

Partnering with hospitals to create an accountable care organization

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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, hospital and other out-patient services are provided by one or more entities under common control.¹ 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 and costly readmissions.
- Need for physician cooperation to minimize length of stay, vendor, standardization, and unnecessary or duplicative costs.
- Need for interoperable electronic health records (EHR).

- Need to demonstrate, not just provide, quality patient care.
- Need to address reduced overall 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 or reduced total cost of care metrics.
- Need for alignment with physicians to effectuate bundling arrangements or shared savings programs that are applicable to ACOs and narrow network insurer plans.
- Need for improved coordination in the transitions of care.

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

¹ 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.

the extent to which they would internalize strong physician governance as a core value.

Appendix I sets forth a checklist that is useful in evaluating a hospital as a potential ACO partner 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 and efficiency will be essential. To achieve that goal, ACOs must meaningfully produce and fairly allocate shared savings revenues among providers to implement evidenced based medicine, improved patient engagement and compliance, population health, chronic disease management, and coordinated care over a variety of practice settings and transitions. Since the object of the integration is to produce better quality and outcomes for less cost through the effective use of technology, significant coordination of care, avoidance of duplication or unnecessary expenses, greater access, targeted resources to create patient engagement in their health and strong patient satisfaction, and use of the most efficient situs of care, 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 advanced by physician leaders with the temperament, professional reputation and passion to improve quality. This will involve improved and more timely patient access to services in the most cost effective setting, and resources to facilitate the patient engagement to improve their risk profiles and health outcomes. These physicians should 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 physi-

cians 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. These arrangements might include service line co-management agreements, professional services agreements, provider based joint ventures, community based health information exchanges, collaborative disease and population health initiatives, ACO formation or participation in bundled payment programs.

- 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. In pursuing this strategy, physicians will consider how much near term cash they may realize by affiliating with the hospital, what market based income protections are available, and the value of aligning early with the hospital to gain first-mover advantage in the design of the new organization. A critical first step is the development of a shared vision as to how care transformations will be initiated to improve access, reduce preventable emergency room visits, reduce readmissions and infection rates, and assure coordination of care and information access as patients transition from care settings.

Attached as Appendices 2 and 3 are two sample issues listings. Appendix II sets forth the issues appropriate for testing the waters of partial integration. Appendix III 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. ACO regulations provide Five Safe Harbors relative to ACO activities. These Safe Harbors require significant transparency, strong conflicts of interest policies, and lengthy documentation retention. The shared savings methodologies will need to relate to the purposes of the ACO program and generally should support initiatives that improve the patient experience, reduce the trend in cost and address population health and patient access and engagement. A portion will of necessity be required to address the infrastructure investments needed to implement the care protocols (both IT and in development and monitoring) and to reimburse practices for uncompensated activities (behavior health support, outreach, patient monitoring, patient education and home assessments). Achievement of 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. Often this will be expressed as achieving certain established quality benchmarks.

A significant portion of savings will come from physician pre-hospitalization interventions, alternative practice settings and patient interventions that improve the health profile of patients with ambulatory sensitive conditions so as to avoid acute events and 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. In the end, following the simple rule of what is in the best interest of the patient will inform many of these changes. The medical home pilots across the country have established that hospitalizations and total costs can be significantly reduced by programs that target and engage patients in their health and provide substantially greater access to primary care services during non-business hours. 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 co-management agreements.
- Other management services organization (MSO) arrangements and EHR connectivity arrangements.
- Gainsharing arrangements.
- Professional service arrangements with strong incentives

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, when located in close proximity to the hospital 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 co-management agreements

Hospitals desiring to create “centers of excellence” and to create a fully integrated continuum of care have entered into service line co-management agreements in which physician entities and their designated administrators assume or share 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 and are generally of short duration.

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 one 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.

The Medicare Shared Savings Program (MSSP) ACO Safe Harbors

The final regulations relating to the MSSP ACO safe harbors include broad and uniform protection to arrangements by and between the ACO and ACO physician participants. They are self executing and cover the various federal prohibitions intended to protect beneficiaries and prevent program abuse. The waivers do not cover private payer ACO activities, integrated delivery or pilot projects. Transactions that implicate multiple waivers need satisfy only one waiver condition. These waivers are in addition to and do not supplement existing Stark exceptions or other anti-kickback safe harbors. Accordingly, presently compliant arrangements do not need to be revisited.

In exchange for being self executing, the rule contains significant documentation and disclosures requirements. Each of the rules requires contemporaneous documentation of both the arrangement and authorization. The documentation must describe the arrangement, the parties, the subject matter, and financial terms and importantly must also contemporaneously document the basis for the good faith determination by the governing body as to the arrangement's reasonable relationship to the MSSP purposes. Finally, records need to be maintained for 10 years following the completion of the arrangements or, as to the start-up waiver, 10 years after submission of the application or reasons for failure.

Transparency is required including public disclosure of the parties, the date, the items, services, facilities or goods covered but not financial terms. Generally, these disclosures should be web searchable. The commentary to the final rule makes clear that ACO applicants and participants relying on the waivers may be routinely asked to supply documentation as part of program compliance. Accordingly, compliance officers will need to have systems and policies in place to assure that documents are preserved and that the requisite contemporaneous determinations and documentation occur and are timely disclosed.

Gain-sharing

Central to the ACO concept will be shared savings either across a given population or an episode of care. The regulations applicable to the MSSP will provide safe harbor protection as to gain sharing prohibitions under specific circumstances for approved ACO applicants. To be eligible:

- The ACO must be in a MSSP ACO Participation Agreement and remain in good standing.
- Financial relationship is reasonably related to the purposes of MSSP.
- The relationship falls within a Stark exception (42 CFR 411.355 through 411.357) thereby expanding Stark exception by also waiving Gain Sharing and Anti-Kickback prohibitions.

Independent of ACOs in MSSP, 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 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.

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. Importantly, there are many physician-only ACOs that have proved successful both financially and on quality measurements. Partnering with a hospital is no replacement for the type of physician practice commitments that are necessary for ACO success. 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.