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## Forming a Legitimate Physician-Hospital Alliance

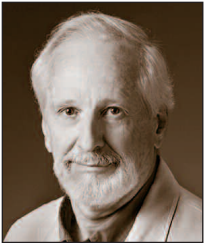


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By David Ollier Weber

*The Federal Trade Commission's antitrust rules have barred many hospital-physician alliances, but the Greater Rochester Independent Practice Association in upstate New York found a way to integrate with the FTC's approval.*



**David Ollier Weber**

“Are you familiar with the term ‘clinical integration’?” the editor inquired.

It sounded obvious enough. “Clinical integration” conjured for me something like disease management, in which a group of caregivers all cooperate and coordinate their efforts across disciplines and settings to improve outcomes for patients with a particular chronic or complex condition.

I wasn’t altogether wrong—it has been used in that sense. But something about the editor’s question hinted that “clinical integration” possessed another, narrower, more specific significance in the ever-mutating health care lexicon.

### Getting a Leg Up

Oddly, it turns out, the term is a coinage not of physicians or hospital administrators or health policy mavens, but of government antitrust attorneys. It first appeared in the joint U.S. Federal Trade Commission and U.S. Justice Department’s “Statements of Antitrust Enforcement Policy in Health Care,” published in 1996.

“Clinical integration,” as the FTC then outlined it, represents “an active and ongoing program” by a group of independent physicians—often in league with one or more hospitals—to:

“(1) [establish] mechanisms to monitor and control utilization of health care services that are designed to control costs and ensure quality of care;

“(2) selectively [choose] network physicians who are likely to further these efficiency objectives; and

“(3) [invest] significant ... capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”

What in this eminently sensible concept had engaged a government lawyer’s interest?

The anticompetitive potential, of course. Whenever a bunch of independent doctors and hospitals put their heads together to sing in chorus, there’s an “inherent” suspicion they’re not doing it to please the audience (patients and payers) but rather to overpower the weaker individual voices of their rivals in the noisy marketplace. United States courts have consistently taken this position.

And indeed, many such initiatives—especially when joint fee negotiation is part of the picture—have been slapped down by the FTC and by judges in recent years as mechanisms designed primarily to give members (who would otherwise be on their own and competing against one another) clout in jawboning with health plans and employers over reimbursement levels.

Getting a leg up on the competition is as American as Freedom Fries. But so is a level playing field. The ruthless excesses of 19th-century steel and railroad cartels—then called trusts—to fix prices and divide up exclusive territories to drive out competition led to the Sherman Antitrust Act of 1890. Its first application in health care turned on credentialing and peer review by hospital medical staffs in the 1970s. Managed care added another dimension to the FTC’s scrutiny of joint ventures in health care when community physicians formed independent practice associations (IPAs) or allied themselves with hospitals in physician-hospital organizations (PHOs) and began to bargain collectively with payers over fee schedules.

Depending on an intricate set of conditions, including financial risk to participants and the market share they command together, a joint venture can be illegal under the Sherman Act per se, or it can be permissible under the “rule of reason.” That is, even though it may confer some economic advantage to its members at the expense of their unaffiliated competitors, it can reasonably be expected to make available a new, better and cheaper product for consumers. That’s why a clinical integration (CI) program with the characteristics described in the FTC’s 1996 statements—which is what the agency was proactively making clear—is actually likely under the rule of reason to be a lawful endeavor, notwithstanding the fact that it is negotiating no-risk contracts on behalf of its members.

## Why Are You Doing This?

There’s a big caveat, though. The real and demonstrable *raison d’être* of any CI organization has to be to gain efficiencies, hold down costs and improve outcomes to the benefit of patients. Price agreements must be “ancillary” to the main endeavor—simply one, arguably essential, means by which member doctors, hospitals and allied organizations (that would otherwise be inclined to hum their own tunes) can be kept on pitch and on key to achieve the lasting harmonies that elevate patient well-being.

That was not the case in Hickory, N.C., the FTC maintained in 2004. There Frye Regional Medical Center and its parent, Tenet Healthcare Corporation, were charged with price fixing for their participation in the Piedmont Health Alliance, a PHO whose collective fee negotiation was deemed “not reasonably necessary to achieving any efficiency-enhancing integration.”

The Frye cease-and-desist order was among more than 30 the FTC has issued since 2002 to physician-hospital organizations and IPAs for what the agency judged to be faux CI, according to the American Medical Association. Most turned out their lights meekly, but North Texas Specialty Physicians, a 600-member IPA in Fort Worth, chose to fight a 2003 FTC price-fixing allegation only to lose in federal appeals court this year. Fifth circuit judges agreed that the quality of the organization’s professional services was in no way enhanced by its “anticompetitive” group contracting strategy.

Advocate Health Partners (AHP), a network of 2,900 independent physicians affiliated with the Advocate Health Care hospital system in the Chicago area, fell afoul of the FTC in 2006 for collectively negotiating fee-for-service contracts “without,” the agency charged, “any efficiency-enhancing integration of their practices.”

“Au contraire!” yelled AHP. And early last year the FTC relented to the extent of allowing the organization to continue to market its clinical integration program to insurers on the basis that AHP’s 20 CI initiatives do include care management, screening and prevention protocols, generic prescribing, computerized provider order entry (CPOE) and a pay-for-performance component. But the FTC said it would keep a gimlet eye on the program.

One way to avoid costly and embarrassing after-the-fact reverses is to seek an advisory opinion in advance from the FTC staff on the likely legality of a clinical integration proposal before any fee-for-service payment dickering begins. That was the avenue taken in 2002 by a Denver IPA called MedSouth and in 2006 by Suburban Health Organization, a “super PHO” made up of eight smaller PHOs at as many hospitals in the Indianapolis area. Results varied.

MedSouth received the benefit of the doubt based on a rule of reason analysis. The FTC gave the go-ahead for collective fee bargaining by the independent members because they promised to share an electronic clinical data system, to establish practice guidelines and monitor individual adherence, to measure members’ performance, and to discipline or boot out colleagues who failed to meet the mark. Those are exactly the earmarks of a licit CI program limned by the FTC in its 1996 statements. Nor did a revisit to MedSouth five years later cause the FTC to change its mind.

The Indianapolis group, on the other hand, flunked the feds' rule of reason test largely because the 192 primary care physicians involved were employed by the Suburban Health hospitals. Thus, FTC analysts reasoned, the modest CI elements proposed—mostly educational information sharing—and the fact that the hospitals themselves could enforce practice patterns to improve quality of care by their employed doctors without horizontal integration, weren't enough to justify noncompetitive contract negotiation.

## Rochester Gets a GRIPA

The first new favorable opinion on a clinical integration model issued by the FTC since its initial MedSouth advisory—and only the second ever—went to the Greater Rochester Independent Practice Association (GRIPA) last September.

GRIPA is an alliance of about 450 private practitioners and 200 employed physicians in 41 specialties who admit patients to 528-bed Rochester General Hospital or its ViaHealth partner, Newark Wayne Community Hospital in upstate New York. In addition to the physicians and the hospitals, who split ownership, the GRIPA clinical integration network includes labs, imaging facilities and pharmacies, all sharing patient information—and for the doctors, prompts for office and bedside best-practice guidelines—through a secure Web portal called GRIPA Connect.

GRIPA has been negotiating capitated risk contracts for its members since its formation in 1996, notes Chief Medical Officer Eric Nielsen, M.D. Between 2003 and 2006, it returned some \$7.1 million to participating physicians from withholds keyed to efficiency. GRIPA physicians received a set payment for each patient seen, out of which 15 percent was withheld in an escrow account. At the end of the year any money left over in the account after actual costs of care were met was shared as a sort of bonus. Profits were also used to build a data-sharing infrastructure; identify patients most at risk; employ a staff of 45 care managers, data analysts, IT specialists and an in-house actuary; and track member doctors' compliance with guidelines. Most important, says Nielsen, “our physicians were already working together, cross-referring and engaging with each other, and we had a good relationship with the hospital system.”

In fall 2004, recalls Nielsen, longtime GRIPA attorney Robert Iseman contemplated this landscape and declared, “You know, you're already halfway to clinical integration! You ought to do it!”

Planning meetings were launched, hospital and physician representatives drew up a business plan, and in June 2006 a request for an advisory opinion was submitted to the FTC. GRIPA proposed to contract jointly for sale of its participating physicians' services to health plans on a fee-for-service basis. The network would operate nonexclusively, meaning its individual physicians would remain free to negotiate and contract separately with health plans and other customers who didn't want to purchase the network services.

“In addition to agreeing to adhere to all of GRIPA's practice requirements under the program,” the FTC observed, “the physicians, who have a history of working together under GRIPA's HMO risk contracts, will invest significant time and effort in collaboratively developing and overseeing implementation of the program's practice guidelines and protocols. They also will participate in monitoring and evaluating their peers' performance and addressing any performance deficiencies, including disciplining and, if necessary, even expelling from the organization physicians who continue to fail to comply with the program's requirements and adhere to its standards.”

The GRIPA Connect Clinical Integration initiative, the agency agreed, “has the potential to result in the achievement of significant efficiencies that may benefit consumers.” The letter also concluded that joint contracting by GRIPA “appeared to be subordinate to the program's primary purpose of interdependently improving the quality and efficiency of the member physicians' services.” Thus it would not be considered illegal price fixing per se.

## Wiggle Room

Developing a CI program that will withstand antitrust scrutiny is neither easy nor cheap. Every GRIPA physician, for example, is provided with a tablet computer and is trained in its use. (It takes about two hours to learn to access the Web portal, Nielsen says.) What with licensing and support staff, he estimates, the setup cost has come to about \$7,000 per physician—and will total \$3,500 a year thereafter.

But the connectivity provided is a bargain compared with the expense and disruption of installing a full-fledged electronic medical record (EMR) system for a doctor in community practice, he points out. (In Rochester, the average medical group numbers fewer than five physicians.) And GRIPA Connect Clinical Integration gives the two ViaHealth hospitals breathing space while they select and implement their own in-house EMR.

Robust electronic data-sharing would seem to be a crucial element in any CI program. But the journey, agree most who have set out on this route, begins with the wetware: physicians, and their ungrudging buy-in.

“The demands to enhance quality and value require physicians and hospitals to work together,” asserts Loren Hamel, M.D., senior vice president for organizational effectiveness at three-hospital Lakeland Health Care System in St. Joseph, Mich. His organization expects to invest some \$20 million in an EMR/CPOE system within the next two to three years, he says. Meanwhile, the focus at Lakeland is on currying more doctors to assume “collaborative leadership” at the hospital.

“We involve physicians in every step we can,” Hamel explains, “from creating strategy to process improvement. Our target is 33 percent physician membership of the board.” Lakeland coordinates physician recruitment to the community and has established a liaison service to maintain ongoing communication and collegiality among providers. “We won’t bring any physician to town if he or she can’t get along well with others,” Hamel declares.

Declining interest in risk-based contracting by health insurers and HMOs is a major motivator for the growing romance between doctors and the hospitals that care for their patients. “Just improving quality is great,” acknowledges GRIPA’s Nielsen, “but setting up a clinical integration program is very expensive and time-consuming. Nobody would go to all that effort without the incentive of being able to contract [for fixed fees].”

Under the CI safe harbor carved out by the FTC in 1996, joint ventures like GRIPA can cut a variety of no-risk deals with payers. (“I’d have to say it was a pretty smart person [at the FTC] who came up with the wiggle room to write that,” approves Nielsen. “They were ahead of the game.”)

“We’re telling them [the payers] to go ahead and pay our physicians a set fee but establish P4P (pay-for-performance) targets for the network,” he explains. “If we meet the guidelines, you pay us so much [additional] money.” In turn, he continues, “We could pay a management fee to doctors for caring for diabetic patients, say. Or the payer could give a little higher conversion rate for professional services. The payer would save money and the physicians would make a slightly higher fee.

“Those are the kinds of things we’re negotiating right now,” he declares. “We’ve had very good acceptance by several payers and employers in the community. But we have to teach them how to do things under this unfamiliar system. We’re proposing a new model of contracting, and they don’t yet understand the language we’re using.”

GRIPA has no guarantee that the FTC won’t, somewhere down the road, decide its operations amount to price fixing and pose an unfair restraint of trade for other doctors in the Rochester market. Nielsen expects to hear again from the feds before many years have passed.

“We represent only about 30 percent of the physicians in the community,” he notes, “and we can’t register many more without being anticompetitive. But ours is a model other physician groups in the community can emulate. We have an IT platform that could be replicated. And a lot of organizations have some of the pieces in place. What the FTC advisory opinion did for us was assure us [that] we were on the right track.

“It took six months to prepare the request and 15 months from the time of request to get the opinion,” he adds. “A lot of organizations might not want to wait two years before beginning contracting. But probably because of our opinion, others won’t have to go for one.”

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