

# The Training of the "Helpless" Physician

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## Introduction

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Each year medical schools turn out well-trained doctors, highly skilled and competent in every phase of practice -- except surviving economically. Medical training programs do not provide young physicians basic information about doctors' options in the workforce -- for example, the pros and cons of private practice vs employment -- nor is there any effort to explain to them the larger economic forces at work in healthcare in the United States, so physicians do not understand the competitive forces that are shaping today's radically changing economic climate. One attempt to institute a seminar-style course in "real-world" healthcare economics at a major State University School of Medicine was met with a refusal to fund even the modest travel stipends for the national experts lined up to teach the course. Also, disillusionment with the realities of the profession is not limited to our broken healthcare system. For the first time in its history, McGill University School of Medicine, Montreal, Quebec, Canada, is experiencing fourth-year students dropping out after being exposed to real-world medicine in their preceptorships.

Few American physicians -- young or old -- understand that in the last 15 years healthcare economics have been radically changed. Physicians have largely abandoned the pure fee-for-service model that has been the economic cornerstone of Western medicine since Roman times. In its place doctors now contract with health plans for rates negotiated in bulk under so-called "managed care" plans. Economically, there can be no greater change in a personal services industry than changing how people get paid; yet medical students, residents, and fellows are provided virtually no education on the nature or implications of this profound change. The need for such practical education has never been greater.

In the meantime, while taking advantage of physician's failure to comprehend and respond to these economic changes, health plans across the country have systematically merged into huge monolithic companies and have converted from nonprofit to for-profit status. According to *Fortune Magazine*, there are 7 healthcare insurance and managed care companies in its 2006 "Top 500" list, generating revenues of over \$212 billion. As a result of the for-profit consolidation of the health plan industry, the well-being of health plan profit margins for shareholders must now compete with the well-being of patients' health.

Just as health plans have merged over the last decade, hospitals, too, have aligned. Most local markets now have just 1 or 2 hospital systems that have complete control over these markets. Many of these systems are generating significant net revenues and behaving like for-profit companies despite their tax status as charities. Meanwhile, in the face of these ever-consolidating markets, doctors remain locked in a cottage industry model. The latest available statistics have shown that 82% of physicians practice in groups of 9 or fewer.<sup>[1]</sup> Doctors, having received no training in adapting to the current market conditions that are occurring rapidly around them, are ill-equipped to function in this radically changed economic -- and ethical -- landscape. These changes unavoidably are undermining the very core of the physician-patient relationship.

In place of old-fashioned fee-for-service medicine in virtually every medical market in America, the economic lifeblood of today's medical practice depends almost entirely on contracts. Almost all of a physician's private patient flow depends on his or her contractual relationships: Private patients are provided either under an employment contract with an employer or they come into the practice through a contract between the physician and a health maintenance organization (HMO) or preferred provider organization (PPO). However, few young

physicians are trained in how to analyze contracts, or when, where, and how to get the appropriate help with their contracting relationships. Instead, unfortunately, they are blithely following the model of older physicians who literally signed away fee-for-service medicine and continue, for the most part, to accept what health plans offer without significant legal or economic scrutiny.

As for nonprivate patients, 36% of the average physician's patient base is paid for by the federal and state government, yet no medical training program offers a practical course in coping with Medicare and Medicaid regulations and claims procedures. Nor is there any medical school training about the practical implications and economic ramifications of treating the 45 million Americans without any health insurance.

Beyond the basics of medical economics, young physicians are generally not introduced to the regulatory and political environment in which they will have to practice. Although most trainees quickly comprehend the concept of malpractice, few appreciate the impact of interlocking laws that require reporting and disclosure of any malpractice claim or disciplinary investigation. The tight web of mandatory reporting requirements runs from every hospital and state licensing board to the National Practitioners' Data Bank and is reinforced by self-disclosure requirements on virtually every professional application. ("Have you ever been named in a lawsuit or been the subject of disciplinary investigation" is a typical question on such applications.) The combined effect of reporting and disclosure means that any black mark on a doctor's record -- even the disclosure of a mere unproven allegation -- can deprive the doctor of economically valuable advantages, such as hospital privileges, employment, or participation in a managed care plan. Understanding the power of this reporting network, including the possibility of its abuse, should be an essential part of every doctor's preparation for the real world.<sup>[2]</sup>

The foregoing are but a few examples of the practical areas not addressed by medical training. More insidiously, however, medical training is inculcating a culture among physicians that may be deepening their woes and contributing to the decline of the profession.

## **Training "Helplessness" Instead of Resilience**

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Modern psychological theory has focused on how individuals can be trained to be "helpless" and how that feeling of "helplessness" contributes to a sense of depression and isolation.<sup>[3]</sup> Helplessness can be trained into individuals when, regardless of repeated best efforts that should be rewarded, no reward is forthcoming; as a result, the individual eventually learns to give up and sinks into a lonely feeling of futility and malaise. It would appear that collectively the medical profession has mastered this art and is suffering the symptoms en masse.

Unfortunately, medical training is helping to create the foundation for the profession's helplessness. Regardless of the new limitations on work hours, conditions in many training programs remain reminiscent of medieval, monastic, ascetic orders. Self-deprivation -- especially sleep deprivation -- continues to be viewed as a necessary virtue, especially during subspecialty training. Learning is still most often imposed on the basis of the model of strict authoritarian discipline, with a high degree of emphasis on shame and fear of failing. Good patient care is so expected of trainees that it is rarely rewarded. Residents' pay is usually set at bare subsistence levels or below, so there is no financial reward for the hard work of medical training, and indeed most medical graduates emerge with huge school loan debts.

Psychologically, young physicians often expect residency and fellowship to be the crowning experience of their long educational path. Since they were 5 years old, these young people were told that they were the brightest and the best, a message that was socially reinforced as they successfully progressed through school, college, and medical school. Everything about their experience reinforced their belief in the Puritan work ethic: If you

work hard and do well, you will be rewarded -- until they reach residency, a point at which rewards are so few and far between that they begin to believe that if they work hard and do well they will be resented.

Young physicians become so well trained in deferring gratification that many give up on ever getting any meaningful rewards for their sacrifices. With their resilience worn away, many just give up the fight. A dispirited acceptance of one's individual fate seems to be the dominant mood of physicians nowadays rather than a motivated mobilization toward a better lot for the individual practitioner and the profession as a whole. Most doctors focus so hard on trying to provide good patient care -- ie, taking care of others -- that they forget, or have no energy, to take care of themselves. Thus, when some doctors propose positive collective action, they are usually quickly quieted by a few naysayers whose negativity taps into the helplessness learned so well during medical training. The progress of the profession is being effectively paralyzed by its own failure to teach leadership and the skills of self-survival.

Consequently, physicians have lost the social contract or bargain that medicine used to have with America. As Paul Starr observed in *The Social Transformation of American Medicine*, the previous generation of physicians traded years of their earning power to become highly trained, in exchange for significantly higher income and enhanced social status. With physician earnings plummeting over the last decade, it is clear that the medical profession no longer enjoys the benefit of such a bargain.

These changing socioeconomic conditions are undeniable, yet medical education has not adapted one iota. Virtually none of the training programs in the country offer 20 nseconds of business administration or modern medical economics. The rigors of medical training prevent young physicians from acquiring economic survival skills on their own. Instead, medical training effectively places young doctors in a "cocoon," shielding them from the lessons of the real world. While residents and fellows are going through their training, their young nonmedical contemporaries are out in the world making little mistakes with little amounts of money. Meanwhile, residents and fellows are working all the time, living on subpar wages, and amassing mammoth debt from student loans.

So training programs are sending forth untutored and unprepared graduates. Instead of teaching physicians the more businesslike approach of relying on deliberate due diligence and seeking the advice of experienced and qualified advisors, physicians are more inclined to make independent life-or-death decisions that are based on the rapid assessment of a situation and to go it alone and shoot from the hip on the basis of their best instincts. After all, that is how they have been trained to diagnose and treat.

Is this the model for training bold and competent leadership in our most important profession, or are we damning these young people to a future that will thrust them unprepared into a battle for the very survival of the medical profession -- a battle in which the stakes are whether our healthcare will be dominated by profit or by patient need -- a battle that will surely profoundly affect our lives and the lives of the ones we love?

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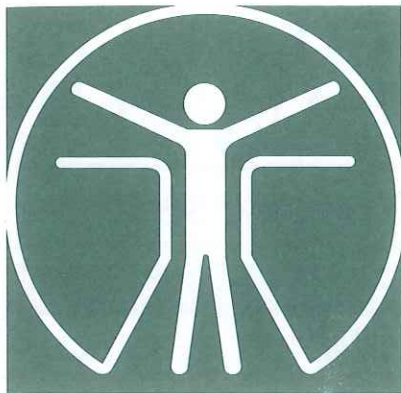
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# THE ABA HEALTH LAW SECTION

# THE HEALTH LAWYER

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## PHYSICIANS POST-PPACA: NOT GOING BUST AT THE HEALTHCARE BUFFET

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The passage of the Patient Protection and Accountable Care Act ("PPACA")<sup>1</sup> has already had a substantial impact on American medicine. Whatever repeals, reformations, defundings, or modifications lie in the future for healthcare reform, the concepts and trends represented by this legislation and its progeny clearly will have an enormous impact on healthcare delivery and the entire healthcare industry. However, no sector of the healthcare industry will be as heavily impacted as the American physician. To risk being accused of hyperbole, PPACA is potentially the final event in a long series of occurrences which will fundamentally transform the structure of the American healthcare industry and the role of the physician in the same. The likelihood of this change has long been expected, but physicians have been amazingly resistant to the predictions. The pressures created by PPACA and the changes it represents may be impossible to overcome.

To understand the potential and probable impact of PPACA for

physicians, it is important to understand the backdrop against which it arrives.

## Pre-PPACA Physician Environment

### Declining Physician Reimbursement

Due to a number of factors, physician reimbursement declined by 25 percent from 1995 to 2008.<sup>2</sup> In the past year alone, physicians have anguished while waiting for Congress to force a delay to the sustainable growth rate ("SGR"), which repeatedly threatened to further reduce Medicare payments to physicians by at least 25 percent. Relief finally came in late 2010 for a one-year period and again in December 2011 for another two months,<sup>3</sup> but these temporary fixes leave a specter of uncertainty hanging over physician practices.

This decline in reimbursement naturally has resulted in a corresponding decline in physicians' compensation. According to the most recent data available, from 1995 to 2003 a physician's net income adjusted for inflation declined seven percent for many specialties.<sup>4</sup> This decline has been both consistent and exponentially increasing.



# Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet

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Perhaps the greatest factor contributing to declining physician reimbursement is the struggle to reduce the insupportable rate of healthcare inflation, by both private insurers and the government. The physician compensation component of these costs is perhaps the easiest cost factor to reduce because physicians are generally organized into small, independent practices that cannot jointly negotiate for higher fees due to American antitrust laws. In this battle, physicians have very little ability to negotiate higher rates from insurers because physicians have been slow to consolidate, whereas hospitals and insurers have consolidated quickly, enabling them to better negotiate to protect their interests. In many states, only one insurer dominates the market.<sup>5</sup> In many towns, only one hospital operates. Consolidation in these markets gives both the hospitals and the insurance companies an enormous advantage over physicians, who have to negotiate as individual small practices, whereas the much larger insurance companies are able to exert irresistible leverage in negotiations to reduce the rates paid to doctors for their medical services. Meanwhile, the consolidated hospital systems have a negotiating advantage in their compensation discussions with insurers as well as with physicians for call pay and other physician compensation.

Another factor creating the decline in physicians' income is their reduced ability to benefit from ancillary services. As physicians' fees have decreased, they have looked to the revenues from ancillary services to supplement their compensation. However, the federal government has limited physicians' ability to utilize ancillary services to supplement their income through further narrowing the opportunities available to physicians under the federal Anti-Kickback ("AKS")<sup>6</sup> and Stark laws.<sup>7</sup> These diversification efforts are often viewed

by the government as efforts to overutilize ancillary services to increase physician revenue. In fact, the frequently used in-office exception to the Stark law, which allows a physician to refer a patient to the physician's office if it is for in-office MRI, CT, PET or other radiology services, has been modified by PPACA to require physicians to notify the patient of similar services offered by other providers in the area.<sup>8</sup> Additionally, both Medicare and private payors have reduced the fees paid for ancillary services provided by doctors on an outpatient basis.<sup>9</sup>

In addition to diminishing compensation, physicians have been subject to continuing operating cost increases. Not only have rent, labor, and malpractice insurance costs continued to rise,<sup>10</sup> but increased administrative costs demanded by insistent regulatory requirements have overwhelmed medical groups.<sup>11</sup> The physicians are caught in the squeeze between decreasing reimbursement and increasing costs with no clear solution in sight.

## Regulatory Pressure

The regulatory pressures on physicians are overwhelming. Pressures to comply with false claims provisions, compliance plans, AKS and Stark regulations, The Health Insurance Portability and Accountability Act ("HIPAA"), the Occupational Safety and Health Act, the Controlled Substances Act and licensing requirements, coupled with potential recovery audit contractor ("RAC") audits and Medicaid fraud unit investigations and increased scrutiny from the Centers for Medicare & Medicaid Services ("CMS") as well as potential for prosecution by the U.S. attorneys offices all combine to exhaust the resources of even the largest healthcare providers. To smaller medical groups, the resources that must be dedicated to these regulatory demands are impossible to financially support.

Another factor discouraging physicians is the reality that even technical violations can support both civil and criminal prosecution that is both costly and frightening. For example, the failure to sign a written contract can, and has, resulted in a claim for refund of all Medicare dollars paid to the hospital as the result of referrals from the doctor that didn't sign the contract. Further, this is not an uncommon claim in the present compliance environment.

## Culture Change

Another fundamental change in the physician's environment has been a change in the culture of American medicine. Very little room exists in modern American medicine for TV doctor Marcus Welby, whose idyllic practice never bothered with numbers issues like costs. Today's regulatory requirements and economic pressures demand a highly efficient business model for a physician practice. In the past, the physicians could give free care because they were generating revenue sufficient to subsidize that care. In today's world, that margin does not exist. Consequently, physicians are required to work long hours, see many patients, and spend substantial amounts of time on non-patient activities, such as medical teaching, administration and research.

Meanwhile, younger physicians graduating from medical school have a different view of their career than their seniors. Generally, these younger physicians are interested in shorter work hours, reduced administrative responsibilities, and fewer leadership requirements. They typically are more interested in working as physician-employees than in creating an independent practice with all its corresponding responsibilities.<sup>12</sup> These factors, plus a daunting number of actual and anticipated physician baby boomer retirements, create increasing pressure on physicians to find a new business model.<sup>13</sup>

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## Lack of Capital

A number of physicians have and are making efforts to respond to the changing healthcare landscape in innovative and creative ways, implementing cost-cutting measures for their patients and implementing electronic health record ("EHR") systems. However, in addition to the regulatory constraints, physicians are impeded significantly in these efforts by a lack of access to capital. Physician practices do not provide a structure to develop capital resources, since most of the profit is paid in compensation to their doctors.<sup>14</sup> As a result, physicians are either abandoning these innovative efforts in frustration or having to partner with others to survive.<sup>15</sup>

## Federal Policy Pressure

The final element in the pre-healthcare reform physician environment is the clear federal regulatory policy designed to encourage physician groups to move into integrated systems or larger physician groups. The examples of this policy are numerous: (i) the loopholes or exceptions that have been developed which allow hospital-owned groups to circumvent certain AKS and Stark requirements;<sup>16</sup> (ii) the quality bonus programs developed by Medicare, which are from a practical standpoint only available to large physician organizations because only these large practices have the infrastructure to measure for these quality metrics and deliver them across a large patient population; (iii) the requirement to move to EHRs, which is an expense outside the realm of possibility for most small physician groups; (iv) the ACE Demonstration pilot program, which bundles physician-hospital payments;<sup>17</sup> and (v) the push to Accountable Care Organizations ("ACOs").<sup>18</sup>

As a consequence of many of these changes in the culture

and economics of physician practice, medical practices have already begun to change dramatically. Large integrated systems have begun to develop, and their preferred methodology for integration has been employment of physicians. The push toward physician hospital employment is a new trend. In the recent past, managed care organizations experienced increasing enrollment rates in the late 1980s and early 1990s and more physicians left private practice in favor of employment opportunities as hospitals tried to build larger integrated systems.<sup>19</sup> However, as Health Maintenance Organization ("HMO") enrollment slowed, the impetus for integrated care diminished. Additionally, the hospitals discovered that these physician groups were expensive and difficult to operate. Consequently, by the turn of the century, many of these hospital groups had been disbanded and the doctors returned to private practice.<sup>20</sup> By 2000, only slightly more than 7.5 percent of all physicians were employed by hospitals.<sup>21</sup>

This state of affairs has dramatically changed. In 2008, 13 percent of all physicians were employed by hospitals.<sup>22</sup> A survey of residents in 2008 indicated that 22 percent expected to be employed by hospitals, as opposed to 2003, when only five percent had the same expectation. This expectation was corroborated by survey results from the Medical Group Management Association ("MGMA"), which reported that in 2009 more than half (65 percent) of established physicians were placed in hospital-owned practices and almost half (49 percent) of physicians hired out of residency or fellowship were placed within hospital-owned practices.<sup>23</sup> Some preliminary statistics from the last 12 months show that this trend has continued through 2011, with 74 percent of hospital leaders planning to hire even more doctors in the near future.<sup>24</sup> While many attribute PPACA and the threatened cuts

to Medicare as speeding up this trend, the race to physician employment actually began in 2009 with Medicare cuts in imaging. However, it is difficult to ignore the activities occurring right now between physicians and hospitals as they seek ever-more imaginative ways to integrate their structures.

As can be seen, the long-standing American physician business model was under great pressure from environmental factors before the passage of healthcare reform. With diminishing compensation, increasing regulatory pressures, changing physician culture, lack of access to capital, and federal policy pressures, the small independent practice that has dominated the healthcare delivery system was already on the ropes. However, PPACA has created significant cause to ask whether this business model can survive given the future course of healthcare.

## PPACA Provisions Directly Impacting Physicians

### Anti-Kickback Reforms

As mentioned earlier, the pre-PPACA environment for physicians reflected an ever-increasing regulatory scrutiny by the federal government and state governments for healthcare fraud. However, the statutes and regulations made some defenses available to doctors to contest fraud claims brought by the federal or state governments. PPACA effectively eliminated some of the government's barriers to prosecuting physicians by clarifying previous rulings in circuit courts and precluding defenses typically used by defense attorneys to contest fraud claims.<sup>25</sup>

One example is the change to the AKS' requirement that the government prove a knowing and willful violation of the statute.<sup>26</sup> Prior to PPACA, circuit courts disagreed on the issue of whether a person had to have actual knowledge that he was

violating the AKS.<sup>27</sup> PPACA added the following language regarding scienter: "With respect to violation of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section."<sup>28</sup> This change clarifies that concern and reduces the burden of proof for the prosecution, since the prosecution does not have to prove a predominant intent to violate the AKS, but only that one motive of defendant was to generate referrals.

### Changes to the Stark Laws

#### *Disclosure of Imaging Ownership*

Federal regulators and policymakers have long believed that allowing physicians to receive revenue from imaging owned by the physicians invites over-utilization of those services. Through various mechanisms, including the federal anti-markup provisions,<sup>29</sup> the elimination of shared ownership of imaging facilities,<sup>30</sup> and the elimination of the per-click payment structure,<sup>31</sup> CMS has greatly reduced the ability of the physicians to own imaging facilities.

For example, as noted above, PPACA requires physicians referring patients for imaging services within their group practice to give their patients written notice that the patient may obtain this service outside the physician's group practice.<sup>32</sup> This provision applies to MRI, CT, and PT scans, as well as "any other radiology and imaging equipment that the Secretary determines appropriate."<sup>33</sup> In addition to this notification, the physician is required to provide a written list of alternative suppliers in the area where the patient resides.<sup>34</sup> The number of patients that will change their mind and seek imaging elsewhere is likely to be de minimis, but the burden on physician practices and the opportunity for a prosecutable mistake or violation on the physician's part are significant, although the final rule by CMS does ease some of the administrative burdens on physicians.<sup>35</sup> While this new rule can

adversely impact physicians' ability to own and operate an imaging facility, many also believe that the trade-off in offering the patient the choice is important and outweighs the potential impact on physicians.

#### *Self-Disclosure Protocol*

Under Section 6409 of PPACA, the Department of Health and Human Services ("HHS") was authorized and required to create a self-disclosure protocol that allows physicians to self-report Stark violations to the government.<sup>36</sup> This provision seemingly will allow CMS to compromise or waive Stark sanctions, which it had heretofore not had the ability to do. It was hoped that the regulations promulgated under this provision would give some greater definition as to what types of Stark violations would be subject to waiver or reduction in penalty. However, the recently promulgated regulations do little more than quote the language of the statute and are very unhelpful in determining how these self-disclosures may impact physicians.<sup>37</sup> In fact, to date only two cases have been settled by CMS under the new rules, with no guidance as to how the settlements were obtained and what, if any, further action was taken against the self-referring entities.<sup>38</sup>

#### *Physician Ownership of Hospital Prohibition*

Probably the most important change to the Stark law contained within PPACA is the prohibition against physician ownership of hospitals.<sup>39</sup> From its inception, the Stark law had contained a provision that allowed physician ownership of hospitals under certain circumstances. In many states, this exception to the Stark law has resulted in a rapid growth of hospitals owned at least partially by physicians. Opponents of physician-owned hospitals argued that this growth of physician-owned hospitals resulted in higher utilization or "cherry-picking" of patients. Consequently, proposals were made

to eliminate cherry-picking or over-utilization.<sup>40</sup>

However, PPACA opted for complete prohibition, subject to a grandfathering provision. The final result is that a physician-owned hospital holding a Medicare provider number prior to March 23, 2010 (the date of PPACA's enactment) cannot expand the number of beds, procedure rooms, and operating rooms for which it was licensed on that date.<sup>41</sup> PPACA grants a small exception for hospitals that were in construction and that did not have their Medicare provider number on March 23, 2010.<sup>42</sup> Those hospitals were allowed to continue construction and operate as long as they completed their construction before December 31, 2010 and obtained their Medicare provider number before that date.<sup>43</sup> In addition, no physician-owned hospital may expand the percentage of ownership in the hospital after the date of enactment.<sup>44</sup>

The consequence of this change will be the eventual elimination of any hospitals developed by physician owners. Those hospitals that presently have physician ownership will be able to continue for some unknown period of time. Their inability to expand will likely require many of them to divest their physician ownership or ultimately fail economically.<sup>45</sup>

The irony of this change is that it eliminates one method for integrating physicians and hospitals. Another irony is the reality that much of the competition for existing hospital systems has been created by expansion of physician-owned hospitals.<sup>46</sup> The elimination of this competition combined with the continued concentration of the hospital industry will ensure that hospitals will not have as many competitive pressures to reduce their rates or perform services more efficiently.<sup>47</sup> The only pressure on hospitals to reduce rates and perform services efficiently will come from the payment methodology. These same

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payment methodologies if applied to physician-owned hospitals would generate the same incentives to provide more quality services at higher efficiency, without the anti-competitive impact.<sup>48</sup>

## False Claims Act

The False Claims Act ("FCA")<sup>49</sup> has become the statute of choice for federal prosecutors in the enforcement of the AKS and Stark law. While the penalties and remedies in the FCA already give the prosecutor a substantial advantage, PPACA further strengthened the FCA in several ways:

1. PPACA affirmatively requires providers to report and return overpayments and to report in writing the reason the overpayment occurred.<sup>50</sup> No longer can physician practices arguably engage in a cost-benefit analysis of repayment and hope to "fly under the radar." While the federal government has long held that overpayments must be refunded, PPACA dramatically increases the requirements for and consequences of overpayments.<sup>51</sup> The new law creates an affirmative and express obligation to make repayment, and the failure to do so is now another violation of the FCA.<sup>52</sup> A report of an overpayment must be made within 60 days after discovery of the overpayment.<sup>53</sup> Failure to do so is deemed to be a false claim.
2. PPACA amends the AKS to clarify that claims for services resulting from the kickback constitute a false claim.<sup>54</sup>
3. PPACA expands the reach of the FCA to payments made in connection with any insurance plan issued under the new health benefit exchanges.<sup>55</sup> Therefore, the FCA will not apply just to Medicare or Medicaid, but to any private insurance plans issued under the exchanges. This is a substantial expansion of the types of payments subject to the FCA.
4. The *qui tam* provisions of the FCA were also expanded so that it is now

easier for whistleblowers to collect from these claims. First, the law changed the limitations of public disclosure. In the past, if facts used to demonstrate a violation of the FCA were already made in state proceedings or private litigation, they were not available for a relator to utilize in a whistleblower claim and the whistleblower would not be entitled to recovery. Under PPACA, revelations in a state proceeding or private litigation are no longer public disclosures that would disqualify a relator from recovering under a whistleblower claim.<sup>56</sup>

The original source exception was broadened, as well. Prior to PPACA, the whistleblower had to have knowledge of the facts underlying the allegation that was "direct and independent..."<sup>57</sup> The language is now changed to say that knowledge that is "independent of and materially adds to the publicly disclosed allegations" is and will entitle the whistleblower to recover.<sup>58</sup>

## Other Provisions Strengthening Compliance Authority

In addition to the changes to the FCA, PPACA strengthened the government's compliance resources in other ways:

1. PPACA expanded administrative penalties available to CMS. Now, Medicare and Medicaid payments to a provider can be suspended "pending an investigation of a credible allegation of fraud."<sup>59</sup> Further, CMS can exclude any entity that knowingly makes or causes to be made a false statement or omission in an application agreement, bid, or contract to participate as a provider under a federal healthcare program.<sup>60</sup>
2. PPACA authorized the Secretary of HHS to mandate providers to have a compliance program.<sup>61</sup> These mandatory compliance programs

will apparently be rolled out to different categories of providers over the next several years. However, it is very likely that physicians will be included in these mandated compliance programs.

3. PPACA expanded the resources available to prosecute fraud and abuse.<sup>62</sup> Three hundred million dollars was added to the funds available to prosecute fraud and abuse over the next 10 years. PPACA authorized increased provider scanning and enhanced oversight of providers. It expanded the use of RAC audits for Medicaid and Medicare Parts C and D. It also broadened HHS' subpoena power to apply to cases involving allegations that a party is defrauding federal healthcare programs. Nor did healthcare reform ignore the criminal penalties for healthcare fraud. PPACA required that federal sentencing guidelines be amended to increase sentences for defendants convicted of federal healthcare offenses and added violations of the AKS to the category of offense.

These enhancements to the prosecution are considered by the government to be important tools needed to reduce fraud and abuse and, thus, reduce healthcare costs. That may very well be true, but the increased compliance costs they create adds exponentially to the costs of practicing medicine. These changes further increase the pressure on the small practice to seek protection from a larger organization that can afford the resources necessary to comply with the labyrinth of federal and state regulations.

## PPACA Reforms Beneficial to Physicians

Although there are a number of healthcare PPACA provisions that could be viewed as detrimental to physicians, PPACA did provide certain

benefits to physicians, particularly in the area of reimbursement for primary care.

1. Primary care physicians will receive a 10 percent incentive payment for all Medicare charges.<sup>63</sup> This payment is inclusive for primary care practitioners, defined by Section 5501 as a physician with a specialty in family medicine, internal medicine, geriatrics, and pediatrics.
2. General surgeons performing major procedures in health professional shortage areas from 2011 to 2015 will receive a 10 percent incentive payment.<sup>64</sup>
3. Psychotherapy services were subject to a five percent incentive payment through December 31, 2010.<sup>65</sup>
4. PPACA authorizes the Secretary of HHS to establish geographic payment adjustments for physicians in 56 localities, which include 42 states, Puerto Rico, and the Virgin Islands.<sup>66</sup> These provisions allow the geographic practice cost index ("GPCI") to be adjusted as follows: For 2010, the law reinstated a floor of 1.00 on the work GPCI that expired December 31, 2009. For 2010 and 2011, Medicare increased the practice expense GPCI in all payment locales that had a practice expense GPCI below the floor of 1.00 (Montana, North Dakota, South Dakota, Utah, and Wyoming). These changes had the effect of payment increases in a number of states.
5. The Medicare quality reporting incentive payments of one percent was paid in 2011 and 0.5 percent will be paid from 2012 to 2014 for voluntary participation in patient quality reporting.<sup>67</sup> Additionally, a 0.5 percent payment will be made to physicians who participate in a qualified maintenance of certification program.<sup>68</sup> However, the physician payment will be reduced 1.5 percent in 2015 for physicians who do not successfully participate in the patient quality reporting

program. In 2016, a two percent penalty may be assessed for failure to participate.

6. Medicaid payments for primary care physicians were raised to Medicare rates for 2013 and 2014.<sup>69</sup>

Of course, one major potential benefit created by PPACA to physicians is the substantial expansion of insurance coverage to the large numbers of patients who presently do not have healthcare insurance. Some already estimate that between an aging population and overall population growth, U.S. physicians' workload will increase by 29 percent from 2005 to 2025.<sup>70</sup> Theoretically, the further expansion of potential payments and payor sources by an increased number of insured patients should be a benefit to doctors.

However, in reality many physicians around the country are already fully occupied in providing patient care. They are not missing the patient volume, but they are being squeezed by reduced reimbursement for those patients and increased cost of care as described earlier. The increased demand for access to doctors may only bring more criticism on the doctors as they develop long delays for appointments or limit their practices. This is what occurred in Massachusetts when universal insurance was implemented.<sup>71</sup>

#### **Indirect Implications of PPACA for the Physician Industry**

One of the major new initiatives legislated in PPACA is payment methodology reforms and incentives to create new types of integrated delivery organizations, such as ACOs.<sup>72</sup> Except for ACOs, the statute does not describe in detail what these organizations will look like. However, an examination of the various proposed structures leaves little doubt that these innovations will drive the healthcare industry in general and physicians in particular to significant integration.

#### *Medicare Shared Savings Program*

PPACA's ACO program is called the "Medicare Shared Savings Program" or "MSSP". Generally speaking, an ACO is an organization of physicians and other healthcare providers held accountable for the overall quality and cost of care delivered to a defined population of traditional fee-for-service Medicare beneficiaries, who are assigned by CMS to an ACO.<sup>73</sup> The theory behind the ACO concept is that coordination of care (and thus cost-savings) is difficult to achieve without integration among the providers that deliver patient care. Therefore, ACOs are incented, in the form of "shared savings" discussed herein, to manage care in a manner that results in cost savings.<sup>74</sup> The ACO also holds providers accountable for clinical outcomes by required clinical outcomes reporting and other performance measures.<sup>75</sup>

While extremely similar to the players in the alphabet soup of managed care players in the 1990s – the independent physician associations ("IPA"s), the physician-hospital organizations ("PHO"s), and the HMO<sup>76</sup> – ACOs differ significantly in that the accountability rests with the providers, rather than the insurers; no health plan intermediary is required to contract with the provider organization; ACOs have great flexibility in their provider composition; and ACOs allow for payment under a fee-for-service arrangement.

The ACO Shared Savings concept gets heightened attention under PPACA. PPACA established an ACO program for Medicare, which is scheduled to begin in 2012.<sup>77</sup> While the MSSP applies only to Medicare, many anticipate that third party payors likely will follow this trend.<sup>78</sup> In fact, PPACA allows for preferential participation in the Medicare ACO program for organizations that have ACO arrangements with third party payors.<sup>79</sup>

One of the other initiatives created by PPACA was legislative

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direction to the Secretary of HHS to create and begin operation of the Center for Medicare & Medicaid Innovation ("CMI") no later than January 1, 2011.<sup>80</sup> PPACA charges CMI with testing innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care. In selecting such models, HHS must give preference to models that also improve the coordination, quality, and efficiency of healthcare services furnished to Medicare or Medicaid beneficiaries or beneficiaries of both programs. PPACA also gives HHS the authority to waive certain laws such as the AKS and Stark law while testing payment models.

## *National Pilot Program on Payment Bundling*

PPACA calls for the Secretary to establish a pilot program for integrated care, using episodic payments centered around hospitalization.<sup>81</sup> This pilot program will be available to entities comprised of providers of services and suppliers including a hospital, a physician group, a skilled nursing facility, and a home health agency. These entities will be required to submit an application to the Secretary of HHS to provide applicable services. The Secretary is authorized to develop various payment methods for these pilot programs.<sup>82</sup> Those payment methods can include bundled payments and bids from entities for episodes of care.

## *Family Medical Homes*

The federal government has participated in family medical home pilot projects for several years, as noted below. PPACA authorizes HHS to provide grants or contract directly with states to establish community-based interdisciplinary, interprofessional teams to support primary care practices.<sup>83</sup> These teams must agree to provide services to eligible individuals with chronic conditions.

PPACA sets out a number of requirements for a family medical home. Since these entities are not hospital centric, they require personal physicians to lead other health providers in caring for the patients. It is assumed that care will be coordinated through all of the providers using integrated healthcare technology, which some argue must be updated to meet the new demands.<sup>84</sup> Interestingly, it has a requirement that payments recognize the primary care value and should reflect both physician and non-physician value, including non-face-to-face visits in care management.

Presently, there are estimated 26 ongoing medical home pilots encompassing more than 14,000 physicians in over 4,500 practices, treating five million patients.<sup>85</sup> So far, the results have been mixed. Overall, not all physicians and other providers adapt quickly to this change in their practice. Further, many times patients do not perceive this change to be beneficial. In particular, the use of nurse practitioners and paraprofessionals often are perceived by the patients to be a restriction on their access to care. However, data does suggest that patient outcomes improve and costs become lower with use of a medical home, but it requires substantial investment in technologies and infrastructure to obtain this success.<sup>86</sup>

## **Other Programs**

PPACA is a cornucopia of innovative delivery models. These models include demonstration projects such as Integrated Hospitalization Care,<sup>87</sup> Medicaid Global Payment Project,<sup>88</sup> and the Pediatric Accountable Care Program.<sup>89</sup> CMI<sup>90</sup> has 20 models listed for testing, including the patient-centered medical home, payment and practice reform in primary care, and direct contracting with providers.<sup>91</sup> PPACA provides six billion dollars of federal money to develop nonprofit,

member-run health insurance programs to compete with the existing programs. It authorizes payment changes to hospitals, which would require doctor participation to achieve. These changes include value-based purchasing, reductions in payments for hospital infections, and reductions in payments for hospital re-admissions.

Although these proposed programs may appear, at first, like a helter-skelter fashioning of a lab experiment with the American healthcare system as the guinea pig, most of these proposed programs involve integration among providers in some fashion, whether through legal entities or contractual relationships. These integration efforts will require the ability of participants to develop cross-professional and facility organization that will involve administration and technology. Moreover, most of these programs involve the use of electronic communications of health records among these participants.

These programs also involve reformed payment structures that eschew the fee-for-service model for other joint payments that must be shared by the various providers through some formulaic or other methodology. If these models expand and proliferate, the role of the physician in these models is critical. The current, fragmented physician structure of the industry will have a difficult time positioning to provide this type of integrated care because it cannot generate the necessary capital, nor provide the infrastructure, the leadership, or the operational administration to cope with these requirements without collaboration among themselves.

## **Options for Physician Roles after Healthcare Reform**

Given the current environment and the implication of healthcare reform, what will be the role of the physician in the future? This question

is quite different from what *should* be the role of the physician in the future. The economic difficulties, combined with the policy imperatives embodied in PPACA, create a strong probability for a new reality in the immediate future. Physicians will have to decide whether and how they want to participate in the new delivery models. Some physicians may choose to retire. Others may practice in rural areas that may not be greatly impacted. However, most will be required to change their practices if they are to continue practicing. Physicians may consider the following options available to them:

#### **Remain as Independent, Small Practitioners**

As noted above, physicians in small practices are under extreme economic pressure. They are entrapped in a web of the following potentially debilitating circumstances:

1. A fragmented, unaffiliated professional group with no ability to gain market leverage;
2. Highly regulated reimbursement rates in an environment emphasizing cost reductions;
3. Ever increasing layers of regulation directed at reducing their ability to generate supplementary revenue;
4. A highly complex set of regulations demanding costly technology and infrastructure; and
5. A substantial number of impending retirements with young replacement lacking entrepreneurial incentives.

In the face of this harsh environment, it will be difficult for physicians to maintain the existing fragmented practice.

#### **Concierge Medicine**

An increasing number of physicians have turned to concierge medicine, also known as retainer or boutique medicine, to retain their individual practices. Physicians providing concierge medicine charge their

patients directly, usually on a flat fee basis, for basic primary care medical services. These direct payments from the patients can be used as the sole source of income for the physicians, who take no insurance, or they can be used as supplementary payments to those physicians who take insurance, in addition to the concierge payments.

This business model has several limitations. First, the model typically works best for people in good health, since specialty and hospital care are not covered. Second, this model is harder (though not impossible) to apply to the low-income population. Third, as payment methodologies change from fee-for-service to bundled payments, shared savings, and other payment structures, the fee-for-service model utilized by many concierge doctors as the basic underpinnings of their economic viability may not be available. For example, a concierge physician who takes commercial insurance on a fee-for-service basis but receives supplemental payments from the patients will, in many cases, lose the ability to obtain those fee-for-service payments because of provisions in the insurers' provider contracts prohibiting balance billing.<sup>92</sup> Fourth, the government and private payors may push to preclude concierge medicine, which has been regarded with some disfavor as a model favoring the wealthy. Also, some payors won't contract with a physician offering concierge medicine since it's seen as violative of his or her contract. On the other hand, some medical home pilots for chronic patients look much like a concierge model with longer visits and closer attention from the doctor. If the healthcare system continues to integrate, concierge medicine's role is unclear, although it may become part of the options available.

#### **Large Medical Groups**

Another possible structure for physicians in this new reform world is the large physician-owned medical

group. These groups may be single-specialty or multi-specialty. If this group is large enough, it will be able to use its leverage in the market to partner with hospitals in the development of an integrated delivery system. Their ability to deliver large numbers of physicians to an integrated system in a coherent and organized fashion will make them an attractive partner for hospitals seeking to develop large delivery systems. Because of this value to the integrated delivery system, these larger medical groups should be able to negotiate better economic positions for them in the system as well as greater roles in the ownership and governance of these systems, although the regulatory limitations for this kind of partnership is unclear and depends largely on the Secretary of HHS and her action or inaction on the authority granted to her regarding waivers of the AKS and antitrust laws.<sup>93</sup>

However, large medical groups are not without challenges. Over the last few decades, physicians have resisted self-governed integrated organizations. These opportunities include chances for dissension and disagreement between the personalities owning the group over compensation and control, particularly if the group is multi-specialty. To keep pace with the other players, the group will require access to capital. Physician organizations have been unable to develop internal capital and have no methods to obtain outside investor capital. Finally, the rapid integration of a fragmented medical community into a large medical group requires extraordinary leadership. Physicians have not been trained to provide that type of leadership, and natural-born physician leaders are too few to develop many of these organizations in a short period of time. As a result, either the concept of physician leadership in the healthcare market will need to be redefined based on new models of organization or potentially only those large medical groups already in existence will be able to pursue this option.<sup>94</sup>

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## Management or Service Line Companies

Another model for physicians involves using management or service line companies with adjunct medical groups.<sup>95</sup> Many large specialty groups today, particularly hospital-based physicians, have organized and compete against each other for hospital contracts. Many hospitals find it very simple to contract with a group that will do a turn-key job and provide all of the outsourced medical and related administrative services for the hospital on a contract basis, as opposed to developing its own hospital-based group. These groups may contract on a regional basis or even develop into a standard corporate structure without substantial physician ownership. Rather, they will be run much like their hospital clients, with limited physician input. These groups will need to be able to manage physicians and provide effective medical services, which historically they have failed to do.

## Options for Rural Physicians

While rural physicians must overcome the difficulties inherent in being small independent practitioners, rural physicians may be strong players in their locale. Because of the rural hospitals' need for physicians, those physicians, if united, even outside a single medical group, can exert enormous pressure on a hospital. Consequently, rural physicians may be able to continue in small groups with the hospital as the only coalescing entity in the community. The hospital's role will be increasingly complicated as it receives payments in a bundled or short-shared savings form but has to pay physicians in a standard fee-for-service mode. While frustrating for hospital administrators, this scenario may be the only one in which they likely are able to retain their present business model of the independent practice. This model is not without antitrust, AKS, and

Stark concerns since it relies on payments by the hospital in order to maintain the physician's practice. However, the extreme need in these communities will require either policy changes or more lenient prosecution at some point.

## Hospital Employees

By far, the quickest method of creating integrated delivery systems is the hospital employment of physicians. An increasing number of physicians are looking for employment from hospitals as a stop-gap measure against reduced compensation. Hospitals are comfortable with the employer-employee relationship and believe that they will be better able to position themselves in a changing marketplace and control physicians as employees rather than as partners or contracted physicians.<sup>96</sup> Additionally, physician employment reduces many of the complexities of the AKS and Stark laws.<sup>97</sup> Clearly, under Stark the compensation for the physicians would still have to be measured by fair market value. However, this model eliminates such complicating concerns as ancillary service income, stand-in-the-shoes restrictions, and physician ownership of facilities.

What the employment model does not do is eliminate a potential future fraud and abuse concern. Specifically, as reimbursement continues to decline for physicians, many hospital-employed physicians may not be profitable individually. It may cost more to hire them and to pay their expenses than the amount of revenue they generate in their practices. In effect, the hospital would have to subsidize the physician's practice. At least one federal prosecutor has taken the position that a payment to a doctor that would put the physician's medical practice in a losing posture is automatically a violation of the Stark law.<sup>98</sup> This conundrum may evaporate

as healthcare reform progresses and the Secretary grants waivers to the Stark law and AKS. However, in the interim, this problem is a real concern for rural hospitals in particular because the reimbursement for physicians in rural areas is largely low-paying Medicare and Medicaid. Therefore, in order to attract physicians to rural areas, hospitals often need to subsidize the physician practice. Stark and anti-kickback issues create obstacles to those subsidies when the doctor is unable to generate enough revenue to support his or her own salary. The question becomes "Why is the hospital paying the doctor more than he can earn?" One assumes that the hospital needs the doctor to refer to the hospital. The problem with this answer in a world with Stark and anti-kickback laws is obvious.

Employment will result in a transformation of the physician's practice. Physicians will clearly have less control over their office operations and clinical methods. On the other hand, they will no longer be saddled with the administrative and operational duties of running the practice. Essentially, the physician looks more like part of the labor force that must negotiate with its employer for compensation changes.

Employed physicians also face the significant question of what roles they play in governance of the hospital. Most of the highly respected integrated systems in the country have developed from physician-centric organizations, and physicians presently retain a substantial role in the governance of those delivery systems. However, hospital-centric organizations have not developed that type of physician participation and governance. Of course, they have their medical directors and public relations doctors. Nonetheless, the medical staffs have been the core of the physician leadership. In integrated delivery systems, many physicians are not

involved in the hospital at all but perform strictly outpatient roles. In hospital-employment situations, physicians will have a hard time negotiating meaningful leadership roles in the delivery systems unless the hospital administration is receptive. Perhaps changing payment methodologies will convince hospital administration that physicians have to take an important role. However, more likely, those changes may exacerbate tensions and hospital administrators will continue to operate their top-down organizational structures, expecting physicians to perform as employees.

### Partnering with Health Insurers

Recently, several of the large health insurance companies have ventured into the acquisitions of providers. United Healthcare acquired Monarch, a large physician network in California. Humana acquired Concentra, a large provider of worker's compensation care nationally. Cigna has acquired a medical group in Phoenix and a large physician management organization, HealthSmart, in the South and Southeast. Meanwhile, Blue Cross Blue Shield in Pennsylvania and West Virginia has acquired a six-hospital system.

This new trend creates possible options for physicians. Obviously, insurers are at least experimenting with the idea that they can better control costs if they control the physician through employment or other mechanisms. Thus, a possible option is to partner with an insurance company through employment or other contractual means. In some cases, this may be a very positive option for physicians. However, it should be noted that in the 1970s and 1980s, Prudential was a major player in healthcare through its subsidiary, PruCare. PruCare had associated medical groups, which were exclusive to PruCare, in many of its markets. This ultimately was a failed model and should be studied to make sure that it does not occur again.

### Insurance CO-OPs

One of the more obscure provisions in PPACA was the funding of so-called insurance CO-OPs, which enable communities to set up insurers locally. PPACA also provided substantial funding to allow these CO-OPs to organize. Presently, these seem to be developing in the Midwest as local communities struggle to find competitors in their insurance markets. Although these organizations cannot be controlled by providers, certainly physicians could take a major role in organization of these CO-OPs and provide services to the members of these organizations.<sup>99</sup>

### Caveats

#### Physician Shortages

A major unknown in this portrait of American medicine's future is the impact of the impending physician shortage. The United States is beginning to experience a dramatic shortage of physicians. Presently, the United States has 352,908 primary care physicians, and the Association of American Medical Colleges estimates that 45,000 more will be needed by 2020.<sup>100</sup> Recently, the Association of American Medical Colleges projected that nationwide physician shortages would rise to 62,900 doctors in five years and 91,500 by 2020.<sup>101</sup>

These shortages are not only in primary care. A national survey conducted by the National Association of Children's Hospitals and Related Institutions found that the top pediatric specialist shortages were in neurology, developmental-behavioral pediatrics, gastroenterology, general surgery, and pulmonology.<sup>102</sup> Moreover, this shortage will be exacerbated by the increase in demand. To some degree this physician shortage may be moderated by the use of physician extenders. Also, some people argue that a reduction in specialists will be a good development as unnecessary procedures will be reduced. However,

with the increased demand and already existing shortage, doctors will be at a premium in many locations.

The impact of this shortage on the physician landscape after reform is hard to project. This shortage likely would increase the leverage of physicians in securing positions. However, the present regulatory scheme may create limitations on this economic pressure. Presently, compensation of physicians is limited to fair market value. The fair market value is determined by consultants who look at compensation for similar physicians in the same region. If that present compensation has been depressed because of regulatory limitations on reimbursement, no clear mechanism will allow higher compensation to be paid to a new physician than is already paid in the market. No doubt, the government and/or the valuation consultants will eventually articulate a methodology that will allow this increase, but it may be delayed. Further, this physician shortage likely will not change the overall trend toward hospital employment of physicians rather than partnership between hospitals and physicians, because many of the factors discussed earlier which lead to a resurgence of physician employment still remain. The physician shortage will most likely eventually result in stabilizing and, perhaps even increasing physician compensation, but it will probably not change the trend toward integration of the providers into large delivery systems.

#### Intractable Management Issues

One of the reasons that it has been so difficult to consolidate physicians is the difficulty of managing them. As early as 2003 studies have shown that lack of cooperation by physicians and lack of leadership rank among the most frequently cited barriers to forming large medical groups.<sup>103</sup> The large, integrated systems like Mayo Clinic, Permanente, and Geisinger are historical anomalies that developed in unique communities under unique circumstances.<sup>104</sup> The industry has

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already witnessed the debacle of physician management companies efforts to corral physicians into manageable organizations at the end of the century, as most of these companies are now defunct or out of the management business. Hospitals have also made a hash of managing physicians for the most part in the past.

Presently, it appears that hospitals and other non-physician organizations are rushing into ACOs and other integrated entities by trying to capture as many physicians as possible and making hurried decisions to implement the ACO without creating effective management.<sup>105</sup> Some physician-run organizations are being implemented successfully, but those examples are few and far between for the reasons cited above. Not much thought is going into how those organizations can best be organized to insure the loyalty and cooperation of the physicians. The pressures of change likely will not allow for any cautious contemplation of new organizational structures that will avoid the past problems. For example, should doctor leaders from the acquired groups be given major decision power over the groups? Should the members of the group be able to select their own leaders of the employed group? Does the existing hospital medical staff model have potential application to these medical groups? Should the management group administering the medical group be the boss of the medical group or vice versa? It will take years to develop a new workable model. As usual, the industry likely will try to fix this after the great consolidation slows down. Those entities trying to react to this consolidating imperative should direct some resources to sharply questioning the existing ideas on how to make these groups effective, efficient delivery systems.

## The "Quality Conundrum"

Finally, one very important caveat is the push to new "quality" frontiers in

medicine. These initiatives range from safety guidelines to hospital infection control to medication error prevention to "quality" profiles and measures. While the country's current healthcare system clearly needs to strive for improved quality, outcomes, and efficiencies, some of the new proposed measures seem geared to drive the industry toward protocol-driven medicine rather than striving for innovation and improvement.<sup>106</sup> Such "cookbook" medicine is controversial in medical circles and its contribution to quality is questioned by many.

## Conclusion

After implementation of health-care reform, it is difficult to imagine any significant survival of the present fragmented physician industry structure, except in rural areas. The most likely portrait of physician life in the United States 10 years from now will include some large integrated systems in which physicians play an important role as partners. However, the majority of physicians will be employees of these integrated systems without any particular governance role. It remains to be seen how much physicians will participate in those organizations and at what compensation level they will be paid. Likely they will have roles akin to the medical staff in present hospitals. They will be much less entrepreneurial and much more of an employed labor mindset. Organized medicine will have declined substantially, perhaps to be replaced by unions. Depending on how the regulatory scheme develops, concierge medicine may or may not be an important part of the delivery system.

If the delivery systems are able to accommodate this form of healthcare, it may flourish. However, if it is seen as ineffective at reducing costs and providing care, those systems will not survive. All in all, it is hard not to conclude that the age of the fiercely

independent, entrepreneurial physician will rapidly decline over the next five years. Whether this is a good or bad thing for the health of the United States is not clear, but it will have a substantial impact on how doctors see themselves and how patients see their doctors.



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- 26 The AKS prohibits individuals or entities from knowingly and willfully offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid or any other federally funded program (except the Federal Employees Health Benefits Program). 42 U.S.C. § 1320a-7b(b) (2006).
- 27 E.g., *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995); Cf., *United States v. Starks*, 157 F.3d 833 (11th Cir. 1998). Prior to PPACA, a few circuit courts required a specific intent to violate the AKS.
- 28 Section 6402(f)(2) of PPACA (Pub. Law 111-148).
- 29 42 C.F.R. § 414.50 (2008).
- 30 73 Fed. Reg. 48434 (Aug. 19, 2008).
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- 34 On November 2, 2010, CMS posted its final rule implementing this section of PPACA. In it, some of the administrative burdens on physicians were softened, but much of the section remained intact. CMS requires that the disclosure be made for all MRI, CT and PET services, but declined to expand the requirement to other imaging services. Physicians must give notice to the patient of at least five "suppliers", which is reduced from the initial requirement of 10. "Suppliers" includes all competing physicians in the area, but does not include providers of imaging services such as hospitals. Further, to help ease the burden somewhat, CMS is requiring that physicians include only suppliers within 25 miles of the physician's office, since the physician cannot possibly create an individualized notice for each patient regardless of where they live. CMS also clarified, however, that notice must be given to the patient each time the service is needed, and not only on the initial visit, although the requirement that the physician get the patient's signature and keep the signed notice for documentation has been removed. Finally, CMS will not make an exception to this requirement for emergency or one-time bases, nor will CMS provide standard disclosure language. See Centers for Medicaid & Medicare Services, Final Rule, 75 Fed. Reg. 73443 (November 29, 2010).
- 35 *Id.*
- 36 PPACA, Pub. L. No. 111-148, sec. 6409, 124 Stat. 119 (2010). See also Ethics in Patient Referral Act (commonly referred to as the "Stark Act") 42 U.S.C. § 1395nn.
- 37 For more information on the regulations, see CMS Self-Disclosure Protocols: [https://www.cms.gov/PhysicianSelfReferral/98\\_SelfReferral\\_Disclosure\\_Protocol.asp#TopOfPage](https://www.cms.gov/PhysicianSelfReferral/98_SelfReferral_Disclosure_Protocol.asp#TopOfPage).
- 38 *Id.*
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- 40 Following two separate moratoria, one in 2003 enacted by Congress and again by CMS in 2005, the Medicare Payment Advisory Commission ("MedPAC") and CMS launched investigations into specialty physician-owned hospitals which were excluded from Stark liability based on the "whole hospital" exception. The subsequent reports and testimony to Congress paved the way for the changes outlined in Section 6001 of PPACA. See MedPAC, "Report to the Congress: Physician-Owned Specialty Hospitals" and Michael Leavitt, "Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," Health and Human Services (2005).

continued on page 14



# Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet

continued from page 13

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- 43 *Id.*
- 44 *Id.*
- 45 Tim Eaton, HEALTH LAW REFORM TARGETS PHYSICIANS-OWNED HOSPITALS (Austin Am. Statesman, May 29, 2010).
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- 51 Mark Gallant, Salvatore Rotella, Jr., and Melanie Martin, PROVIDERS BEWARE: HEALTH CARE REFORMS MAKE FAILING TO PROMPTLY REFUNDS OVERPAYMENTS – INCLUDING THOSE ATTRIBUTABLE TO IDENTIFIED STARK VIOLATIONS – POTENTIAL FALSE CLAIMS ACT VIOLATIONS, Cozen O’Conner Health Law Alert (April 26, 2010). <http://www.cozen.com/admin/files/publications/health042610.pdf>.
- 52 See *supra* note 32 at sec. 6402.
- 53 *Id.*
- 54 *Id.* at sec. 6402.
- 55 *Id.* at sec. 1313.
- 56 *Id.* at sec. 10104.
- 57 31 U.S.C. § 3730(4)(A) & (B).
- 58 See *supra* note 32 at sec. 10104. Some believe that this change will have a significant impact on *qui tam* complaints because it may open the door for whistleblowers to rely on secondhand or indirect information when making an allegation, as long as allegations add new information to what is already available in the public domain. See McDermott Will & Emery, HEALTH CARE REFORM: LEGISLATION EXPANDS FALSE CLAIMS ACT, WHISTLEBLOWER CASES EXPECTED TO INCREASE, (March 31, 2010) [http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object\\_id/a3520977-8f8a-4b5b-a83d-26ada4315a1d.cfm](http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/a3520977-8f8a-4b5b-a83d-26ada4315a1d.cfm).
- 59 See *supra* note 32 at sec. 6402.
- 60 *Id.* at sec. 6408.
- 61 *Id.* at sec. 6401.
- 62 *Id.* at sec. 6402.
- 63 *Id.* at sec. 5501.
- 64 See *supra* note 32 at sec. 5501.
- 65 *Id.* at sec. 3107.
- 66 *Id.* at sec. 3102.
- 67 *Id.* at sec. 3002.
- 68 Effective January 2011, any physician who meets specified requirements may have their “Physician Quality Reporting System” quality percent for that year increased by 0.5%. Requirements include submitting quality measures data for a 12 month reporting period and completing a certification program for a year. See Centers for Medicaid & Medicare Services, PHYSICIAN QUALITY REPORTING SYSTEM MAINTENANCE OF CERTIFICATION PROGRAM INCENTIVE GUIDANCE, [https://www.cms.gov/pqrs/downloads/MOC\\_Guidance\\_Final\\_1\\_2\\_3.pdf](https://www.cms.gov/pqrs/downloads/MOC_Guidance_Final_1_2_3.pdf).
- 69 See *supra* note 32 at sec. 1202.
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- 73 *Id.* at sec. 3022.
- 74 *Infra* at 2.
- 75 See generally Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, & Jonathan S. Skinner, *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFFAIRS w219, w219-31 (2009), <http://www.dartmouth.edu/~jskinner/documents/FisherESFostering.pdf>.
- 76 These three players formed a large part of the managed care framework throughout the 1990’s. HMOs are health insurance groups that provide a range of coverages. IPAs are groups of individually practicing physicians who often contract with one or more HMOs to care for patients on a flat fee basis. Patients are restricted to the network of IPA physicians in order to receive coverage. PHOs are corporations formed by one or more hospitals and its medical staff that contract with HMOs to provide medical services in the managed care market. See Assistant Secretary for Planning and Evaluation, THE BASICS OF MANAGED CARE, U.S. Department of Health and Human Services (1994). <http://aspe.hhs.gov/Progsys/Forum/basics.htm>.
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- 82 See *supra* note 32 at sec. 3023.
- 83 *Id.* at sec. 3502.
- 84 Christine Sinsky, THE PATIENT-CENTERED MEDICAL HOME NEIGHBOR: A PRIMARY CARE PHYSICIAN’S VIEW, *Annals of Internal Medicine*, Vol. 154, No. 1, 61-62 (Jan. 4, 2011).
- 85 <http://www.mainequalitycounts.org/major-programs/patient-centered-medical-home/35/168-pcmh-summary.html>.
- 86 *Maximizing Family Medicine Practice Post PPACA*, California Academy of Family Physicians (November 21, 2010), <http://www.familydocs.org/advocacy/health-care-reform/maximizing-fm-post-ppaca.php>.
- 87 PPACA sec. 2704. This demonstration establishes a bundled payment demonstration project under Medicaid in up to eight states beginning in January 2012.
- 88 *Id.* at sec. 2705. This project requires the Secretary of HHS to coordinate with CMI to develop a payment system for up to five participating states which would have the states pay large safety net hospital systems or networks under a global capitated payment model.
- 89 *Id.* at sec. 2706. This project requires the Secretary of HHS to establish a five-year Pediatric ACO demonstration which states can apply to participate in.
- 90 CMI was created in CMS to test innovative payment and delivery system models that can deliver quality care at lower cost levels. CMI is authorized to develop new methods to deliver healthcare and test them through pilot projects. Such flexibility to develop innovative systems had not been available to CMS before PPACA.
- 91 *Id.* at sec. 3021.
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- 93 See *supra* note 32 at sec. 3022(f).
- 94 F.J. Crosson, Allan Weiland and Robert Berenson, PHYSICIAN LEADERSHIP “GROUP RESPONSIBILITY” AS KEY TO ACCOUNTABILITY IN MEDICINE, *The Permanente Journal*, Vol. 8 No. 3 (Summer 2004).
- 95 Under this model, a management company is typically set up that is jointly owned by a hospital and independent physician members of the staff. The physicians in this arrangement retain their independence (they are not employed by the hospital) and allow hospitals to provide medical services without establishing a hospital owned medical practice. The management company will usually manage one or more service lines that are offered by the hospital. For example, a management company could be set up to manage the surgical services or the cath lab. See Marshall Burack, PHYSICIAN-HOSPITAL MANAGEMENT ARRANGEMENTS, *Akerman Senterfitt* (Sept. 26, 2011).

- <sup>96</sup> Physician employment has been cyclical in the past 20 years based on the regulatory environment. As discussed above, the 1990s saw a rapid increase in physician employment followed by a period of sparse HMO enrollment which led to many physicians opening independent practices. The recent Medicare cuts in imaging in 2009, combined with a new generation of physicians with priorities centered around a balanced work life and a nationwide recession which has depressed incomes, physician employment by hospitals has starkly risen over the past two years.
- <sup>97</sup> 42 C.F.R. § 1001.952(i) (2011); 42 C.F.R. § 357(c) (2011).
- <sup>98</sup> This logic becomes particularly onerous in rural hospital communities. There, the patient mix is strictly Medicaid and some Medicare, combined with self-pay.
- <sup>99</sup> See also, Robin Fisk and Leah Stewart, *CO-OPs: A Little Known Provision of the Health Reform Law, The Health Lawyer*, Volume 24 No. 1, (October 2011). 21- 25.
- <sup>100</sup> Suzanne Sataline & Shirley S. Wang, *Medical Schools Can't Keep Up*, THE WALL STREET JOURNAL Digital Network, April 12, 2010, <http://online.wsj.com/article/SB1000142405702304506904575180331528424238.html>.
- <sup>101</sup> Carolyn Krupa, *Physician Shortage Projected to Soar More than 91,000 in a Decade*, AMEDNews.com, October 11, 2010 at <http://www.ama-assn.org/amednews/2010/10/11/prsb1011.htm>.
- <sup>102</sup> Press Release, Children's Hospital of Wisconsin, National Shortage of Pediatric Subspecialists Poses Challenge to Children's Access to Care (1/13/2010), at <http://www.chw.org/display/ppf/docid/28018/islisting/yes/thispage/1/newsnavid/45450/router.asp>.
- <sup>103</sup> Lawrence Casalino, et al. BENEFITS OF AND BARRIERS TO LARGE MEDICAL GROUP PRACTICE IN THE UNITED STATES, *Arch Intern. Med.* Vol. 163, 1958-1964 (Sept. 2003).
- <sup>104</sup> These major systems were all founded by doctors in the early to mid-20<sup>th</sup> century by doctors. As they grew, they acquired hospitals and became nonprofit integrated systems over many years. It is difficult to replicate the environment which allowed this to develop and it certainly cannot be done in a short period of time.
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- <sup>106</sup> Jason Fodeman. THE NEW HEALTH LAW: BAD FOR DOCTORS, AWFUL FOR PATIENTS, *Galen Institute* (April 2011).

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## The Commonwealth Fund Blog

### ACOs: Making Sure We Learn from Experience

April 12, 2012

**Tags:** [accountable care organizations](#) [Medicaid](#) [patient-centered care](#) [safety net](#)



By [Elliott Fisher, M.D.](#), and [Stephen Shortell, Ph.D.](#)

A year ago, accountable care organizations (ACOs) were little more than a concept that offered both promise and peril in the reform of health care delivery. Now, with the proliferation of private payer ACOs, the new Medicare Shared Savings Program ACOs, and the Pioneer ACOs, there will soon be several hundred health care organizations with payment contracts in place that meet the key criteria of the ACO model: responsibility for a defined population of patients and financial incentives that reward improving care and slowing cost growth. (See the map below for all Medicare ACOs.)

But if ACOs are to achieve their promise, we must acknowledge that we still have much to learn in at least four areas:

- 1) *Contract design.* The structure of the payment incentives will be key, and little is known about optimal designs. Issues include: the degree of risk taken on by participating providers; how the rewards are calculated and shared; how payment thresholds and caps are set, if at all; and how these might vary for organizations at different stages of development and in different parts of the country.
- 2) *Organizational capabilities.* While some certifying organizations and learning networks are measuring presumed requirements for success of an ACO, such as advanced health information technology, care management capability, and leadership and governance, the difficult work of validating these to determine whether and when they predict actual performance remains to be done. Further, we need to learn how these tools and processes are best implemented in different organizational settings operating in different markets.
- 3) *Impact on patients.* The ACO model should meet the needs of all those served by the organization, but special attention should be paid to those most likely to benefit from coordinated care: those who are sick, frail, poor, or have serious mental illness. The extent to which ACOs can meet the needs of these vulnerable populations is of particular importance, given the likely expansion of insurance coverage for these groups in 2014.
- 4) *Impact on community-level health and costs.* In addition to examining ACOs' impact on patients, it will be important to assess their impact on the health status and health care costs of the broader community. For example, performance measures and payment models might encourage providers to form partnerships with health departments, schools, and community-based organizations to reduce the burden of illness in their communities by addressing the underlying social and environmental determinants of health. Many observers are concerned that ACOs that contract with Medicare could take advantage of any market power they gain from consolidation to shift costs to private payers by raising prices for the privately insured. For this and other reasons, tracking community-level health care costs will be important.

To learn from ACOs' early experiences, three challenges will need to be overcome.

First, common definitions and measures of a core set of contract attributes and organizational capabilities will be needed. Examples of these include electronic health record functionality, the use of care management processes, and quality improvement measures. A number of ACO assessment tools are currently in use or under development, including several surveys (American Medical Group Association (AMGA), Premier, Dartmouth-Berkeley, Brookings-Dartmouth, UC-Berkeley ACO Safety Net Readiness Assessment, HRET Hospital Assessment of ACO Readiness); site visit-based assessments (Premier; AMGA, Brookings-Dartmouth); data collection processes (the Medicare Shared Savings Program and Premier application processes); the UC-Berkeley National Survey of Physician Organizations and the National Committee for Quality Assurance ACO certification program. While each of these groups will want to assess different domains of ACO capabilities to meet their own needs, much will be gained by forging agreement on a set of measures for a core set of ACO capabilities. Without this, it will be difficult if not impossible to compare findings across studies and cumulative knowledge will be seriously compromised.

There also needs to be consensus on at least a core set of performance measures so we can learn whether ACOs are successful. The 33 measures included in the federal ACO programs are a good starting point for measuring the impact of ACOs on covered populations and communities. These should be augmented with measures of cost and resource use and, as soon as possible, more advanced outcome measures such as patient-reported functional health status.

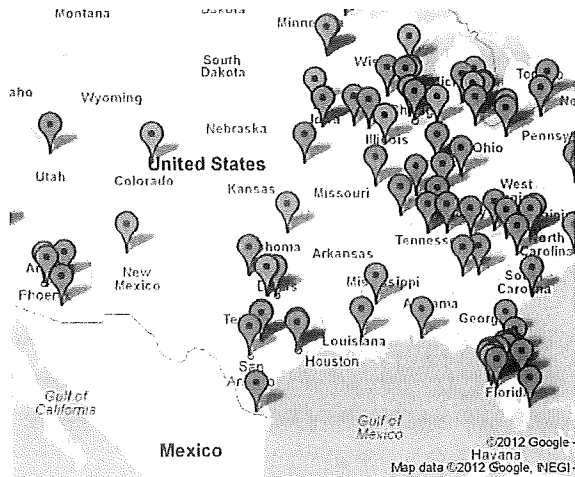
The second major challenge will be to track performance at both the ACO and community levels. This will require collecting and merging data from all of the public and private payers potentially affected by these contracts—from those whose populations are covered by the ACO contract and those who are not. Release of provider- and plan-specific pricing information raises issues of contractual commitment and competitive advantages on the one hand and antitrust concerns on the other. But without at least some common information on the quality of care, resource use, and relative pricing on the part of ACOs, it will be impossible to assess their performance. And without community-level aggregation, we will be hard pressed to know whether the new payment model is having an impact on what matters: the quality and affordability of care and the health of our communities.

A third challenge is to create transparency in sharing data and results among all ACO participants. While legitimate proprietary interests should be respected, greater learning will occur if those involved exchange data and results. This will require discussion among the federal government, consulting firms, think tanks, learning networks, and the academic research community. The goal should be to develop ground rules or guiding principles that balance the legitimate self-interest of participants with the need for shared learning to improve health care quality, promote population health, and control costs.

Success in meeting these challenges will depend on commitment by private and public stakeholders to craft a path forward that meets

their interests as well as the public good. Further, a process is needed to coordinate data collection initiatives, beyond what individual organizations can do on their own. This will require funding, perhaps from the Centers for Medicare and Medicaid Services, foundations, and other groups that have invested in efforts to improve health and health care.

The goals of accountable care—supporting providers' efforts to work together to achieve better care, better health, and lower costs—are compelling. But translating principles into practice requires learning. Let's not miss the opportunity.



View [Accountable Care Organizations](#) in a larger map

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**Marquerite Callaway of Callaway Leadership Institute says:**  
April 12, 2012

Thanks to both of you, leading health system researchers, for providing clear guidance on what needs to be better defined, evaluated, and learnings captured to make the most of this new model of care delivery and coordination. Great thinking! Keep it up. Rapid transparency and information sharing across participants and the public is vital to accelerated innovation in any complex system. Only when the Howard Hughes Medical Foundation created the infrastructure and provided funding that linked basic scientists across the globe seeking to unlock the human genome sequence was discovery accelerated. Perhaps the Commonwealth Fund is playing a similar role in healthcare innovations. I would suggest one additional area of careful evaluation: what kind of specific leadership qualities are required to fulfill the full potential of ACOs, Medical Homes, and other innovations that bring a new set of stakeholders to the table to find optimal solutions? The right leadership is an essential ingredient.

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- 2007-Present    **Physicians' Advocates:** Berkeley, CA; Paris, France. *Principal Attorney, Legal Strategist and Policy Analyst.*
- Medical:** Representing physicians in all aspects of their practices as well as their relations with hospitals, payers and managed care organizations; strategic planning for medical practices and health care delivery systems.
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- 2001-2006        **BondCurtis LLP:** Berkeley, CA; Paris, France. *Principal Attorney.*
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- 1974 - 1979      **Hassard, Bonnington, Rogers & Huber:** San Francisco, CA. *Associate.* Emphasis in health law and policy, malpractice and tax law; helped draft and defend MICRA, the medical malpractice tort reforms of 1975; authored monographs for the California Medical Association on the malpractice crisis; lectured and spoke to physicians statewide on malpractice issues.

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Supreme Court of the United States, 1979  
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U.S. Court of Appeals, Ninth Circuit, 1974  
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Northern District, California, 1974

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National Advisory Board Member, University of California at Davis—NIH Center for Asthma, Allergies, and Immunology

**MAJOR PRESENTATIONS**

California Society of Healthcare Attorneys, “ACOs and the Medical Staff of the Future”, Monterey, CA, April 20, 2012.

American College of Surgeons Annual Session, “The Medical Professional – Death or Resurrection?”, San Francisco, October 26, 2011.

Mississippi State Medical Association Annual Session Medical Affairs Forum Speech, Natchez, Mississippi, June 5, 2010.

Golden Gate Breakfast Club, San Francisco, California, January 27, 2010. “To Health in a Hand Basket.”

Physician Group, Yakima, Washington, November 30 2009. “Saving Medicine: A Community Based Strategy for Patients and Physicians.”

Physician Group, Helena, Montana, December 1, 2009. “Saving Medicine: A Community Based Strategy for Patients and Physicians.”

The Patient-Physician Alliance, Pleasanton, California, October- November, 2009. Leadership Seminar Series (four lectures on physician leadership, “followship” i.e. working together, patient alliance, strategies)

J-1/H-1B Foreign Physician Immigration Conference, Pederson Immigration Law Group, P.C., Baltimore, Maryland, October 24 2009. “Getting to yes: Why You Need an Experienced Contract Negotiator on Your

Team.”

15<sup>th</sup> Annual J-1/H-1B Foreign Physician Immigration Conference, Pederson Immigration Law Group, P.C., Chicago, Illinois, 2009, “Getting to Yes: Why You Need an Experienced Contract Negotiator on Your Team.”

Governing Council of Organized Medical Staff Section of the American Medical Association, June 12, 2009, “Important Contract Considerations for Physicians When Considering Employment.”

Washington State Medical Association, Chelan, Washington, May 16, 2009. “Can 600,000 Lemmings Be Wrong? How Doctors Are Giving Away Their Pay Power and Profession.”

Governing Council of Organized Medical Staff Section of the American Medical Association, November 6, 2008. “Doctor Heal Thyself: A Strategy For Saving The Medical Profession And, With It, Organized Medicine.”

Okefenokee Medical Society Meeting, Waycross, Georgia, October 27, 2008. “Can 600,000 Lemmings Be Wrong? How Doctors Are Giving Away Their Pay Power and Profession.”

American Society of Medical Association Counsel Fall Meeting 2008, Hilton Head Island, South Carolina, September 13, 2008. “Doctor Heal Thyself: A Strategy For Saving The Medical Profession And, With It, Organized Medicine.”

14<sup>th</sup> Annual J-1/H-1B Foreign Physicians Immigration Conference, Pederson Immigration Law Group, P.C., Chicago, Illinois September 2008, “Negotiating Your Employment Contract”

Southern Medical Association Annual Scientific Assembly, Advances in Medicine 2008, Nashville, Tennessee, August 8, 2008. “Can 600,000 Lemmings Be Wrong? How Doctors Are Giving Away Their Pay Power and Profession and What Can Be Done About It.”

13<sup>th</sup> Annual J-1/H-1B Foreign Physicians Immigration Conference, Pederson Immigration Law Group, P.C., Miami, Florida March 2008, “Negotiating Your Employment Contract”

12<sup>th</sup> Annual J-1/H-1B Foreign Physician Immigration Conference, Pederson Immigration Law Group, P.C., Chicago, Illinois, 2007, “Negotiating Your Employment Contract”

Integrated Behavioral Health Learning Session, Community Clinic Consortium, Walnut Creek, California 2007, “A Survey of the Law Relating to Mental Health Records”

Health Care Fraud 2005, American Bar Association, Palm Springs, California, 2005, “The Capital Conundrum: The Regulatory Role In Health Care Reform”

Redwoods Conference Center, Mill Valley, California, December 2003, “The New Medicare Legislation”

California Medical Association 7<sup>th</sup> Annual Leadership Academy, La Quinta, California, November 2003, “Medical Staff Self-Governance”

Macy Foundation, New York, New York, November 2003, “Quality of Care in Physician Offices”

The Center for Practical Health Reform, Las Vegas, Nevada, October 2003, “Development of a National Networking Strategy for the Center for Practical Health Reform”

Governor’s Select Task Force on Healthcare Professional Liability Insurance, Miami, Florida, November 2002, “Success! A Generation of Experience with California’s Medical Injury Compensation Reform Act (MICRA)”

NORCAP Educational Forum, San Francisco, California, December 2001, “Legal Reporting Requirements and

Unanticipated Outcomes for Doctors”

California Pacific Medical Center, San Francisco, California, March 2001, “New Laws Affecting Physicians”

American Society of Medical Associates Counsel, Phoenix, Arizona, September 1999, “Up From the Ashes: Empowering Physicians in the New Millennium”

American Society of Medical Association Counsel, Williamsburg, Virginia, September 1999, “*The Alternative—A Physician Dominated Future*”

California Academy of Attorneys for Healthcare Professionals, San Diego, California, August 1999, “Summary Suspension and Hospital Peer Review”

American Association of Family Practitioners, San Francisco, California, September 1998, “Contract Analysis and Negotiation”

Professional Liability Underwriters Society National Meeting, Seattle, Washington, August 1998, “Liable? I Wasn’t Even There! Professional Liability Over the Internet”

Fish Memorial Hospital, Deland, Florida, April 1998, “They’re Turning Healthcare Upside Down: How to Survive and Thrive in the Midst of the Largest Corporation Reorganization in the History of America”

Northern Alabama Physicians, Huntsville, Alabama, 1995: “The Physician's Winning Strategy”

Beacon Medical Group, St. Louis, Missouri, 1995: “Strategic Planning Seminar”

National Health Lawyers Association, Chicago, Illinois, 1994: “The State of the Corporate Practice of Medicine Rule” presented for California Medical Association General Counsel

Hartford, Connecticut Patient-Physician Alliance, August, 1994: “Physicians' Guide to the Future” Seminar

American Medical Association Board of Trustees, San Francisco, California, 1994: “The MSO Strategy”

University of California, Regents' Scholars Lecture, Davis, California, 1992-Present: “The History of Medical Law: From Hammurabi to Hillary”

National Health Lawyers Association, Chicago, Illinois, 1993: Medical Staff Issues: “Credentialing Issues for Physicians and Their Attorneys: Basic and Advanced” (two presentations)

Television Interview for the Health Network, National Network, 1993: “Managed Care”

California Medical Association, Hospital Medical Staff Section, Anaheim, California, 1993: “Physician Empowerment: Alternatives to a Hospital Dominated Future”

National Health Lawyers Association, Chicago, Illinois, 1992: Medical Staff Issues: “Peer Review Proceedings”

University of California, Berkeley, Health and Medical Apprenticeship Program, 1989-1992: “Annual Medical Malpractice Debate”

University of California, Berkeley, Health and Medical Apprenticeship Program, 1991: “Social, Political, and Ethical Issues in Health and Medicine”

International AIDS Conference, Bangkok, Thailand, 1990: “AIDS and HIV Positive Physicians”

California Medical Association Executive Committee, Millbrae, California, 1985: “No Fault Malpractice Insurance—A Modest Proposal”



National Health Lawyers Association, Washington, D.C., 1982: "Hospital-Physician Contracts"

American College of Medicine, Scottsdale, Arizona, 1978: "Malpractice Reform"

American College of Medicine, Scottsdale, Arizona, 1977: "17<sup>th</sup> International Conference on Legal Medicine"

Over 100 additional presentations and seminars given throughout the United States regarding the relationship of physicians, medical groups, MSO's and managed care, antitrust, physician unity, self-determination, economic changes within healthcare, and healthcare reform.

### **MEDICAL STAFF PRESENTATIONS**

Riverview Hospital, Red Bank, New Jersey, October 2012

Florida Neurological Society, Lake Buena Vista, Florida, February 2008

Beebe Medical Center, Lewes, Delaware, December 2007

St. Luke's at Wood River, Ketchum, Idaho, November 2007

Moreno Valley Community Hospital, Moreno Valley, California, May 16, 2007

Campbell County Medical Association, Gillette, Wyoming, April 11, 2007

Holmes Regional Medical Center, Melbourne, Florida, March 17, 2007

Marin General Hospital, Novato, California, December 18, 2006

San Bernardino Community Hospital, San Bernardino, California, December 12, 2006

Southwest Florida Regional Medical Center, Fort Myers, Florida, December 7, 2006

Saint Louise Regional Hospital, Gilroy, California, June 15, 2006

### **PUBLICATIONS**

#### **Books and Chapters**

"Asthma and the Law" *Bronchial Asthma*, 2010

"Asthma and the Law" *Bronchial Asthma*, Third, Fourth and Fifth Editions, published by Humana Press, 2006

"Annotated Model Physician Employment Agreement," published by *American Medical Association*, 2000

"Legal Issues In Asthma: Asthma and the Law" *Asthma Management Handbook*, from University of California at Davis 1999, 2005

"Legal Issues in Pain Management: Walking the Tightrope Between Legal Restrictions and Medical Ethics," *Pain Management Handbook*, 1998

"Medical Malpractice: Handling Internal Medicine Cases," *Annual Update*, 1993.

"Medical Malpractice: Handling Internal Medicine Cases," *Shepard's/McGraw-Hill, Inc.*, September 1992 (Co-author with Alvin Lee Block, M.D., J.D.)

#### **Articles and Bylaws**

"Building A Foundation For Excellence," *Florida Medical Magazine*, Spring 2010.

"Florida Model Medical Staff Bylaws," Florida Medical Association, March 2010.

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- “Washington State Model Medical Staff Bylaws,” Washington State Medical Association, May 2009.
- “Tennessee Model Medical Staff Bylaws,” Tennessee Medical Association, October 2008.
- “Survive and Thrive! The Physicians’ Advocates Manual for Incorporated and Unincorporated Medical Staffs,” August 2007.
- “Training The ‘Helpless’ Physician,” <http://medgenmed.medscape.com/viewarticle/561725> September 2007.
- “Sham Peer Review,” [www.medgenmed.com](http://www.medgenmed.com) November 2005.
- “Defining Health Care: The Necessary Foundation of Any Health Policy,” *In Publication*, Spring 2010.
- “The War is On: Why Your Medical Staff Needs to Incorporate and Obtain its Own Independent Counsel”, [www.medscape.com](http://www.medscape.com), Winter 2004.
- “Up From The Ashes”, *California Physician Magazine*, Fall 1999.
- “The Alternative—A Physician-Dominated Future: What We Have Learned About MSO’s and PPM’s,” *California Physicians Legal Handbook*, January, 2004. Available at [www.cmanet.org](http://www.cmanet.org)., CMA-On Call, Doc. #0234 (MSO’s & PPO’s).
- “California Business and Professions Code Section 805 Reporting Issues: Responses From Three Perspectives,” *California Health Law News*, Summer 1997
- "Are You Going to Be a Casualty or a Leader of the Health Care Revolution?," *Family Practice Management*, July/August 1996.
- "Strategic Use of MSO's," *California MGMA "Snapshot"*, July, 1997 and *Cincinnati Medicine*, Winter 1994.
- "A Primer on Credentialing for Physicians and Their Attorneys," *National Health Lawyers Association*, November 1993.
- "A Discussion of Advanced Credentialing Issues for Physicians and Their Attorneys," *National Health Lawyers Association*, November 1993.
- "Just What the Doctors Ordered", *San Francisco Business Times*, August 13-19, 1993.
- "Pro-Physician MSO's: A Winning Managed Care Strategy," *HealthSpan*, July/August 1993.
- "A Physician-Friendly Strategy for Hospital Success," [pre-publication of above] *HealthSpan*, 1993.
- "Antitrust in Physician Groups," *San Francisco Medicine*, July 1993.
- "An Alternative to Hospital-Dominated Groups," *California Physician*, April 1993.
- "Representing Physicians in Disciplinary Peer Review Proceedings," *National Health Lawyers*, November 1992.
- "Steps in Representing Physicians in A Peer Review Disciplinary Action," *National Health Lawyers*, November 1992.
- "Creative Contracting and Competition: An Antitrust Analysis," *San Francisco Medicine*, May 1985.
- "Medical Adversity Insurance: A Modest Proposal," *California Physician*, August 1985.
- "You and the Bare Physician," *Resident and Staff Physician*, April 1982.

"Malpractice and Discipline," *San Francisco Medicine*, January 1981.

"Can You Afford to Burn Up Your Malpractice Policy?," *Legal Aspects of Medical Practice*, May 1978.

"The Truth about Malpractice Arbitration," *Private Practice*, April 1977.

"Arbitration for Physicians in Private Practice," *California Medical Association*, 1975.

"Loss of Professional Liability Insurance: Interruption or Termination of Medical Practice" *California Medical Association*, 1975.

"Insolvency Planning," *California Medical Association*, 1975.

"Enforcing California's False Advertising Law: A Guide to Adjudication," 25 *Hast. L. J.* 1105, 1974.

### APPELLATE ACTIVITY

Lead appellate counsel in scores of cases before the higher courts, including the United States and California Supreme Courts, as well as author of many friend-of-the-court briefs.

The following is a list of published opinions in which Mr. Bond appeared:

*Sun v. Taiwan*

201 F.3d, 1105 (9<sup>th</sup> Cir.) Feb. 3, 2000

*N.N.V. v. American Association of Blood Banks*

75 Cal.App. 4<sup>th</sup> 1358 (Cal.App.4 Dist. Oct. 28, 1999)

*Taiwan v. United States District Court for the Northern District of California*

128 3d 712 (1997);97 Daily Journal, D.A.R. 12,977;1997 WL 634359 (9th Cir.)(NO. 97-70375)

*Plunkett v. Spaulding*

52 Cal.App.4th 1513B, 60 Cal.Rptr.2d 377 (Cal. App. 3 Dist. Feb. 18, 1997)

*Kellogg v. Asbestos Corp. Ltd.*

41 Cal.App.4th 1397, 49 Cal.Rptr. 2d 256 (Cal.App.1 Dist. 1996) (NO. AO050344)

*Hrimnak v. Watkins*

38 Cal.App.4th 964, 45 Cal.Rptr. 514 (Cal. App. 3 Dist. Sept 28, 1995) (NO. C016836)

*Spann v. Kaiser Foundation Hosp.*

34 Cal.App.4th 644, 40 Cal.Rptr. 360 (Cal. App. 1 Dist. Apr 27, 1995) (NO. A063310)

*Lineaweaver v. Plant Insulation Co.*

31 Cal.App.4th 1409, 37 Cal.Rptr. 902 (Cal. App. 1 Dist., Jan 31, 1995) (NO. A060263)

*Williamson v. Plant Insulation Co.*

23 Cal.App.4th 1406, 28 Cal.Rptr.2d 751 (Cal. App. 1 Dist., Mar 30, 1994) (NO. AO57581)

*DiGrazia v. Anderlini*

22 Cal.App.4th 1337, 28 Cal.Rptr.2d 37 (Cal. App. 1 Dist. Dec 29, 1994) (NO. A059040)

*Coughlin v. Owens-Illinois, Inc.*

21 Cal.App. 4th, 572, 26 Cal.App.4th 1511, 27 Cal.Rptr.2d 214, *Prod. Liab. Rep. (CCH)* ¶13, 853 (Cal. App. 1 Dist. Dec 29, 1993) (NO. A050481)

*Wilson v. Irwin Memorial Blood Bank*

14 Cal.App.4th 1315, 18 Cal.Rptr.2d 517 (Cal. App. 1 Dist. Apr 9, 1993) (NO. A054946)

*Traxler v. Varady*

12 Cal.App.4th 1321, 16 Cal.Rptr.2d 297 (Cal. App. 1 Dist. Jan 29, 1993) (NO. A053098)

*Osborn v. Irwin Memorial Blood Bank*

5 Cal.App.4th 234, 7 Cal.Rptr.2d 101, 73 Ed. Law Rep. 1067 (Cal. App. 1 Dist. Apr 8, 1992) (A044982)

*Alef v. Alta Bates Hospital.*

5 Cal.App.4th 208, 6 Cal.Rptr.2d 900 (Cal. App. 1 Dist. Apr 7, 1992) (NO. A050598)

*Irwin Memorial Blood Centers v. Superior Court (Falconer)*

229 Cal.App.3d 151, 279 Cal.Rptr. 911, 59 USLW 2664 (Cal. App. 1 Dist. Apr 10, 1991) (NOs. A051352, A052325)

*Jellinek v. Superior Court (Duvall)*

228 Cal.App.3d 652, 279 Cal.Rptr. 6 (Cal. App. 6 Dist. Feb. 15, 1991) (NO. H007823)

*Coe v. Superior Court (Irwin Memorial Blood Bank)*

220 Cal.App.3d 48, 269 Cal.Rptr. 368 (Cal.App. 1 Dist. May 9, 1990) (NO. A048198)

*City of Oakland v. Delcon Associates*

168 Cal.App.3d 1126, 214 Cal.Rptr. 734 (Cal. App. 1 Dist. June 6, 1985) (NO. A012024, CIV. 52180)

*Fein v. Permanente Medical Group*

38 Cal.3d 137, 695 P.2d 665, 211 Cal.Rptr. 368, 53 USLW 2460 (Cal. Feb 28, 1985) (NO. S.F. 24336)

*American Bank and Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc.*

36 Cal.3d 359, 683 P. 2d 670, 204 Cal.Rptr. 671, 41 A.L.R.4th 233 (Cal. Jul 9, 1984) (NO. S.F. 24171)

*American Bank and Trust Co., v. Community Hosp. of Los Gatos-Saratoga, Inc.*

33 Cal.3d 674, 660 P.2d 829, 190 Cal.Rptr. 371 (Cal. Mar 31, 1983) (NO. S.F. 24171)

*Payton v. Weaver*

131 Cal.App.3d 38., 182 Cal.Rptr. 225 (Cal. App. 1 Dist., Apr 26, 1982) (NO. CIV. 50094)

*Fein v. Permanente Medical Group*

121 Cal.App.3d 135, 175 Cal.Rptr. 177 (Cal. App. 3 Dist., Jun 30, 1981) (NO. CIV. 18349)

*Johns-Manville Products Corp. v. Contra Costa Superior Court*

27 Cal.3d 465, 612 P.2d 948, 165 Cal.Rptr. 858, 9 A.L.R.4th 758 (Cal. Jul 3, 1980) (NO. S.F. 24086)

*American Bank and Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc.*

104 Cal.App.3d 219, 163 Cal.Rptr. 513 (Cal. App. 1 Dist., Apr 4, 1980) (NO. CIV. 45785)