

Physician Organizations

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—from a declaration of the American Bar Association

Together We May Prosper: The Demand for Healthcare Reform and Two Innovative Models for Physician-Hospital Alignment

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Amidst one of the worst economic periods in our nation's history, nearly every American is experiencing a sustained belt-tightening period. As the demand for healthcare reform tops the front page and monopolizes legislative sessions, physicians are clearly no exception. With inflation outrunning increases in Medicare and Medicaid reimbursement and expenses skyrocketing, physicians must find cost-cutting measures. Healthcare reform itself may drive physician-hospital alignment opportunities. No longer limited to physician employment, today's alignment models, such as gainsharing arrangements and Accountable Care Organizations (ACOs), are designed to promote both economic efficiency and clinical quality. This article outlines the reimbursement trends driving the need to align, discusses the role of clinical integration in alignment strategies, and explores two innovative models for physician-hospital alignment.

Reimbursement Trends Driving Alignment

Without question, healthcare expenses are growing, and with them, federal healthcare program expenditures. The Kaiser Family Foundation estimates that Medicare alone, currently 3.6% of the United States Gross Domestic Product (GDP), will grow to 4.2% of GDP by 2018 and to 6.4% of GDP by 2030.¹ At the current growth rate, the Medicare Part A Hospital Insurance Trust Fund is projected to be insolvent by 2017.² Simply put, without a reduction in costs or other reforms, Medicare may not survive another decade.

Reimbursement trends over the past few years have reflected this reality, particularly for physicians. Medicare physician reimbursement has increased a mere 0%, 0.5%, and 1.1% for calendar years 2007-2009, respectfully.³ As small as these increases were, each was a result of last-minute legislative intervention, without which the statutorily calculated adjustments would have been

approximately -5%, -11%, and -5%, respectfully.⁴ Even graver is the 2010 Medicare Physician Fee Schedule (MPFS) Final Rule, which calls for a 21% cut in physician reimbursement effective January 1, 2010.⁵ While the national average for Medicaid physician reimbursement has fared slightly better, with average yearly increases of approximately 2.5% for calendar years 2003-2008, only primary care provider reimbursement grew at the inflation rate.⁶ Even with the greater yearly increases, average Medicaid fees across the United States remain only 69% of Medicare fees for the same services.⁷

Hospitals have fared slightly better than physicians in recent years, but that is changing as well. For 2010, hospitals face a mere 2.1% increase in Outpatient Prospective Payment System (OPPS) payments and a nearly zero, if not negative, adjustment in Inpatient Prospective Payment System (IPPS) payments.⁸ Looking forward, healthcare reform will likely result in sustained, stagnant reimbursement for hospitals. Both the House's Affordable Health Care for America Act of 2009 (H.R. 2962) and the Senate's Patient Protection and Affordable Care Act (H.R. 3590) call for reductions to the Medicare market basket updates to inpatient hospital reimbursement, as well as cuts to Disproportionate Share Hospital payments.⁹ As these trends demonstrate, physicians and hospitals alike will be facing a do-more-with-less scenario for the foreseeable future, and one way to save cost is through the efficiencies inherent in alignment.

The Role of Clinical Integration in Alignment Strategies

Despite the recent increase in physician employment by hospitals and health systems, healthcare remains very fragmented, making it difficult to: (1) achieve gains from treatment efficiency; (2) effectively manage care; (3) avoid duplication; and (4) focus on quality. To achieve many healthcare reform goals, entities that are otherwise competitors must collaborate. The natural extension of this collaboration is jointly negotiating with commercial payors and employers to manage healthcare delivery. Ordinarily, this joint negotiation may be considered price-fixing, which is generally a per se unlawful restraint on trade under the Sherman Act,¹⁰ unless the potential pro-competitive efficiencies of the integrated network outweigh the price agreement's anticompetitive effects.¹¹ Any clinical integration model must pass this test, called the "rule of reason."

The position taken by the Department of Justice (DOJ) and Federal Trade Commission (FTC) with respect to clinical integration began taking shape in 1999.¹² In their Statements of Antitrust Enforcement Policy in Health Care (1996 Statements), the DOJ and FTC indicated that joint contracting plans for non-financially integrated networks will pass antitrust muster if: (1) the clinical integration is likely to produce significant efficiencies that benefit consumers; and (2) any price agreements with payors are reasonably necessary to realize those efficiencies.¹³ Since the 1996 Statements, guidelines, reports, and speeches issued by the FTC have both reaffirmed the acceptance of clinical integration and attempted to sharpen the characteristics of a clinical integration program.



The FTC has also approved several specific clinical integration scenarios, the most recent being in 2009 on behalf of Tri-State Health Partners.¹⁴ In its decisions, the FTC has found the following characteristics to be persuasive hallmarks of clinical integration: (1) systems and programs to improve quality and efficiency, including (a) clinical guidelines and practice standards, (b) a web-based clinical-information system, and (c) referral requirements and/or guidelines; (2) the network is selective in choosing participants by (a) utilizing a participating provider contract and (b) limiting participation to fully committed providers in a variety of specialties; (3) a significant investment of capital by participants, both (a) monetary capital and (b) human capital; (4) mechanisms for evaluating performance and facilitating continuous progress, including (a) the use of performance metrics, (b) identifying benchmarks for comparison, (c) using the system infrastructure to facilitate evaluation, and (d) having a follow-up action plan; (5) a pricing agreement that furthers the network's integration; (6) non-exclusivity, unless it is so small that an exclusive arrangement would not be anticompetitive; and (7) steps are taken to maintain the confidentiality of participating providers' pricing information so that participants cannot enter into collateral agreements, thus preventing "spillover effects" from affecting the market.¹⁵

TriState Health Partners Inc., a physician-hospital organization located in Hagerstown, MD, sought FTC approval for an arrangement aimed to: (1) facilitate cooperation and collaboration among its member physicians; (2) create a comprehensive program of care management by engaging everyone associated with TriState; and (3) offer a previously unavailable, integrated set of services

desirable to self-insured employers who want to lower health-care costs in an effort to offer a competitive advantage over other health plans.¹⁶ Pursuant to the proposed arrangement, TriState would create clinical practice guidelines to improve clinical efficiency and a program to monitor the physicians' adherence to those guidelines.¹⁷ Physicians would be required to refer their patients to other member physicians (though the patient still had the choice of which physician to select) and to grade their peers.¹⁸ TriState also proposed the implementation of a web-based health information technology system that will help identify high-risk and high-cost patients, and facilitate the exchange of patients' treatment and medical management information.¹⁹

The FTC, in part guided by the 1996 Statements, determined that it would not challenge TriState's proposal because of three principal reasons:

- The program had the potential to lower healthcare costs and improve the quality of care for patients;
- TriState's collective negotiation of contracts with payors, including the prices paid for participating physician services, would be "subordinate and reasonably related" to the overall proposal to integrate healthcare for its members, prompting application of the rule of reason; and
- There would not be an increase in the market power of either TriState or the physician members as a group because all concerned were still free to contract individually outside the proposed program.²⁰

Accordingly, the FTC determined that it would not recommend the commencement of any legal enforcement action against TriState or its providers as long as the proposed plan was followed and no anti-competitive activities arose, like the exercise of market power.²¹

Although no bright-line test exists, the FTC is clearly comfortable with clinical integration models, which will facilitate new models of alignment involving independent physicians, health systems, and their employed physicians. The challenge for these parties is going the extra yard to ensure that the clinical integration is pure and not simply a facade for collaboration among competitors.

Two Innovative Models for Physician-Hospital Alignment

While the DOJ and FTC have become comfortable with clinical integration, both Congress and the Centers for Medicare & Medicaid Services (CMS) have advanced from comfort to active promotion of physician-hospital alignment. A number of cost-savings initiatives in today's healthcare reform proposals are targeted at improving efficiency through alignment. The following outlines two such models.

Gainsharing

The first model, known as gainsharing, involves the payment of remuneration (to physicians and practitioners by hospitals), which represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician to

improve overall quality and efficiency.²² CMS views permissible gainsharing as methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to beneficiaries and to develop improved operational and financial hospital performance with gainsharing.²³ Though such payments potentially implicate the federal Civil Money Penalties Act (CMP), Anti-Kickback Statute (AKS), and Physician Self-Referral Statute (Stark), the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) has issued at least fourteen Advisory Opinions approving gainsharing plans since 2001.²⁴

These approved gainsharing plans largely focused on standardization of devices, medications, and supplies used for particular procedures.²⁵ For example, the most recent opinion outlines a program involving a hospital, interventional radiology group, and a vascular surgical group that is designed to share the hospital's cost savings directly attributable to certain changes in the groups' cardiac catheterization procedures.²⁶ Specifically, these changes involved standardization of the types of cardiac catheterization devices and supplies (stents, balloons, interventional guidewires and catheters, vascular closure devices, diagnostic devices, pace-makers, and defibrillators) employed by the groups to perform catheterizations at the hospital.²⁷ In approving this program, the OIG cited a number of safeguards designed in the program to prevent underutilization and overutilization and ensuring patient safety.²⁸ Such safeguards included the following:

- The parties agreed to use independent third party to administer the program, including developing the cost-savings metrics and measuring cost savings during the program;
- Preferred products would be chosen first based on safety, then on cost;
- Quality would be continuously monitored, with a drop in quality indicators resulting in termination of gainsharing payments;
- Physician productivity would be compared to historical data, preventing overutilization;
- Cost savings would be measured on an initiative-specific basis, preventing cost shifting;
- Aggregate payments to physicians would be capped; and
- The program would be disclosed to all affected patients.²⁹

Similar safeguards were present in the other thirteen proposed gainsharing programs, and the OIG advised each time that the program met muster under the CMP, AKS, or Stark.³⁰

In 2005, Congress and CMS took this permissive view of gainsharing one step further. Pursuant to a mandate included in Section 5007 of the Deficit Reduction Act of 2005 (DRA), CMS solicited up to six gainsharing demonstration projects, each consisting of one hospital.³¹ The solicitation asked hospitals to propose gainsharing programs that CMS could follow and evaluate to determine if gainsharing "aligns incentives between hospitals and physicians in order to improve the quality and efficiency

of care,” while improving hospital operational and financial performance.³² To date, two projects have been accepted into the program—one at Beth Israel Medical Center in New York and one at the Charleston Area Medical Center in West Virginia. While the demonstration project is set to expire on December 31, 2009, both H.R. 3962 and H.R. 3590 propose to extend it through September 30, 2011. Such commitment by Congress suggests that gainsharing may prove to be an increasingly important cost-savings tool for physicians and hospitals going forward.

ACOs

As healthcare reform evolves, a second, innovative alignment model likely will emerge—ACOs. An ACO would typically include a hospital, physicians, both primary care physicians and specialists, and possibly other medical professionals.³³ Services provided by these physicians would be billed fee-for-service, but the participants in the ACO would coordinate their care and have goals related to quality benchmarks.³⁴ Examples of such benchmarks may include low mortality rates or reducing hospital readmissions.³⁵ Members of an ACO would share in any cost savings or Medicare incentive payments made as a result of meeting its benchmarks, as well as any Medicare penalties imposed as a result of failing to meet its benchmarks.³⁶

The ACO structure will differ depending upon its goals and market. However, it will involve a single entity owned by healthcare providers. The single entity will enter into participation agreements with payors (potentially including governmental payors), and have comprehensive clinical and quality guidelines and robust information technology systems. While ACOs could be integrated delivery systems, they can also take advantage of clinical integration and include independent physicians.

ACOs are gaining traction. In its June 2009 report to Congress, the Medicare Payment Advisory Commission dedicated a chapter to the benefits of ACOs.³⁷ Several prominent organizations, including the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution, are instituting pilot programs to test the ACO concept.³⁸ Additionally, a current proposal suggests that Medicare may tie both bonuses and penalties to payments as a result of an ACO meeting or failing to meet the benchmarks.³⁹ Congress is receptive to such a program because it would give Medicare substantial leverage over providers to improve quality. If enacted, H.R. 3962 would direct Medicare to issue incentive payments to qualifying ACOs for meeting what it calls “performance targets.”⁴⁰ H.R. 3590 also includes an ACO demonstration project, but it is targeted to pediatric ACOs.⁴¹ Innovative health systems and physician groups will likely start planning now for ACOs.

Conclusion

Alignment may offer a solution as reimbursement trends and increasing costs require physicians and hospitals to do more with less. Regulators, Congress, and a growing number of physicians and hospitals are looking to the efficiencies inherent in alignment to generate substantial cost savings. Through models such as gainsharing and ACOs, hospitals and physicians may collaborate to provide safe, quality care more efficiently.

- 1 Medicare Spending and Financing Fact Sheet, Kaiser Family Foundation (May 2009), available at www.kff.org.
- 2 *Id.*
- 3 See 2010 Medicare Physician Fee Schedule Final Rule, available at www.federalregister.gov/OFRUupload/OFRData/2009-26502_PI.pdf; and Conversion Factor, CCH Med-Guide ¶ 3410 (2009).
- 4 *See id.*
- 5 *See id.*
- 6 Karen E. Stockley, Aimee F. Williams, and Stephen Zuckerman, *Trends in Medicaid Physician Fees, 2003-2008*, Health Tracking (April 28, 2009).
- 7 *Id.*
- 8 See 2010 OPPTS Final Rule, available at www.federalregister.gov/OFRUupload/OFRData/2009_26499_PI; 74 Fed. Reg. 43,754 (Aug. 27, 2009); and CCH Med-Guide No. 1559 (2009).
- 9 Affordable Health Care for America Act of 2009, H.R. 2962 §§ 1103; 1112 and 1131; and Patient Protection and Affordable Care Act, H.R. 3590.
- 10 15 U.S.C. § 1, *et seq.*
- 11 *See FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986).
- 12 *See* Statements of Antitrust Enforcement Policy in Health Care, DOJ, and FTC (Aug. 1999), available at www.justice.gov/atr/public/guidelines/0000.htm.
- 13 *Id.*
- 14 *See, e.g.,* TriState Health Partners Inc., FTC Advisory Op. (Apr. 13, 2009), available at www.ftc.gov/os/closings/staff/090413tristatealetter.pdf; Greater Rochester Independent Practice Association Inc., FTC Advisory Op. (Sep. 17, 2007), available at www.ftc.gov/bc/adops/gripa.pdf; MedSouth Inc., FTC Advisory Op. (June 18, 2007), available at www.ftc.gov/bc/adops/070618medsouth.pdf; MedSouth Inc., FTC Advisory Op. (Feb. 19, 2002), available at www.ftc.gov/bc/adops/medsouth.shtm; Suburban Health Organization Inc. (Mar. 28, 2006), available at www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf.
- 15 *See id.*
- 16 TriState Health Partners Inc., FTC Advisory Op. (Apr. 13, 2009), available at www.ftc.gov/os/closings/staff/090413tristatealetter.pdf.
- 17 *Id.*
- 18 *Id.*
- 19 *Id.*
- 20 *Id.*
- 21 *Id.*
- 22 DRA 5007 Medicare Hospital Gainsharing Demonstration Solicitation, CMS, available at www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/DRA5007_Solicitation.pdf.
- 23 *Id.*
- 24 *See* OIG Adv. Op. 01-1 (2001); OIG Adv. Op. 05-02 (2005); OIG Adv. Op. 05-03 (2005); OIG Adv. Op. 05-04 (2005); OIG Adv. Op. 05-05 (2005); OIG Adv. Op. 05-06 (2005); OIG Adv. Op. 06-22 (2006); OIG Adv. Op. 07-21 (2007); OIG Adv. Op. 07-22 (2007); OIG Adv. Op. 08-09 (2008); OIG Adv. Op. 08-15 (2008); OIG Adv. Op. 08-16 (2008); OIG Adv. Op. 08-21 (2008); and OIG Adv. Op. 09-06 (2009).
- 25 *Id.*
- 26 OIG Adv. Op. 09-06 (2009).
- 27 *Id.*
- 28 *See id.*
- 29 *See id.*
- 30 *Id.*
- 31 *See supra* note 22.
- 32 *Id.*
- 33 Jane Cys, *Accountable Care Organizations: A New Idea for Managing Medicare*, American Medical News (Aug. 31, 2009).
- 34 *Id.*
- 35 James Arvantes, *MedPac Considers Accountable Care Organizations as Possible Path to Health Care Reform*, AAFP News Now (April 20, 2009).
- 36 *See supra* notes 33, 35.
- 37 *See supra* note 33.
- 38 *Id.*
- 39 *See supra* note 35.
- 40 H.R. 2962 § 1301.
- 41 *See* H.R. 3590 § 2706.