New Physician Practice Models

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HEALTH POLICY ALTERNATIVES, INC.
WASHINGTON, DC

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Dr. Desmarais has declared no conflicts of interest related to the content of his presentation.
Call your doctor today!
Al Gore goes to Capitol Hill to testify about global warming...

On the plus side, I guess we don't need to fix the economy!
Q13. Which of the following best describes your employment status in 2011, 2013, and what you expect it will be in 2015?

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Independent (physician-owned) private practice</td>
<td>57%</td>
<td>54%</td>
<td>44%</td>
<td>56%</td>
<td>47%</td>
<td>40%</td>
</tr>
<tr>
<td>Employed by a university or academic department</td>
<td>25%</td>
<td>25%</td>
<td>23%</td>
<td>24%</td>
<td>24%</td>
<td>22%</td>
</tr>
<tr>
<td>Private practice owned by a hospital or hospital corp.</td>
<td>12%</td>
<td>15%</td>
<td>20%</td>
<td>13%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Employed in a staff model HMO</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
<td>7%</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>None of the above (not working or retired)</td>
<td>1%</td>
<td>1%</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Response rate: 28 percent

Responding physicians: 3,466

Weights constructed to correct for possible non-response bias

All data are weighted

- 53.1% of non-solo physicians received all or the largest share of their compensation from salary
- 31.8% of non-solo physicians received all or the largest share of their compensation based on their personal productivity
### Figure 1. Percentage Of Non-Solo Physicians Who Receive At Least Some Compensation From Five Types Of Payment Methods (2012)

<table>
<thead>
<tr>
<th></th>
<th>Salary</th>
<th>Personal productivity</th>
<th>Practice financial performance</th>
<th>Bonus</th>
<th>Other</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All physicians</strong></td>
<td>60.2%</td>
<td>50.5%</td>
<td>30.1%</td>
<td>27.1%</td>
<td>3.0%</td>
<td>2886</td>
</tr>
<tr>
<td><strong>Ownership status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner</td>
<td>44.0%</td>
<td>54.2%</td>
<td>48.6%</td>
<td>26.7%</td>
<td>2.2%</td>
<td>1350</td>
</tr>
<tr>
<td>Employee</td>
<td>76.1%</td>
<td>46.9%</td>
<td>14.7%</td>
<td>28.4%</td>
<td>3.1%</td>
<td>1396</td>
</tr>
<tr>
<td>Independent contractor</td>
<td>49.6%</td>
<td>52.1%</td>
<td>17.1%</td>
<td>19.0%</td>
<td>8.9%</td>
<td>140</td>
</tr>
<tr>
<td><strong>Type of practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single specialty group</td>
<td>54.1%</td>
<td>50.9%</td>
<td>37.6%</td>
<td>24.8%</td>
<td>2.2%</td>
<td>1617</td>
</tr>
<tr>
<td>Multi-specialty group</td>
<td>58.8%</td>
<td>59.7%</td>
<td>23.3%</td>
<td>30.4%</td>
<td>2.9%</td>
<td>794</td>
</tr>
<tr>
<td>Faculty practice plan</td>
<td>84.6%</td>
<td>46.2%</td>
<td>21.3%</td>
<td>39.6%</td>
<td>2.8%</td>
<td>110</td>
</tr>
<tr>
<td>Direct hospital employee</td>
<td>79.4%</td>
<td>37.2%</td>
<td>15.8%</td>
<td>22.7%</td>
<td>6.8%</td>
<td>176</td>
</tr>
<tr>
<td>Other</td>
<td>83.7%</td>
<td>26.4%</td>
<td>14.9%</td>
<td>31.5%</td>
<td>6.6%</td>
<td>189</td>
</tr>
</tbody>
</table>

Source: AMA 2012 Physician Practice Benchmark Survey.

Notes: For ownership status, significance tests are shown relative to the owner category. For type of practice, they are shown relative to the single specialty category. ‘a’ is p<0.01, ‘b’ is p<0.05 and ‘c’ is p<0.10.
<table>
<thead>
<tr>
<th>Number of payment methods that factor into final compensation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>51.8%</td>
</tr>
<tr>
<td>Two</td>
<td>30.3%</td>
</tr>
<tr>
<td>Three</td>
<td>13.2%</td>
</tr>
<tr>
<td>Four</td>
<td>4.7%</td>
</tr>
<tr>
<td>More than four</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: AMA 2012 Physician Practice Benchmark Survey.
### Figure 4. Distribution Of Group Practice Physicians By Payment Method (2012)

<table>
<thead>
<tr>
<th></th>
<th>Salary</th>
<th>Personal productivity</th>
<th>Practice financial performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Only</td>
<td>Largest share but not 100%</td>
<td>Only</td>
</tr>
<tr>
<td><strong>Owner</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single specialty group</td>
<td>6.6%</td>
<td>25.2%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Multi-specialty group</td>
<td>5.9%</td>
<td>29.4%</td>
<td>30.5%</td>
</tr>
<tr>
<td><strong>Employee</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single specialty group</td>
<td>32.0%</td>
<td>38.0%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Multi-specialty group</td>
<td>25.5%</td>
<td>38.5%</td>
<td>23.4%</td>
</tr>
</tbody>
</table>

Source: AMA 2012 Physician Practice Benchmark Survey.

Notes: Significance tests are within owner status category, for single compared to multi-specialty groups. ‘a’ is p<0.01, ‘b’ is p<0.05 and ‘c’ is p<0.10.
<table>
<thead>
<tr>
<th>Some of the External Forces at Play</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flat Medicare physician payments vs. practice cost increases (minimal updates, sequestration cuts, etc.)</td>
</tr>
<tr>
<td>Medicare penalties for failure to become meaningful users of electronic health records</td>
</tr>
<tr>
<td>Medicare penalties for failure to satisfy Physician Quality Reporting System requirements</td>
</tr>
<tr>
<td>Medicare value-based modifier and increasing interest in performance-based payment methodologies</td>
</tr>
<tr>
<td>Movement to bundled payment</td>
</tr>
<tr>
<td>Movement to accountable care organization model, with shared savings and/or shared losses</td>
</tr>
<tr>
<td>Growing interest in global payment (e.g., partial or full capitation)</td>
</tr>
<tr>
<td>Narrowing of health plan provider networks</td>
</tr>
<tr>
<td>Movement to provider tiering</td>
</tr>
<tr>
<td>Increasing transparency/public reporting of physician performance data</td>
</tr>
<tr>
<td>Greater focus on care coordination</td>
</tr>
</tbody>
</table>
Source: 2013 Medicare Trustees’ Report; American Medical Association, “Now is the time to transform the broken Medicare System,” 2013
The Value-Based Modifier

Clinical care
Patient experience
Population/Community Health
Patient safety
Care coordination
Efficiency
Total overall costs
Total costs for specific conditions

Quality of Care Composite

VALUE MODIFIER SCORE

Cost Composite
<table>
<thead>
<tr>
<th>Quality/cost</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Average quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-1.0%</td>
<td>-2.0%</td>
</tr>
</tbody>
</table>

* Groups of physicians eligible for an additional +1.0x if reporting measures and average beneficiary risk score in the top 25 percent of all risk scores.
Growing Provider Interdependence

- Medicare inpatient hospital payments partially dependent on minimizing hospital readmission rates (e.g., all-cause, unplanned readmissions of patients originally admitted for an acute exacerbation of COPD), which can stem from actions taken or not taken by non-hospital staff.

- Medicare outpatient hospital payments partially dependent on hospitals obtaining data from physicians and other sources and reporting related quality measures to CMS.
  - Appropriate follow-up interval for normal colonoscopy in average risk patients
  - Improvement in patient’s visual function within 90 days following cataract surgery
SGR Reform: Common Themes

- Repeal the SGR methodology
- Provide specified updates to the Medicare physician fee schedule conversion factor for several years
- Implement a new performance-based methodology for future updates or incentive payments, under which individual physicians or physician groups are assessed against specified performance measures
- Allow physicians participating in certain alternative payment models (APCs) to ignore the new performance-based methodology and/or receive specified bonus payments/more generous future payment updates
MSSP and Pioneer ACO Counts by County: May 2013
(counties with more than 1 percent of an ACO’s assignees)
8. WHICH BEST DESCRIBES YOUR FEELINGS ABOUT ACOs?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>They are likely to enhance quality/decrease cost</td>
<td>9.0%</td>
</tr>
<tr>
<td>Quality/cost gains will not justify organizational cost/effort</td>
<td>21.8%</td>
</tr>
<tr>
<td>Unlikely to increase quality/decrease cost</td>
<td>40.6%</td>
</tr>
<tr>
<td>Unsure about structure or purpose of ACOs</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

The Physicians Foundation, *A Survey of America’s Physicians: Practice Patterns and Perspectives, 2012*
About 47% of 114 ACOs that started the program in 2012 have lowered expenditures below expected levels in the first 12 months.

About 25% of 114 ACOs generated shared savings—with more than $126 million going to the ACOs and $128 million in net savings for the Medicare Trust Funds.

CMS says these interim results are “within the range originally projected for the program’s first year,” with a “great majority” of the program’s overall net impact “projected to phase-in over the program’s ensuing years.”
CMS is seeking input on models that:

- Transition ACOs to full insurance risk;
- Hold ACOs accountable for total Medicare expenditures (Parts A, B, and D);
- Integrate accountability for Medicaid outcomes; and/or
- Offer ACOs payment arrangements with multiple accountability components (such as shared savings/losses, episode-based payments, and/or care management fees).
Bundled Payments for Care Improvement (BPCI) Initiative

- Model 1: Retrospective Acute Care Hospital Stay Only (hospital services only)
- Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care (including physician services during the episode)
- Model 3: Retrospective Post-Acute Care Only
- Model 4: Prospective Acute Care Hospital Stay Only (including inpatient physician services)

***Participating organizations must give Medicare a discount.
***Gain-sharing permitted under all 4 models.

So far, 232 organizations have entered into agreements to participate. On February 14, 2014 CMS invited more organizations to participate in Models 2-4.
Seeking input regarding procedural episode-based payment opportunities.
- Focus is on specialty practitioners and outpatient care.
- Scope includes both surgical and non-surgical procedures.
- CMS says payment model could include “any or all” services furnished throughout the duration of the episode, including anesthesia, diagnostic tests, prescription drugs, and even facility payments (e.g., ASC).

Seeking input regarding complex and chronic disease management episode-based payment opportunities
- CMS says intent is to incentivize specialists to more efficiently manage care.
- Scenarios could include situations where the specialist is responsible for the preponderance of the care received by a Medicare beneficiary.
Medicare is creating a new code to describe non-face-to-face, care management and coordination services furnished by a physician practice to patients with two or more chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

To qualify to receive yet-to-be-specified Medicare payment amounts for these services, a practice will need to meet yet-to-be-specified standards.

Effective date: January 1, 2015.
Cracking the Code on Health Care Costs

A Report by the State Health Care Cost Containment Commission

The Miller Center • University of Virginia
“The goal is straightforward but ambitious: Replace the nation’s reliance on fragmented, fee-for-service care with comprehensive, coordinated care using payment models that hold organizations accountable for cost control and quality gains.”

States should use health spending programs they administer or oversee to support formation of high-performing coordinated care organizations that accept risk-based, global payments. Programs that states can use for leverage include Medicaid, the state employee health program (which can be combined with local government employees for increased influence), and health insurance exchanges.”
Better Care, Lower Cost Act

- Sponsored by Senator Ron Wyden (D-OR)

- Targeted at “medically complex” Medicare/dual eligible patients who are at enhanced risk for hospitalization, limitations on activities of daily living, or other significant health concerns as a result of their chronic disease(s)

- Envisions a new type of entity, the Better Care Program (BCP), which could involve a multidisciplinary team of health professionals, a health plan, independent health professionals partnering with an independent risk manager, networks of individual practices of health professionals (including Federally qualified health centers, rural health clinics, etc.), and certain other organizational frameworks.
Qualified BCPs must include physicians, nurse practitioners, registered nurses, social workers, pharmacists, and behavioral health providers who commit to caring for BCP-eligible individuals.

Qualified BCPs would be paid on a capitated basis and would be responsible for the full continuum of care required by BCP-eligible individuals (except for long-term care).

BCP-eligible individuals would voluntarily enroll in a BCP.
- BCPs would be allowed to modify usual cost-sharing to incentivize use of high-value, high quality services.

- Bonus payments would be available for BCPs meeting quality and other requirements.

- Proposed start-date for the new option: January 1, 2017.
“Leaders in multiple practices reported that transitions from one payment model (e.g., fee-for-service) to another (e.g., shared savings or capitation) would be complicated, with physicians receiving mixed incentives from different payers. In response to these concerns, several practices sought economic security by increasing their size or becoming affiliated with hospitals and large delivery systems. Leaders of smaller, independent practices that did not initiate such growth or affiliation described feeling pressure to join larger systems, sensing that it would become more difficult in the future to remain independent from these systems as a consequence of health reform.”
Does your current physician practice participate in the following:

A. One or more accountable care organizations (ACO)
B. One or more bundled payment arrangements
C. Both ACO and bundled payment arrangements
D. None of the above
Does your current physician practice participate in the following:

A. One or more accountable care organizations (ACO)
B. One or more bundled payment arrangements
C. Both ACO and bundled payment arrangements
D. None of the above

A. 11%
B. 19%
C. 17%
D. 53%
Given what you have heard today regarding external forces affecting physician practices, do you believe that small, single specialty physician practices (1-2 doctors) will remain viable over the next 5 years?

A. Yes  
B. No  
C. Not Sure
Given what you have heard today regarding external forces affecting physician practices, do you believe that small, single specialty physician practices (1-2 doctors) will remain viable over the next 5 years?

A. Yes  
B. No  
C. Not Sure
Practice Models vs. Model Practices

- Concierge/direct-pay practice variations
- Hospital or other employment status
- Physician-hospital organizations
- Market-spanning single specialty groups
- Large multi-specialty group practices
- Independent practice associations
- Patient-centered medical homes/ambulatory intensive care units (medical homes for high-risk patients)
- Extensivist model (care coordination for people with chronic illness)
- Accountable care organization
- Risk-bearing physician groups
- Physician group- or hospital-sponsored health plans
- Virtual groups
- Globally integrated health delivery system
- Many Others
## CONTINUUM OF RISK

<table>
<thead>
<tr>
<th>Modality</th>
<th>Mechanism</th>
<th>Risk Assumed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for service</td>
<td>Payment per visit per procedure</td>
<td>Malpractice, pat. satisfaction, practice expense</td>
</tr>
<tr>
<td>Disease/condition management</td>
<td>FFS plus medical management fee</td>
<td>Above plus patient adherence</td>
</tr>
<tr>
<td>Professional capitation</td>
<td>PMPM physician services only</td>
<td>Above plus diag. testing specialty visits</td>
</tr>
<tr>
<td>Global cap</td>
<td>PMPM all health services (minus drugs, mental health post acute)</td>
<td>Above plus hospitalization &amp; adverse events</td>
</tr>
<tr>
<td>Full insurance risk</td>
<td>Monthly premium per enrolled life</td>
<td>Above plus selection risk admin + capital cost</td>
</tr>
<tr>
<td>Community cost trends (ACO)</td>
<td>Fee for service plus bonus vs. budgeted cost trend</td>
<td>Malpractice patient satisfaction admin expense</td>
</tr>
</tbody>
</table>

Total Physicians vs. Truly Independent\textsuperscript{1} - Projected Change, 2000-2013 (000s)

\begin{center}
\begin{tabular}{|c|c|c|c|}
\hline
\hline
Total Physicians & 683 & 723 & 757 & 793 \\
\hline
\end{tabular}
\end{center}

57\% are Independent
49\% are Independent
43\% are Independent
33\% will be Independent

1. Estimated
Sources: Accenture Analysis, MGMA, American Medical Association
Perceived Benefits of Hospital-Based Employment

- Relief from administrative responsibilities
- Greater access to leading-edge health information technology tools
- A more manageable work week
- Stability in a business environment made uncertain by developments such as payment reforms

Source: Accenture Physician Survey, 2011
### Employed Physicians vs. Practice Owners

<table>
<thead>
<tr>
<th>Perception</th>
<th>Employed</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat/mostly agree hospital employment is a positive trend</td>
<td>37.7%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Somewhat/mostly disagree hospital employment is a positive trend</td>
<td>62.3%</td>
<td>88.9%</td>
</tr>
</tbody>
</table>
“[I]t is possible for a physician practice to be acquired by a hospital, not change locations or even practice operations, yet the hospital now receives significantly higher Medicare payments if it meets the criteria for achieving provider-based status.”

“The recent acceleration in hospital employment of physicians runs the risk of raising costs and not improving quality of care unless broader payment reform reduces incentives to increase volume and creates incentives for providers to change care delivery to achieve real efficiencies and higher quality.”

Center for Studying Health System Change, “Rising Hospital Employment: Better Quality, Higher Costs?” Issue Brief, August 2011
Addressing Medicare payment differences across settings: Ambulatory care services

Dan Zabinski and Ariel Winter
March 7, 2013
If migration to OPDs continues at current rate...

- Medicare spending on E&M visits would be $1.2 billion higher per year by 2021 due to shift in site of care; beneficiary cost sharing would be $310 million higher

- Medicare spending on echocardiograms and nuclear cardiology studies would be $1.1 billion higher per year by 2021; cost sharing would be $285 million higher

Data are preliminary and subject to change
Principles for paying for same service in different settings

- Patients should have access to settings that provide appropriate level of care
- Prudent purchaser should not pay more for a service in one setting than another
- Medicare should base payment rates on resources needed to treat patients in lowest-cost, clinically appropriate setting
Physician compensation models “should encourage and incentivize physicians to be more accountable” for:

- Patient outcomes
- Overall patient satisfaction
- Administrative responsibilities (e.g., electronic health record implementation)
- Physician recruiting
- Serving on committees
- Practice marketing efforts
- Mentoring young physicians new to the practice

“[I]f the physician is paid merely for his or her clinical effort, every dime of the cost savings generated by more effective and better coordinated physician care is captured and absorbed as profit by health insurers or their self-funded employer customers. By assuming some level of risk for the future cost of caring for their patients, not only do physician groups and IPAs reap the rewards for more effective clinical care but also they might escape the costs of minute-by-minute surveillance of their practices and reduce the administrative complexity of health care payment.”

Organization proposed to form a network to offer clinically integrated services as a vehicle for improving quality of care, reducing costs, and increasing patient satisfaction, and to jointly negotiate the payer contracts for its physicians’ services.

About 280 participating physicians, representing about 38 specialty practice areas.
- Includes most of the physicians who practice in and around Norman, Oklahoma

$350 membership fee and $150 annual dues, plus ongoing financial contributions, in the form of “withholds” from reimbursements made to them by payers who contract with the Norman PHO, to support the network’s clinical integration activities.

The PHO will be non-exclusive, allowing payers to contract with individual member physicians independently from the PHO
Norman PHO will require all participating physicians to participate in all contracts between Norman PHO and payers.

Norman PHO anticipates that its proposed new program will generate meaningful savings and efficiencies that will benefit patients, payers, and participating providers.

The program will involve developing, implementing, and enforcing evidence-based practice guidelines, and use of an electronic platform by participating physicians.

The electronic systems will be used to perform medical record audits and to generate reports on individual and aggregate performance relating to cost, utilization, and quality of care measures.
Norman PHO and its participating physicians will be making meaningful contributions, including investments of human capital, time, and money, to the development of the infrastructure, capabilities, and mechanisms necessary to jointly realize their projected efficiencies.

Norman PHO expects to negotiate higher reimbursement rates for its participating physicians “because the proposed program will require increased utilization of physician resources to offer the potential to achieve greater efficiency, improved care, and, ultimately, lower costs for network patients.”
Norman PHO: Projected Benefits

- **Patients**: improved outcomes; better adherence to preventive screenings and services; reduced medical errors, etc., etc., etc.

- **Payers**: centralized credentialing and contracting; more satisfied beneficiaries; elimination of unnecessary duplication of services, etc., etc., etc.

- **Participating Providers**: reduced paperwork; greater ease of scheduling; improved patient diagnosis and treatment plans through timely receipt of diagnostic information and availability of clinical practice guidelines, etc., etc., etc.
Important that Norman PHO is developing a program that promises meaningful cost reductions and efficiencies, and improved quality of care.

Important that the joint contracting of physician fees “appears to be subordinate [that is, “ancillary”] to the network’s effort to improve efficiency and quality through the clinical integration of its participating physicians.”

Important that Norman PHO plans to take steps to avoid operating as a de facto exclusive network.

Important that Norman PHO plans to take steps to warn participating physicians to avoid taking collective action in dealing with payers outside of the PHO (“spillover effects”).

In light of the above, FTC staff would not recommend an antitrust enforcement action against Norman PHO (February 13, 2013 Advisory Opinion).
Acquired the Saltzer Medical Group, a for-profit, physician-owned multispecialty group, effective December 31, 2012.

Combined entity included 80% of the primary care physicians in Nampa, Idaho.

In January 2014, the Federal District Court concluded the arrangement was anti-competitive and ordered St. Luke’s to unwind the acquisition.

The court concluded that there was a substantial risk the combined entity would use its dominant market share to negotiate higher reimbursements with health plans, and charge more services at the higher hospital billing rates.

The court also found that St. Luke’s had not carried its burden of showing convincing proof of significant and merger-specific efficiencies arising as a result of the acquisition.
Deal included a 5-year professional services agreement (PSA) that prohibited the Saltzer physicians from becoming employed by or financially affiliated with other health systems or hospitals.

The PSA provided Saltzer physicians a guaranteed salary with additional compensation based on RVUs.

Although the district court judge believed that the acquisition would have the effect of improving patient outcomes if left intact, he argued that there are other ways to achieve the same effect that do not run afoul of the antitrust laws.
What factor(s) does the Federal Trade Commission consider important in determining that a health care arrangement, such as a physician-hospital organization, which involves joint contracting of physician fees, would not be challenged as anti-competitive:

A. The arrangement is expected to generate meaningful savings and efficiencies, and improved quality of care.
B. The joint contracting of physician fees is ancillary to the arrangement’s efforts to improve efficiency and quality through clinical integration.
C. There is evidence that participants in the arrangement will avoid taking anti-competitive actions, such as collectively agreeing to refuse to contract with payers outside of the arrangement.
D. All of the above.
What factor(s) does the Federal Trade Commission consider important in determining that a health care arrangement, such as a physician-hospital organization, which involves joint contracting of physician fees, would not be challenged as anti-competitive:

A. The arrangement is expected to generate meaningful savings and efficiencies, and improved quality of care.
B. The joint contracting of physician fees is ancillary to the arrangement’s efforts to improve efficiency and quality through clinical integration.
C. There is evidence that participants in the arrangement will avoid taking anti-competitive actions, such as collectively agreeing to refuse to contract with payers outside of the arrangement.
D. All of the above.

A. B. C. D.

9%
88%
3%
0%
Launch of the Region's Largest Orthopaedics Practice

Published January 7, 2014

Bethesda, MD – In order to empower the private practice model, which studies have proven delivers the most efficient, compassionate and highest-quality care, 128 leading orthopaedic physicians have united to form The Centers for Advanced Orthopaedics (The Centers). Encompassing 32 zip codes throughout Virginia, District of Columbia, Maryland, West Virginia and Pennsylvania, The Centers is the largest provider of orthopaedic and musculoskeletal care in the regions it serves. Facing mounting pressure to join large institutions and hospitals, where a Medical Group Management Association study found physician productivity can fall as much as 25%, The Centers was founded to preserve the personalized patient focused service and standard of care that can only be found in the private practice model.

“As doctors, our vision has always been focused on how to improve the patient experience and provide the best possible care,” said Dr. Nick Grosso, President of The Centers for Advanced Orthopaedics. “Through strength in numbers and a unified vision, we can bring all the advantages of the personal care that patients expect from private practice, combined with the efficiencies and resources of one of the nation’s largest orthopaedic networks.”
Centers for Advanced Orthopaedics

- Described as a “joint corporation”
- 25 practices, about 130 physicians
- 32 zip codes, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
- Share administrative, technology and marketing costs, as well as reimbursement contracts with insurers and employee benefit plans
- Includes various orthopedic specialists and non-orthopedic professionals, including podiatrists, neurologists, rheumatologists, psychiatrists, physical therapists, etc.
Centers for Advanced Orthopaedics

- Greater purchasing power (malpractice insurance, medical supplies)
- Negotiating power vis-à-vis insurers, etc.
- Clinical cooperation, identification of best practices
- “Practices will continue to operate as individual business units managed by their physicians, who now share ownership in the umbrella corporation, too.” (Washington Post, January 14, 2014, p. A11)
- Presented as a better alternative to hospital employment (for patients and physicians)
Kindred Healthcare: Post-Acute Care Integration

- Embarked on a 5-year plan to create integrated-care markets across the country
- So far, Kindred has established 12 such markets
- Each is designed to provide a full array of post-acute services, including transitional hospital care, short-term rehabilitation, skilled nursing, home health, palliative care and hospice
- Patients referred by hospitals to Kindred facilities are assigned to a transitional-care nurse, who acts as their care navigator throughout the duration of their post-acute care
- Integration allows Kindred to accept bundled payments for episodes of care
Given what you have heard today regarding external forces affecting physician practices and recent physician practice model developments, are you likely to consider changing your existing physician practice model over the next 3-5 years?

A. Yes
B. No
C. Not Sure
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TIME FOR EASY QUESTIONS