The mid-1970s and early 1980s gave us the onslaught of health maintenance organizations (HMOs) along with some of the early capitation models. Hospitals joined other hospitals to become health systems. Physicians practicing in small settings grew their groups or joined independent practice associations (IPAs).

New forms of managed care organizations and products appeared in the 1980s, including preferred provider organizations (PPOs), and point of service options. Physician hospital organizations (PHOs) emerged as joint ventures between hospitals and physicians to access managed care contracts. Hospitals created medical foundations in California to acquire physician practices and in many other states acquired physician practices and employed physicians.

Consolidation continued in the hospital industry and in the 1990s, we experienced the emergence of physician practice management (PPM) companies, which sought to monetize the value of physician organizations. Consolidation and joint ventures continued into the first decade of the 21st century.

In 2008 and the first part of 2009, many hospitals' financial reserves plummeted. Although many have recovered somewhat, few are at their high point of a few years ago. Bad debts and charity care were on the rise. Hospitals experienced less elective procedures. Managed care contract relationships between hospitals and health plans became increasingly strained. Many hospitals and physicians are still in joint ventures, which are losing money. Stagnant or decreasing reimbursements, along with lifestyle preferences have lead to many physician defections from medical groups and hospital medical staffs, and some physician groups are even starting to implode. Hospitals are experiencing greater difficulty in recruiting new physicians and significant regulatory hurdles in doing so.

Decreasing resources available to hospitals have resulted in putting off infrastructure and capital investments, including in the all important information technology (IT) area for electronic health record development. Even before the enactment of health care reform, the marketplace...
was experiencing an even greater consolidation in both the hospital and physician sectors. Financially distressed hospitals have been looking for a lifeline, both in terms of a health system with the necessary capital, but also, a physician integration strategy.

There was a lack of primary care capacity before health care reform. Now with another 32 million individuals added to the system, that lack of primary care capacity will be even more severe. There has been a movement toward patient-centered medical homes, greater use of technology and a greater focus on quality, outcomes and cost-effectiveness.

What does health care reform bring us? It brings the hospital value-based purchasing program. For the first year, on or after Oct. 1, 2012, a percentage of a hospital’s Medicare payments will be tied to hospital performance on quality measures related to common and high-cost conditions.

It also brings a hospital readmissions reduction program; effective for readmissions on or after Oct. 1, 2012. Medicare inpatient hospital payments for certain conditions for potentially preventable Medicare readmissions within 30 days will be reduced. The conditions or measures for which these reductions will be applied increases in number in fiscal year 2015.

Health care reform calls for a national pilot program on payment bundling. That is, a program to encourage hospitals, physicians and other providers to improve the coordination, quality and efficiency of health care services through bundled payment models will be developed. Such services will include acute care inpatient services, physician services, outpatient hospital services, and post-acute care services.

It focuses on improvements to the physician quality reporting initiative, physician feedback program, value-based payment modifiers under the physician fee schedule and the development of accountable care organizations (ACOs) and clinical integration. Health care reform provides for the creation of a shared savings program by Jan. 1, 2012, which can be accessed by providers/suppliers who participate as ACOs, provided that they have established a mechanism for shared governance. Thus, ACOs and clinical integration are the physician hospital joint ventures of the second decade of the 21st century.

ACOs that seek to participate in the shared savings program must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to them, participate for three years, have a formal structure to receive and distribute payments for shared savings, and have sufficient primary care professionals for their assigned beneficiaries. The ACO leadership and management structure must include clinical and administrative systems, have defined processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care. ACOs will have to demonstrate they meet the patient-centered criteria that will later be established.

ACO-based integration focuses first on patient care coordination, enabling physicians and hospitals to work together better to achieve quality and cost improvement. The IT platforms developed by ACOs will be the platforms for integration of the providers’ efforts on coordination of care and measurement of quality. Information will originate with the physicians providing the care and be shared across all providers within the ACO.

The IT systems will allow the ACO to track the clinical progress by patient, physician, and for the organization as a whole. Critical patient data will be tracked and compared to evidence-based guidelines. Health and biomedical informatics will be key. Shared information will allow physicians
treating any patient to have an up-to-date picture of how the patient’s condition is progressing, no matter which physician is managing the care at any point in time. It will allow for better coordination of care, management of episodic care, chronic conditions, and involve quality measurement tools with feedback on quality and cost for more aggressive case management.

New models for ACOs and clinical integration are emerging in the context of physician-hospital joint ventures. These new models seek to achieve substantial clinical integration and clinical and economic efficiencies. The joint negotiation of managed care contracts must be collateral or ancillary to the goal of true clinical integration. If these new models are to survive antitrust scrutiny, they should include a medical management system, the development and implementation of clinical protocols, a system of performance reporting and benchmarking with peers on a regional and national basis. In addition, these models should include procedures for taking corrective action, whenever necessary, and develop methods to manage high-cost and high-risk patients aggressively. Patient information must be appropriately shared.

The program for clinical integration should develop dynamic clinical practice guidelines, and the participants should continually develop improved practice parameters and protocols that reflect scientific advancements. Member physicians should demonstrate that they have made a meaningful investment in the new organization. The physicians should participate in all managed care contracts, and when appropriate, refer to in-network providers. They should participate in medical management programs and play significant roles in program committees.

The traditional medical foundation or hospital employed physician model needs to add a structure and options for the inclusion of independent community physicians through a clinically integrated system. In the newest joint venture models, the PHO might have HMOs, PPOs and the Medicare and Medicaid programs paying it, with the hospital and IPA/physician organizations receiving payments in a clinically integrated model. The expanding role of the physician organization under health care reform will require that the hospital needs be met through greater cooperation between a hospital and a medical foundation and the affiliated medical groups and community physicians linked through clinical integration. Comprehensive service line management models are emerging which enable the bundling of physician and hospital payments. The service line co-management company may manage hospital and physicians services, provide administrative and medical leadership and direction to the hospital and physician components of the model. Incentives need to be built in for improving operating and quality performance, along with strategic, operational and other activities.

Today’s health care lawyers are working on these joint venture models in the context of ACOs and clinical integration to better position our health care system to address the new dynamics of the health care marketplace and health care reform. Skills in the areas of managed care, corporate law, health care regulatory law, bankruptcy/restructuring, tax and tax-exemption, medical practices, valuation, and health and biomedical informatics are necessary to truly position health care providers in the marketplace for health care reform and the pending changes. The second decade of the 21st century holds the promise for much innovation and demand for top quality health care lawyers who have the requisite expertise to structure these physician-hospital joint venture ACOs in the context of clinical integration.

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