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Principal Strategic Options for Orthopedists to Remain Independent in Our Rapidly Evolving Health Care System

Authored by Michael L. Blau, Esq., Foley & Lardner LLP

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Background

Market and government reforms are transforming the health care landscape. These changes are being driven by the economic, and some would say, social and moral, imperative to reduce the unsustainable rate of growth of health care spending in this country. Those costs make the United States the most expensive health care system in the world; drain federal and state coffers and crowd out other social priorities; strain household budgets and cause an unacceptable rate of medical bankruptcies; and make health care unaffordable or inaccessible for far too many Americans. Orthopedic surgery is responsible for its fair share of these rising health care costs. It accounts for up to 10% of all health care expenditures by some estimates.

Virtually everyone agrees that the time is now to seriously reexamine our fragmented, expensive healthcare system and to innovate sustainable ways to cure its ills. The private market is moving inexorably in this direction. through new value-based purchasing and alternative payment arrangements (like P4P, shared savings, bundled payment, episode of care, and global capitation arrangements); through reorganization of providers into ACOs, medical homes and other clinically integrated care organizations that span the full continuum of care and are focused on population health management (PHM); through new health insurance product designs that involve higher patient co-pays for more expensive care options; through limited, tiered and exclusive provider networks; through redesign of care delivery processes; and through practice acquisitions and industry consolidation to achieve economies of scale.

The offices of health care executives today are replete with talk of bold initiatives to re-imagine, re-design and re-build our system of “sick” care, which is focused on acute and episodic care, into the PHM system of the future, which is be focused on proactively keeping patients healthy. The current pace and extent of planning for the change to PHM and value based care is unprecedented—and, there is a growing sense of urgency--that the stakes are high, resources are constrained, and that the right investments need to be made before opportunities disappear or are claimed by others. The prospect of change of this magnitude can be exhilarating. It can drive innovation, and create new opportunities for community orthopedics. But, it can also

be unsettling, breed uncertainty and create a lot of anxiety. That is what many community-based orthopedic surgeons report feeling today. They are concerned about reimbursement reductions; about reduction in demand for elective services due to increased patient co-pays; about being excluded from payer contracting networks; about losing referral sources as primary care physicians and other specialists align with specific networks; about the pressure to give up their practice autonomy and become employees of hospitals, strong multi-specialty groups or health systems; and about the projected reduction in need for orthopedic surgeons under stringent managed care systems that incent lower specialist utilization rates.

For better or worse, Massachusetts is leading the charge in change. Almost universal health care was mandated in 2006, using the individual mandate, health insurance exchange, and sliding subsidy scale model that become the archetype for expanding coverage under the Affordable Care Act. Eligible Massachusetts residents are those who do not receive health insurance coverage through their employer, or who are unemployed and not eligible for Medicaid (MassHealth). The new program was projected to cover 215,000 individuals at a cost of \$725 million. Unfortunately, the initial legislation did not address spiraling costs. As a result, by 2011 the new program covered 342,000 individuals at a cost of \$1.35 billion. To address costs, in 2012, the Commonwealth enacted chapter 224: An Act to Improve the Quality of Health Care and Reduce Costs. The Act contained a number of major provisions including linking the annual rate of growth in health care spending to the Gross State Product. As a result hospitals, provider organizations and health plans in Massachusetts are accelerating their efforts to create cost-conscious, continuum of care networks. What happens in Massachusetts is unlikely to stay in Massachusetts. Chapter 224 is also likely to become a model for containing health care costs in other states, and may be a roadmap for future federal legislation.

In the face of these changes and challenges, community-based orthopedic surgeons want to know what strategic options they have to remain independent, to survive during the transition to PHM arrangements, and to succeed in the more integrated systems of the future.

Some Preliminary Considerations

This White Paper is intended to help orthopedist make informed choices about their potential pathway(s) to success in their local markets. It is almost a cliché to say that all health care is local, and that what works in one market may not work in another. But, it is also generally true. If the local health care market is dominated by a single large health system, multi-specialty group or commercial payer, an orthopedic group may have no choice but to play ball with it in some way. The dominant health system or multi-specialty group may have the inside track to the better payer contracts and payment rates in the market, whether directly or through an affiliated ACO (accountable care organization) or other payer contracting organization. Or, that health system or multi-specialty group may have the better vision and resources to develop a regional PHM system that is attractive to patients, payers and employers. In either case, it may be in the orthopedic group's short or long term best interest to link with that dominant organization as a vendor, and use what bargaining power your group may have to negotiate for a fair share of orthopedic care dollars under its payer contracts.

An orthopedic group or network will be in a stronger position to negotiate with other provider organizations or third party payers if it has a critical mass of quality orthopedists. A large, high quality group or network may be relatively indispensable to other provider organizations and to payers that need a broad and deep enough network in local and regional markets to meet patients needs in a conveniently accessible, timely, and high quality, manner. Critical mass also provides some protection against anticompetitive tactics, since it makes it more difficult for even a large health system to justify the effort and expense to try to replicate the group or network's capacity. Duplicating the capacity of a large, well-developed orthopedic group or network could take considerable time, involve substantial financial risk and an uncertain outcome--and such duplicative effort may ultimately not be successful and is more likely to increase system costs than result in any cost savings to consumers/employers. The more rational result may be for the dominant health system players to do business with such a potent orthopedic group or network on reasonable terms. The pathway to future success is therefore likely to be predicated on the orthopedic group or network having a critical mass of the quality orthopedists practicing in the local or regional market. This White Paper discusses a number of options for building an orthopedic group or network of sufficient size to have market significance, within applicable antitrust constraints.

To successfully build a sizable orthopedic group or network entails bringing together significant numbers of orthopedists and orthopedic groups on a regional or state-wide basis. Another preliminary question is whether the right orthopedists and orthopedic groups are free to combine or collaborate. That is, have the quality orthopedist or groups in the local or regional market already made contractual commitments that may preclude or delay their ability to join in a larger orthopedic enterprise? Have they obligated themselves to exclusive participation agreements with an IPA, PHO, ACO, or payer? Have they delegated their payer contracting authority away to a health system or other third party agent? Have they entered into non-competes or restrictive covenants with their local hospital that prohibit them from joining a competing network? If so, what is the duration of those constraints, and how easy or difficult is it to get out from under them?

Even if a group can overcome the considerable hurdles to build critical mass in its market, size alone is not sufficient to assure success. Many payers, ACOs and employers are offering only general inflation rate increases (i.e., currently 2-3%) for physician services, and are reducing payments for ancillary services. Payers are typically no longer offering to increase payments by the rate of health care cost inflation (which historically has been closer to 5.5%). Payers are only offering the opportunity for providers to keep pace with health care inflation if the providers are willing to go at risk for demonstrating that they can provide a better health care value proposition. Under new alternative payment contracts, providers can receive additional payments in the form of bonuses for measurably improving quality and outcomes; shared savings produced by reducing cost and utilization; and/or surpluses generated by budget-based payment bundles, episodes of care payments, or capitation arrangements. Negotiating for some combination of general inflation increases and value-based payments (by demonstrating quality and cost-effectiveness) will probably be the best way in the foreseeable future for independent orthopedists to optimize their bottom-line financial results. The emerging message from the payer community is that orthopedists are unlikely to do as well financially in the future without

accepting some risk for the quality and cost of care they provide, and doing the real work necessary to create a new value proposition in orthopedic care.

Getting the timing right in transitioning from fee for service to value or risk-based payment arrangements is also a key preliminary consideration. If an orthopedic group gets too far out ahead of the market by aggressively seeking early participation in alternative payment arrangements, it may end up leaving considerable fee for service dollars on the table, and take a significant hit to bottom-line physician compensation. Conversely, if an orthopedic group is too far behind the market in moving to alternative payment and delivery arrangements, it may lose risk-based opportunities to competitors, and may be foreclosed from those opportunities in the future. Once too far behind the market, the group may never be able to catch up. To complicate matters further, the timing of the transition to value and risk-based arrangements may be dictated by very specific local market conditions and state regulation. For example, providers in major urban/suburban parts of states like Massachusetts and California may be propelled years ahead of providers in neighboring regions or states in transitioning to alternative payment and delivery arrangements.

Summary of Options to Preserve Independent Private Orthopedic Practice

The options outlined in the following sections range from major structural changes (e.g., formation of a “SuperGroup”) to simpler contractual approaches (e.g., co-management agreements), and are summarized below:

Orthopedic SuperGroups: “SuperGroups” are fully integrated organizations that combine and consolidate independent orthopedists and orthopedic groups into a single practice with a single tax identification number. SuperGroups can be monolithic, standardized organizations with central control, or may be organized around operating divisions that afford more autonomy and flexibility to smaller groups of physicians within the SuperGroup. The principal **advantages** to SuperGroups is that they improve market position, thereby easing contracting, recruitment, and growth; enhance access to capital and sophisticated management resources; enable expansion of clinical programming and achievement of quality goals; while improving the quality of life for physicians (e.g., less call). The primary **disadvantage** of SuperGroups is that they are costly and complex to form and manage. See pages 7 to 11.

Orthopedic Medical Home: The Orthopedic Medical home is an approach to the delivery of orthopedic care that focuses on improving the health of a population that requires on-going orthopedic care, enhancing the patient’s experience of care, and reducing or controlling the cost of care. While the Medical Home model was originally developed around the delivery of primary care, the National Committee on Quality Assurance and the Commonwealth of Massachusetts are developing standards for certifying specialty Medical Homes. **Advantages** of the Medical Home model include its appeal to payers, patients and providers as a verifiable “value-added” approach to care. The primary **disadvantages** are the cost of information technology and administrative infrastructure to track, monitor and pro-actively manage patients, and the model does not markedly change an orthopedic group’s market position or power to the extent of other models such as the SuperGroup. See pages 11 to 12.

Orthopedic Networks: An orthopedic network is comprised of independent orthopedists and orthopedic groups which, if properly structured from an antitrust standpoint, can jointly negotiate price and other terms with third party payers. If a network does not meet the financial and/or clinical integration standards for joint pricing, it may still facilitate contracting with third party payers by implementing some form of “messenger model” arrangement whereby each participating orthopedic group acts independently in assessing proposed contract pricing. “Messenger model”, however, is a weak alternative to joint pricing through a clinically integrated network, because payors can do an end-run around a messenger model network by simply insisting on contracting separately with network participants, and refusing to recognize the network as the contracting agent of its participating practices. The primary **advantage** of this model is that it enables formation of a sizable group with market significance that can jointly contract while preserving the independence of existing practices. The primary **disadvantage** is the infrastructure expense to support clinical integration and management of utilization and financial risk; and the difficulty in gaining agreement on, and compliance with, common care protocols and pathways to demonstrate clinical integration. See pages 12 to 19.

Orthopedic Accountable Care Organization: An ACO is an enterprise that is financially and clinically accountable for a patient’s total—or specialty—healthcare. While an orthopedic group could not alone form a Medicare-certified ACO, it could form, or be part of, a commercial orthopedic ACO that assembles a network of orthopedic care across the spectrum of orthopedic care (including physician office, inpatient, ambulatory surgery, outpatient, rehab, and home based care). Through a commercial ACO, the orthopedic group could contract with third party payers to be accountable for meeting financial and clinical metrics, and share in any resulting orthopedic cost savings. An orthopedic group could also participate in one or more Medicare-certified ACOs sponsored by a health system or primary care based medical group. The **advantage** of participating in a Medicare-certified ACO is that the cost of the ACO infrastructure would be shared with others. The principal **advantage** to forming a single specialty or multispecialty ACO is that it may be very attractive to a payer which would partner in its development and would provide the orthopedic group with clinical and risk management technology and resources. A principal **disadvantage** to forming or participating in a Medicare-certified ACO is that ACOs do not have a track record of producing a sustainable return on investment, and primary care physicians may have first dibs on sharing in any ACO cost savings. See pages 19 to 24.

Hospital Alignment Strategies the Preserve Independence—Co-Management and Professional Services Agreements (PSA): Co-Management agreements and PSAs are hospital alignment arrangements. They are independent contractor arrangements between orthopedic groups and hospitals that are intended to align the parties around quality, efficiency and process improvement of the hospital’s orthopedic service line. Orthopedists are paid under the agreements for providing certain non-traditional services, such as for serving as the business partner of the hospital in managing the orthopedic service line. Orthopedists may also be paid performance bonuses or incentives under these arrangements for meeting pre-determined service line quality and efficiency standards and targets. PSAs may also be used to convert physician ancillary services (or entire orthopedic practices) to hospital outpatient services, and to staff hospital (or hospital-affiliated medical group) sites with orthopedists employed by the group. The **advantage** of these approaches is that they permit the group to maintain its independence while realizing increasing practice revenue through payments for value added professional, management, and medico-administrative services provided to the hospital. The **disadvantage** is that the group will be closely aligned with one hospital, which may adversely affect other relationships and referral sources. See pages 24 to 34.

There are also **hybrid options** that involve combining some aspects of a SuperGroup and network or orthopedic ACO. See pages 34-35. In addition, arrangements with **other strategic partners** (e.g., management service organizations, practice management companies, private equity companies, health information technology companies) are described at page 34. Finally, “**Innovation Grants**” funded by the Centers for Medicare Medicaid Services (CMS)’ Center for Medicare and Medicaid Innovation are discussed at page 35.

Options to Preserve Independent Orthopedic Practice—Narrative

Orthopedic SuperGroups

As discussed above, one of the factors for success in remaining independent is attaining critical mass in a market, but within antitrust constraints. One way to achieve such critical mass is to form an Orthopedic SuperGroup in a region or state. To be an Orthopedic SuperGroup, the organization should have, or plan to include, a sufficient number of quality orthopedic generalists and specialists, at a sufficient number of key locations, to be vital, if not indispensable, to any health system, ACO, Medical Home, or payer whose members need access to high quality, affordable orthopedic care across the region or state.

Definition: An Orthopedic SuperGroup is a fully integrated organization that combines and consolidates independent orthopedists and orthopedic groups into a single group practice entity that practices under a single tax identification number.

There are many good business reasons to consider forming an Orthopedic SuperGroup.

Advantages:

- Improved market position for recruitment, growth and future success
- Enhanced bargaining power in relation to payers and vendors
- Improved access to capital for technology and growth
- Economies of scale (e.g., insurance, employee benefits, staffing, operations)
- Improved ability to develop and support ancillary revenue enhancements (e.g., an ASC, imaging, PT/Rehab, clinical trials)
- Better management resources for strategic and business planning
- Central information technology platform and clinical integration
- Increased capacity to accept risk for the quality and cost of orthopedic services, and to manage care and utilization
- Greater array of specialized programs and services (e.g., spine, hand, joint, chronic back pain, sports medicine, etc.)
- Quality improvement through peer interaction
- Improved quality of life (e.g., more coverage/less call)

There are also distinct legal advantages to consolidating separate orthopedic practices into a single, fully integrated SuperGroup. Legal advantages include:

- The ability of participating orthopedists and groups to jointly price, or collectively bargain, with payers and vendors, without engaging in illegal price fixing in violation of federal and state antitrust laws.
- The ability of participating orthopedists and groups to cross refer to one another, while sharing an economic relationship, without violating federal and state Anti-Kickback Statutes.
- The ability to share ancillary revenue without violating the Stark Law.

Disadvantages:

Every structure, of course has its disadvantages. Depending on the variant of SuperGroup chosen, it will have some disadvantages over maintaining an existing small group or solo practitioner model. These include:

- Can be costly and complex to form (see detail provided below).
- More complicated to govern and manage because of the size of the enterprise.
- Over time, may be less nimble.
- Less individual physician autonomy because of the need for centralized infrastructure and management.

Antitrust Constraints:

There are antitrust constraints on how large a SuperGroup can be. Under applicable Federal Trade Commission Safety Zones and Guidances, an Orthopedic SuperGroup can, with impunity, include up to 20% of the orthopedists in the relevant geographic market on an exclusive basis (i.e., the orthopedists can only contract with payers through the SuperGroup, and not on their own outside of the SuperGroup), and up to 30% on a non-exclusive basis (i.e., the orthopedists can also contract on their own or through other intermediaries, like an IPA or PHO); and a Medicare certified ACO can contract on a non-exclusive basis with a SuperGroup that has up to a 50% market share. The relevant geographic market for antitrust purposes is generally considered the area (defined by zip codes) from which the constituent orthopedic groups draw either 75% or 90% of their patients for such services. It is possible, in the future, that the antitrust enforcement agencies may analyze the geographic market for orthopedic services more narrowly, or may evaluate separately the service markets for orthopedic subspecialty services (although they have not historically done so). At bottom-line, based on antitrust enforcement agency precedents, if the market for orthopedic services is relatively fragmented and unconcentrated, a SuperGroup can probably include up to 40%-50% of the orthopedists on an exclusive basis in the relevant service market (i.e., outpatient ambulatory orthopedic services and/or inpatient orthopedic services) in the relevant geographic market (i.e., the 75% or 90% patient draw area) without raising any material antitrust concern. However, if the market is such that including 40-50% of the orthopedists permits the SuperGroup to negotiate payments at rates above those available in a competitive market, the SuperGroup could be challenged. An informed health care antitrust assessment would be advisable in such instances.

SuperGroup Structural Options:

There are a few structural options for organizing an Orthopedic SuperGroup. Those options include forming (1) a traditional medical group, with standardized operations and a single compensation pool, (2) a holding company, with subsidiary orthopedic groups, or (3) a “group practice without walls”, with each orthopedic group operating as a separate division and profit/loss center of a single practice entity. The holding company model is generally the least favored of these options because it does not solve the Anti-Kickback and Stark law issues arising from cross-referrals and shared ancillary services. The traditional group

practice and group practice without walls options do. Of these, the group practice without walls model is the most flexible, and tends to be the path of least resistance for forming SuperGroups. For example, orthopedists can flounder over trying to get their colleagues to agree on shared governance, shared economics and shared identity (name and brand) when trying to consolidate into a traditional centrally controlled medical group. There is an art to defining governance in a traditional group where there are many participating orthopedists and groups. The participants need to find the right balance of constituent interests and voting power so that all components of the SuperGroup feel that they are adequately represented, and that participating groups (and particularly smaller groups with minority interests) are comfortable that their interests will not be subordinated to the interests of others.

In contrast, the group practice without walls provides what may be more palatable solutions for these key governance and organizational challenges. Instead of shared governance solely through a single central governing board, the group practice without walls permits each orthopedic practice that joins the SuperGroup to retain “semi-autonomy” as a separate operating Division of the SuperGroup. That semi-autonomy is reflected in establishment of a Divisional Council for each Division (comprised of the members of governing board of the orthopedic group at the time it joins the SuperGroup) that can be delegated authority by the governing board of the SuperGroup to operate and manage the Division on a day-to-day basis, as long as the Division manages itself within the Division’s budget and financial means. The budget of each Division in a group practice without walls is typically set on a “bottom-up” basis. That is, the Divisional Council recommends the Division’s budget to the SuperGroup governing board, based on the Division’s historical revenues and costs, and based on its plans for capital improvements, new recruits, and other anticipated changes. The SuperGroup governing board reviews the recommended Division budget and approves it, so long as the Division is projected to have the financial means to operate within its proposed budget. Once the Division budget is set, the Division is free to manage itself, through its Divisional Council (or Division leadership approved by the Divisional Council) and can decide, for instance, who to hire and its own schedule. The SuperGroup governing board, however, retains ultimate authority to set enterprise-wide policy and oversee operations of the SuperGroup and all of its Divisions.

Note: These SuperGroup models assume the formation of a new entity to house several formally independent practitioners or groups. In that case, a new tax identification number would be required and assets would have to be moved into the new entity, and contracts would have to be assigned to it. Alternatively, an existing group could serve as the “host” group, and the other groups could either merge into or contribute their assets to the host. In that case, the host group would maintain its tax identification number. These different transactional structures have different tax and liability consequences, and professional advice on these matters should be considered in determining how to structure the transaction.

Also note that any material change in governance or operations of an orthopedic group that has more than \$25 million in net patient service revenue will now require filing a notice of material change with the new Massachusetts Health Policy Commission (HPC). Formation of a provider organization that will engage

in payer contracting for any provider also requires filing a notice of material change with the HPC. Forming a SuperGroup may entail such a material change in governance or operations. If so, HPC will conduct an initial cost and market impact assessment to determine whether the transaction is likely to have a significant impact on competition in the market or on the Commonwealth's ability to meet its cost growth benchmark (currently 3.6%). If HPC finds that the transaction is likely to have such an impact, then the transaction cannot close until 30 days after the HPC issues its final cost and market impact report (for which there is no prescribed deadline).

When it comes to shared economics, the group practice without walls model also provides greater flexibility than the traditional medical group model. In the traditional medical group model, all revenue and expenses of the group are pooled, and physician compensation is payable out of a common pool defined by the organization's net operating income (i.e., the group's revenues, net of its expenses, before physician compensation and benefits). There are typically common compensation methodologies for all physician owners of the group, on the one hand, and all physician employees, on the other. In contrast, in the group practice without walls model, each Division is a separate profit and loss center. All revenues arising from Division practitioners are allocated to their Division, and all expenses incurred by a Division are allocated to that Division. Expenses that are incurred at the SuperGroup level for central business office functions that the Divisions agree to centralize (e.g., central HR, IT, payer contracting, financial reporting) are assessed on an equitable basis against all Divisions. The net amount left in each Division after debiting the Division's direct expenses and its allocable share of centralized business office expenses, is available for distribution to Division physicians, generally in any legally permissible manner. In this way, the Divisions can define their own compensation methodologies for at least their own physician owners. So as not to create unhealthy internal competition among Divisions, generally all Divisions offer the same employment package to new recruits, and let the recruit decide which Division the recruit would prefer to join, among those that are hiring new physicians.

With respect to shared identity (or retaining existing identity and brand), the group practice without walls model also generally provides greater flexibility than the traditional group practice model. In the typical traditional group practice, the practice operates under a single name, and tries to build brand identity with that name. In the group practice without walls, each Division typically retains its pre-existing name and brand, and uses it as a d/b/a ("doing business as" name) along with the name of the SuperGroup. For example, if the name of the SuperGroup is US Orthopedics, and the name of the group joining the SuperGroup is Allied Orthopedics, then after consolidating into the SuperGroup, the signage and letterhead for that Division may read: Allied Orthopedics, a Division of US Orthopedics. Such co-branding retains local identity while also providing an opportunity to establish a strong state-wide or regional brand.

That said, there can be numerous other obstacles to successful consolidation of orthopedic groups into a SuperGroup. Some of the other principal obstacles are:

- Different cultures
- Different IT platforms (especially if the group has undergone a recent IT conversion)
- Different billing arrangements
- Different debt profiles
- Different payment contracts/rates
- Different practice values
- Different use of mid-level providers
- Different staff salary and benefit structures
- Different buy-sell arrangements
- Different quality and utilization profiles
- Lack of trust

Of these, different cultures and lack of trust may be the obstacles that are the most difficult to overcome. Tremendous strides in that direction can be made, though, through an inclusive, engaged and respectful planning process by which the SuperGroup is collaboratively designed and developed. That planning process should address all material structural, governance, operational, technological, and financial design features of the SuperGroup. Such an inclusive and comprehensive planning process is a key to getting sufficient buy-in from participants for them to join in the SuperGroup consolidation.

Building An Orthopedic Medical Home

Community based orthopedic surgeons have the opportunity to make a significant contribution toward achieving the so-called Triple Aim of health care by building orthopedic medical homes. As defined by the Institute for Healthcare Improvement, the Triple Aim of healthcare is to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of care.

Definition: The Orthopedic Medical Home is an approach to the delivery of orthopedic care that can be adopted by any orthopedic group, SuperGroup or network to accomplish the goals of the Triple Aim. This approach entails assuming responsibility for coordinating orthopedic care with other system components, including primary care, enhancing the quality of orthopedic care, and ensuring that the care is efficiently delivered to control costs. To accomplish these goals, the orthopedic medical home focuses on, inter alia, “right-siting” orthopedic care; curbing overutilization of imaging and surgical services; standardizing use of cost effective protocols, treatment regimens, implants and supplies; and pro-actively monitoring patient pain and surgical outcomes to avoid avoidable ED visits and hospital admissions. If community orthopedic surgeons do these things, they should have the opportunity to share in the resulting cost savings.

Most orthopedic organizations will technically not be able to meet the eligibility standards of the NCQA (The National Committee on Quality Assurance) to be recognized as a Patient Centered Medical Home (PCMH). Under those standards, the only practices that can qualify as a PCMH are those that provide first contact, continuous, comprehensive,

whole person care for patients, and that treat patients through team-based care that is coordinated or integrated across the health system. Whole person care includes provision of comprehensive care and self management support and emphasizes the spectrum of care needs, such as routine and urgent care; mental health; advice, assistance and support for making changes in health habits and making health care decisions. Preventive care is also a key expectation for clinician focus. Accordingly, PCMH certification is reserved by the NCQA principally for primary care practices – including family practitioners, general practitioners, internists and pediatricians. Orthopedic practices would qualify only if they provide such whole patient primary care services for at least 75% of their patients, as some pain management and chronic arthritis programs may attempt to do. That said, Massachusetts has recently enacted legislation that sets up a process for certifying specialty medical homes by the Commonwealth’s new health Policy Commission. The standards for certification have not yet been promulgated, and it is currently unknown whether orthopedic practices would be eligible for such certification. In the future, specialist medical groups, like orthopedic practices, will be able to participate in NCQA’s Patient-Centered Specialty Practice Recognition Program. This program is currently under development and will recognize specialty practices that have successfully coordinated care with their primary care colleagues and each other, and that meet the goals of providing timely access to care and continuous quality improvement.

Advantages:

The advantages of forming an orthopedic specialty Medical Home include:

- Ease of implementing the approach versus other more sweeping structural changes
- Appeal to payers and other provider-partners as a verifiable “value-added” approach
- Enhanced appeal to patients due to focus on patient experience
- Assists in recruiting physicians who are interested in enhancing the quality of care for their patients.

Disadvantages:

The disadvantages of relying on the orthopedic specialty Medical Home include:

- Does not address other market factors addressed by more sweeping structural changes (e.g., size and resources)
- Would require significant infrastructure resources to implement and the approach may not be recognized in the market place if not certified by NCQA and the Commonwealth
- May be resisted internally as undesired change
- May not be rewarded, or adequately rewarded, by payors.

Nonetheless, as discussed in the Preliminary Considerations section above, it is likely that orthopedic groups will need to be able to demonstrate a new and better value proposition in

the future to optimize financial opportunities with payers, ACOs and other payment sources. It would therefore be advisable for orthopedic groups to be “care ready”—that is, ready to deliver on coordinated and reduced cost orthopedic care when the time is right and shared savings opportunities present themselves.

Forming an Orthopedic Network

Definition: If the obstacles to forming an Orthopedic SuperGroup prove too daunting or insurmountable, it may be easier to obtain critical mass by forming a single specialty contracting network comprised of independent orthopedists and orthopedic groups. Such a network could be structured to be financially and/or clinically integrated, consistent with antitrust laws, so that it can jointly negotiate prices and other terms. Otherwise, the network will have the much more limited contracting options discussed below.

Advantages:

The key advantages to the orthopedic network model include:

- Enables combination of a sizable group capable of pricing services jointly in the market place while preserving the independence of the constituent practices
- Enables independent groups to combine resources to develop clinical care approaches and other infrastructure (e.g., technology and sophisticated contracting staff) that would be likely beyond the resources of participants acting alone
- Increases opportunities for contracting with health systems, ACOs, payers and other provider networks
- If clinically integrated, increases physician remuneration through the contracts to the extent payers are willing to pay for value-added services (e.g., greater care coordination) through the network.

As described below, an orthopedic network can jointly negotiate prices if it bears sufficient financial risk or is sufficiently clinically integrated. Otherwise, the network will need to resort to what is known as “messenger model” pricing. The disadvantages of organizing a network turn in large measure on whether or not it can jointly price and bind participants to payer contracts.

Disadvantages:

- Can be expensive and time-consuming to develop a clinically integrated network
- While less difficult to organize, a messenger model approach is less likely to be attractive to the market place or to physicians because it doesn’t create a new product or necessarily positively affect physician reimbursement; and payers can refuse to deal with it
- Potentially subject to state regulation if it is a risk-bearing organization.

Network Formation

To be successful, such a network, like a SuperGroup, would need to include a sufficient number of quality orthopedists, at a sufficient number of key locations to be vital to payers whose members need access to high quality, affordable orthopedic care in those markets. Such a network could be a carve-in (or carve-out) network for any health system, PHO, ACO or PCMH that enters into a pay for performance, shared savings, managed care or risk contract with a payer.

One gating issue in forming an orthopedic network is the extent to which prospective orthopedists and orthopedic groups are already under contractual constraints or restrictive covenants that may prohibit or delay their joining the network. If the orthopedist/group is already a member of an IPA, PHO or ACO, the orthopedist/group may have contracted away its ability to join another network, at least until it can terminate its existing contract. Generally, IPA, PHO and ACO participation agreements can be terminated on between 90 days and 1 year notice. During any termination notice period, the orthopedist/group may be permitted to participate in any contract that the orthopedic network enters into with any new payer that is not doing business with the other network. Orthopedists/groups also need to assess whether they will lose referral sources if they leave their current IPA, PHO or ACO to join an orthopedic network. This concern can be addressed over time if the orthopedic network is successful in becoming a sidecar or carve-in to multiple contracting organizations, including any existing IPAs, PHOs and ACOs with which those orthopedists/groups currently participate.

Financial Integration

To be able to bargain collectively with payers and other payment sources for a fair share of health care dollars under such network arrangements, the participating orthopedists/groups would need to be substantially financially and/or clinically integrated for antitrust purposes. Financial integration consists of sharing "substantial financial risk." Examples include capitation agreements, withhold pools, "global fee", certain payment bundles, episodes of care, case rates, and certain bonus arrangements. A key to substantial financial risk arrangements is that there must be shared risk—that is, a substantial portion of the orthopedist's payment must be based on the aggregate performance of physicians in the network (or risk pool), and not just based on individual quality or utilization performance. Programs, like the Medicare PQRI program, that provide bonuses for individual physician quality performance do not involve substantial shared financial risk, and would not qualify the network as a financially integrated network for single signature contracting. Indemnity, fee for service, and PPO payment arrangements similarly do not involve shared financial risk.

To collectively bargain for these non-risk contracts, the network must either be doing so much risk contracting that the non-risk arrangements are viewed as inconsequential, or the orthopedists in the network must be substantially clinically integrated. In contrast, clinical integration focuses on the quality-control, information systems, and protocols established by a physician network, that lead to increased quality, efficiency, information sharing, and modification of utilization and practice patterns.

Clinical Integration

Statement 8 (B)(1) of the Department of Justice/Federal Trade Commission (FTC) Policy Statements defines clinical integration as follows:

“Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of inter-dependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”

To achieve clinical integration, the orthopedic network must commit to a serious effort to establish goals relating to the quality and utilization of orthopedic services, to monitor participants’ performance concerning those goals, and to take concrete steps, where necessary, to modify participants’ actual practices. To do so, the network will need to make significant investments in the information systems, data analysis and reporting capabilities, and the human and administrative resources, necessary to implement care and utilization management programs.

In their Policy Statements, the antitrust enforcement agencies also state that they will examine whether the clinical integration activities are likely to result in significant decreases in utilization, increases in quality, and decreases in aggregate costs (including transaction costs) over what would otherwise be the case. Monitoring and timely corrective action, where needed, are also important to an effective clinical integration program. Thus, the provider network should actively monitor the practice patterns of individual providers to assure that they are achieving efficiencies, and should only select and retain participating providers who further efficiency goals.

The use of clinical practice guidelines also helps qualify a network as clinically integrated, because such use reflects an effort to have all network physicians follow best clinical practices, reduce variation in care, and standardize quality care. Use of clinical protocols, coupled with utilization review targeted at compliance with clinical guidelines, can demonstrate that the network is coordinating care to achieve higher quality and/or lower costs, thereby distinguishing itself by delivering better (and pro-competitive) value-based care to patients.

The network should generate and report individual and aggregate utilization and cost profiles to educate network providers about how to achieve high-quality, cost-effective care, and thereby seek to change/standardize provider behavior. The profile information should also be used by the network to discipline and, if necessary, terminate providers who are persistently non-compliant. With effective enforcement, the network is more likely to change physician behavior for the better.

In summary, substantial clinical integration can be evidenced by:

- Integration of practitioners (and institutions) that present the opportunity for true collaboration and productive sharing of information reflecting actual “interdependence”
- Participation of a care continuum of providers with a requirement of in-network referrals
- Treatment of a broad spectrum of orthopedic diseases and disorders and adoption of corresponding clinical protocols
- Integrated information technology whereby network participants can efficiently exchange information regarding patients and practice experience
- Integrated information technology whereby utilization and claims information can be gathered, analyzed, and communicated in order to improve treatment and quality, and reduce utilization rates and cost
- Integrated information technology whereby physician compliance and performance is measured against collective, physician-authored benchmarks
- A high level of physician investment, both economically and in terms of training and use of the system, and agreement among physicians to comply with the standards, benchmarks, and protocols put in place by the network,
- Timely and effective sanctions for non-compliance.

Perhaps the most important guidance issued by the FTC regarding clinical integration is that it will “focus on substance, rather than form, in assessing a network’s likelihood of producing significant efficiencies.” In other words, it will assess the impact of the clinical integration efforts on utilization, cost and quality in real, rather than hypothetical, terms.

Ancillary Constraints

The existence of sufficient clinical integration does not, by itself, guarantee that joint contracting by an orthopedic network will pass muster under the antitrust laws. Joint contracting must also be reasonably necessary to accomplish the goals of the clinical integration plan, and the FTC will look carefully to see if there are alternative means of achieving efficiencies, other than joint contracting, that do not threaten competition. In that regard, the following further features of a clinical integration program should reduce antitrust risk:

- If the network is non-exclusive and allows for independent contracting by participating providers where payers and the network cannot come to agreement on

- terms within a reasonable and defined period (e.g., 90 days)
- If the network does not involve unnecessary exchange of pricing information among physicians and/or hospitals
 - Joint pricing should only apply to services that are part of the clinically integrated program
 - Investment in the IT and human resources necessary to implement an effective clinical integration program

Messenger Model Arrangements

If the network participating providers do not achieve substantial financial and/or clinical integration to permit prices to be jointly negotiated, then the network can resort to pricing, using “messenger model” arrangements, for non-risk contracts. Under a messenger model arrangement, independent participating providers in the network typically give the network a limited right of first opportunity to attempt to arrange for a contract with payers on behalf of each participating orthopedist/group. The longer the right of first opportunity period, the greater the risk that the period will be viewed as an unreasonable restraint on competitive pricing. Under the messenger model, the network does not have direct contracting authority (it does not have single-signature authority) on behalf of participating providers. Rather, each participating provider must sign its own payer contract once an agreement is reached.

There are two varieties of messenger model arrangements: the “pure” messenger model and the so-called modified messenger model.

Pure Messenger Model

Under the pure messenger model, the network serves as a “messenger” to communicate offers from payers to participating orthopedists/groups and to communicate the providers’ responses back to the payers. The participating orthopedists/groups retain the right unilaterally and independently to accept, reject or counter the payer offer. Generally, the network will need to give the providers the opportunity to consider the payer’s offer and cannot reject it out of hand. Essentially, the network simultaneously conducts separate negotiations on behalf of each of its independent participating providers. Once agreement is reached, participating orthopedists/groups can either opt in or opt out of the contract. Opt-in arrangements require affirmative, separate approval by participating providers and carry less antitrust risk than opt-out arrangements. Under opt-out arrangements, the participating provider is deemed to have approved the contract and defaults to participating in the contract, unless the provider affirmatively opts out.

Modified Messenger Model

Under modified messenger model arrangements, participating orthopedists/groups each designate in advance to the network the price point that the provider would accept from the payer (e.g., 130 percent of the Medicare allowable for a particular service). Each of the providers must unilaterally and independently determine its own acceptable price point without collusive discussions or agreements with other participating orthopedists or the network. The participating

provider typically agrees in its participation agreement that if the payer offers a contract with pricing at or above the provider's specified pricing, then the participating provider will be bound to accept and sign the contract. If the payer does not offer that price, then the network may reject the contract offer on the participating provider's behalf. Otherwise, the modified messenger model process is substantially the same as the pure messenger model arrangement described above.

No Price Information Sharing

Under messenger model arrangements for non-risk contracts, the network cannot share with participating providers the prices that participating orthopedists/groups are willing to accept for their services, and the network cannot otherwise facilitate collusive pricing among participating providers. Rather, the network (or its agent) must act as a "black box" — that is, pricing information that goes in from one participating provider cannot go back out to any other participating provider. Some national payers have gotten aggressive in challenging messenger model arrangements that appear to be facilitating common pricing or that use a common agent that has not implemented adequate black box policies to ensure that there is no leakage of pricing information to participating providers.

Weaknesses of the Messenger Model

The principal weakness of messenger model arrangements for non-risk contracts is that a motivated payer can do an end run around the network and require separate direct negotiations for non-risk contracts with each participating provider. All the payer needs to do is wait out the right of first opportunity period, at the end of which the payer can directly approach participating providers to negotiate contract rates. The network, at that point, has no contractual right to stop the payer from separately negotiating and contracting with the participating provider and would risk facilitating an illegal "group boycott" if the network tried to influence participating providers collectively not to negotiate or contract with the payer. For these reasons, it is advisable for networks to attempt to achieve substantial financial and/or clinical integration to permit the network to exercise binding, single signature authority on behalf of all participating orthopedists/groups for all payers and products (whether risk or non-risk).

Risk-Bearing Provider Organizations

Under the recent cost containment legislation in Massachusetts ("Chapter 224"), larger providers and provider organizations are subject to greater regulation. Pursuant to Chapter 224, an orthopedic network with 15,000 or more covered lives and/or with more than \$25 million in annual net patient service revenue, and that contracts with payers on behalf of one or more orthopedist, must register with the Health Policy Commission as a "provider organization". Registration standards have not yet been promulgated. Once they are, any orthopedic network that is required to register and does not do so will be prohibited from contracting with any payer.

In addition, if the orthopedic network is a risk-bearing provider organization that bears downside risk under a payer contract, then the orthopedic network will need to obtain a risk certificate from the Division of Insurance. Again, the standards for certification as a risk bearing

entity have not yet been developed or adopted by the Division of Insurance. But, when risk certificate rules are adopted, it is anticipated that they will require any risk-bearing orthopedic network to demonstrate that it has adequate solvency protections in place (e.g., stop loss insurance, reinsurance, surplus reserves, letter of credit, surplus notes, etc.) to cover its downside risk.

The Division of Insurance has also recently clarified that any orthopedic network that assumes downside risk from an employer self-insured health plan will be viewed as engaging in the business of insurance in Massachusetts, and would need to be licensed as a form of insurance company (e.g., an HMO, medical service plan, preferred provider arrangement, or general casualty insurer), and subject to all of the associated insurance reserve, accounting, reporting and regulatory requirements. That is because self-funded plans under ERISA are exempt from state insurance regulation. As a result, there are no solvency or consumer protections in place to back-stop networks that do business with ERISA plans. For this reason, an orthopedic network will probably be unable to do any direct employer contracting in Massachusetts.

Cost and Market Impact Review

Formation of an orthopedic network would involve formation of a provider organization that will engage in payer contracting for participating orthopedists. As noted above, forming such a network may entail a material change in operations requiring the filing of a notice of material change with the Massachusetts health policy Commission. If so, HPC will conduct an initial cost and market impact assessment to determine whether the transaction is likely to have a significant impact on competition in the market or on the Commonwealth's ability to meet its cost growth benchmark (currently 3.6%). If the HPC finds that forming the network will likely have such an impact, then the transaction cannot close until 30 days after the HPC issues its final cost and market impact report (for which there is no prescribed deadline). The same would be true for the Orthopedic ACO options discussed below.

Orthopedic ACO

Orthopedists may be able to form an Orthopedic ACO (Accountable Care Organization) with a major commercial insurer and with other health system components to provide the full continuum of orthopedic care in a coordinated manner, from physician office to acute care, to post-acute care, and home-based services.

Definition: Typically, an ACO is a separate provider organization and payer contracting vehicle which arranges for and coordinates care among the ACO's participating providers. For example, under the Affordable care Act, to qualify as an ACO, the organization must:

- Establish a formal legal structure having shared governance that allows the ACO to distribute shared savings payments to participating providers and suppliers
- Include enough primary care physicians to care for the Medicare fee-for-service population assigned to the ACO and have a minimum of 5,000

such Medicare beneficiaries assigned to it

- Have a leadership and management structure that includes clinical and administrative systems
- Define processes (such as through telehealth, remote patient monitoring, and/or other technologies) to promote evidence-based medicine and patient centeredness, report on quality and cost measures, and coordinate care
- Agree to be accountable for the quality and cost of care provided to Medicare fee-for-service beneficiaries assigned to the ACO
- Agree to participate in the Medicare Shared Savings Program (MSSP) for at least three (3) years
- Agree to be accountable for the quality and cost of care provided to Medicare fee-for-service beneficiaries assigned to the ACO
- Demonstrate that it meets patient-centeredness criteria established by the Secretary, such as the use of patient and caregiver assessments or individualized care plans

Eligible ACOs can participate in the Medicare Shared Savings Program. Each independent provider who participates in a Medicare ACO will continue to submit its own claims and be paid by Medicare on a fee-for-service basis for the services it provides. However, the Medicare ACO will be eligible to receive additional “shared savings” payments if the ACO (i) meets applicable quality of care and performance standards and (ii) is able to provide services at a cost that is at least 2% less than the applicable cost “benchmark” for services historically provided to Medicare patients assigned to the ACO. ACOs can participate in the MSSP without taking any downside risk for a period of up to 3 years. This opportunity for Medicare payments “plus” additional shared savings payments with no downside risk has made forming ACOs to participate in the MSSP program an attractive proposition. As of January 1, 2013, there have been 246 ACOs approved and certified by CMS to participate in the MSSP, with 17 in Massachusetts.

Those ACOs that can qualify for the MSSP, however, are generally primary care oriented organizations—that is, they are either medical groups/IPAs or health systems/PHOs with a strong primary care base. That is because Medicare fee for service patients are assigned to a Medicare ACO based on the primary care physician from whom they receive the plurality of their primary care services. Patients are not assigned to a MSSP participating ACO based on their orthopedic or other specialist physician, unless the patient does not have a primary care physician and receives a plurality of the patient’s primary care services from an orthopedist or specialist. It would rarely be the case that an orthopedist provides the plurality of primary care services for a Medicare patient. Accordingly, as a practical matter, there cannot be an orthopedic-only ACO for MSSP purposes.

This leaves two ACO opportunities for orthopedists: they can either be vendors to a Medicare certified ACO, or they can form or participate in a commercial ACO--that could be an orthopedic-only ACO.

Advantages:

- The advantages of participating in a Medicare ACO are that (i) the infrastructure costs would be shared with others, and (ii) the orthopedic group improves its chances of maintaining referrals from ACO participating providers which it might otherwise lose.
- The advantages of forming a single specialty or multi-specialty commercial ACO with a commercial payer are that (i) the payer would share in and support its development and (ii) the orthopedists would have access to the payer's care and utilization management systems and experience.

Disadvantages:

The potential disadvantages are described in greater detail below but may be summarized here as follows:

- The Medicare-certified ACO is experimental and early experience suggests that it may not yield a return on investment over the long term, and so may not be sustainable
- The formation of a multi-specialty group to partner with a payer for the purpose of launching a comprehensive physician-led ACO is very difficult and carries a high degree of risk.

Medicare ACOs

Orthopedists/orthopedic groups can contract directly with an ACO that participates in the MSSP, or indirectly through another ACO participant (e.g., a participating IPA, PHO, orthopedic network or other provider organization). Some of the top concerns of orthopedists about participating in a Medicare certified ACO include:

- Experimental nature of MSSP—CMS' Physician Group Demonstration Program was the forerunner to the MSSP program. There were 10 medical groups that participated in the Physician Group Demonstration Program. Of those, half were able to demonstrate some shared savings during the term of the program, but none were able to show a return on investment (ROI). That is, the infrastructure costs (technology and human) of developing and operating the ACO exceeded the amount of shared saving produced by the program. This leaves significant uncertainty about the potential return on investment to be generated by the MSSP; and, if there is little or no ROI, then it is unlikely that there will be any upside

reward for participating orthopedists (who, in any event, will generally stand in line behind primary care physicians when it comes to allocation of any shared savings surpluses). And, even if there proves to be a return on investment for the ACO, will it be shared with orthopedists? Will the ROI be re-based out of existence when the cost benchmark is lowered in 3 years to take into account cost savings achieved during the initial contract term?

- No or limited role in ACO governance --Each Medicare ACO participant (with a separate TIN) must be represented and have meaningful participation in governing body decision-making of the Medicare ACO. At best, orthopedists will be one voice among many who are represented on the ACO governing board. But, there is no requirement or assurance that any orthopedist will have a seat on the governing board at all. They may be “meaningfully” represented, for instance, by a primary care physician from an IPA of which the orthopedists are members.
- Orthopedists may be less likely to be allocated a fair share of any shared savings realized--Each ACO must specify its method of allocating and distributing shared savings dollars, and all specialties do not need to be included or treated equally. Since Medicare ACOs are primary care focused, and since orthopedics is a relatively expensive specialty, there is concern that the ACO may attempt to exclude orthopedists from, and have them not participate in, any shared savings distributions.
- The MSSP raises cash flow concerns, particularly with Pioneer ACOs— Under the MSSP, physicians are paid directly by CMS on a FFS basis, and receive distributions, if any, of shared savings from the Medicare ACO. Final reconciliation of annual shared savings will occur 12-24 months after the end of the applicable year. Shared savings distributions therefore will have a similar lag time. In contrast, a Pioneer ACO, if it has a successful first 2 years of operation, will directly be paid 50% of the Medicare FFS payments. In other words, providers will only be paid by Medicare 50% of the FFS rate for their submitted claims and will have to rely on the ACO for the other half of its payment. This leaves a significant question of when orthopedists will be paid by the ACO in relation to when they incur implant, supply and other out-of-pocket costs.
- Cross-cutting shared savings and FFS incentives can create inconsistency and confusion in orthopedic behavior—This problem is exacerbated if other payers pay for orthopedic services on a FFS basis, on a basis other than a shared savings basis, or reward different performance standards. Inconsistent payer incentives can lead to somewhat schizophrenic physician behavior.

- The MSSP shared savings opportunity (to the extent applicable to orthopedists) could incent participating orthopedists to stint on care, with potential adverse effect on the quality of care. Hopefully, orthopedists would not let this happen. But, participation in the MSSP may also incent participating orthopedists to avoid higher cost new (and better) diagnostics and therapeutics to reduce orthopedic costs below the applicable cost benchmark.
- Patient freedom of choice—Patients are free to choose their providers, and the Medicare ACO is prohibited from requiring in-network referrals. This means that patients can go out-of-network with impunity, limiting the ability of the ACO and participating orthopedic providers to coordinate and manage the cost of their care. Medicare patients can also opt-out from sharing CMS claims data with ACO providers. If the Medicare patient does so, it becomes difficult, if not impossible, to coordinate and manage the patient’s orthopedic care across different providers and sites of care.

ACO Contracting For Orthopedic Services

Orthopedists participating in an ACO, including a Medicare ACO, should seek to address the foregoing concerns when negotiating any ACO participation agreement. (Note that the orthopedists may be in a better bargaining position to do so if they have formed an Orthopedic SuperGroup, Orthopedic Network, or commercial Orthopedic ACO that includes a critical number and sites of quality orthopedists/groups). Key terms to be negotiated with the ACO include:

- Service level—Will the participating orthopedists be expected or required to redesign their care processes to provide better value-based orthopedic care? Will they need to have extended office hours, provide home-based monitoring, standardize use of implants and supplies, follow clinical protocols, meet specified quality and efficiency standards, obtain prior authorization for ancillary and elective services, and/or become certified for NCQA’s Patient-Centered Specialty Practice Recognition Program? What performance standards will apply?
- Payment method and rate—What is the payment method by which orthopedists will be paid—e.g., fee for service (within or outside the ACO), shared savings, bundled payments, episodes of care, risk pool surpluses/withholds, subcapitation? What will be the rate, amount or allocation of payment? When will orthopedists be paid—e.g., bi-weekly or monthly, subject to periodic reconciliations at specified junctures? Will the orthopedists receive potential upside reward from risk based arrangements? Will the orthopedists assume any downside risk, and what protections will the orthopedists have to mitigate any such downside risk?
- Payment guarantee—If the ACO is a shell entity, without any significant assets, is there a creditworthy ACO sponsor (e.g., health system) that will guarantee the ACO’s financial obligations to the orthopedists? Will the ACO have sufficient reserves, stop loss

insurance, reinsurance and other solvency protections to assure that orthopedists will get paid their due, notwithstanding adverse claims experience?

- Term/termination—What is the duration of the ACO contract, and how easy or hard is it to get out of?
- Restrictive covenants—Is the ACO contract exclusive? The MSSP does not require specialists, such as orthopedists to participate on an exclusive basis in a Medicare ACO; but it also does not prohibit Medicare ACOs, as a business matter, from entering into exclusive relationships with specialists that would prevent them from providing services to any competing Medicare or commercial ACO. Does the contract include any non-compete or non-solicitation provisions? Orthopedists should consider resisting ACO contracts that would tie their hands and prevent them from participating in multiple ACO or provider networks. The ability to participate in multiple networks may be important to hedge the orthopedist's bets, and remain able to receive referrals from PCPs who are exclusive to other networks.
- Compliance with ACO requirements—The ACO contract must comply with applicable legal requirements and ACO policies. For example, a Medicare ACO cannot require in-network referrals. It must permit patients the freedom to obtain out-of-network services.
- Access to records and audit right—Orthopedists would be well-advised to negotiate for a right to access the books and records of the ACO, and to obtain an audit right, so that the orthopedists can assure they are paid all amounts due to them under the ACO contract.
- Dispute resolution process—In the event of a dispute, it is generally preferable for the matter to be resolved confidentially, and on a somewhat less expensive basis through an alternative dispute resolution process (e.g., internal CEO level meetings, mediation, arbitration), rather than through resort to the courts.

Commercial Orthopedic ACO

Orthopedists may be able to avoid or manage the ACO concerns outlined above by developing their own commercial ACO. While an orthopedic-only ACO will not qualify to participate in the MSSP, enterprising orthopedists may be able to design and implement an orthopedic-only ACO to do business with commercial insurers. Such a commercial Orthopedic ACO would need to include a health system partner (and potentially other orthopedic care continuum providers) and an interested commercial insurer. The commercial insurer would pay for the value produced by the Orthopedic ACO in reducing costs and improving quality (such as described above in the Orthopedic Medical Home model), while the health system partner would work with the orthopedists on transitions of care and in redesigning value-based inpatient and outpatient orthopedic care processes. The Orthopedic ACO could be a sidecar or carve-in vendor to any other ACO, PHO, PCMH, network or commercial payer. Commercial ACOs such as this have already been developed and implemented by other specialists (e.g. The Orthopedic ACO in Miami, which is comprised of Advanced Medical Specialties, Baptist Health System and Florida Blue).

Multi-Specialty Group ACO

Alternatively, orthopedists can form, join or consolidate with a strong or dominant multi-specialty group that qualifies to be a Medicare ACO, and/or that can build an Orthopedic Medical Home as an adjunct to its multi-specialty ACO or Primary Care Medical Homes (if any). Orthopedists could sponsor formation of a new multi-specialty group, by pulling together and consolidating select, unaffiliated primary care physicians and specialists in the market or region. But, as difficult as it is to form a single specialty SuperGroup, it is even more difficult to find sufficient common ground among physicians practicing in multiple specialties to forge a successful, dominant multi-specialty group. That is not to say that creation of such an organization is beyond the reach of all orthopedists; but, it is to say that forming a successful multi-specialty group, at the instigation of orthopedists, is likely to be a lengthy and expensive process with fairly uncertain results. It may be more realistic for orthopedists to consider joining an existing strong or dominant multi-specialty group. Orthopedists can negotiate the terms on which they would join such a group. For example, they may prefer to become a semi-autonomous, self-governing Division of the multi-specialty group (in much the same way that separate orthopedic groups can become semi-autonomous Divisions of a SuperGroup). Or, orthopedists could enter into an ACO participation agreement with the multi-specialty group to participate as the orthopedic component of its ACO operations. In any event, a relationship with a strong multi-specialty group that has an adequate base of referring providers to support the orthopedists may be an option worth considering.

Hospital Alignment Models That Preserve Independent Orthopedic Practice

There are a variety of hospital alignment models that respect and preserve at least some modicum of independent orthopedic practice. Principal among them are Co-Management Arrangements, Professional Services Agreements (PSA) and Leased Employee Agreements.

Definition: Under all of these arrangements, the orthopedic group remains intact. It continues to be governed by its existing governing board; it continues to determine compensation and benefits for its physicians and staff; and it continues to employ all (or in the case of certain PSAs, most) of its personnel. As described in greater detail later, under a co-management arrangement, the orthopedic group enters into a contract with a hospital to manage with the hospital the orthopedic service line in such a way that certain concrete goals are met. Under a PSA, the group may sell the hospital certain practice assets and then enter into a contract with the hospital whereby it will provide its professional services to staff hospital (or hospital affiliated medical group) sites.

Advantages:

The primary advantages to entering into these contractual arrangements are as follows:

- The group is able to continue to function as an independent group that has a contractual arrangement with the hospital and thereby preserves some level of autonomy
- The group may be able to increase physician compensation through the arrangement; additionally, through a sale of assets in connection with a PSA, the group may be able to monetize its assets

Disadvantages:

- Members of the group will have to spend considerable time fulfilling additional contractual duties and under a co-management arrangement will have some portion of remuneration at risk based on meeting performance goals;
- The group will be more closely aligned with one hospital, which may affect existing relationships and referral sources not aligned with that hospital.

There is a distinct trend in the health care industry today toward increased integration and consolidation among providers. From the hospital perspective, the preferred model for integrating with orthopedists is to directly employ them. Hospitals have good business and legal reasons for preferring an employment model. From a business perspective, employment permits the hospital to better control its destiny in the marketplace. Under an employment arrangement, the hospital negotiates with payers for both hospital and orthopedist payment rates, bargains for bundled or capitated payments, and determines how those payments will be internally allocated between the hospital and orthopedists (and/or other providers). Under an employment arrangement, the hospital can also largely dictate the terms of employment, including physician duties, clinical and quality/efficiency standards, service levels and compensation methodology. And, the hospital can change compensation arrangements over time (as employment contracts expire) to adjust to evolving third party payment methods and economic conditions. Moreover, physicians graduating from orthopedic training programs are increasingly willing to become hospital employees for reasons of work-life balance, and changed expectations about the relative burdens and benefits of independent private practice.

From a legal perspective, the employment model also has distinct advantages. Under an employment arrangement, the hospital can collectively bargain with commercial payers for both hospital and physician rates, without engaging in illegal price-fixing in violation of federal and state antitrust laws. The hospital can also require employed orthopedists to refer in-network to the hospital, without violating federal or state anti-kickback statutes that prohibit paying for patient referrals. And, non-profit hospitals can employ orthopedists for competitive purposes, and not just for community benefit purposes. These particular legal advantages may not be available to a hospital that enters into an independent contractor arrangement with an orthopedist or orthopedic group, such as through the Co-Management and PSA arrangements described below.

However, for many independent private practice orthopedic groups, employment is simply not an acceptable option. The owners of these independent groups have operated

successful small businesses for many years. They have developed valuable orthopedic, spine, sports medicine, rehab, musculoskeletal and orthopedic imaging centers. They have assembled talented and loyal workforces, and they have earned a good living. They treasure their autonomy and independence, and are not interested in selling out to, or being taken over by, a hospital. If they became hospital employees, rightly or wrongly, they are concerned that they would become but one of many hospital priorities; that hospital processes can be bureaucratic, slow and not particularly physician-friendly; and that orthopedic interests may be lost, diluted or unduly compromised along the way.

Here, the good news for independent orthopedic groups is that there is also a pronounced trend toward hospital-orthopedic collaborative arrangements that do not involve employment. The Co-Management and PSA models are emerging as the preferred hospital affiliation arrangements for orthopedic groups that are interested in preserving an independent (but aligned) status.

Orthopedic Service Line Co-Management

Under a Service Line Co-Management arrangement, orthopedists with staff privileges at the hospital are engaged by the hospital, on an independent contractor basis, to serve as its business partner to “co-manage” the hospital’s orthopedic service line—and the orthopedists are rewarded for their efforts and results in improving the quality, efficiency and operations of the service line. Either the agreement may be with orthopedists in their individual capacity, or with orthopedic groups whose physicians have staff privileges at the hospital. The scope of the service line co-managed by the orthopedists may be limited or comprehensive. It may involve only outpatient clinic and ambulatory surgical services, or it may involve responsibility for all outpatient and inpatient orthopedic services and/or ancillary services (e.g., orthopedic imaging, PT, pharmacy, and/or complementary medicine).

Participating orthopedists, under the Service Line Co-Management arrangement, become involved in all business decisions relating to the service line, including strategic and business planning; budget development; non-physician staffing decisions (e.g., job descriptions, scheduling, performance evaluations, and hiring, firing and disciplining hospital personnel who staff the service line); service line pricing; purchasing and materials management; developing and implementing quality and efficiency standards and clinical protocols; information systems; and re-engineering work flow processes. The participating orthopedists may also provide an Orthopedic Medical Director (or program sub-Directors) to assist in the clinical oversight and medical direction of the service line.

A joint operating committee consisting of representatives from both the hospital and participating orthopedists typically governs the service line, under a Service Line Co-Management Agreement. The operating committee generally makes decisions by concurrent approval (e.g., by vote of a majority of the physician representatives and a majority of the hospital representatives on the committee). The committee meets regularly to co-manage the service line and address service line issues as they arise. The recommendations of the operating committee are generally adopted and implemented by the hospital. In this manner, the parties “co-manage” the orthopedic service line, and become mutually responsible and accountable for its performance. But, for legal reasons (i.e., due to hospital licensure,

accreditation and Medicare certification requirements and standards), the hospital must maintain ultimate control over service line decisions. Accordingly, all recommendations of the operating committee are reported through the Hospital's normal reporting chain of command for final approval. In practice, the operating committee's recommendations are usually well informed, and are readily approved.

There are typically two levels of compensation to participating orthopedists/groups under the service line co-management agreement: a base administrative fee and a series of contingent performance bonuses based on meeting specified performance improvement targets. The base fee pays for the efforts of participating orthopedists in co-managing the service line. The base fee reflects the projected number of hours of physician time needed to accomplish the tasks assigned under the agreement at a reasonable hourly rate for the administrative services provided (e.g., \$250/hour/per physician).

In contrast, the performance bonuses are based on meeting specific, pre-agreed quality and efficiency improvement targets in areas such as: adherence to clinical protocols, administration of antibiotics before surgery, improved on-time starts in the OR, reduced OR turn-round time between procedures; reduced morbidity; improved patient satisfaction, employee satisfaction, and physician satisfaction; reduced employee turnover; standardized use of less expensive but clinically equivalent implants, devices, drugs and supplies; and reduction of adverse events. Improvements are measured in relation to base-line performance to assure that they reflect quality, efficiency and process improvement. Performance standards and targets must also be consistent with national norms, to assure that the parties are not aiming too low. This means that the parties need to have the means to capture, monitor, and analyze relevant performance data.

A fixed dollar amount is earned by the participating orthopedists for achieving each specific performance goal (e.g., \$25,000 for a 5% increase in timely completion of medical records over base-line performance). The performance fees may be scaled so that participating orthopedists are paid part of the fee for improved performance that is short of the specified target goal (e.g., \$15,000 for a 3% improvement; \$20,000 for a 4% improvement; and the full \$25,000 for a 5% or greater improvement over base-line performance). The parties also have some degree of discretion to give greater priority and reward to certain performance targets because they are of greater significance to the hospital than others (e.g., reduced infection rates may be double weighted at 10% of total performance fees, while improved employee and physician satisfaction may only be allocated 5% of total fees).

For the legal reasons discussed below, it is important that both the base fee and the performance fees be established through an independent appraisal by an experienced health care valuator to assure that no more than fair market value is paid for either the co-management services rendered or the performance results achieved. It is also advisable that performance standards and targets be independently validated by an outside clinical expert as being consistent with national norms, and above base-line performance. The outside expert should also verify that the orthopedists have earned the bonuses they are paid, and that they have not compromised quality of care in their pursuit of earning performance bonuses.

Under the Service Line Co-Management Agreement, participating orthopedists can share as much as 2% to 4% of the service line revenues, in aggregate, from the combination of base and performance fees. These fees, however, cannot be set or paid on a percentage of revenue basis. Rather, for regulatory compliance reasons, the fees must be expressed on as fixed, fair market value fees. So, for instance, on a fair market appraised value basis, a hospital with a \$40 million outpatient orthopedic service line may be able to justify paying participating orthopedists annually between \$800,000 to \$1.6 million in co-management fees (if all performance targets are met). Of this, the base fees generally—on an independently appraised basis—constitute approximately 50-70% of the total fees, and the contingent bonus fees constitute the remaining 30-50% of total fees.

Note that it is advisable to reset performance standards and targets, and reappraise the contract, not less frequently than every two years, to assure continuous quality/efficiency improvement (as opposed to payment for maintaining performance improvements already attained), and to assure that the payments to participating orthopedists remain at all times within a fair market value range. If the participating orthopedists have optimized performance (e.g., 100% of treatment plans and summaries are timely prepared), there is a question of whether the participating orthopedists can, in later years, continue to be rewarded for maintaining performance at this optimal level. There are grounds for saying that the participating orthopedists can be paid for maintaining optimal performance. There is value in having such performance achievements not backslide, particularly if and when new orthopedists join the medical staff and are introduced into the co-management arrangement. On an independent fair market valuation basis, however, the value attributed to maintaining optimal performance may be somewhat less than the value of initially attaining that level of performance.

Co-Management Legal Considerations

Service Line Co-Management Agreements can implicate a number of federal health laws and regulations, including the Civil Monetary Penalty Law, the False Claims Act, the prohibition on inurement and private benefit by tax-exempt organizations, as well as the Stark Law and the Anti-Kickback Statute. Synthesizing these legal constraints (without going through a technical analysis of each) yields the following principles for a legally compliant Service Line Co-Management arrangement:

- No stinting—i.e., participating orthopedists cannot be rewarded for limiting or reducing items or services to Medicare patients under their care (e.g., the performance bonuses they earn should not be tied to generalized cost savings or beating the cost budget of the service line);
- No steering—i.e., participating orthopedists cannot dump more acute or complex cases on other hospitals for purposes of meeting performance standards (e.g., to improve morbidity or survivorship statistics);
- No cherry-picking—i.e., participating orthopedists cannot be rewarded for accepting easier or better paying cases in order to meet performance standards;

- No gaming—i.e., the hospital cannot use accounting tricks or fudge results to justify making payments to the orthopedists, if, in fact, participating orthopedists have not met their obligations or performance targets under the contract;
- No payment for changes in volume/referrals—i.e., the hospital cannot pay participating orthopedists for any increase in referrals, utilization, volume, revenues, or profits;
- No payment for quicker-sicker discharges—e.g., the hospital cannot pay participating orthopedists for reducing the average length of stay of orthopedic inpatients;
- Limited gain-sharing permitted—i.e., the hospital can share cost savings with participating orthopedists generated by substitution or standardization of lower cost items of equivalent clinical quality (e.g., standardize use of lower cost implants and supplies; substitute generic drugs for brand name pharmaceuticals);
- Must be fair market value; independent appraisal strongly advised—i.e., fair market value is key to regulatory compliance for Service Line Co-Management Agreements (among other things, to meet applicable Stark Law fair market value or indirect compensation exceptions, and approximate Anti-Kickback Statute safe harbor for personal services and management contracts).

Note that Service Line Co-Managements Agreements can be structured to be legally defensible. On January 7, 2013, the Office of the Inspector General of HHS (“OIG”) issued Advisory Opinion 12-22 that approved a cardiology co-management arrangement structured in the manner discussed above. That said, Co-Management Agreements carry some irreducible legal risk. This is because they may not meet any Anti-Kickback Statute “safe harbor”. The Anti-Kickback Statute is federal law that prohibits paying for Medicare or Medicaid referrals. That statute is very broad, and is potentially implicated by any financial arrangement between a hospital and referring physicians. The OIG has promulgated “safe harbors” to protect certain limited health care business transactions that, in the estimation of the OIG, pose no material threat of healthcare fraud or abuse. The safe harbor that Service Line Co-Management Agreements most closely approximate is the personal services and management contracts safe harbor. But, that safe harbor requires “aggregate compensation” under the contract to be “set in advance”. Under a Service Line Co-Management Agreement, minimum compensation is set in advance (i.e., the base fee), and maximum compensation is set in advance (i.e., the base fee plus all bonus fees, if all performance targets are met); but, aggregate actual compensation to be paid to participating orthopedists under the contract may not be “set in advance” since the actual amount that the physicians will earn under the contract is not known at the beginning of the contract (i.e., the amount of performance fees that will be earned, is not known until year end when it is determined how many performance targets have been met). For this reason, “aggregate compensation” may not be viewed as having been set in advance in the Co-Management Agreement.

The Service Line Co-Management Agreement should, nonetheless, be legally defensible as long as the parties obtain an independent fair market value assessment of the payments under the contract. This will help to negate any adverse inference that the payments are for an improper purpose--to induce referrals among the parties, rather than solely to improve quality and efficiency of the orthopedic service line.

In Advisory Opinion 12-22, the OIG indicated that it is also advisable for the parties to engage an independent clinical expert to validate that the performance standards and targets

included in the Service Line Co-Management Agreement are consistent with nationally recognized clinical quality standards. An independent clinical expert can also objectively monitor the performance of participating orthopedists under the Agreement, and independently verify whether they have met their performance targets, and have earned their performance bonuses. Further, an independent monitor can confirm that the Service Line Co-Management Agreement has not caused participating orthopedists inappropriately to change case mix or payer mix, increase volume, reduce care, or adversely affect the quality of orthopedic services rendered. This would help to reduce any inherent legal risk associated with the Service Line Co-Management Agreement to a reasonably acceptable degree.

Service Line Co-Management Agreements are becoming an increasingly popular means of aligning orthopedists and hospital interests in improving quality, efficiency, and operations of the hospital's orthopedic service line. These arrangements, properly structured, are legally defensible, and can help to preserve and support the independent private practice of community orthopedists in an era of transition and change. Service Line Co-management Agreements can also be combined with the type of PSA arrangements discussed below.

Orthopedic PSA Models

The PSA model provides a means by which a community-based orthopedic group can maintain a significant modicum of independent private practice, while aligning in a meaningful way with a preferred strategic hospital partner. The PSA Model involves a contract with the orthopedic group to convert all or a portion of the orthopedic group's existing practice site(s) to either (1) a practice site of a hospital affiliated group practice, or (2) a hospital-licensed facility. For example, the parties may convert only the orthopedic imaging services at the site to hospital licensed services, and may conduct office visits and consult services in the name and under the provider numbers of the hospital's affiliated medical group. In either event, the practice site(s) continue to be staffed by the orthopedic group, but the services are billed by the hospital or a hospital related entity. Alternatively, the PSA may involve the development of a new practice site (e.g., a new musculoskeletal center), that is staffed by the orthopedic group and operated as either a hospital licensed service or as a service of a hospital affiliated group.

Services performed at the site that are hospital licensed services are billed under the hospital's provider numbers, and may be paid by payers at hospital outpatient rates. Hospital outpatient rates may be 30-150% higher than payments by the same payers for such services at physician fee schedule rates. Orthopedic services billed by the hospital at outpatient rates may include not only the facility component of orthopedic services, but also the professional component of those services (including examination, management, consultation, and interpretation services). It may also include associated imaging, PT, pharmacy, and lab services. If the hospital would qualify for 340B pricing on drugs, there is a further economic advantage to the hospital in billing for pain clinic drugs at hospital outpatient rates. The hospital outpatient rates for some or all of these services provide the economic foundation for a PSA arrangement that can be a financial win-win for both the orthopedic group and the hospital.

Under the PSA (and ancillary agreements), the orthopedic group can receive the following economic benefits: (1) maintaining physician compensation rates for a defined period (generally based on a fair market wRVU rate), (2) fair market employee lease and management fees for the administrative services of non-physician staff, and (3) fair market medical director or co-management fees for co-managing the hospital's orthopedic service line and meeting mutually agreed quality, efficiency and operational improvement targets. These fees, combined, may in certain instances increase current physician compensation and benefits for the duration of the PSA.

The following are some of the principal business and legal considerations and constraints relating to PSA arrangements.

- **Physician compensation**—Under the PSA, the orthopedic group is generally initially paid on an aggregate wRVU basis. For health regulatory compliance reasons, the wRVU rate (and any other financial arrangement with the orthopedic group) must be set at fair market value through an independent appraisal process. Typically, fair market value will approximate the physician compensation and benefit pool generated by the number of wRVUs performed by the group during the immediately prior 12 month period. This compensation methodology holds the orthopedic group harmless against any (i) reduction in reimbursement for orthopedic services for the duration of the valuation opinion on the wRVU rate, and (ii) any free care or bad debt arising from services rendered. That is because the hospital (or its affiliate) is required to pay the wRVU rate for all services rendered by the orthopedic group under the PSA, regardless of whether the hospital collects for the service. The wRVU payments are made to the group as a whole, and the group, in turn, remains free to set individual compensation for physician-members of the group.
- **Ancillary Transactions**—In order to convert the site to a hospital or hospital-affiliated practice location, the hospital (or its affiliate) typically takes assignment of the lease for the applicable space, and will purchase for fair market value all of the tangible assets (furniture, fixtures and equipment) that is located within that space. As discussed below, at termination or expiration of the PSA, the orthopedic group typically would have the opportunity to re-assume the lease and re-acquire the tangible assets for their then fair market value (unless the PSA is terminated without cause by the orthopedic group or the PSA terminates due to the orthopedic group's material breach).
- **Medicare Provider Based Status**—For any services performed at the practice site(s) to qualify to be paid by Medicare at hospital outpatient rates, the portion of the site(s) in which those services are rendered must meet the Medicare provider based status rules. Under those rules, the site(s) must meet state law requirements for hospital services, including hospital licensure and accreditation standards. These standards may include physical space requirements, such as corridor widths for ambulance stretchers, numbers of wash basins per square foot, building code compliance, etc. Unless these physical space requirements are waived by the applicable state Department of Public Health, the cost of renovations to meet these requirements will

need to be considered in assessing the feasibility of converting to hospital outpatient services under the PSA.

- The Medicare provider based status rules also require that the hospital outpatient orthopedic services at the site(s) be under the ultimate clinical, administrative and financial control of the hospital. Consistent with this requirement, under the PSA, the orthopedic service line at site(s) can, in the first instance, be overseen by an Operating Committee comprised of designees of the orthopedic group and designees of hospital administration, and operated in the manner described in the Co-Management Section above. While retaining its ultimate decision-making authority, the hospital could agree under the PSA that reasonable recommendations made by the Operating Committee would be approved and implemented by the hospital.
- The Medicare provider based status rules would also preclude the orthopedic group from leasing non-physician clinicians (other than PTs, NP/PAs) to the hospital at any off-campus location. Thus, registered nurses, radiation techs, pharmacy techs, and lab techs, would need to be directly employed by the hospital at any off-campus site. An off-campus location is any licensed hospital site located more than 250 yards from the main hospital building. An off-campus location can be treated as an outpatient department of the hospital for Medicare reimbursement purposes if it is located within thirty-five (35) miles of the main hospital.
- Payer repercussions—It can be expected that commercial payers will react to converting orthopedic group sites to hospital outpatient rates by trying to renegotiate their payer contracts with the hospital when the opportunity arises (i.e., when the existing agreement expires or is up for renewal). The outcome of such renegotiations will depend on the relative bargaining strength of the parties at that juncture.
- Patient Co-Pays--It should also be noted that after converting a practice site(s) to hospital outpatient services, patients will be subject to higher co-insurance amounts (based on the higher hospital rates). This may be an issue for some patients, particularly for poorer patients who are involved in a continuing course of treatment at the time of the conversion.
- Durability—While the orthopedic group may want to lock-in a good PSA deal for as long as possible, there are limits to the duration of PSA arrangements. One limiting factor is the duration of the independent fair market appraisals. Valuation opinions for PSAs may be good for as short as 2-3 years, depending on the valuation firm's perception of economic volatility in physician compensation rates. Another limiting factor for tax-exempt organizations may be IRS Rev. Proc. 97-13 which limits the duration of use of tax-exempt bond financed property under agreements, such as certain PSAs, to as short as 2-3 years and as long as 15 years, depending on the structure of the financial arrangement. For these reasons, the PSA agreement may have a relatively long term structure (e.g., 5-10 years), but may need to be revalued or

renewed after only a few years. Also, as discussed above, any performance incentives that are paid under any co-management feature of the arrangement may need to be reset at least every two years.

- **Unwind Rights**—In part because of the above durability issues, orthopedists entering into a PSA would be well advised to negotiate “unwind rights”. Unwind rights would permit the orthopedic group to reconstitute itself as a fully intact independent private practice at the end of the PSA arrangement, and not be subject to any post-termination non-compete. Accordingly, at the end of the PSA, the orthopedic group should be able to regain any space or assets that have been leased or sold to the hospital; redeploy its staff; and have access to all books, records and data necessary for the group’s on-going operations. Otherwise, at the end of the PSA, the orthopedists may, as a practical matter, have no options left but to become hospital employees or relocate.
- **Legal Risk**—Like Co-Management Agreements, PSAs carry some irreducible Anti-Kickback Statute risk. That is because, like Co-management Agreements, PSAs may not meet the personal services and management contracts safe harbor, as arguably “aggregate compensation” under the PSA is not set in advance. The wRVU rate under the PSA will be set in advance, but the total number of wRVUs that the orthopedic group will perform during the year, by definition, cannot be known in advance. Again, the Anti-Kickback Statute risk is mitigated to a legally defensible degree by obtaining an independent fair market value appraisal of the wRVU rate (and of any other financial element of the PSA transaction) by a experienced health care appraiser using valuation methods that comply with health regulatory requirements. This will help to negate any inference that any amount is being paid under the PSA for an improper purpose—to induce patient referrals, rather than to purchase necessary orthopedic services at a reasonable rate, to coordinate and improve those services, for the benefit of the community served by the hospital.

The current health care imperative is to slow the rate of growth of health care spending to a sustainable level. PSA and Co-Management arrangements, in the short term, may add to total health care costs, but may provide a needed bridge to a new generation of aligned and integrated relationships in which providers can share financial risk for quality and efficiency improvements, and be jointly responsible for providing ever-more coordinated, patient centered, and accountable care that ultimately reduces the rate of growth of health care costs.

Arrangements With Support Service Providers

Increasingly, practice management and health information technology companies are developing support services to help sustain independent private practices while connecting them with other components of the health system. They are doing so through development of integrated electronic medical record, practice management, clinical decision support, supply chain management, human resource management, patient registries, care management,

utilization/cost management, telehealth, home-based monitoring, and other support systems. Some of these IT related solutions hold the promise of interoperating with hospitals and other segments of the health care system, so that orthopedists can clinically integrate across a broader continuum of care on a virtual (rather than on a practice consolidation) basis. These information technologies, coupled with sophisticated data analytics and patient navigators/community health workers, hold the further potential to improve care, while helping to keep care in the community at the right site, right level of care and right cost of care. Frequently the most cost-effective location of care is at a physician office, ambulatory care center, or in the patient's home—all of which are sites of physician directed services. A big set of questions for orthopedists right now is who will defray the cost of licensing these new technologies; training staff and physicians to use them; and making up for lost productivity in the adoption process? And who will pay for “gap” services, such as patient navigation and care coordination, that are not currently recognized by payers for reimbursement purposes? Some practice management companies and IT vendors may provide some financial or in-kind assistance toward this end. Also, under capitated and risk based payment arrangements, orthopedists may have incentive to invest in these types of technologies and care processes that hold the prospect of reducing the cost and utilization of orthopedic services

Orthopedic groups may also want to consider creating their own joint venture management service organization (MSO) to attract venture or private equity capital to invest in developing and deploying these technologies and care processes. Such an MSO could provide the IT platform for orthopedic practices to be care ready and risk ready—that is, to obtain the tools to be ready to provide value based care and to manage financial risk for the quality and cost of care provided. Such an IT platform, customized with best in class solutions for orthopedic practices, could be of significant value to any orthopedic group that wants to remain independent. It may further provide a nitus to organize potential orthopedic group “users” to form a jointly owned MSO that can try to access venture capital to develop or license such a suite of services. Such an MSO may also provide the infrastructure for an Orthopedic SuperGroup, Orthopedic Network, Orthopedic ACO or for Orthopedic Medical Homes. With access to capital through venture capital or private equity companies, the MSO may also be able to grow to scale, and reduce unit costs for participating orthopedic groups.

Hybrid Arrangements

Orthopedists can enter into arrangements that are hybrids of the models discussed above. For example, they could form an Orthopedic SuperGroup among a coalition of the willing. For those who are unwilling to consolidate their practices in this manner, the SuperGroup could extend its reach by developing a wrap-around financially and/or clinically integrated network or commercial Orthopedic ACO that includes the other independent practices.

Innovation Grants

The Center for Medicare and Medicaid Innovation (CMMI) was initially appropriated \$10 billion by Congress to award innovation grants to pilot new business models for providing

value-based care. Innovative orthopedists should consider developing new payment and delivery arrangements for value-based orthopedic care that could be funded by such an innovation grant. Money may be available to experiment with orthopedic medical home, orthopedic ACO, orthopedic payment bundle or episode of care, and/or financially or clinically integrated orthopedic network arrangements. This is by no means an exhaustive list of potential projects that could be funded by innovation grants; the only limits for such grants are the limits of imagination for designing future systems of orthopedic care.

This document is intended to provide background on the range of options that orthopedic groups can consider in meeting the challenges of health care reform in a rapidly changing market. This white paper is not intended to provide legal advice and should not be relied on for that purpose. Experienced legal counsel should be retained to provide specific legal advice if you want to consider pursuing any these options.