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The Way Forward?

Mounting pressures on hospitals and physicians both suggest that new models of working may be the way of the future

BY JEREMY N. MILLER

PHYSICIANS WERE FACING daunting challenges *before* the passage last March of the Patient Protection and Affordable Care Act: declining reimbursement, rising overhead, increasingly burdensome government regulation, and a severe recession. Health care "reform" will likely only exacerbate these pressures. As a result, many physicians are in a state of high anxiety and question whether private practice as they—and their patients—have known it can survive. Hospitals are facing similar challenges. Health care reform will result in a reduction in reimbursement, penalties for preventable readmissions and preventable hospital acquired conditions, bundling of payments, value-based purchasing, and many other significant challenges. Thus, hospitals, like physicians, need to operate

ever more efficiently while, at the same time, maintaining or improving patient care and patient satisfaction.

The clear message of the health care reform law, and the marketplace, is that the current trajectory of health care costs ($2.5 trillion in 2009 and rising) is unsustainable. In order to survive, physicians, hospitals and other industry players will be expected to do better with less. The theory is that this can be achieved if hospitals, physicians and other providers do a much better job of coordinating and managing patient care, and move away from a volume-based system to one that is focused upon providing value. This article will examine some of the options physicians and hospitals are exploring to better align their interests and still deliver high-quality, affordable, patient-centered care.

To Be or Not to Be....

MANY OBSERVERS believe that the health care industry is in the early stages of revolutionary change that will unfold over the next 10 years. The existential question for physicians is will they be key stakeholders who help to shape and implement that change, or will others determine their destiny? In facing this challenge physicians have a number of advantages and disadvantages. On the plus side, it is physicians (and other health care professionals), and not administrators, actuaries or bureaucrats, who will continue to treat patients and provide care. It is physicians who will remain the focal point when ordering health care goods and services, developing "best practices," practicing evidence-based medicine, and coordinating patient care. Because the vast majority of Americans like their physicians, physicians have a tremendous reservoir of goodwill. For these and other reasons, most astute hospital boards and managers recognize the unique role physicians can and must play in a value-based health care delivery system, and are actively seeking out physician organizations and leaders with whom to partner.

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But physicians also face daunting challenges. Physicians are frequently disorganized and fractious (the days of the medical staff speaking with one voice are long gone). Many physicians, particularly younger ones, do not belong to local, state or national professional associations outside of their specialty, thus limiting their ability to affect national health care policy. Physicians are aging: according to a recent report by the California HealthCare Foundation nearly one-third of physicians in the State are 60 and older. Additionally, many younger physicians are much more comfortable than their predecessors with working for someone else. At a time when practices require more capital, physicians no longer have the financial reserves or access to funds they once enjoyed. Physicians have to comply with ever more complex government regulations, for example, HIPAA, Medicare billing rules, the Stark Law, and employment laws. As a result, many physicians are so dispirited and overwhelmed, that they are prepared to let someone else take responsibility for dealing with the coming restructuring of the health care payment and delivery system.

Haven't We Seen All of This Before?

PHYSICIANS SHOULD be forgiven if they have a certain sense of déjà vu about the latest buzz term—"hospital-physician alignment." In the 1990s, physician-hospital organizations (PHO), integrated delivery systems (IDS), management services organizations (MSO), and practice acquisitions were all the rage. Many of these early hospital-physician alignment strategies failed for a number of reasons including (a) hospitals' often mistaken belief that if they could run a hospital they could do a better job than the physicians of managing a medical practice; (b) trying to form "instant groups" from physicians who had never practiced together before; (c) paying a premium for practices, guaranteeing salaries, and then watching physician productivity drop; (d) emphasizing locking up patients and referrals rather than better managing patient care; and (e) not viewing physicians as true partners.

So is it different this time? Honestly, no one can say for sure. But the following changed circumstances suggest it is: (a) health care spending in 1995 was less than 14 percent of the gross domestic product; in 2009 it was 17.3 percent. Projections are that unless the cost curve can be bent, by 2019, health care spending will account for more than 20 percent of the GDP. Even in these politically polarized times there seems to be a consensus that "something must be done" because the current path is unsustainable for our nation; (b) we are in the worst recession since the Great Depression and funds are scarce at all levels of government; (c) unless the "individual mandate" portion of the health reform law is repealed in the courts (which currently seems unlikely) or by a change in who controls the Presidency and Congress, by 2014, an estimated 32 million currently uninsured Americans will have health coverage; (d) hospitals and physicians have learned some hard lessons from the 1990s as to what alignment strategies do and do not work; (e) physi-

cians seem much more receptive to the idea of partnering with hospitals, and have lower financial expectations; (f) there is a great need for sophisticated and expensive information technology and electronic medical records systems; and (f) there will be more financial incentives for providing value across the care continuum as we move away from volume-based payment.

Alignment Options Range from Less Integrated to More Integrated

HOSPITAL-PHYSICIAN alignment can be viewed as a continuum of integration. To the far left (less integrated) is the traditional medical staff membership relationship. This relationship does involve a certain degree of integration as codified in the medical staff bylaws, and hospital rules and regulations, and through service on hospital boards and committees. On the far right (more integrated) are hospitals that directly employ physicians to practice medicine. In California (and some other states) direct employment is prohibited by the corporate practice of medicine doctrine. There are noteworthy exceptions to California's corporate practice of medicine prohibition including employment by Knox-Keene Plans (staff model HMOs), nonprofit community clinics, universities, and by federal, state and local governments.

This article will primarily focus on the following alignment options that fall between the extremes of medical staff membership and direct physician employment: gainsharing, bundled payments, service line co-management arrangements, accountable care organizations, and hospital-based foundations. There are many other options along the integration continuum, and these options are not necessarily mutually exclusive. For example, the following arrangements all involve a certain degree of physician-hospital integration and alignment: (a) service on hospital boards and committees (b) medical director agreements, (c) hospital- based physician contracts, (d) hospitalist and intensivist contracts; (e) call coverage agreements; (f) management services agreements; (g) joint ventures for imaging and ambulatory surgery centers; (h) "pay-for-performance" agreements; (i) information technology integration; and (j) shared risk pools in managed care contracts.

Gainsharing: Physicians Share in the Rewards of Cost Reduction

ACCORDING TO THE OFFICE of Inspector General's Special Advisory Bulletin:

> "While there is no fixed definition of a 'gainsharing' arrangement, the term typically refers to an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts. In most arrangements, in order to receive any payment, the clinical care must not have been adversely affected as measured by selected quality and performance measures.... Gainsharing arrangements seek to align physician incentives with those of hospitals by offering physicians a share of the hospital's variable cost savings attributable to Medicare and Medicaid reimbursement."

In attempting to establish gainsharing arrangements, the parties have to be very careful to not violate the Medicare–Medicaid Anti-Kickback Statute (42 U.S.C. Section 1320a-7b), the "Stark Law" (42 U.S.C. Section 1395nn) and the Civil Monetary Penalty law (42 U.S.C. Section 1320a-7a[b]), which prohibits a hospital from making payments to a physician as an inducement to reduce or limit the provision of items or services to Medicare or Medicaid patients under the physician's direct care.

A number of gainsharing arrangements with cardiologists for cardiac catheterization procedures have been approved by the Office of the Inspector General. Most recently, in Advisory Opinion No.09-06 (June 23, 2009), the Office of the Inspector General approved a gainsharing arrangement involving a hospital, and cardiology, vascular surgical and interventional radiology groups. The hospital shared a percentage of its cost savings from the physicians' implementation of various cost-reduction measures for certain cardiac catheterization procedures. These focused on standardizing the types of devices and supplies (such as stents, balloons, vascular closure devices, and pacemakers) used by the physicians, after first ensuring their clinical safety and effectiveness. Subject to many other factors and quality safeguards, each group was eligible to receive 50 percent of the hospital cost savings achieved by the whole group.

In Advisory Opinion No. 08-09, the Office of the Inspector General conditionally approved a gainsharing arrangement whereby a hospital shared with groups of orthopedic and neurosurgeons a percentage of its cost savings directly attributable to the physicians' implementation of cost reduction measures with respect to the use of specific medical devices and supplies during spine fusion surgery. In Advisory Opinion No. 07-22, the OIG conditionally approved a gainsharing arrangement with anesthesiologists who implemented cost reduction measures related to anesthesia services provided during designated cardiac catheterization procedures.

Although strict measures will be required to ensure that patient care will not be compromised in any way, gainsharing arrangements may enable hospitals and certain physicians to align their incentives and profit from reducing the hospital's costs.

Bundled Payments: Integrated Care that Aims to Improve Efficiency

SECTION 3023 of Patient Protection and Affordable Care Act directs the Secretary of the U.S. Department of Health and Human Services to establish a 5-year national pilot program on payment bundling by January 1, 2013. The directive is to establish a "program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services." The Secretary of Health and Human Services is to determine which conditions are "most amenable to bundling across the spectrum of care" taking into consideration factors such as whether the condition has a mix of chronic and acute conditions, and surgical and medical conditions, and presents "an opportunity for providers and suppliers to improve the quality of care furnished while reducing total expenditures." An episode of care means the 3 days prior to admission through the 30 days following discharge. The bundled payment is to cover applicable services provided during the episode of care. Applicable services are to include acute inpatient, physician services inside and outside of an

acute care hospital, outpatient hospital services, and post-acute services including home health care, skilled nursing, and inpatient rehabilitation. The payment will also cover "care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities." Finally, an entity that is comprised of a hospital, physician group, skilled nursing facility and home health agency may submit an application to provide bundled services pursuant to the pilot program.

According to a recent article for the American Academy of Orthopedic Surgeons, Hoag Hospital in Newport Beach has already developed a successful bundled payment system for hip and knee replacement surgery. And Medicare has had a successful 5-year demonstration project for coronary artery bypass graft surgery. Further, beginning in 2011, Medicare will have a bundled payment for outpatient dialysis treatment, supplies, and for certain related lab tests and drugs. So bundling is already moving forward on several fronts. For more information, I recommend the May 2010 American Hospital Association report on the recent history and future prospects for bundled payments. You can find it at *www.hret.org/bundled/resources/BundledPayments.pdf*.

Clearly, significant integration of the hospital, physicians and other providers will be necessary in order to successfully manage care being paid for in a bundled payment, rather than on a fee-for-service basis. Hospitals and physicians will need to address key issues such as who will control the care coordination and how the bundled payment will be split up among the participating providers. Bundled payments also raise potential legal issues under the corporate practice of medicare, the Anti-Kickback Statute, the Stark Law, and the Civil Monetary Penalty law.

Accountable Care Organizations: Gainsharing on a Broader Scale?

ONE OF THE MOST intriguing and widely discussed provisions in the Patient Protection and Affordable Care Act (Section 3022) requires the Secretary of Health and Human Services, not later than January 1, 2012, to establish a cost-savings program that promotes accountability for a patient population of at least 5,000 Medicare fee-for-service beneficiaries, and coordinates Part A and Part B services and items and encourages investment in infrastructure and processes for high quality and efficient service delivery. Eligible providers and suppliers may work together to manage and coordinate care through an "accountable care organization." ACOs that meet quality performance standards established by the Secretary of Health and Human Services are eligible to receive payments for shared savings.

Among the requirements to be eligible to participate as an ACO are that the providers and suppliers have established a mechanism for shared governance; the ACO is willing to become accountable for the quality, cost and overall care of the Medicare FFS beneficiaries assigned to it; the ACO agrees to enter into a participation agreement for at least a three year period; the ACO has a formal legal structure enabling it to receive and distribute payments for shared savings to participating providers and suppliers; the ACO has a sufficient number of primary care physicians and other professionals; the ACO must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telemedicine and remote patient monitoring; and be able to demonstrate that it meets patient–centeredness criteria specified by the Secretary of HHS, including the use of patient and caregiver assessments or the use of individualized care plans.

In addition to receiving regular Medicare fee-for-service payments, participating ACOs will be eligible to receive payment for shared savings if the ACO meets quality performance standards to be established, and if the estimated average per capita Medicare expenditures under the ACO for Part A and B services for the assigned Medicare fee-for-service beneficiaries (adjusted for beneficiary characteristics) is at least the percent specified by the Secretary below the applicable benchmark. It is again left up to the Secretary of HHS to determine the amount of the savings that will be paid to the ACO.

Arguably, ACOs can be viewed as gainsharing arrangements on a much broader scale. It seems that virtually every hospital and medical group of significant size is considering whether it needs to form or participate in an ACO. One major problem is that the concept is so vaguely defined in the Patient Protection and Affordable Care Act, it is difficult to know how to proceed. Currently unanswered questions include how to be financially responsible for a patient population that is not required to stay within the ACO network of providers; where will the expenditure benchmarks be set and what percentage of the savings will be shared with the providers; what will quality performance standards look like; and how many primary care physicians will be required? CMS is expected to issue proposed rules in the fall to clarify some of these key issues. ACOs also raise a host of potential compliance issues under the anti-trust laws, Stark, the Anti-Kickback Statute, the Civil Monetary Penalty law and, in states such as California, the corporate practice of medicine.

ACOs should not be viewed as being limited to serving only Medicare patients. In fact, ACO initiatives involving collaboration among hospitals, physicians and insurance companies have been launched in Northern California among Hill Physicians Medical Group, Blue Shield of California and Catholic Healthcare West, and through the ACO Readiness and the ACO Implementation Collaboratives being developed through the Premier Alliance and its health system members. The latter ACOs' goal is to assume responsibility for coordinating and improving the care of 1.2 million patients.

ACOs ave the potential to be a game-changer. ACOs might be physician-led, hospital-led or a partnership between the two. In either case it would seem that the physician entity would need to be large enough to be a meaningful partner with the hospital in the ACO. Large multi-specialty groups and, perhaps, independent practice associations would seem likely candidates for this role.

Service Line Co-Management: Physicians Running a Hospital Department

SERVICE LINE or department co-management arrangements typically involve creating a hospital and physician-owned (or physician only) entity that enters into an agreement with the hospital to manage a hospital service line or department (for example, orthopedics or cardiovascular surgery). The management entity is usually paid a combination of a fixed fee

plus an incentive payment if certain specified quality, patient satisfaction, and operational goals are met. Performance is measured against baselines established using historic hospital or national or regional data, objectively measured and tracked. Physician ownership of the management entity is typically limited to physicians who practice in the specialty being managed and who can meaningfully participate in developing and providing the management services. Typical management duties include participation in joint operational meetings with the hospital; providing medical director services; developing capital and operating budgets and strategic plans; assisting with personnel selection and management and equipment selection; developing and implementing processes; and developing, implementing and monitoring quality and efficiency standards.

Because the physician owners of the management entity will be members of the hospital's medical staff and admitting patients, the ownership of the management entity, its capitalization and profit distributions, and the compensation terms of the management agreement need to be carefully structured in order to comply with the Anti-Kickback Statute and the Stark Law. In addition, the incentive portion of the management fee must not violate the Civil Monetary Penalty statute with respect to any possible incentives to reduce patient care to Medicare and Medicaid patients.

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Hospital-Based Foundations: Physicians as Employees—Almost

SECTION 1206(L) of the California Health & Safety Code authorizes the creation of an outpatient clinic owned and operated by a nonprofit, tax-exempt corporation. The nonprofit corporations which operate these clinics are generally referred to as medical foundations. The clinic must conduct medical research and health education, and provide health care to its patients through a group of 40 or more physicians representing at least 10 board-certified specialties. Two-thirds of the physicians must practice at the clinic on a full-time basis. Further, the physicians must be independent contractors to, rather than employees of, the clinic. Medical foundations operate under a limited exception to the prohibition against the corporate practice of medicine.

Over the past twenty or so years, most medical foundations have been hospital-sponsored. Typically, a nonprofit community hospital becomes the sole corporate "member" of the medical foundation. Even though the hospital does not actually own the medical foundation, it is able to exert significant control through it ability to appoint the foundation's board and approve other important decisions. Such control also enables the hospital to provide financial and other support to the medical foundation. The medical foundation—which cannot employ physicians directly, typically will then enter into a professional services agreement with a large multi-specialty group (which does employ the physicians) meeting the criteria outlined above. Frequently, the medical group has been formed as part of the creation of the medical foundation. The foundation usually owns the medical facilities and equipment and employs the non-physician personnel. The foundation contracts with third party payors and likely pays the medical group on a percentage of gross revenues basis.

Among the better known hospital-based foundations which have been operating for a number of years are the Palo Alto Medical Foundation, the Sutter Medical Foundations, the Scripps Medical Foundation, the CHW Medical Foundation, and the Cedars-Sinai Medical Care Foundation. Currently, the Hospital Association of Southern California is attempting to establish a "master" foundation that would include a number of hospitals and medical groups around the state. Not surprisingly, the California Medical Association is very concerned about the HASC plan.

In California, it is widely viewed that hospital-based foundations are as close as hospitals can get to directly employing physicians. As such, they offer the "opportunity" for a high degree of integration and alignment with physicians. But many physicians view alignment in the foundation context more as control. Nevertheless, perhaps because of physician fears over the future of private practice medicine, the foundation movement seems to have gained momentum in California over the past several years.

In the End

SOME PHYSICIANS view the prospect of greater alignment with hospitals as an opportunity to have a significant role in the creation of a value-based, coordinated, patient-centric health care delivery system. Others physicians, with some justification, fear they do not have the resources to prevent themselves from becoming role players in a system of someone else's design. In order to prevent the latter scenario from becoming a self-fulfilling prophecy, physician leaders need to educate themselves about the changing medical market place and be prepared to take decisive action.

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