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Physicians Committed to a Better Health Care System for All Americans

Health Reform and the Decline of Physician Private Practice

A White Paper Examining the Effects of The Patient Protection and
Affordable Care Act On Physician Practices in the United States

Includes results of *Physicians and Health Reform*,
a survey of 100,000 physicians



White Paper and survey conducted on behalf of The Physicians Foundation by Merritt Hawkins
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The views expressed are those of the authors. Members of the Advisory Panel provided strategic direction and review of the White Paper and may hold views and opinions divergent from some of those expressed herein. Panel members represented their own views and opinions and not necessarily those of the institutions with which they are affiliated.

The Physicians Foundation is devoted to advancing physician practices and improving healthcare quality for all Americans. More information about the Physicians Foundation can be found at www.physiciansfoundation.org.

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EXECUTIVE SUMMARY

Like society itself, medical practice has been evolving rapidly in the United States over the last 50 years, in response to technological, economic, demographic, political and related influences. Passage of the Patient Protection and Affordable Care Act (“health reform”) promises to accelerate this evolution in a variety of significant ways.

The Physicians Foundation called upon Merritt Hawkins and an Advisory Panel of healthcare experts to assess how health reform is likely to affect the ways in which physicians practice in the United States. This White Paper reflects the results of Merritt Hawkins’ and the Advisory Panel’s analysis.

Meeting over a period of two days, the Advisory Panel delineated some general themes and projections, concluding:

- 1) Health reform is comprised of two elements: “Informal reform,” (i.e., societal and economic trends exerting pressure on the current healthcare system independent of the Patient Protection and Affordable Care Act), and “formal reform,” (i.e., the provisions contained in the Act itself).
- 2) The current iteration of health reform, both formal and informal, will have a transformative effect on the healthcare system. This time, reform will not be a “false dawn” analogous to the health reform movement of the 1990s, but will usher in substantive and lasting changes.
- 3) The independent, private physician practice model will be largely, though not uniformly, replaced.
- 4) Most physicians will be compelled to consolidate with other practitioners, become hospital employees, or align with large hospitals and health systems for capital, administrative and technical resources.
- 5) Emerging practice models will vary by region—one size will not fit all. Large, Accountable Care Organizations (ACOs), private practice medical homes, large independent groups, large aligned groups, community health centers (CHCs), concierge practices, and small aligned groups will proliferate.
- 6) Reform will drastically increase physician legal compliance obligations and potential liability under federal fraud and abuse statutes. Enhanced funding for enforcement, additional latitude for “whistleblowers” and the suspension of the government’s need to prove “intent” will create a compliance environment many physicians will find problematic.
- 7) Reform will exacerbate physician shortages, creating access issues for many patients. Primary care shortages and physician maldistribution will not be resolved. Physicians will need to redefine their roles and rethink delivery models in order to meet rising demand.

- 8) The imperative to care for more patients, to provide higher perceived quality, at less cost, with increased reporting and tracking demands, in an environment of high potential liability and problematic reimbursement, will put additional stress on physicians, particularly those in private practice. Some physicians will respond by opting out of private practice or by abandoning medicine altogether, contributing to the physician shortage.
- 9) The omission in reform of a “fix” to the Sustainable Growth Rate (SGR) formula and of liability reform will further disengage doctors from medicine and limit patient access. SGR is unlikely to be resolved by Congress and probably will be folded into new payment mechanisms sometime within the next five years.
- 10) Health reform was necessary and inevitable. The impetus of informal reform would likely have spurred many of the changes above, independent of formal reform. Net gains in coverage, quality and costs are to be hoped for, but the transition will be challenging to all physicians and onerous to many.

These and other conclusions are examined in more detail in this paper.

Physician Survey

The report includes results of a physician survey conducted by Merritt Hawkins on behalf of The Physicians Foundation. Some 2,400 physicians who responded to the survey indicated how they reacted to health reform and enumerated ways in which they may alter their practice plans in the next one to three years as reform is implemented.

Key findings of the survey include:

- 1) The majority of physicians responded unfavorably to passage of health reform.
- 2) The majority of physicians believe health reform will increase their patient loads while decreasing the financial viability of their practices.
- 3) The majority of physicians plan to alter their practices patterns in ways that will reduce patient access to their practices, by retiring, working part-time or taking other steps.
- 4) Physician practice styles will be increasingly less homogenous. The full-time, independent practitioner accepting third party payment will largely be supplanted by employed, part-time, locum tenens, and concierge practitioners.

Complete results of the survey are included in this paper.

The Physicians' Perspective

Health reform is a large, moving target with multiple working parts. This White Paper focuses on its potential effects on physician practices. It is intended as a resource that physicians can use to both consider the implications of health reform and to navigate through the post-reform practice environment.

In concert with The Physicians Foundation's mission, the White Paper also is intended as a forum for presenting the physicians' perspective to policy makers, the media and the general public. How physicians view the practice of medicine, and how they choose to practice, is of fundamental importance to the quality and access to medical care afforded to all Americans. The Physicians force and patient access to the highest quality medical care.

The majority of physicians believe health reform will increase their patient loads while decreasing the financial viability of their practices.



Case Studies

Physician Practice Models Likely to Proliferate In the Post-Reform Era

Medical Home Case Study: Medical Clinic of North Texas

Although the medical home concept is not new, its proponents were glad to see the idea receive approval in the recent healthcare reform law. The law includes medical home demonstration projects for Medicare and Medicaid. The concept, in which a physician leads a team of clinicians in the delivery and coordination all of a patient's healthcare services, has shown that it can reduce costs, improve care and even decrease clinician burnout.¹ The medical home has been endorsed by four medical societies and propelled forward by the Patient-Centered Primary Care Collaborative, a coalition of large employers, insurers, consumer groups and doctors. In addition to federal medical home initiatives, a number of insurers have projects underway. For the Medical Clinic of North Texas (MCNT), a large multi-specialty group in the Dallas-Fort Worth area, this was a logical next step in improving patient care and one which a growing number of practices are expected to take post-reform.

But for Richard Johnston, MD, an Advisory Panel member, practicing internist and the president of MCNT, the journey to coordinated care started long before the clinic began working on the medical home model. To be able to track patient procedures and their outcomes, an electronic medical record is a key component—and that is one of the reasons Dr. Johnston's four-doctor practice made the decision to join MCNT in 2004. It is the type of move he thinks more and more small practices will make in response to healthcare reform and changing market conditions. Dr. Johnston noted that his colleagues at the four-doctor practice had concerns about its human resource policies, and HIPAA and OSHA compliance. In addition, the doctors were reluctant to invest in an electronic medical record. "We needed a higher level of management," he said. "We just couldn't stay on top of it." Since Dr. Johnston's group joined the clinic, MCNT has grown. In 2004, the clinic numbered 80 to 90 physicians and today it has nearly 150 doctors in nearly 50 locations, offering a raft of specialties. At MCNT, physicians are compensated based on productivity, with a small bonus distributed for patient outcomes, amounting to only 1 percent to 2 percent of salary. Dr. Johnston says this wasn't a transformative change for the four doctors from their previous compensation model.

The clinic has started medical home projects with insurers Cigna and Blue Cross Blue Shield of Texas, but the clinic's size was only one factor in the insurers' selection of MCNT. Dr. Johnston notes the fact that the clinic had an electronic medical record in place for many years, setting it apart in the Dallas-Fort Worth market. Both insurers had data showing MCNT to be a provider with high quality outcomes that delivered care efficiently.

Medical Home Pilot Projects

The projects appealed to the clinic's physicians because this model results in better patient care, said Dr. Johnston. "Unfortunately, it also costs money upfront," he added. To help with those costs, the insurers have paid for the clinic to hire embedded nurse coordinators to make sure a patient is getting appropriate care in the most efficient setting. The insurers also helped fund some of the clinic's IT initiatives, which in turn are producing data the insurers want to monitor. In both two-year contracts, the MCNT will continue to receive fee-for-service payments, creating stability for doctors. In addition, the clinic has the opportunity to keep a portion of the savings it generates. While other such pilot projects have generated savings², both MCNT projects—one started in late 2009 and another in January 2010—are too nascent to show their results. The Cigna project covers about 6,000 to 7,000 patients, while the Blue Cross contract includes care for 18,000 to 20,000 patients. Each contract involves all of MCNT's physicians, but the doctors treating adults have the most metrics to monitor and are likely to make the largest financial impact.

Dr. Johnston points out that the clinic already had in place a number of functions to facilitate the medical home projects. For instance, a search engine can go through a patient's medical record to identify tests or processes that are missing or late, and standing order sets prompt physicians to ask for particular procedures or tests when a patient presents with an abnormal lab result or a particular condition.

Dr. Johnston noted that if a practice is already functioning at a high level, such as hitting the standard for diabetes patients to receive a foot exam annually 80 percent of the time, it takes considerable effort to raise that to 90 percent. "A lot needs to be done before the doctor enters the exam room," says Dr. Johnston. "If the patient has a long list of concerns, you may never get around to that foot exam."

Dr. Johnston's practice, even before it joined MCNT, employed mid-level providers—one nurse practitioner and two physician assistants—so his practice's doctors were comfortable caring for patients with them. But to improve performance, non-physician clinicians need to be precise in their tasks.

To hit the 90th percentile for quality standards, said Dr. Johnston, "Every clinician has to be operating at the highest level of their license consistently." And that requires pervasive care coordination and extensive staff training. For instance, the certified medical assistants employed at MCNT receive an additional 12 weeks of training to perfect techniques in giving injections, how to use the clinic's electronic medical records, and learn more about disease processes in an effort to improve encounters with patients.

MCNT continues to work on building its capabilities. It is now trying to reach Level Three recognition of its medical home status from the National Committee for Quality Assurance. Practices must meet criteria to become a recognized medical home. To achieve the first level in the Physician Practice Connections—Patient-Centered Medical Home, a provider must achieve 25 to 49 points of 100 possible points in the following nine standards. To achieve Level 3, as MCNT is striving to do, the practice must reach at least 75 points in enactment of these standards.

NCQA Scoring Criteria³

STANDARD 1: ACCESS AND COMMUNICATION—9 POSSIBLE POINTS

- A. Has written standards for patient access and patient communication*
4 possible points
- B. Uses data to show it meets its standards for patient access and communication*
5 possible points

STANDARD 2: PATIENT TRACKING AND REGISTRY FUNCTIONS—21 POSSIBLE POINTS

- A. Uses data system for basic patient information (mostly non-clinical data)
2 possible points
- B. Has clinical data system with clinical data in searchable fields
3 possible points
- C. Uses the clinical data system
3 possible points
- D. Uses paper or electronic-based charting tools to organize clinical information*
6 possible points
- E. Uses data to identify important diagnoses and conditions in practice*
4 possible points
- F. Generates lists of patients and reminds patients and clinicians of services needed (population management)
3 possible points

STANDARD 3: CARE MANAGEMENT—20 POSSIBLE POINTS

- A. Adoption and implementation of evidence-based guidelines for three chronic conditions*
3 possible points
- B. Generates reminders about preventative services for clinicians
4 possible points
- C. Uses non-physician staff to manage patient care
3 possible points
- D. Conducts care management, including care plans, assessing progress, addressing barriers
5 possible points
- E. Coordinates care/follow-up for patient who receive care in inpatient and outpatient facilities
5 possible points

STANDARD 4: PATIENT SELF-MANAGEMENT SUPPORT—6 POSSIBLE POINTS

- A. Assess language preference and other communication barriers
2 possible points
- B. Actively supports patient self-management*
4 possible points

STANDARD 5: ELECTRONIC PRESCRIBING—8 POSSIBLE POINTS

- A. Uses electron system to write prescriptions
3 possible points
- B. Has electronic prescription writer with safety checks
3 possible points
- C. Has electronic prescription writer with cost checks
2 possible points

STANDARD 6: TEST TRACKING—13 POSSIBLE POINTS

- A. Tracks tests and identifies abnormal results systematically*
7 possible points
- B. Uses electronic system to order and retrieve tests and flag duplicate tests
6 possible points

STANDARD 7: REFERRAL TRACKING—4 POSSIBLE POINTS

- A. Tracks referrals using paper-based or electronic system*
4 possible points

STANDARD 8: PERFORMANCE REPORTING AND IMPROVEMENT—15 POSSIBLE POINTS

- A. Has written standards for patient access and patient communication*
3 possible points
- B. Measures clinical and/or service performances by physician or across practice*
3 possible points
- C. Survey of patients' care experience
3 possible points
- D. Reports performance across the practice or by physician*
3 possible points
- E. Sets goals and takes action to improve performance
3 possible points
- F. Produces reports using standard measures
2 possible points
- G. Transmits reports with standardized measure electronically to external entities
1 possible point

STANDARD 9: ADVANCED ELECTRONIC COMMUNICATIONS—4 POSSIBLE POINTS

- A. Availability of Interactive Website
1 possible point
- B. Electronic Patient Identification
2 possible points
- C. Electronic Care Management Support
1 possible point

*Must pass elements

PPC-PCMH SCORING⁴

Level of Qualifying	Points	Must Pass Elements at 50 Percent Performance Level
Level 3	75-100	10 of 10
Level 2	50-74	10 of 10
Level 1	25-49	5 of 10

The difference between the medical home and the gate keepers of the 80s and 90s, stated Dr. Johnston, is that, in those earlier efforts, providers did not measure quality because they did not have the methods to do it. “How can you measure quality without electronic records?” asked Dr. Johnston, “The point is to prove outcomes; the dollars are predicated on that.” He added that in MCNT’s current medical home projects doctors are still paid fee for service and hence not financially penalized—unlike the earlier gatekeeper model—for ordering additional services for patients.

MCNT is only one of many practices that value the medical home model and believe investing in it is the key to the future. As of July 31, 2010, 892 practices have been recognized as by the NCQA as Patient-Centered Medical Homes since the program was launched in 2008. Also of as July 31, 2010, 508 applications were pending. The number of Patient-Centered Medical Homes will undoubtedly grow; the NCQA receives about 165 applications each month.⁴

Even though MCNT had a robust medical record before the medical home recognition project, it still had to make adjustments. For instance, the practice had no way to confirm if a patient had completed a suggested appointment with a specialist outside of the medical clinic, said Joanna Diehl, an MCNT project manager who has worked on the clinic’s efforts to embrace the medical home model. The clinic had to create a way for the patient’s electronic medical record to list the referral and to get the outside specialist to agree to send a report to the medical clinic about the outcome of that visit. “The clinic often didn’t receive information about the referral visits, but the primary care physician is held accountable for that care,” said Diehl. The clinic was able to work out an arrangement with specialists to send back reports of the visits, performed essentially in return for remaining in MCNT’s referral network.

In the Dallas-Fort Worth market, insurers are not the only ones interested in the development of this model. The clinic has been approached by several self-insured employers interested in direct contracting. Before the clinic pursues these contracts, Dr. Johnston states, the employers need to complete more computations on how various co-pay levels would affect their plans’ finances. For MCNT’s part, the data generated from the medical home projects will provide more precise information for employers on the cost savings that the clinic can generate from care coordination.

To prepare for a direct contract that financially incentivizes patients to choose MCNT physicians for care, the clinic needs to align primary physicians outside the clinic. Dr. Johnston said this is necessary in case patient demand becomes too great under the direct contracting arrangement. This alignment would be more complex than simply sending patients to outside physicians, he noted, as these doctors would have to follow MCNT protocols and be credentialed by the clinic.

Although MCNT has spent considerable effort coordinating care, the clinic has held back from aligning with a hospital. "In a fee-for-service market, the push to align is not strong," said Dr. Johnston. But the clinic's stance may change. "Aligning with a hospital or hospitals might be something we have to look at," noted Dr. Johnston. "I don't think global payments [for patient care] will happen anytime soon, but 'soon' used to be five-to-ten years and now it's two-to-three. The pace of change is picking up."

1. Reid, R., et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs*. 2010; 29 (5): 835-843.
2. Milstein, A. and Gilbertson, E., "American Medical Home Runs," *Health Affairs*. 2009; 28 (5): 1317-36.
3. Patient-Centered Primary Care Collaborative. *Proof in Practice A compilation of patient-centered medical home pilot and demonstration projects*. 2009, pp. 89-90.
4. *Ibid.*
5. Information received from the National Committee for Quality Assurance, August 2010.

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Concierge/Direct Contracting Case Study: Qliance

As reimbursements decline, administrative time required for billing increases, and treatment pre-authorization remains a barrier to professional satisfaction, primary care physicians and even some specialists have found an alternative to traditional private practices: concierge-style practice. In these practices, physicians limit their panel of patients and charge them directly with a monthly fee. In exchange, patients can have more interaction with their doctors, such as unlimited and longer appointments, and access to physicians by phone and email.

A 2005 GAO study noted the growth of concierge practices between 2000 and 2004,¹ and some Advisory Panel members predict the trend—especially among older doctors—will continue into the future. The Survey of Physicians and Health Reform included in this White Paper indicates that 16% of physicians plan to switch to a concierge practice in the next one to three years. A number of firms stand ready to benefit from that possible trend, such as Concierge Choice Physicians and MDVIP. These firms help physicians determine whether their practices could successfully make the transition and they provide the support needed to become a concierge practice. The American Academy of Private Physicians, a professional organization of concierge and direct care providers, has a membership of about 500 and estimates the current number of concierge physicians at over 3,500.

Several models for concierge practice exist, including those that charge a monthly fee and also bill insurers for services, and those that split their practices between concierge and insurer-covered only patients, allowing patients to stay with a physician whether or not they choose the concierge model.² Others, like Qliance in Seattle, Washington, have bypassed insurers entirely, relying solely on monthly payments from patients.

While Qliance is a small practice, it is growing. Its nine doctors and three nurse practitioners currently care for nearly 4,000 patients at three locations in the Seattle, Washington area, and work with 80 employers who offer the service to their employees. Garrison Bliss, M.D., the internist who co-founded the practice in 2007 and serves as its president, plans to hire more clinicians and open two new locations by mid 2011. Dr. Bliss changed to the concierge-style practice in 1997, converting Seattle Medical Associates, believing the style improves both care for the patients and improves conditions for doctors. He later started Qliance in an effort to reduce monthly costs and create a model that could easily grow in scale. In the insured model, he noted, the net income per visit forces them to rush patient visits, which need to number 25 to 35 patients a day. All of this reduces the time available to diagnose and properly care for patients. "The insurer-based system has lots of incentives to see patients for five minutes, charge for it and be really good at billing," he said. At Qliance practices, doctors see 10 to 12 patients a day, with average visits lasting 30 to 60 minutes. Urgent care needs from patients receive same-day or next-day visits.

Qliance offers two levels of service. Level 1 offers office visits and remote hospital coordination with providers including nurse practitioners, internists or family practice doctors. A slightly more costly Level 2 offers only physician providers and, in addition to office visits, offers hospital rounding to coordinate care with hospitalists and specialists. At Qliance, a family pays a one-time \$99 registration fee and then a monthly fee for each member of the family, based on age, not health

status. For instance, a teen's fee for Level 1 service is \$54, while a 45-year-old would pay \$69. For Level 2 service, those rates would be \$54 for the teen, and \$99 for the 45-year-old. Patients pay extra for such items as durable medical supplies, third party services and lab tests. Qliance recommends that patients use its services with a high deductible plan, or a health savings account, or both. These additional plans would cover major medical expenses such as hospitalizations.

Qliance doesn't include some of the benefits available at high-end concierge practices, such as house calls or providers that accompany patients to specialist appointments. Dr. Bliss pointed out that unlike some concierge models, he believes the costs to patients at Qliance make it affordable to 80 percent to 90 percent of Americans. Also, the practice doesn't exclude patients based on their health status or pre-existing conditions.

"Our objective is not to simply take care of wealthy people; they will always be able to afford health care," said Dr. Bliss. "The image of the concierge doctor taking care of the wealthy so they don't have to hang out with the unwashed masses doesn't fit here. In our practice, the venture capitalist sits in the same waiting room as the biker and no one has to sit very long."

Patients have reacted well to the model. "Patients who come here from traditional settings do experience a difference," Dr. Bliss stated. "They're seeing that primary care doesn't have to be on roller skates and that they can sit for 30 minutes with a physician and no one gets fidgety." The leadership at Qliance is now collaborating with insurers on how to develop high-deductible wrap around products to dovetail with its service model, which Dr. Bliss refers to as a Direct Primary Care Medical Home. Proponents of this model make a comparison to car insurance, pointing out that Americans don't use their auto insurance to pay for maintenance, such as having the transmission fluid changed and tires rotated.

But for the model to be affordable for patients, the costs have to be low, which Dr. Bliss said he's accomplished by bypassing insurers—and the overhead practices must carry to interact with them—from the equation. For instance, the practice uses a no-film digital x-ray service and negotiated a low fee for a local radiologist to read the images, costing patients \$17 out-of-pocket for any set of films. Qliance also has a dispensary with generic medications that it sells to patients at cost. "Anything that is a significant cost, say more than \$10," said Dr. Bliss, "We charge the patients at our cost and they pay cash."

This model may also get a boost from the insurance exchange feature in the healthcare reform law, which allows a direct practice medical home with a wrap around insurance product to substitute for any of the mandated insurance designs, as long as it provides the same coverage. In addition to his practice, Dr. Bliss has co-founded the Direct Primary Care Coalition, whose web site lists more than 60 Direct Primary Care Medical Home practices in 21 states.

BENEFITS OF DIRECT PRIMARY CARE MEDICAL HOMES

Half hour- to hour-long office visits

No limits for pre-existing conditions

No deductible or copayment to minimize barriers to usage

Same day or next day appointments for urgent care

Affordable, predictable monthly fees

All routine primary and preventive care including vaccinations, many lab tests, women's health service, on-site procedures such as suturing, casting, splinting, ongoing management of chronic diseases such as diabetes and hypertension

On-site X-ray laboratory and "first-fill" prescription medicine dispensary

Coordination of any needed specialist and hospital care and/or

Open seven days per week, often with extended hours, plus phone and email consultations and 24-hour phone access to a physician for urgent after-hours issues.

Source: Bliss, G. Get Ready for More Direct Primary Care Medical Homes: Opening the Door to Insurance-Free Primary Care in State-Run Exchanges. Bureau of National Affairs' Health Care Policy Report. April 12, 2010.

Economic Model for Doctors

In a case study about Qliance he co-authored for Health Affairs, Dr. Bliss explained the finances behind the model that make it so attractive to physicians. At \$60 per month, the annual revenue for each primary care practice patient is \$720, or 2.6 times higher than the average of \$276 computed in 2008 by the Medical Group Management Association. MGMA figures show average annual revenue in 2008 of \$621,338 per primary care physician, if the physician carries the average patient panel of 2,251. In the direct care model, a physician can generate the same annual revenue by seeing just 863 patients.³

Physicians at Qliance are paid on a salary, with bonuses amounting to 20 percent of their total compensation. Those bonuses are paid based on three indicators. First to be considered is the provider's panel size, with a full panel numbering 800 for a Level 1 provider and numbering 500 for a Level 2 provider, a doctor that is providing inpatient rounding. "We want providers to be at or near a full panel size," said Dr. Bliss. The last two criteria to determine bonuses are patient satisfaction and satisfactory benchmarks on quality measures. "The providers who are here know they are responsible for giving patients the care they need and making sure the patients are happy about their care," he stated. "If patients are happy they stay, and that will maintain a provider's panel size."

Quality and Cost

Dr. Bliss thinks this model has the ability to both improve quality and lower costs. For instance, if a patient has knee pain, Qliance providers could manage that symptom over the course of multiple office visits, and possibly avoid an MRI scan and a specialist referral. "In the insurer-based system, there's an incentive to do the scan because it's a way to get patients out of your office and get an answer quickly," said Dr. Bliss. "There's no way to turn one office visit into three because there is no time to spend with patients."

A Qliance analysis of downstream utilization costs showed that a sample of more than 2,000 patients under 65 had 54 percent fewer specialist referrals and used the emergency room 62 percent less over a one-year period compared to national benchmarks. One reason for these lower numbers, said Dr. Bliss, is that the practice is open nights and weekend hours. "One way to stop the use of unnecessary care is simply to be available," he said. But he also says the practice is still researching whether its patients tend to be healthier than the general population. Critics of concierge practices charge that they care for healthier patients, a charge Dr. Bliss denies, noting that two-thirds of his panel are Medicare patients, which often have more health concerns than younger individuals.

But if doctors are not at risk financially for the health of their patients, as the physicians at Qliance are not - are they incented to keep patients healthy? "The patients are the enforcers," he said. "They will not pay out of pocket for mediocre care. They will not keep coming back, and as a physician, you won't like your job very much if you are ineffective," stated Dr. Bliss. At Qliance, patients can drop the service at any time; they pay month-to-month.

Challenges and Solutions

Qliance has had its share of challenges. "It was a brand new machine," said Dr. Bliss, "and we had to evolve the manuals and invent the technology." For instance, the practice needed an EMR that included cash prices for lab tests, and Qliance had to create its own. In fact, the practice is still working on an EMR that will make a dash board available to clinicians showing quality measures, patient satisfaction and give them tools to manage care. For instance, Dr. Bliss would like physicians to be able to see all the patients in their panels who had taken hemoglobin A1c tests with scores that need follow-up. "We want to be able to generate a list of outliers and let our clinicians focus on those patients," stated Dr. Bliss. To create the EMR, Qliance has hired a highly qualified technical staff with the help of venture capital. Since 2006, Qliance has garnered \$13.5 million in investments from such industry moguls as Amazon founder Jeff Bezos and Dell Computer's Michael Dell.⁴ "We're taking advantage of being a venture capital driven organization," says Dr. Bliss. "I have no idea how a regular primary care practice is going to do this."

Other hurdles included the need to explain to Washington State regulators that the practice assumes no risk and shouldn't be regulated as an insurer. Qliance also has faced unrealistic patient expectations. "Sometimes patients wanted a prescription refill to be sent within an hour, and we didn't meet that time frame," stated Dr. Bliss.

While Dr. Bliss acknowledges that this model will take primary care physicians out of the supply pool as they limit their patient panels, he thinks it's a risk worth taking to make primary care more attractive, bringing both practicing physicians and medical residents back into the fold. "We could triple the number of primary care physicians if we paid adequately for primary care and corrected the incentive systems," he stated, adding that the doctors who choose primary care in graduating classes have sharply fallen, and that doctors in their 50s and 60s don't want to stay in the specialty.

"You have to increase supply and you can't do that if you just tweak the old system around the edges," he stated. "Whatever the short term downside of the model is, compared to the upside, it's a drop in the bucket."

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Physicians at Qliance are paid on a salary, with bonuses amounting to 20 percent of their total compensation.



Community Health Center Case Study: United Health Centers of San Joaquin Valley

Federally-qualified community health centers are a linchpin in the nation’s healthcare delivery system, providing care in underserved areas—both rural and urban—and to those who are poor, uninsured and underinsured.¹ Their role will become even more important when 32 million Americans have coverage for healthcare. The chart below underscores the role community health centers play in providing care for the underserved.

COMMUNITY HEALTH CENTERS		
	Health Center Population	US Population
% AT OR BELOW THE POVERTY LEVEL	53%	17%
% UNDER 20% OF THE POVERTY LEVEL	69%	32%
% UNINSURED	38%	15%
% MEDICAID	36%	14%
% MEDICARE	8%	12%
% RURAL	44%	16%

Source: National Association of Community Health Centers. United States: At A Glance. 2009.

Community health centers, numbering 1,250 with about 8,000 delivery sites, are already the largest network of safety net primary care services in the nation. These health centers will be strengthened over the next five years by \$11 billion of additional funding allocated in the healthcare reform law. Of this amount \$9.5 billion will go towards operations and patient services and \$1.5 billion for construction and renovation. “Community health centers are at the heart of a modern, reformed healthcare system in America,” said President Barack Obama during National Health Center Week in August, 2010. “We must continue to invest in these centers and ensure that comprehensive, culturally competent and quality primary healthcare services are accessible in every community across our nation.”

According to estimates from the National Association of Community Health Centers (NACHC), this additional investment will allow health centers to double their current capacity, reaching 40 million patients in 2015. Also that year, the centers are estimated to generate \$54 billion in total economic activity and create 284,000 new full-time equivalent jobs in their local communities.²

The funds for community health centers are part of a larger investment in primary care, including \$1.5 billion in funding for the National Health Service Corps, with community health centers providing venues in which service corps members can work. In addition, funds to increase the number of primary care residency slots in community settings were included in healthcare reform, with the aim of training 500 additional primary care physicians by 2015.

In an environment in which physicians find themselves increasingly frustrated with administrative paper work, reimbursement issues, the demand to invest in information technology, and other challenges, practicing in one of the nation’s federally funded community health centers is an option that might be attractive. While most health centers focus on primary care physicians—those specializing in family practice, pediatrics, internal medicine, obstetrics/gynecology—some health centers employ psychiatrists and a few have specialists such as general surgeons, geriatricians, rheumatologists or pulmonologists.

In 2008, these centers served more than 17 million unique patients with about 67 million visits. Included in that number are nearly 32 million visits to 8,445 primary care physician FTEs. About half of all community centers serve rural populations and offer sliding fee scales based on the patient’s ability to pay. These health centers also receive higher Medicaid rates for primary care services, more than the Medicaid fee-for-service rates a private physician office would receive. The health center’s cost-based reimbursement policy is required by section 330 of the Public Health Services Act.

Ron Yee, M.D., an Advisory Panel member who is chief medical officer at a seven-site community health center based in Parlier, California, says he does not have trouble recruiting physicians. Dr. Yee’s organization, United Health Centers of the San Joaquin Valley, does not have heavy turnover. In fact, physicians who are not part of the NHSC program, in which they are working at the center in return for loan forgiveness, stay about ten years. Dr. Yee’s experience is not unusual. According to a recent survey of 402 community health centers, annual turnover rates for physicians are relatively low, ranging from a high of nearly 8 percent to a low of less than 1 percent. (See chart.)

ANNUAL TURNOVER RATES	
Family Practitioner no/OB	7.78%
Family Practitioner w/OB	0.75%
Internal Medicine Physician	4.75%
Pediatrician	3.68%
OB/Gynecologist	2.79%
Nurse Practitioner	8.36%
Physician Assistant	7.46%

Source: National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010.

Health Center Pay

While Dr. Yee noted that physicians may earn less base pay working at a community health center than in other venues, there are a number of opportunities to augment their incomes. While United Health Centers offers salaries that are 60 percent to 70 percent of the pay in Dr. Yee's local market, physicians also can receive a productivity bonus. Many health centers determine how many patients a clinician needs to see each day for the center to break even—at Dr. Yee's center that number is 23—and then set a bonus around that number. At United Health Centers, doctors who average have 23 appointments a day can receive about \$17,000 annually in bonuses, while seeing 25 patients at day could result in nearly a \$29,000 bonus.

Similar to a private practice, physicians can make more by working more. Dr. Yee noted that working on Saturdays, in addition to regular hours, garners extra pay, as does taking call. If a physician is willing to take call from the local hospital and the health center, Dr. Yee's organization adds \$6,000 to the doctor's base salary. Physicians also earn additional money from the health center for each service they provide at the hospital, such as assisting with a delivery and providing follow-up care. "A physician could add \$44,000 [annually] by working ten deliveries a month, [caring for the mother and baby] at the hospital," Dr. Yee noted.

Another addition to salary is the loan forgiveness program through the National Health Service Corps in which doctors can receive \$145,000 in loan repayments over five years. After that period, physicians can renew the contract until all their loans are paid off.

According to NACHC's most recent salary survey, only about 12 percent of community health centers reward staff with retention bonuses, with average bonuses for physicians ranging from \$467 to nearly \$10,250. The average length of service to receive a bonus ranged from 3 to 4.4 years of service.³ United Health Centers does not offer a retention bonus, but does offer a signing bonus ranging from \$5,000 to \$7,000, depending upon its needs and the physician's experience and qualifications.

Some physicians at Dr. Yee's community health center make more than \$200,000 a year, adding salary, productivity bonuses, pay for taking call, and loan forgiveness. Dr. Yee pointed out these physicians are not concerned with overhead and hiring staff, and have medical, dental and retirement benefits. "Compared to working in a private practice, these doctors actually do pretty well financially," said Dr. Yee.

PERFORMANCE MEASURES

Health Centers Could Select More Than One Response.
Numbers From 402 Respondents.

RVUs	108
Patient Visits	313
Number of Capitated Lives	22
Case Management	76
Patient Satisfaction	312
Site Efficiency	133
Practice Productivity/Profitability	245
Other*	24

*Included gross billings, quality of care and teamwork.
National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010.

PERFORMANCE MEASUREMENT USED FOR BONUSES

Health Centers Could Select More Than One Response.
Numbers From 402 Respondents.

RVUs	64
Patient visits	152
Number of Capitated Lives	6
Case Management	16
Patient Satisfaction	105
Site Efficiency	49
Practice Productivity/Profitability	131
Other*	31

*Includes gross billings, quality of care, teamwork
Source: National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010

Benefits: Lifestyle and Practice Customization

Knowing that pay is not likely to be a health center's most attractive benefit for physicians, Dr. Yee tries to attract them with two benefits that are not related to income: lifestyle and practice customization. "We give them a lot of time off up front," said Dr. Yee, adding that the day a doctor starts, he or she has seven weeks of leave, including four weeks of vacation, a week of educational leave, and nine paid holidays, including the individual's birthday. Doctors do not have to take call, but if they do, Dr. Yee works to set a reasonable schedule, such as every sixth weekend and one day a week. Because each of the seven sites at United Health Centers is staffed with two to seven clinicians, full-time doctors—who work 40 hours a week—are not locked into a strict nine-to-five schedule. "We try to be reasonable and flexible to support clinicians and their families. If they intermittently need to modify their schedules to attend family events we try to be accommodating," states Dr. Yee.

Part-time employment is also an option. At United Health Centers, two or three individuals can make up make up one FTE. Ten of the center's 25 doctors are part time. Dr. Yee added that because the center provides benefits at 20-hour-per-week level, most staff work at least that many hours.

"Our staff have flexibility and feel supported," said Dr. Yee.

Dr. Yee also works to make practice customization an option for the center's physicians. "I find out if there's a niche they want to fill, and allow them to do that." For instance, one physician prefers to perform procedures; she is able to perform many of the center's vasectomies and small surgical procedures. "We refer internally so she has a good case load to keep her skills up, and we are able to keep the cases internal to the center, so there is better continuity of care," Dr. Yee states.

In addition, physicians who want to teach have an opportunity to help train undergraduates and medical students because the center is an elective training site for University of California San Francisco. Eleven of the physicians at United Health Centers are associate clinical professors at the school.

Physicians also manage patient cases whose primary care provider is a mid-level clinician. In addition to 25 physicians, United Health Centers employs five physician assistants and two nurse practitioners. The center uses mid-levels not as physician extenders, but as practitioners. "They don't see only coughs, colds and the easy stuff," said Dr. Yee. If a mid-level has a more complex case he or she sees the patient most of the visits, and that patient might see a physician only once or twice a year. Essentially, the mid-levels have their own patient panels, says Dr. Yee, and whether the center can list the mid-level as the patient's primary care clinician depends on the payer. On the whole, though, this makes for more staff satisfaction for nurse practitioners and physician assistants. "They like it because it uses all their skills," said Dr. Yee. "They feel good about their practice."

Through experimentation, Dr. Yee has also learned the staffing pattern it takes to make physicians satisfied with their work flow. The winning formula involves having three exam rooms and two medical assistants for each physician. Often patients at the health center only speak Spanish, so if a single medical assistant was on duty, he or she would be in an exam room translating for a physician. During that time, no other medical assistant duties would be performed, such as checking in patients or performing simple lab tests. "Without that ratio, we create a bottleneck," explained Dr. Yee.

Stepping Stone to Other Settings

Dr. Yee pointed out that most of the doctors he hires are mission-minded and fresh from residency. While community health center managers prefer and strive to have long-term relationships with physicians, these jobs can prepare physicians for private practice, in the event they choose to leave. This preparation is evident both in terms of complex cases and cutting edge projects in quality improvement. A number of community health centers have affiliations with university medical centers and participate in their quality initiatives. The health centers also help the doctors in developing diagnostic and treatment skills. "This setting provides some of the richest experiences medically, with a higher rate of chronic diseases and difficult cases," Dr. Yee stated. But a doctor going to work at a community health center today may not be using an electronic medical record; less than half of them have one.⁴ United Health Centers and five other health centers received a \$2.9 million grant in 2010 to implement electronic medical records. Dr. Yee expects his health center's electronic records system to be in place in 2012, and says other health centers will take similar initiatives. "They are all heading in that direction," he said.

In the Wake of Healthcare Reform Measures

While Dr. Yee believes the national healthcare reform law will help the uninsured—and the population community health centers serve—he is not certain how the law's provisions will affect his health center. NACHC estimates that their members will be able to double their capacity because of the additional funding, going from treating 20 million patients to 40 million by 2015. Toward that end, United Health Centers is gearing up to add space, breaking ground in 2010 on a 20,000-square foot administration building, freeing up more space for medical and dental care, and allowing the center to start offering behavioral health services. This expansion was funded in part by a \$1.5 million federal grant from the 2009 American Reinvestment and Recovery Act. Dr. Yee predicted that his organization will add staff and extend hours.

But he is not sure if the future funding will ultimately bolster the center's operations. It currently receives a federal grant of \$4.6 million annually to treat the indigent, and that amount could be decreased when more of the center's patients are covered by Medicaid. "We may gain on one side, but lose on the other. We could be in worse financial shape, depending on how the healthcare reform law is implemented in California," said Dr. Yee. "That's a question mark."

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Accountable Care Organization Study

Lehigh Valley Health Network
University of Michigan Faculty Group Practice

While the new healthcare reform law encourages clinical integration in a number of pilot projects, perhaps the most direct encouragement is the Medicare Shared Savings Program for Accountable Care Organizations (ACOs), slated to start in 2012. In these Medicare projects, provider organizations that meet specified quality standards and accept accountability for patients are able to share savings with the government. The organizations will enter into a three-year agreement and must be able to care for at least 5,000 Medicare patients. ACOs would not be penalized if they do not meet savings targets.¹

Perhaps no part of healthcare reform has generated more activity on the part of provider organizations. News reports indicate that hospitals and physician groups are finding ways to connect now to be ready for the future.^{2,3} And provider groups are spending considerable efforts to make sure they make the change completely and correctly. One example: about 80 provider organizations are studying ACOs in the Accountable Care Organization Learning Network, a joint project of the Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. The program, which started in 2009, offers members monthly webinars and an ability to share best practices. In 2010–2011, the network will produce an implementation guide.⁴ At the same time, Premier Health Alliance, a consulting and purchasing network owned by not-for-profit hospitals, is working on two collaboratives designed to help members develop the capabilities necessary for ACOs. One collaborative works on ACO readiness, while another is focused on implementation.⁵

While hospital systems and networks are investigating the transformation to ACOs, Advisory Panel members recommended that physicians should lead such organizations. They are not alone. Harold D. Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, writes in a recent White Paper produced for AMA members that there is little evidence to prove that any particular type of provider or organizational structure cannot serve as an Accountable Care Organization. . . The goal of the Accountable Care Organization is to take responsibility for managing the costs and quality of healthcare for a population of patients, not necessarily to deliver every health service itself.⁶ In fact, CMS indicates that physicians in group practices and networks of practices are ACO candidates.⁷

A growing number of hospitals are planning on acquiring group practices or employing physicians, in part to prepare for the ACO model (see chart below).

PHYSICIAN/HOSPITAL ALIGNMENT

According to a survey of 258 hospital leaders:

74% say they plan to employ a greater number of physicians in the next 12 to 36 months

70% say they have received increased requests from physician group for employment

61% plan on acquiring medical groups in the next 12 to 36 months

*Includes gross billings, quality of care, teamwork

Source: National Association of Community Health Centers. Health Center Salary & Benefits Report 2009-2010

Principles of the ACO Model

- 1) Local accountability: ACOs will be comprised of local delivery systems with patients empirically assigned to the organization. ACO spending benchmarks will be based on historical trends and adjusted for patient mix, making the local system account for cost, quality and capacity.
- 2) Shared savings: ACOs with expenditures below their benchmark will be eligible for shared savings payments. Savings can be shared among all stakeholders and allow for investment that can improve care and slow cost growth.
- 3) Performance Measurement: Measurement is essential to ensure that appropriate care is being delivered and that cost savings are not the result of limiting necessary care. ACOs will report patient experience data in addition to clinical process and outcome measures.

Source: Brookings-Dartmouth ACO Learning Network. Overview of the ACO Model.

Requirements for an ACO

- 1) Formal legal structure to receive and distribute shared savings.
- 2) Sufficient number of primary care professionals for the number of assigned beneficiaries (5,000 minimum).
- 3) Participation in the program for at least three years.
- 4) Sufficient information regarding participating ACO healthcare professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared saving.
- 5) A leadership and management structure that includes clinical and administrative systems.
- 6) Defined processes to promote evidenced-based medicine, report the necessary data to evaluate quality and cost measures, and coordinate care.
- 7) Meet patient-centeredness criteria, as determined by the Secretary.

Source: CMS/Office of Legislation. Medicare Accountable Care Organizations Shared Savings Program, Preliminary Questions and Answers. June 2010.

ACOs are not just groups of aligned providers. For most physician practices or networks, substantial investment in technology and staff commitment to change processes has to take place. These organizations not only track a patient's medical record to various providers, but must develop the ability to meet benchmarks on quality standards. Following are two case studies of organizations preparing to be able to contract with Medicare as an ACO. One is a private health network in Pennsylvania that is working to align with its physicians, both in employed and unemployed models, in an effort to improve cost and quality metrics. Another is an academic physician practice that participated in the CMS Medicare Physician Group Practice Demonstration Project to drive its performance to a higher level.

Case Study: Lehigh Valley Health Network, Aligning With Physicians

Organizations like the Lehigh Valley Health Network, which include physicians and hospitals under one umbrella, are arguably the most likely ACO models. The network, based in Allentown, Pennsylvania, includes two hospital campuses with 1,000 beds and a hospital-owned 500-doctor multi-specialty practice, and another 200 doctors that are exclusively aligned, that is, they practice medicine only at Lehigh Valley hospitals.

Michael Rossi, M.D., an Advisory Panel member and a cardiologist who serves as the executive director of the network's physician practice, Lehigh Valley Physician Group, noted that the journey to alignment with hundreds of doctors was a long one. The hospital-owned physician practice began in 1992 as a place to employ physicians in support specialties for the hospital, such as the surgeons who operated on trauma patients and burn victims. The practice also was home to faculty that trained residents. When it started, the group totaled 24 doctors.

Over the next ten years, the practice saw a gradual increase, precipitated by physician and community need. For instance, when Pennsylvania medical malpractice premiums soared in the mid and late 1990s, ob/gyns who wanted to stay in the area joined Lehigh Valley's physician group. They no longer paid high premiums, as this cost was born by the physician group. Pediatricians followed the obstetricians into the employed group. In the last decade, when many specialists began to charge to take call at hospitals or simply no longer performed that service, the employed practice welcomed specialists who would perform that service, in turn ensuring that the network's hospitals had coverage. Dr. Rossi said that the network also has acquired some primary care practices whose doctors wanted to access the network's electronic medical record and to participate in its quality initiatives.

Dr. Rossi has some experience creating larger practices. When he came to Allentown in 1992, he joined one of the two "large" cardiology practices in town. Each had about ten physicians. He realized that the practice wasn't reaching its fullest potential because it spent most of its energy competing with the other large practice in town. The doctors were trying to get primary care physicians to change their referral patterns instead of being focused on quality, program development and growth. "We were trying to get a bigger piece of the pie instead of growing the pie," states Dr. Rossi.

Eventually, he became managing partner of the practice and helped facilitate the merger of the two large cardiology practices. He also championed a closer alignment with the hospital: The cardiology practice moved onto rented space at the hospital campus in the late 1990s and several of the practice members became involved in program leadership at the hospital. One physician became director of the cardiac cath laboratory, another become the director of the electrophysiology laboratory, for which they received small stipends, while they continued to practice medicine. In turn those

physicians had influence on how the hospital's program developed regarding treatment protocols. The cardiology practice was able to add additional sites, treating more patients, creating opportunities for both the practice and the hospital. Dr. Rossi himself later served as the first full-time chief of cardiology for the network, before he assumed his current role with the employed group practice.

Dr. Rossi attributed the success of the hospital's efforts with physicians to two principles. First, there was an understanding between physicians in the community and the hospital that the hospital would not aggressively pursue physicians to have them join the hospital-owned practice. "The employed physician group would only respond if we were approached," said Dr. Rossi. "That way the hospital wasn't seen as pushing private practice out." A legacy of that decision is evident in the fact that 300 physicians not exclusively aligned with the Lehigh Valley Health Network still are part of its active medical staff.

Second, the hospital made it clear it was serious about closer alignment with physicians and that they didn't have to be employees. The network uses clinical affiliation agreements, similar to the one which was used with Dr. Rossi's practice. Another example involves a pulmonary critical care group with which the hospital contracts. The hospital helped fund technology and additional staffing for an advanced ICU, with after-hours coverage by a remote intensivist, which resulted in improved cost and patient outcomes for the hospital. The pulmonary critical care practice is now able to care for more patients as a result of these upgrades.

Lehigh Valley Health Network also leases practices and offers private practice physicians the opportunity to be voluntary clinical faculty.

The network has a Physician Hospital Organization that contracts for an Independent Practice Association that is only open to members of Lehigh Valley's Medical Staff. "There's a vision that the PHO could be a way to spread the network's electronic medical record to community physicians, but we haven't done that yet," states Dr. Rossi.

Financial Integration

In his role as executive director of the employed physician group, Dr. Rossi is working on converting 39 different compensation models to just one. As contracts expire, physicians are transferred to the new compensation plan, a model in aligning financial and quality incentives.

The new compensation plan includes a salary based on benchmark data, with a productivity expectation built in to it, and the salaries have a 2.5 percent to 10 percent withhold—departments within the practice can choose the level. "It's not a lot of money, but it's enough to get doctors' attention," stated Dr. Rossi. This money is returned to physicians based on minimum standards including such areas as patient satisfaction, quality metrics, graduate medical education, and cost effective care. "It's not meant to be a high bar, but create a threshold at a place where we didn't have one before," said Dr. Rossi.

A third piece of the employed doctors' compensation involves an incentive plan in which physicians share in dollars generated when the 90 practices within the employed group perform better financially than the projected budget. That money is distributed based on the performance of the individual practices, the 500-physician group practice and the network. Individual departments or divisions within the Lehigh Valley Physician Group can set the metrics for doctors to receive those

dollars. Dr. Rossi pointed out that physicians get the maximum incentive payment, which can be up to 10 percent of their salary, if all three entities perform well. By connecting the doctors to the overall network this way, stated Dr. Rossi, they have a vital reason to be involved. “If you are working on reducing length of stay or the cost of surgical equipment, now the doctors are engaged—before it was a burden.”

While the network has been able to create Valley Preferred PPO that serves more than 200,000 patients, Dr. Rossi believes that network hasn’t reaped the full benefits of its effort because payment in the market is still largely fee-for-service. Half of the payer mix for the practice is fee-for-service or managed care discounted fee-for-service, 30 percent Medicare, 10 percent Medicaid and another 10 percent self-pay. But Dr. Rossi predicts a change. “Whether it’s an accountable care organization model, where the ACO accepts global capitation, or Medicare moving to value-based purchasing, global payment or bundled payments, it makes sense for the hospital and physician to be aligned and to be as integrated as possible.”

For Dr. Rossi, the alternative is untenable. He describes a possible future scenario in which a payer remits \$1,000 to a hospital for a cardiac care episode, which it must divide among all the doctors who cared for the patient. “Who’s going to negotiate those different fee schedules?” he asked. “It becomes a nightmare.”

But before such payment types arrive in Allentown, Lehigh Valley Health Network continues to work on alignment, in various forms. The network is currently leasing a primary care practice for seven years. “We are setting the expectation that if doctors want to partner with us, they must do it exclusively,” stated Dr. Rossi. “If the future is about efficiency, quality and standard work practices, we can’t see existing in a world where doctors are going to three different hospitals and learning three different medical record systems. It’s about focusing your energy to produce better quality and greater value.”

Case Study: University of Michigan Faculty Group Practice and the Medicare Pay for Performance Demonstration Project

In the mid-2000s, the University of Michigan Faculty Group Practice plan had a number of pieces in place to enable it to deliver high quality care, but David Spahlinger, M.D., an internist and Advisory Panel member who is executive director of the faculty group practice, wanted to see performance improve even more. In fact, he thought it was a necessary step for the practice to continue to thrive.

Dr. Spahlinger, who also serves as clinical associate professor of internal medicine and senior associate dean for clinical affairs at University of Michigan’s medical school, championed the faculty practice’s participation in Medicare’s Physician Group Practice Demonstration. This pay-for-performance project allowed practices to share in cost savings. Even with the resources of a large practice—the University of Michigan group includes 1,700 doctors who care for patients at three university hospitals and 40 university health center—participating in this project required a substantial investment.

“I had to ask for \$800,000 for the infrastructure,” stated Dr. Spahlinger, “but I convinced the board this would position us for the future.”

The Medicare demonstration project was mandated in the Medicare, Medicaid and SCHIP Benefits and Improvement Protection Act of 2000, with the goals of:

Encouraging coordination of Part A and Part B medical services, promoting cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams, and rewarding physicians for improving health outcomes.⁸

In the demonstration project, practices continue to be paid Medicare fee for service rates. The savings the group practices generate are judged by comparing its Medicare patients to local market Medicare patients not served by those providers, adjusted for case mix. After practices meet a 2 percent savings threshold, they can earn up to 80 percent of the savings they generate, while the Medicare trust fund retains the other 20 percent. Practices earn the payments both by demonstrating savings and reaching benchmarks on quality measures.

The program started in 2005 with only 10 quality measures for diabetes patients. More measures were added, so that at year three and after, 32 such measures in five different disease modules are assessed by Medicare.

See below the measurements in the Heart Failure module:

PHYSICIAN GROUP PRACTICE DEMONSTRATION QUALITY MEASURES FOR HEART FAILURE PATIENTS

- | | |
|---|--|
| 1) Left ventricular function assessment | 7) Ace Inhibitor Therapy |
| 2) Left ventricular ejection fraction testing | 8) Warfarin Therapy for Patients with Atrial Fibrillation |
| 3) Weight measurement | 9) Influenza Vaccination for HF patients 50 years and older |
| 4) Blood pressure screening | 10) Pneumonia Vaccination for HF patients 65 years and older |
| 5) Patient education | |
| 6) Beta-Blocker Therapy | |

Source: CMS. Physician Group Practice Demonstration Quality Measurement and Reporting Specifications, Version 2. 2005.

For each measure, group practices can satisfy quality requirements in several ways: reaching a certain percentage of compliance; reaching a percentage benchmark based on indicators from the Medicare Health Plan Employer Data and Information Set (HEDIS) scores; or registering a certain percentage of improvement in compliance over previous years. The quality performance payment is based on the percentage of the quality targets a practice has met in the project year. During the first three years of the project, the weighting of savings and quality measures shifted from 70 percent based on savings and 30 percent based on quality measures to a 50/50 percent split.⁸ "If you don't hit the benchmarks on the quality measures," stated Dr. Spahlinger, "you can lose half of your performance payment."

At the time the Michigan faculty practice began the program in 2005, it already had quality initiatives in place and a robust information technology program, with a disease registry and tracking systems. But the practice added a complex care management group made up of nurses and social workers. This group identifies high risk patients and makes sure the patients have timely follow-up appointments after inpatient discharges and emergency department visits.

In fact, Dr. Spahlinger pointed to this program as the one that helped the practice succeed. “Caring for the highest cost, most complex patients—end stage renal disease, heart failure patients—that’s where we saved money,” he said. Dr. Spahlinger makes the point that to reduce costs, providers need to aim at preventing hospital readmissions. Providers do not save the Medicare program money by reducing length of stay because hospitals receive one payment for the stay through DRG methodology. In order to stop readmissions, said Dr. Spahlinger, providers need to keep in touch with these patients, making sure they get the necessary interventions, medications and care. “Patients are pretty sick when you discharge them from the hospital now,” he added. “You don’t want them waiting two weeks for a follow-up appointment.”

The Michigan faculty practice was successful in saving \$34 million over risk-adjusted expected costs over a four-year period, treating 18,000 to 20,000 patients in each year of the program. The practice retained savings expected to be in excess of \$12 million for the four-year period. Dr. Spahlinger pointed out that practices must wait for their performance payments; it takes about a year for the data to come back. In August of 2010, the practice did not have data for the fifth year of the project, which ended March 31, 2010. In addition, CMS withholds 25 percent of its performance payments to the practice, to use in case the practice loses instead of saves money the next year.

During the project, the Michigan faculty practice had its share of challenges. The percentage of Medicare Advantage patients that were attributed to the practice increased from 4 to 25 percent. These patients tend to be healthier and they are excluded from the pay-for-performance project. The practice found its percentage of high-risk patients—those needing costly care—increasing as a result.

Dr. Spahlinger also pointed out that patients are assigned retrospectively, that Medicare looks at where patients get a plurality of their care for attribution to the practice. “This is really managed care, but we are putting it on top of a fee-for-service free-for-all,” he said. For the program to be effective, patients should choose a primary care provider and then let him or her manage their care prospectively, he argued. The practice treats some 40,000 Medicare patients, but only about half that amount was considered to be attributed to the demonstration project.

“We had to cast a much wider net,” stated Dr. Spahlinger, noting that many patients that received the benefit of all the practice’s quality programs were not counted by Medicare. “All these patients received better care, but we have to concentrate our dollars where they will have the most benefit,” said Dr. Spahlinger. “If we had been able to better focus our resources, we could have had better results.”

But this hasn’t dampened his enthusiasm. The practice is already negotiating a continuation of the pay-for-performance project. Dr. Spahlinger said the past participation will make it easy for the practice to take on an ACO shared savings contract, as the new Medicare project will have a similar design.

And aside from improving quality and gaining performance payments, the project has led to another positive change at the faculty practice—a more collaborative culture. Leaders at the practice had wanted staff to improve their ability to work together across departments and as a whole. “The best way to do this is to provide shared responsibility,” said Dr. Spahlinger. “A project like this ends up bringing people together to solve problems.”

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Affiliated Rural Group Case Study: Medical Associates

Rural healthcare delivery has traditionally faced a wide range of significant challenges. Patient populations tend to be older and more dispersed, and rural clinicians often have to work longer hours to care for patients. It's also harder to attract physicians to rural areas. The raw numbers bear this out—19.2 percent of the U.S. population live in rural areas, but only 11.4 percent of physicians practice there.¹ A number of measures in the ACA strive to bolster rural healthcare delivery and to increase the number of physicians practicing in rural areas (see “Health Reform and the Physician Work Force” in this paper.) While health reform provisions may help, they are not enough to change the market conditions that are forcing some rural practices to make changes and seek new partners.

Medical Associates, a six-doctor practice in Le Mars, Iowa, sits in a town of 9,000 in the rural Midwest, with a market area that is home to 20,000 potential patients. The practice came to the decision in 2008 that it had to take action to insure its future. The primary impetus was that it could not recruit physicians. “Most candidates were not willing to buy into a practice,” said practice administrator Julie Sitzmann, who has been at her job for 18 years. “We were going to be in a better position for recruitment if we were part of a system.” The changes, though not directly driven by health reform, better position the practice to operate in the post-reform environment, Sitzmann indicates.

The practice hired a consultant in the spring of 2008 to help the physicians consider their options. It considered selling to large systems outside of Le Mars and a large physician group in Sioux City, Iowa. In the end, the practice rejected these potential partners. “We didn’t have the same agenda,” said Sitzmann. She explained that the large health systems wanted to buy the practice for its hospital admissions, but that would have forced both doctors and patients to drive out of town for routine inpatient care. Another concern was that the large physician group would enter contracts with payers that weren’t favorable to Medical Associates. “In Sioux City, that group is one of several providers, where as we are the only game in town,” said Sitzmann. This gives Medical Associates bargaining power that might not be reflected in the larger group’s negotiations.

In the end, Medical Associates, now called the Family Medicine Clinic, chose Floyd Valley Hospital located in Le Mars. “We could get the best deal from the hospital,” said Sitzmann, “because it had the most to gain from owning us.” The clinic began operation as a hospital department July 1, 2009.

Floyd Valley Hospital, a 25-bed critical access facility with 300 employees, has realized improvements from the purchase. With the doctors and hospital as one entity, the organization was able to change to the more favorable Provider-Based Medicare reimbursement, adding about 10 percent more to its Medicare revenues.

“Medicare and other payers were nudging us together,” said Mike Donlin, who has served as the hospital’s administrator for 12 years. “We’ve had a long courtship. The hospital always let it be known that we were willing to talk.”

Donlin does not want to repeat the problems of the hospital practice purchases of the 1990s. “We are not making any sudden drastic changes,” he noted, adding that practice was not in distress before the purchase. The doctors still have much influence in how the practice is run, comprising four of six voting members on the clinic operations committee. Donlin and the hospital’s director of finance are the other voting members.

In the purchase arrangement, the hospital owns the practice, but the physicians are employees of the Avera Medical Group, which provides a benefit package for the physicians. Avera Medical Group is part of Avera, a health system based in Sioux Falls, South Dakota, with which Floyd Valley Hospital has an affiliation. The other employees of the Family Medicine Clinic, including three physician assistants and five nurse practitioners, are employed by the hospital.

The hospital has a lease agreement with Avera Medical Group for the doctors’ services. Pay is structured on a productivity basis using RVUs, similar to how the doctors were paid before the purchase. The agreement includes a four-year guaranteed minimum and a ceiling, with doctors earning 85 percent to 125 percent of their previous income. “We wanted to do something straightforward the first few years in which doctors could make about what they made in private practice,” stated Donlin. In some ways, the arrangement is seamless: the practice continues to be at the hospital, where it leased space before the purchase, and Floyd Valley Hospital hired Sitzmann to continue as administrator.

Sitzmann and Donlin hope the practice purchase will allow new efficiencies, and it is already bearing fruit. The merger of the practice and hospital radiology departments is saving money and eliminating duplication. “We haven’t tinkered with back office or lab operations,” noted Donlin. “The hospital won’t dictate those kinds of changes, and the clinic operations committee will do what makes sense.”

More changes are in the offing. The practice is trying to recruit two family practice physicians that practice obstetrics, which Sitzmann is hoping will be easier with an employed model. The practice lost two physicians in the last four years, creating hectic call schedules for the physicians who practice obstetrics. “These physicians are on call every fourth night and every fourth weekend, and that is too much,” said Sitzmann.

But the physicians also have another purpose in making new hires. “We see that reimbursement is going toward being value-based, rather than volume-based,” said Sitzmann, “so we want our doctors to be able to spend more time with patients and more time coordinating their care.” These changes, she said, will help the doctors position the practice to be a candidate for the National Committee on Quality Assurance’s medical home designation. “In merging with the hospital, the doctors had the future in mind,” said Donlin.

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Compliance Issues and Physician Practices

The Patient Protection and Affordable Care Act (“ACA”) and other recent amendments to existing laws present a host of compliance issues for physician practices. The federal government is stepping up enforcement of healthcare laws, giving these compliance efforts even greater urgency. As evidence of the Government’s intent to focus on compliance, the ACA has allocated an additional \$350 million through 2020 to fight healthcare fraud and abuse. In addition, payments for care may now be suspended by CMS during investigations of “credible allegations of fraud,” with the definitions of a “credible allegation” to be determined by the Department of Health and Human Services (“HHS”). Significant changes are made in the ACA to existing criminal and civil enforcement provisions that remove or substantially weaken historically available defenses; other provisions are designed to create transparency in manufacturer-provider and other relationships.

Jane Jordan, Chief Health Counsel at Emory University in Atlanta and a member of the Advisory Panel for this White Paper, advises practices—no matter their size—to create and implement their own compliance plans as a major way to address these changes in the law and increased government enforcement initiatives. Although physician practices are not currently required to have such plans, Jordan thinks they will eventually become mandatory as HHS creates a list of providers that must adhere to such a requirement. “It’s just a matter of time before you must have a formal plan; good practice and common sense mandate that you do so now,” she says. If practices do not implement compliance plans and follow them strictly, they will put themselves at a huge risk.

Guidance for such plans was issued in 2000 by the Office of the Inspector General in connection with the passage of the federal sentencing guidelines: under those guidelines, if a party had an effective compliance plan in place in the event of a conviction of a crime, the court could reduce the sentence of the convicted party¹. At that time, the OIG stated that in order for a compliance plan to be effective for reduced sentencing, all entities, including physician practices, as part of their compliance plans, must:

- Conduct internal monitoring and auditing
- Implement compliance and practice standards
- Designate a compliance officer or contact
- Conduct appropriate training and education
- Respond appropriately to detected offenses and develop corrective action
- Develop open lines of communication and enforce disciplinary standards through well-publicized guidelines

While the OIG stated in 2000 that it did not expect smaller companies (including physician practices) to implement all of these components, the list could help practices that were evaluating areas in which they were at risk for government enforcement so their plans could be drafted accordingly. In today’s environment of increased enforcement, these guidelines become even more critical as practices evaluate the need to implement their own compliance programs.

A further aspect of an effective compliance plan is the interplay with good human resource practices, which will be more important than ever, as whistleblowers now have access to more legal avenues for reporting suspected violations of fraud and abuse and other laws. The ACA now allows individuals to use public information—even news reports—as the evidentiary support for an allegation, a new twist to the laws governing the basis for a whistleblower suit. Among other things, human resource policies must provide would-be whistleblowers with a safe place to report a troubling occurrence, and a clear and objective process to address that occurrence. Jordan noted that most whistleblowers are not primarily seeking monetary rewards, but are truly troubled about billing or other matters at their organizations and want to see those issues resolved. “You always want this person to have his or her concerns addressed,” said Jordan, “without fear of reprisals.” Indeed, practices must understand that an employee has a legal right to bring compliance issues to the attention of his or her employer without fear of termination.

Transparency

Since the advent of the Sarbanes-Oxley law in the early part of the decade following the Enron and other similar crises in large publicly held companies, transparency in the financial practices of corporations has become a mandate. The new ACA now adopts that focus on transparency in certain changes to portions of the Stark Law as well as new “sunshine” provisions regarding disclosure of physicians’ financial relationships with industry. For example, practices now must give written notice to patients about the ownership of in-office ancillaries and give patients a list of local alternatives when referring them to an ancillary’s service or product. “Practices need to demonstrate that they have given patients a choice,” said Jordan.

Another change to existing laws are that following the development of policies and procedures by HHS, physician owners or investors in hospitals will have to disclose their ownership to their patients referred to the hospital, in addition to including this fact on the hospital’s web site and in any of the hospital’s advertisements. Additionally, hospitals must tell patients prior to admission if it does not have a physician on premises during all hours in which the hospital will provide services to the patient. For both of these requirements, HHS will implement policies and procedures within eighteen months of the ACA’s enactment. At that time, these disclosure requirements will begin.

Also in the next few years, both pharmaceutical firms and medical device manufacturers will be required to report to HHS their financial relationships with doctors. This requirement goes into effect in March, 2013, for payments (subject to some exclusions, including product samples, educational materials that directly benefit patients and permitted discounts and rebates) that were made in 2012. Many device manufactures and pharmaceutical companies are already making this information publicly available on their web sites, following several instances of non-disclosure to research universities by employed physicians of their payments for outside consulting services. Jordan recommends that physicians follow the lead of the pharmaceutical companies and device manufacturers and take preemptive action to make this information public now, again in the interest of total transparency. She noted that physicians would not want patients to learn from another source about a financial relationship and wonder, “Why didn’t my physician tell me?” Jordan pointed to numerous physician practices already taking these steps.

The Cleveland Clinic, for instance, details on its web site the financial relationships of individual doctors who serve as consultants for firms or are participating in a drug trial, and details the amount of payments on an annual basis. Jordan predicts that eventually these “sunshine” provisions in the ACA will apply directly to physicians. “The clear trend is toward total transparency in financial relationships,” she said.

Changing Legal Standards Affecting Physician Relationships and Payments

The ACA has limited certain ownership options currently available for doctors and also created harsher standards for laws regarding disclosure of financial relationships and discovery of possible overpayment.

Physician Ownership In Hospitals

First, physician ownership of hospitals has been severely limited. While previously doctors could invest in whole hospitals under the “whole hospital” exception under the fraud and abuse laws, such arrangements formed after this year will be ineligible to receive Medicare and Medicaid payments. Existing hospitals that are wholly-owned by the doctors who invest—numbering 265 nationwide²—will be grandfathered in only if they have a provider agreement with Medicare by December 31, 2010.

Furthermore, hospitals cannot increase the percent of physician ownership. Going forward, only under limited circumstances will these hospitals be able to add beds and operating rooms. While this aspect of the ACA faces at least one legal challenge filed in June, 2010, the measure is already in effect, since the ban on expansion started March 23, 2010. Physician Hospitals of America (PHA), Sioux Falls, South Dakota, is one of the plaintiffs in the suit. The organization argues that preventing the expansion and opening of new hospitals will hurt access to care and hamper competition. It further argues that these hospitals provide jobs and tax revenues to communities, noting that these hospitals employ more than 75,000 full and part-time employees and have an average yearly payroll of \$13 million, with \$3.4 billion in a total annual payroll nationally.³ It is likely that similar lawsuits will be filed with respect to other aspects of the ACA, and indeed, there are numerous states which have or are in the process of filing suits to challenge the constitutionality of the ACA itself. The likelihood of success of any of these lawsuits is impossible to predict, and even an ultimately successful result would be years in the making as the cases wind their way through the judicial process.

The critics of physician-owned specialty hospitals have charged that the facilities “cherry pick” patients, treating only those that are not severely ill, because they create a greater financial reward. Some evidence supports this claim.⁴ Critics also say that these hospitals treat low numbers—if any—patients who are uninsured or underinsured.

The ACA also freezes physician investment in hospitals as of March 23, 2010. Therefore, if a hospital has a new physician investor, another physician must sell his or her interest or all physicians must reduce their percentage of ownership. This could be difficult if each physician owner has only a 2 percent investment, which was the average found in a GAO study of physician ownership of specialty hospitals.⁵

PHYSICIAN-OWNED HOSPITALS

Multispecialty

Actual Number 149
Average Staffed Beds..... 40

General Acute

Actual Number 54
Average Staffed Beds.... 233

Heart

Actual Number 18
Average Staffed Beds..... 65

Orthopedic

Actual Number 18
Average Staffed Beds..... 24

Rehabilitation

Actual Number 12
Average Staffed Beds..... 34

Long Term Acute Care

Actual Number 8
Average Staffed Beds..... 30

Emergency Care

Actual Number3
Heart and General Acute ...1
Multispecialty Children's....1
Multispecialty Women's1

Source: Silva, P. Physician-owned hospitals: Endangered Species? American Medical News. June 28, 2010.

New Deadlines for Overpayments

Another aspect of the ACA that is already in effect (as of May 22, 2010) but which has not received wide attention is critically important in terms of compliance with respect to payments from CMS. Prior to the ACA, a “false statement” was required to prove a violation of the False Claims Act, one of the most serious fraud and abuse acts to which physicians and providers are subject. Under the ACA, “knowing” and “improper” concealment or simple avoidance of an obligation is sufficient and represents a critical change in the applicability of the law. Previously, physicians and other providers did not have a time deadline to determine if an “overpayment” had occurred and if a repayment was due to CMS; there was time, for example, to carefully evaluate a bill and conduct an audit or other confirmatory process to determine if in fact an overpayment had occurred and the amount that the payment should be. Now physician practices have a 60-day deadline “after the date on which the overpayment was identified OR the date any corresponding cost report is due, if applicable” for reporting and returning overpayments. This part of the ACA also does not define the term “identified,” leaving physicians unsure in some cases when the countdown to the deadline begins. Because of the vague wording, identification could be when overpayment is strongly suspected or when it is actually quantified. Interestingly, CMS had proposed a 60-day deadline for overpayment returns previously, in 1998 and 2002, but did not continue efforts to finalize the requirement because of widespread criticism.⁶

In addition, the new law creates an “obligation” under the False Claims Act for failure to report and return the overpayment. Doctor practices that have delays in returning identified overpayments would be liable for potential prosecution under the False Claims Act; if successfully prosecuted, practices could pay treble damages and fines for each claim. While the measure has already taken effect, the yet-unpublished regulations will be key in determining how strictly this new measure will be applied.

“Intent” No Longer a Factor in Anti-Kickback Statute

An important but often overlooked change in the Anti-Kickback Statute (the criminal statute that applies to all relationships where referrals of business occur from one healthcare entity to another) now makes it easier for a physician to run afoul of the law. Prior to the ACA, a key requirement for prosecution was to demonstrate that an individual (or entity) had to have actual knowledge that an arrangement was violating the law or that he or she had specific intent to violate the law. That aspect of the Anti-Kickback Statute, and key defense, has been removed. “These lower thresholds will make it easier for the government to indict and convict the alleged violators,” said Jordan. In addition, the statute was amended to make an Anti-Kickback violation a false or fraudulent claim under the False Claims Act, creating a second avenue for prosecution. Lastly, the sentencing guidelines for persons convicted of healthcare offenses related to federal healthcare programs when the loss involves more than \$1 million will have increased offense levels.

Other Important Changes

The Recovery Audit Contractor (“RAC”) program, in which third party auditors look for improper provider payments and can retain 9 percent to 12.5 percent of what they recover, will be expanded to Medicare Part C, Medicare Advantage Plans, and Part D, prescription drug coverage. Jordan warns that the broad powers afforded to the RAC auditors could be dangerous: for example, a RAC settlement for improper payment does not necessarily negate liability under the False Claims Act, so practices could be possibly prosecuted under that statute after paying a settlement, a kind of “double jeopardy,” says Jordan.

In addition, the healthcare reform law encourages states to pass their own Stark laws, and physicians need to be aware of state statutes that place limitations on financial arrangements between practices and vendors. In some states that already have these “Baby Stark” laws in place, the prohibitions on physician relationships with referral sources can often be harsher than the federal statute, and should be carefully monitored.

Although not in the new reform law, another recent development demands the attention of physician practices. In 2009, the privacy requirements of the Health Insurance and Patient Affordability Accountability Act (“HIPAA”) that applied to physician practices were amended to extend to a practice’s business associates. The HIPAA requirements have also been expanded and extended under the recent Health Information and Technology Act (“HITECH”) Jordan recommends that if practices use intermediaries for billing or other functions, or deal with any third party in any way that involves the use of patient health information, that the practice carefully document the relationship with that business associate and update the contract to account for the new changes. One potential provision that could assist practices greatly (although it will likely be resisted by the vendors) is to include an indemnification provision whereby the vendor indemnifies the practice for any action on the part of the vendor/intermediary that might violate HIPAA.

Although not part of the ACA as a new enforcement initiative, Jordan had one other word of precaution and advice regarding preventive steps that a physician practice can take—the use of electronic medical records, which was recognized as a necessary step on the future of healthcare and funding made part of the federal stimulus bill. Jordan believes that physicians without electronic medical records (EMR) will be more at risk for a medical malpractice suit if most providers in their market have an EMR. The law has long recognized the standard of “reasonable care” in a particular

community, and that standard now includes an EMR in many metropolitan areas. Jordan presents a scenario in which a patient is injured because a pharmacist or nurse couldn't read a doctor's handwriting, or a patient's allergies were unknown due to paper charting that omitted the information.

"With all the emphasis on IT, an EMR is becoming an assumption and a 'must have', not something that's 'nice to have,'" she said.

Lastly, practices need to make sure they are following all provisions of the ACA as employers, such as the requirement that the health plans they offer contain the extension of dependent care for children under age 26 and a removal of lifetime caps on coverage. Practices can check to see if they are qualified to be on a "grandfathered" plan which will allow them more flexibility in structuring their health plans. Also importantly, practices will want to look at how these changes will impact their health insurance cost.

Recent Developments/New Self-Disclosure Process for Stark Violations

On September 23, 2010, CMS released its long awaited self-disclosure protocol for physician self-referral prohibitions, as required by the ACA. Entities that discover even inadvertent Stark noncompliance often have no good options. Repayment of prohibited claims can be unaffordable, but failure to repay can expose an entity to False Claims Act liability and attendant qui tam suits. Moreover, with very few exceptions, negotiated settlement has not been an option: the HHS OIG's self-disclosure protocol is no longer available for Stark violations, and, until now, CMS has provided no similar avenue for redress.

Now the OIG has issued a Self Referral Disclosure Protocol ("SRDP") that provides a framework for physician practices to self-disclose actual or potential violations of the Stark Law. Consistent with similar frameworks developed by the OIG, disclosure is required within 60 days after an "overpayment was identified." The SRDP states that parties generally may not make repayments while a self-disclosure is pending, but that timely disclosure will suspend the 60-day period during which parties otherwise are required to repay overpayments under PPACA. Among other things, the SRDP provides that the disclosure must include a "description of the existence and adequacy of a pre-existing compliance program," which adds to the importance of implementing effective compliance programs as part of a physician practice's compliance effort.

The disclosure must identify the total amount "due and owing" from the entire period "during which the disclosing party may not have been in compliance with the physician self-referral law." Importantly, the ACA authorizes the OIG to reduce parties' repayment obligations under Stark. CMS did not, however, set a stipulated penalty for technical noncompliance. A self-disclosing party therefore will not know at the outset of the process whether self-disclosure will result in a reduced repayment obligation. Factors that CMS has said it will consider in determining the repayment amount include:

- The nature and extent of the violation

- The timeliness of self-disclosure (in practice, because self-disclosure must be made within 60 days of discovery, this likely refers to the timeliness of discovery)

- The disclosing party's cooperation

- Litigation risk

- The disclosing party's financial condition

While the SRDP did not provide as much relief as initially hoped when the ACA was first passed, there is now at least a process for self-disclosure and possible reduction in Stark penalties. “It’s likely that practices will have to pay something,” said Jordan, “but at least they can get resolution of their situation.” In any event, availability of the process significantly changes the calculus as to how parties should address Stark noncompliance, and continues the increased pressure—including that arising from the recent changes to the False Claims Act—to have in place effective preventive and compliance mechanisms.

Ten Things to Remember

- 1) Whistleblowers will have relaxed standards for reporting
- 2) Providers must, within 60 days of identifying a Medicare or Medicaid overpayment, report and return it
- 3) The Anti-Kickback Statute no longer uses intent for or knowledge of law violation as a standard in judging whether an individual has broken of the law
- 4) Doctors making referrals to in-office ancillaries must now give patients information about the ownership and a list of alternative providers
- 5) Doctors must tell patients of the physicians’ ownership interest in a hospital, if patients are referred there
- 6) Doctors now have a self-disclosure process available to them under the Stark law, and an HHS representative will have the authority to settle the matter
- 7) States may pass their own versions of the Stark law (and some already have)
- 8) The Recovery Audit Contract program now will be used with Medicare Parts C and D
- 9) Practices should check that the health and other benefit plans they offer employees comply with the healthcare reform law
- 10) Proof of compliance is key: have a good and effective compliance program in place

1. Federal Register. Vol. 65. No. 194, p. 56434.

2. Physician Hospitals of America. “Federal Lawsuit and Injunction Filed Challenging Limitations on Physician Owned Hospitals in Healthcare Reform.” June 3, 2010.
www.physicianhospitals.org/documents/PHATSJHPressRelease060310.pdf

3. Ibid.

4. GAO Report. Specialty Hospitals: Information on National Market Share, Physician Ownership and Patients Served. GAO-03-683R, April 18, 2003.

5. Ibid.

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