

IS YOUR ORGANIZATION READY FOR ACCOUNTABLE CARE?

The Accountable Care Organization (ACO) model is a relatively new concept that has gained relevance after its introduction as one of Medicare's pilot programs in the Patient Protection and Affordable Care Act (PPACA). ACO development is now occurring at a rapid pace fostered both by the financial incentives to be provided under the Medicare's Shared Savings Program - beginning on January 1, 2012 – and by the concurrent initiatives of commercial managed care organizations and state Medicaid programs.

Key Challenges Facing ACO development

Accountable Care requires multiple competencies. It demands skills in such core areas as leadership, governance and the management of risks, talent, clinical care and health information. There is no single template or right answer. Under the pressure of cost containment, capital demands and complex relationships, clients must nonetheless make choices and take action. Experienced legal advice is critical in meeting the challenges facing ACO development.#

Operational Challenges

- Devising methodologies to allocate global, episode-of-illness and bonus payments among ACO participants while avoiding subsidies and paybacks potentially viewed as illegal payments
- Achieving financial and clinical integration of physicians and hospitals sufficient to allow single signature contracting with payors
- Creating provider networks that are not considered to be market dominant
- Avoiding specialist domination of the physician component of the ACO
- Aligning government and commercial insurer payment methodologies
- Creating limited provider networks acceptable to consumers
- Creating legally compliant quality and efficiency criteria
- Assisting payors in devising performance incentive payments to the ACO and its participating providers, including shared savings programs

Legal Challenges

- Reallocation of risk dollars/cross-subsidization: Stark; anti-kickback; tax exemption
- Connectivity and EMR: HIPAA; HITECH; Red Flag and state privacy and data breach laws; Stark; anti-kickback; tax
- Network standards and referral restrictions: Stark; anti-kickback; antitrust
- Consumer directed care, public reporting: risk management; malpractice
- Performance-based credentialing: medical staff; antitrust; reporting requirements
- Network formation and contracting: antitrust
- Role of the board: fiduciary obligations

OUR EXPERTISE

The Health Care Practice of Ropes & Gray understands industry challenges. Our group has over four decades of experience with health care delivery system innovation. We are a national practice of over 60 health care lawyers with the resources of a thousand-lawyer firm behind us. We cultivate the deep expertise and practical know-how expected of industry experts. We stand apart in our track record of teamwork with our clients and our colleagues. Our approach to guiding clients as they adopt Accountable Care delivery systems mirrors the competencies and characteristics required to succeed in Accountable Care: team-oriented, interdisciplinary, flexible, solutions-oriented.

OUR EXPERIENCE

We have helped multiple clients prepare to participate as ACOs in Medicare's Shared Savings Program and to face the challenges of payment reform more generally. Our engagements range from advising hospitals, IPAs and MCOs on integration alternatives within the ACO framework to acting as outside legal counsel on ACO formation to advising on continuing operations for established ACOs. Our work with developing ACOs has allowed us to identify the following features as necessary both to satisfy Medicare's ACO requirements and to succeed in fashioning ACO arrangements with commercial plans. Examples of our relevant experience are listed next to each feature.

INTEGRATED CARE

Promoting selective, scalable, high-performing provider networks that combine different categories of providers and different care settings and that rely on evidence-based best practices, processes for quality improvement and clear action steps for improving performance

- Counsel to financially and clinically integrated, multi-hospital system comprised of Catholic and non-sectarian hospitals. Clinical integration based on hospitals' adoption of multiple clinical care protocols, benchmarks to test and verify improvements in quality and penalties for failure to achieve quality and efficiency standards.
- Advised several Massachusetts hospital and physician groups, including specialty providers, in developing their integrated care strategies to respond to Massachusetts payment reform initiatives promoting ACOs and to commercial payor ACO initiatives involving risk-sharing against both quality and efficiency/cost standards.

THE MEDICAL HOME

Establishing a patient-centered care model

- Counsel to pioneer disease management company since its founding. Assisted in creating effective management of chronic care from business and clinical perspective (close coordination among payors, physicians and other providers, and patients) and legal perspective (creation of organizational structures compliant with reimbursement laws as well as improper inducement, privacy, licensing and corporate practice laws). Through careful contracting, defined relative scopes of authority and measurement and payment systems.

Managing utilization of services

- Assisted company in creation of program to reduce occurrence of sepsis in inpatient settings by establishing clinical protocols and provider reward systems funded by hospital cost savings.

FINANCIAL INTEGRATION

Establishing structures and processes needed to implement and administer payment methodologies (fees and bonuses) and to manage financial risk

- Assisted company in creation of value-based purchasing program to facilitate quality and efficiency improvements. Program structured on bonus system scoring hospitals on compliance with protocols. Maximum rewards for hospitals improving quality while containing costs.
- Advised many Medicare Advantage plans, capitated provider groups, and support organizations on risk-adjusted payment methodologies including health status and severity adjustment as well as on documentation requirements. Similarly, advised several capitated provider groups in disputes over achievement of quality and efficiency for performance measures.
- Advised major hospital network on its economic integration program, risk pools and penalty and performance reward programs in light of national quality, patient satisfaction and efficiency measures.

CREATION OF LEGAL STRUCTURES

Creating a formal legal structure that will allow the organization to coordinate operations among participating providers

- Served as transactional counsel to major West Coast hospital in creation of medical foundation. Transaction involved development and implementation of modified service delivery methods and compensation structures through agreements among hospital, large multi-specialty medical group, affiliated university and management company. Alignment established by agreements sets groundwork for participation in Medicare's shared savings program and future governmental and private reimbursement programs based on collective accountability for costs and care.
- Counsel to nonprofit, tax-exempt organization in structuring ACO as new nonprofit, tax-exempt entity with hospital system's parent organization acting as parent organization with limited reserved powers with respect to the ACO. ACO's board comprises equal representation from hospital system and participating physicians.
- Served as transaction counsel to health care system in formation of ACO comprised of multiple hospitals, physicians employed by a physician organization that comprised part of the system (PO) and physician members of medical staff not employed by the PO. ACO structured as limited liability company whose members are system's parent entity and newly formed physician organization. Physician organization structured as LLC. Drafted all organizational documents, including LLC operating agreements and agreements between PHO and PO, between PHO and participating hospitals and between PO and participating physicians.

GOVERNANCE

Instituting a board and management leadership structure

- Conduct numerous training workshops for hospital boards and management on their fiduciary duties to improve and maintain quality. Workshops focus on use of quality dashboards allowing board to maintain appropriate oversight of management's and providers' efforts, and increasing requirements imposed on boards and management to fulfill their legal obligations.

INFORMATION MANAGEMENT

Establishing the HIT capabilities and compliance programs to satisfy reporting requirements, population management, care coordination and monitoring, managing and reporting performance and efficiency indicators

- Assisted numerous clients in obtaining and implementing electronic health records for their own clinical use and to provide to members of their medical staffs. Also assisted hospitals in qualifying for “meaningful use” payments.

DATA SHARING FOR QUALITY IMPROVEMENT AND COST REDUCTION

Measuring and reporting care results at the individual provider level under programs designed to promote price transparency and comparability in measures of cost and quality.

- Served as general counsel to collaborative effort of over 50 national employers and seven health plans to capture and access data derived from patient care to measure physician and hospital efficiency and quality as part of an initiative to demonstrate feasible methods of data aggregation and measures deployment.
- On behalf of coalition of purchaser entities, payors and providers, obtained precedential business review letter from U. S. Department of Justice permitting establishment of information exchange program providing data on relative costs and resource efficiency of more than 300 California hospitals. DOJ determined that proposed information exchange may reduce health care costs by improving competition among hundreds of California hospitals and facilitating more informed purchasing decisions by group purchasers of health care services.

OPERATIONAL MANAGEMENT

Creating effective contractual relationships with payors, including Medicare, Medicaid, commercial payors and employers to leverage capabilities and performance

- Currently assisting two academic medical centers in working with their states to develop ACO programs within their states' Medicaid programs through state plan amendments and demonstration projects. Programs would leverage disproportionate share hospital funding and other supplemental Medicaid payments to support ACOs. Programs are being developed under existing state Medicaid authority (including a federal Section 1115 waiver).

INTEGRATED AND FINANCIAL MANAGEMENT

Creating innovative approaches for health plans to respond to the increased focus on value and to manage clinical and administrative costs consistent with the new medical loss ratios required by federal and state law

- Advised health plan on provider performance incentive program based on hospitals' and physicians' joint satisfaction of quality and efficiency targets. Program has helped provider collaboration when treating enrollees and has led to more cost-effective care.
- Advising fully integrated HMO in expanding its provider network using ACO structure to include out-of-network providers. ACO network will build on HMO's existing information technology and administrative infrastructure to accommodate physicians maintaining agreements with payors outside the system. Initiative designed to attract employers seeking broader provider network and to serve as strategy for geographic growth. To learn more, please visit:
<http://healthreformresourcecenter.ropesgray.com/acoanddsr/> or contact your regular Ropes & Gray attorney.