Practice Integration and ACOs: What Physicians Need to Know

Ronald Dunlap, MD

2010: Obama Signs the ACA

2012: Patrick Signs Chapter 224
The Big Shift

Clinical Integration

Clinical Integration is NOT:
- Employing physicians
- An IPA or PHO
- A Network
- Multiple joint ventures

Clinical Integration IS:
- Physician-led clinical teams
- Patient-centered coordinated care
- Preventive, acute, and chronic management of health
Physician-Led Clinical Integration

Top Physician Issues

- Form and structure
- Governance
- EHR interoperability
- Analytics
Massachusetts Medical Society

Changing Practice Environment
Considerations for Joining an ACO

June 26, 2013

Contents

• ACO in the Context of Clinical Integration
• Practice Readiness for an ACO
• How to Approach an ACO
• Governance Considerations
• Legal Considerations
Physician/Hospital Alignment – Clinical and Financial

It is important to draw a distinction between clinical and financial integration between hospitals and physicians.

Less Integrated

- Clinical Integration:
  - On Medical Staff
- Financial Integration:
  - No Financial Relationship

More Integrated

- Clinical Integration:
  - Information Sharing/EMR
  - PHM Performance
- Financial Integration:
  - Shared-Risk Arrangements
  - Employment

Level of Organizational Integration Can Be a Factor

Physician/Physician Integration
- Multispecialty Medical Group
- Single-Specialty Medical Group
- Virtual or Clinically Integrated Group
- Group Practice Without Walls
- IPA
- Solo Practice

- Independent – Medical Staff Privileges Only
- Physician Hospital Organization (PHO) or IPA Support
- Interoperable EPM/EHR – Clinical Integration Support
- Full-Service PSA
- Employed Medical Group

Physician/Hospital System Integration
Three Core Attributes of an ACO

Organized Care
- Greater hospital/physician alliance.
- Accountability for the care of an entire patient population.

Payment Reform
- Payment system alignment through regulatory requirements.
- Volume-to-value based reimbursement.

Performance Measurement
- Periodic reporting of key clinical and financial metrics.
- Transparent, accessible health data to make informed, data-driven decisions.


State/Attorney General Perspective
(Attorney General Report, April 24, 2013)

- Performance Risk Without Incentives for Coordination
  “Providers are taking on increased performance risk under extremely complex contracts that lack consistency in incenting providers to coordinate care, manage costs, and successfully take on risk.”

- Insurance Risk Without Mitigation by Health Plans
  “Providers are taking on increased insurance risk without consistent mitigation by health plans. Contracts between health plans and providers vary widely with respect to protecting against extraordinary claims and adjusting for the health status of patient population.”

- Alignment Unexplained by Care Coordination
  “Providers are aligning in ways that are not explained by care coordination or risk contracting requirements…. Provider consolidation and alignments have significant market implications, particularly where consolidation may undermine efforts to promote value-based decisions by purchasers.”

Practice Readiness for Joining an ACO

Do not join an ACO for the sake of joining – know “why,” determine if you are ready, and understand the risks/benefits.

Potential Myths – Health System ACO Readiness
(Study by The Commonwealth Fund)

Dominating Market Share
- Organizations with a large portion of the market share are not necessarily poised to be successful as an ACO.
- In fact, in some cases, systems with a smaller market share were able to move toward accountable care before the market-dominant systems.

Employing Physicians
- Many health systems have been employing physicians to be part of their ACOs.
- However, some of the highest-performing ACOs had the lowest proportion of employed physicians, according to the study.

Strong Financial Position
- One of the highest-performing organizations studied in the report had a relatively poor financial standing.
- This may suggest that organizations with suboptimal finances can prove successful in accountable care.

Source: The Commonwealth Fund, 2012. The study analyzed data from 59 health systems of varying sizes, geographic locations, and characteristics.
**Financial Impact**

<table>
<thead>
<tr>
<th>Gain-Sharing/One-Sided/Asymmetrical Model</th>
<th>Two-Sided/Symmetrical/Shared-Risk Model</th>
<th>Global Risk/Partial Capitation Model</th>
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</thead>
<tbody>
<tr>
<td><strong>Coverage Model</strong></td>
<td></td>
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<tr>
<td>Current contracts.</td>
<td>Primarily FFS but can include bundled payments.</td>
<td>FFS and prospective fixed payments.</td>
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<tr>
<td><strong>Risk Level</strong></td>
<td></td>
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<tr>
<td>No risk of losses regardless of benchmarks.</td>
<td>At risk for losses beyond benchmarks.</td>
<td>Higher risk; more downside possible.</td>
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<td><strong>Financial Incentives</strong></td>
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<td>Modest due to limited risk.</td>
<td>Higher percentage of shared savings.</td>
<td>Notable incentives if budget is managed.</td>
</tr>
<tr>
<td><strong>Infrastructure Requirements</strong></td>
<td></td>
<td></td>
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<tr>
<td>Moderate health IT infrastructure.</td>
<td>Moderate health IT infrastructure and track record in managing care.</td>
<td>Robust health IT infrastructure and demonstrated track record in finance and quality.</td>
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<tr>
<td><strong>Considerations</strong></td>
<td></td>
<td></td>
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<tr>
<td>This is attractive to new entities, risk-averse providers, or entities with limited organizational capacity.</td>
<td>This increases the incentive for providers to lower costs due to the risk of losses.</td>
<td>This may need to comply with state regulatory oversight to take on financial risk.</td>
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<td><strong>Care Management Capabilities</strong></td>
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**Health System Perspective**

**Essential Components of Clinical Integration**

- Care Delivery Transformation
- Clinical Integration
- Governance/Organizational Framework
- Robust Provider Network
- Performance Management and Analytics
- IT Infrastructure

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DISCUSSION DRAFT
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7/1/2013
Participation in Network Tiers and Trade-Offs

Network Contractors
- No governance or decision-making participation.
- FFS only.
- For example, radiology group.

Network Participants
- No governance or decision-making participation.
- FFS with shared savings.
- For example, home health agency.

Network Affiliates
- Participation in decision making.
- Potential risk sharing.
- For example, aligned independent medical group.

Network Core
- Ownership.
- Governance.
- Risk sharing.
- Surplus sharing.

Increasing Level of Commitment and Exclusivity

Physician Participation – Governance (ACO)

- Established ACOs have well-defined requirements for physician representation with respect to governance/oversight or management.
- PPACA mandates that public ACOs have shared governance (75% of the ACO’s governing body be composed of ACO participants).
- Many private ACOs mirror the requirements of public ACOs in this regard.
- NOTE: Participation in the governance/oversight of an ACO should not be confused with participation in the governance of a PHO or hospital-owned medical group.
Physician Participation – Committee Types

<table>
<thead>
<tr>
<th>Committee Type</th>
<th>Charge of Committee</th>
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<tbody>
<tr>
<td>Oversight</td>
<td>• Strategic and clinical planning.</td>
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<td>• Communications.</td>
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<td>• Workforce planning.</td>
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<td>• Alignment and policy development.</td>
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<td>• Contracting strategy/oversight.</td>
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<td></td>
<td>• Budget development and management.</td>
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<tr>
<td>Contracting</td>
<td>• Contract execution.</td>
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<td></td>
<td>• Financial performance.</td>
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<td></td>
<td>• Funds flow development.</td>
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<td>Clinical Integration</td>
<td>• Clinical focus areas.</td>
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<td></td>
<td>• Performance measures.</td>
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<td></td>
<td>• Care delivery models.</td>
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<td></td>
<td>• Utilization management/quality assurance.</td>
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<tr>
<td>Network Development</td>
<td>• Provider network development.</td>
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<td>• Recruitment/staffing.</td>
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<tr>
<td>Data and Analytics</td>
<td>• Information management.</td>
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<td></td>
<td>• Reporting.</td>
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<td></td>
<td>• Business intelligence.</td>
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<td></td>
<td>• Infrastructure.</td>
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Legal Considerations

“It’s a simple stress test – I do your bloodwork, send it to the lab, and never get back to you with the results.”
Legal Structure and Requirements of ACOs

Who Can Be an ACO?

- Existing entities may qualify to become ACOs, including integrated delivery systems.
- Under federal guidelines, any group of providers, practitioners, and/or suppliers of items and services covered under Medicare Parts A and B that meet certain criteria may form a Medicare ACO.
- The recently passed Massachusetts healthcare cost containment legislation, “Chapter 224,” creates a process for ACOs to be certified and charges the newly formed HPC with establishing minimum standards for certified ACOs.

Legal Implications of Engaging in an ACO

1. Can the ACO bear the financial risk?
2. Does the ACO have the appropriate IT resources?
3. What are the termination provisions of the agreement?
4. Will joining the ACO bind the group/physician to exclusive participation in one ACO?
5. Does the agreement violate the law and/or existing contractual obligations?
Legal Implications of Engaging in an ACO (continued)

6. What are the compensation terms in the agreement?
7. What is the process for the submission of claims and payment?
8. Who owns the medical record?
9. Does the agreement include a right to audit the ACO's records?
10. What covered lives will a physician be responsible for?

Stark, AKS, Antitrust, and ACOs

- Stark law.
- Anti-Kickback Statute (AKS).
- Antitrust issues.
- Applicability?
- ACOs do not exist in a vacuum.
“It’s the only treatment option he has under his current health plan.”

Questions & Answers

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