Gotham Heights ACOs: To Join or Not to Join?

An Analysis of Transactional Options for Family Health

Team 16 L.L.P.

Prepared specifically for Family Health, S.C.

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Applicable Law[1]

Federal Laws

Civil Monetary Penalty (CMP) Law	42 U.S.C. § 1320a–7a, *et al.*
Gainsharing CMP	
Beneficiary Inducement CMP	
Stark (Self-referral)	42 U.S.C. § 1395nn, *et al.*
Anti-kickback Statute	42 U.S.C. § 1320a-7b, *et al.*
Antitrust[2]	
Tax Law	
HIPAA (Health Insurance Portability and Accountability Act)	
Federal Waivers[3]	

State Laws

Corporate Practice of Medicine

State Insurance Laws

State Licensing Laws

Non-Profit Laws

[1] See Appendix A for a detailed description of each law.
[2] Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 209 Fed. Reg. 76, *et al.* (October 28, 2011).
[3] Medicare Program; Final Waivers in Connection With the Shared Savings Program, 212 Fed. Reg. 76, *et al.* (November 2, 2011).

Executive Summary

Family Health should not delay partnering with two of the emerging ACOs. Although joint venturing is a plausible alternative in the future, the risk this strategy currently poses for Family Health does not make it an attractive investment at this time. Instead, Team 16, L.L.P. recommends that Family Health contract with a hospital-based ACO. Specifically, it should negotiate with Lexis and Health America.

Accountable Care Organizations (ACOs) are transforming the way medicine is practiced. Although ACO development is currently being spurred by Medicare, the rest of the market will soon follow. ACOs integrate and align providers, and introduce new reporting requirements. The reimbursement model for ACOs is based on a fee-for-service (FFS) structure incorporating cost expenditures and quality measures (cost/quality). Once the new structure becomes entrenched in the system, payment for all patients, government and commercial, will be based on the new system. Eventually, the medical payment model will move toward a more episodic approach--away from FFS--but retaining a quality requirement. ACOs will become the contracting vehicle of the future.

To survive in the modern market, Family Health has to adopt new IT systems and modify its practice standards. Failure to associate with an ACO will delay this process and put it at a competitive disadvantage. Foregoing the opportunity to collect patient data now under the cost/quality reimbursement system will make Family Health a less attractive candidate to ACOs later. Finally, contracting now will allow the practice to cultivate valuable relationships, providing insight into the ACOs economic situation, professional culture, and relationship with providers. This data is necessary to select the right ACO partner if Family Health decides to joint venture in the future.

I. Family Health

A. Scope of Representation

Team 16 L.L.P. has been asked to review the position of Family Health, S.C. in the evolving health care market of Gotham Heights. The analysis and recommendations contained in this memo and accompanying oral presentation represent what Team 16 L.L.P. has concluded is best for Family Health as an entity.[4] The individual shareholder-physicians making up Family Health are encouraged to seek independent counsel for advice on what is best for them personally.

B. Factual Scenario

Family Health has become a successful, high-end practice by catering primarily to commercially insured and self-pay patients. More specifically, Family Health caters to the reproductive needs of middle-class to affluent women via its marquee infertility services and supporting ancillary services.

The practice is also dedicated to serving the general health care needs of women and children, but reproductive services are its main focus. Family Health has physicians with reproductive, endocrinology, and infertility subspecialties on staff. In addition, it owns an ambulatory surgery center focused exclusively on surgeries related to fertility issues, a centralized lab with fertility-related testing and procedure capabilities, and high-tech medical imaging equipment (hereinafter referred to as "imaging center"). Only a large volume of infertility patients would justify this infrastructure. Infertility treatments are consumer driven, and normally only commercially insured patients and those with disposable income (both associated with high socio-economic groups) can access these

[4] MODEL RULES OF PROF'L CONDUCT R.1.13(a).

services.[5]

Although Medicaid covers pregnant women,[6] it offers limited infertility benefits so Medicaid payments do not represent a large component of the practice's payment mixture. Furthermore, Family Health does not have pediatricians on staff and does not serve many Medicaid children (or children generally). While Family Health's urologists and family practice physicians possibly serve Medicare beneficiaries, it is improbable that these patients constitute a significant portion of the practice's revenue. Medicare beneficiaries are almost universally beyond childbearing age and do not seek infertility treatments, although infertility services are covered.[7]

Even beyond these assumptions of patient/payer mixture, a more accurate assessment of Family Health's options requires additional information. For example, what other groups in Gotham or its vicinity compete with Family Health for infertility and OB/GYN services? Besides hospital-based Accountable Care Organizations (ACOs), are other ACO alternatives emerging in Gotham that could also approach Family Health in the near future? Do state laws like the Corporate Practice of Medicine prohibition affect integration capabilities between hospital and providers (and therefore partnering options) in Gotham? Lastly, how does Family Health's legal structure, S.C., affect partnering options and what types of associations are permissible for S.C. entities under state law? Notwithstanding these limitations, the recommendations that will follow

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[5] Kaiser Family Foundation, *State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings*, (Nov. 2009) at 12, explaining that only a few state Medicaid programs cover infertility treatments as family planning, and then only some of the time.

[6] Id.

[7] *See* CMS, *Medicare Benefit Policy Manual*, Cpt. 15, §20.1, *available at* http://www.cms. gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

are generally applicable for Family Health.

The presence of ACOs in Gotham will transform the healthcare market. In considering each of its options, Family health has five major business concerns:

(1) The anticipated patient mix over the next 5 to 10 years for each portion of the practice.

(2) The effects of each option on Family Health's level of control, reimbursement, and reputation.

(3) Family Health's infertility services: Considering the overall revenue and proportion of self-pay versus private-pay patients is necessary to decide if and how quickly Family Health should expand these services.

(4) Family Health's ambulatory surgery center: If joint-venturing with an ACO, retaining this part of the practice could put Family Health in direct-competition with its partner. Yet, it could be offered as an asset in lieu of capital to an ACO partner in the transaction.

(5) Family Health's imaging center and laboratory: As with the surgery center, these assets could be offered in lieu of capital in an ACO partnership transaction.

II. Changing Landscape

Health care reform has already begun to change the U.S. health care market in important ways. Family Health needs to prepare for the next major wave of change—ACOs—that will significantly transform Gotham's health care market.

A. An Explanation of Accountable Care Organizations

The ACO is a model for integrated patient care championed under the Patient

Protection and Affordable Care Act (ACA).[8] It is an organization that through integration and risk sharing brings providers together and rewards them for improving quality and controlling costs. ACOs aim to increase access to health care, and improve outcomes and efficiency while cutting costs.

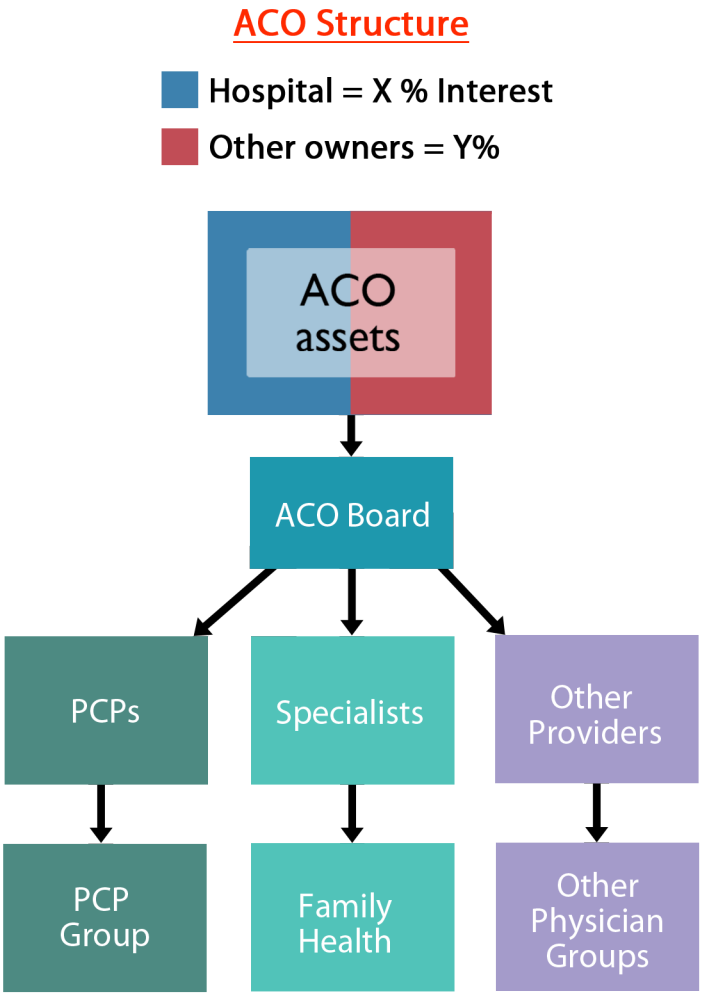
ACO models vary but Medicare's ACO Shared Savings Program (SSP)[9] illustrates possible organizational structures and reimbursement methodologies. ACOs can be (1) hospital-based, (2) physician-based, or (3) a hospital-physician hybrid. Diagram 1 below depicts a hospital-based ACO's basic structure. An ACO is a separate legal entity independent of its provider members. This entity can employ or contract with physicians and hospitals to provide health care services. Provider reimbursement methods by ACOs vary but the SSP provides a glimpse into the new quality/cost payment reimbursement model that will soon permeate the rest of the health care market.

The ACO's governing structure should reflect the reality that clinical decisions must be made by individual doctors, including those comprising Family Health, physician members of other groups invited to join the ACO, and those employed by the hospital directly. Maintaining an adequate firewall between a physician's professional judgment and the ACO's commercial interests is crucial. For ACOs comprised of multiple independent entities, such as hospitals and one or more independent physician groups, the governing board must be separate and unique to the ACO.[10] An ACO

[8] The Patient Protection and Affordable Care Act, GPO 111-148, (Mar. 2010), *available at* http://www.ncsl.org/ documents/health/ppaca-consolidated.pdf.
[9] Id. at §3022.
[10] CMS, Memoranda: Additional guidance for Medicare Shared Savings Program Accountable Care Organization applicants, (Mar. 2012), *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-

consisting of a hospital and physician group practice could include members from each board. However, the ACO's governing board has oversight responsibilities and fiduciary duties to the entire ACO enterprise, not merely their representative factions, so there is the potential for a conflict of interest.

DIAGRAM 1



A common misperception is that ACOs are merely a revised version of managed care models that surfaced in the 1980s and 1990s. ACOs, however, differ in several

Payment/sharedsavingsprogram/Downloads/Memo_Additional_Guidance_on_ACO_Participants.pdf

important ways. For example, ACOs have greater flexibility in building a provider base through affiliation options ranging from employment to management service organization (MSO) and physician-hospital organization (PHO)/ ACO contracts. Unlike capitation, which place PHOs at great financial risk, ACOs allow for payments under traditional fee-for-service (FFS) arrangement and can contract directly with providers without a health plan intermediary. Most importantly, accountability for outcomes and quality rests with providers rather than with health insurers.

B. Reimbursement Under Cost/Quality

Medicare's ACO SSP provides a framework for reimbursement models in the future. To calculate shared savings or losses, the Center for Medicaid and Medicare Services (CMS) uses cost and quality components. The cost component is measured by comparing beneficiaries' expenditures for previous year(s), along with other factors, to their expenditures while in the ACO. The quality component measures beneficiary's satisfaction, hospital readmission prevention, adoption of IT technologies, and the management of chronic conditions, among other things.[11] Providers will require additional IT infrastructure to fulfill the reporting requirements associated with the quality component.

Under the new system, providers will still receive payments under a FFS arrangement. However, based on the cost and quality components, the ACO will either share savings or losses with the insurer. To cover possible loses the ACO will retain a percentage of the provider's billed services during the agreement period to create a "risk-pool." If at the end of the agreement period the ACO meets its goals, physicians obtain

[11] See Appendix B for a detailed description of the payment mechanism.

the FFS from that risk-pool in addition to a "shared savings bonus." Yet, if the ACO fails, physicians lose that part of the FFS, as the ACO uses the risk-pool funds to compensate the insurer for the losses.

C. ACOs Under Health Care Reform

With few exceptions, delaying the creation of, partnering, or contracting with an ACO is an unsound financial strategy. First, because the Supreme Court upheld the ACA, it is now difficult to modify or repeal it. Second, pressure from federal and state governments and the private sector will push providers to coordinate care. For example, economic policies advanced by the Independent Advisory Board, a group established by the ACA to limit Medicare spending growth, will drive the market in this direction. Some states are already considering ACO initiatives for their Medicaid populations. Private insurance plans are scrambling to satisfy states' insurance commissioners' and employers' demands to control costs.[12] The ACA does not provide a specific waiver allowing private payer arrangements with ACOs, but there is sufficient flexibility for these entities to participate in commercial plans.[13]

Although ACO development is spurred by new Medicare payment arrangements, the rest of the market (Medicaid and commercial insurers) will soon follow. Proof of this transformation is evidenced by the fact that all six of Gotham's acute-care hospitals have approached Family Health, a practice serving few Medicare beneficiaries. Once the new quality/cost reimbursement structure becomes entrenched in the system, it will fundamentally transform the physician-hospital relationship. Private insurers and

[12] Kocher, Robert, and Nikhil R. Sahni, *Physicians versus Hospitals as Leaders of Accountable Care Organizations*, THE NEW ENGLAND JOURNAL OF MEDICINE, (Jan. 2013).
[13] Federal Register 76.212, at 68006.

Medicaid will require hospitals and physician groups to report on quality metrics and tie reimbursement to outcomes. Eventually, the medical payment model will move toward a more episodic approach--away from FFS--but retaining a quality requirement. ACOs will become the contracting vehicle for the future U.S. health care market.

D. ACOs Changing the Gotham Market

It is inevitable that ACOs are forming in Gotham. Its health care market has already shown a trend toward hospital consolidation and formation of ACOs. The current layout, composed of six acute-care hospitals, will change in the coming years. Mergers, acquisitions, and closures will limit the number of hospitals and ACO partnering options. Like the hospital landscape, some but not all ACOs that emerge will survive. A changing market presents risks that Family Health needs to consider as it explores possible ACO partnerships. The practice should evaluate each hospital/ACO's reputation with physicians, compatible infrastructure, financial stability, cultural compatibility and managerial capabilities. Family Health must find a partner capable of surviving the changing market.

III. Transaction Options for Family Health

The future of Family Health depends on choosing one of several partnering options to ensure its stability. The American Medical Association published ACO partnering options for physicians under its Practice Management Center in a helpful guide, "ACOs, CO-OPs and Other Options: A "how-to" manual for physicians navigating a post-health reform world 3rd edition" which will help frame our discussion.[14]

[14] David W. Hilgers et al., *ACOs, CO-OPs and other options: A "how-to" manual for physicians navigating a post-health reform world.* (2012), 3rd edition.

A. Undesirable Options

Some transaction options can be disregarded as undesirable for Family Health. These include the option to form an independent practice association (IPA), the option for employment by a hospital/ACO, and the option to stay independent, via one of two methods.

1. Form an Independent Practice Association

Family Health could form an independent practice association with other physicians and groups. IPA members increase their leverage when negotiating capitated rates or FFS contracts. The fatal flaw in this option is the time and resources necessary to organize a group of this magnitude. A successful IPA requires a specific structure, governance, and an adequate primary care physician (PCP) to specialist ratio. Also, if the IPA ends up with a significant number of PCPs and few infertility specialists, Family Health would not gain additional leverage. Lastly, if the IPA cannot bear capitation risks and does not intend to share risk when it contracts, it could violate antitrust laws. Family Health is a small group that runs an efficient and successful practice, and the added task of organizing an IPA would force the practice to divert significant resources that could otherwise further the development of the business.

2. Employment by Hospital[15]

Family Health could sell its practice with the individual shareholder-physicians then becoming employees of one of Gotham hospitals/ACOs. The pros of this approach include a better work-life balance, and limited financial and legal liability for Family

[15] It is assumed that Gotham is located in a state lacking a corporate practice of medicine (CPoM) statute. Alternatively, if this is a CPoM state, that the hospitals and/or ACO can employ physicians because of a statutory exception.

Health's shareholder-physicians. Yet, given Family Health's business goals this is not an acceptable option. First, Family Health would lose control over its business because employees lack authority to make business decisions for the entity. Second, if the acquiring entity changes the name "Family Health," the reputation associated with the name is lost. Finally, salaries under an employment contract would be lower than current physician compensations.

3. Options to Stay Independent

Family Health could stay independent by simply maintaining the status quo and watching to see how the market changes before taking action. Alternatively, it could stay independent while attempting to grow the practice.

a) Watch and Wait

Family Health is financially stable, enjoys a great reputation and could simply watch and wait while ACOs transform Gotham. This is not a sound business decision. The new payment model will inevitably transform the OB/GYN, urology, and other components of Family Health's practice. In addition, Family Health's marquee service, infertility treatments, is paid to a large extent by commercial insurers that will soon push for cost/quality-based reimbursement. In fact, some commercial insurers already require physicians to follow certain treatment protocols and report data on infertility services. The introduction of new IT systems championed by ACOs will only accelerate this trend.

The new reimbursement model will alter the way physicians practice medicine. To survive in the modern market, Family Health has to adopt new IT systems and modify its practice. Failure to associate with an ACO will delay this process and put Family Health at a competitive disadvantage. Foregoing the opportunity now to collect patient

data under the cost/quality reimbursement system will make Family Health a less attractive candidate for ACOs later. In the near future, ACOs and commercial insurers will compare performance of different practices using this data. Family Health's failure to collect patient information means ACOs may avoid contracting with the practice or offer unfavorable terms because a lack of metrics translates to additional risk.

b) Attempt to Grow the Practice

Family Health is not under immediate financial pressure and can afford continuing operations under its current model while also attempting to expand. The overall revenue and proportion of self-pay versus private-pay patients, particularly for infertility services, will inform Family Health's decision to expand these services.

Growth is achievable by adding physicians or merging with other groups. If Family Health becomes sufficiently large it can offer more services and gain leverage to negotiate better rates with ACOs. This allows for more flexibility in the future to either partner or remain independent. While the idea seems attractive, this strategy presents challenges and risks. Adding physicians requires investing additional time, money, and infrastructure. Unless partners are willing to dilute their shares, new physicians would have to be paid salaries. Also, expanding through mergers requires finding partners interested in this alternative and presents financial and legal risks. Family Health would have to have a specialist investigate the finances of potential partners. Furthermore, after finding a financially stable partner, Family Health would have to conduct extensive negotiations over valuations of the practices, shared ownership, and reimbursement. The right economic partner may not have a compatible mindset and professional culture. Lastly, both merging and employment present unknown malpractice risks.

B. Recommended Option: Associate with a Hospital/ ACO

Finally, Family Health has the option to collaborate with one of the interested acute-care Gotham hospitals. This would take one of two forms: joint venturing (partnering) with a hospital-based ACO or contracting (associating) with a hospital-based ACO. The decision between joint venturing and contracting is difficult. Creating a new ACO owned solely or championed by Family Health is not feasible. Capital investments beyond Family Health's capabilities or capacity are required to create the ACO's framework and infrastructure. A physician group of Family Health's size has neither the time nor management expertise to run an ACO while tending to the everyday demands of the practice.

a) Joint Venturing

Joint venturing represents Family Health's most difficult decision. The potential risks associated with this action are great. For example, joint venturing inextricably ties Family Health to a single ACO; it is expected that partner-providers in one ACO will be forbidden from contracting as providers with other ACOs. However, joint venturing with a successful ACO could be very profitable.

The practice could either partner with an established ACO or invest in one that is being formed and championed by a hospital, which would make Family Health a hub for the ACO model. Investing in a forming ACO arguably gives Family Health a chance to influence its structure and governance. Yet, realistically the practice has little leverage to effect major changes. Furthermore, attempting to influence an ACO requires investing time and resources.

There are potential economic benefits for Family Health if it joint ventures with

an ACO. ACO partners who are also providers get FFS from procedures they perform, FFS distributions from assets owned by the ACO, and shared savings and bonuses. Control is an additional benefit of joint venturing. As a shareholder, Family Health is guaranteed at least one seat on the ACO's board of directors, giving it a say in future business decisions of the ACO. By investing in an ACO now Family Health will acquire a larger share of the entity. If Family Health does not joint venture and the ACO becomes successful, its valuation will increase causing partnering in the future to be more expensive.

Family Health's financial status makes investing enough money to acquire an interest in an ACO unlikely. However, it could offer its ancillary assets (ambulatory surgery center, imaging center, and/or laboratory) in lieu of capital in one of three ways:

1) Give up a percentage of one or more of Family Health's ancillary assets.

2) Invest some of its ancillary assets, in whole, while retaining others.

3) Invest all of its ancillary assets in the ACO.

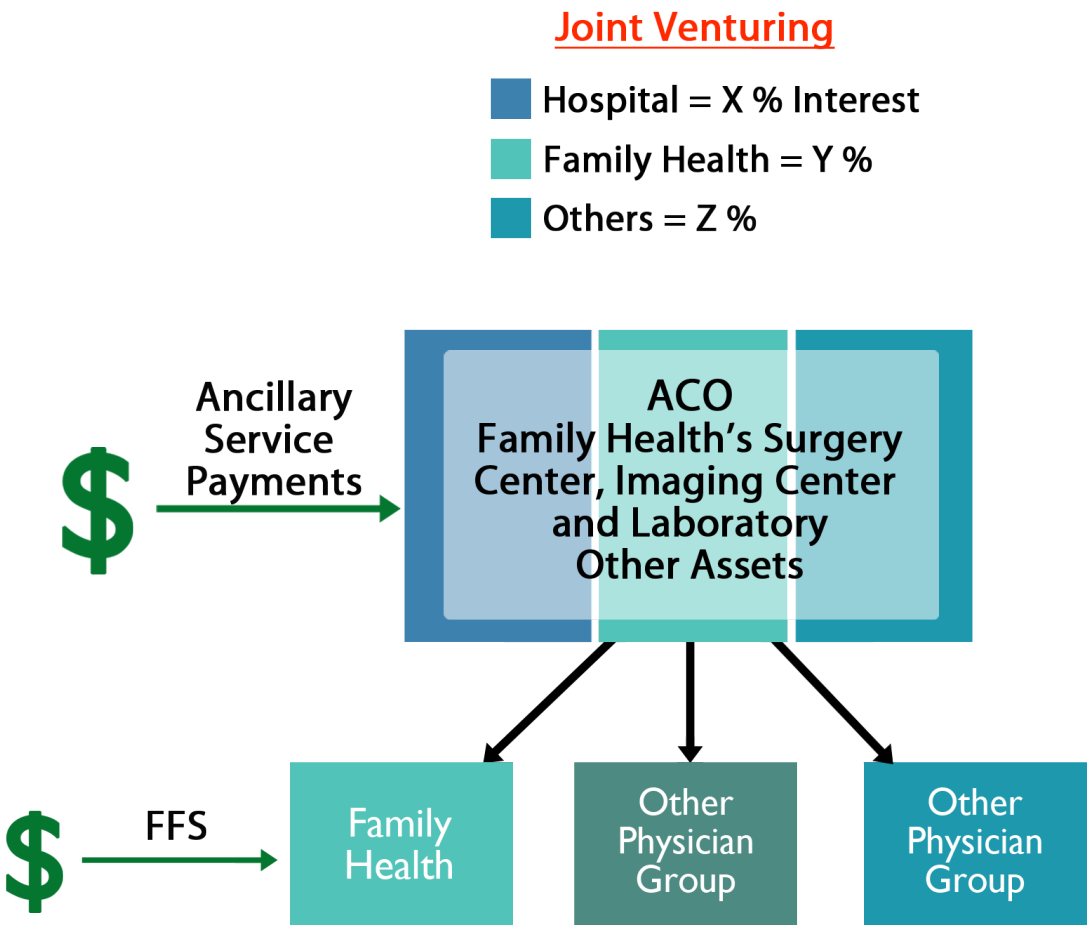
Giving up a percentage of one or more ancillary assets presents legal risk, which prevents it from being a viable option. Stark Law prohibits physicians from self-referring government covered Designated Health Services (DHS) to entities where the physician (or an immediate family member) has a financial relationship.[16] Stark's "in-office ancillary services exception" does allow self-referrals in the context of a physician's own practice provided certain requirements are met.[17] One requirement is that the referring physician or physician group *wholly* own the entity receiving the referral.[18] If Family

[16] 42 U.S.C. § 1395nn.
[17] Id.
[18] Id.

Health's or the ACO's physicians referred government-covered patients to these facilities with shared ownership, they would be operating outside this exception, in violation of Stark.

Because of Stark's "in office ancillary service" exception requirements and the expensive startup costs associated with an ACO, Family Health has to surrender one or more ancillary assets in their entirety to joint venture. Investing ancillary assets but retaining one, could create direct competition and conflicts of interest between Family Health and the ACO. This is the case if the ACO owns the same type of asset that Family Health chose to retain. This conflict of interest is exacerbated if a physician-shareholder occupies a seat on the ACO's board because of the fiduciary duties board members owe to the entity. The consequence of investing all of Family Health's ancillary assets in their entirety is the loss of the immediate FFS revenue generated by these services. This rerouting of income, as seen in Diagram 2 below, could put significant financial strain on Family Health's individual physician-shareholders. The expectation is that the investment's rate of return in the ownership is higher than the practice's forgone ancillary income. Nonetheless, if the ACO is unsuccessful, Family Health will not only lose ancillary revenue and the capacity to generate revenue in the future, but also the capital required to partner with another ACO.

DIAGRAM 2



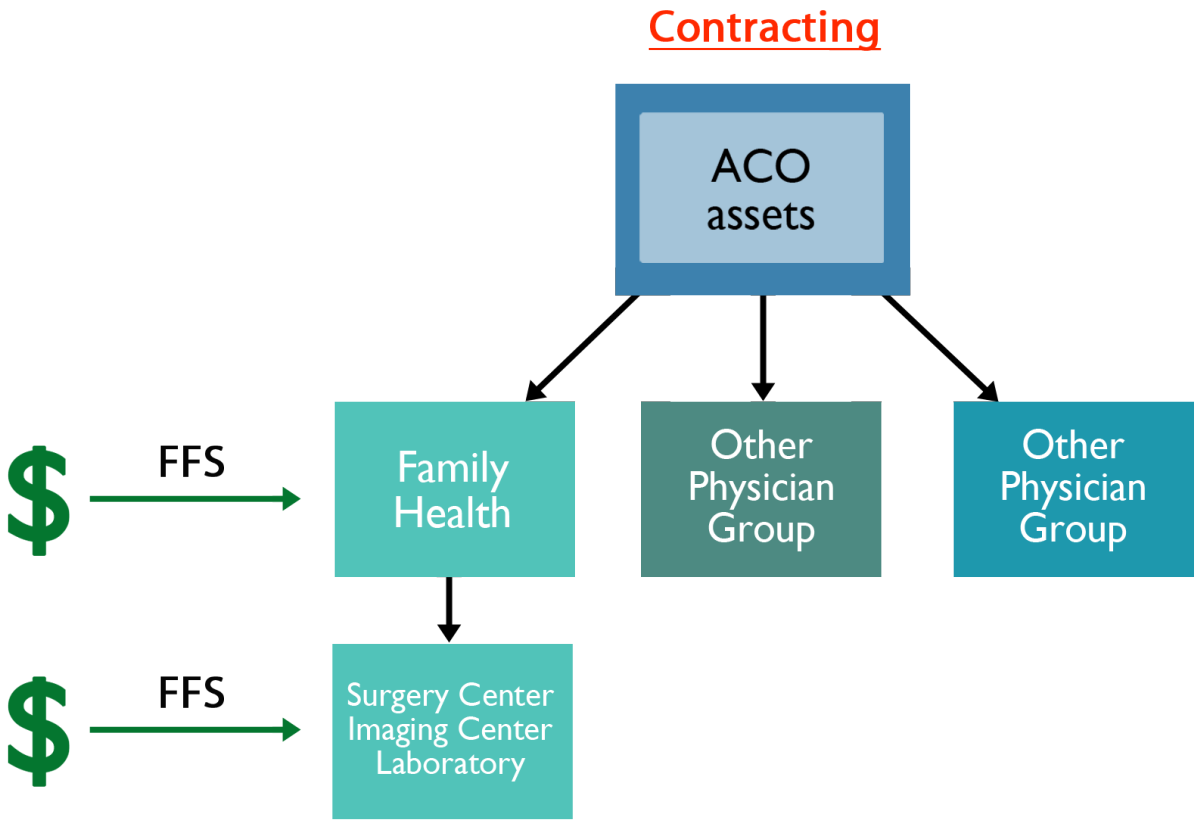
Perhaps the biggest risk to Family Health of joint venturing is the future success of the ACO, which is anything but certain. The final decision between joint venturing and contracting will depend on the risk averseness of Family Health. Due to the uncertainty of a transforming market in Gotham and the risks expounded above, Team 16 L.L.P. does not recommend this option for Family Health at this time; although it could be a worthy alternative in the future.

b) Contracting

At this point in time, contracting with several ACOs is Family Health's best

option. Unlike joint venturing, contracting allows the practice to participate in more than one ACO as a provider, earn shared-savings, and bear only the minimal risk associated with the FFS withholding retained by the ACOs to cover any losses. By retaining its ancillary facilities, Family Health will continue receiving direct FFS payments, as seen in Diagram 3 below. The revenue generated from multiple non-exclusive contracts for these services could outweigh the distribution payments under an exclusive joint venture arrangement.

DIAGRAM 3



As previously discussed in the section titled "Options to Stay Independent: Watch and Wait," the new reimbursement model will alter the way physicians practice medicine. Contracting will allow the practice to adopt the newly required IT systems and commence the adaptation process necessary to survive in the new quality/cost market.

Because ACOs negotiate on behalf of its physician providers, they have great leverage to negotiate better FFS rates. Finally, contracting with several ACOs now will allow Family Health to cultivate valuable relationships, which provides valuable insight into the ACOs economic situation, professional culture, and relationship with providers. This information is necessary to select the right ACO partner if Family Health wants to joint venture in the future.

Family Health should seek favorable contract terms in its participation agreement. Its leverage is measured according to their patient capacity and reputation. Since the practice enjoys both; it should consider:

1) *Exclusivity*

Ideally, Family Health would be able to form non-exclusive contracts with several ACOs. This gives Family Health the opportunity to dilute risk and reap benefits from involvement with multiple ACOs. Family Health's involvement with numerous ACOs presents a conflicts of interest which forbid it from bargaining for board representation.

2) *Capitation*

Family Health should avoid capitated payment arrangements. The capitation payment model provides for a fixed-payment per-member per-month (PMPM) for covered services, regardless of actual costs to providers. ACOs are expected to operate on FFS plus quality incentives primarily but capitation or partial capitation for some services is still possible. Family Health simply cannot bear the capitation risk and should negotiate to continue receiving FFS payments

3) *FFS Withholding*

Family Health should negotiate for the ACO to retain only a small percentage of

its FFS payments. Although ACOs are expected to have standardized terms for all providers, Family Health's reputation and capacity might allow it to bargain for more favorable withholdings.

4) *Effect of Not Meeting Performance Benchmarks*

ACOs will bargain for the right to cancel provider contracts if they fail to satisfy cost/quality performance benchmarks. To protect its contractual arrangement, Family Health should negotiate for notice and a probationary period before the ACO can terminate their contract.

5) *Option Contract*

Family Health can negotiate for an option contract that give it the right, subject to certain terms, to joint venture during or shortly after concluding its contract. Securing this provision will be difficult, but worth the effort.

While Family Health will not receive every provision it attempts to secure, it should take full advantage of the negotiation process with each ACO.

IV. Potential Hospital Partners

Finding the right ACO partner to contract with is crucial in the evolving health care market. Even if Family Health does not joint venture, it risks the FFS withholding (risk-pool) if the ACO they contract with fails cost/quality benchmarks. In addition, partnering with the wrong ACO could hurt Family Health's reputation.

Factors to considered in evaluating the prospective partner include: association options offered, reputation, financial stability, culture/relationship with physicians, socioeconomic population served, business focus, and whether the ACO is of sufficient size to benefit from economies of scale and risk spreading. While Team 16 L.L.P. does

not recommend joint venturing now, these same factors are informative in finding the right ACO to contract with or to joint venture if Family Health decides to pursue it in the future.

A. Green State University Medical Center

This educational system wants to acquire Family Health and employ its physicians under a faculty practice plan. This partnership does have a few advantages; it's a market leader in quaternary care with the financial backing of a major university, has a strong research focus, and is actively growing its network to attract patients in Gotham and suburban communities. But, as mentioned previously, employment is not a reasonable option for Family Health. Specifically, employment with Green means physicians are part of an academic system, which refocuses Family Health's purpose from providing profitable fertility and OB/GYN services to teaching and monitoring medical residents. As employees, physician salaries are expected to decrease, and they would no longer enjoy revenue generated by ancillary services and shareholder distributions. Employment also diminishes Family Health's control. Employment by Green does not fit Family Health's vision for adapting with the changing market.

B. Memorial Health

Memorial does not have the infrastructure that would make it a desirable partner for Family Health. For example, larger hospital systems have health IT systems adept to justify the needs of an ACO. As a freestanding institution, Memorial lacks IT interconnectivity, experience, capacity, and will have to develop such systems to communicate with providers. Also, its small size means fewer patients and more risk. Also, Lexis has expressed an interest in acquiring Memorial. An acquisition would

imperil Family Health's contract with Memorial and potentially subject the practice to the control of the new owner if the contract carries over. Furthermore, Family Health does little business with Memorial, which makes it difficult to determine the type of relationship it would have with Family Health. Memorial's unpredictable position makes it an unsuitable partner.

C. St. Peter's Hospital

St. Peter's Hospital is not a reasonable contracting partner for Family Health, despite its positive qualities. Family Health enjoys a good relationship with St. Peter's because it performs most of its obstetrical deliveries there. St. Peter's also belongs to a state system, which helps shoulder financial risk. However, it ranks third in the Gotham market behind Health America and Lexis in terms of hospital reputation and has a slow developing physician network. A large network is essential if the ACO is to meet cost/quality benchmarks. Also, St. Peter's parent organization may not remain in Gotham for much longer, and like Memorial, it is the only hospital of its system in Gotham. This means St. Peter's is likely to merge or sell to another institution, which again puts Family Health at risk of its contract turning over to a different institution. Lastly, it is a Catholic system that adheres to religious doctrine. Since fertility treatments are a major part of Family Health's business, it should not form a relationship that would be strained over differing ideologies.

D. Health America

Family Health should contract with Health America. This institution is a national for-profit health system known for being a strong, financially-centric hospital operator. Strong finances allow it to invest in growing a network and overcoming any hardships.

As a national system, it has the knowledge and familiarity with the health IT systems necessary to run a large network. In addition, its size gives it the resources to serve a large population and spread financial risk. The fact that they are aggressively expanding to increase market share evidences its intent to form a strong community network. Although Family Health does not do any business with Health America, it is known as a physician-friendly institution. All of these factors make this entity's ACO ripe for success in the modern market.

Health America is expected to scale back unprofitable services and move aggressively to grow its market share. For-profit hospitals are known to streamline and improve delivery systems by improving efficiency, because they do not enjoy the tax savings of eleemosynary institutions. Being a national system, the hospital not only benefits from economies of scale but also has knowledge of elaborate protocols and standards to improve efficiency and quality.

The downside of this potential partner is its geographic location; the hospitals it acquired are located in financially challenged areas. Although quality and cost metrics adjust for chronic conditions and other factors inherent in low income areas, they do not adjust for socio-economic variations in usage. Therefore, operating in a financially challenged areas could be a barrier to reach the cost and quality benchmarks. ACOs could be penalized for hospital admissions associated with Chronic Obstructive Pulmonary Disease (COPD) or asthma. The rationale is that these measurements are Prevention Quality Indicators (PQI) prove how comprehensive the delivery system is. Yet, self-reported access to care only explains some of the variation in these hospitalizations as according to some studies, individuals from low-income ZIP codes have more COPD

hospitalization per capita than individuals from high-income ZIP codes.[19]

Coordinating with an ACO in a financially depressed area puts Family health at risk of losing FFS retained by the ACO to the extent they share risk for the ACO's overall population. Despite its geographic location, Health America is a good contracting partner for Family Health because it is financially stable, physician friendly, and has the knowledge and resources necessary to develop the infrastructure to form and run a successful ACO.

E. Lexis

Lexis is the most attractive partnering option for Family Health. Like Health America, it is financially strong and enjoys an excellent reputation. Lexis' expansion strategy attempts to create the ideal structure for an ACO. Its letter of intent to acquire Memorial Health shows its plan to stay in Gotham and grow. Increasing capacity gives it the ability to serve more patients and dilute risk. Likewise, by partnering with community-based physicians, the ACO is more likely to satisfy the reimbursement quality/cost metrics because many metrics require interactions with patients through follow-ups. Patients are more likely to comply with treatment protocols if their physician is conveniently located near their residence.

Family Health is already familiar with Lexis because it admits some of its patients there. Through these interactions, it has witnessed first-hand the physician-friendliness of this institution. Also, its medical staff is open to faculty and independent physicians, which gives physicians the option to remain focused on private practice or to take on faculty responsibilities. Its expansion strategy is suitable to creating the right cultural

[19] CMS, *Accountable Care Organization 2013 Program Analysis Quality Performance Standard measure Specifications* (Dec. 21, 2012), *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf.

attitude among ACO partners. By expanding in collaboration with physicians, Lexis involves providers, which gets them invested in the process. A sense of ownership means physicians are more likely to work hard to achieve benchmarks. In addition, because Lexis is in the early stages of development, physicians, including Family Health's individual shareholder-physicians, can influence and fine-tune the ACO's structure and culture to achieve the appropriate balance of interest among providers. Lastly, Lexis offers a wide range of partnership options including employment, Management Service Organization/ ACO contracts, and Physician Hospital Organization/ ACO contracts. This flexibility is important as Family Health's long-term partnering needs evolve as the health care market changes. Because of Lexis' strong finances, culture, and long-term ACO strategy, it is an ideal partner for Family Health.

V. Conclusion

To keep up with the changing health care market in Gotham, Family Health should contract non-exclusively with one or more ACOs. Lexis Health system will make an ideal partner for Family Health because of its reputation for working well with physicians. Family Health should also contract with Health America, as it is a financially strong institution with the infrastructure and capacity to grow. Both of these institutions are aligned with Family Health's long-term goals and could help the practice to adapt and survive in a chaotic health care environment.

Appendix A: Applicable Law

Federal Laws

1. Civil Monetary Penalty (CMP) Law[20]:

Civil penalty law enforced by the Office of the Inspector General (OIG):

Gainsharing CMP: Prohibiting hospital payments to physicians to reduce or limit services. This law could factor in if ACOs attempt to induce doctors to reduce services to meet savings.

Beneficiary Inducement CMP: Prohibits inducement to beneficiaries to use health services. This law prohibits ACOs from "bribing" patients to get services. This law generally is not an issue for ACOs as they are attempting to reach services. Yet, because of quality component requirements, ACOs could try to incentivize patients to get preventive services.

2. Stark[21]

The Stark statute applies to physicians who refer Medicare and Medicaid patients for "designated health services" to entities with which they (or an immediate family member) have a "financial relationship." Yet, this law is defined more by its exceptions than by the actual rule. Determining whether Stark applies to a particular arrangement, is a three question inquiry: (1) does the arrangement involve a referral of a Medicare or Medicaid patient by a physician (or immediate family member of a physician) (2) is the referral for a designated health service? and (3) is there a financial relationship of any kind between the referring physician (or family member) and the entity to which the referral is being made? If the answer to any of these three questions is no, then Stark does not apply. If the answer to all three questions is yes, the arrangement may be exempted from Stark under any of a host of statutory exceptions. Referrals and claims that violate Stark are each punishable by a $15,000 civil monetary penalty, any claim paid as a result of an improper referral is considered an overpayment, and circumvention schemes are punishable by a $100,000 civil monetary penalty. No intent to violate the Stark law is required in order to be liable.

3. Anti-kickback Statute[22]

Criminal law with a felony penalty enforced by the Department of Justice (DOJ). It punishes *anyone* who knowingly and willfully offers or pays someone to induce the purchase, leasing, ordering, arranging, or recommending the purchasing of services or items for which payment may be made by Medicare or Medicaid. Contrary to Stark, which applies only apply to physicians (or their family members), any person can violate this law.

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[20] 42 U.S.C. § 1320a–7a, *et al.*

[21] 42 U.S.C. § 1395nn, *et al.*

[22] 42 U.S.C. § 1320a-7b, *et al.*

4. Antitrust[23]

Antitrust laws penalize anti-competitive market behavior such a price-fixing. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) created guidelines for ACOs to follow in light of new antitrust issues because the purpose of an ACO is to increase the public's benefit through market integration. The two agencies use the "Rule of Reason", which is a balancing test, to determine whether the procompetitive efficiencies of the organization outweigh the anticompetitive effects. These guidelines allow for ACOs to use joint pricing and joint contracts with private payers to improve healthcare quality and meet ACO standards. The guidelines allow for ACOs that meet certain standards to operate within a safety zone that will not be challenged by the agencies unless their practices go above and beyond normal circumstances. A few exceptions exist for ACOs not within the standard safety zone. One exception is for ACOs in rural areas. A second exception applies to an ACO participant that has more than 50 percent of the market because it is the only provider of its type within the participant's services area. Even ACOs that operate outside the standards for the safety zone will not be reviewed as long as they are still procompetitive and legal. When an ACO violates the antitrust law outside of the standards and exceptions in the ACO antitrust guidelines, the Department of Justice will enforce the laws through any of its traditional enforcement methods. For example, private entities may still file lawsuits for antitrust violations, and the Department of Justice can criminally prosecute antitrust violations.

Tax Law

ACOs can be taxable for-profit entities, taxable non-profit entities, or 501(c)(3)s. For tax-exempt entities taking part in ACOs, capital contributions, private inurnment/benefits, excess benefits, and unrelated business income taxes could raise issues under the Internal Revenue Code.

HIPPA

Under the MSSP application, an ACO must verify that Medicare beneficiaries' personal information and claims data is being collected and used by a HIPAA-covered entity or as a business associate of a HIPPA-covered entity, and will be appropriately safeguarded.

Federal Waivers[24]

SSP Waivers:

The ACO's integrated and risk-sharing structure allows entities and their providers to fall within some exceptions existent before the ACA was enacted. Yet, existent exceptions at the time did not sufficient shield providers from liability and complicated hospital-provider integration. To resolve this problem, Section 1899(f) of the ACA authorizes the HHS Secretary to waive parts of the aforementioned federal laws as needed to carry out the ACO SSP programs. Under this power, in conjunction, CMS and

[23] Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 209 Fed. Reg. 76, *et al.* (October 28, 2011).

[24] Medicare Program; Final Waivers in Connection With the Shared Savings Program, 212 Fed. Reg. 76, *et al.* (November 2, 2011).

the OIG released rules connected to the SSP. Separately from meeting applicable waiver requirements ACOs need not to take special action to be covered by a waiver. Yet, any actions taken by the ACOs pursuant to the waivers have to be "reasonably related" to the "purposes of the SSP."

There are five waiver options available for ACOs and each addresses different circumstances. The first two (the ACO pre-participation waivers and the ACO participation waiver) collectively address most start-up and operating arrangement issues. Two additional waivers address shared saving distributions and arrangements to comply with Stark. The last waiver addresses beneficiary incentives to promote preventive care and compliance with treatment regimes to involve patients in quality and care improvements. It is worth noting that the waivers were intentionally not codified to allow flexibility in case modifications are required.

State Laws

Corporate Practice of Medicine (CPoM)

These laws are in effect in eight states and prohibit non-physicians from employing physicians. Although these laws vary by state, in general, they require: (1) physicians to practice independently, (2) physicians not be controlled by non-physicians, (3) no interference in the physician-patient relationship, (4) no interference in medical decision-making or medical judgment, and (5) prohibition of physician's fee "splitting" with non-physicians.

State Insurance Laws

1. The use of "risk sharing" language in proposed rules raised issue of whether the ACO assumes risk in an insurance capacity under state law. CMS believes "risk sharing" under the MSSP is not insurance risk but clarified that it does not preempt any state laws and participants are expected to comply with any state requirement.

2. State requirements of fertility treatment coverage:

State Licensing Laws

All providers and entities under an ACO must adhere to state medical licensing law.

Non-Profit Laws

Tax exempt status under state laws differs from federal tax exempt status. Organizations may fall within state property, sales and income tax exemptions.

Appendix B: Cost/Quality Based Reimbursement

The Center for Medicare and Medicaid Services (CMS) implemented a cost/quality reimbursement model option for newly formed ACOs under its Shared Savings Program (SSP). Providers will still receive payments using the Fee-For-Service (FFS) rules. Yet, based on a *Benchmark* and *Quality Component*, the ACO will either share savings or losses with CMS. To cover possible loses the ACO retains a percentage of the provider's billed services during the agreement period. If at the end of the agreement the ACO met its goals, physicians obtain the FFS that the ACO withheld in addition to a "shared savings bonus." Yet, if the ACO fails, physicians lose the FFS percentage the ACO retained.

The Benchmark

The *Benchmark* is a proxy of what the total Medicare FFS Parts A and B expenditures would be for assigned beneficiaries during the previous three years in the absence of the ACO. Given that usage of services varies across time depending on health conditions and that inflation affects prices, on top of measuring expenditures, the *Benchmark* also adjusts for beneficiary health characteristics and national growth rates in Medicare. Savings or loses are calculated comparing the ACO's "Performance Year" expenditures of all Assigned Beneficiaries against the *Benchmark*. To illustrate, consider an SSP-ACO commencing activities in January 2012.

Savings or losses = Benchmark – Performance Year

Benchmarks*	***Performance***	***Year***		***Savings or Loses***
Benchmark 1	← compared →	2012	=	Year 1
Benchmark 2	← compared →	2013	=	Year 2
Benchmark 3	← compared →	2014	=	Year 3

* Values are calculated based on three components: (1) Actual Expenditures, (2) a Risk Score (controlling for health condition of beneficiaries), and (3) national Medicare growth rates.

The Quality Component

The goals of the *Quality Component* are improving the beneficiary's satisfaction, preventing hospital readmissions, improving physician participation in the Electronic Health Record (EHR) Incentive Program, and managing chronic conditions. The *Quality Component* is divided into four *Domains*: (1) Patient/Caregiver Experience, (2) Care Coordination/Patient Safety, (3) Preventive Health, and (4) At Risk Populations. Each Domain in turn is composed of different "measurements." Data submissions methods for each measurement(s) include a patient satisfaction survey, claims data, the number of ACO physicians who successfully qualified for the EHR Incentive Program, and monitoring and controlling of chronic conditions using the ACO GPRO Web Interface.[25]

[25] Providers will use the Web Interface to collect some quality measures (i.e. chronic condition management) and CMS will randomly select a patient sample from the ACO for a given calendar year.

In contrast to the *Benchmark*, which is based entirely on comparing expenditures from the ACO's own beneficiaries, the *Quality Component*'s *Domain*'s measurements will be compared against a national minimum attainment level.[26] The aggregate *Quality Component* value, which is measured as a percentage, is determined using a complex formula. This figure serves as the Savings or Loses multiplication factor to determine the value of the ACOs shared savings or loses. The following formulas and two-step process explain how the cost and quality components interact:

(1)

Benchmark		***Performance Year***		***Savings or Loses***
Benchmark 1	← compared →	2012	=	Year 1*

(2)

Shared Savings = (Year 1) (Quality Component [%])
Shared Losses = Year 1 — (Year 1 * Quality Component [%])

*Year 1 = Benchmark — Performance Year

It is important to note that sharing of savings is dependent upon reaching a Minimum Savings Rate (MSR). The MSR is a minimum savings threshold that once attained allows CMS to share part of the savings with the ACO. If the ACO achieves some savings but does not meet the MSR, it will not be entitled to any sharing. Yet, if it meets the MSR, it will share from the "first dollar" of savings and not only on savings above the MSR (up to a performance payment limit). Shared savings eligibility is also contingent on the ACO meeting a minimum *Quality Component* score. Essentially, reaching the MSR allows the ACO to obtain a bonus on top of the FFS charges already attained.

On the other hand, the Minimum Loss Rate (MLR) dictates if the ACO will suffer losses. The MLR is the inverse of the MSR; it is a loss threshold which if surpassed requires the ACO to give back a percent of the billed FFS. Like savings, ACOs share form the "first dollar" once the MLR is reached; like the MSR too, losses are capped. If the ACO surpasses the MLR, a high *Quality Component* score will help the entity minimize its losses.

[26] CMS, *Accountable Care Organization 2013 Program Analysis Quality Performance Standard measure Specifications* (Dec. 21, 2012), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf