

11 & 12 Provider Organizations and Compensation Models

Learning Objectives

In this lesson, we discuss the Provider Organizations that are part of the healthcare environment. We start by explaining the meaning of “integration” and discussing the levels of provider integration found in provider organizations. We then describe specific types of provider organizations and compensation models.

After completing this lesson, you should be able to:

- Explain what it means for providers to integrate
- Describe some of the advantages of provider integration
- Discuss some of the types and levels of provider integration
- Describe the general characteristics of several types of provider organizations
- Discuss the impact of the Affordable Care Act (ACA) on provider integration
- Explain difference between fee-for-service and value-based compensation models

Provider Integration

Provider Integration

Different provider organizations are characterized by different types and levels of provider integration. For providers, **integration** occurs when two or more previously separate providers combine under common ownership or control, or when two or more providers combine business operations that they previously carried out separately and independently.

Two Components of Provider Integration

As is evident from this definition, provider integration has two components:

- structural
- operational

Structural integration involves bringing previously separate providers under common ownership or control.

Operational integration is the consolidation of operations that were previously carried out separately by each provider into a single operation.

Structural Integration

As we have discussed, structural integration involves bringing separate providers under common ownership or control. Structural integration may be complete or partial.

In a complete structural integration, previously independent providers are brought under common ownership and control. Mergers and acquisitions are example of complete structural integration.

Mergers and Consolidations

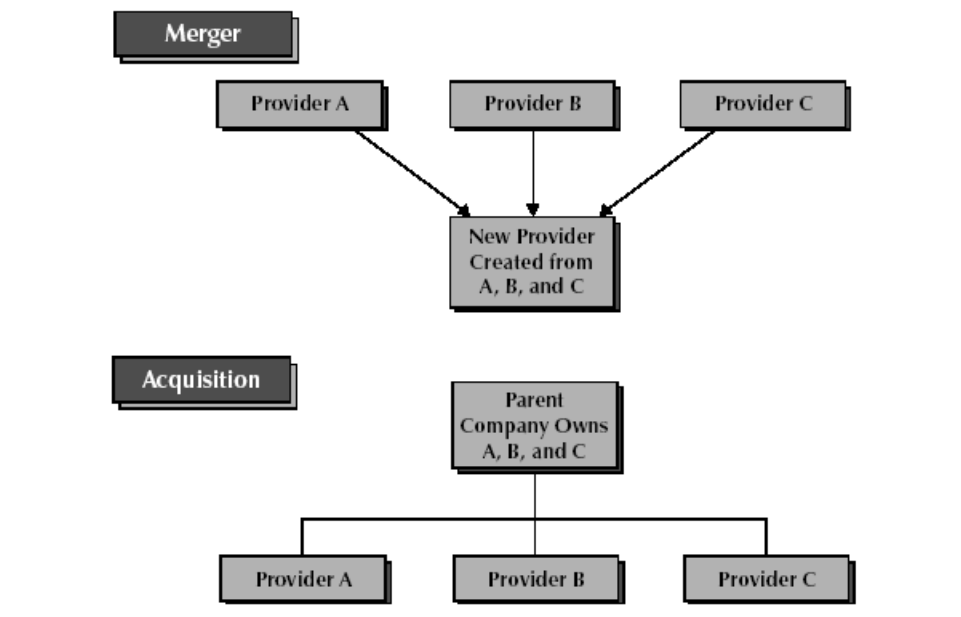
A **merger** occurs when two or more separate providers are legally joined. One provider may absorb the other entirely, or the providers may combine to form a new organization with all the original companies being dissolved. The second type of merger is called a **consolidation**.

Mergers in the field of healthcare are not limited simply to providers. Mergers may also involve health plans and entities that have long acted as intermediaries on their behalf. Such mergers in fact, are helping to reshape the healthcare industry. Recent examples include health plans merging with pharmacy benefit managers (PBMs).ⁱ

Acquisition

In an **acquisition**, one organization buys another organization. An organization that owns other organizations is often know as a parent company.

The organizations owned by the parent are often called subsidiaries. Subsidiaries owned by a parent company are often referred to as brother-sister organizations.ⁱⁱ



Joint Venture

One type of partial structural integration is a joint venture. In a **joint venture**, two or more separate organizations combine resources to achieve a stated objective.

The participating companies share ownership or the venture and share responsibility for its operations.

Although there is generally a single source of control over the joint venture, the venture itself is not a separate legal entity. Usually, the organizations maintain their separate ownership and also maintain separate control over their operations outside the joint venture. ^{iii iv}

Minimal Structural Integration

Other provider organizations are characterized by minimal structural integration.

In these organizations, the providers who are members of the organization execute contracts in which they agree to cooperate and act as one body in certain transactions.

However, each provider maintains complete separate ownership and may also maintain complete control over its operations in all other business transactions.

Operational Integration

Operational integration can be thought of as having two components:

- business integration
- clinical integration

Business Integration

Business integration involves combining one or more separate business (nonclinical) functions into a single function.

Example: A group of providers might decide to form an organization to carry out billing, collections, and contracting with health plans for the entire group of providers.

Clinical Integration

Clinical integration involves making a variety of health services available to patients from the same organization or entity.

Clinical integration offers a number of potential advantages for the delivery of high-quality healthcare. Patient information is often consolidated in one location – for example in single medical record (even in this day of electronic medical records different systems may not be compatible). ^v

In addition, administrative processes are often more streamlined than in situations in which a number of providers furnish healthcare independently.

Suppose Jean Kelly's employer has contracted to receive healthcare for its employees from Aggregate Healthcare System, an integrated delivery system (we discuss integrated delivery systems later in this lesson). Ms. Kelly visits her primary care physician, who sends her to get her blood drawn and to get an X-ray, and refers her to a specialist. The specialist examines Ms. Kelly and schedules her for surgery.

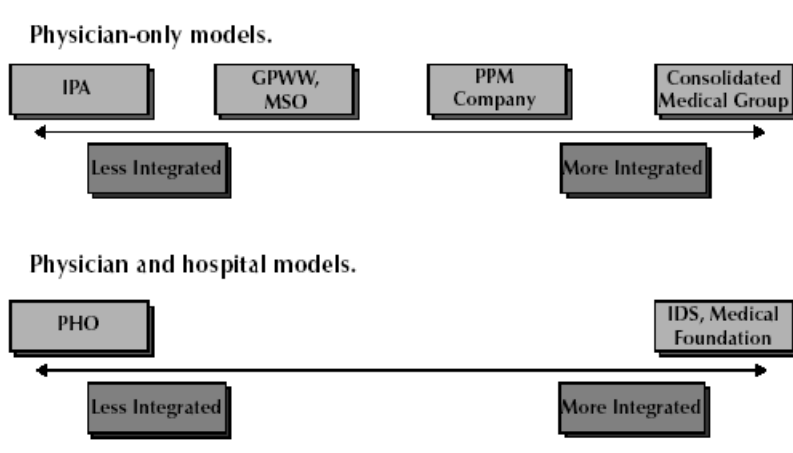
Later, Ms. Kelly is admitted to the hospital and the specialist performs the surgery. After the hospital stay, Ms. Kelly is visited by a home healthcare nurse once a day for several weeks. All the services that Ms. Kelly receives – primary care and specialist physician services, the blood tests and X-ray, hospital and surgical services, and home healthcare nurse – are furnished by a single provider organization: the Aggregate Healthcare System.

All the Aggregate healthcare professionals that treat Ms. Kelly work with the same medical record. Thus, each provider that treats Ms. Kelly has access to the same accurate and complete information regarding her health status, which helps ensure that she receives consistent and high-quality care. In addition, Ms. Kelly encounters a minimum of administrative requirements when receiving her various healthcare services.

Continuum of Operation Integration

The amount of operational integration displayed by each provider organization falls somewhere on a continuum stretching from minimally integrated to fully integrated.

This illustration demonstrates the continuum of operational integration.



Provider Organizations with the Lowest Level of Integration

In the provider organizations characterized by the lowest level of integration, the provider members create an organization to perform a single business function. Apart from this function, the providers maintain fully independent operations.

Example: Providers often form legal entities whose sole purpose is to negotiate with health plans on behalf of all the member providers. Many IPAs and PHOs, discussed later in this lesson, are examples of this type of private organization.

Integrated Delivery Systems (IDS)

At the opposite end of the continuum of operational integration are **integrated delivery systems (IDS)**.

An IDS is a provider organization – highly integrated from a business and clinical point of view – that offers consumers a full range of healthcare services “from birth to death,” including physician services, hospital services, and ancillary services.

Between these two extremes are organizations that provide a number of (usually business) services to providers but leave the responsibility for carrying out certain other operational tasks in the providers’ hands.

Of the organizations that we discuss later in this lesson, group practices without walls (GPWWs), Management Services Organizations (MSOs), and Physician Practice Management (PPM) companies fall into this category of integration.

Practice Management Services	Administrative Support Services
Consulting	Billing
Seminars	Collections
Marketing	Staffing
Strategic Planning	Appointment Scheduling
Practice and Procedures	Contract Negotiations with MCOs
Financial Services	Claims Processing
Legal Services	Medical Record Keeping
Information Management	Equipment Purchase and Maintenance

Advantages of Provider Integration

Integration promises advantages to both providers and others healthcare participants.

In a general sense, there are two potential advantages integration can supply to providers.

The first advantage is greater operating efficiency and effectiveness. If, instead of duplicating functions performed by other providers, providers share these functions, the cost of these functions to each provider should be smaller. In addition, an organization performing business functions for several providers, may possess or develop considerable expertise in these functions. Thus, the providers may benefit from better marketing, strategic planning, information systems, and other business services.

Integration may also improve providers’ contracting position with health plans. A group of providers can offer a more extensive array of services to a health plan than a single provider. The health plan may

therefore be willing and able to offer more favorable contract terms to the provider group than to individual providers.

Disadvantages of Provider Integration

The main disadvantage to providers of integration is a loss of autonomy and control over their own work environment. There are some providers who prefer to work as independent, small business owners rather than as part of a larger group or as an employee of a large organization.

For health plans, healthcare purchasers, and healthcare consumers, provider integration offers greater provider operating efficiency and potentially lower costs for all participants.

Integration also has the potential to make it more convenient for consumers to obtain healthcare by allowing them to obtain a wider array of healthcare services from the same source. On the other hand, there are some consumers who prefer the intimacy of a long-term relationship with an independent practitioner providing healthcare services in their neighborhood.

Provider Integration Models

In this section, we discuss prevalent types of provider organizations. Although we attempt to describe common characteristics of each model, the characteristics of the various types of organizations do evolve due to overall healthcare industry changes. Thus, some organizations you encounter may differ from our descriptions

Some types of provider organizations feature physician integration only, others integrate physicians with one or more hospitals. Both types of organizations – physician-only or physician-hospital – may decide, in addition to providing healthcare services, to accept the insurance risk related to the services provided.

Physician-Only Integration Models

In this section, we discuss physician-only integration models. The models that we will discuss include:

- independent practice associations (IPAs)
- group practices without walls (GWWs)
- management service organizations (MSOs)
- physician practice management companies (PPMs)

These organizations can perhaps best be described to integrating to some extent, the practices of a number of physicians. Most of these organizations contract with health plans, and sometimes directly with healthcare purchasers, on behalf of the member physicians. In addition, many such organizations furnish providers with other services besides contracting with payors.

Independent Practice Associations (IPAs)

One minimally integrated physician-only organization is the **independent practice association (IPA)**.

An IPA is made up of individual physicians or physicians in small group practices. It generally performs only one service for its member physicians—contracting with health plans, employers, and/or accountable care organizations (ACOs) on their behalf.^{vi}

In terms of contractual relationships there are two types of IPAs:

- messenger model
- stop loss insurance

The Messenger Model

In the **messenger model**, the IPA does not enter into a contract with a health plan.

Its role is only to negotiate on behalf of its member physicians the terms of contracts between those physicians and health plans. The physicians themselves enter into contracts directly with the health plans, based on the terms negotiated by the IPA.

The **messenger model** is most often used with fee-for-service or discounted fee-for-service compensation arrangements.

More commonly, the physicians each contract with the IPA, and the IPA enters into a contract with the health plan.

In this model, the method by which the IPA is compensated by the health plan may or may not be same as the method by which the IPA compensates its member physicians.

Example: An HMO might compensate an IPA by capitation, and the IPA might compensate its doctors by capitation or by some other method, such as fee-for-service or discounted fee-for-service.

Stop Loss Insurance

An IPA (or other organization) that accepts capitation from a health plan may limit its risk by buying **stop-loss insurance**.

In this arrangement, if the IPA spends more than a certain amount per year on an individual, the insurer issuing the stop-loss insurance reimburses the IPA for expenditures in excess of that amount.

Example: An IPA might purchase stop-loss insurance to cover all spending on any individual in excess of \$50,000 in a year.

Group Practice Without Walls (GPWW)

A model that generally has a greater degree of integration than an IPA is a **group practice without walls (GPWW)**, also called a clinic without walls.

This is a legal entity that combines multiple independent physician practices under one umbrella organization and performs certain business operations for the member practices or arranges for these operations to be performed.

A GPWW may maintain its own facility for business operations, or it may hire another company to provide this function. Physician income is usually based on the performance of both the individual physician and the group.

Who Owns a GPWW?

A GPWW may be owned by its member physicians, by a hospital, or by a physician practice management company.

When the member physicians own the GPWW, how does it differ from an IPA?

A GPWW performs business operations for physician members, while IPA members generally conduct their own business operations. (The IPA only negotiates contracts.) On the other hand, a GPWW differs from a consolidated medical group in that the GPWW physicians maintain their practices independently at multiple locations. ^{vii} ^{viii}

Management Services Organization (MSO)

Another physician-only model in the middle of the integration continuum is the **management services organization (MSO)**.

An MSO, owned by a hospital or a group of investors, provides management and administrative support services to individual physicians or small group practices.

One purpose of MSOs is to relieve physicians of nonmedical business functions so that they can concentrate on the clinical aspects of their practices. Because MSOs integrate business functions that were previously separate, they can generally achieve economies of scale, and these cost savings may be passed on to physicians, health plans, and purchasers.

MSO Arrangements

In some cases, MSOs simply provide business services to physicians for a fee. In other cases, MSOs purchase the tangible assets (buildings, equipment, and supplies) of physicians and lease them back to them.

In these situations, the physicians continue to own their own medical records and health plan contracts and continue to practice in their own offices. This arrangement relieves physicians of yet another nonmedical aspect of running a practice. ^{ix} ^x ^{xi}

Physician Practice Management (PPM) Company

One type of MSO is the **physician practice management (PPM) company**. This is an organization, owned by a group of investors, that purchases physician practices. Note that PPM companies generally purchase the entire practice, not just the tangible assets as previously discussed.

The PPM company usually gives a physician a long-term contract to continue working in his practice, and sometimes it gives him an ownership interest in the company. The PPM company manages the practice, particularly the non-medical aspects.

Most PPM companies focus on developing a network of either primary care physicians or physicians in a certain specialty, such as cardiology or oncology. PPM companies were active in the 1990s and then fell from favor following several high-profile bankruptcies. In recent years, there have been a resurgence of PPM activity. ^{xii}

Consolidated Medical Group

Full structural and operational integration of physician practices is embodied by the **consolidated medical group**, also referred to as the medical group practice or clinic model. This is a large single medical practice that operates in one or a few facilities rather than in many independent offices. The group may be formed from previously independent practices. The group is often owned by a parent company or a hospital, and it may be a single-specialty or multi-specialty practice.

Advantages of a Consolidated Medical Group

A consolidated medical group can offer several advantages to health plans, including:

- lower costs because of economies of scale resulting from the group's integrated and centralized operations,
- access to a sizeable and stable group of physicians, and
- greater ability to monitor and manage quality and utilization.

Physician-Hospital Models

In addition to organizations that integrate physician practices, there are also those that integrate, to a lesser or greater extent, physicians with one or more hospitals.

These organizations contract with health plans on behalf of the physicians and hospitals they represent and may contract directly with purchasers. Some serve other purposes in addition to contracting.

Physician-Hospital Organization

A **physician-hospital organization (PHO)** is a joint venture of a hospital and many or all of its admitting physicians. Its primary purposes are contracting with health plans and marketing.

Apart from these functions, the physician practices and hospitals typically do not merge their operations. They continue to be independently owned and operated, but they serve patients under the

terms of the contract between the PHO and the health plan. Participating physicians and hospitals share responsibility for managing and administering the PHO.

Physician Hospital Community Organization

Many PHOs are affiliations of one or more hospitals and an IPA or other association of physicians.

A PHO is similar to an IPA, but it includes at least one hospital and usually a wider variety of providers. Sometimes a rural community contracts with a PHO and becomes a party to a health plan contract, resulting in an entity called a **physician hospital community organization (PHCO)**.

Two Types of PHOs

A PHO may be classified as one of two types:

- Open PHO
- Closed PHO

Open PHO

Membership in an **open PHO** is available to all of a hospital's eligible medical staff.

Typically, open PHOs have more specialists than PCPs. Sometimes an IPA or a GPWW represents all or some of the physicians in an open PHO.

Closed PHO

A **closed PHO** limits the number of specialists for each specialty.

A variation of the closed PHO is the **specialist PHO**, which includes only providers of a certain specialty, such as psychiatrists or pediatricians. ^{xiii}

Common Compensation Arrangements

Common compensation arrangements for PCPs in a PHO are discounted fees and capitation. Specialists are typically paid on a discounted FFS basis. Increasingly though there is a move to value-based care.

Because a PHO can offer a broad range of healthcare services under one umbrella, participating in a PHO gives physicians and hospitals greater leverage in negotiating contracts with health plans and employers. Also, joining a PHO enables hospitals to improve their relationships and enhance their collaboration with physicians and market their services more effectively. Other reasons hospitals and doctors form PHOs include sharing financial risk and enhancing the quality of care.

Integrated Delivery System (IDS)

As previously mentioned, an **integrated delivery system (IDS)** is a provider organization that is fully integrated operationally (both in terms of business and clinical) and provides a full range of healthcare services, including physician services, hospital services, and ancillary services.

Because of this comprehensiveness, an IDS can be in a strong position to attract and negotiate with health plans or purchasers.

Various IDS Integration Structures

Although an IDS is fully integrated operationally, it may or may not be highly integrated structurally.

- Some IDSs are structured as contracts between providers that maintain ownership and substantial control over their own practices.
- In other IDSs provider practices are owned and controlled by the IDS. This type, the **employment model IDS**, generally owns or is affiliated with a hospital, purchases or establishes physician practices, and retains the physicians as employees.
- Some IDSs assume insurance risk.^{xiv}

Medical Foundation

In some states laws prohibit a corporation from owning a physician practice, making an employment model IDS impossible.

In these states some hospitals and health plans have instead created **medical foundations**, not-for-profit entities that purchase and manage physician practices. However, to maintain its not-for-profit status, a medical foundation must meet certain requirements related to the benefit it provides to the community, and this may make it difficult for it to compete with other organizations that are not subject to this requirement.^{xv}

Provider Organizations That Assume Insurance Risk

Risk Organizations

Some of the provider organizations described in this lesson (such as some IDSs, consolidated medical groups, IPAs, and PHOs) not only integrate provider functions but assume insurance risk. They are commonly referred to as **at-risk organizations**.

An at-risk provider organization contracts directly with purchasers and health plans.

Division of Functions

For a health plan, contracting with an at-risk provider organization has the advantage of relieving the plan of all or part of the responsibility of developing a provider network. But certain issues may arise in relation to the division of responsibilities between the plan and the provider organization.

- The provider organization may want to handle credentialing and claims payment because it does so for other payors (such as Medicare) and wants to spread the costs over a broader business base. But the health plan may also want to perform these functions so that it can make sure

they are done correctly and in accordance with the contract. The health plan also needs claims data for quality and utilization management.

- To control costs more effectively, the health plan may want fewer network providers than the provider organization.

This division of functions may be governed by state regulations or influenced by the requirements of accreditation agencies. For example, in many states laws require HMOs to perform certain functions.

How an At Risk Provider Organization Provides Insurance

To provide insurance, an at-risk provider organization needs to develop, acquire, or otherwise gain access to expertise in many areas of insurance operations, including actuarial science, underwriting, claims, and quality and utilization management.

The provider organization can perform these functions itself or contract with another entity such as an insurance company or other health plan to provide them.

Depending on the state in which it operates and exactly how it operates, an at-risk provider organization may have to obtain an insurance company license and comply with the laws and regulations that apply to such organizations. In some states an at-risk provider organization does not need an insurance license but is required to maintain substantial financial reserves.

Emerging Models

Accountable Care Organization (ACO)

An accountable care organization (ACO) is a group of healthcare providers who deliver comprehensive and coordinated care with an emphasis on screening, prevention, and ongoing management of chronic diseases, thereby improving the quality of care received by patients.

Example: In an ACO a primary care physician and a specialist might work together to treat an adult with type II diabetes, monitoring her diet and medication to prevent hospitalization and the possible amputation of a limb.

History of the ACOs

The term was first coined in 2006 in an article by industry leader Elliott Fisher.

Although many of the underlying concepts were already being pursued by private commercial health plans, ACOs received considerable attention due to their inclusion in the Affordable Care Act (2010) legislation which directed the Secretary of Health and Human Services (HHS) to create the Medicare Shared Savings Program. ^{xvi}

ACO Compensation Models

Private ACOs have considerable flexibility devising their compensation models. Although most include risk sharing the extent of such risk sharing, upside, downside, or a combination of both can be tailored to the particular needs and competencies of participants. ^{xvii}

Example: An ACO might agree to accept a smaller share of upside risk rather than a higher portion of upside risk along with downside risk because it lacks the necessary insurance experience and financial resources to withstand a potentially huge monetary outlay.

Example: Another ACO with deeper experience and financial pockets might opt for a higher share of potential savings in return for assuming all or a portion of the downside risk.

Medicare Shared Savings Program

ACOs participating in the Medicare Shared Savings Program have less flexibility. They must participate in one of four tracks with various levels of risk: ^{xviii}

Track	Financial Arrangement	Description
1	One-sided	Track 1 ACOs <i>do not</i> assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.
1+	Two-sided	Track 1+ ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk but may share in the greatest portion of savings if successful.

As mentioned earlier in our studies, most ACOs are currently participating in either Track 1 or Track 1+ with limited risk sharing. ^{xix}

The goal of the CMS *Pathways to Success* program is to move increased numbers of ACOs providing coverage to Medicare enrollees into two-way (upside and downside) risk contracts. As part of this, CMS proposes to replace the current four tracks with what it is termed Basic and Enhanced Tracks starting in July, 2019. ^{xx xxi xxii xxiii}

Patient-Centered Medical Home (PCMH)

A **patient-centered medical home (PCMH)** is a model of healthcare delivery in which each patient has a personal physician who is responsible for providing or coordinating care for her on a continuous basis.

In an effort to achieve better health outcomes and more efficient use of resources, the PCMH model seeks to replace healthcare delivery in which a person receives various medical services from a succession of different providers in reaction to illnesses that arise with a strong, long-term physician-patient relationship and continuity and coordination of care.

Main Features of a PCMH

The main features of a patient-centered medical home include the following:^{xxiv}

- The personal physician
- Physician directed care
- Whole person and patient centered care
- Coordination of care
- Quality and Safety
- Enhanced Access to Care

The Personal Physician

The personal physician. Each patient in a PCMH has an ongoing relationship with a personal physician. The personal physician serves as the patient's first contact point when she needs care, and he coordinates her care with specialists, other healthcare professionals, laboratories, and hospitals.

The personal physician is responsible for providing or coordinating preventive care, the treatment of acute illnesses and chronic conditions, and (where appropriate) assistance with end-of-life issues. He or she is responsible for care across settings, including the doctor's office, the hospital, and the patient's home. He also plays an educational role, helping patients understand test results, procedures, and treatment options.

Physician-directed Care

Physician-directed care. In a PCMH the personal physician leads a team of providers who collectively assume responsibility for ongoing care of the patient.

Example: For a particular patient the personal doctor might coordinate the services of a specialist, a lab technician, and a dietician.

Whole Person and Patient Centered Care

Whole person and patient-centered care. The strong and ongoing relationship between the patient and the personal physician allows an approach that includes the whole person and is patient-centered.

Instead of medical conditions being treated in isolation, a patient's total physical condition and health history are taken into account more fully, so that overlapping and negative interactions of treatments are avoided.

Also, a personal doctor can be aware of both a patient's mind and body; can consider her personal values, preferences, and quality of life in weighing clinical alternatives and priorities; and can educate her and her family about her medical options and how to stay healthy.

Coordination of Care

Coordination of care. The PCMH model coordinates healthcare not just within a medical practice, but across all components of the healthcare system including specialty care, hospitals, nursing homes, home health agencies, community-based services, and even care provided by family and friends.

PCMH coordination relies heavily on technology, including electronic medical records and databases and registries.

Quality and Safety

Quality and safety. The PCMH model seeks to provide optimal outcomes by delivering evidenced-based medicine and using clinical decision-making support tools to guide treatment.

The PCMH design also avoids patient safety risks that can arise from the lack of communication and coordination of treatments that often occur in a fragmented healthcare delivery system.

Enhanced Access to Care

Enhanced access to care. The PCMH model seeks to make access to care more available through expanded office hours and technology. Alternatives to face-to-face communications, such as email and telephone conversations, can play a role in non-emergency situations.

Primary Care Provider Compensation

There are a variety of approaches to compensating the primary care provider at the center of the PCMH model. These include:

1. enhanced fee-for-service evaluation and management payments
2. additional codes for medical home activities within the fee-for-service payment system
3. per patient per month medical home payments to augment fee-for-service visit payments
4. risk-adjusted per patient per month payments

Mixed PCMH Payment Compensation

These four approaches are not mutually exclusive alternatives.

A PCMH model may include a mix of fee-for-service payment for physician visits, additional compensation for care management, and incentive payments for achieving measurable quality goals.

Upside shared savings can also be incorporated into the compensation received by participating providers in PCMHs. These varied approaches seek to recognize the time and effort physicians spend

guiding patients' overall care and pays them for it, in contrast to pure capitation and pure fee-for-service.^{xxv xxvi xxvii xxviii}

Notes:

ⁱ Shelby Livingston, Justice Department Greenlights Cigna-Express Scripts Merger, Modern Healthcare, September 17, 2018, available at: <http://www.modernhealthcare.com/article/20180917/NEWS/180919903/cigna-express-scripts-merger-okd-by-justice-department>

ⁱⁱ 26 CFR 1.1563-1, Definition of Controlled Group of Corporations and Component Members and Related Concepts, available at: <https://www.law.cornell.edu/cfr/text/26/1.1563-1> Figure 5A-1 illustrates integration by merger and by acquisition.

ⁱⁱⁱ Todd Kelly and Eric Jackson, Key Issues in Joint Ventures, ABA Health eSource, Vol. 11, No. 10, June, 2014-2015, available at: https://www.americanbar.org/publications/aba_health_esource/2014-2015/June/key.html

^{iv} Dan Avery and Matt Henry, Understanding Healthcare Joint Venture Entities, Becker's Hospital Review, August 2, 2017, available at: <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/understanding-healthcare-joint-venture-entities.html?tmpl=component&print=1>

^v Dean F. Sittig, Elizabeth Belmont, and Hardeep Singh, Improving the safety of health information technology requires shared responsibility: It is time we all step up, Healthcare, Vol. 6, Issue 1, pp. 7-12, March 2018, available at: <https://reader.elsevier.com/reader/sd/pii/S2213076417300209?token=2DB15F2F3F54E96428F4EBB64AEB29F70BA6F506F7C8ACEF2BEB15808D6A8801C348B116425870B1392829266C28DB13>

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^{vii} Harris County Medical Society (HCMS), Group Practice Without Walls (GPWW), Fact Sheet, available at: https://www.hcms.org/Practice_Resources/PracticeOperations/PracticePaymentModels/gww/

^{viii} Continuum Group, Group Without Walls: A New Breed of ACO, Fact Sheet, available at: <https://www.carecloud.com/continuum/group-without-walls-a-new-breed-of-aco/>

^{ix} Joe Laden, The Physician-Owned Management Services Organization, Anesthesia, (April, 2014), available at: <http://www.anesthesiallc.com/publications/anesthesia-industry-ealerts/20-communique/past-issues/spring-2014/302-the-physician-owned-management-services-organization>

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- ^{xii} Becker's Hospital Review, Physician Practice Management – A New Chapter, Feb. 19, 2014, available at: <https://www.beckershospitalreview.com/hospital-physician-relationships/physician-practice-management-a-new-chapter.html?tmpl=component&print=1>
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- ^{xiv} Alain C. Enthoven What is an Integrated Health Care Financing and Delivery System (IDS)? and What must would-be IDS Accomplish to Become Competitive with them? Health Economics & Outcome Research Vol. 2 Issue 2, (May 2016), Open Access 2: 115. Doi: 10.4172/2471-268X.1000115, available at: <https://www.omicsonline.org/open-access/what-is-an-integrated-health-care-financing-and-delivery-system-idsand-what-must-wouldbe-ids-accomplish-to-become-competitive-with-heor-1000115.php?aid=73212>
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