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Joining or aligning with a physician-led integrated health system

Your guide to better decision making.

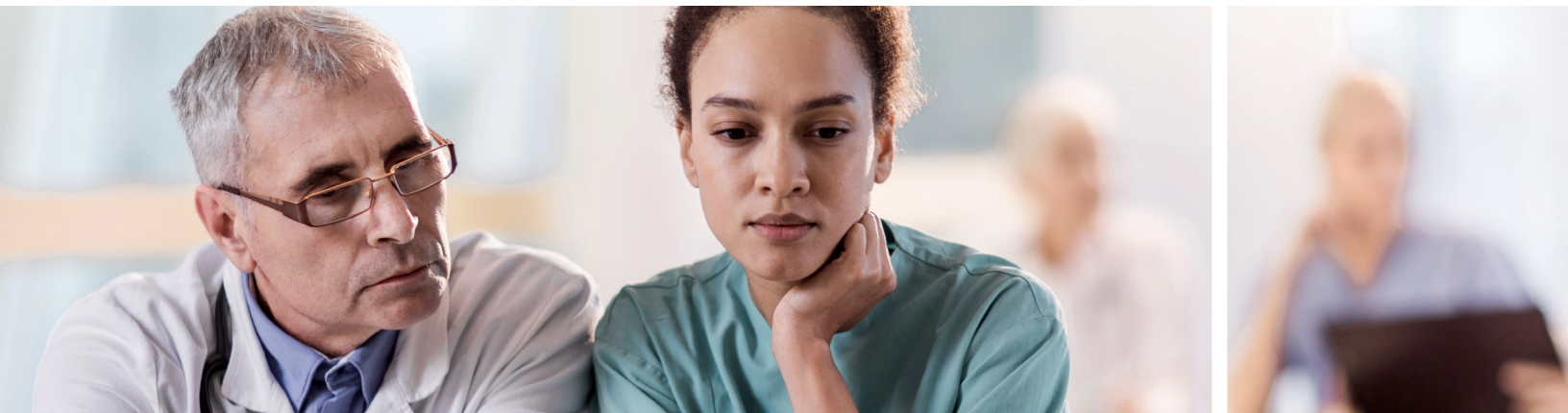


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Introduction

As a result of the COVID-19 pandemic, physicians are actively exploring ways they can provide high-quality care for their patients and have a sustainable medical practice that provides them professional satisfaction. The American Medical Association supports physicians in all practice settings and specialties and is committed to providing resources that assist physicians in choosing and pursuing the model of care delivery that best suits them and their patients.

This guide focuses on the physician-led integrated system (also referred to in this document as “system”), a practice option many believe to be a particularly effective model for advancing quality and cost-effective care, and outlines what physicians should consider when deciding whether to join or align with a physician-led integrated health system. Physician-led integrated health systems, for purposes of this document, are all forms of physician-led health delivery systems, including physician groups, accountable care organizations (ACOs), independent community hospitals, academic health centers and multi-hospital health systems.

This guide is not intended to be an exhaustive, detailed review of all potential scenarios, nor should it be considered formal legal advice. This document is for discussion and informational purposes only. The ideas, principles and other elements laid out in this document do not represent official policy of the AMA. The principles and key elements outlined in this document are provided for discussion and informational purposes only and do not constitute legal advice. The reader should consult qualified legal and tax advisors for legal and tax advice, which relies on specific facts and circumstances.



Defining physician-led integrated health systems

The current medical education process balances the art and science of medicine with the clinical ethics of putting the needs of the patient first. Physicians have found the environment that provides significant professional satisfaction is one that allows them maximum autonomy to practice medicine. Anecdotes from physicians in clinical environments controlled by non-physicians who focus on metrics rather than the patient reveal expressions of significant professional dissatisfaction. Health systems led by a physician who advocates for the patient at the leadership level are regarded by physicians as better environments in which to practice medicine. The AMA defines physician-led integrated systems by a set of common characteristics, although a system may not demonstrate all these characteristics.

Physician-led integrated health systems:

- a. Have physicians in defined leadership roles at high levels in the organization, with meaningful decision authority and/or input regarding strategic, quality and operational issues, as well as a defined communication channel to the organization's governing body
- b. Provide integrated, comprehensive primary and specialty services
- c. Coordinate care across multiple conditions, providers and settings over time
- d. Use shared, patient-centered data
- e. Implement clinical care processes using guidelines, pathways, protocols, checklists and related tools
- f. Apply performance and outcome measures for both internal quality and external accountability
- g. Possess organizational leadership committed to improving value as a top priority and a system accountability to drive improved performance

It is important to understand that employing a physician as a president/CEO/board chair does not ensure integrated leadership will exist. There are other key traits a truly integrated organization should demonstrate.

Types of physician-led integrated health systems

Physician-led integrated health systems exist in several forms that vary in organizational structure, size, specialty distribution and other attributes. The following examples are some of the more common types of systems. This is not an all-inclusive or mutually exclusive list; however, as there are other organizational arrangements that can be considered and some practices may fit into more than one or not any of the descriptions below. For example, some systems may comprise several types of practices (e.g., Henry Ford Health System, Baylor Scott & White Health, etc.), while others may not fit exactly into any one category, such as Confluence Health in Washington and others.

Multispecialty/integrated physician group

Successful group practices are characterized by a culture that values coordination, teamwork and collaboration. Members of the group are expected to share in those values and commitments that translate into behavioral expectations and performance. Physicians who are extremely independent in their work habits and who value autonomy above all else may not find a high degree of professional satisfaction in a group practice setting such as a physician-led integrated health system.

Physician-owned practices

This business model allows physicians to own the practice through equity shares. The financial risk is shared between the owners, and decisions on investment and profit sharing are made by the group. Obtaining capital for infrastructure, including information technology (IT) and the physical facility, may be challenging due to uncertainty in new payment models. Hospitals or venture capital firms may provide funding in exchange for equity but if the physician ownership percentage falls below 50 percent, decisions may be influenced by non-physician equity partners. Some states prohibit majority ownership by non-physicians through laws that ban the corporate practice of medicine. An example of a physician-owned practice includes Iowa Clinic.

Foundation model

In this model a non-profit foundation owns the “bricks and mortar” and the physician group provides the clinical expertise. Access to capital through the bond markets may be easier. Some examples of a foundation-owned organization are Cleveland Clinic and Billings Clinic in Montana.

Accountable care organization

This is an entity that is clinically and fiscally accountable for the entire continuum of care for a given population of patients. An ACO is expected to continuously provide better quality care while improving the health of the population with a lower per capita cost. It is expected that value is being documented with data that is shared for purposes of external accountability. Basic characteristics include primary preventive care services, 24-hour coverage, coordination of specialty services and participation in care management. Effective governance and an integrated infrastructure are needed to execute an ACO. One example is the Baylor Scott & White Quality Alliance in Texas.

Physician-hospital organization

This type of entity creates a formal relationship between physicians and hospitals that provide physician and hospital services and contract with payers. Governance and infrastructure costs are shared. Many physician-hospital organizations have become ACOs by way of contracting with the Medicare Shared Savings Program. Advocate Physician Partners in Illinois is one example of a physician-hospital organization.

Independent practice association

Independent practice associations (IPAs) were created to allow contracting between independent physicians and payers without creating anti-trust conflicts. Some have a loose affiliation and use a messenger model in which the IPA serves only as an intermediary to relay offers between managed care organizations and physicians. Others have evolved to become a coordinated network that shares patient data to improve quality and outcomes. Effective governance and investments in infrastructure are important components to achieve practice redesign. An example is the Mount Auburn Cambridge IPA in Massachusetts.

Virtual group

The virtual group is an evolution of what used to be referred to as a “group practice without walls.” This entity might be most attractive to small practices and those in rural areas that lack the infrastructures to create an IPA to qualify as an ACO. By coming together as a virtual network, they can share capabilities through economy of scale in data collection, analysis and reporting. The aggregation of patients can qualify for population incentive payments. Technical support for information technology needs can be shared. There is also an advantage of peer group input as practice redesign occurs. An example is the Grand Junction Colorado Physician Network.



Assessing the performance of a physician-led integrated health system

In evaluating the performance of a physician-led integrated health system, there are several important aspects to consider. Below are some of these and relevant questions to ask when conducting a review.

Mission/strategic plan

Complex organizations function most effectively if they have a defined purpose and a way to achieve goals. These are captured in a mission statement that succinctly states why the organization exists. A strategic plan outlines how the organization plans on achieving its mission. Having a clear mission and strategic plan allows individuals within the organization to focus on what the organization wants to achieve and how they can play a role in achieving its mission.

Questions to ask

- Does the system have a mission statement and a strategic plan?
- If so, does evidence demonstrate that the mission and strategic plan permeate the daily functioning of the system?
- Do the system's mission and vision statements closely align with the personal beliefs and ethics of the physician considering joining or aligning with the system?

Governance and culture

The governance and culture of a health system can have a significant effect on day- to-day operations, clinical care, physician professional satisfaction and peer-to-peer relationships. Physicians seeking to align with a physician-led integrated health system may find valuable insight from individuals within the organization, as well as members of the community that may have outside-looking-in opinions or beliefs about the health system. For those physician-led systems that are integrated with a hospital or health system, the [“Integrated Leadership for Hospitals and Health Systems: Principles of Success”](#) outline characteristics that can foster collaborative physician-hospital leadership.

Questions to ask

- How are physicians represented on the governing board, i.e., do they have a seat or elected representative?
- To what extent does the physician-led integrated health system have governance that engages physicians in key decisions? (Two mechanisms to achieve this level of engagement are the dyadic leadership model, which comprises a physician and non-physician administrator who share responsibilities, or the triadic model, which includes a nurse leader.)
- Does the system culture embrace ongoing professional education in leadership? Is the education inter-professional and onsite? Is it expected that physicians obtain their own resources for leadership education and training or is there a dedicated institutional fund that physicians can use both for onsite and offsite education?
- Does the system have programs or opportunities for early career physicians who want to explore the possibility of assuming leadership responsibilities within the system?
- Is there transparency about financial, quality and compensation-related information? Has the health system undergone financial challenges in the last five years? If so, how was that communicated and handled?
- How is patient engagement and experience measured, and is feedback provided to individual practitioners? Is there an active program to help physicians understand feedback and address areas of deficiency in patient satisfaction?
- Are individual physicians accountable for the overall patient experience as reported by measures such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores (e.g., how quickly was an appointment made, how did the lab technician treat you as a patient, etc.)?
- Do physician peers perceive the culture of the system to be driven by physicians or by non-physician administrators?
- Has the physician-led integrated health system conducted a culture or physician satisfaction survey and, if so, are the results available? Are physicians happy? Are they professionally satisfied?
- What are the staff turnover rates? Are there notable patterns in turnover that could implicate problems with leadership, culture or other issues?

Organizational structure

Physicians should ask to see formal documents that outline the governance structure and how physicians fit in. For example, is there a seat on the governing board elected by the physicians or does the governing board appoint seats without input from physicians? If there are no such documents or if the physician role is unclear, it is important to ask for clarity.

Questions to ask

- Is the structure of the physician-led integrated health system one of a vertical integration that includes primary care, all other specialties, hospital, home health, hospice, nursing home and pharmacy? If a component is missing from vertical integration, how are those services provided?
- If the system has an academic structure, are physicians expected to participate in teaching (undergraduate, graduate and continuing medical education) and research? If so, how is that time compensated?
- What is the care coordination process? Does the system rely on accredited patient centered medical homes (PCMH) that involve primary and specialty care? What is the relationship with other community-based health care organizations, including nursing homes, home health agencies and pharmacies? How does the system's IT network enable coordinated care? Is care coordination provided by the system, the individual practices or outsourced? Ideally, care is coordinated by the system with electronic medical records that can be shared with all health care entities.

Commitment to quality and value

As more health care organizations continue to move to value-based payment systems, it is important to know about the physician-led integrated health system's commitment to quality and value and if any changes to that commitment are planned.

Questions to ask

- Does the physician-led integrated health system have a structured quality program? What is the physician role in the program? If there is a need for change in the process of care delivery or methods to improve outcomes, how easy or cumbersome is it to make change?
- How is the use of metrics (e.g., chronic disease registries) and benchmarks (e.g., specialty-specific quality targets) selected and implemented in the system? How often and from whom is feedback provided? Is the feedback individualized and provided personally, or is it housed in a data repository for individuals to access? Ideally, metrics are provided to individual physicians in an understandable format with calls to action that can help physicians improve quality.
- What is the system's view on public transparency of metrics and patient comments? Does the system use comments and rankings from public consumer review websites (e.g., ZocDoc.com, Healthgrades, etc.) in its quality improvement efforts? Does it employ staff that monitors those public sites and addresses adverse or unfounded commentary?
- While it is important to provide cost-effective delivery of services, a procedure/test that is not indicated but done in cost-effective manner may not be a good marker of success. How is cost effectiveness measured? Are measures of appropriateness included in the cost effectiveness measures? How are those linked to individual compensation? Are compensation models for outcomes different for primary care versus other specialties?
- Is compensation tied to patient health outcomes? If so, does the system use a risk-adjustment program applicable to your specialty to account for circumstances beyond your control? What support is provided to help with patients who have low health literacy or other social determinants of poor health outcomes?
- What are the accreditation expectations for physicians? What support is provided for accreditation of PCMHs? Are physicians expected to participate in Maintenance of Certification programs offered by the American Board of Medical Specialties? If so, is there financial and administrative support provided by the system to obtain needed credits? Are physicians provided financial and administrative support for continuing medical education and medical licensure requirements?
- Does the system have evidence of their commitment to quality and value? What are their awards, ratings and rankings from independent organizations? IPAs and ACOs can receive awards from state medical societies, the National Patient Safety Foundation, AMGA, the National Quality Forum and others. Some website ranks or other awards to look for include:
 - Hospital Compare.org
 - Quality Check.org
 - Truven Top 100
 - AMGA Awards
 - NQF Awards
 - NPSF Awards
 - TJC Awards
 - American Heart Association Awards
 - Cancer Care Designation
 - State medical society awards
- Does the physician-led integrated health system have a financial bonus award structure for achieving? If so, who is eligible to receive a bonus (e.g., c-suite executives, practicing physicians, front line personnel, etc.)?

Effective use of IT and evidence-based medicine

Depending on the size of the health system, the infrastructure needed for effective information technology may include a separate department of information technology that procures and updates hardware and software. With value-based payment, health systems can provide tools and just-in-time reminders to busy clinicians to assure that evidence-based medicine is consistently practiced.

Questions to ask

- What IT systems are in place? Is there a robust IT infrastructure?
- Is the organization progressive in its approach to integrating IT resources?
- How are patients and the community linked to the health care delivery system? Are there patient portals that allow individual communication between patients and clinicians?
- Does the patient have access to telemedicine for primary and specialty care? If physicians are measured and compensated on electronic and telecommunicated patient interactions, what mechanisms exist to provide help for patients who are not computer literate or have a language barrier?
- When was the last time the electronic medical record platform was changed? Are there plans to update to a new system within the next two years? It is important to discuss with physicians in the system their observations of IT support in the hospital and ambulatory settings.
- How is evidence-based medicine supported? Are there computer-driven protocols whose adherence is measured? How are these chosen? Is this feedback provided to physicians? If alteration is needed in a protocol, how difficult is ordering a different test or medication?
- What IT support is offered within the health system? Is there sufficient financial support to ensure future investments into IT infrastructure?



Determining whether a particular physician-led integrated health system is the right fit

In addition to considerations about organizational attributes such as governance, infrastructure and commitment to mission, there are many qualitative aspects of a physician-led integrated health system that anyone interested in alignment should be aware of.

Tolerance for risk

Changing any function of a physician's medical practice can expose the physician and practice to potential risks. Choosing to join or align with a physician-led integrated health system is no exception. Risk is the potential of gaining or losing something of value. Physicians must make decisions about their medical practice based on how the outcome will affect them, their family and their ability to care for patients.

Choosing ownership, alignment or employment

While ownership provides the greatest potential financial benefit, it also provides the greatest financial risk. Employment provides the highest security but may limit financial reward and the degree of control. Alignment can provide the ability to retain some financial control of individual practice, but likely requires giving up full autonomy. Participating as an aligned physician requires adherence to clinical protocols, care coordination and other components of integration that are key elements of a physician-led integrated health system.

If the system is owned by physicians, it is important to understand how to participate in ownership before joining. Commonly, equity shares are owned by the senior physicians. A new physician may be on salary for a few years then later given the opportunity to join the equity stake by purchasing shares. The cost may be prohibitive for those with large amounts of student loan debt or other expenses that absorb their salary. Some systems may contract to repay a physician's loans in exchange for agreement to practice there for a set number of years.

If the system is owned by a private equity/venture capital entity, their profit motive may not provide a long-term security in stable salary or employment.

Financial health of the system

If the health system is a tax-exempt organization, its IRS Form 990, as well as other public documents on community benefit and charity care, can be reviewed. The amount of debt the system has, as well as the last five years of growth or decline, can help with understanding the financial state of the organization. Regardless of tax-exempt status, health systems usually have to borrow capital, therefore ratings by credit agencies (e.g., Moody's, Standard & Poor's) play a role in assessing financial solvency. These ratings can provide information about whether the system is stable or at risk for financial insolvency.

Other metrics, or hallmarks of success or trouble, can include the stability of the c-suite, including the chief executive, medical, nursing and financial officers. Rapid turnover of any of those positions can be a warning about the organization's culture, mission and alignment of leadership goals.

Questions to ask

- What kinds of contracts does the system have with insurers? With which insurers does it have contracts? Are there risk contracts? If so, are they upside or downside? Are there plans to enter into these type of contracts?
- What are the quality and financial performance results (per-member-per-month targets vs. actual costs) of each clinical program and insurance product (e.g., bundled payment for procedures and Medicare Advantage risk)?
- Are there service lines that are fully integrated internally or are there external partnerships?
- If there are external partnerships, how long have they been in existence? Are there quality and financial parameters that need to be met on a regular basis to continue

Compensation models

By way of the move from fee-for-service to value-based payment, with bundling based on diagnosis or procedure, value metrics will provide additional variables to physician compensation structures. It is important to understand how the health system's compensation structure was constructed. Was it the product of considerations for human resources and legality, with minimal physician input? Legal concerns regarding compensation in a hospital system are impacted by federal and state fraud and abuse laws such as the federal anti-kickback and Stark statutes. For tax-exempt hospital systems, IRS rules regarding fairness of compensation may limit how much employed physicians are compensated. Physician groups that are limited liability companies or professional associations have more flexibility in providing compensation packages than do tax-exempt organizations. It is also important to know whether compensation and benefits are bound in a contract or set in a non-binding promise that can be altered without input.

Metrics and measurement

Measurement of value, which includes patient satisfaction, access and patient clinical outcomes, is part of some physician compensation models. Quality and other metrics may also be linked to compensation. Considerations to raise include how those metrics are measured, what feedback is provided to the physician and what improvement programs the system offers.

Questions to ask

- Is continued employment or other arrangements tied to physician performance?
- If so, what are the notification requirements and appeal rights to challenge reported metrics?
- Through what systems are performance metrics measured? What feedback is provided to physicians and how is it provided?
- What performance improvement programs are available?

Shared cost

Assignment of shared costs is another important concern for a physician considering joining a physician-led integrated health system. Those in academic medicine are sometimes assessed a “dean’s tax,” a portion of the physician’s income that is allocated to support of the medical school.

Questions to ask

- Are the infrastructure’s costs clearly outlined?
- Are contributions at the individual physician level, or at a department or system level?
- How are cost overruns paid for? Are there allocations based on a formula or is it unclear?
- Do physicians feel comfortable providing input to suggest waste elimination or cost-saving process improvement changes?

Family support

Physicians with families will benefit from understanding what (if any) family support the physician-led integrated health system provides. Common ways to check is to ask families who have been with the system more than 10 years why they have stayed, and for those who have been there less than three years, why they joined and what would they change.

Questions to ask

- Besides providing health insurance benefits, is there paid parental leave?
- Are childcare services available in the system?
- Is there flexibility in physician schedules to allow time for family activities?
- Is time spent caring for sick family members deducted from vacation, paid time off or another type of leave allowance?
- Is there a support group for spouses?



■ Clinical considerations

Scope and type of services

A search on a health system's website using the patient portal can provide a view of how a patient may be cared for in the system. It will be important to understand how patients with multiple medical conditions, including mental health disorders, are accessing and being helped by the system. Outsourcing case management may result in breakdowns in communication. If there are disease-specific management programs, knowing how those link to coordination of care may be important. Does a common medical record link to community physicians and resources seamlessly, or do paper processes dictate how care is documented and delivered? Questions to those working in the emergency department can help validate if the processes of care coordination are effective or not.

Clinical autonomy

A physician-led integrated health system may attempt to control costs by reducing variation in process improvement principles. Knowing if physicians have the ability to advocate for the unique needs of a particular patient and what administrative barriers exist will be important to know. It may be helpful to talk with primary care physicians who are part of the system about their experiences. Also, becoming familiar with how adherence to protocols is measured, and how changes are implemented, can help physicians understand the system's commitment to quality infrastructure.

Expectations for system improvement activities:

Commissioning various physician committees is part of how physician-led integrated health systems can achieve consensus and effect change.

Questions to ask

- Is there an expectation of a certain amount of time to participate on committees?
- If so, are physicians financially compensated for that time, separately from regular pay?
- If no additional compensation is provided, and committee meetings are scheduled during clinical time, are necessary adjustments made to report active time not providing patient care?
- Does the system provide just-in-time education on process improvement theory, committee functioning and other aspects of administrative medicine, or is the expectation that physicians will learn as they serve?

Measuring key attributes of a physician-led integrated health system

The following checklist can be used to assess whether a system may be a good fit. If less than 50 percent of the attributes are perceived to exist within the system, this suggests the system may have challenges that could prevent it from being the right fit. In other words, the more attributes that are present the stronger the system may be. Attributes that are absent or un-assessable should be inquired about to determine if the system has efforts in place to address those attributes.

Key attribute	Yes	No	Not assessed	Comments
The mission and strategic plan of the physician-led integrated health system aligns with your professional goals and personal ethics				
The system governance structure includes physician leadership and direct input to operational decisions				
Individual physician compensation (and, if employed, requirements to maintain employment) is transparent				
The system provides additional benefits in addition to insurance (health, liability), PTO and retirement				
The system supports, financially and administratively, the individual physician's needs for CME and MOC				
The system IT system provides accurate, timely and actionable reports to the individual physicians				
The system provides all care coordination of patients managed by individual physicians				
There is evidence of stability in key leadership positions (CEO, CMO, COO, CNO) over the last five years				
The system is financially solvent with a strong bond rating				
The system has a track record of successful management of risk/value based contracts				
The physicians within the system are professionally satisfied				



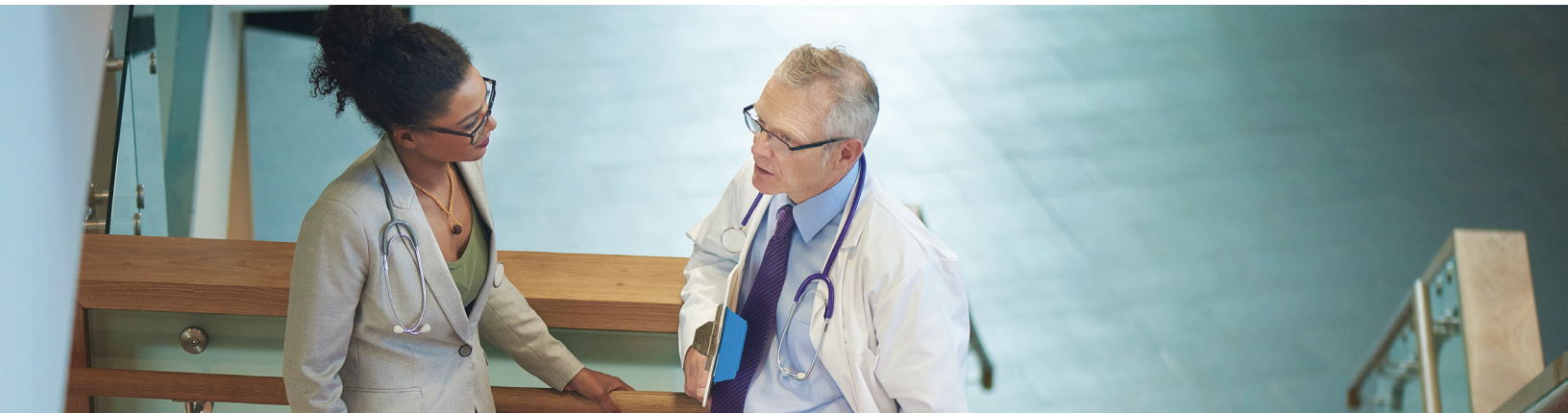
Physician-led integrated health systems in today's health care environment

Value-based payment (VBP) is a payment model that offers financial incentives for meeting certain performance measures. Value-based care intends to link reimbursement to patient outcomes and/or quality of care. Accurate, timely and actionable data is a key for success in VBP. Today's health IT infrastructure allows for electronic communications, big-data aggregation and sophisticated programs with predictive analytics. This is essential to successful VBP because it enables practices to focus on the small percentage of individuals with the largest disease burden (and subsequent cost), allowing the physician and health care team to improve overall patient health and prevent avoidable diseases.

To successfully administer such risk-based contracts, physicians should know the population they serve and implement effective outreach programs for preventive services such as immunizations and screening tests. This will help enable the practice to meet outcome measures which are part of VBP. For those patients in the risk-based contract who have existing disease processes, a physician-led integrated health system should have in place means to identify, through effective risk assessment and home and telemedicine programs, removal of barriers to obtain medications and therapies. When a disease must be managed in a hospital setting, it is imperative that the care be efficient, timely and effective since hospital costs for patients with multiple co-morbidities are typically the largest expenditure. It is recognized that significant influences on the health of patients are social determinants, which include housing, transportation, health literacy and family support. An individual physician or small practice may find it challenging to manage large populations without the necessary information technology, supporting personnel and financial capital. Aligning with another entity and pooling resources can enable a physician to participate in VBP with risk contracts.

Questions to ask

- Does the physician-led integrated health system qualify for the Medicare Alternative Payment Model, which would provide an automatic increase in payment?
- What is the projected timeline of the practice's plans for a health IT interface that will allow timely, accurate and actionable data sharing?
- How will the system share the risk and reward with physicians?
- Is financial investment in infrastructure required? If so, is it based on the number of beneficiaries of the VBP payer in a physician's practice or another model?
- If the system plans on qualifying under a public or private payer VBP, has it established and met quality thresholds for which bonuses will be paid?
- Are data reporting and reimbursement administered under each physician's Tax ID?



Alignment options for independent practices

Aligning with a health system as an independent practice may be a desirable option for physicians who don't want to relinquish profits to a hospital, want to maintain autonomy in practice, or simply prefer working for physician leaders rather than hospital administrators. There are several ways in which physicians can align with an integrated health system and still remain an independent practitioner.

Accountable care organization

When considering joining an accountable care organization or ACO, it is important to understand the track record of governance, information technology infrastructure and compensation.

Questions to ask

- Are contracts negotiated both with CMS and private payers?
- If so, how are patients insured by Medicare or other insurers identified in the practice, and what is the risk if a patient leaves the ACO network to obtain care elsewhere?
- Is the ACO protected by an antitrust safety zone granted by the Federal Trade Commission and Department of Justice?
- Is there an upfront fee or dues to join the ACO or a requirement for active participation in ACO committees?
- What information technology interfaces are needed to link a practice with the ACO?

Physician-hospital organization

The structure of a physician-hospital organization (PHO) can vary depending on whether a state prohibits the corporate practice of medicine and does not allow a hospital to directly employ a physician.

PHO's can be a mechanism of employment or a parallel to a traditional medical staff-hospital relationship. Understanding the legal and governance structures is important. Tensions may arise if the governance comprises physicians employed by the hospital but no longer in-patient care, potentially causing those who provide clinical care to feel undervalued. It is beneficial if communication and input are sought from and used by those impacted by decisions.

Questions to ask

- Is the alignment part of the medical staff membership of the hospital?
- Will it require using hospital resources for patients, including referrals in most circumstances?
- If so, has there been a legal opinion that would permit such requirements under federal and state fraud and abuse laws?

Independent practice associations

Independent practice associations (IPAs) provide physician groups an opportunity to collaborate in practice while remaining independent. Aligning with an IPA may be a good choice for a physician group looking to pool resources with practices in a geographically similar area. When considering alignment with a clinically integrated IPA, it will be important to know the extent of its integration, how long it has been in existence, its governance structure and turnover rates, as well as the financial and time costs of participation.

Questions to ask

- What are the financial and time costs of participation? What does the IPA offer its members in turn for financial investment?
- What is the extent of the IPA's integration, i.e., do the participating practices share an EHR, case managers, coding and billing, clinical guidelines and reporting as a group for quality measures?
- How long has it existed? Does it have high or low turnover rates?
- What is the governance structure?
- What is the track record with risk-based contracts, if any?
- Does the IPA gather patient information from different independent physician practices?
- How is payment for patient care allocated between primary and non-primary care?
- Can independent physicians' contract outside the IPA?
- Does the IPA reserve the right to first review and approve all contracts?
- What is the IPA's financial reserve?

Virtual groups

Virtual groups are a way for solo and small practices to pool resources for the purposes of quality reporting and improvement. They are ideal for rural practices responsible for patients within a large geographic area.

Question to ask

- Is the virtual group an accredited patient centered medical home?
- Is the IT infrastructure updated and reliable?
- What are the upfront costs to join? How are ongoing infrastructure and other costs allocated?

Other models

As the U.S. health care system evolves, significant changes are taking place to help physicians and practices provide better care and achieve the Quadruple Aim of providing better care, improved health, lower per capita costs and improved professional satisfaction. There may be other alignment options established in addition to those listed here. When aligning with *any* practice model, it is important to consider how the organization will respond to financial pressures, regulatory changes, and the physician's need for his or her independent practice to survive.



Conclusion

No single model of care delivery will allow physicians to meet all the diverse needs of America's patients in our evolving health care environment. This is due to a variety of factors, including the emphasis on care coordination across settings, advancements in new technologies and treatments, differing expectations of patients and the emphasis on value. The AMA works to support physicians in all practice settings and specialties. We show this commitment by assisting physicians in pursuing the model of care delivery that best suits them and their patients, and by providing resources to help physicians succeed in all practice settings.

There is evidence to suggest that physician leadership underpins those systems that are the best at providing high quality care, ensuring improved health outcomes at a lower cost, and supporting professional satisfaction. As physicians consider joining or aligning with a physician-led integrated system, understanding the system's history and its goals for the future will be important in the decision-making process. While this guide provides information about important considerations, key questions to ask and resources to assist in the decision-making process, it is not an all-inclusive document. The AMA will strive to continue developing helpful resources and tools to assist physicians in practice transformation.

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Glossary and acronyms

Clinical autonomy

In this document, clinical autonomy refers to the physician's ability to make clinical care decisions that they deem in the best interest of the patient independent of any outside constraints imposed on them by an organization or entity such as a hospital, health system or payer.

Physician-led integrated health system

A health care system led by physicians who advocate for the patient at the leadership level and provide integrated, comprehensive primary and specialty care, coordinating care across multiple conditions, providers and practice settings.

Multi-specialty/integrated physician group

A type of integrated practice in which physicians work in a collaborative, team-oriented group and provide care across specialties.

Physician-owned practices

A type of practice model that allows physicians to own the practice through equity shares, where financial risk, and decisions on investments and profit sharing are shared between owners.

Foundation model

A type of practice model in which a non-profit foundation owns the physical "bricks and mortar" practice and the physician group provides the clinical expertise.

ACO (accountable care organization)

Groups of doctors, hospitals and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.

Physician-hospital organization

An entity that provides a formal relationship between physicians and hospitals and enables the sharing of governance and infrastructure costs.

IPA (independent practice association)

A business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, ACOs and/or managed care organizations (MCOs).

MCO (managed care organizations)

A health care delivery system organized to manage cost, utilization and quality.

Virtual group

A network of practices that enables the sharing of IT support, data collection, analysis and reporting, as well as the qualification for population incentive payments.

PCMH (patient centered medical home)

A model of the organization of primary care that delivers the core functions of primary health care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

HIPAA (Health Insurance Portability and Accountability Act)

Federal law enacted in 1996 that improves portability and continuity of health insurance coverage in the group and individual markets, combats waste, fraud, and abuse in health insurance and health care delivery, promotes the use of medical savings accounts, improves access to long-term care services and coverage and simplifies the administration of health insurance. Typically referred to in the context of the

Privacy Rule, which provides patients with rights over their health information and sets rules and limits on who can look at and receive health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written or oral. The Security Rule is a federal law that requires security for health information in electronic form.

VBP (value-based payment)

Physician reimbursement that reward health care workers with incentive payments for the quality of care they provide to patients, aimed at better care for patients, better health for populations and lower overall cost.

MACRA (Medicare Access and CHIP Reauthorization Act)

Federal law enacted in 2015 that replaced the Sustainable Growth Rate and implemented the Quality Payment Program (QPP), aimed at reforming how clinicians are reimbursed for services provided to Medicare patients and providing tools and resources to help clinicians provide high-quality care at a better value for patients.

QPP (Quality Payment Program)

MACRA-initiated program implemented by the Centers for Medicare & Medicaid, focused on reforming the clinician payment system to reward high-value, patient-centered care. The QPP consists of two tracks from which physicians and practices can choose, Merit-based Incentive Payment System (MIPS) or advanced alternative payment models (APMs).

MIPS (Merit-based Incentive Payment System)

Incentive-based payment system implemented within the QPP, a consolidation of former pay-for-performance systems.

APMs (alternative payment models)

A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population. Advanced APMs are a subset of APMs, primarily applicable for reimbursement from Medicare under the QPP, that let practices earn more for taking on some risk related to their patients' outcomes.