



Accountable Care Organizations and Medical Foundations: Opportunities and Risks of New Payment and Delivery Models

Francisco J. Silva
CMA General Counsel and Vice President

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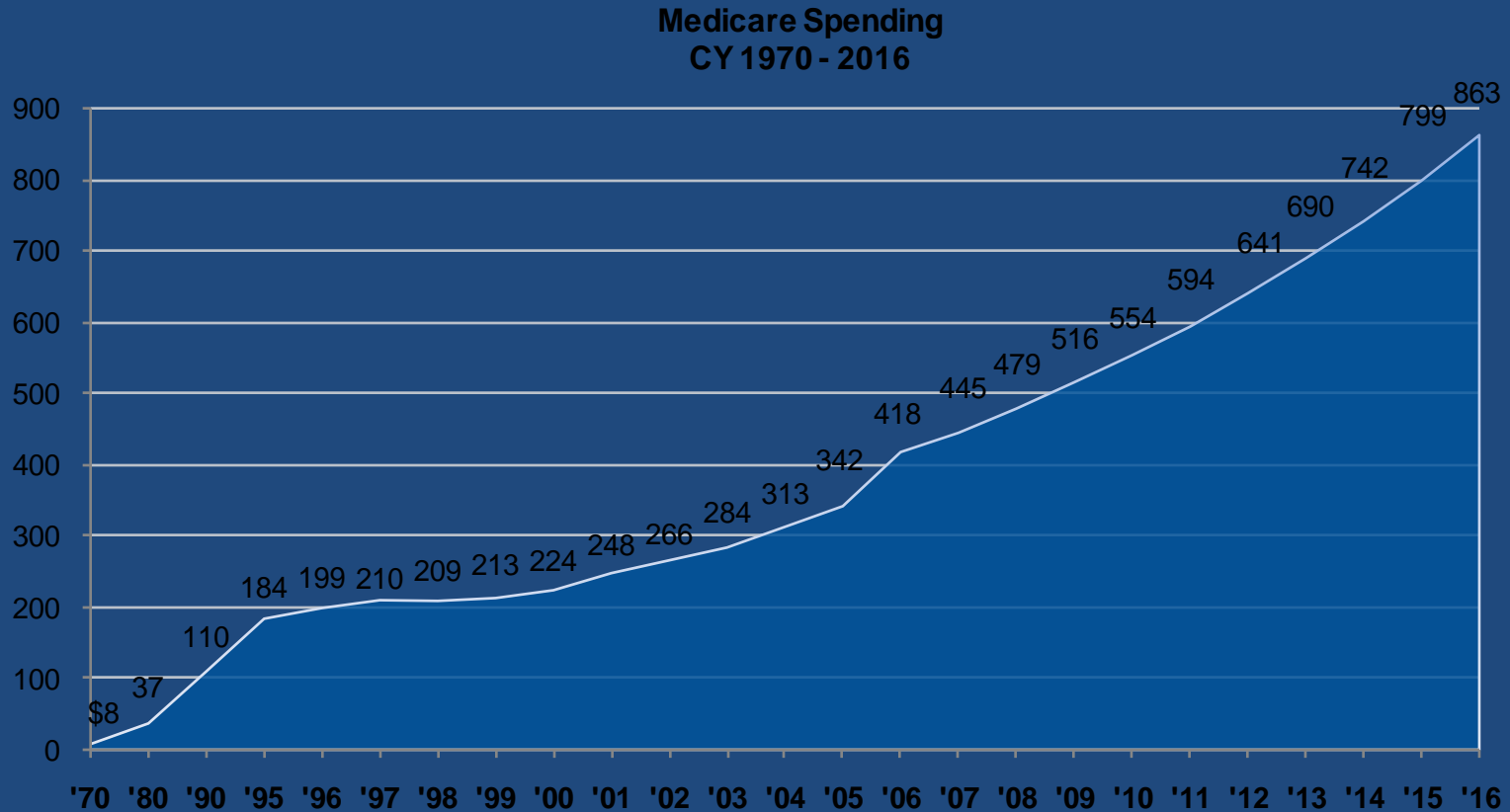
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Introduction

- Health care reform legislation (Affordable Care Act (ACA) or Patient Protection and Affordable Care Act (PPACA)) driving changes in health care delivery systems and payment models
- Quality, Cost and Coordination of Care key benchmarks and objectives
- Desire to access federal funds, improve outcomes, provide patient-centered care, and health care market dynamics will motivate physicians and hospitals to work collaboratively

The Cost Problem

Medicare Spending



Source: Modern Healthcare's By The Numbers - December 2007 (CMS, 877-267-2323, cms.gov)

ACA's Options to Address Growing Costs and Expand Access

- Increase taxes
- Cut reimbursement rates
 - ✓ Under FFS, Medicare thinks of costs as a series of fees. Accordingly, to cut costs it cuts fees.
- Redistribute funds and do more with the same amount of money

Incentivize Reduction of Costs While Maintaining or Enhancing Quality

- Affordable Care Act establishes pilots and laws to test and evaluate new Medicare health care delivery and payment models
- Programs based on general assumption re FFS: current fee for service system incentivizes overutilization and not outcomes, coordination or efficiency of care

New Payment and Delivery Models

For Example:

- Accountable Care Organizations (ACOs or “shared savings”)
- Medical homes
- Bundled payments (i.e., bundled payments for episodes of care)
- Establishment of new Center for Medicare and Medicaid Innovation (CMI) by 2011
 - 10 billion in funding in addition to Medicare Pt. A and Pt. B
 - Preference to innovative payment and service delivery models that reduce spending while preserving or enhancing quality
 - Broad discretion to Secretary

ACOs

- By January 1, 2012 Secretary must establish ACO program designed to improve quality and cost-efficiency of care to Medicare fee-for-service beneficiaries (Pt. A and Pt. B)
- But must start now b/c of long term planning required to start and implement ACO
- Even if not interested, have to recognize and understand ACO goals and potential impact

ACO: Payment and Delivery Reform

- The ACO concept couples payment and delivery systems reforms
- Allow entities that are “ACOs” to experiment with different payment models in Medicare FFS:
 - ✓ Shared savings
 - ✓ Partial capitation
 - ✓ Secretary’s discretion

ACO: Payment Reform

- **Shared savings**: ACO concept allows physicians to be jointly rewarded for the efficiencies they achieve in both the Medicare Physician Pt. B and the Hospital Pt. A program
 - ✓ **Based on Fee-for-service**: Under the ACO model the ACO's providers will continue to bill Medicare under the current fee-for-service system.
 - ✓ **Quality and Cost benchmarks**: If the medical care delivered by the ACO's providers meets the yet to be determined CMS quality standards and the total cost of this care is below the yet to be established cost benchmark, CMS will share a portion of the cost savings with the ACO.
- **No capitation type risk**: The opportunity to share in cost savings without taking any downside capitation type risk is attracting the attention of many hospitals and physicians alike.

ACO: Delivery Reform

- Who is an ACO professional?
 - ✓ Physician, physician assistant, nurse practitioner, or clinical nurse specialist
- What entities are eligible to participate as ACOs?
 - ✓ ACO professionals in group practice
 - ✓ Network of individual practices of ACO professionals (i.e., IPA)
 - ✓ Partnership or joint venture arrangements between hospitals and ACO professionals
 - ✓ Hospitals employing ACO professionals
 - ✓ Others as determined by Secretary

ACO: Delivery Reform

Requirements to qualify as an ACO:

- ✓ Established mechanism for shared governance
- ✓ Leadership and management structure that includes clinical and administrative systems (i.e., integration)
- ✓ Formal legal structure that would allow it to receive and distribute payments for shared savings
- ✓ Accountable for quality, cost, and overall care of the Medicare fee for service beneficiaries
 - ❑ Must build systems to track and report costs for both Pt. A and Pt. B
 - ❑ Must build systems to track and report quality for both Pt. A and Pt. B
 - ❑ Must “define processes to promote evidence-based medicine and patient engagement . . . and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.”

ACO: Delivery Reform

Requirements to qualify as an ACO:

- ✓ 5,000 beneficiaries assigned to it
- ✓ Enough primary care providers to serve beneficiaries assigned to it
- ✓ Agree to participate in program for 3 years
- ✓ Meet "patient centeredness" criteria yet to be specified by HHS (i.e., use of individualized care plans, use of patient and caregiver assessments)

Legal Issues

- Patient Referral Laws
 - ✓ Secretary has discretion to waive these statutes for the purpose of implementing the ACO program
- Selection and Exclusion of Physicians
 - ✓ *See Potvin v. Metropolitan Life Insurance Co.*
- Antitrust laws
 - ✓ Attorneys say clinical integration model safest way to move toward ACO formation

Summary of ACOs

- No “one size fits all” solution: the provisions of the law are sufficiently flexible to allow the full range of organizational structures to participate as an ACO
- Key benchmarks: quality outcomes, patient-centered care, and value (i.e., cost)
- Creating an “integrated culture” among providers will be critical (including, virtual integration)
- Need capital to develop and implement systems

California Delivery Models

- “Out of the box” potential for rapid ACO or hospital/ACO joint venture
 - ✓ Capitated Medical Groups
 - ✓ IPAs
 - ✓ Medical Foundations
 - ✓ Integrated Systems
- Characteristics of these models
 - ✓ Existing primary care and specialists provider agreements
 - ✓ Existing agreements with hospitals
 - ✓ Existing quality improvement, utilization review, informatics and payment systems
 - ✓ Third party payer contracting and medical management know-how

1206(I) FOUNDATIONS DEFINED

California law authorizes certain medical “clinics” to operate without a license. (Health & Safety Code 1206.) One type of clinic which is so authorized is a clinic which meets the requirements set forth in subdivision (I) of that section.

1206(I) FOUNDATIONS DEFINED

“1206(I) foundation” clinics must:

- conduct medical research and health education;
- provide health care to “its patients” through a group of:
 - 40 or more physicians and surgeons who are independent contractors,
 - representing not less than 10 board-certified specialties,
 - at least two-thirds of whom must practice full-time at the clinic; and
- be exempt from taxation in accordance with 501(c)(3) of the Internal Revenue Code.

WHY THESE CLINICS ARE EXEMPT FROM LICENSING LAWS

1. Tax-exempt bond financing

1. 1978 Santa Barbara Medical Foundation 501(c)(3) clinic fell within definition, which at the time was a clinic requiring licensure
2. 1980 Palo Alto Medical Clinic, same structure
3. Entities forced to operate like hospitals vis-à-vis certificate of need and licensure

2. 1980, AB 2279 Creation of Health & Safety Code 1206(I)

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FOUNDATION MODEL

A 501(c)(3) non-profit corporation (foundation)

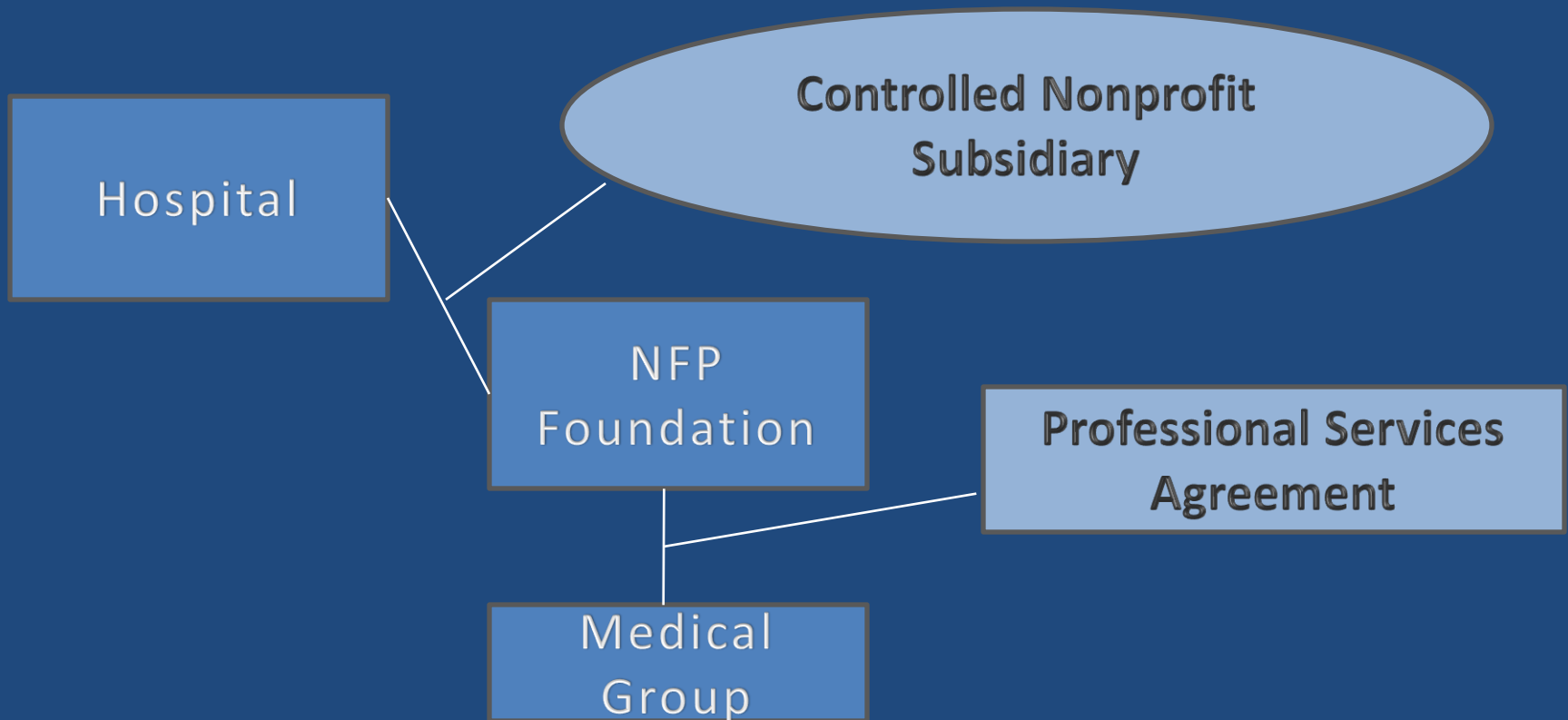
- Purchases assets of medical group
- Enters into an independent contract with physician group
- Owns clinic, facilities, supplies and equipment, management information and billing systems
- Holds managed care contracts

MEDICAL FOUNDATIONS AS A PHYSICIAN-HOSPITAL ALIGNMENT STRATEGY

- 1990's → Recognition that foundation could be sponsored by the medical group itself, or by others, such as a hospital or health system
- With latter, foundation would benefit from capital resources of hospital and strategic alliance with physicians
- San Diego Chief Medical Officer:
 - “It is the foundation model that is key to partnership and legally sharing capital.”

Foundation

Health & Safety Code Section 1206(I)



DRIVERS FOR FOUNDATIONS

Hospital Perspectives

1. The hospital industry is facing a financial crisis

- Over ½ are technically insolvent or at risk of insolvency*

*Alvarez & Marsal Healthcare Industry Group “Hospital Insolvency: The Looming Crisis” at www.alvarezandmarsal.com

DRIVERS FOR FOUNDATIONS (cont.)

2. Loss of lucrative outpatient procedures to ASCs

- i. 300% increase in outpatient surgeries since 1996 (CDC 1/2009)
 - Cataracts
 - Benign Tumors
 - Cancer
 - Esophageal disease; and
 - Diverticulosis

DRIVERS FOR FOUNDATIONS (cont.)

3. An increase in bad debt, driven by number of uninsured
 - i. 73% ↑ in consumers having difficulty paying out-of-pocket costs
(11/2008 survey in California)

DRIVERS FOR FOUNDATIONS (cont.)

4. Decrease in hospital utilization

- i. Length of stay decreased by nearly 20% since 1980.
- ii. Evolution in technology and use of pharmaceuticals.
- iii. Generational differences.
- iv. Third party payors limitations – increased time in observations units with fewer admissions.

DRIVERS FOR FOUNDATIONS (cont.)

5. Reimbursement rates for hospitals outpatient services are higher for same services provided in other settings (for some services as much as 200%)*

*OIG Report “Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers” (2003)

DRIVERS FOR FOUNDATIONS (cont.)

6. Physicians are food

- “Primary care feeds specialists – specialists feed hospitals” (HCA)
- Average PCP generates \$2 million in annual hospital revenue from the physician’s patient base.

7. Participation in global billing contracts and other new payment models (including those incentivized by health reform)

PHYSICIAN PERSPECTIVE

- MGMA Study
 - 2005 → 2/3 medical practices MD owned
 - 2009 → <1/2 MD owned
- Young Physicians
 - Medical school debt
- All Physicians
 - Regular hours
 - Income stability
 - Decreased business risk
 - Access to improved systems
 - Less administrative hassles
 - Access to capital

COMPLEX IMPLEMENTATION HURDLES FOR FOUNDATION

- Separate foundation
- Clinic
- Medical Group with at least 40 physicians, at least two-thirds practice full time at the clinic
- Ten board certified specialists
- Tax exempt under federal law
- Medical research and education

Note: CMA active in ensuring compliance with each of these requirements

COMPLEX IMPLEMENTATION

TAX EXEMPTION

- Section 501(c)(3) Exemption
- ✓ Must operate to benefit public, not private interests
- ✓ Enforcement: Lawsuits & Complaints

1. Practice Requirements:

- Provide charity care
 - ✓ Participation in Medicare and Medicaid is a factor
 - ✓ Charity care policies must be available to public
 - ✓ Accept all indigent patients needing urgent care, potentially including necessary follow-up care to hospitalized indigents, at free or discounted rates

COMPLEX IMPLEMENTATION TAX EXEMPTION (cont.)

Practice Requirements:

- ❑ **Medical research and health education:** Conduct “significant” programs of medical research and health education (i.e., cardiac information, pregnancy counseling, community health fairs);
- ❑ **Open medical staff:** Ensure that its hospitals maintain an open medical staff to all qualified physicians, consistent with nature and size of facilities, and
- ❑ **No referral requirement:** Not require physicians who contract with it to refer to its hospitals.

COMPLEX IMPLEMENTATION TAX EXEMPTION (cont.)

2. Foundation Governance

- ❑ A “community board” in which **independent persons** representative of the community comprise a majority.
- ❑ Physicians in, or related to, the medical group cannot control the foundation board. Instead, some rulings have limited the medical group to no more than 20% physician control!

COMPLEX IMPLEMENTATION

Kickback/Fee-Splitting Issues

- **Practice-Assets Acquisition**. The physicians' practices must be purchased "at or below fair market value." This value can include intangible assets, such as trademarks and tradenames, warranty rights, utility rights, patient files and records, software, an in-place workforce, contracts to provide medical services, non-competition agreements, and goodwill.

FOUNDATION & ACO ISSUES TO CONSIDER

- **WARNING:** Seek advice of expert before signing any agreement.
- Governance is key (e.g., professional services agreement and governance of entity).
- Balance of trust and control to ensure success and to work through issues.
- “Shared values.”

FOUNDATION & ACO ISSUES TO CONSIDER

- **Control of new organization:** How much control of the new foundation/ACO will the physicians have?
- **Control of administrators running organization:** How much control will the physicians have over the administrators hired for it by the foundation/ACO?
- **Selection of directors of organization:** How will directors, including non-physician directors, be selected?
- **Compensation:** How is compensation determined?

FOUNDATION & ACO ISSUES TO CONSIDER

- **Control of clinical decisions:** How much say will the physicians/group have on utilization and quality improvement standards and protocols, the adoption of practice parameters, the development of drug formularies, or the purchase of new technologies?
- **Control of credentialing, medical practice policies, & employment of physician members:** Will the foundation/ACO or the medical group have the last word on credentialing, medical practice policies, and hiring and firing of physician members?

FOUNDATION & ACO ISSUES TO CONSIDER

- **Impact of charity care requirement:** In the case of foundations, what impact will the obligation to provide charity care have on the medical group?
- **Impact of health education requirement:** What research of health education obligations might be imposed?
- **Compensation enough to cover new obligations:** Will the compensation arrangement now and in the future be adequate to cover the quality measures, charity care, research, and education obligations?

FOUNDATION & ACO ISSUES TO CONSIDER

- **Fairness of future contract negotiations:** Will future contract negotiations likely result in a fair split of income or will the hospital or IPA administrators, for example, have an unfair advantage?
- **Dispute resolution or dissolution:** What provisions are in place to protect the physicians and/or medical group in the event of a dispute or dissolution of the agreement?

FOUNDATIONS & ACOs

ISSUES TO CONSIDER

- Impact on community physicians differs depending on status
 1. Participants
 2. Non-participants
- Must make individual determination

CMA RESOURCES AVAILABLE

- PHYSICIAN-HOSPITAL ALIGNMENT TAC, etc.
- Principles/Policy
- New On-Calls
- Model Governance Document
- Webcasts by Professor & attorney Anthony Schiff
- RELEVANT CMA ON-CALLS INCLUDE:
 - 0226 Decision-making Authority for Integrated Entities
 - 0210 The Antitrust Laws: What Physicians Can Do
 - 0218 Legal and Practical Considerations re Medical Foundations
 - 0228 Medical Group: How to Form
 - 0230 Medical Partnerships and Corporations
- Free for members at www.cmanet.org

WHAT CMA RESOURCES ARE CURRENTLY AVAILABLE (cont.)

- Center for Economic Services
 - A. Reimbursement Helpline
 - CES provides one-on-one educational assistance to physician members and their staff: (888) 401-5911
 - B. Payor Relations
 - Intervenes on the physician member's behalf with the payor on complex issues
 - C. Contract Analysis
 - Performs analysis of the major payor contracts and alerts physicians to any problematic provisions.
 - D. Formal Complaint Assistance
 - Assist physicians and their staff in filing formal complaints with regulators

CMA RESOURCES ARE CURRENTLY AVAILABLE (cont.)

■ Center for Economic Services

E. Toolkits offered

- Best Practices – free download at www.cmanet.org/bestpractices/
- Taking Charge – free download for members only
- Back to Basics – free download for members only coming soon!
- Payor Profiles – free download for members only
- Mini-toolkits – free download for members only
- Educational Webcasts – members only can view presentations

WHAT CMA RESOURCES ARE CURRENTLY AVAILABLE (cont.)

- Strengthen your medical staffs through CMA's Organized Medical Staff Section (OMSS)
- Contact CMA at medstaffhelp@cmanet.org