and cost-effectiveness metrics. And if physicians themselves lack the capacity to evaluate themselves in terms of quality and cost-effectiveness, then they will require resources from their nonphysician ACO collaborator to assist in performing this function. Accordingly, a health insurer's data system may be a valuable asset that health insurers can bring to the table. However, it is highly unlikely that the health insurer will be able to secure the requisite physician "buy-in" to make an ACO a success unless, among other things: (1) the physicians are able to help select or develop the quality and cost-effectiveness metrics; (2) the methodology, including any risk adjustment mechanisms, that the health insurer utilizes to determine physician performance is fair, statistically valid and fully transparent; (3) physicians have access to the universe of data that the health insurer utilizes when evaluating performance; (4) physicians receive timely and readily understandable feedback concerning performance with professional assistance from respected peers when improved performance is desired; and (5) physicians have an opportunity to appeal performance determinations that they believe are inaccurate.

#### **D. Patient experience data**

Health insurers have access to a wealth of patient experience data. This data is a key asset that enables health insurers to respond to the desires of diverse patient populations. For those physicians interested in maximizing patient satisfaction in an ACO collaboration, access to such data might make collaboration with a health insurer attractive. However, that data will be of value to physicians only to the extent the health insurer provides access to that data, as well as the risk adjustment necessary to ensure that "apples are compared to apples" before any scores are attributed to individual physicians.

### **IV. Allocation of decision-making authority within the ACO**

There will be a multitude of decisions that the physician leaders and health insurers will have to make in the ACO's start-up phase and over the course of the ACO's operations. Those leaders and representatives will have to negotiate how they will allocate authority between themselves to make these decisions and how this allocation will be reflected in the ACO's bylaws and other governing documents. The remainder of this chapter is designed to assist physician leaders in these negotiations.

Perhaps the most important issue for the practicing physician and consequently for the physician leadership who will represent that physician in the ACO is the extent to which the physician will retain control over areas that affect his or her practice if the physician decides to participate in the ACO. Physicians will be less inclined to enter into an ACO collaborative if physician leadership does not retain full control or possess the weight of decision-making authority over key areas of professional and financial concern or if the physician feels that his or her voice as expressed by that leadership will not be heard with respect to other, less "core" issues. The chapter entitled "**ACO governance issues**" discusses some of the ways in which decision-making authority within an ACO may be apportioned so as to protect the interests of physician leadership and by extension practicing physicians. In addition to that chapter and the following issue listings, the AMA's accountable care organization (ACO) principles adopted at the AMA's 2010 Interim Meeting, which are reproduced in chapter one, "**Accountable care organizations—overview.**"

## **A. Issues over which physician board leadership will likely desire complete control or the weight of decision-making authority**

There are certain types of issues over which physician leadership will likely want to negotiate complete control on behalf of practicing physicians. For example, because practicing physicians will feel strongly about controlling purely clinical matters, physician leadership will probably want to negotiate exclusive decision-making authority within the ACO concerning such matters. Outside of these purely clinical concerns, there exists a broad spectrum of issues over which the practicing physician, while not insisting on complete control, may nevertheless find the exercise of ultimate decision-making authority important. With respect to these issues, there are many ways physician leadership and health insurer representatives may allocate authority. For example, physician leadership and health insurer representatives may negotiate the allocation so that, although physician leadership retains ultimate decision-making authority, that leadership must consider informal, or formal, input from the health insurer prior to exercising that authority. Again, the chapter entitled **“ACO governance issues”** provides further information concerning some of the ways to structure ACO control in a manner that confers on physician leadership the weight of decision-making authority.

### **1. List designed to help physician leadership identify the types of issues over which it will likely want to negotiate complete control.**

The following issues listing is designed to help physician ACO leadership identify the types of issues over which that leadership may wish to negotiate for full control, since these issues represent core clinical concerns:

- setting the ACO’s purely medical policies;
- determining medical conditions that can be referred to another physician specialist;
- the diagnostic tests that the ACO will deem appropriate for a particular medical condition;
- the information that must be included in ACO patients’ medical records;
- whether a particular patient visit requires a particular billing code;
- communications that are of a purely clinical nature with ACO patients; and
- determining whether a patient has an emergency medical condition.

### **2. List designed to help physician leadership identify the types of issues over which it will likely want to negotiate ultimate, but not perhaps not exclusive, control**

This issues listing identifies some of the types of issues over which ACO physician leadership may want to negotiate ultimate decision-making authority. These types of issues are not purely clinical in nature. Nevertheless, they are of sufficient importance to the practicing physician that physician leadership may want to negotiate the weight of authority with respect to those issues on behalf of practicing physicians. Accordingly, physician leadership may be willing to accept an allocation regarding these issues in which that leadership may not make decisions prior to receiving input from representatives of the health insurer. The specifics of this input may vary widely depending on the nature of the negotiations in the ACO’s unique circumstances. Speaking generally, one method of allocation could take the form of a requirement that the physician leadership consult with the health insurer prior to rendering a decision. Another allocative method could see physician leadership needing to consider a formal recommendation from the health insurer with respect to certain issue types before making a decision. Issue types here could include the following:

- practice parameters employed by the ACO;
- treatment decisions that involve bioethical issues;
- ACO credentialing for specific procedures: not only establishing general credentialing standards but also determining when and how those standards are applied to individual physicians and other health care providers;
- scheduling on-call coverage;
- handling impaired physician members of the ACO;
- which CME courses should be taken;
- terminating physicians from the ACO on discretionary grounds (i.e., quality of care and business concerns, failure to comply with utilization review procedures, “without cause” terminations);
- approving the physicians’ annual practice budget;
- establishing the ACO’s bioethics policies;
- determining the types of technology that the ACO will employ;
- to whom the ACO physicians can refer, including circumstances in which the specialist is not an ACO participant;
- the credentialing standards that will be used to determine which physicians may be admitted as ACO participants;
- credentialing decisions concerning whether an individual application for ACO membership is accepted or rejected;
- developing the ACO’s utilization review (UR) and quality assurance (QA) plan;
- implementing the ACO’s UR or QA plan;
- enforcing the ACO’s UR and QA plan, except when enforcement involves termination from the ACO;
- whether and when the ACO will utilize limited license practitioners (LLPs);
- whether the ACO should consider an LLP’s application for admission to the ACO;
- the ACO’s selection of independent LLPs and “physician extenders”; and
- the ACO’s development of drug formularies and any limitations on the selection of medical devices.

**B. List designed to help physician leadership identify those types of issues over which decision-making authority might be shared with, or deference given to, the health insurer.**

This listing identifies some of the types of issues over which ACO physician leadership may find it appropriate to negotiate joint decision-making authority with the health insurer. In other cases, depending on the issue involved, that leadership might find it appropriate to allow the health insurer varying degrees of decision-making deference, in which the health insurer could be required to consult with or receive a formal recommendation from physician leadership prior to exercising ultimate decision-making authority. The issues likely to fall under this category include:

- the hours the ACO should require the physician to work;
- non-clinical decisions concerning medical records of the ACO's patients;
- the level and scope of medical liability coverage for the ACO and the individual physician;
- how the ACO will compensate the individual physicians and other health care professionals, including but not limited to, how any shared savings will be allocated between the health insurer and physician(s);
- settling cases for all parties named in a lawsuit;
- marketing the ACO;
- setting the global budget for the LLP compensation;
- mergers, acquisitions, conversions and affiliations involving the ACO;
- the ACO's ownership and scope of ancillary ventures;
- establishing the ACO's grievance policies;
- selection of personnel to hold key administrative positions;
- coding and billing procedures;
- controlling administrative data;
- compensation for allied health and lay staff; and
- selecting purely administrative personnel that do not hold key positions.

## **V. Conclusion**

The way in which physicians practice medicine and are reimbursed for their services is evolving rapidly. The ACA's authorization of ACOs signals a continuation and affirmation of emerging payment methodologies based on the quality and cost-effectiveness of services provided. To survive in an environment in which these emerging methodologies predominate, physicians will need to collaborate and develop, or have access to a partner who possesses, sufficient systems and other infrastructure that will enable physicians to demonstrate the quality and cost-effectiveness of their services and/or improve them where appropriate. Although some physicians may view the prospect of a health insurer collaborative with caution, in the right circumstances, a health insurer could bring to the table resources that would make ACO collaboration beneficial for the physician.

## Chapter 5: CO-OPs and accountable care

**Mark E. Rust**

Physicians who have done the hard work of becoming clinically accountable by meeting “clinical integration” standards or becoming an “accountable care” organization<sup>1</sup>—or even one that is taking the first steps toward that status—might wonder whether the journey will leave them a passive reactor to private payers and the federal government or whether it is possible to take the next logical leap in efficiently, effectively and jointly delivering care. That active step would be to contract directly with patients and their employers by becoming a regional health insurer. Physicians may be pleased to learn that the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA) not only creates a new program to make this feasible—it actually proposes a method to fund the costs and reserves that have traditionally provided the greatest barrier to this type of activity.

A relatively obscure provision in the ACA, Section 1322, describes “Consumer Operated and Oriented Plans.” This section creates an entirely new nonprofit in health care delivery yet one with features that physicians and other health care providers will find familiar. A “CO-OP,” as the ACA labels it, is a federally tax-exempt health insurance corporation complying with all state laws operated by its “members.” It is primarily aimed at competing for the business of individuals and small groups by advertising on the state insurance exchange, which will spring into existence in 2014, just as demand for cost-effective coverage explodes under new mandates contained in the Affordable Care Act.

Importantly, existing health insurers are forbidden from either “operating” or “interfering” with the development of a CO-OP, providing special protection to physicians who bring that consideration to the development of such an enterprise. Finally, between now and July 1, 2013, the federal government has authorized the expenditure of \$6 billion in loans for start-up costs and outright grants for the reserves required to establish these “non-profit health insuring corporations.”<sup>2</sup> This chapter will describe the special legal and practical issues associated with the development of a CO-OP and explain why physicians and other health care providers may be the biggest unintended beneficiaries of such an undertaking.

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<sup>1</sup> As described by the FTC and Justice Department, “clinical integration” is a degree of clinical and financial interdependence among otherwise competing providers sufficient to avoid per se condemnation of joint fee negotiating activities. “Accountable care” is a phrase adopted by Congress to describe a new option to be used by Medicare to pay the services of a provider group that, almost by definition, will need to have a high degree of clinical integration. The term “clinically accountable care” is a term coined here to describe the marriage of joint provider group oversight of care and direct fiscal responsibility for providing high-quality medical care at, ultimately, lower cost to the consumer. *See*, 42 U.S.C. § 18042(b).

<sup>2</sup> 42 U.S.C. § 18042(b).

## **Providers as ideal consumer sponsors**

One reason analysts of the ACA have been slow to recognize the potential for CO-OPs is that the sponsors of the ACA spawned an idea and funded it but remained agnostic about what type of “consumer” would undertake the labor to “organize” or help “operate” this new entity. Most consumers lack the sophistication, motivation and will to organize themselves into a functioning entity, develop a business plan, risk some upfront costs that might not get repaid and see a complex idea through to completion without the profit motive. On the other hand, health care providers (i.e., physician organizations or hospitals and physician groups working in league with one another) have both the motivation and the will, and if they are working toward clinical accountability, the sophistication as well. What may not be immediately apparent in a quick review of Section 1322, however, is that providers are consumers too. They purchase health insurance in individual and group markets for themselves and their beneficiaries. Large hospitals may self-fund and administer their plans, but by 2014, the advantage of this approach will become more limited. As a result, providers are the ideal “consumers” to sponsor and start a CO-OP: their initial creation of a CO-OP makes their long-term, day-to-day control likely, while their purchase of their own product could not make for a better self-advertisement.

The second reason the CO-OP provisions have not gotten much attention is that they were written by a coalition of conservative Democrats and Republicans in the Senate, early in the debate, at a time that most observers assumed the final health care reform bill would be the subject of debate with the House and substantially changed. The Senate election in Massachusetts, and history, intervened: the Senate version, with minor modifications, became law. It had promised something like the group cooperatives that exist under state law in the states of Washington, Minnesota and Wisconsin. But the language drafted by the Senate, which included federal funding and tax-exempt status, necessarily excluded treatment as a cooperative under state law. The Senate drafters appear to have satisfied their public promise to provide a “CO-OP” alternative by creating an acronym, CO-OP, utilizing the words “Consumer, Operated, Oriented and Plan.”

## **CO-OP sponsors and members**

With the arguable exception of the word “plan,” none of the other key words are defined.<sup>3</sup> However, based on the type of cooperatives that the Senate drafters modeled their legislation after, and on traditional state law principles, several observations can be made with confidence prior to the promulgation of regulations (which could take longer than a group can afford to wait if it wishes to organize itself sufficiently, and on a timely enough basis, to obtain federal funding).

First is the notion of “consumer operation.” The ACA says the CO-OP will be run by “members.” Although there is no definition of “member,” a close study of the mentions of “member” in the statute indicates that the chapter meant it in the sense of “beneficiary” and the equivalent of “owner” in non-profit parlance.

In practice, as evidenced by existing health care cooperatives on which the drafter’s ideas were modeled, the operation of a CO-OP will be conducted by a board. Certain powers, including the power to vote the board in and out, as well as make certain changes to the bylaws, or changes to the structure of the organization, would require the affirmative vote of a majority—or possibly supermajority—of the members. This means the group that first organizes the entity will draft a set of bylaws and rules for board membership that will guide the organization into the indefinite

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<sup>3</sup> 42 U.S.C. § 18042(a)(2).

future. In the absence of that board doing a poor job, under traditional governance principles, there is no reason to expect a surprising or sudden change to the body that oversees CO-OP management. Provider sponsors who also make the first commitment to purchase their insurance through the CO-OP would, as a practical matter, have substantial influence.

The board would oversee managers and work closely to conduct the CO-OP's day-to-day operations. What may be quite surprising to providers new to the world of insurance and benefits administration is that much of the infrastructure for an insurance company can be rented. What's more, the talent to be rented exists in most every region of the United States.

### **Insurance company infrastructure: practical perspectives**

An insurance company's core operation consists of claims processing and payment, provider network formation and contracting, marketing and benefit policy underwriting/actuarial projections. A lightly organized, provider-sponsored CO-OP will find that each of these functions can be acquired without the need to recruit, employ or otherwise invest in skill set infrastructure. In virtually every region of every state in the country, well-run third party administrators (TPAs) already do much of this same work for the self-funded plans of larger employers. As they have already developed the skill set of benefit plan design, administration, claims processing and marketing, they are poised to lease such services to CO-OPs; and as they make their money on volume, they are also motivated to do so. They often work closely with actuaries in plan design, and those actuaries would be available for contract assistance to the CO-OP as well. In fact, the drafters of the CO-OP section envisioned that, over time, CO-OPs from around the country might get together and purchase these and other services through a "Purchasing Council,"<sup>4</sup> which the law specifically permits. At the end of the day, while the formation of an insurance company seems daunting, the fact is that for providers much of the cost and infrastructure of operations can be defined in a services leasing agreement, and the start of payment for services on such an agreement can wait for actual operations. They can also be priced according to scale. This leaves only the establishment of reserves and provider network contracting/reimbursement models as hurdles for the CO-OP. The ACA speaks to the first directly and the second only indirectly.

### **Government-backed funding of reserves and costs**

Any undertaking of this effort has costs associated with it and comes with some risks. However, the federal government has authorized spending up to \$6 billion to reduce or eliminate those risks by outlining a program of loans and grants that started with the appointment in July 2010 of an advisory committee to design grant-making rules.<sup>5</sup> By July 2013, the authorized \$6 billion should have been committed pursuant to those rules.<sup>6</sup>

First, the \$6 billion will be used to provide loans for start-up costs. Since, as noted above, much of the cost of investing in insurance infrastructure can be avoided by renting existing expertise on a yearly or multi-year basis and by including the expense into the premium (as health insurers normally do), the start-up costs will be largely limited to the consultants, accountants, and lawyers with whom a steering committee might work in the CO-OP's formative stages to prepare for and apply to the state and federal government for licenses and grants and to develop the provider delivery protocols and paradigm that will make the delivery of services attractive, efficient and competitive.

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<sup>4</sup> 42 U.S.C. § 18042(d).

<sup>5</sup> 42 U.S.C. § 18042(b)(4).

<sup>6</sup> 42 U.S.C. § 18042(b)(2)(D).

As a practical matter, those start-up costs would likely need to be advanced by the provider group until the CO-OP's federal application is accepted, but this loan might then be reimbursed by the CO-OP from the funds it receives from the federal government. Alternatively, if a hospital or other community foundation were involved in the formation of a CO-OP, a one-time-only gift from the foundation might help defray some of those up-front expenses and would prove advantageous in any decision the government would make concerning how to award grants under the ACA.<sup>7</sup> Any loans that the CO-OP receives from the federal government for start-up expenses would need to be repaid to the federal government within five years of operation from premium cash flow.<sup>8</sup>

The grants for reserves will be more substantial and will need to be repaid over a 15-year period,<sup>9</sup> but their treatment is far different from a loan. Loans generally come with an interest rate reflective of risk; are provided, if at all, only with security; and must be booked and treated as a liability to a third party. The grants in this program are specifically required in the ACA to be treated as "surplus notes,"<sup>10</sup> and thus none of these three attributes of loans apply. No security will be required, and the note is directed to be treated as an asset, very much like paid-in capital. In other words, it is as if the government is funding the program as the 100 percent "owner," except it expects no control and full repayment only in the event the operation survives 15 years. Otherwise, like any other investor, the government will simply lose its initial funding grant to the degree that the operation ceases to exist.

### **Tax-exempt entities: "owners" and private beneficiaries**

Those unfamiliar with nonprofit corporations often ask who the "owner" of such an entity is. The answer under state law is at once "no one" and "someone." There is no owner, as such, in a nonprofit corporation. Such entities are formed at the state level under the "not-for-profit" corporation laws and, to apply for federal tax-exempt status, must affirm and ensure that not a penny of revenues will ever inure to the benefit of any private individual. Thus, there is no profit maximizing or asset value motivation in such an entity; no profit can be distributed on a regular basis and, upon dissolution, whatever assets remain in the entity must be directed to another tax-exempt entity.<sup>11</sup>

While there is no "owner" for distribution purposes, each state makes clear that there must be a party that acts like an owner for purposes of taking responsibility for management and governance. In each state, this party is called the nonprofit "member." A member may be an individual or another corporation. This nomenclature in the CO-OP context is somewhat confusing, since the ACA requires that a CO-OP be run by "members" and, in context, probably means something slightly different in the ACA than the state law's use of the term. In any event,

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<sup>7</sup> 42 U.S.C. § 18042(b)(2)(ii).

<sup>8</sup> 42 U.S.C. § 18042(b)(3).

<sup>9</sup> The total amount to be set aside for reserves varies by state, and there is no one formula that can accurately predict what an insurance commissioner might require of a start-up health insurance company. Because of the interlocking agreements of the 50 states, Puerto Rico and the District of Columbia through the National Organization of Life and Health Insurance Guarantee Association, that organization and the National Association of Insurance Commissioners will likely provide more certainty regarding national recommendations for CO-OPs over time. But states would likely want to see, in general, a minimum of \$2 million in reserves or legitimate insurance guarantees for any organization of sufficient size to organize an actuarially relevant health insurance organization.

<sup>10</sup> 42 U.S.C. § 18042(3).

<sup>11</sup> It is possible, and somewhat common, for state not-for-profit corporations to be organized as federally taxed entities. Some states allow these type of organizations to distribute assets to individual members on dissolution. This, however, is one thing that cannot be done if an entity such as a CO-OP is to qualify as an entity exempt from federal taxation.

it can safely be said that if the initial provider sponsors act as “members” for both purposes, they will be able to write the rules of governance that will keep the organization functioning under a board until such time as the board does their work badly enough to either be replaced or lose entirely in the market.

One thing a tax-exempt board may not do, however, is foster a situation in which one or more private individuals are paid for their services at rates wholly out of line with the benefit those services provide to the community. This balancing of private and public interest is a mainstay of tax-exempt analysis and can be well-illustrated by the compensation paid to a tax-exempt hospital’s chief executive. Although the total dollars paid may sound high as an absolute matter, the only question is whether it is in line relative to what other hospital CEOs are paid in the marketplace. If it is, then the likely value to the community of the services he or she provides in managing the hospital outweighs the “private benefit” the executive receives in the payment and is perfectly appropriate in a tax-exempt setting.

### **CO-OPs and contracts with providers**

This “private benefit” analysis will become important in the final and most vital piece of CO-OP formation analysis: what a provider network can do to help deliver high-quality services while reducing costs and how the network may be paid for those services. These questions, when they arise in the CO-OP context, involve both antitrust and tax exemption analysis.

Briefly, the antitrust laws will not permit otherwise competing health care providers to collectively agree on the price for their services, even when doing so for the good of society, such as an agreement to a ceiling on rates.<sup>12</sup> Collective negotiation by providers is only permitted when the providers either are at substantial financial risk or when they are clinically integrated.<sup>13</sup> The type of provider groups that would be interested in forming a CO-OP should, almost by definition, be able to meet either or both of those requirements.

This brings us back to where we started this chapter: any group of physicians or other health care providers that takes the time and effort to become an “accountable care organization” under the ACA and get in line to accept a new form of payment based on episodic care management, disease management, bundled payments and bonuses for utilization reductions, is an organization clinically accountable enough to contract using new models with health insurers to achieve the same objectives, which will require either shared financial risk or the sort of “clinical integration” the Justice Department has already approved for groups who are sharing and learning from their data. These groups establish protocols, manage clinical services and outcomes, reward those members who perform well and eventually exclude those who cannot.

The question of the degree to which provider network contracts authorized by a provider-sponsored CO-OP board may reward providers for effective care delivery raises a private benefits issue not dissimilar from the example of the hospital CEO given above. While both antitrust and tax exemption compliance will be front and center in the operation of provider-sponsored CO-OPs, the fair market nature of compensation will, in a sense, take care of itself after a time as providers will need to be motivated through reimbursement to deliver care with good outcomes and attractive to patients, while at the same time doing so in a manner that reduces costs and lowers premiums. In a nutshell, provider-sponsored CO-OPs have the

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<sup>12</sup> *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

<sup>13</sup> U.S. Department of Justice and Federal Trade Commission, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust* (1996); these statements evolved from an earlier set first published in 1993.

possibility of marrying the very best of pay-for-performance and “dose of competition”<sup>14</sup> worlds by cutting out the intermediary between providers and patients, all backed with funds by a federal government willing to take a calculated risk.

### **Insurer operation or “interference”**

Importantly, the ACA prohibits existing health insurers and health insurer affiliates from operating a CO-OP or “interfering” in their operation by others.<sup>15</sup> While what it means to “operate” a CO-OP may be apparent, it is not so apparent to the casual observer what might constitute “interference.” Over time, it might be that the definition of the latter becomes more important.

To the degree that an existing large physician group or large health system might consider the idea of CO-OP formation, practical considerations will include how such a decision will affect their next contract negotiation with the market’s largest health insurer. CO-OPs are most likely to form in regional areas where contracting with large health insurers with a huge market percentage is essential to provider survival. Such health insurers are the most likely party to be disadvantaged by competition for market share by such an entity. These dynamics may affect terms to be established in its next provider contract.

It is not clear on its face what the drafters meant by their concern regarding “interference” in the establishment or operation of CO-OPs, other than their awareness of limits in trying to predict the future behavior of markets or details of organizational dynamics with any certainty. Regulators are charged with working to interpret those words from year to year to ensure there is as little friction as possible between the broad aims of the ACA and the specifics of the marketplace. Any national association of CO-OPs that may form will likely view this potential issue as one in which every CO-OP has a high degree of interest.

### **Conclusion**

There is nothing new about provider-sponsored insurance companies: many physician-sponsored and hospital-system-sponsored health insurers, as well as health insurers formed by a joint venture between physician groups and hospitals, have successfully and efficiently serviced regional patient populations for years, at least since the passage of the federal HMO act in the early 1970s. Most often, those provider-sponsored groups have started out as HMOs developed into health insurers that offer PPO products to meet consumer demand. The biggest threat to formation or survival has generally been for hospitals the reaction of larger payers and for physicians, shifting reserve requirements that left an otherwise smoothly-functioning entity without an ability to meet those state demands. Through the Affordable Care Act, the federal government appears dedicated to addressing both of those issues. As a result, the forward-thinking “accountable care organization” would do well to consider an end game that does more for a potential patient population larger than just Medicare by being an early adopter indeed leader in CO-OP formation.

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<sup>14</sup> The Justice Department has answered calls by the AMA and others to deal with health insurers that maintain high market share and thus wield advantageous power with a white paper describing a model environment in the socioeconomic delivery of health care, which it titles “Improving Health Care: A Dose of Competition” – Justice Department. This document can be accessed at [www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf](http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf).

<sup>15</sup> 42 U.S.C. § 18042(c)(3)(B).

## Chapter 6: Guidance on earning electronic health records incentive payments

Larry M. Zanger

### Background

Many physicians considering changing their practice situation in the wake of health reform will also be interested in the potential impact this may have on their ability to take advantage of the federal government's incentive payments for the meaningful use of certified electronic health record (EHR) systems. This chapter summarizes those incentives and then discusses the major issues which should be considered in EHR contracts.

The EHR incentive payments were implemented prior to the enactment of the Patient Protection and Affordable Care Act of 2010 (ACA). The Health Information Technology for Economic and Clinical Health (HITECH) Act was part of the American Recovery and Reinvestment Act of 2009 (ARRA) and provided more than \$30 billion for the creation of a health information technology (HIT) infrastructure and the adoption and meaningful use of EHR systems.<sup>1</sup> Both eligible hospitals and professionals may receive incentives for the adoption of a so-called "certified" EHR system and its "meaningful use" by the adopter. This chapter is focused only on the incentives and challenges for an eligible professional. Visit [www.ama-assn.org/go/hit](http://www.ama-assn.org/go/hit) for much more detailed information on the HITECH Act including checklists and other information on implementing an EHR as well as access to the American Medical Association's (AMA) new online community for physicians who are interested in HIT.

### Financial incentives for implementing EHR

Medicare Part B and Medicaid programs will make incentive payments to eligible professionals, including physicians, beginning in calendar year 2011. An eligible professional may receive up to \$44,000 in incentives if the professional adopts and demonstrates meaningful use of a certified EHR for five consecutive years starting in either 2011 or 2012; that amount decreases if the adoption occurs in 2013 or 2014, and no payments will be made if the professional's adoption of EHR occurs in 2015 or after. The incentive payment is based on an amount equal to 75 percent of the Medicare Part B allowable charges under the Medicare Physician Fee Schedule for covered professional services for up to five years, subject to a maximum limit depending on the year of adoption and certification.<sup>2</sup>

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<sup>1</sup> The ARRA is cited as Pub. L. No. 111-5 and can be accessed at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h1enr.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.txt.pdf). The HITECH Act is located at Title XIII Health Information Technology of the ARRA.

<sup>2</sup> 42 C.F.R. § 495.102

Those eligible professionals who qualify under Medicaid can receive aggregate incentive payments of up to \$63,750 (\$42,500 for pediatricians) provided that the first payment year is no later than 2016. The incentives are based on a 30 percent patient volume (20 percent for pediatricians) and are equal to 85 percent of “Net Average Allowable Costs” for certified EHR technology and support services for that technology, subject to the annual cap.<sup>3</sup> The way these payments are spread out under each incentive payout is outlined in [Appendix 1](#).

### **Financial penalties for failing to implement EHR**

It should be noted that these payments are not the be-all and end-all for eligible professionals. In September 2010, Physicians’ Reciprocal Insurers (PRI) posted the results of a survey it conducted of 500 physicians regarding physicians’ implementation of EHR software and the impact on that decision of the EHR incentive payments and penalties. One significant survey result revealed that while 85 percent of surveyed physicians were aware of financial incentives that Medicare and Medicaid offered for implementing EHR systems, more than 35 percent of surveyed physicians did not know that they face government-assessed financial penalties in the form of Medicare payment reductions for not complying with meaningful use (see below) of EHR by 2015. More specifically, beginning in 2015 and after, physicians who cannot demonstrate meaningful use of EHR will have their Medicare reimbursement reduced. The reduction starts at one percent and increases each year that the physician cannot make this demonstration, up to a maximum of 5 percent. The survey found, however, that this payment penalty did not seem to have its intended effect of encouraging EHR implementation, as more than 65 percent of the physicians who were aware of these financial penalties said that those penalties would not cause them to implement EHR.<sup>4</sup>

### **“Meaningful use” or “certified” EHR technology**

The financial incentives provided under Medicare and Medicaid are available to eligible professionals who implement and demonstrate “meaningful use” of “certified” EHR technology. On July 13, 2010, the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced two complimentary final rules to explain the implementation of the incentive programs.

The CMS regulations specify the objectives that eligible professionals must achieve in payment years 2011 and 2012 to qualify for the incentive payments; the ONC regulations specify the technical capabilities that EHR technology must have to be certified and support eligible professionals in meeting the meaningful use objectives.<sup>5</sup>

There is a two-pronged test to determine whether an eligible professional will be able to obtain the monetary incentives provided under HITECH. First, eligible professionals must adopt so-called “certified EHR” and second, eligible professionals must establish “meaningful use” of the certified EHR. EHR systems are certified by organizations that have been authorized by the ONC to perform such certifications. Visit [www.ama-assn.org/go/hit](http://www.ama-assn.org/go/hit) for a list of certified EHR.

### **Key definitions**

“Certified EHR” means (a) “complete EHR” that meets the requirements included in the definition of “qualified EHR” and that has been tested and certified in accordance with the ONC’s certification program, or (b) a combination of “EHR modules” that have been tested and

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<sup>3</sup> 42 C.F.R. § 495.310

<sup>4</sup> Information regarding the survey can be accessed at [www.pri.com/news/news/2010-09-22/](http://www.pri.com/news/news/2010-09-22/)

<sup>5</sup> The CMS regulations can be accessed at [www.cms.gov/EHRIncentivePrograms/01\\_Overview.asp#TopOfPage](http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage). The ONC regulations can be accessed at <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1196&parentname=CommunityPage&parentid=6&mode=2>

certified in accordance with the ONC’s certification program, which also meets the requirement of “qualified EHR.”<sup>6</sup>

“Complete EHR” means EHR technology that has been developed to meet, at a minimum, all applicable certification criteria adopted by the Secretary of Health and Human Services (Secretary).<sup>7</sup> The ONC has stated that the term “complete EHR” includes EHR technology that can perform all of the applicable capabilities required by certification criteria and to distinguish it from EHR technology that cannot perform those capabilities.

“Qualified EHR” means an electronic record of health-related information on an individual that: (a) includes patient demographic and clinical health information, such as medical history and problems lists; and (b) has the ability: (i) to provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with and integrate such information from other sources.<sup>8</sup>

“EHR modules” means any service, component or combination thereof that can meet the requirements of at least one certification criterion adopted by the ONC.<sup>9</sup> While the ONC provides that the use of EHR modules may enable an eligible professional to create a combination of products and services that collectively meets the definition of certified EHR, the eligible professional bears the responsibility for ensuring that the certified EHR modules are capable of working together to support the achievement of meaningful use and are interoperable.

### **Eligible professionals and demonstrating meaningful use**

Medicare “eligible professionals” include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, optometry or chiropractic.<sup>10</sup> Medicaid “eligible professionals” including the following who meet Medicaid patient volume requirements: physicians and dentists; nurse practitioners; certified nurse-midwives and physician assistants practicing in federally qualified health centers (FQHCs) or rural health clinics (RHCs) that are led by a physician assistant.<sup>11</sup> Professionals who provide 90 percent or more of their covered services (based on claims) in a hospital inpatient or emergency room setting are not eligible under either program.<sup>12</sup> The 90 percent computation is based on the place of service codes on claims for reimbursement for the relevant professional.<sup>13</sup>

Eligible professionals must meet a core set of meaningful use objectives and associated measures: including five of 10 so-called “menu set” objectives and associated measures (including one public health measure).<sup>14</sup> However, certain objectives and measures may not apply to the particular provider and therefore, the eligible professional need not comply with such measures if an exclusion is permitted. If the eligible professional practices at multiple sites, 50 percent of the patient encounters (based on the place of service codes) must be at sites with certified EHR. The AMA’s excellent summary of the meaningful use requirements is attached as [Appendix 2](#), and [www.ama-assn.org/go/hit](http://www.ama-assn.org/go/hit) offers additional information including links to the actual regulations.

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<sup>6</sup> 45 C.F.R. § 170.102

<sup>7</sup> Ibid

<sup>8</sup> Ibid

<sup>9</sup> Ibid

<sup>10</sup> 42 C.F.R. § 495.100

<sup>11</sup> 42 C.F.R. § 495.304(b)

<sup>12</sup> 42 C.F.R. § 495.4

<sup>13</sup> Ibid

<sup>14</sup> 42 C.F.R. § 495.6(e)

Once the EHR system has been installed and is capable of use, an individual eligible professional (and not his or her practice group as a whole) must visit [www.cms.gov/ehrincentiveprograms/](http://www.cms.gov/ehrincentiveprograms/) to register on the incentive program Web site. Eligible professionals must demonstrate meaningful use to the CMS through a one-time, secure Web-based attestation beginning in 2011 and subsequent attestation and electronic reporting of clinical quality information.<sup>15</sup> An eligible professional's first participation year requires a 90-day continuous reporting period; subsequent participation years require a full calendar year for reporting purposes. Therefore, an eligible professional may submit attestation beginning as early as April 2011 (indicating 90 days of continuous use during 2011) and would receive incentive payments beginning in May 2011.

## **Evaluation and contracting issues**

Against this background, it is clear that eligible professionals have a lot to gain or lose by the adoption of an EHR system. This will also be true for physicians who are contemplating participation in an ACO or other new practice arrangement. To the extent that physicians intend to delegate decision-making responsibility for EHR system decisions, they should ensure that those who will be making these decisions really understand their EHR needs, and are fully qualified, either personally or through access to expert consultants, to negotiate an appropriate EHR contract. The following outlines some of the major considerations.

When deciding which of the many EHR systems available to adopt, the physician's first consideration should be whether the EHR system is being offered by an experienced vendor of computerized health information systems. Obviously, it is important that the vendor has received or is in the process of receiving certification of its system or modules, and that the EHR system has a good reputation among the physician's peers in terms of both implementation and usability. Cost is another consideration. Despite the availability of the annual Medicare or Medicaid incentive payments, implementation of the EHR system will precede receipt of those payments. Again, the earliest date on which an incentive payment can be received for the initial participation year is one month after attestation of 90 days of meaningful use during the first reporting period, and the totality of payments will be made over an extended period of time spanning to five or six years. However, since some vendors are willing to help eligible professionals finance the implementation of EHR systems, the possibility of such assistance may be a key initial consideration when exploring which of the available EHR systems the eligible physician should acquire and implement.

As a consequence of the large number of issues that surround the licensing and implementation of a certified EHR system, it may be most helpful to discuss those issues in the context of an eligible professional entering into an agreement with an EHR vendor.

An eligible professional must clearly understand that while an EHR vendor can provide a certified EHR (the first of the two tests necessary for the incentive payments to begin), only eligible professionals can satisfy the meaningful use requirement. As a result, this dichotomy between EHR certification and meaningful use will be central to any agreement between an EHR vendor and an eligible professional.

Due to the inherent complexity of EHR systems and the effect that implementation of that system will have on the eligible professional's practice (it will result in changes in work flows and documentation routines, and it will impact all of the business and medical records of the eligible professional), the acquisition and implementation of an EHR system should be viewed as a collaboration between the EHR system vendor and the eligible professional. Without such

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<sup>15</sup> 42 C.F.R. § 495.8(a)

collaboration, it will be impossible for the vendor to accomplish its obligations and to deliver the certified EHR system. And the eligible professional will not be able to implement an EHR system that fulfills the professional's expectations and needs unless the professional invests the time and resources necessary to assist the vendor in the implementation. To that end, unless the eligible professional already has a competent information technology professional involved in its practice, it would be advisable to retain an information technology consultant to help with the evaluation and implementation of the EHR system.

In negotiating an agreement with an EHR vendor, an eligible professional must be mindful of various provisions that are involved in the licensing and implementation of that system:

- The agreement must contain a detailed confidentiality provision that protects the financial and business records of the eligible professional to which the EHR vendor must, of necessity, be exposed.
- The EHR vendor must also sign a business associate agreement with the eligible professional, as required by the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, because the vendor will have full access to the protected health information (PHI) of all of the eligible professional's patients.
- There must be a detailed work plan agreed to by the parties and appended to the agreement. The work plan must contain a description and timetable outlining when and how the EHR system will be implemented. The eligible professional's payment obligations in the agreement should be contingent on the professional's acceptance of deliverables. The professional should also be able to retain a substantial portion of the total to be paid until the professional has accepted the entire EHR system and the EHR system has obtained certification.
- The agreement must indicate whether any hardware or additional software (other than the EHR) is included in the price. Will the EHR vendor provide ongoing software maintenance and support, and is it included in the price?
- The parties must decide if the EHR vendor will provide off-the-shelf or customized products. The parties must also decide whether the deliverables will be individual modules to be integrated into the eligible professional's existing information technology system or if the new system will be delivered to supplant the existing system the professional may be utilizing. Note that if the EHR vendor is supplying individual modules to coordinate with the existing health information technology of the eligible professional, in order for the eligible professional to achieve meaningful use, the eligible professional will want to be sure that each vendor has obtained certification of its part of the EHR system.
- Each party must specify the availability of resources. If the eligible professional does not have an information processing department, the professional may be obligated to hire an information technology consulting firm to work with the EHR vendor on the professional's behalf.
- If the EHR system's implementation will not completely change all of the eligible professional's information technology, the vendor must warrant that the installed EHR system will be compatible with the existing health information technology and other information technology of the eligible professional.

- The EHR vendor must undertake to fully indemnify the eligible professional against any infringement by the EHR system of any intellectual property rights of third parties as well as various personal actions of the vendor's staff. In addition, the parties will need to discuss whether the EHR vendor will indemnify the professional against any intellectual property infringement by any third-party software included in the EHR system.
- The parties must detail acceptance testing for the EHR system, an area that would be greatly assisted by an information technology professional either on the staff of or hired by the eligible professional.
- Based on the testing, the EHR system will be accepted as implemented.

In drafting the agreement between the EHR vendor and the eligible professional, the following additional provisions need to be reflected:

- The parties must clearly delineate their responsibilities and the interdependency of the vendor's obligations on the eligible professional's approval of each of the deliverables. Obviously, if the eligible professional does not promptly perform expected tasks, the vendor cannot be expected to comply with the timetable in the agreement.
- There must be a clear definition of the products (the various modules and components to be delivered and installed by the vendor) and the services that the vendor will be providing (implementation, training, data conversion, ongoing maintenance and support).
- The agreement must clearly describe the resources that each party is expected to contribute to the project, when the resources are to be provided and the timing of the roll-out of the various deliverables.
- The vendor must provide the eligible professional with user documentation that is warranted by the vendor to clearly reflect the EHR being delivered co-ordinate with the eligible professional's underlying information technology systems so that the use of the EHR in the eligible professional's environment is seamless.
- If the vendor is to train the eligible professional's technology staff and end users on the EHR system, the number of sessions, content of the sessions and location of the training must be detailed.
- The vendor must provide the eligible professional with full insurance coverage, including workers' compensation, commercial general liability, automobile and information technology errors, and omissions insurance. The policy must provide that the eligible professional will be included as an additional insured and that the eligible professional will be notified if there are any changes in the coverage after the agreement is signed.
- There is also an array of standard and specific representations and warranties that will have to be negotiated with the vendor.
- Vendors typically seek to negotiate limitations of liability. The eligible professional must be sure that these limitations are fair and related to the actual risks to which the eligible professional is exposed. Remember, as between the party selling the EHR and the party buying the system, the seller is best able to know what may be wrong with the system and protect the buyer from those risks.
- Each agreement must contain a section that contemplates breaches, remedies and termination. This includes the eligible professional's right to terminate for breaches by the EHR vendor, keeping in mind that the eligible professional has time limits on adoption of the

EHR system and that termination, though satisfying, may be counterproductive to the eligible professional's ultimate goal. The better tactic might be for the eligible professional to negotiate penalties (reductions in the price paid) for the EHR's failure to meet the agreed timetable.

The final issues to be considered are the risk of the eligible professional's achievement of meaningful use:

- Remember that there are two parts to the test that permits the eligible professional to obtain the financial incentives of HITECH. The first is that the EHR is certified, and the second is that the eligible professional has achieved "meaningful use" of the EHR. To protect the first part, the eligible professional must obtain a warranty from the EHR vendor assuring the professional that the vendor has obtained, or applied for, certification of its EHR system or modules from an ONC-authorized testing and certification body. If the certification is in process, the agreement must require that full payments are not due to the vendor until certification has been received, and if the certification requires revisions to the EHR system as delivered, the vendor must make those revisions at its expense. A related issue arises when the vendor itself modifies a deliverable. The warranty must indicate that if the vendor does modify a deliverable, the deliverable will either remain certified or the vendor will obtain recertification at its expense.
- The agreement must clarify the steps to be accomplished by each party and the timetable necessary for the eligible professional to achieve meaningful use in 2011 or 2012.
- Within the detailed implementation work plan there must be a detailed meaningful use implementation schedule. The work plan must indicate what support, if any, the vendor will provide toward the eligible professional's meaningful use implementation efforts—training, assistance with certification, conversion of existing record and the like.
- If the vendor is planning to implement third-party software in its certified product, that fact must be disclosed and a determination of who is certifying the third-party product delineated. A license agreement covering the third-party product must address the responsibility for certification of the third-party product, indemnification of any intellectual property infringement, and the flow-down of third-party license representations and warranties and licensing requirements.
- The agreement must confirm what assurances the vendor will provide regarding updates to the installed system that may be necessary for the eligible professional to meet any of the meaningful use requirements applicable beyond 2011 or 2012.

If an eligible professional, or professional group that includes an eligible professional, will rely on the EHR of a facility to demonstrate meaningful use, the professional or group should take reasonable steps to confirm the certification of the facility's EHR. If an eligible professional is asked to amend his or her employment agreement or other contracts with the facility to address the reassignment of the right to receive the incentive payments, the agreement should be carefully reviewed to ensure that it is within the Stark safe-harbor for facility-sponsored information technology arrangements.

Regardless of what the vendor states, it is imperative that the eligible professionals separately vet the certification of the EHR. As mentioned previously, there is a Web site on which the ONC lists certified EHR: <http://onc-chpl.force.com/ehrcert>.

As is clear from this chapter, the adoption of a certified EHR system and the achievement of meaningful use is a very arduous task. Eligible professionals should remember that the incentives or penalties that are the consequences of this task are not insignificant.

## Chapter 6 Appendix 1: Incentive payment matrices

<b>Medicare incentive payments</b>					
Calendar year	First calendar year in which the eligible professionals receives an incentive payment				
	2011	2012	2013	2014	2015+
2011	\$18,000				
2012	\$12,000	\$18,000			
2013	\$8,000	\$12,000	\$15,000		
2014	\$4,000	\$8,000	\$12,000	\$12,000	
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016		\$2,000	\$4,000	\$4,000	\$0
<b>Total:</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>	<b>\$0</b>

<b>Medicaid incentive payments</b>						
Calendar year	First calendar year in which the eligible professionals receives an incentive payment					
	2011	2012	2013	2014	2015	2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
<b>Total:</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>

## Chapter 6 Appendix 2: Summary of the meaningful use requirements

### Overview of Medicare incentives in the Centers for Medicare and Medicaid Services (CMS) final rule on meaningful use of certified electronic health records<sup>1</sup>

#### Eligibility

**Medicare eligibility:** For Medicare incentive payments, an eligible professional (EP) is a doctor of medicine or osteopathy, dentist or dental surgeon, podiatrist, optometrist or chiropractor. EPs can register for the program starting in January 2011.

**Hospital-based professionals:** Hospital-based EPs (i.e., inpatient and emergency room departments) are not eligible for the Medicare incentive payments nor are the majority of hospital-based EPs eligible for Medicaid incentive payments (the only exception to this rule is for those EPs practicing predominantly in a Federally Qualified Health Center [FQHC] or Rural Health Clinic [RHC]). Refer to Attachment 3 for details on Medicaid eligibility. CMS defines hospital-based EPs as those who furnish at least 90 percent of their professional services in a hospital setting, either inpatient or emergency room, in the year preceding the payment year. CMS will determine non-eligibility based upon site of service codes (code 21 for inpatient hospital and code 23 for emergency room, hospital). EPs providing services in outpatient settings, including ambulatory clinics, are eligible for incentives.

#### Program structure and process for receiving incentives

**Common set of criteria for Medicare and Medicaid incentives:** In order to qualify for the Electronic Health Record (EHR) incentive programs under the Medicare and Medicaid programs, a physician must be a “meaningful user” of a certified EHR. CMS has developed meaningful use criteria that applies to EPs, including physicians, participating in the Medicare Fee-For-Service (FFS) and the Medicare Advantage (MA) incentive programs, and is the criteria are the standard for those participating in the Medicaid incentive program. States can add additional meaningful use criteria to the Medicaid program only if they pertain specifically to public health objectives and data registries.

**Reporting period:** For the first year an EP applies for and receives an incentive payment, the EHR reporting period will be 90 days for any continuous period beginning and ending within the calendar year (i.e., EHR reporting period can be Jan. 1, 2011 to April 1, 2011; March 13, 2011 to

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<sup>1</sup> This document is a summary of CMS’ final rule on the Medicare and Medicaid Electronic Health Record Incentive Programs set forth by the “American Recovery and Reinvestment Act of 2009.” Visit [www.cms.gov/ehrincentiveprograms/](http://www.cms.gov/ehrincentiveprograms/) to view the entire rule and requirements.

June 11, 2011; etc.). For every year after the first payment year, the EHR reporting period will be for the entire calendar year.

**Three stages for meeting meaningful use criteria:** In general, Stage 1 criteria will require: (1) electronically capturing health information in a structured format; (2) using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible); (3) implementing clinical decision support tools to facilitate disease and medication management; and (4) using EHRs to engage patients and families and reporting clinical quality measures and public health information. The reporting requirements vary based on when a physician begins reporting. Stages 2 and 3 will be defined in future rulemaking.

	1st payment year	2nd payment year	3rd payment year	4th payment year	5th payment year
2011	Stage 1	-	-	-	-
2012	Stage 1	Stage 1	-	-	-
2013	Stage 2	Stage 1	Stage 1	-	-
2014	Stage 2	Stage 2	Stage 1	Stage 1	-
2015	TBD	TBD	TBD	TBD	TBD
2016	TBD	TBD	TBD	TBD	TBD

**Registration:** EPs can register for the program starting in January 2011. CMS will provide more details on the registration process in the future.

**One-time switch policy:** EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs are able to participate in only one program, and have to designate which one they wish to participate in. After their initial designation and receipt of an incentive payment, EPs are allowed to change their program selection only once and only for a payment year prior to 2015.

**Payment process:** For EPs, the payment year is based on the calendar year starting in 2011. Incentive payments will be made electronically on a rolling basis by a single payment contractor as they ascertain that an EP has demonstrated meaningful use for the applicable reporting period and has reached the threshold for maximum payment. Payments will be made as a single consolidated, annual payment. Incentive payments will be tracked using the qualifying EP's Tax Identification Number (TIN) and National Provider Identifier (NPI). EPs who do not use TINs but use a social security number (SSN) will be tracked by their SSN. Incentive payments are tied to the individual EP and not his or her place of practice. For 2011, incentive payments will be made as early as May 2011 to EPs who successfully demonstrate they are a meaningful user of a certified EHR.

**Demonstration of meaningful use:** For 2011, EPs are required to demonstrate that they satisfy each of the proposed meaningful use objectives through a one-time attestation following the reporting period, which will also cover the identification of the certified EHR technology they are utilizing, and the results of their performance on all the measures associated with the objectives of meaningful use.

## Incentives

**Medicare FFS incentives:** EPs who are meaningful EHR users are eligible for incentives based on an amount equal to 75 percent of their allowed Medicare Part B charges for covered professional services subject to the annual maximum limits specified below:

Calendar year (CY) Note: A payment year equals a CY	First CY in which the EP receives an incentive payment				
	2011	2012	2013	2014	2015 and subsequent years
2011	\$18,000	-	-	-	-
2012	\$12,000	\$18,000	-	-	-
2013	\$8,000	\$12,000	\$15,000	-	-
2014	\$4,000	\$8,000	\$12,000	\$12,000	-
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0; -1% of Medicare fee schedule (penalty)
2016		\$2,000	\$4,000	\$4,000	\$0; -2% of Medicare fee schedule (penalty)
<b>Total:</b>	\$44,000	\$44,000	\$39,000	\$24,000	\$0

For example, a physician with a total of \$15,000 in allowed Medicare Part B charges in 2011 is eligible for up to \$11,250, while a physician with a total of \$30,000 in allowed Medicare Part B charges in 2011 is eligible for the maximum amount, \$18,000.

**Additional incentives for providing services in health professional shortage areas:** An EP who furnishes more than 50 percent of covered services in a geographic health professional shortage area (HPSA) is eligible for an additional 10 percent incentive on top of the maximum incentive payment amount. CMS will determine eligibility by reviewing the frequency of services provided over a 1-year period (January 1 through December 31). Note: FQHCs are not entitled to any Medicare or Medicaid incentive payments under this incentive program.

### Criteria EPs must meet to receive incentives

**Two categories of measures for reporting:** There are two categories of objectives and associated measures to be reported on: (1) health IT objectives, which include a “core set” and a “menu set,” that focus on an EP’s use of certain EHR functions (e.g., entering medication orders using Computerized Physician Order Entry [CPOE]); and (2) clinical quality measures, which focus on processes, experience, and/or outcomes of patient care, observations, or treatment.

### Health IT measures

**Stage 1 meaningful use criteria for EPs:** EPs must successfully meet all 15 core objectives and measures as well as five objectives and measures of the EP’s choice from a menu set. EPs have an option to exclude certain objectives/measures that are not applicable to his or her practice.

**Health IT “core” measures:** The core measures set include: (1) record more than 50 percent of patient demographics; (2) record more than 50 percent of patient vital signs and chart changes;

(3) maintain up-to-date problem list of current and active diagnoses for more than 80 percent of patients; (4) maintain active medication list for more than 80 percent of patients; (5) maintain active medication allergy list for more than 80 percent of patients; (6) record smoking status for more than 50 percent of patients age 13 or older; (7) provide clinical summaries to patients for more than 50 percent of all office visits within three business days; (8) upon request, provide more than 50 percent of patients with an electronic copy of their medical record within three business days of request; (9) generate and transmit more than 40 percent of permissible prescriptions electronically; (10) more than 30 percent of patients with at least one medication in their medication list have at least one medication ordered through computerized provider order entry (CPOE); (11) enable functionality for drug-drug and drug-allergy interaction checks; (12) perform at least one test of EHR's capacity to electronically exchange key clinical information; (13) implement at least one clinical decision support rule; (14) conduct or review a security risk analysis, implement security updates as necessary and correct identified security deficiencies; and (15) report clinical quality measures.

**Health IT “menu” measures:** EPs must choose five from a menu of 10 measures. The menu measures set includes: (1) implement drug formulary check system and have access to at least one internal or external drug formulary; (2) incorporate more than 40 percent of clinical laboratory test results in the appropriate format; (3) generate at least one listing of patients with a specific condition; (4) provide more than 10 percent of patients with patient-specific education resources; (5) perform medication reconciliation for more than 50 percent of transitions of care; (6) provide a summary of care record for more than 50 percent of patient transitions or referrals; (7) perform at least one test of data submission and follow-up submission if successful to immunization registry (where registries can accept electronic submissions); (8) perform at least one test of syndromic surveillance data submission and follow-up submission if successful to a public health agency (where public health agencies can accept electronic data); (9) send reminders for preventive and follow-up care (per patient preference) for more than 20 percent of patients age 65 or older or age five or younger; and (10) provide more than 10 percent of patients with electronic access to their medical record within four days of it being updated in the EHR. Refer to Attachment 1 for details on the core and menu sets.

### **Reporting method for 2011: attestation/reporting method for 2012: attestation**

#### **Clinical quality measures**

**Stage 1 clinical quality measures criteria for EPs:** Clinical quality measures adopted for the Medicare EHR incentive program would also apply to EPs in the Medicaid EHR incentive program. CMS limits the clinical quality measures to those for which electronic specifications are available as of the date of publishing of the final rule. EPs are required to submit information using certified EHR technology on: three core clinical quality measures and three additional clinical quality measures. Refer to Attachment 2 for details on quality measures.

### **Reporting method for 2011: attestation/reporting method for 2012: using certified EHR technology**

#### **Other program criteria**

**MA organizations:** Incentive payments are available to qualifying MA organizations for the adoption and meaningful use of EHR technology by their affiliated EPs. MA-affiliated EPs are employed or subcontracted by an MA organization and on average provide at least 20 hours of patient care services per week. For a subcontracted EP, at least 80 percent of his or her professional services have to be furnished to enrollees of the qualifying MA organization.

**E-prescribing of controlled substances:** For purposes of the e-prescribing meaningful use objective, a “permissible prescription” is based on the guidelines for prescribing Schedule II controlled substances, which were in effect when the notice of proposed rulemaking was published on Jan. 13, 2010. Therefore, EPs will not be able to count the e-prescribing of controlled substances towards the 40 percent threshold requirement. EPs will have to electronically transmit 40 percent of non-controlled substances to meet the e-prescribing measure.

**Participation in the meaningful use incentive program and other incentive programs:** An EP can participate in both the meaningful use incentive program as well as the Medicare Physician Quality Reporting Initiative (PQRI) if they qualify for both programs. If the EP chooses to participate in the **Medicare EHR** incentive program, he or she cannot participate in the **Medicare e-prescribing** incentive program simultaneously. If the EP chooses to participate in the **Medicaid EHR** incentive program, he or she **can** participate in the **Medicare e-prescribing** incentive program simultaneously. Visit [www.cms.gov/erx incentive](http://www.cms.gov/erx incentive) for details regarding the Medicare e-prescribing incentive program.

**Online posting of names of Medicare EPs who are meaningful EHR users:** The Department of Health and Human Services (HHS) will list in an understandable format the names, business addresses and business phone numbers of successful EHR users. HHS will not post information on group practices because incentive payments will not be based at the group practice level.

**Document maintenance for compliance review:** EPs will need to maintain evidence of qualifications to receive incentive payments for 10 years after the date they register for the incentive program.

## **Overview of clinical quality measures reporting in the CMS final rule on meaningful use**

### **Clinical quality measures**

Clinical quality measures have been defined as measures of processes or experience and/or outcomes of patient care, observations or treatment that relate to one or more of the Institute of Medicine (IOM) domains of health care quality (e.g., effective, safe, efficient, patient-centered, equitable and timely).

### **CMS’ measure selection and related information**

- Clinical quality measures adopted for the Medicare EHR incentive program would also apply to EPs in the Medicaid EHR incentive program.
- CMS limits the clinical quality measures to those for which electronic specifications are available as of the date of publishing of the final rule. Visit [www.cms.gov/QualityMeasures/03\\_ElectronicSpecifications.asp#TopOfPage](http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage) to view these specifications.
- EHR specifications must only be obtained from the specification documents for the EHR incentive program regardless of measure use in other incentive programs.
- All selected clinical quality measures for submission by Medicare and Medicaid eligible professionals for 2011 and 2012 are NQF-endorsed<sup>®</sup>. However, CMS is not limited to selecting only NQF-endorsed measures in the future.

- Certified EHR technology must be able to calculate measure numerators, denominators and exclusions for each of the clinical quality measures listed in the final rule. These measures are listed in [Table 6](#) below.

### **Reporting Clinical Quality Measures**

- Use of an attestation methodology by EPs to submit summary information to CMS on clinical quality measures to demonstrate meaningful use of certified EHR technology for the 2011 reporting year. If the capability exists by calendar year 2012, HHS may require electronic receipt of the data.
- EPs are required to submit information using certified EHR technology on: three core clinical quality measures (outlined in [Table 7](#) below) and; three additional clinical quality measures (listed in [Table 6](#) below—cannot be core or alternate core measures).
- Although CMS requires all EPs to report core measures, there is no requirement to satisfy a minimum value for any of the numerator, denominator or exclusion fields for clinical quality measures. The value for any or all of those fields, as reported to CMS or the states, may be zero.
- If an EP reports zero values for their three additional clinical quality measures, then for the remaining clinical quality measures in [Table 6](#) (other than the core and alternate core measures), the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator. If this is done, the EP is exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures) in [Table 6](#).
- EPs are not penalized in the Stage 1 reporting years (2011-2012) as long as they have adopted a certified EHR and that EHR calculates and the EP submits the required clinical quality information.
- In an effort to avoid duplicative and redundant reporting, efforts are underway to align reporting timeframes across CMS programs. In addition, in an attempt to align reporting requirements for Pediatric EPs, the EHR incentive final rule contains Clinical Quality Measures that are also in the CHIPRA initial core measure set.
- 19 of the 44 measures listed in [Table 6](#) were re-tooled by the AMA-convened Physician Consortium for Performance Improvement (PCPI).

### **2011—Medicaid**

- For all applicable Medicaid patients, EPs would have to demonstrate use of certified EHR by capturing data elements and calculating results for CMS.
- States could accept attestation if infrastructure is not available; however,
- It is expected that Medicaid providers will qualify for the incentive payment by adopting, implementing or upgrading to EHR technology and will not need to attest to meaningful use in 2011. It is expected that Medicaid EPs will be utilizing certified EHR technology to submit to the individual states by the following year.

**Clinical quality measures for submission by Medicare or Medicaid eligible professionals for stage 1: 2011 and 2012 payment year (Table 6 in the final rule)**

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
PQRI 1 NQF 0059	Title: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus  Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%	National Committee for Quality Assurance (NCQA)  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 2 NQF 0064	Title: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus  Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDLC level in control (less than 100 mg/dl)	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 3 NQF 0061	Title: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus  Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 5 NQF 0081	Title: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)  Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD who were prescribed ACE inhibitor or ARB therapy	American Medical Association-sponsored Physician Consortium for Performance Improvement (AMA-PCPI)  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 7 NQF 0070	Title: Coronary Artery Disease (CAD): Beta- Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)  Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed betablocker therapy	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
PQRI 110 NQF 0041	Title: Preventive Care and Screening: Influenza Immunization for Patients = 50 Years Old  Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	Alternative core
PQRI 111 NQF 0043	Title: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older  Description: Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 112 NQF 0031	Title: Preventive Care and Screening: Screening Mammography  Description: Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 113 NQF 0034	Title: Preventive Care and Screening: Colorectal Cancer Screening  Description: Percentage of patients aged 50 through 80 years who received the appropriate colorectal cancer screening	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp">www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp</a>	
PQRI 6 NQF 0067	Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD  Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 8 NQF 0083	Title: Heart Failure: Beta- Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)  Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD and who were prescribed beta-blocker therapy	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
PQRI 9 NQF 0105	<p>Title: Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD</p> <p>Description: Percentage of patients aged 18 years and older diagnosed with new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 12 NQF 0086	<p>Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</p> <p>Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 18 NQF 0088	<p>Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</p> <p>Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 19 NQF 0089	<p>Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</p> <p>Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
PQRI 53 NQF 0047	Title: Asthma: Pharmacologic Therapy  Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment	AMA-PCPI Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 64 NQF 0001	Title: Asthma Assessment  Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 66 NQF 0002	Title: Appropriate Testing for Children with Pharyngitis  Description: Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 71 NQF 0387	Title: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer  Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 72 NQF 0385	Title: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients  Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
PQRI 102 NQF 0389	<p>Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients</p> <p>Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer</p>	<p>AMA-PCPI Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 115 NQF 0027	<p>Title: Preventive Care and Screening: Advising Smokers to Quit</p> <p>Description: Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking</p>	<p>NCQA Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 117 NQF 0055	<p>Title: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient</p> <p>Description: Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam</p>	<p>AMA-PCPI Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 119 NQF 0062	<p>Title: Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients</p> <p>Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months</p>	<p>NCQA Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
PQRI 128 NQF 0421	<p>Title: Adult Weight Screening and Follow-Up</p> <p>Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.</p>	<p>CMS/Quality Insights of Pennsylvania (QIP) Contact information: <a href="mailto:PQRI_inquiry@cms.hhs.gov">PQRI_inquiry@cms.hhs.gov</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	Core

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
PQRI 163 NQF 0056	Title: Diabetes Mellitus: Foot Exam  Description: The percentage of patients aged 18 through 75 years with diabetes who had a foot examination	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 197 NQF 0074	Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol  Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines)	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 200 NQF 0084	Title: Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation  Description: Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy	AMA-PCPI  Contact information: <a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 201 NQF 0073	Title: Ischemic Vascular Disease (IVD): Blood Pressure Management Control  Description: Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
PQRI 204 NQF 0068	Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic  Description: Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
NQF 0004	Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement  Description: Percentage of adults aged 18 and over diagnosed with AOD abuse or dependence and receiving a related service who initiate treatment Assessment of the degree to which members engage in treatment with two additional AOD treatments within 30 days after initiating treatment	NCQA  Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
NQF 0012	<p>Title: Prenatal Screening for Human Immunodeficiency Virus (HIV)</p> <p>Description: Percentage of patients who gave birth during a 12 month period who were screened for HIV infection during the first or second prenatal care visit</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="http://www.ama-assn.org">www.ama-assn.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
NQF 0013	<p>Title: Blood pressure measurement</p> <p>Description: Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged &gt; 18 years with diagnosed hypertension</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="http://www.ama-assn.org">www.ama-assn.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	Core
NQF 0014	<p>Title: Prenatal Anti-D Immune Globulin</p> <p>Description: Percentage of D-negative, unsensitized patients who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="http://www.ama-assn.org">www.ama-assn.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
NQF 0018	<p>Title: Controlling High Blood Pressure</p> <p>Description: Percentage of patients with last BP &lt; 140/80 mm Hg</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
NQF 0024	<p>Title: Weight Assessment and Counseling for Children and Adolescents</p> <p>Description: Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	Alternative core
NQF 0028	<p>Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention</p> <p>Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention</p>	<p>AMA-PCPI</p> <p>Contact information: <a href="http://www.ama-assn.org">www.ama-assn.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	Core

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
NQF 0032	<p>Title: Cervical Cancer Screening</p> <p>Description: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>		
NQF 0033	<p>Title: Chlamydia screening in women</p> <p>Description: Percentage of eligible women who were identified as sexually active that had at least one test for chlamydia during the measurement year.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
NQF 0036	<p>Title: Use of appropriate medications for asthma</p> <p>Description: Percentage of patients who were identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the measurement year.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	
NQF 0038	<p>Title: Childhood Immunization Status</p> <p>Description: Percentage of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	Alternative Core
NQF 0052	<p>Title: Low back pain: use of imaging studies</p> <p>Description: Percentage of patients with new low back pain who received an imaging study (plain x-ray, MRI, CT scan) conducted on the episode start date or in the 28 days following the episode start date.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a></p>	

Measure number	Clinical quality measure title & description	Clinical quality measure developer & contact information	Electronic measure specifications information	Core clinical quality measure
NQF 0075	<p>Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</p> <p>Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDLC&lt;100 mg/dL.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	
NQF 0575	<p>Title: Diabetes: Hemoglobin A1c Control (&lt;8.0%)</p> <p>Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c &lt;8.0%.</p>	<p>NCQA</p> <p>Contact information: <a href="http://www.ncqa.org">www.ncqa.org</a></p>	<a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp">www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp</a>	

<b>Measure group: Core for all EPs, Medicare or Medicaid (Table 7 in the final rule)</b>	
<b>NQF measure number &amp; PQRI implementation number</b>	<b>Clinical quality measure title</b>
NQF 0013	<b>Title:</b> Hypertension: Blood Pressure Measurement
NQF 0028	<b>Title:</b> Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention
NQF 0421 PQRI 128	<b>Title:</b> Adult Weight Screening and Follow-up
<b>Alternative core measures</b>	
NQF 0024	<b>Title:</b> Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	<b>Title:</b> Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
NQF 0038	<b>Title:</b> Childhood Immunization Status

## Chapter 7: Managing antitrust risks associated with accountable care organizations

**Henry S. Allen, Jr. and George M. Sanders**

When Congress created accountable care organizations (ACO) in the Affordable Care Act, it recognized that clinical integration is the most promising path towards reducing medical costs while at the same time improving care. The hope is that the creation of ACOs will reduce Medicare costs, while at the same time improve care and access to care. Many physicians have already embraced clinical integration and either possess or are developing functioning clinical integration programs. While these organizations have typically sold their services to commercial health insurers, they will, most likely, have developed an organization that should easily qualify as an ACO. The premise underlying the ACO portion of the Affordable Care Act is that the legislation will give many other providers an incentive to form new ACOs that will initially have their focus on the Medicare market. It is widely presumed that physicians that form an ACO for the Medicare market will use the organization to sell integrated medical services in the private insurance market.

While Congress has encouraged the formation of ACOs, it has not granted ACOs blanket immunity from the antitrust laws. More importantly, even if the Medicare aspects of an ACO had some immunity from the antitrust laws, an ACO contracting with private health insurers would not receive immunity from the antitrust laws. Thus, as with current clinical integration efforts, physicians will have to structure ACOs in a manner consistent with the federal antitrust laws. Physicians, however, will not have to develop new antitrust legal theories for ACOs. The antitrust analysis used to evaluate physician IPAs and other clinical integration models apply equally to ACOs.

In an effort to address the antitrust treatment of ACOs, the Federal Trade Commission (“FTC”) and the Antitrust Division of the United States Department of Justice (“DOJ”) have issued their proposed Statement of Antitrust Enforcement Policy regarding accountable care organizations (“Proposed ACO Policy”). While the Proposed ACO Policy does address some of the open antitrust issues ACOs will face, it leaves open some important issues and raises some new ones. The Proposed ACO Policy represents a first step, and it may be substantially modified before it is formally adopted by the FTC and DOJ.

### **I. The Sherman and Clayton Acts: A general overview**

The antitrust laws consist of a number of federal laws that prohibit a wide range of anticompetitive conduct. While these laws are expressed in very general terms, they are supplemented by a significant body of case law and by actions taken by the federal agencies responsible for the public enforcement of the antitrust laws. In the case of physician mergers and

integration efforts, the primary antitrust laws that physicians must consider are Section 1 of the Sherman Act and Section 7 of the Clayton Act.

### **A. Section 7 of the Clayton Act**

Section 7 of the Clayton Act (Section 7) prohibits mergers that may substantially lessen competition. While most clinical integration efforts are not created by mergers, some physician groups may merge as a precursor to forming or joining an ACO. To that extent, the merger will need an antitrust analysis independent of the antitrust analysis underlying the formation of the ACO.

An analysis under Section 7 asks whether a merger will result in such a concentration of economic power in the hands of the merged entity that the new entity could exert market power. “Market power” is commonly understood to mean the ability by a firm to raise price above the competitive level or to reduce output below the competitive level.

Case law and the federal antitrust enforcement agencies recognize that it is difficult, if not impossible, in most situations to directly measure market power. Given this practical difficulty, market power is typically evaluated indirectly. This indirect evaluation requires identification of the markets in which the merged entity operates. Then, the merged entity’s share of those markets is calculated. With respect to physician practices, market share is commonly calculated by comparing the number of physicians in any given specialty working for the merged entity with the total number of physicians in those specialties who are located in the relevant geographic market. The market share of the merged entity is used as a proxy for market power. How high a market share is needed to create a presumption of market power is a complex issue that depends on many different factors. The issue of market power and its relation to market share is addressed below in Section II B.

### **B. Section 1 of the Sherman Act**

Section 1 prohibits concerted conduct between individual competitors that unreasonably restrains trade. The first and most basic question in any Section 1 analysis is whether the conduct is concerted (i.e., contracts, combinations or conspiracies) or unilateral. Without this distinction, Section 1 would conceivably outlaw every corporation, partnership and independent firm that assembles employees that could have competed against one another. The fact that every individual firm must set its own prices does not turn these firms into price-fixing conspiracies. Instead, the antitrust laws recognize that the marshalling of economic resources and actors is oftentimes essential to the efficient provision of goods and services. For example, Boeing Corporation hires engineers who could theoretically compete against one another and against Boeing Corporation, and to that extent Boeing is a combination of numerous competitors. It is absurd to think, however, that Boeing Corporation violates Section 1 of the Sherman Act when it sets its own prices and decides how much to produce.

If individual physicians form or join an ACO so they can integrate their services and collaboratively sell them, the antitrust inquiry becomes whether this concerted conduct unreasonably restrains trade. The word “unreasonable” is critical because the courts recognized shortly after the enactment of the Sherman Act that some level of cooperation between competitors is oftentimes essential to consumer welfare. Generally speaking, the antitrust laws only condemn those restraints that injure consumers. The Supreme Court has explained that the proper focus of antitrust inquiry is “whether the effect of the practice is to threaten the proper operation of our predominantly free market economy—that is, whether the practice facially appears to be one that would tend to restrict competition and decrease output, and in what

portion of the market, or instead one designed to ‘increase economic efficiency and render markets more rather than less competitive.’”<sup>1</sup>

Arrangements between competitors can enhance efficiency and benefit consumers. The struggle with respect to the enforcement of the antitrust laws is distinguishing concerted conduct that benefits consumers by creating efficiencies and is procompetitive from concerted conduct that harms consumer welfare and is therefore anticompetitive.

### **1. The per se test**

As the antitrust laws evolved, the courts created two basic tests for distinguishing procompetitive from anticompetitive conduct. One test is the application of the so-called per se prohibitions. The per se prohibitions are based on the belief that certain types of behavior are so blatantly anticompetitive that any consideration into their possible procompetitive effects is unnecessary. Accordingly, an arrangement falling under a per se prohibition is condemned as “unreasonable” without conducting any analysis into whether the concerted conduct actually has any effect (positive or negative) on competition or consumers. The traditional per se offences include price-fixing, market allocation agreements, customer allocation agreements, certain group boycotts and some tying arrangements. With respect to per se unlawful price-fixing, for example, the only issue is whether a price-fixing agreement exists. Whether the price-fixing arrangement can benefit consumers or creates efficiencies is not a question a court or an enforcement agency will consider. Relatedly, a court will not determine whether the price-fixing agreement actually harmed consumers.

A benefit provided by the use of per se prohibitions is that the per se prohibitions define with a high degree of clarity the types of concerted conduct in which competitors cannot engage. This clarity, however, comes with some costs. For example, per se prohibitions may outlaw arrangements that are procompetitive and will benefit consumers.

### **2. The rule of reason test**

The second test is the so-called rule of reason. Under the traditional rule of reason test, a court was required to determine whether the restraint was, on balance, anticompetitive. Thus, a court needed to determine whether the concerted conduct was anticompetitive and then determine whether procompetitive benefits also existed. Many types of concerted activity were lawful under the rule of reason because a threshold showing for any liability was the existence of market power. This reflects the recognition by the courts that firms or individuals engaged in concerted conduct could not harm competition if they lacked market power. Put differently, without market power, the concerted conduct could not harm consumers by harming competition.

This traditional dichotomy between the per se rule and rule of reason underwent considerable modification over the last 20 years. Driving this change was the recognition that a broad interpretation of the per se prohibitions would prevent the development of many collaborative undertakings that could create significant benefits for consumers and actually make markets more competitive. This did not mean, for example, that blatant or “naked” price-fixing arrangements were thought to have procompetitive possibilities. What was recognized is that an otherwise lawful joint venture or collaborative undertaking may need a price-fixing component in order to operate efficiently. Condemning the price-fixing component without giving any thought to the efficiencies the venture or collaboration could create would prevent the realization of those efficiencies and stands the antitrust laws on their head. This concern has resulted in the

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<sup>1</sup> *Broadcast Music Inc. v. Columbia Broadcasting Systems, Inc.*, 441 U.S. 1, 19-20 (1979).

steady erosion of the per se prohibitions and their limitation to the most blatant types of anticompetitive conduct. The result is that concerted conduct that was once considered per se unlawful is now analyzed under the rule of reason.

These changes, however, have also changed the rule of reason. Today, the first question under the rule of reason is whether the arrangement raises obvious antitrust concerns or has a component that raises an obvious antitrust concern. A good rule of thumb is that a form of concerted conduct similar to an arrangement that traditionally fell under a per se prohibition will raise antitrust concerns. For example, a joint venture between a group of physicians that, among many other things, negotiates prices with payers for its members will raise an antitrust issue. The joint negotiation of fees embedded in the arrangement is a form of price-fixing. If the arrangement does raise a price-fixing concern, the issue becomes whether the participants can show that the venture has real and substantial procompetitive benefits and the price-fixing aspect is ancillary to the operation of the overall venture. In order to show that the price component of the venture does not constitute naked price-fixing, the participants must show that the price component is “reasonably related” to the procompetitive benefits and “reasonably necessary” to the realization of these procompetitive benefits. Suspect arrangements that are not tied in this manner to a procompetitive efficiency are considered unlawful. When this connection does exist, the analysis will look to whether the arrangement gives the participants in the collaborative activity market power. A collaborative endeavor that gives its participants the ability to exert market power will raise serious antitrust risks. Without market power, however, it is unlikely that the arrangement could harm competition or consumers and is therefore unlikely to raise antitrust problems.

### **C. The enforcement of the antitrust laws**

The single largest source of antitrust enforcement comes from the private sector. The antitrust laws authorize the commencement of private lawsuits for antitrust violations by those persons or entities injured by the unlawful conduct. To give added incentives for private antitrust lawsuits, a successful antitrust plaintiff is entitled to treble damages and the payment of its attorneys’ fees by the defendant(s). Private parties also are oftentimes responsible for reporting possible antitrust violations to the federal enforcement agencies.

The Federal Trade Commission (FTC) and the United States Department of Justice (DOJ), Antitrust Division (Antitrust Division) (collectively referred to as the “Agencies”), also play a significant role in the enforcement of the antitrust laws. The Agencies have the ability to investigate possible antitrust violations and commence enforcement proceedings. The DOJ can also criminally prosecute blatant per se violations of Section 1 of the Sherman Act. The FTC and Antitrust Division, however, do much more than investigate antitrust violations and commence lawsuits. These Agencies provide advisory letters to firms concerned about the possible antitrust ramifications of a proposed collaborative arrangement. These advisory letters are published and provide insight into how the Agencies will evaluate various arrangements. These advisory letters, however, are not binding on a court and therefore have limited value when defending a civil lawsuit. The FTC and Antitrust Division have also issued various guidelines explaining how they will apply the antitrust laws in various settings. The most important guidelines for physicians are the Health Care Guidelines and the Antitrust Guidelines for Collaborations Among Competitors (1999) (“Collaboration Guidelines”). Finally, the FTC and Antitrust Division publish speeches given by their top personnel that provide some additional guidance as to how certain arrangements are viewed.

## II. Applying the antitrust laws to ACOs

The formation of an ACO by individual physicians is the type of collaborative activity that could raise antitrust concerns if not properly structured. As envisioned by Congress, a typical ACO will consolidate numerous primary care physicians and specialists by a series of contracts that fall short of a formal merger. The ACO's goal is to manage and be accountable for the overall costs and quality of care for a defined population. The ACO will make collective decisions concerning the type of care provided by its members. If an ACO branches out to private health insurance markets, it will have to negotiate reimbursement rates with health insurers on behalf of its member physicians.

### A. Addressing the issue of price-fixing

Doctors typically practice in small firms. According to the latest American Medical Association (AMA) Physician Practice Information survey (2007-2008), 78 percent of office based physicians in the U.S. are in practices in sizes of nine physicians and under, with the majority of those physicians being in either solo practice or in practices of between two and four physicians. The antitrust laws treat as competitors firms that practice in the same or related specialty and are in the same geographic market. Therefore, the limitations, created by the antitrust laws, on competitor collaborations would apply to the formation and operation of ACOs.

The Affordable Care Act does not expressly specify the level of financial or clinical integration an organization must have in order to qualify as an ACO. CMS, however, has recently issued proposed regulations that establish clinical integration requirements that ACOs will have to meet in order to participate in Medicare's shared savings program. In the Proposed ACO Policy, the FTC and DOJ have stated that ACOs complying with CMS' clinical integration standards would not face *per se* condemnation. Instead, the ACO would be evaluated under the rule of reason.

One criticism leveled against CMS' clinical integration requirements and the Proposed ACO Policy, however, is their mandating clinical integration as a precondition to participating in the shared savings program and as a precondition to an ACO's entitlement to rule of reason treatment. Under the shared savings program, every ACO participant will share financial risk. Under the FTC and DOJ's prior Health Care Guidelines, financial risk sharing was, by itself, sufficient to prevent *per se* treatment. Given that ACO participants will share financial risk, they should have more flexibility in structuring their ACOs than the current clinical integration model adopted by CMS.

At a more general level, the question is whether the ACO is structured in such a way that it will generate efficiencies that are not reasonably realizable without the creation of the ACO. A closely related question is whether the need for joint negotiations is "reasonably related" and "reasonably necessary" to the creation of the efficiencies promised by the ACO. Simply calling a collection of numerous competing physicians with little practical integration an ACO will not save this collaborative effort from condemnation under the antitrust laws. While the federal antitrust enforcement agencies have not yet addressed any such ACOs, the FTC has previously addressed the issue of sham clinical integration in the Matter of Surgical Specialists of Yakima, P.L.L.C. (SSY).<sup>2</sup> In this action, competing physician practices created a legally separate and distinct limited liability corporation. The FTC alleged that while SSY was characterized as an integrated single entity, the physician practices members of SSY: (1) were separate and independent from SSY in all material respects, (2) were not subject to the control of SSY, (3) did

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<sup>2</sup> See [www.ftc.gov/os/caselist/0210242.shtm](http://www.ftc.gov/os/caselist/0210242.shtm).

not unify their economic interests and incentives through SSY, and (4) were not significantly integrated (either clinically or financially). The FTC accused SSY of fixing prices for its members by jointly negotiating non-risk contracts, because SSY's negotiating fees on behalf of its members constituted the combined action of those members and not unilateral action by SSY.

Physicians forming an ACO can manage their antitrust risk by integrating either financially or clinically. The FTC and DOJ have an antitrust enforcement policy in health care recognizing that physician networks can jointly negotiate fees without violating the per se prohibition against price-fixing, if they have a sufficient level of financial or clinical integration. While the FTC and DOJ developed this policy to address, in part, the development of IPAs, the agencies' theories should apply with equal force to ACOs. The Proposed ACO Policy, however, does not mention financial risk sharing, and it is unclear if the FTC and DOJ will modify the Proposed ACO Policy so that it is consistent with the prior Health Care Guidelines.

### **1. Financial integration**

When otherwise competing physicians financially integrate, there are associated efficiencies that can benefit consumers. Recognizing this consumer benefit, the antitrust laws allow physicians engaging in a proper level of financial integration to jointly negotiate fees without violating the rule against price-fixing. In their Health Care Guidelines, the FTC and DOJ emphasize that the common feature underlying financial integration is the sharing of substantial financial risk.<sup>3</sup> It is believed that this risk-sharing provides strong incentives for physicians to practice efficiently by cooperating in the controlling of costs and in improving quality. The sharing of financial risk also makes it necessary for the physicians sharing the risks to jointly negotiate the fees they received under the risk-based contracts. It is critical, however, that physicians recognize that their sharing risks with respect to risk-based contracts will not justify the joint negotiation of other non-risk contracts.

There are many ways in which physician practices can financially integrate that will place the joint negotiation of fees into the rule of reason and then allow them to demonstrate that the joint negotiation of fees is reasonable. The Health Care Guidelines provide a nonexclusive list of the assorted arrangements that constitute "risk-sharing." These arrangements include: (1) capitated rate arrangements in which the health insurer or other payer pays the network a fixed "predetermined payment per covered life in exchange for the joint venture's (not merely an individual physician's) providing and guaranteeing provision of a defined set of covered services," and (2) risk pools, which are described as the "withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of the amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole."

A capitated payment arrangement creates risk for the network and its physicians because the network must provide the covered services for a fixed rate. If the network does not institute utilization controls and treatment protocols designed to keep costs down, the network and the participating physicians will lose money. This provides strong incentives for the network to institute and for the physicians to follow such controls and protocols. This will have the potential of lowering prices and make the network more competitive.

Risk pools are another common method used by physician networks to create financial risks and rewards that have the benefit of increasing efficiency. If the physician network withholds a

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<sup>3</sup> Statements of Antitrust Enforcement Policy in Health Care ("Health Care Guidelines") that were jointly issued by the DOJ and the FTC in 1996. The statements can be viewed at [www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf](http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf).

significant portion of the funds received under fee-for-service arrangements and pays its participating physicians a discounted fee, the potential distribution of withheld funds creates an incentive to follow efficiency protocols created by the network. No magic number exists for the size of the risk pool. FTC advisory letters suggest that a 15 percent withhold may not be sufficient to justify the joint negotiation of contracts, while a pool within a 15 to 20 percent range might be sufficient. The size of the necessary withhold depends on the nature of the venture and its importance to the participating physicians. For example, the size of the necessary withhold can depend on the number of patients the participating physicians expect to receive under the contract subject to the risk pool.

## **2. Clinical integration**

The FTC has also recognized the strong consumer welfare benefits made possible by properly constituted clinical integration. This type of integration, like the internal arrangements of any firm, should improve the organization and coordination of work and make it possible for the venture to reap the benefits created by the division of labor.

There is no modern case law that addresses the analysis of clinical integration under the antitrust laws. At the moment, the primary source of guidance comes from FTC advisory letters, speeches by FTC commissioners and the Health Care Guidelines. Whether the currently existing advisory letters represent a floor concerning the level of integration necessary for joint negotiations remains to be seen. Nevertheless, Agency guidance provides some positive precedent that physicians can look to in determining whether embarking on a clinically integrated collaborative project makes sense for them in their local health care market.

The FTC requires integration that contains an “active and ongoing program to evaluate and modify practice patterns by the group’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.” The Health Care Guidelines suggest that among the ways a network can satisfy the clinical integration standard is by establishing utilization control mechanisms, selectively choosing group physicians, and investing significant capital both monetary and human to realize efficiencies. Moreover, the network will have to demonstrate that the “prices to be charged for the integrated provision of services are reasonably necessary to the venture’s achievement of efficiencies....” In the absence of financial incentives that will encourage the achievement of efficiencies, the FTC demands a level of clinical integration that compels the participating physicians to act in an interdependent manner.

The FTC has strongly stated in advisory letters that a clinical integration program must have some teeth. Specifically, the program must have the ability and the will to adopt and implement clinical performance measures and measurable performance goals that the physician network enforces by disciplining or terminating physicians who do not adhere to its standards. These integration steps must create a level of interdependence between the participating physicians that makes the joint negotiation of fees “reasonably necessary” to the proper functioning of the venture. For example, in its review of MedSouth, a multispecialty physician practice association in Denver, Colorado, the FTC concluded that MedSouth produced through its clinical integration program sufficient interdependence between its physicians to justify the joint negotiation of fees.<sup>4</sup> MedSouth’s extensive clinical program included a Web-based electronic clinical data record system that allowed its physicians to access and share medical information, including

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<sup>4</sup> Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services & Products Division, Bureau of Competition, FTC, to John J. Miles, (MedSouth, Inc.) (Feb. 19, 2002) (MedSouth Advisory Opinion) at [www.ftc.gov/opa/2002/02/medsouth.shtm](http://www.ftc.gov/opa/2002/02/medsouth.shtm).

transcribed patient records, office visit notes, lab reports and similar clinical information. Also important was MedSouth's plan to adopt and implement clinical performance measures and performance goals and to monitor and enforce physician compliance with those goals and measures. The FTC concluded that in order to establish and maintain the on-going collaboration and interdependence among physicians from which efficiencies flow, it was necessary for the physicians to contract jointly. The FTC reasoned that the price for professional services needed to be established and if it were done through individual negotiations and contracting, then the full participation of the group's members—critical to their on-going collaboration and interdependence—could not be assured.

## **B. The market power issue**

As explained above, the prohibition against price-fixing raises a structural issue for physicians that they can overcome with proper financial risk sharing or clinical integration. Once the structural issue is resolved, the next issue is whether the venture will have market power.

The market power inquiry directly addresses the question whether the physician venture actually has the ability to injure competition and consumers by, for example, forcing fee increases upon payers or preventing the formation of rival physician networks. A venture's ability to increase the fees received by its physicians should be based on its providing an overall better product that consumers want and are willing to purchase at a higher price.

A critical step in any market power analysis is calculating the venture's market shares in the relevant markets for antitrust purposes. The first step in calculating a venture's market share(s) involves identifying the markets in which that venture operates. These markets, however, may not be the same types of markets that are commonly referred to in business planning. A relevant market for antitrust purposes is based on a specialized analysis developed to meet the purposes and goals established by the antitrust laws. Accordingly, it is important that physicians contact antitrust counsel concerning this issue and not rely exclusively on the markets identified in their business plans.

Under the antitrust laws, a "market" consists of what are called the relevant product market and the relevant geographic market. A relevant product market is defined by identifying the products or services provided by the venture and then identifying the reasonable substitutes for those products and services. With respect to physicians, relevant product markets are typically based on specialty or type of practice. For example, patients cannot substitute cardiac services if they have a problem with their eyes. Accordingly, ophthalmic services and cardiac services will typically represent separate product markets. The relevant product market(s) in any given situation will depend on the unique facts and structure of the physician network. Most physician ventures will involve many different relevant product markets.

After the relevant product markets are identified, the next step is identifying the relevant geographic market for those products or services. A relevant geographic market is the area in which consumers can reasonably obtain the relevant products or services. For example, if a physician venture operates in county A, the relevant geographic market will include county A. The issue then becomes whether consumers in county A can reasonably obtain competing services outside county A. Defining a relevant geographic market is a fact-intensive process that will turn on many different factors. For example, geographic markets can vary in size based on the product or service at issue. The size and shape of a geographic market is also influenced by geography.

Once the product and geographic markets are established, market shares are calculated. With respect to physician ventures, market shares are oftentimes based on the number of physicians

that provide the relevant services in the geographic market. For example, if a venture has 10 urologists, and there are 50 urologists practicing in the geographic market, the venture will have a 20 percent market share in urology services. While a high market share does not necessarily mean that a physician venture has market power, a low market share will prevent a finding of market power.

The Proposed ACO Policy addresses the issue of market power by creating a methodology ACOs must use in order to calculate their market shares of what are called Primary Service Areas (“PSA”). The Proposed ACO Policy then establishes various thresholds that will either put the ACO into a “Safety Zone” or will compel the ACO to obtain an approval letter from either the FTC or DOJ before the ACO can participate in the shared savings program.

The PSA approach raises several potential problems that the FTC and DOJ should consider before they choose to use the PSA approach as a market power screen. One potentially serious problem, for example, is that the PSA approach may be biased towards finding higher market shares for PSAs than the market shares associated with properly defined geographic markets. If such a bias exists, the PSA approach could imply that various ACOs have market power when they in fact have no market power. It may also make it impossible for the overwhelming majority of ACOs to fall within the “Safety Zone.”

### **C. Non-exclusive and exclusive dealing**

Market share figures provide a poor estimation of market power when a physician network is a non-exclusive negotiating agent for the participating physicians. Under a non-exclusive negotiating arrangement, the physicians are free to enter into contracts with payers through other ventures or individually. As a practical matter, non-exclusive physician collaborations give payers the ability to walk away from the physician collaboration, without the payers risking the loss of access to any desirable physicians who belonged to the network. Indeed, because health insurers have a strong incentive to free-ride on a clinical integration program’s efforts, health insurers have an incentive to cherry pick the physicians with whom they will deal.

Under these conditions, it is difficult to see how a non-exclusive physician clinical integration effort could exercise market power. Regardless of its size, health insurers have alternatives to even the largest non-exclusive physician collaborative effort. Without the ability to force a payer to do business with the network, the physicians have no mechanism for forcing up fees. Non-exclusive networks therefore should generally be found lawful under the rule of reason, without the need for extensive analysis.

Some physicians may determine that the economic structure of their venture requires exclusivity with respect to the negotiation of provider contracts with payers. Market shares become much more significant when a physician venture is the exclusive negotiating agent for its participating physicians. Under the Health Care Guidelines, an exclusive venture with more than a 20 percent market share will fall outside the so-called antitrust safety zone. It is important to understand, however, the limited nature of the “safety zone.” A venture’s having a market share above the safety zone does not mean that the venture has market power. The safety zones express the FTC and Antitrust Division’s judgment that a venture with a market share falling within the safety zone cannot have market power. Ventures having market shares above the safety zone will not necessarily raise antitrust problems. Some courts, for example, have stated that market shares up to 30 percent cannot, as a matter of law, support a finding of market power. Whether a market share raises a market power issue is an issue a physician venture should discuss with antitrust counsel.

Moreover, even if the exclusive network were found to possess some degree of market power, an antitrust tribunal may nevertheless conclude that, on balance, the exclusive arrangement did not unreasonably restrain trade. For example, if the efficiencies created by the physician venture are significant, the increased efficiencies may prevent an increase in reimbursement rates even if the venture has market power. If exclusive dealing is necessary in order to create the efficiencies, the exclusive dealing arrangement should receive protection under the antitrust laws.

Exclusive dealing arrangements are commonly used to prevent free-riding. Free-riding occurs when a buyer can acquire a bundle of services and not have to pay for all of those services. With respect to clinical integration, free-riding by insurers happens when an insurer can get the improved quality and outcomes generated by the clinical integration program even though it does not have a contract with the clinical integration program. This free ride is made possible by a health insurer's contracting directly with the clinical integration program's physicians.

The improved care and lower costs created by a clinical integration program result from the clinical integration program's (a) creating treatment protocols that improve outcomes and lower costs, (b) teaching these protocols to physicians, (c) making sure these protocols are being followed, and (d) creating the infrastructure needed to support the clinical integration efforts, such as HIT systems and information about their patients. Developing such a program is expensive and requires both a substantial start-up investment and then continuing investments to maintain the program. A clinical integration program, however, cannot force its physicians to provide different levels of care to different patients based on their insurance coverage. An insurer, therefore, has an incentive to let another health insurer contract with the clinical integration program and then contract directly with the program's physicians once the program is up and running. By doing this, the health insurer gets some portion of the quality enhancements created by the clinical integration program but does not have to pay for them.

If enough insurers take a free ride, the clinical integration program will fail, and all or most of the efficiencies created by the program will be lost at some point. Also, the more likely this outcome, the less likely it becomes that physicians will set up such arrangements in the first place. Physicians, especially those in small practices, understand the overwhelming bargaining power of the major health insurers vis-à-vis small physician practices. They know that if the health insurers are free to cut deals around the ACO they will be successful because no small practice will be willing to decline the health insurers' offer and run the risk of being left out in the cold. Therefore, physicians will be unlikely to make the initial investment in a clinical integration program in the absence of ACO exclusive dealing.

At this point in time, clinical integration programs are generally non-exclusive. One of the reasons clinical integration programs have developed in this manner is the uncertainty created by the absence of adequate FTC and DOJ advisory opinions on exclusive dealing. Further, the unnecessarily low safe harbor threshold of a 20 percent market share for exclusive arrangements has created a strong impression that the FTC/DOJ view exclusive dealing arrangements with considerable suspicion. A 20 percent market share threshold is extremely low and harkens back to the time when atomized markets were the fundamental goal of antitrust policy. Today, market shares in the 30 percent range are routinely deemed too low to support market power claims.

Exclusive dealing arrangements appear to be a critical tool that ACOs will need to use. This is not a radical or particularly new idea. Joint ventures in other industries routinely engage in exclusive dealing in order to prevent free riding and to align the interests of its members. Courts have recognized that exclusive dealing is both efficiency enhancing and frequently necessary for the efficient operation of a joint venture.

The Proposed ACO Policy as currently structured does not treat exclusive dealing arrangements favorably. An ACO's physician participants can enter into exclusive dealing arrangements with the ACO under the Proposed ACO Policy if the ACO falls within the "safety zone." Given the PSA approach to calculating market shares, it seems that few—if any—possible ACOs will fall within the "safety zone." Because the Proposed ACO Policy currently ties exclusivity to the "safety zone," it is possible that, as currently drafted, the Proposed ACO Policy will deter the use of exclusive dealing arrangements by ACOs.

#### **D. The DOJ and FTC advisory opinion procedure**

Physicians who are considering forming an ACO and are unsure of the legality of their conduct under the antitrust laws can take advantage of the DOJ and FTC's advisory opinion procedure. There are several advantages to obtaining such an opinion. First, the enforcement agencies will not proceed against the requesting ACO with respect to any action taken in good faith reliance upon the agency's advice. Second, some insurance companies request that an opinion be obtained before they will enter into joint contracting negotiations. Finally, an ACO can gain added confidence that the joint contracting (and perhaps other conduct such as exclusive dealing) is lawful.

Presently, the agencies are required to respond to a request for an opinion within 90 days after all necessary information is submitted. As a practical matter, the process before the FTC has required considerably more time because of a need to respond to FTC requests for supplemental information. Both the FTC and DOJ have expressed an interest in shortening the time for obtaining opinion letters. They have suggested that an expedited process may be forthcoming in connection with the ACO rules now under development.

## Chapter 8: Hospital physician employment agreements

**Wilson Hayman, Steven Mansfield Shaber, Kimberly Licata**

“It is often necessary, when some cherished scheme has failed, to take up the best alternative open.”—Winston Churchill

In the post-health reform world, hospital employment of physicians may become increasingly popular. Physicians considering this option need to appreciate the legal issues surrounding hospital employment so that they can spot (and avoid) pitfalls and negotiate an employment contract under which they can prosper.

### **Choosing between or among hospitals?**

In some cases, more than one hospital may present a physician with an employment opportunity. This scenario may be more prevalent now than in recent years, as hospitals in many markets are increasingly seeking to integrate physicians, via employment, to form ACOs and other health care delivery collaboratives. In such situations, an evaluation of the potential opportunities will involve comparing the hospitals in terms of practice environment and other factors relevant to the long-term success of an employment relationship. The following questions will help a physician perform this comparative analysis.

First, how much practice independence do employed physicians have at each hospital? How much control do employed physicians have with respect to decision-making concerning clinical matters, administrative issues affecting their practice, and practice assets and support services?

Second, what kind of track record does each hospital have when it comes to managing physician practices?

Third, what is the practice environment like at each hospital? What is each hospital’s political environment? Does management work with physicians in a collaborative way, or does management operate under a dictatorial philosophy? If management is physician friendly now, what protections, if any, are in place to ensure that the physician will be protected if new, less amicable hospital leadership comes on board?

Fourth, what voice do employed physicians have with respect to the governance of the hospital or other integrated organizations in which they participate pursuant to employment? If there is a deadlock between physician interests and those of the hospital, is there a mechanism wherein the deadlock might be resolved in a way that is cognizant of physician concerns?

Fifth, what is the respective financial condition of each hospital?

Sixth, how competitive is each hospital in the applicable market?

Seventh, what is the physician's negotiating leverage with each hospital?

Eighth, what does the long-term picture look like at each hospital? What might happen at each hospital to "preserved compensation" as the reimbursement dollar continues to decline? Who controls more of the dollar at each hospital?

In conjunction with the preceding factors, physicians need to appreciate the legal issues surrounding hospital employment so that they can spot (and avoid) pitfalls and negotiate an employment contract under which they can prosper. This chapter discusses some of the key issues and provisions that physicians should carefully consider when discussing hospital employment, including: (1) physician compensation; (2) contract termination; (3) call requirements and compensation; (4) non-competition and non-solicitation provisions; and (5) other miscellaneous contractual provisions. Appendices to this chapter provide checklists of some factors reflecting **fair market value**, **common termination for cause provisions** and **due diligence in hospital employment contracting**.

### **Physician compensation issues**

No term in a hospital-physician employment contract is more important to a physician's satisfaction than compensation. As a result, a physician needs to appreciate the special regulatory limitations on compensation paid by hospitals to physicians and also be armed to negotiate because hospitals have considerable flexibility in this area. Some key issues for physician compensation include: (1) fair market value; (2) compensation methodology; (3) productivity bonuses; (4) percentage of revenue compensation; and (5) referral requirements.

#### **I. Fair market value: what is it and why is it important in hospital-physician employment?**

Hospitals (and their affiliates) are bound by law to provide only "fair market value" total compensation (including base salary and any productivity bonus) to physicians on their medical staffs through either employment or other types of service contracts. These legal limits are imposed by the employment exception to the Ethics in Patient Referrals Act (the "Stark law," 42 U.S.C. § 1395nn) and the Internal Revenue Service's ("IRS") rules for tax-exempt hospitals.

**Defining fair market value.** To identify fair market value for physician compensation, many opt to rely on data from reputable compensation surveys, such as the "Physician compensation and production survey," published annually by the Medical Group Management Association ("MGMA").<sup>1</sup> Typically, hospitals consider a range of compensation using national and regional median salaries in the physician's specialty. However, median salaries can be too low. Salaries significantly in excess of the median salary can often be justified based on productivity or revenues, past productivity and subspecialty skills.

**IRS requirements for compensation paid by tax-exempt hospitals.** The amount of physician compensation paid by tax-exempt hospitals raises issues under the law of tax-exempt organizations, including private inurement (if considered an "insider") and private benefit. See Appendix 1 for a checklist of IRS factors for fair market value.

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<sup>1</sup> MGMA's survey includes certain, limited median compensation data by subspecialty for the four broad geographic regions of the country. It provides more comprehensive compensation information (percentile, etc.) by subspecialty on a national basis. The MGMA survey also contains data about physician productivity, gross charges, physician compensation and collections per both total relative value units (RVUs) and physician RVUs worked (WRVUs) as well as many other data sets on a nationwide basis.

## II. What are common compensation methodologies?

Physician employment agreements should contain one of the following compensation methodologies: fixed salary, base salary with productivity bonus or compensation based solely on productivity. The fixed salary model represents no financial risk to a physician (the hospital bears all the risk) but does not reward the physician for being busy or finding new work (the hospital gets all the gain). On the other end of the spectrum is compensation based solely on productivity (“eat what you kill”). Under this methodology, physicians are completely at risk for the volume and revenue of their practice. If the practice is slow, the physician’s salary will be low. If the practice is very busy, then the physician’s salary will be significantly higher. In the middle lies the system of a base salary with productivity bonus model.

**Fixed salary methodology.** Some agreements set a fixed salary for each year of the contract or for the first year followed by fixed adjustments in subsequent years. This method is often chosen for the first year or two of employment, particularly for physicians new to the area, while the parties assess the needs of a practice. These arrangements are typically converted at some point to (1) a (perhaps lower) base salary with a potentially large bonus or (2) pure productivity.

**Base salary with productivity bonus.** Many agreements contain a lower base salary (perhaps below median) combined with a productivity bonus that could take the physician above median compensation. Sometimes these arrangements are gradually implemented over a period of five years or so. These bonuses may be based on either (1) a percentage of collections, (2) a percentage of net revenue (physician’s revenues minus office expenses and minus physician’s base salary) or (3) physician work relative value units (“WRVUs”) as established by the Centers for Medicare and Medicaid Services (“CMS”), the federal agency that oversees the Medicare and Medicaid programs. The bonus methodology may set a minimum productivity threshold (by a target amount of collections or WRVUs) that the physician must meet to qualify for any bonus.

Total cash compensation will generally be capped, either at a certain dollar amount or by a percentage of base salary. Such caps should be adjusted upward annually by the increase in the consumer price index (“CPI”). Alternatively, the cap may be based on a certain percentile (such as the 90th) in the then-current MGMA physician compensation survey.

When bonuses are paid periodically during the year, they may sometimes be “clawed back” if the physician’s WRVUs or collections drop off toward the end of the year. Physicians should pay attention to how the bonus is calculated and paid out (at the end of the term or a fixed periodic basis with a reconciliation) to avoid making any decision that could compromise a prospective bonus.

**WRVUs, ancillary revenues and bonuses.** Utilizing physician WRVUs in the bonus methodology takes into consideration revenue from some ancillary services. Physician WRVUs, as measured by the Resource-Based Relative Value Scale (“RBRVS”) method, include RVUs for all professional services **plus** the professional component of laboratory, diagnostic and surgical procedures. They do not include practice expense RVUs, the technical component (“TC”) of procedures or non-physician productivity (“NPP”) as used in the MGMA survey.

In the case of compensation based on WRVUs, the physician would be paid a set dollar amount per WRVUs personally performed by physician. As the physician reaches successively higher ranges of WRVUs during the course of the contract year, the contract may increase the amount paid per WRVU as an additional incentive to be productive.

**The matter of indigents and discounts.** Where a hospital-employed physician will be providing substantial care to indigent patients, services at heavily discounted rates or numerous ancillary

services, bonus compensation based upon WRVUs may be an attractive alternative to revenue-based compensations for physicians.

Similarly, using a payer mix multiplier of 1.0 or higher adjusts compensation to take into account low or non-paying patients. This multiplier may be calculated based on (i) a numerator of the national median net fee-for-service revenue per total revenue value units (TRVU) for the physician's specialty based on MGMA data and (ii) a denominator of the net revenues per TRVU for the physician for the most recently ended contract year. The physician's actual annual net revenue is divided by the number of TRVUs to calculate his or her net revenue per TRVU. To calculate the payer mix multiplier, one would subtract the physician's actual annual net revenue per TRVU from the national norm net revenue per TRVU to equal the payer mix multiplier. Bonus compensation using a payer mix multiplier may be an attractive alternative for physicians in practices that treat a large number of uninsured or underinsured patients.

**Compensation solely based on productivity.** A physician's compensation may be paid solely based on a percentage of revenues generated or solely on the basis of WRVUs. With this methodology, physicians should look for the following issues:

1. Is there a cap and/or payer mix multiplier as discussed above?
2. What is the formula for a monthly draw (with a reconciliation at year's end)?

Watch out for hidden factors or requirements that may diminish productivity as measured by the employment contract.

### **III. Legal issues with productivity bonuses or compensation—fraud and abuse.**

Compensation arrangements with physicians implicate federal fraud and abuse laws, namely the Stark law and the Anti-Kickback Statute. Each of these laws contains some type of express exception for employment of physicians (as well as for personal services arrangements for independent contractor relationships) but with very different effects. In the case of Stark, every employment relationship **must** be structured to fit the exception. In contrast, the Anti-Kickback Statute exempts **all** payments (fair market or otherwise) by an employer to a bona fide employee "for employment in the provision of covered items or services" for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs.<sup>2</sup> Because of Stark's nuances, this section focuses on Stark.

**The Stark law and employment relationships.** The Stark law prohibits referrals by physicians who have a financial relationship with the entity receiving referrals (including certain employment arrangements) if a hospital-employed physician provides "designated health services" ("DHS") as defined under Stark, which are reimbursed under Medicare or Medicaid, unless an exception applies. DHS include, among others, all hospital and outpatient services, clinical laboratory services, radiology and imaging, physical therapy, durable medical equipment ("DME"), prosthetics and orthotics, and home health services. The Stark law's employment exception focuses on fair market value and the commercial reasonableness of an arrangement, with particular attention to any productivity bonus.<sup>3</sup> The employment exception permits payments by an employer to a physician who has a bona fide employment relationship if the

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<sup>2</sup> 42 U.S.C. § 1320a-7b(b)(3)(B); 42 C.F.R. § 1001.952(i). While compliance with safe harbors to the Anti-Kickback Statute is not mandatory, the safe harbor for employment agreements is relatively easy to satisfy.

<sup>3</sup> The Stark law defines "fair market value" in this context as the compensation that would result from arm's-length bargaining between well-informed parties who are not in a position otherwise to generate business for the other party. 42 C.F.R. § 411.351.

following requirements are satisfied: (a) the employment is for identifiable services, (b) the amount of remuneration is consistent with the fair market value of the services rendered and is not determined in a manner that takes into account the volume or value of any referrals by the referring physician (except as permitted below), and (c) the remuneration would be commercially reasonable even if no referrals were made to the employer.<sup>4</sup>

**Profit share/incident to services.** If Stark applies and if a physician refers DHS to his or her employer (or an affiliated entity), the physician may receive a productivity bonus based only on services personally performed by that physician. Additionally, the physician employee may receive (a) productivity-related compensation that takes into account “incident to” services or referrals to in-office ancillary services and/or (b) a share of the overall profits from the medical practice (if permitted by IRS requirements), but only if the physician’s employer meets the Stark law definition of a “group practice.”

**In-office ancillary services revenue.** Revenue from ancillary services may be key to the hospital-employed physician’s ability to earn compensation comparable to his or her counterparts in private practice. The “in-office ancillary services” exception to Stark permits an individual physician or group practice (as defined below) to order and provide DHS (other than most DME) in the office of the physician or group practice, if the DHS are ancillary to medical services furnished by the group practice. The physician may also receive compensation from such revenues as a productivity bonus or profit share as discussed above.

The “in-office ancillary services” must be personally provided by the referring physician, a member of his or her group practice, or an individual who is supervised by a member physician. The services must be provided in the same building where the members of the group provide medical services on a full-time basis or in space owned or rented which meets certain other requirements. If the hospital bills for the in-office ancillary services rather than the group practice, then this exception would not be met.

**“Group practice” definition.** To be a “group practice” under Stark, two or more physicians must meet a number of requirements, including being a single legal entity, with each physician providing the full range of services of the group, and with each meeting thresholds on patient encounters.<sup>5</sup> Furthermore, overall profits may only be divided among a subgroup if it has at least five physicians, and the profits may not be divided in a way that tracks designated health services payable by either governmental or private payers. **So how does this apply to a hospital employment contract?**

#### **IV. Limitations on percentage of revenue compensation.**

The IRS has expressed concern about a tax-exempt hospital’s provision of compensation to physicians based on a gross or net revenue stream, which may endanger the hospital’s tax-exempt status. It has specifically addressed this concern with respect to the private activity bond

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<sup>4</sup> 42 U.S.C. § 1395nn(e)(2); 42 C.F.R. § 411.357(c).

<sup>5</sup> Stark requires that: (1) it must be organized as a single legal entity that is recognized by the state as capable of practicing medicine (i.e., professional corporation, faculty practice plan or nonprofit hospital-affiliated corporation, etc.); (2) each physician member must furnish substantially the full range of patient care services that he or she routinely furnishes through the joint use of facilities, equipment and personnel; (3) at least 75 percent of the total patient care provided by the physicians must be furnished through the group and billed under a billing number assigned to the group and collected by the group; (4) the group is a unified business in that decisions are made by a centralized body representative of the group practice that maintains effective control over the group’s assets, budgets and compensation; and (5) special rules on productivity bonuses and profit shares are followed. 42 C.F.R. § 411.352(a).

rules of Section 141 of the Internal Revenue Code, which only apply when bond-financed property is involved.<sup>6</sup>

Percentage of revenue compensation on bond-financed property. Under Revenue Procedure (“Rev. Proc.”) 97-13, the IRS set forth conditions under which a “management contract” using bond-financed property would not result in an impermissible “private business use” under Section 141(b). This generally required that the management contract provide for reasonable compensation with no compensation based, in whole or in part, on a **share of net profits** from the operation of the facility. The IRS ruled that the revenue procedure would be satisfied and the management contract would not result in private business use if among other things the compensation arrangement were based on a percentage of gross revenues (or adjusted gross revenues) from the facility or a percentage of expenses from the facility but not both. Although the IRS went on to list six permissible “safe harbor” compensation arrangements with various compensation, term and termination requirements, it did not sanction any arrangement containing an incentive based on net revenues. Because the Rev. Proc.’s definition of “management contract” includes “an incentive payment contract for physician services to patients of a hospital,” the IRS has at least informally taken the position that this Rev. Proc. applies to a hospital’s **physician employees** based on bond-financed property as well as to independent contractors and management contracts.

Percentage of revenue compensation on non-bond-financed property. On the other hand, Rev. Proc. 97-13 should not apply to the physician employees of a hospital or hospital subsidiary who are not based in (or use as their principal office) bond-financed property. The IRS in exemption applications concerning **non-bond-financed** property has approved paying incentive compensation measured as a percentage of the net revenues that the physician himself or herself generated (including revenues from allied health personnel, such as nurse practitioners working under the physician’s direction and control) when the total compensation is reasonable (generally with a cap) and where there are safeguards as to charity and Medicare/Medicaid care. This would presumably allow compensation based on “incident to” and in-office ancillary services, consistent with the Stark requirements previously discussed. On the other hand, the IRS may not approve payments of net revenue to a group of physicians based on their collective efforts, since that is viewed as a division of the hospital’s net revenue. Payments based on gross revenue, however, are generally viewed as permissible if they are reasonable.

## **V. Contract provisions that require referrals.**

Physicians and other health care providers are understandably concerned whenever “referrals” are discussed, let alone required, by a contract. Fortunately for physicians, the Anti-Kickback Statute has been interpreted to permit an employment contract to require a bona fide employee to refer patients to the employer’s services. The Stark rule also permits a provider to require a bona fide physician employee (or a physician contractor through personal services agreement) to refer to a certain provider, including the employer, but only under the following limited circumstances: (a) the compensation arrangement is set in advance for the term; (b) it represents fair market value for the services performed and does not take into account the volume or value of referrals; (c) it complies with the Stark exception for bona fide employees and/or another applicable exception; (d) the referral requirement is set forth in a signed agreement; (e) the referral requirement does not apply if the patient expresses a preference for a different physician or other health care provider, the patient’s insurer determines a different physician, or the referral

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<sup>6</sup> For qualified state or local 501(c)(3) bonds, not more than 5 percent of the proceeds of a bond issue can be used in a trade or business carried on by a non-501(c)(3) organization.

is not in the patient's best medical interests in the physician's judgment; and (f) the required referrals relate solely to the physician's services pursuant to the employment agreement, and the "referral requirement is reasonably necessary to effectuate the legitimate purposes of the compensation arrangement."<sup>7</sup> An exception similar to (e) would also be required by some state medical boards to ensure that the hospital does not interfere with the professional judgment of the physician.

## **Contract termination**

Physicians considering hospital employment should carefully evaluate the termination provisions in an employment agreement to confirm that they are not losing any existing rights or locking themselves into a relationship without an appropriate way out.

### **I. Basic termination provisions.**

**Two types of termination provisions.** There are two basic types of termination provisions: termination with (or for) cause, and termination without (or for no) cause. Termination without cause provisions permit either party to end the contract before the term naturally expires by giving the other party a certain amount of prior notice of the decision to terminate. The consent of the other party is not needed. Termination with cause provisions permit the employer to fire the employee or the employee to quit on little or no notice because the other party has done something so serious that it breaks ("breaches") a key ("material") term of the contract. Again, consent of the other party is not needed, but in this case, if the employer who fires (or the employee who quits) is wrong about the cause, then the other party will have a right to recover damages for breach of contract. When reviewing a contract offer, physicians should consider what might make the relationship unworkable or simply undesirable and then make certain they will be able to leave employment, either under the termination for cause provision, or by working through the notice period for a termination without cause.

**Cure.** When there is cause to terminate a contract, the contract may allow a party to cure the breach and avoid termination, provided the cure is begun and completed within some specified period of time. At the same time, the contract may say some violations are so serious that they cannot be cured and, therefore, require immediate termination. Contracts often contain a litany of serious violations that allow the physician to be fired with no chance to cure but contain very few violations by the hospital allowing the physician to quit. Physicians should always identify any violation by the hospital they deem sufficiently serious to require immediate termination (such as exclusion from Medicare or Medicaid, fraud and abuse convictions or settlements, or others).

A typical cure provision for physician and hospital, with considerable flexibility, may read:

"The party accused of conduct that would constitute good cause to terminate this agreement shall have 15 days following receipt of specific notice of this conduct during which to cure the stated cause for termination. If it is not reasonably possible to complete the cure within 15 days, then so long as the party has taken reasonable steps to begin the cure, and so long as the party is continuing those steps and other reasonable steps that may become necessary, then the party will have the additional time reasonably needed to complete the cure."

### **II. Termination without cause.**

Employment contract provisions that allow termination without cause are important—if not essential—to professional employment. They allow either party to escape an unacceptable

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<sup>7</sup> 42 C.F.R. § 411.354(d)(4).

professional situation without having to prove the other party has done something “bad.” The key issues with termination without cause provisions are (1) the time frame (the “notice period”) and (2) the means and effective date of notice of termination.

**Time frames.** Termination without cause clauses typically allow either party to end the agreement by giving the other party somewhere between 30 and 180 days prior notice. Periods ranging 60 to 120 days are most common. From the employee’s perspective, a longer notice period is usually better than a short one. A longer period means the employer will either have to allow the employee to keep working and earning, or the employer will have to pay the employee the value of future salary in exchange for having the employee leave sooner than the contract requires. The commonly used 60-day notice period may be too short for the employee’s maximum benefit. That said, a longer termination period may hurt the employee if the employee leaves early and therefore has to pay the employer the cost of hiring a substitute to fill part or all of the rest of the notice period. Only the employee can decide what period is the best under his or her circumstances. Physicians should be aware of (and strive for consistency in) the notice periods required by all agreements they have with the hospital (such as any medical director agreements, research agreements or other contractual relationships) so that a clean break can be made.

**Termination without cause in the first year, a special situation.** For many reasons (some legal, some business), an employment contract may not be terminable without cause during the first year. In other words, the employer can only fire the employee in the first year without paying damages, or the employee can only quit in the first year without paying damages if there is a sufficient reason to do so. This protects each party from a precipitous change of heart by the other. The best possible arrangement for the employee, if it were possible to negotiate it, would be for the employee alone to have the right to terminate the agreement without cause during the first year.

**Notice provisions.** Termination without cause may run from the day notice is given or received; contracts differ in this respect. Occasionally a problem arises proving the actual date of receipt of the termination notice. This problem can be solved by requiring the termination notice to specify the date and time of termination (with time being very important for hospital-based specialties), requiring return receipt or by setting a presumed date of delivery such as:

“Notice to a party is effective on the date of delivery to that party personally or to that party’s home or office by mail, facsimile or email. The date of delivery may be proved by any reasonable evidence, but if there is no evidence of the date of actual delivery, then delivery will be presumed to be on the (third)(fourth)(fifth) day following transmission, by mail or otherwise, unless the party to whom the notice is addressed proves a later date.”

### **III. Termination for cause.**

Termination for cause is an essential element of any employment agreement, but it can be abused or overstated and needs to be carefully considered. Some terms are necessary. Some are acceptable. Some are too trivial or ambiguous to be desirable. Physicians should consider each “cause” listed in a termination for cause provision and either be willing to live with it or remove it. See [Appendix 2](#) for a list of common termination for cause provisions.

**Dubious reasons for termination.** Ambiguity is the principal problem with many provisions allowing termination for cause. These provisions may not adequately describe the conduct that is forbidden, or they may not adequately separate serious instances of bad conduct from trivial ones. Such common vague provisions that would permit termination for cause include a physician’s:

- Unprofessional conduct
- Conduct tending to place the practice or hospital in a bad light
- Conduct injurious to the reputation of the practice or of the hospital
- Disruptive behavior

Be alert for any such vague language. If a physician finds these vague termination provisions in an employment offer, he or she should try to remove or restrict them. If the physician is not able to remove such language from a contract, he or she should—if possible—take the following steps. First, include a cure provision for such terms, such as is described above. Second, modify such terms to require repeated and serious conduct, for example, “Frequently repeated conduct seriously injurious to the reputation of the hospital.” Third, link the terms to patient care, such as “Disruptive behavior directly affecting patient care.” Without limitations, these grounds for termination can be easy to assert and subject the physician to unfair and arbitrary action.

**Hospitals and physicians and their respective different interests.** Physicians and hospitals have different ways of operating and different economic interests. Therefore, it is important that the termination provisions not allow the hospital employer to find fault with the physician for reasons that do not make sense from the physician’s professional perspective. The physician needs to be the sole judge of the standard of care, set the number of patients seen, and determine what services ought to be provided. Nothing in the termination provisions should undermine that authority. In fact, many state medical boards have taken the position that it is unethical and violates the physician-patient relationship for financial incentives or contractual requirements to adversely affect a physician’s medical judgment or patient care.

**Difference between hospital employment and staff membership.** Employment and medical staff membership are two different things. Medical staff membership will be a condition of hospital employment. Employment may also be a condition of medical staff membership; this is common in cases in which there is an exclusive arrangement between the hospital and a group of physicians who provide a particular service, such as anesthesia or pathology. Because of federal and state law, physicians have fair hearing rights to protect their medical staff memberships. Yet there is no such statutory right to a fair hearing before losing employment, and ordinarily employees do not have a right to a hearing before they can be fired. The employment agreement can confer this right on the employee, but usually does not. Promises made in an employment handbook can create this right, but they usually do not. Promises made and rights conferred in the medical staff bylaws might create a right to a hearing before being fired, but they usually do not.

There are three consequences to this tension between hospital employment and medical staff membership. First, the physician should assume the employment agreement controls employment, and hearing rights conferred by the medical staff bylaws do not apply to employment but only to medical staff membership and clinical privileges. This is not to say that physicians have no rights regarding employment with the hospital, but they usually have to enforce those employment rights in a lawsuit, often after having been terminated. Second, the physician should be certain **before he or she signs** the agreement that all the employment rights the physician wants are included in the employment agreement. Finally, as for the physician’s rights as a medical staff member, he or she should be vigilant and not inadvertently waive any such medical staff rights by virtue of becoming an employee. This is particularly important when a hospital uses a template employment agreement with a physician who is already privileged and on the medical staff.

## **Emergency room call and compensation: How is call handled by the parties?**

Physicians are frequently concerned about the call requirements of employment agreements, which can be quite burdensome but call can also be a source of additional compensation. Call requirements are often set forth in medical staff bylaws, departmental rules and private physician-group employment contracts, but they are also the subject of federal law and regulation.

### **I. Sources for call obligations.**

**Medical staff bylaws and rules.** Medical staff bylaws universally address each staff member's obligation to provide on-call coverage. A typical provision might say something like this: "Each member of the medical staff will participate in emergency service coverage to the extent required by the governing body." Another typical provision might say this: "Staff will participate in a fair rotating emergency room call schedule as determined by the applicable department chair." From the physician's perspective, it is usually better to have the question of call decided at the department level.

**Private physician-group employment contracts.** Employment agreements between individual physicians and private physician groups typically address the question of call. Often employment agreements treat call requirements differently depending on whether the call relates to patients of the practice or to emergency department coverage. As to the group's private patients, such agreements typically rotate call among the group's members, sometimes relieving senior members from all call or from some call, provided other junior members cover. As to the group members' duties to cover the emergency room for unassigned patients, the employment agreement typically defers to the hospital medical staff's requirements.

**Federal legal requirements: EMTALA.** The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires hospitals to provide an appropriate medical screening examination performed by a qualified person to any person who comes to the hospital emergency department, provided the hospital has the capacity to treat that person.<sup>8</sup> Virtually each word or phrase of this definition is the subject of federal regulation and litigation. The purpose of the screening exam is to determine whether an emergency medical condition exists, including active labor. If an emergency medical condition is found to exist, the patient must be stabilized and admitted, transferred or discharged. Associated with EMTALA is the requirement that each hospital must maintain a list of on-call physicians from its staff that best meets the needs of its patients and post visible signs of EMTALA rights.<sup>9</sup> The federal government understands that hospitals vary greatly in size and services, so there must be—in principle—a lot of flexibility in the EMTALA requirements. Despite EMTALA, the following statements about call coverage remain accurate:

- No physician is required to be on call all the time. Endless call is unreasonable. However, physicians may not "cherry pick" call.<sup>10</sup>
- Senior physicians may be relieved from call, and if so, that right needs to be included in the employment agreement.
- There is no minimum number of physicians on staff that triggers a requirement that the hospital provide call coverage 24/7.<sup>11</sup> The commonly held idea that if there are three

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<sup>8</sup> 42 U.S.C. § 1395dd.

<sup>9</sup> 42 C.F.R. § 489.24(j).

<sup>10</sup> CMS State Operations Manual, Pub 100-07, Appendix V, Interpretive Guidelines for § 489.24(j)(1).

<sup>11</sup> CMS Director's Memo, "On-Call Requirements – EMTALA." (Jan. 28, 2002).

physicians in a specialty available to take call, the hospital must provide call coverage year-round around-the-clock is a myth.

- Physicians may in some circumstances be paid to take call on a per diem basis.<sup>12</sup>

Hospital-physician employment agreements frequently include requirements and standards by which the physician would be required to comply with EMTALA.

## II. Issues with call in practice.

**Bylaws and contracts.** The call provisions in an employment contract may be more onerous than the provisions in the medical staff bylaws and departmental rules. The physician should not assume the bylaws set a standard that the hospital cannot change to its advantage. The hospital may lawfully demand by contract more of its employed physicians than the medical staff does. Physicians need to face this and deal with it as a negotiable point in the proposed contract. We would suggest the agreement say something like this: “Physician shall provide emergency call on a reasonable basis, as determined by \_\_\_\_\_, but in any event no more frequently than as required by the medical staff bylaws and applicable departmental rules.” Or it might say, “Physician shall provide emergency call on a reasonable basis, as determined by \_\_\_\_\_, but in any event no more frequently than every \_\_\_\_\_ day.”

**Reasonableness of call.** Call provisions need to be reasonable in both directions. These provisions should address frequency of call and the scope of services. For example, a sub-specialist may have core privileges that would suggest competence in a range of procedures that the sub-specialist in fact does not perform. (An orthopedic surgeon may specialize in joint replacement surgery and not be current in spine surgery.) While such issues may be resolved informally among physicians within a private group, once hospital employment occurs, these informal arrangements should be addressed in a hospital employment contract.

**Compensation for call.** To the extent a physician may get specific compensation for taking emergency call, it may be harder to do so after the physician is employed by the hospital. The best time to address this is when the agreement is negotiated. At that time, the economic value of these services can be factored into the physicians’ compensation package. The agreement will need to address the following issues:

- Fair market value of the total compensation
- Parity between any compensation for call and compensation for work generally
- The services being provided by the physician while on call

Failure to address these issues could result in the arrangement being deemed to violate the Stark law and IRS requirements.

## Non-competition and non-solicitation provisions

Physician employment agreements frequently contain provisions relating to non-competition, non-solicitation and/or payment of liquidated damages if competition occurs. While non-competition provisions are generally disfavored as restraints on trade and are strictly construed, courts in most jurisdictions will enforce them in proper cases. (As to this, consult counsel in your state!) The justification for non-competition agreements between an employer and an employee is the belief—which is sometimes true, sometimes exaggerated and sometimes false—that the

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<sup>12</sup> Office of the Inspector General (OIG) Advisory Opinion No. 07-10. However, the OIG has opined that some payments to take call may well violate the Anti-Kickback Statute.

employer has taught the employee the “secret” to running the business and introduced the employee to business contacts.<sup>13</sup> In a physician practice, this means the physician has been introduced to patients or has been given the chance to acquire patients. Any agreement that contains a non-competition clause should be reviewed to assess its compliance with federal and state laws.<sup>14</sup>

## **I. General rules regarding the enforcement of non-competition agreements.**

Generally speaking, there are a few rules that a non-competition agreement must follow. First, non-competition agreements have to be in writing. The rest of the agreement may be oral, but the non-competition provisions must be written.<sup>15</sup> Second, the non-competition provisions in an employment agreement can only be enforced if they are reasonable. To some extent reasonableness is in the eye of the beholder, but in general, non-competition provisions must be reasonable as to time and to territory.<sup>16</sup> The employee-physician should resist a provision that purports to cover areas where the employer has facilities but where the physician does no work and gets no patients. The two most common methods of defining the non-competition territory are (a) by city or county, and/or (b) by drawing a circle with its center at a particular place of employment, such as a hospital or a medical office.<sup>17</sup> Third, non-competition agreements are subject to the rule of public policy. Courts typically recognize that no employer should be able to deprive the public of needed medical services for its own economic reasons.<sup>18</sup> An employed physician may be able to prove that his or her services are necessary and thereby defeat a non-competition clause by showing that (i) the services are unique in the area or (ii) even if the employer is also able to provide the kind of services in question, the employer alone is not able to meet the entire patient need. Finally, these agreements must be supported by “consideration.”<sup>19</sup> If there is a non-competition clause in the original agreement, the fact of employment, the salary and the benefits are all consideration for the non-competition clause. Even if they are also consideration for all of the employee’s other contractual duties, they bind the employee’s promise not to compete after leaving the job. If the non-competition clause is not in the original agreement, however, it cannot be added to the agreement **unless** it is “paid for” with additional consideration.

As stated above, these are general rules, and physicians must check the law in their states.

## **II. Liquidated damages.**

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<sup>13</sup> The justification for non-competition agreements between the buyer and the seller of a business is the buyer’s expectation that he is getting the seller’s book of business and the opportunity to keep it if he can without the seller interfering. Again in medicine, this means patients and relationships with referral sources. To the extent the buyer acquires the business and keeps its old employees, both rationales may apply.

<sup>14</sup> While the physicians should not rely on hospital counsel entirely, they should ask the hospital to provide assurances that the arrangement is legal.

<sup>15</sup> Of course, there may be other legal reasons why the remainder of the agreement needs to be in writing.

<sup>16</sup> In a physician employment agreement, one year is almost certainly reasonable. Two years is most likely reasonable. Three years is problematic, but might be defensible in certain special circumstances. More than three years is very hard to defend. The provisions cannot cover an unreasonable area. They may cover the area in which the employee actually does a significant amount of work and the area from which the employee actually draws significant business.

<sup>17</sup> In medicine, the practice area for a sub-specialist may be larger than the practice area for a primary care physician.

<sup>18</sup> Courts sometimes refuse to enforce a non-competition agreement because a medical specialist has shown that if the non-competition agreement were enforced, patients in the area would have to do without needed services.

<sup>19</sup> Consideration is the lawyer’s name for something given by one person to another to make an agreement binding between them.

Some employment agreements discuss the consequences of competition against the employer in terms of liquidated damages or cost sharing. This is because the employer seeking to enforce a non-compete in court has the burden of proving damages. Having the parties agree in advance to the amount of damages or the remedies available allows the employer to avoid a potential roadblock. Non-competition agreements often permit the employee, who is subject to the non-compete, to “buy” the right to continue working in the area by paying an agreed amount of liquidated damages to the employer. A physician should always try to negotiate such an arrangement as the exclusive remedy for physician’s breach of the non-competition clause. A physician should make every effort to obtain a liquidated damages clause that would allow him or her to continue to work in his or her specialty and in the geographic area without interruption, provided the physician pays the hospital a certain amount of money as damages for his or her breach of the non-competition clause. This amount of money needs to be related to the physician-employee’s salary and the employer’s lost profits and cost of finding another physician. Liquidated damages of several hundred thousand dollars might be reasonable for a highly paid specialist but not reasonable for a primary care physician.

### **III. Non-competition in hospital practice purchase employment agreements.**

Although practice purchase agreements are not the subject of this chapter, the purchase of a practice will frequently lead to employment of the physicians in the acquired practice, and several issues arise when non-competition clauses are included in physician employment agreements following the purchase of the practice by a hospital.<sup>20</sup> Regardless of the boilerplate and caveats in the employment agreements, there will be referral issues in any employment agreement between a hospital and the physicians who sold their practice to the hospital if that agreement contains non-competition provisions. A non-compete in a purchase agreement could apply to the selling physicians for the rest of their employment by the hospital, even if it were not in the employment agreement itself. However, it would not apply to any physicians hired later, unless it were included in their employment agreements. If a hospital includes a non-compete in the agreement when it buys a physician group and starts to employ the physicians, it is fairly transparent that the hospital is “buying” the practice’s patients.

### **IV. Practical tips.**

Several practical tips with respect to non-competition clauses in the purchase situation may be helpful. Although each of these strategies may affect the economics of the deal, it still may be worth asserting. First, physicians may refuse to enter into a non-competition agreement with a hospital that buys their practice and employs them. Second, if unable to refuse a non-compete, physicians may limit the time by insisting that the non-competition agreement does not begin to take effect until some set time after the purchase. This would allow the physicians to unwind the arrangement in the first few years if it proved unworkable. Third, physicians may insist that the non-compete will not take effect if (1) the physician terminates the employment agreement **for cause** against the hospital, or (2) the hospital terminates the employment agreement **without cause** against the physician.

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<sup>20</sup> When a hospital buys a physician group, one basic rationale for a non-competition agreement turns upside down. The hospital is not the person who built the practice, and the hospital is not the person who taught the profession and the business of medicine to the younger physicians in the group. Therefore, the hospital may seem to have less moral or economic claim over the practice than would a founding doctor. Nevertheless, purchase agreements may include non-competes, supported by the purchase price as consideration. If the hospital is purchasing the good will or ongoing business value of the practice, a non-compete would be viewed as a necessary protection for that investment.

## **V. Non-solicitation provisions.**

Non-solicitation provisions prevent an employee from opening a new business and (a) hiring the former employer's other employees or (b) soliciting the former employer's customers. Just as a physician whose practice is purchased by a hospital ought to structure the arrangement so it can be unwound and allow the physician to resume private practice (at least in the early years), so should the physician keep the right (a) to bring former employees back into the practice and (b) to contact patients with information about resuming the private practice. Many medical boards have issued guidance about giving patients their physician's new contact information and about handling patients and patient records. Employment contracts need follow such guidance.

## **Miscellaneous contractual issues for hospital-employed physicians**

Hospital-physician employment contracts contain a number of other provisions that physicians will want to consider. These include provisions related to (1) participation in managed care contracts, (2) professional liability insurance and (3) indemnification.

### **I. Participation in a hospital's managed care contracts.**

Hospitals generally want their physicians to contract with all payers with which the hospital has agreements, and physicians employed by a hospital or its subsidiary are generally required by contract to participate in all hospital managed care contracts. If physicians' compensation is based on collections, then the levels of reimbursement by payers becomes more significant and should be explored with this in mind. This is especially true if the hospital's contracting agent is negotiating rates for both the hospital and the physicians—how can the physicians ensure that the hospital is not negotiating a higher facility fee at their expense?

### **II. Professional liability insurance (“PLI”).**

Malpractice insurance is generally provided by the employing hospital in an employment agreement. Physicians should consider whether their current PLI contains a special endorsement, such as no additional cost tail coverage, and whether any special endorsement exists, negotiate with the hospital for it to assume or reimburse payment for the existing PLI if feasible to avoid losing these benefits. Insurance provisions in employment contracts will identify who is financially responsible for obtaining and maintaining PLI and tail coverage for claims made after the employment terminates but which are based on acts that occurred during term of employment. Who pays for the tail coverage may depend on who terminates the employment relationship and for what reason. These provisions may specify that (i) the physician or the hospital always pays for tail coverage; (ii) payment by either party based upon how termination occurs (i.e., physician only pays if the physician terminates voluntarily (without cause) or is terminated for cause); or (iii) the hospital may pay in accordance with a vesting schedule (i.e., physician pays 100 percent if he or she leaves within one year of employment; amount physician pays decreases by 25 percent for each additional year the physician remains employed in compliance with terms of agreement; hospital pays 100 percent after five years of employment). Tail coverage can be costly and should be considered before accepting an employment offer.

### **III. Indemnification.**

Physicians and hospitals alike are concerned about “indemnification” provisions, the contract terms that say when each party will be liable for any damages or harm (however defined) it causes to other party. Sometimes linked to indemnification provisions are those calling for “contribution” from one party to the other to offset costs or damages paid by one party as a result of acts or omissions of the parties. First, note that courts may have already recognized a right to indemnification or contribution more favorable than what the contract provides in some cases.

Second, indemnification and/or contribution become particularly relevant if certain contractual provisions are breached (i.e., insurance loss or underfunding). Physicians should seek mutuality (there is a provision for the physician and one for the hospital) and similar scope of provisions but beware of terms that would set a different standard for liability (i.e., gross negligence or intentional conduct as the basis for indemnification).

### **Conclusion**

As noted at the beginning of this chapter, hospital employment of physicians is on the rise. Physicians need to be familiar with key contractual provisions and their associated risks and benefits to negotiate good employment agreements and long-term, mutually satisfactory arrangements.

## Chapter 8 Appendix 1: List of IRS factors for fair market value

Although the IRS by letter ruling will not opine on whether compensation paid to a particular employee is reasonable, IRS Information Letter 02-0021 listed the following factors tending to show the fair market value of physicians' compensation:

- Compensation established by an independent board of directors or independent compensation committee
- Figures supported by reliable physician compensation survey data for the physician specialty and geographic locale
- Arm's-length relationship in negotiating compensation
- Inclusion of a reasonable ceiling or maximum on the amount the physician may earn
- The compensation formula takes into account measures of quality and patient satisfaction
- The compensation methodology does not transform the arrangement into a joint venture or impermissible means of profit-sharing by a tax-exempt organization
- The compensation arrangement serves a real business purpose as opposed to an impermissible benefit to the physicians
- Compensation is based on services personally performed by the physician

## Chapter 8 Appendix 2: List of common termination for cause provisions

### **Common causes for termination, capable of cure**

- Failure to maintain proper medical records
- Failure to prepare medical records in a timely fashion
- Failure to bill and code correctly
- Repeated disruptive behavior, as clearly identified and described in the employee handbook
- Repeated failure to cover call
- Breach of a material provision of the agreement

### **Common causes for termination, incapable of cure**

- Death or permanent disability, best defined with regard to the applicable disability insurance policy
- Loss of license to practice medicine following a hearing
- Active suspension of license to practice medicine for more than [30, 60 or 90] days, following a hearing
- Exclusion from Medicare or Medicaid following a hearing and any available appeal
- Conviction of a felony, guilty plea to a felony or plea of no contest to a felony
- Conviction of a misdemeanor involving personal injury, non-consensual sexual behavior, alcohol, illegal substances, theft, fraud or deceit, or a plea of guilty or of no contest to such a misdemeanor
- Incarceration for more than [30, 60 or 90] days
- Loss of medical staff membership after completion of all steps provided in the medical staff fair hearing plan
- Loss of hospital clinical privileges necessary to perform the professional services required by the contract after completion of all steps provided in the medical staff fair hearing plan
- Alcohol use affecting work or substance abuse affecting work if such is established after all steps provided in the medical staff fair hearing plan or by the Medical Board

- Sexual relations with patients if such is established after all steps provided in the medical staff fair hearing plan or by the medical board.

## Chapter 8 Appendix 3: Due diligence checklist for physicians considering hospital employment

### **History.**

- **Other physicians.** What is the experience of the hospital's current physician employees who would be in an analogous situation to you?
- **Management.** What is the history with the hospital's management of physician practices? Does the hospital appear to understand the operations and economics of physician practice?
- **Strategic goals.** Does history indicate that the hospital can help the physician practice accomplish its mission through strategic planning, investment in equipment, etc.?
- **Trust.** Do you have faith in the hospital's board and administration, based on a track record of cooperation and fair dealing which would indicate the hospital deserves your trust?
- **Governance.** In light of the very different modes of operation and cultures of hospitals and physician organizations, does the structure allow for significant physician input into governance of the physician organization and autonomy in clinical matters?

### **Compensation.** What will be the effect of the proposed compensation provisions? Are they for fair market value?

### **Termination.** What are consequences of the termination provisions for the practice or the individual physician? In the event of termination, can the physician:

- Continue to practice in the community?
- Purchase the right to continue to practice in the community ("Pay to play")?
- Remain on the medical staff of the hospital?
- Retain most or all clinical privileges at the hospital?

- Fairness.** Are all the contract provisions fair? For an established physician in the community who joins a hospital affiliate, is any non-compete linked to the hospital's purchase of the practice's good will and value as an ongoing business? Did the physician share in that purchase?
- Clarity.** Are the terms clear and unambiguous?
- Legal review.** Has there been a full legal review by an independent attorney hired by the physician of all contract provisions to ensure there are no surprises and all contractual provisions comply with applicable laws?