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New Payment and Delivery Models Under Health Reform Require New Relationships Between Physicians and Hospitals

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A primary objective of health reform is to integrate a fragmented healthcare delivery system. The current system is criticized as too costly and inconsistent in delivering quality and improving patients' health; a result that is often attributed to the payment models of Medicare and some private insurance companies which do not align the financial incentives of physicians and hospitals to accomplish these goals. Medicare pays hospitals a lump sum (i.e., a diagnosis related group or ''DRG'' payment for inpatient care, and an ambulatory payment classification or ''APC'' payment, for outpatient care) based on the patient's diagnosis or code for services rendered, which generally does not change regardless of the length of stay or amount of care provided. Thus, a hospital actually can lose money if more care, or more expensive care, is provided to patients. Conversely, physicians generally are paid for each service they render to patients (''fee-for-service''), and therefore are paid more if they provide more care. In addition, doctors determine the care that is to be provided in hospitals, yet bear no financial consequence for the cost of that care. Further, neither doctors nor hospitals are focused on the total cost of care for patients, since they each receive payment for discreet services without regard to total cost. Thus, hospitals and physicians are motivated by different, and often adverse, financial incentives, and neither payment model rewards consistent high quality and low cost care. A goal of health reform is to align these misaligned incentives, thereby improving quality, reducing costs and improving patient outcomes.

This article discusses the new payment and delivery models included in the Patient Protection and Afford-

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able Care Act of 2010 (''PPACA'')[1] and how these changes will require new relationships between physicians and hospitals.[2] It will also discuss current legal impediments to structuring appropriate physician/hospital alignment and several options that can be used now so that physicians and hospitals can be structured to succeed under the new payment and delivery models of health reform.

New Payment and Delivery Models under Health Reform

Value Based Purchasing

Since 2002, the Centers for Medicare & Medicaid (''CMS'') has been changing payment policy from paying solely for volume to one that drives high quality care. In July 2002, CMS enacted the National Voluntary Hospital Reporting Initiative to encourage hospitals to report voluntarily on certain quality metrics. The program evolved over the ensuing years so that, today, hospitals that fail to report quality data are penalized financially. In 2011, hospitals are required to report on 45 inpatient and 11 outpatient quality metrics or face a reduction in the annual market basket update of 2 percent for failing to report.[3]

Physicians have had their own version of ''pay for reporting.'' Under the Physician Quality Reporting Initiative (''PQRI''), physicians are eligible to receive a bonus if they report on certain quality metrics applicable to their practice. CMS started the program in 2007, and it has been expanded so that today there are 179 metrics for physician reporting.[4] Physicians receive a bonus equal to 2 percent of the Medicare payments received during the applicable reporting period simply by making the report. For physicians, the ''pay for reporting'' program uses a financial ''carrot'' rather than the ''stick'' approach used under the hospital program.

While financially incentivizing hospitals and physicians to report quality data may be considered a good first step, it fell short of the ultimate goal articulated by Congress in 2006 of only paying for demonstrated quality of care.[5] CMS took the first step to remedy this shortcoming in 2008 when it enacted the Hospital Acquired Conditions (''HAC'') payment policy.[6] Under HAC, hospitals are no longer paid for inpatient treatment of certain conditions which can be prevented if evidence-based practice is followed unless those conditions were present on admission. Coupled with three National Coverage Determinations issued in 2009 eliminating coverage for certain ''Never Events'' identified by the National Quality Forum[7], CMS embarked on its first endeavor to tie payment directly to quality of care (or, in this case, to withhold payment based on poor quality of care). CMS intends to extend the HAC payment policy to ''health care associated conditions'' occurring in outpatient departments, physician offices, and other settings as well. PPACA addresses implementation of the HAC program and mandates the Secretary of the Department of Health and Human Services to study and submit a report to Congress by Jan. 1, 2012 about expanding the HAC policy.[8]

With the passage of PPACA, Congress implemented the Value Based Purchasing program (''VBP'') first developed by CMS in 2007.[9] VBP is a payment model that directly ties reimbursement to performance. Section 3001 of PPACA enacts VBP for hospitals effective as of Oct. 1, 2012 based on reported performance on metrics related to five specific conditions: acute myocardial infarction, heart failure, pneumonia, surgeries, and health care-associated infection.[10] In FY 2014 and after, the metrics must also include efficiency measures, including Medicare spending per beneficiary.[11] Under VBP, a hospital's reimbursement from CMS will directly depend on its performance under the quality targets and not simply for reporting them. Beginning Oct. 1, 2012, the hospitals' risk based on their performance will be limited to 1 percent of their Medicare payments, with the risk increasing each year to a maximum of 2 percent by 2017.[12] For physicians, the PPACA directs the Secretary of HHS to develop and implement a VBP for physicians.[13] The payment change must be implemented beginning in 2015 for specific physicians and groups of physicians, and by 2017, will expand to all physicians and groups of physicians, including other

[1] Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) as amended by the Health Care and Education Affordability and Reconciliation Act of 2010, Pub. L. 111-152).

[2] Although many of the changes discussed in this article apply to all healthcare entities, this article will focus only on hospitals and physicians.

[3] The Reporting Hospital Quality Data for Annual Payment Update (''RHQDAPU'') program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and authorized a 0.4 percentage point reduction in the annual market basket update for hospitals that did not successfully report. The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points. Additionally, CMS enacted the Hospital Outpatient Quality Data Reporting Program (''HOP QDRP'') in 2009, which is modeled after RHQDAPU and also imposes a 2 percent reduction to a hospital's annual update for outpatient services for failing to report the outpatient metrics.

[4] Centers for Medicare & Medicaid, *2010 PQRI Measures List*, http://www.cms.gov/PQRI/Downloads/2010_PQRI_MeasuresList_111309.pdf (Nov. 2009).

[5] Deficit Reduction Act of 2005 (signed into law on Feb. 28, 2006).

[6] IPPS FY 2009 Final Rule, https://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp.

[7] Centers for Medicare & Medicaid, *CMS Issues Three National Coverage Determinations to Protect Patients From Preventable Surgical Errors*, http://op.bna.com/hl.nsf/r?Open=bbrk-8azum6; (Jan. 2009).

[8] Patient Protection and Affordable Care Act, Section 3008(b) (2010).

[9] Centers for Medicare & Medicaid, *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program*, https://www.cms.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf (Nov. 2007) which analyzes various options that CMS was considering for forming the Medicare VBP program including the following: (1) a potential Performance Assessment Model to calculate a Performance Score, (2) options to convert the score into incentive payment, (3) options for performance measure criteria, (4) potential phased approach to transitioning RHQDAPU to VBP, (5) a redesign of current data transmissions, (6) improvements to Hospital Compare website, and (7) an approach to monitoring VBP effectiveness.

[10] Social Security Act, § 1886(o)(2)(B)(i).

[11] Social Security Act, § 1886(o)(2)(B)(ii).

[12] Social Security Act, § 1886(o)(7)(C).

[13] Social Security Act, § 1848(p)(1).

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eligible health care practitioners, as determined by the Secretary.[14]

Although VBP is expected to move the dial toward improving quality, some limitations of the VBP payment model are that it separates out the incentives for hospitals and physicians (and therefore does create financial alignment) and it does not address directly total cost or quality of care. Thus, unlike the other payment models proposed by PPACA, the VBP model would not *require* a change to the legal relationship of hospitals and physicians. That said, a hospital's success under VBP is directly tied to the performance of its physicians, as the quality targets forming the basis of the hospital VBP are largely driven by physician rather than hospital performance. Therefore, although not an absolute requirement, it is highly likely that hospitals will need to engage physicians differently if they are to perform well under VBP.

Bundled Payments.

Bundled payment under PPACA is a pilot program defined as ''comprehensive [payment], covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary)''.[15] Bundled payments are currently the subject of the Acute Care Episode (''ACE'') demonstration conducted by CMS at five organizations. ACE started in 2009 and is testing whether bundled payments improve the quality of care while reducing costs for discreet episodes of care.[16]

Under a bundled payment system, hospitals and physicians receive a single payment for an ''episode'' of care, rather than for each isolated treatment, which payment must be shared among them. The PPACA requires CMS to establish a ''national pilot program on payment bundling'' by Jan. 1, 2013.[17] Like many of the payment models designed to align hospital/doctor financial interests, bundled payments will require a new legal relationship between physicians and hospitals since hospitals and physicians will be required to share a single payment.

Accountable Care Organizations.

The goal of Accountable Care Organizations (''ACOs'') is to improve both the quality of care and the patient experience while decreasing cost for a defined population of patients. ACOs are comprised of physicians, hospitals and other providers and suppliers who are structured to work together to achieve these goals.[18] The concept of ACOs grew out of the Physician Group Practice Demonstration Project (''PGP'') established by CMS in 2005. The PGP was a pay-for-performance demonstration project for physicians mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. The goal of the demonstration was to breakdown the silos between payment for Medicare Part A and Part B services to improve both the cost efficiency and health outcomes of patients. Physician groups in the demonstration continued to receive fee-for-service payments, but were eligible for bonuses when they demonstrated cost savings and met quality performance targets. The program has been largely successful, evidenced by the bonuses CMS has distributed to some of the participating physician groups.[19]

There is no required legal structure to which ACOs must adhere, rather, ACOs may be structured in a variety of ways, such as: integrated delivery systems, physician hospital organizations (''PHOs''), independent practice associations (''IPAs''), partnerships of PHOs or IPAs, hospitals, large group practices, joint ventures owned by physicians, hospitals and others, or any variation so long as a legal structure is in place to allow the participants to share a single payment.[20] PPACA imposes eight requirements that an ACO must meet before it can receive a shared savings payment from CMS.[21] These requirements include a commitment to provide patient centered care, participate as an ACO for at least 3 years, have a formal legal structure to allow the ACO to receive and distribute shared savings to participants, and include primary care and other health care professionals for at least 5,000 Medicare beneficiaries. ACOs also would be required to have in place a leadership and management structure and clinical and administrative systems, including technology, that can define and implement processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care through care management.[22]

In October 2010, the National Committee for Quality Assurance (''NCQA'') released proposed standards for certifying ACOs and is seeking commentary on the draft standards until Nov. 19, 2010.[23] The NCQA divided the draft standards into seven major categories, focused on Program Structure Operations, Access and Availability, Primary Care, Care Management, Care Coordination and Transitions, Patient Rights and Responsibilities, and Performance Reporting.[24] While not finalized, the NCQA's draft standards can be used as a guidepost by organizations desiring to structure as ACOs.

Becoming an ACO has important financial benefits to its participants. Particularly for new ACOs, the shared savings payment model would allow for the continua-

[14] Social Security Act, § 1848(p)(4)(B).

[15] Social Security Act, § 1866D(c)(3)(C)(i)(I).

[16] Centers for Medicare & Medicaid, *Details for Medicare Acute Care Episode Demonstration*, https://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1204388&intNumPerPage=10

[17] Social Security Act, § 1866D(a)(3).

[18] Health Affairs, Health Policy Brief – Robert Wood Johnson Foundation, *Accountable Care Organizations. Under the Health Reform Law, Medicare Will be Able to Contract with These to Provide Care to Enrollees. What are They and How Will They Work?* (July 2010).

[19] For performance year three (March 2008), five physician groups participating in the demonstration received over $25,000,000 in bonus payments based on a portion of the savings realized by Medicare. Also, during the first three performance years, physician groups increased their quality scores an average of 11 percentage points on congestive heart failure measures, 6 percentage points on coronary artery disease measures, 10 percentage points on cancer screening measures, 10 percentage points on diabetes, and 1 percentage point on hypertension measures.

[20] Social Security Act, § 1899(b)(1).

[21] Social Security Act, § 1899(b)(2).

[22] Social Security Act, § 1899(b)(3)(B).

[23] National Committee for Quality Assurance, *Accountable Care Organizations (ACO) Draft 2011 Criteria*, http://www.ncqa.org/tabid/1266/Default.aspx (Oct. 2010).

[24] *Id.*

tion of current reimbursement for each participant (for hospitals, DRG or APC payments, and for physicians, fee-for-service) while allowing the ACO participants to share an incentive bonus if they succeed in reducing the total cost of the care for a defined population below a target established by CMS based on previous expenditures, while improving quality and the patient experience. [25] Thus, the shared savings payment for ACOs combines the security of maintaining the current payment methodology while providing an added bonus to physicians, hospitals and others that can work together to manage a population of patients to reduce the total cost of care while improving quality and the patient experience.

It is widely recognized that shared savings alone will not be enough to achieve the goal of ''bending the cost curve,'' and it is likely that the shared savings payment methodology will evolve so that ACOs ultimately will be required to bear more risk for the cost of care.[26] Partial capitation has emerged as the ultimate goal for ACO payment. Capitation as a way of controlling the cost of care was highly touted in the 1990s as the solution to the health care cost crises. Under capitation, hospitals and physicians are paid a fixed amount or cap for each patient or ''enrollee'' and must provide all of the care within the cap or bear the financial risk of not doing so. Capitation was a feature of health maintenance organizations (''HMOs'') and soon fell out of favor in the 1990s because it did not consider the quality of care provided and often resulted in the withholding of necessary care in order to meet the financial goal or cap.

Partial capitation will likely be the ultimate payment model for ACOs once ACOs demonstrate that they can effectively manage the total cost of care. Since ACOs differ from the HMOs of the 1990s in that their financial awards also will be based on improving quality and patient experience, it is anticipated that ACOs will be effective in delivering care that is not only cost effective but also high quality and well-liked by patients. Importantly, however, ACOs will require new legal relationships between hospitals and physicians as they must align and work together differently to meet the triple aims of being cost effective, high quality and high satisfaction care delivery.

Patient Centered Medical Homes.

A principal objective of health reform is to redirect the focus of care back to the patient. Indeed, patient-centered care is one of the statutory requirements that ACOs must meet. The concept of patient-centered care is best achieved through the structure of the Patient Centered Medical Home (''PCMH''). PPACA includes pilots or demonstrations designed to test the effectiveness of PCMHs to reduce cost and improve quality of care.[27] In fact, inclusion of PCMHs into ACOs is now widely recognized as essential.[28]

PCMHs are team-based models of care led by primary care physicians who maximize health outcomes by providing continuous and coordinated care throughout a patient's lifetime. In a PCMH, each patient's personal physician is responsible for meeting or overseeing all of a patient's health care needs. The primary care physician in a PCMH works with a team of other health professionals, such as nurses, therapists, hospitals and other physicians to provide both wellness services and optimal care to meet the specific needs of each patient. Thus, the primary care physician in a PCMH is uniquely poised to avoid costly duplication or unnecessary care for a patient, and to effectively guide the patient through the array of resources needed to improve health. PCMHs provide patients with greater resources through collaborations among the primary care physicians and other health professionals; better access to primary care though open scheduling and enhanced methods of communication, such as e-mail and telephone; care coordination; and enhanced health information technology systems for tracking tests, results, screens, and preventative care.[29]

PCMHs first emerged in the 1960s as a way of providing pediatric care to children with special needs.[30] Eventually the notion of PCMHs broadened from the pediatric setting to encompass family care. PCMHs were first tested by seven national family medicine organizations[31] in 2002 under The Future of Family Medicine: A Collaborative Project of the Family Medicine Community.[32] Pursuant to the Tax Relief and Health Care Act of 2006, Congress mandated a demonstration to test the PCMH model for Medicare, and CMS has just completed its open solicitation period for participants.[33]

It is anticipated the PCMHs will be a key component of ACOs. Patients likely will be assigned to ACOs by their selection of a primary care physician, and unlike other participants in ACOs which may be able to participate in more than one ACO, primary care physicians likely will be exclusive to only one ACO. Because of this, any physician/hospital alignment strategy that is based on preparing for ACOs should place special emphasis on primary care.

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[25] Social Security Act, § 1899(a)(1)(B).

[26] Health Affairs, Health Policy Brief – Robert Wood Johnson Foundation, *Accountable Care Organizations. Under the Health Reform Law, Medicare Will be Able to Contract with These to Provide Care to Enrollees. What are They and How Will They Work?* (July 2010).

[27] Social Security Act, § 1181.

[28] National Institutes of Health, Mark B. McClellan et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2656392/ (Jan. 2009).

[29] The Journal of the American Osteopathic Association, John Cruickshank, DO, *The Patient-Centered Medical Home Approach to Improve Dyslipidemia Outcomes* (April 2010).

[30] The New England Journal of Medicine, Elliott S. Fischer, M.D., *Building a Medical Neighborhood for the Medical Home*, http://www.nejm.org/doi/full/10.1056/NEJMp0806233 (Sept. 2008).

[31] The seven national family medicine organizations were the following: American Academy of Family Physicians, American Academy of Family Physicians Foundation, American Board of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, North American Primary Care Research Group, and Society of Teachers of Family Medicine.

[32] Robert Graham Center, Center for Public Studies in Family Medicine and Primary Care, *The Patient Centered Medical Home*, http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmh.Par.0001.File.dat/PCMH.pdf (Nov. 2007).

[33] Centers for Medicare & Medicaid, *Details for Multi-Payer Advanced Primary Care Initiative*, http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1230016 (July 2010).

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Current Legal Impediments

Although alignment of physicians and hospitals is essential for both to succeed under the new payment and delivery models of health reform, current laws, specifically the Anti-Kickback,[34] Stark,[35], and civil monetary penalties laws (''CMP'')[36] may actually impede efforts to create the business structures necessary under PPACA. The Anti-Kickback law prohibits individuals or entities from offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by any federally funded program.[37] The Stark law precludes physicians from referring for designated health services to any entity in which he/she (or his/her family) has a financial relationship and precludes the entity from submitting a claim from the prohibited referral.[38] The CMP precludes a hospital from directly or indirectly giving, and a physician from receiving, payments as an inducement for reducing or limiting services.[39]

Ironically, these laws that are now impeding efforts to align hospitals and physicians to realize the goals of health reform were first enacted to achieve the exact same results, i.e. reduce costs and ensure that quality care was provided in the best interests of patients. These laws were enacted against the backdrop of the current fee-for-service payment system to prevent financial motives from increasing the utilization of services and eliminating patient choice. Recognizing that the public policy underlying these laws may not apply when physicians and hospitals are no longer reimbursed based on volume, but instead are paid for improved quality, lower cost, and a better patient experience, Congress in the PPACA gave authority to CMS to waive application of these laws to groups of hospitals, physicians and others who come together as ACOs.[40] How this waiver authority will be exercised remains to be seen, and current efforts to align hospitals and physicians still must be guided by these fraud and abuse laws along with other laws.

Current Options for Structuring Hospital/Physician Alignment

While it cannot be disputed that hospitals and physicians must structure their relationship differently to succeed under the new payment and delivery models of health reform, the exact structure they pursue is largely variable and can depend on the unique characteristics of the current relationship among them and the market in which they practice. Thus, there is no right or wrong in selecting the alignment structure to pursue. Given that these new payment and delivery models will be in place by 2012, however, hospitals and physicians need to begin now to select their structure and implement it so they are poised to perform well once these changes become reality. Currently hospitals and physicians remain constrained by the fraud and abuse laws discussed above (along with other laws, such as the antitrust laws), however, a number of legal structures are available today to align physicians and hospitals without running afoul of these laws.

Employment Model

Hospitals may directly employ physicians, provide all of the facilities, equipment and staff to support the physicians' practice, and bill and collect for the physicians' services. Under this highly integrated structure, the hospital is responsible for, and bears the entire financial risk, of the physicians' practice. The physicians are paid by the hospital for all of their professional services, which may include incentives to lower costs and improve quality. The physicians benefit as hospital employees because they have hospital supplied access to all necessary facilities and staff to perform services. The hospital benefits from employing physicians because there is greater ease in meeting regulatory requirements when dealing with employed physicians, rather than physicians in a less integrated structure. Often, employment is preceded by the hospital purchasing the physician's practice, which may or may not include restrictive covenants that keep the physician loyal to the hospital through non-compete agreements, among others.

As applied to the new models of care, employment in and of itself will not result in the health care delivery changes that are required to perform well as an ACO or share a bundled payment, unless the hospital is successful in bringing together a broad group of physicians, employed or not, to redesign care processes to provide evidenced based medicine and to achieve efficiency in providing services. However, employment does provide a legal structure that would allow for payment of incentives to the physicians if the delivery changes can be implemented.

Tax-Exempt Affiliated Entity Model

Rather than the hospital itself employing physicians, a tax-exempt entity affiliated with the hospital may provide physician services for the system, and this separate entity either can employ or contract with physicians or physician groups to provide all physician services for the system. This structure also results in a high degree of integration between the hospital and the physicians providing services through the tax exempt affiliate. Similar to the employment model, the tax exempt affiliated entity typically acquires the physicians' practice to establish the relationship, provides all of the facilities, staff and equipment to support the physicians' practice, and bills and collects for the physicians' services. To establish a tax exempt affiliated entity, certain IRS requirements for exemption must be met which affect the structure of the affiliate's board and the role that the physicians can play in setting compensation and other financial aspects of the affiliate's operations.

The tax exempt affiliate model often is used in states where a strong corporate practice of medicine prohibition prevents the hospital from employing physicians directly (in which case the entity contracts with physicians rather than employing them). However, the model may be used in states where direct employment by the hospital is not prohibited. There are several benefits of the tax-exempt affiliated entity model. First, it can achieve a high degree of alignment between physicians and the hospital while still permitting the physicians a sense of independence and autonomy. It is not uncom-

[34] Social Security Act, § 1128B (b).
[35] Social Security Act, § 1877.
[36] Social Security Act, § 1128A (b).
[37] Social Security Act, § 1128B (b).
[38] Social Security Act, § 1877.
[39] Social Security Act, § 1128A (b).
[40] Social Security Act, § 1899 (f).

mon in this model for the physicians to retain their corporate organization under state law, which organization then contracts with the tax exempt entity through a professional services agreement, although individual contracts and employment where permitted also can occur. Additionally, using a separate tax exempt entity may help separate the malpractice liability for the physicians' professional services from the hospital. Also, the tax-exempt model may make compliance with the CMP easier if the affiliate, and not the hospital, provides the incentive to control costs.[41]

"Pay-for-Quality" Model

The ''Pay for Quality'' structure is based on an Advisory Opinion issued by the Office of Inspector General in 2008.[42] The structure involves the creation of a new legal entity to which all physicians who have been on the hospital's active medical staff in relevant departments for at least one year can join. The entity then contracts with the hospital to provide various tasks and services to improve quality and promote efficiency. Payment to the new legal entity can be based on a percentage of pay-for-performance and VBP dollars earned by the hospital (up to 50 percent) and then distributed to the physician-owners on a per capita basis. Thus, the structure incentivizes a broad group of physicians on the medical staff, whether employed or not, to develop the change in care delivery necessary to improve the hospital's performance under VBP and may serve as the legal structure necessary to support an ACO.

The principal advantage of the structure is that it successfully aligns the financial incentives of a broad group of physicians and the hospital to improve quality and efficiency without requiring the hospital to expend significant capital to purchase multiple physician practices or to assume the financial risk of operating those practices. Indeed, the structure keeps in place the physicians' private practices and aligns the physicians financially with the hospital only as to quality and efficiency, the key focus of the payment and delivery model changes described above. The structure also can be beneficial in that it brings together both employed and non-employed physicians to support the work needed to redesign care processes to promote evidence-based medicine, resulting in improved quality and reduced cost, and can serve as the legal structure necessary to distribute either bundled or shared savings payments as an ACO. The principal disadvantage of the structure is that extreme care must be taken when structuring and operating the entity in order to comply with the fraud and abuse laws discussed above.

Joint Ventures and Physician Hospital Organizations ("PHO")

Joint ventures between hospitals and groups of physicians could be formed to allow common ownership over several physician practices. This would allow the joint venture participants the opportunity to work together to coordinate care and change care processes to improve quality and efficiency. These joint ventures would be subject to the various regulatory requirements that govern the establishment of physician/hospital joint ventures in other contexts and may provide for a high degree of integration without the physicians giving up total control to either the hospital or its tax exempt affiliate. The joint venture model also would allow for the sharing between the hospital and a broad group of physicians of both the risk and reward of performing well under the new models of care and may qualify as the legal structure necessary to distribute shared savings or bundled payments as an ACO. State law, such as the corporate practice of medicine or professional corporation requirements, may limit the ability of hospitals and physicians to jointly own physician practices.

PHOs are a form of hospital/physician joint venture that exists primarily for managed care contracting and physician network development. These organizations also could be used as the vehicle to distribute shared savings or bundled payments as an ACO. PHOs of the past typically do not become involved in the delivery of care and in this regard a PHO likely would need to do more than just contracting and network development to achieve the delivery system changes needed to be successful under the new payment models. However, their use is becoming more common, particularly if they can achieve ''clinical integration'' to allow for collective negotiation of managed care contracts by the participants under the anti-trust laws.[43]

Conclusion

Health reform will bring about significant change to both how providers are paid and how care is delivered. The new structures are focused on rewarding improved quality and reduced cost and will require the development of new legal relationships between hospitals, physicians and other providers across the care continuum. While existing laws create a maze of regulation through which providers must navigate to restructure their legal relationships, the models described above can be developed under the current regulatory requirements. Creating these new legal relationships now is essential if hospitals and physicians are to succeed once the new payment and delivery models become effective.

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[41] The CMP law only applies to *hospitals* that directly or indirectly pay to reduce or limit services. Therefore, it arguably may not apply if an entity other than the hospital provides the incentive without involvement by the hospital.

[42] Office of Inspector General, *OIG Advisory Opinion No. 08-16*, http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-16A.pdf (2008).

[43] U.S. Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 8, http://www.justice.gov/atr/public/guidelines/0000.htm#CONTNUM_61 (Aug. 1996).

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