

# The ABCs of Accountable Care Organizations

By Bryan A. Liang and Tim Mackey

With the passage of health care reform, the future of provider organizations is now in flux. Efficiency is the keyword as new regulations are drafted and funding for demonstration projects is put into place. One approach contemplated by reform in this vein is the use of accountable care organizations (ACOs).

Health care reform is focused on cost control, especially in the government's Medicare and Medicaid programs. High variability in regional spending and failure to slow growth and expanding ranks of those within these programs fueled by the baby-boomer generation and the poor economy has created an unsustainable pace of cost increases. In combination with expanded insurance access under reform, the result is that millions of previously uninsured people at a cost of \$1.2 to \$1.5 trillion over the next decade will be added to patient care systems.

Yet the current, traditional fragmented fee-for-service payment model under Medicare and private insurance programs does not support coordinated care that is cost effective or high quality. Under fee-for-service, financial incentives may result in overutilization, waste, and a focus on care provision at the individual practitioner level, as well as fragmented care and penalizing improvements in care efficiency due to fewer reimbursement opportunities. This leads to lack of coordination and faulty transitions that are adverse to patient care. Provider integration is hence the primary approach to achieve efficiency under reform.

This is where ACOs come in. The use of ACOs, consisting of connected providers collectively held accountable for cost and quality of care, has been widely discussed. ACOs provide for shared responsibility and coordinated care utilizing different payment methods including modified fee-for-service payments, or a partial capitation based on patient populations to provide appropriate incentives to providers.

ACOs would have patients assigned to it by public or private payers and provide primary and multi-specialty care. As outlined by current proposals, an ACO would have at least one hospital, a minimum of 50 primary care and specialist physicians, commit to be in service for at least three years, and serve a minimum of 5,000 patients. Meeting these pre-set quality goals would make it eligible to receive incentive payments, as well as potential penalties assessed if goals are not met. Incentive payments and penalties would be split between the members of the ACO.

This new type of provider class will allow the Centers for Medicare and Medicaid Services (CMS) to shift its purchasing actively to cost efficient and high quality integrated health care systems rather than its passive role as a claims payer under Medicare Parts A/B and/or a certifier of Medicare Advantage programs. This could modernize CMS into a value-based purchaser and incentivizer of positive provider behavior. Thus, the potential of ACOs is tremendous: to provide physicians and hospitals with an appropriate infrastructure to render coordinated, high quality, evidence-based patient care that emphasizes efficiencies through technology while eliminating unnecessary costs and procedures. Studies show that cost savings of \$300 — \$400 per patient year may be realized. The enactment of the HITECH Act has also helped incentivize adoption of information technology crucial to effective integrated delivery of care.

ACOs will be eligible to share in Medicare cost savings beginning 2012. In preparation, providers will need to create separate legal structures responsible for care that will receive payments and provide



compensation, operate through an integrated provider network, demonstrate quality improvement and performance reporting, and use health information technology.

To position themselves effectively for ACOs, physician groups may need to retool. Entities already employing an integrated structure, such as physicians in foundations or employed in academic departments, will have an advantage in creating or participating in ACOs. Physicians in smaller private practices must assess these new structures and determine how to begin the process of integration — and, in fact, competition — for patients who may be drawn, enrolled in, or assigned to ACOs.

ACO formation will require express attention to legal issues. One significant early issue is structure, which requires ACOs to be separate legal entities, with ownership and more importantly, governance, shared between hospital and physician representatives. This relationship and investment, including a robust information technology system, must be appropriately designed so that corporate and privacy issues under state and federal law are appropriately addressed, and clear divisions of responsibility and security are put into place.

Operationally, ACOs would likely have a separate administrative staff that establishes protocols, while organizing and assessing patient care on inpatient and outpatient levels. The ACO as a separate entity would identify, integrate, and align the interests of physicians, other providers, and hospitals. In addition, ACOs would take on financial risks, and ultimately distribute profits to contracting partners and cover ACO administrative costs. This

set of ACO roles — broker, negotiator, program administrator, and others — should also be carefully addressed in shared governance and regulatory perspectives within bylaws or through adopted policies.

Other operational legal issues will need to be addressed at both the federal and state levels. First, ACOs may be subject to prohibition of the corporate practice of medicine in the state. Hence, crafting relationships in California will require substantive attention to this issue as current legislative initiatives offer limited relief for direct hospital/physician integration through employment. Existing legal structures such as medical foundations, hospital-based clinics and joint venture management service organizations have been utilized to encourage physician integration and may translate to ACOs.

In addition, fraud and abuse laws are also implicated in ACOs. For example, the Anti-Kickback Statute/Civil Monetary Penalty Law and the Stark Self-Referral Prohibitions may be involved in ACO operations. Since efficiencies/profits from hospital and physician payments will be shared between ACO providers; such split payments may represent illegal kickbacks based on earlier interpretations of the Anti-Kickback Statute. Further, the wide array of services covered under ACO bundled payments may represent prohibited self-referral to the ACO-owned entity by those with an ownership interest — i.e., physicians and hospitals. ACOs and their providers will likely have to negotiate contracts based on quality measures or outcomes, under temporary pilot programs, or under previously accepted profit-sharing models such as the narrow gainsharing or “pay for performance” program guidance noted in advisory opinions.

Further, federal antitrust laws may be involved when any integration of separately acting groups is possible. In *Arizona v. Maricopa County Medical Society*, the U.S. Supreme Court held that non-integrated medical care associations that set fees charged to insurers constituted *per se* violations of the Sherman Act. This led to Department of Justice and Federal Trade Commission's creation of antitrust “safety zones” and expanded protection for “clinical” integration under a rule of reason analysis. Hence, for ACOs, an emphasis on establishing quality and efficiency improvements is an important method to justify clinical integration necessary to avoid antitrust liability.

Finally, attention to nonprofit status is important when relevant, particularly with increased scrutiny of providers, such as the recent Illinois Supreme Court ruling that rejected tax exempt status for Provena Covenant Medical Center. In particular, if a nonprofit hospital is considering integration with a for-profit physician group, issues of private inurement under the tax code must be addressed. Further, any potential profit-motive for the nonprofit entity should be anticipated to ensure that exempt status is not affected by ACO participation.

The future landscape for health care providers, patients, and government has many unknowns. However, one area of continued focus is rising costs. ACOs represent an emerging model to attempt to stem these cost increases while improving efficiency and quality. Ensuring that ACO legal concerns are seen, understood, and then hopefully addressed may allow the goals of health care reform to begin to be accomplished.

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# Justice-Involved Veterans: A Mounting Social Crisis

By Guy Gambill

In May 2008, national veterans advocates met with medical professionals, justice and legal professionals, active duty military personnel and federal staff to discuss growing concern about the number of veterans, many with trauma-related health issues, who were coming into contact with the justice system. Hosted by the National GAINS Co-Occurring Disorders and Justice Center, the convening resulted in the creation of a brief, “*Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions*.” The development of this brief couldn't have been more timely. Within six months, six state veterans' jail diversion pilots were launched. Since then, another 12 federally-funded state jail diversion efforts that preference veterans have been created.

What justifies the increasing attention to justice-involved veterans, featured so often in public media over the past few years? From a statistical-historical standpoint the issue first rose to the surface of public attention in 1985; in that year, the National Vietnam Veterans Readjustment Study (NVVRS), which was mandated by Congress and implemented by the Vietnam Veterans of America, surveyed a large and

representative sample of Vietnam veterans. This study yielded a wealth of information on a broad range of social markers that today we would categorize under the heading “readjustment factors.” The NVVRS noted that 11 percent of all surveyed had been convicted of a felony, while 34.2 percent had been arrested for a misdemeanor offense. Though it was not released publicly until 2000, the Department of Justice, Bureau of Justice Statistics (DOJ-BJS) report, “*Veterans in Prison or Jail*” noted that in 1985, 21 percent of all men in prison were veterans — a total of 154,600. By 1998, that number had risen to 225,700.

The DOJ-BJS 1985-1998 statistical portrayal was sound, with one critical exception: the press release that accompanied the report stated there was “no significant difference between incarceration rates amongst veterans and the general population.” While the percentages are roughly the same, this does not take into account that the military selects against many of the factors that are correlated with justice involvement, such as a history of mental illness, a prior criminal record, and drug abuse. All else being equal, one would expect veterans to have less justice involvement. Also, as noted in both the 2000 DOJ-BJS report and in the follow up to that in 2007 (which added additional information through 2004), an exceedingly high percentage of men who served in Vietnam had justice contact. The 2007 report noted that already 4 percent of all inmates were Iraq or Afghanistan veterans, although at that point in time (2004), few Americans had served in those conflicts and even fewer had returned to civilian life.

Understanding the scope of involvement by veterans in the justice system has proven to be a challenge. Without knowing whether someone is a veteran at the time of arrest or incarceration, it is difficult to formulate effective programs and policies. The Federal Data Privacy Act was passed in 1968 (and amended in 1972) at a time in our national history when many veterans were ambivalent about their status as such. The Act created rules regarding the gathering, maintenance and dissemination of veterans' information. Corrections and law enforcement agencies often did not gather information on veterans as a result. For example, in the state of Minnesota, only two out of 87 counties ask at point of booking about veterans status or military service. As a result, isolated snap-shots in time must be used to estimate the scope of the issue of veteran justice involvement. Travis County (Austin), Texas, for instance, which has a population of about 100,000, issued a report indicating that in one 90-day period of 2008, 454 veterans were booked into the county jail.

Through what data we do have, as well as the “anecdotal” information from around the country, it's clear that the problem of veterans returning home only to end up behind bars is colossal — and getting worse. While the next national survey on the part of DOJ-BJS is not due until 2013, we cannot wait until then to take steps to reduce the number of veterans who, primarily as a result of post-traumatic stress disorder, chemical addiction and other problems related to their combat service, are engaging in behaviors that culminate in contact with the justice system.

I am often asked how, as it relates to becoming justice-involved, Iraq and Afghanistan veterans compare to those from previous conflicts. I believe the numbers of justice-involved veterans from these current wars will exceed those of Vietnam. This is partially due to changes in sentencing: in 1985 we did not yet have many of the current domestic abuse statutes, enhancements for drug offenses, mandatory minimums, zero tolerance or an array of firearms possession charges.

Other factors or considerations are also of great import. The minority composition of the Army in Vietnam hovered around 20 percent or less of the total. Today's Army is comprised of over 40 percent soldiers of color. Persistent racial disparities, specific cultural characteristics (the high resistance on the part of African-American men to seeking mental

healthcare, for instance), and the lack of mental health and justice professionals of color who understand veterans issues does not bode well for the future. The unprecedented use of the National Guard and Reserve, the nature of the conflicts where our soldiers are serving, and the difficult economic climate to which our military are returning all play a role.

The current approaches to this issue — The Veterans Courts and Justice Initiatives — were borne from a broad national recognition that we inappropriately responded to large numbers of veterans during the Vietnam era in a punitive or reactive manner (the criminal justice system) when a set of supportive and preventative responses (a public health approach) would have proven far more effective. By now focusing on the public health approach, the hope and expectation is that we will not generate large numbers of veterans who tumble through multiple systems for decades, facing not only incarceration but homelessness, poverty and social isolation.

However, the emerging model derives out of the Miami-Dade Drug Court model. Most veterans courts limit participation to non-violent offenses alone; not surprisingly, given the manifestations of Post Traumatic Stress Disorder, this eliminates many veterans. It is my belief that eligibility for veterans court programs should not be based on category of crime, but upon whether a service-related mental health disorder was at the root of the offense.

Currently, all of the veterans courts are post-plea. What veterans advocates and the public are led to believe is that if a participating veteran successfully completes all the court requirements, the court will erase the justice record. That is simply not true and, in my opinion, a real disservice to the veteran. In this age of data-harvesting, an arrest record never really goes away. And as we've seen with drug courts, the natural process of relapse and recovery can cause a person to “fail” the court, and then end up with a conviction that, through true diversion or the regular judicial process, he might have avoided.

Unfortunately, the recommendations of those who understand this issue in an experiential and professional sense are often not heeded. In the GAINS brief mentioned earlier, one of the five recommendations regarded building capacity for peer services. I believe this is the single most important piece in reducing veteran justice involvement. Despite all of the well-meaning professionals involved, without peer involvement beginning from the first day back on U.S. soil, we will surely end up with a scenario every bit as bad as that of the post-Vietnam era.

What might be the most lasting impact of the 2008 convening was that it brought together a wide

variety of individuals who had led efforts within their respective states or, at the federal level. At that time, one could find very little activity at either federal or state levels with regard to justice-involved veterans. At this juncture, over 30 states have some type of legislation underway addressing one or more aspects of the problem — and a growing number of veterans advocates are gathering in support of Vets Court legislation in the state of California.

Without a doubt, we have a long way to go to create a truly comprehensive response to veterans returning from combat. Whatever resources it will take to come up with that response, though, will certainly be less than those that will be expended — in our criminal justice system and elsewhere — if we do nothing.

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