In these situations, the physicians will often face unfavorable contract terms, and their contracts would not be terminated later. In August, the Coalition for Quality Care wholly dropped their contracts, although they were not given any assurances that they would not be terminated at up to 11 hospitals. A week later, the physicians were told the plan to terminate 10 of their contracts was driven by the need to use a national provider for emergency department, and hospitalist care in favor of using a national provider for urgent care and hospitalist care.


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In the News...

Organizations Can Help Docs Retain Their Independence

Many physicians are leaving independent practices and joining health systems as employees. Others, however, who wish to maintain their autonomy, are joining independent practice associations (IPAs). This is according to an article in the August 7, 2014, issue of Medical Economics. Advantages of IPAs include stronger negotiating power through an alliance with other physicians and data sharing thanks to technology they may not be able to afford independently. IPAs are just one possible way to become more productive, free yourself from time-draining minutiae, and trim unnecessary costs to preserve your independence — without sacrificing your relationships with patients,” according to the article.

Is the Hospital of the Future Not a Hospital at All, at Least Not as We Know It?

Writing on Microsoft’s HealthBlog (July 7, 2014), Worldwide Health senior director Bill Crounse, MD, reported on the health industry consulting firm Triple Tree’s assessment of how changes in reimbursement, alternate care sites, and rising consumer expectations are “blurring the lines” of where and how care is being delivered. Triple Tree’s Viewpoint Report gives many examples of where some of the most forward-thinking facilities are partnering with hotel chains and home health service companies to provide overnight accommodations and monitoring for patients needing post-surgical or post-procedural care. Oncology, urology, otolaryngology, gynecology, and gastroenterology may be next. And who wouldn’t rather stay in a fancy hotel or even his or her own bedroom than a hospital room, which can be a breeding ground for infection?

Another Year of Pay Hikes for Non-Profit Hospital CEOs

Total base compensation grew an average of 24.2 percent from 2011 to 2012 for 147 hospital-system chief executives surveyed, according to Modern Healthcare magazine. Twenty-one of them, or 14.3 percent, got 50 percent increases. Among the executives on the list in the metropolitan area is Mount Sinai Health System’s Dr. Kenneth Davis, whose base compensation increased 40.6 percent between 2011 to 2012. According to the article, the survey suggests that hospital-system CEOs receive increases in base compensation that are about four times greater than increases received by average workers, whose annual pay hikes have run about 2 percent in recent years.

Doctors Feel Pressure to Accept Risk-Based Reimbursement

“As insurers step up efforts to cover more lives with value- and performance-based contracts, physicians are under the gun to adapt to an altered reimbursement reality,” according to Jacqueline Fellows, writing in HealthLeaders Media on July 24, 2014. Cigna covers one million healthcare consumers under its quality- and performance-based reimbursement model, called Collaborative Accountable Care (CAC), the carrier announced. And Cigna is not the only large insurer refining its reimbursement approach to accommodate a value-based healthcare system. Larger physician groups have the resources for this transition, according to a March study in the Journal of Health Services; smaller physician groups, however, are not ready or capable.

Practice Management of America

Practice Management of America, Inc. (“PMA”) is a full healthcare management organization, (“MSO”) that provides a broad array of services to medical practices. There are three service categories: Management Services, Patient Care Income and Contracting. PMA’s goals are to reduce administrative burdens by providing management services; to provide income via expanded patient service opportunities; and to engage in at-risk/shared savings contracts.

Optum Buys Local MSOs

The United HealthCare unit Optum has purchased the medical management operations of two large group practices, it was reported in Crain’s HealthPulse on August 22, 2014. The practices are ProHealth Medical Management, the MSO of the ProHealth group practice based on Long Island, which was purchased in July, and WestMed Practice Partners, a multispecialty group based in Purchase, New York, on which it closed in May. Optum will likely purchase other major assets in the New York market, according to the article.

Obama Administration: Driving Provider Consolidation and Increased Costs

Writing in Life Science Leaders magazine, John McManus, president and founder of the McManus Group, states: “The increasing consolidation of healthcare providers has undeniable, deleterious consequences for consumers; yet what is the Obama Administration doing about it? Making things worse.” A May 2014 Health Affairs Study found that when hospitals buy physician practices, the result is higher hospital prices and increased spending. For example, the average price of a colonoscopy in a hospital was $1,363 compared to $265 — less than half — in a community setting (e.g., an ambulatory surgery center).

The Risks of Hospital Mergers

In 1994, the state of Massachusetts let its two most prestigious and expensive hospitals, Massachusetts General and Brigham and Women’s, both affiliated with Harvard, merge into a single system known as Partners HealthCare. That was a serious mistake, according to an editorial in the New York Times on July 7, 2014. Investigations by the state attorney general have discovered that the merger gave the hospitals leverage to drive up healthcare costs in the Boston area by “demanding high reimbursements from insurers that were unrelated to the quality or complexity of care delivered.” Martha Coakley, the attorney general, is trying to forge an agreement with the hospitals that would slow the price increases and limit the number of practices they can purchase — for the time being. The lesson for other states is that they should examine hospital mergers very closely before they are approved, because they are very hard to undo.

$40 an Hour...

That’s the approximate cost of life (average increase in lifespan = 120 days) for Provenge, the designer vaccine for hormone-resistant prostate cancer. A one-time dose for a one-time cost of $100,000. Medicare has been covering the cost, but many bioethicists question remains unanswered, and the debates will go on and on. What about Revlimid for multiple myeloma at $10,000 a month, or Gleevec for leukemia at $4,000 a month, or Tarceva for pancreatic cancer at $4,000 a month, or Avastin for metastatic breast cancer at $8,000 a month? When is a drug considered cost-effective? The most widely quoted figure is $50,000 for a year of life. However, it’s been that for decades, and many cancer drugs are way over that.

Higher costs are generally more accepted for cancer treatment, but there’s no rule on how much is too much. Then there is also the difficult price-justification issue. Insurers decide if they will pay, and they typically do pay if Medicare approves its use. The new healthcare law will be a game changer. No preexisting illness denials, elimination of lifetime limits, etc. etc. The financial burden will be significant. The difficult decisions in making recommendations for patients with cancer will reside with the provider. For now there is no “one size fits all” solution. Each case must be dealt with individually — and therein lies the value of the doctor-Patient relationship.

Way more than $40 an hour.