Health System Reform:  
AN IMPLEMENTATION CHECKLIST  
FOR HOSPITALS  

Prepared as a Desktop Reference for Senior Management
In the months since the Patient Protection and Affordable Care Act (PPACA) was enacted, organizations have been inundated with law and consulting firm client advisories, articles and seminars—all focused on summarizing the new health care reform law. But to what extent have those articles and seminars provided a clear plan of action and said clearly, “Do this”?

This document provides that action plan. McDermott Will & Emery health lawyers—the team recently ranked “Health Team of the Year” by Chambers USA—have prepared this publication to help hospital and health system executives make sense of the new health care reform law, and translate it into specific action steps for their institution.

The following checklist provides hospital and health system executive leadership with concise implementation recommendations to address each of the key themes of the health care reform law: fraud and abuse enforcement, insurance reforms, reimbursement, employment matters, tax-exempt status, information technology, corporate governance and, especially, strategic alliances.

Ultimately, the checklist is intended to serve as a “yardstick” by which hospital and health system executives can measure their progress in responding to health system reform changes.

A yardstick from which to measure the effectiveness of the hospital’s response to reform.

Please visit http://www.mwe.com/info/healthreformchecklist/ to access the online version of the checklist, which contains links to the complete McDermott Health Law Reform library. The library includes additional resources on each separate theme covered in the Checklist, and contact information for McDermott lawyers who specialize in these topics.
Tax Exempt Status

ACT SECTION 9007(a)

SUMMARY

The Act amends the Internal Revenue Code (IRC) by adding new Section 501(r), which imposes additional requirements that hospitals and other organizations whose operations include hospital operations must satisfy in order to continue to meet the standards for tax exemption under Section 501(c)(3). The additional requirements imposed on a hospital by new IRC Section 501(r) include those relating to (a) periodic conduct of a “Community Health Needs Assessment” and the adoption of an implementation strategy to meet the needs identified in the Assessment; (b) establishment of a financial assistance policy and a policy relating to emergency medical care; (c) limitations on amounts charged for emergency care provided for individuals eligible for assistance under the hospital’s financial assistance policy; and (d) foregoing extraordinary collection practices against individuals until the hospital has made reasonable efforts to determine whether an individual is eligible for assistance under the hospital’s financial assistance policy.

IMPLEMENTATION RECOMMENDATIONS

1. Brief the appropriate internal board committees (e.g., audit, finance, compliance) on the significance and scope of the new requirements and on the oversight obligations necessary to achieve compliance.
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<tr>
<td>2.</td>
<td>Identify which entities and/or which parts of entities are subject to the new requirements. Section 501(r) applies to any organization described in Section 501(c)(3) that operates a facility that is required by a State to be licensed, registered or similarly required to be licensed as a hospital whether or not the operation of the hospital is its primary purpose or function. Thus, for example, Section 501(r) applies to a university that may directly own a hospital or a church that may operate a facility licensed as a hospital.</td>
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<td>3.</td>
<td>Once each hospital (which can either be a small division of a larger entity or a freestanding entity) is identified, conduct a comprehensive review of that hospital’s operations for compliance with the new requirements.</td>
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<td>4.</td>
<td>For each hospital, review the existing financial assistance policy for compliance with the Act and determine whether such policy is made “widely available” as now is required, under the PPACA, such as by posting the policy on the hospital’s website.</td>
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<tr>
<td>5.</td>
<td>For each hospital, review the manner in which charges are determined for emergency and other medically necessary services provided to patients who qualify under the hospital’s financial assistance policy. Determine the hospital’s “lowest hospital charge” for purposes of complying with the new financial assistance policy requirements. (Note: this determination may be more difficult than it first appears). [Section 501(r)(1)(C)]</td>
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<tr>
<td>6.</td>
<td>For each hospital, review existing billing and collection arrangements and procedures for consistency with new requirements, especially the “reasonable efforts” standard which is thus far undefined in the new law. [Section 501(r)(1)(D)]</td>
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<td>7.</td>
<td>Develop and maintain internal protocols for ensuring continued compliance with new requirements and review existing policies for consistency with same.</td>
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### Tax Exempt Status

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<td><strong>8.</strong></td>
<td>If specialty services (e.g., a cancer center), ambulatory surgery centers, outpatient departments or other service lines are operated under the hospital license, determine whether they are compliant with the new requirements.</td>
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<tr>
<td><strong>9.</strong></td>
<td>Begin an identification process for internal and external resources to provide a community needs assessment to each hospital, which will be required under Section 501(r) for tax years beginning after March 23, 2012. [Section 501(r)(1)(A)]</td>
</tr>
<tr>
<td><strong>10.</strong></td>
<td>Monitor the development and release of guidance from the Internal Revenue Service and the Department of Treasury, and adjust the policies and procedures accordingly and as needed.</td>
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**ADDITIONAL RESOURCES**
**Corporate Governance**

**ACT SECTIONS**

N/A

**SUMMARY**

The Act, with its broad-ranging changes to the health care financing system, presents hospital and health system governing boards with a significant fiduciary challenge. These boards will be expected to appropriately familiarize themselves with relevant provisions of the Act in order to be well positioned to advise executive management on Act-related strategic opportunities and challenges; and exercise oversight with respect to organizational response to the Act’s requirements.

**IMPLEMENTATION RECOMMENDATIONS**

1. Use health care reform as an opportunity to emphasize the board’s core role of providing strategic advice and direction to executive management.

2. Conduct in-depth PPACA briefings on the implications of health care reform to hospital and health system boards and key committees, with a special focus on related enterprise risks and opportunities. Provide periodic updates as developments mandate.

3. Evaluate possible board structural changes—including the alteration and/or expansion of committee structure and charters—prompted by the PPACA (e.g., the addition of a “Strategic Alignment” committee).

4. Evaluate possible board composition changes (e.g., adding members with unique skill sets, possible increasing board size) prompted by the PPACA.
## Corporate Governance

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<tr>
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<th>Assignment</th>
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<tr>
<td>5.</td>
<td>Assign oversight of specific PPACA issues to board committees with appropriate expertise and charters (e.g., those with responsibility for strategic planning, enterprise risk management, finance, physician integration, compliance, executive compensation, quality of care and nominating/governance).</td>
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<tr>
<td>6.</td>
<td>Monitor unique conflicts of interest arising from the participation of physician board members in board discussions of confidential corporate opportunities involving strategic alignment.</td>
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<tr>
<td>7.</td>
<td>Work with executive management to determine the appropriate information flow to the board on health care reform developments (both internally and externally), including competitive marketplace developments.</td>
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<tr>
<td>8.</td>
<td>Develop governance-level management tools to position the board to exercise oversight of, and to evaluate, organizational reform initiatives.</td>
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**ADDITIONAL RESOURCES**
SUMMARY

The Act includes many significant anti-fraud and Medicare/Medicaid program integrity initiatives, including, but not limited to:

- **Transparency requirements:** Drug and device companies must publicly report payments to teaching hospitals and physicians. Although the term “teaching hospital” is not defined, presumably it will include any hospital with an approved residency training program. Even if a hospital is not a teaching hospital, financial ties between medical staff members and drug and device companies can have clinical care conflict of interest implications for the physicians and the hospital.

- **Revisions to principal federal anti-fraud laws:** Program integrity initiatives under the Act are intended to eliminate improper federal expenditures and preserve federal health care program assets for other reform initiatives.

IMPLEMENTATION RECOMMENDATIONS

Determine whether information about the institution or its physicians will be reported by drug and device companies under the “Sunshine” provisions of the Act and the collateral effect on institutional conflict of interest standards and guidelines relating to relationships with drug and device manufacturers.

1. All hospitals should consider establishing policies that appropriately limit the relationships medical staff physicians may have with drug and device companies even if they are not teaching hospitals. In doing so, they should...
address the challenges presented by imposing such requirements on all members of the medical staff, even if they are not employed, particularly with respect to annual and periodic reporting of the details of financial interests.

b. All hospitals should review their conflict of interest policies and revise them as necessary to require internal reporting of vendor relationships for the purposes of determining whether, even if permitted under the vendor relationship policies, they will give rise to conflicts in research, medical education or clinical care. Consideration should be given to using value and ownership percentage thresholds for reporting that are more conservative than those historically used.

c. Teaching hospitals should establish a mechanism for identifying and assessing their own institutional relationships with drug and device companies. Emerging conflicts of interest standards suggest that other hospitals would be well served to do the same.

d. Hospitals should confer with leading vendors concerning the form and content of the public disclosure they will use for complying with the “Sunshine” provisions so that, to the extent possible, the hospitals’ own internal records will be consistent with those disclosures. A lack of consistency can raise doubts as to the accuracy and completeness of a hospital’s conflict of interest reporting program and increase enforcement risk. This will be particularly important for hospitals that choose voluntarily to publicly report vendor relationships.

2. Adopt new (or revise any existing) policy requiring prompt reporting and repayment of any Medicare/Medicaid overpayment. Failure to return an overpayment within 60 days after identification of the overpayment gives rise to False Claims Act liability.
### Fraud and Abuse

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<th>Ensure the compliance program includes the review and monitoring of Medicare and Medicaid enrollment issues for all entities in the system.</th>
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<td>4.</td>
<td>Brief the Compliance Committee on the Anti-Kickback Law and False Claims Act enforcement implications of the Act and the new requirements for different system entities (e.g., home health, durable medical equipment (DME), skilled nursing, physician). Use the Act as an opportunity to review with the Compliance Committee the scope and purpose of the Anti-Kickback Law and False Claims Act.</td>
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<td>5.</td>
<td>Working with counsel, review the liability profile of any hospital-physician transactions where the approving anti-kickback legal opinion was based on application of the Hanlester intent standard articulated by the U.S. Court of Appeals for the Ninth Circuit. The Act effectively overrules that standard and provides that a person need not have actual knowledge of the Anti-Kickback Law or specific intent to commit a violation of the Anti-Kickback Law.</td>
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<td>6.</td>
<td>Brief the Compliance Committee on the new Stark Self-Referral Disclosure Protocol and determine if there are any transactions appropriate for self-disclosure.</td>
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<td>7.</td>
<td>If not already completed, revise the corporate compliance program to incorporate those changes to compliance officer-reporting protocol and remediation activity recommended by the April 2010 amendments to the Federal Sentencing Guidelines.</td>
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**ADDITIONAL RESOURCES**
Insurance Reforms

**SUMMARY**

The Act significantly reforms the health insurance market by establishing new requirements related to underwriting, scope of benefits and rating requirements for health plans and health insurers. Provisions of the Act that may affect hospitals in the near term include the Medical Loss Ratio (MLR) requirements (80 percent for small-group and individual markets and 85 percent for large-group markets) applicable to health insurers and the premium rates they charge. In addition, there will be a fairly immediate expansion of coverage to include dependents up to age 26, the elimination of pre-existing condition exclusions for children and the creation of a temporary insurance program by the secretary for uninsured people denied coverage due to pre-existing conditions. In addition, with respect to emergency services, health plans that do not have grandfather status must provide emergency services coverage without the need for prior authorization, and the cost sharing required by the health plan must be the same requirement for emergency services rendered regardless of the hospital’s participation status.

From a longer term perspective, Medicare Advantage payments to health plans will change whereby high quality plans will be eligible for incentive payments beginning in 2012. An MLR standard of 85 percent will be applied to Medicare Advantage health plans as well.
Other longer term issues in the private insurance market include the creation of state-based insurance exchanges for 2014, in which health insurers will compete. Guaranteed issue and guaranteed renewal of insurance coverage will be extended to the entire private insurance marketplace at this time.

**IMPLEMENTATION RECOMMENDATIONS**

1. Evaluate current data and information systems which help track quality and efficiency of health care services as health plans will need to align themselves with hospitals that have these capabilities.

2. Consider new strategic initiatives with health plans that may now need to gravitate to a more select group of providers in order to better manage health care costs and improve quality.

3. Review payment arrangements and administrative capacities to carry out certain health management and quality improvement functions as these arrangements may have an effect on how health plans report and satisfy the new MLR standards.

4. Be prepared to participate in new payment arrangements with health plans that focus on the importance of managing the costs of health care while improving quality outcomes.

5. Consider alternative approaches with health plans in fostering the appropriate use of the hospital’s emergency room services.

6. Analyze the economic impact of how current gaps in coverage are being filled by both private insurers and state high-risk pools between now and 2014.

**ADDITIONAL RESOURCES**
Reimbursement

SUMMARY
A major priority of the PPACA is to incentivize hospitals to improve quality. Beginning as early as 2012, Medicare payments to a hospital will be adjusted, in some cases significantly, based on the hospital’s performance on various quality measures and in comparison to its peers. Hospitals should take steps now to prepare for these changes.

IMPLEMENTATION RECOMMENDATIONS

1. Evaluate the hospital’s Medicare quality measure reporting performance and performance on the quality measures themselves compared to other hospitals. Based on this self-analysis, develop a reporting and performance improvement plan to ensure flawless reporting before Medicare implements a value-based purchasing program.

2. Evaluate the hospital’s policies and procedures designed to minimize readmissions, as well as the hospital’s readmission statistics. Compare readmission rates to peer benchmarks and model Medicare reimbursement implications of readmission performance. Revise policies and procedures to minimize readmissions as necessary.

3. Evaluate the hospital’s acquired-condition statistics and payment penalties, especially as compared to peer hospitals. Evaluate and revise policies and procedures to minimize acquired-condition rates.

4. If the hospital employs physicians, evaluate their quality measure reporting performance and performance on the quality measures themselves compared to other physicians. Develop plans to improve physician performance.

5. If the hospital system includes other non-hospital provider types, such as skilled nursing facilities, long-term care hospitals and ambulatory surgery centers, evaluate their quality reporting capabilities, and consider integrating their quality measurement systems with those of the hospital. Consider alliances with other providers or management companies that can add critical expertise.

ADDITIONAL RESOURCES
SUMMARY

The Act places many new mandates on employer-sponsors of health benefit plans and will require virtually every employer, including hospitals, to re-evaluate its health benefit plan design and administration in light of these new requirements. The provisions of the Act that will have the greatest impact on employer plan sponsors are insurance market reforms and whether to maintain status as a grandfathered health plan; the Early Retiree Reinsurance Program; tax reform in the area of health care flexible spending accounts and the elimination of the Medicare Part D retiree drug subsidy deduction; new reporting and disclosure obligations to the U.S. Departments of Health and Human Services (HHS) and Labor (DOL) and the Internal Revenue Service; and the implementation of new pay-or-play mandates and penalties in 2014.

IMPLEMENTATION RECOMMENDATIONS

1. Evaluate current plan design to determine what changes are required to comply with the short- and long-term market reforms, such as coverage of adult dependent children to age 26, removal of annual and lifetime limits on essential health benefits, removal of preexisting condition exclusions, first-dollar coverage of preventive care services, and enhanced internal and external claims and appeal procedures.

2. Analyze whether to maintain status as a grandfathered health plan and what impact that will have on the employer's future ability to make changes to plan design, change insurance carriers or implement new cost-sharing features under the plan with regard to co-payments, coinsurance, out-of-pocket maximums and premium increases.
### 3. Update plan documents, summary plan descriptions and open enrollment materials to incorporate the new market reform benefit mandates and make other participant-required disclosures, such as special enrollment opportunities for adult dependent children.

### 4. Evaluate whether to participate in the Early Retiree Reinsurance Program; enter into agreements with vendors necessary to disclose claim information to HHS and evaluate how program reimbursements will be used.

### 5. Evaluate whether to continue to maintain a retiree prescription drug program and how to plan for the elimination of the deduction of the Medicare Part D retiree drug subsidy.

### 6. Evaluate changes required to be made to health care flexible spending account plans and amend plan documents and employee communications accordingly.

### 7. Analyze the affect of pay-or-play mandates on employers and taxes on Cadillac plan designs, and how to best strategize and implement plan design changes to minimize the tax impact on the employer.

### ADDITIONAL RESOURCES
Health Information Technology

ACT SECTIONS

1311
2702
2717
2718
3001
3002
3011
3012
3021
3023
3501
3502
6301

SUMMARY

Having a health information technology (HIT) infrastructure to support the coordination of care, quality measurement and reporting, and new payment models is clearly a key ingredient in PPACA’s recipe for health care reform. An HIT infrastructure that supports PPACA’s reform elements will also be a valuable resource for conducting streamlined biomedical research and, ultimately, for adapting to the slow and steady movement toward the delivery of personalized medicine. Accordingly, all stakeholders should move swiftly and deliberately to build a solid HIT foundation for responding to PPACA, either on their own or through public and private collaborations.

IMPLEMENTATION RECOMMENDATIONS

1. Evaluate the capacity and capability of the hospital’s current HIT infrastructure to support robust quality measurement, analytics and reporting, care coordination and alignment of incentives under new payment and reimbursement models.

2. Accelerate electronic health record (EHR) system implementation and integration in both the acute and ambulatory care settings. Take the following key considerations into account in developing an EHR strategy:

   a. The current flexibility under fraud and abuse laws to donate EHR technology items and services to physicians.
### Health Information Technology

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<td>b.</td>
<td>Financial incentives available under the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act for meaningful use of certified EHR technology.</td>
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<tr>
<td>c.</td>
<td>Health information exchange initiatives under development at community, regional and state-wide levels.</td>
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<tr>
<td>d.</td>
<td>The prospects for leveraging an EHR system for the development of robust information repositories.</td>
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3. Become familiar with Health IT Regional Extension Centers in the areas that have received federal funds to support physician implementation of EHRs, and educate the hospital’s affiliated medical staff members on the availability of these programs.

4. Supplement EHR system infrastructure—at least for the short-term—with available quality and reporting capabilities currently available on an Application Service Provider and other subscription-type basis.

5. Explore opportunities to outsource certain aspects of the HIT infrastructure strategy, development and implementation.

6. Anticipate and explore opportunities to collaborate with others (e.g., other hospitals and health systems, state governments, universities) in order to leverage the hospital’s human and capital resources, to reduce the learning curve and to accelerate the transition to an optimal and sustainable HIT infrastructure.

## ADDITIONAL RESOURCES
The Act imposes significant Medicare and Medicaid cuts (estimated at $330 billion) and authorizes a number of initiatives designed to shift the payment system from traditional fee-for-service (FFS) to budgeted (e.g., shared savings, bundled payments based on episodes of care, capitation) or value-based (e.g., pay-for-performance) payment models. Successful performance under these payment reform initiatives will be a provider’s best bet to offset these painful cuts. At the heart of the payment reform initiatives are accountable care organizations (ACOs), which are intended to integrate hospitals and physicians into single health care delivery systems that can be held clinically and financially accountable for the continuum of care provided to Medicare beneficiaries. Many non-governmental insurers are anticipating, or are likely to follow, these federal experiments in the financing and delivery of health care services.
GENERAL MARKET DRIVERS

Even before the introduction of ACOs, many health systems, planning for the projected dramatic growth in the Medicare population, were undertaking a strategic assessment of their Medicare margin (or lack thereof). While Medicare provided coverage to 43.3 million seniors in 2000, baby boomers will cause this number to nearly double to 78 million by 2030. At present, many hospitals lose money on Medicare patients and make up the shortfall on privately insured patients. The ability of private insurers to continue to absorb “cost shifting” of this magnitude is doubtful. To remain competitive and financially viable in this new environment, hospitals and health systems will need to be able to make a “margin from Medicare” by bending the cost curve downward and raising quality through achieving measurably positive outcomes and efficient care. The objective is to be able to provide “accountable care” rather than to just become an ACO as technically defined in the Act.

KEY CONCEPTS

1. Don’t wait to decide whether your system will be an ACO for purposes of contracting with Medicare in 2012. Certain kinds of critical analysis and operational changes will be necessary regardless of this decision. Now is the time to begin the ACO assessment, planning and implementation process.

2. Consider the functional, operational and cultural changes necessary to make your system “accountable.” These will not be found in any “cookbook” -- one size will not fit all.
UNDER THE ACT, ACOs MUST:

- Have defined processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.

- Enter into at least a three-year agreement with HHS and have at least 5,000 Medicare beneficiaries, without engaging in risk selection (e.g., avoiding sicker patients).

- Demonstrate that it meets defined criteria for “patient-centeredness,” including use of individualized care plans and patient and caregiver assessments.

- Be accountable for the quality, cost and overall care of the Medicare FFS beneficiaries assigned to the ACO.

IMPLEMENTATION RECOMMENDATIONS

Conduct a “gap analysis” of the hospital’s readiness to become, or to become part of, an effective ACO within the next two to three years. ACOs are not “PHO (Physician-Hospital Organization) version 2.0.” Learn from past experience to avoid the financial, operational and cultural obstacles to the rendering of “accountable care.”

1. Perform the key elements of a gap analysis, which are:

   - Clinical: Do you have all of the necessary ACO clinical components (e.g., hospitals, physicians, long-term care, home care, etc.)?

   - Infrastructure: Do you have all of the necessary ACO infrastructure components (e.g., interoperable HIT system, etc.)?

   - Financial: Do you have the financial resources necessary to fund the clinical and infrastructure ACO components described above?

   - Data Capture and Reporting: Do you have, and can you capture, report and analyze performance metrics, including patient satisfaction, quality measurement and improvement, best practice and evidenced-based medicine protocols, and chronic disease management?
**Strategic Alignment**

- **Payment Models**: Can you operate efficiently under payment models other than FFS, per diem or diagnosis-related groups?

- **Existing Alignment Models**: Have you surveyed and evaluated your existing and planned alignment models? Do these models support the system’s development into a fully integrated clinical organization capable of providing accountable care?

- **Physician**: Do you have the governance and management infrastructure to effectively operate an employed or leased physician division as a co-equal component with the systems’ hospital division, capable of working together to provide horizontally aligned, clinically integrated accountable care?

- **Access**: To the extent you do not have such components and/or resources, can you acquire them (or obtain access to them) by means of affiliations, purchases or contractual arrangements?

3. Under the guidance of a special board-level Strategic Alignment Committee, develop and implement a plan to create or join an ACO. Engage all stakeholders in the process, including physicians, other health professionals and providers, area employers, third party payors and patients.

4. Determine which of the following payment models the ACO will have the ability to participate in effectively (including Medicare ACO models):

- **Shared Savings**
  - All of the physicians and facilities treating the ACO’s assigned Medicare population are paid on a traditional FFS basis.
  
  - The ACO receives a share of the savings that Medicare realizes with respect to cost benchmarks established by the Centers for Medicare & Medicaid Services for the ACO’s assigned Medicare population if the ACO meets quality performance metrics and exceeds the cost reduction benchmark.
  
  - The ACO distributes the shared savings payment to its participating physicians and facilities.
• **Partial Capitation**
  - The ACO assumes financial risk for some, but not all, of the Part A and Part B services furnished to the ACO’s assigned Medicare population.
  - The ACO is paid a risk-adjusted per-beneficiary, per-month payment for the capitated services.
  - Those Part A and Part B services not covered by the partial capitation payment are paid on a traditional FFS basis.
  - The ACO presumably passes the risk and capitation payment through to its participating physicians and facilities who manage the utilization and quality of the capitated services.

• **Bundled Payment/Episode of Care**
  - The Act mandates a pilot program, based upon providing a single payment for all physician and facility services rendered during an episode of care involving hospitalization.
  - The length of an episode of care includes three days prior to hospitalization, the length of the inpatient stay and 30 days post-discharge.
  - The secretary of HHS must select up to 10 clinical conditions for this pilot program.
  - There are no requirements to date as to how an ACO would redistribute the bundled payment to participating physicians and facilities.

Determine whether the ACO will contract with private insurers and include independent, competing providers. If the latter, determine:

• The implications of the concentration of providers through the ACO in each relevant product and geographic market.

• Whether competing providers are sufficiently integrated through the ACO, financially and/or clinically, within the meaning of the antitrust laws.

• Whether joint contracting with private payors is reasonably necessary to achieve the pro-competitive purposes of the ACO within the meaning of the antitrust laws.
6. Do not wait for the anticipated ACO regulations to become effective. Medicare, Medicaid and many HMOs, PPOs and other insurers, including self-funded employers and union health and benefit funds, will want to contract with ACOs.

- Immediately begin creating or converting existing managed care integrated delivery systems (e.g., PHOs, other contractual risk-sharing and/or care management arrangements) to establish an ACO.

- Use the next few years to build the HIT and other managed care infrastructure necessary to thrive—not just survive—during upcoming payment reform.

In short, when the music stops in your local market’s game of affiliation musical chairs, will you have a seat, or be sitting on the floor looking up at the winners?

ADDITIONAL RESOURCES
Hospital-Hospital Alignments

SUMMARY
The PPACA has fundamentally changed the future operating landscape for hospitals, health systems and academic medical centers, prompting them to re-examine their strategies for achieving their core missions. In this new environment, institutions are re-evaluating whether they have the size, scale and market position to meet the new demands that will be imposed upon them as health care reform is implemented. In doing so, many have recognized that growth and scale are critical to meeting the new cost, quality and reporting obligations that will be imposed upon them. In light of this, an increasingly important aspect of an institution’s strategy will be the active consideration of mergers, acquisitions, member substitutions, joint ventures and clinical affiliations with other hospitals, health systems and academic medical centers.
IMPLEMENTATION RECOMMENDATIONS

1. Conduct an introspective analysis of the current and pro forma cost structure of the hospital, analyzing the following critical questions:
   a. Is the hospital large enough to capture economies of scale?
   b. Does the hospital have the ability to further reduce costs or capital expenditures without sacrificing clinical quality or market share?
   c. Would additional capital projects deteriorate the hospital’s credit rating to such an extent that its cost of capital would increase?
   d. Is the cost structure sustainable in light of the likely reimbursement cuts and increased costs that the Act is likely to bring?

2. Based upon the foregoing review, and on a more general review of the hospital’s balance sheet, debt capacity and market position, determine whether the hospital is in a position to be an acquirer, an equal partner in a merger or clinical affiliation, or an acquisition target.

3. Develop a strategic transactions plan which clearly articulates the charitable and strategic goals of the hospital in pursuing strategic transactions and realistically analyzes the paths available for meeting these goals. For example:
   a. A smaller hospital or health system that has been struggling to maintain its market position might have a strategic transactions plan which includes goals of maintaining acute care hospital services in the local community, improving physician recruitment efforts, enhancing the hospital or health system’s credit profile, or increasing revenue through new capital programs. The path it articulates might include evaluating a member-substitution transaction with a larger, regional nonprofit health system and/or hiring financial advisors to gauge the interest of a potential sale or joint venture with a for-profit operator.
b. A larger regional hospital or health system with significant financial resources might have a strategic transaction plan that includes the charitable goals of (i) developing and expanding service lines; (ii) maintaining local community control over acute care hospital assets in the region; (iii) maintaining state-of-the-art technology and clinical programs; (iv) creating enhanced patient access to care; and/or (v) improving the quality of certain discrete service lines, or the efficiency with which all care is delivered. The path it articulates might include an acquisition of a smaller hospital, a clinical affiliation and management relationship for one of its service lines (e.g., oncology, cardiology, etc.) with a nationally ranked academic medical center known for its expertise in the service line or a merger with a health system of equal size.

c. A large academic medical center might have a strategic transaction plan which focuses on a charitable goal of bringing evidence-based clinical protocols and world class care to communities outside of its immediate service area. The path it articulates might include entering into agreements to manage the clinical programs of regional health systems which are interested in the expertise and branding that a relationship with the academic medical center might bring; and/or creating foreign subsidiaries to develop hospitals and clinical programs abroad.

4. Regularly maintain and update a detailed market analysis that provides an understanding of how changes in the hospital, hospital-physician and provider/insurer relationships in the market may affect the institution’s performance and its ability to successfully execute its strategic transaction plan.

5. Confidentially “game plan” various possible growth/change of control alternatives as opportunities may arise or changes in the marketplace may require. Establish mission and market related goals and objectives for each identified opportunity.
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<th>6.</th>
<th>Establish a working group at the governance level (e.g., a special board committee) charged with the responsibility of working with executive leadership to facilitate the evaluation and board-level consideration of specific opportunities that may be presented.</th>
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<td>7</td>
<td>For a proposed transaction with a competitor, determine the transaction’s potential effects on competition. If there could be competitive concerns, identify and quantify potential transaction-specific efficiencies—reductions in cost, improvements in quality and access—that are likely to offset those concerns.</td>
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<tr>
<td>8.</td>
<td>Consider the economic (credit rating), additional regulatory (e.g., state approvals, mission benefits) and other key feasibility issues fundamental to the implementation of any transaction alternative.</td>
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**ADDITIONAL RESOURCES**