Clinical Integration and Accountable Care Organizations

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Disclosures

- I have served in the past as a consultant to the FTC and to provider organizations on cases related to clinical integration

"I see by your copy of 'Newsweek' that Lyndon Johnson has decided not to run for reëlection."

Today's talk

- Two meanings of clinical integration
- Clinical integration: background
- Clinical integration and ACOs
- What's at stake?

Two Meanings of Clinical Integration

1) clinical meaning

2) legal meaning

Clinical Integration – Clinical Meaning

- Coordination among physicians, hospitals, and other providers in the health care system to provide high quality, cost-efficient care

Clinical Integration – Legal Meaning

- It is *per se* illegal for physicians who are not in the same medical group or employed by the same hospital to attempt to negotiate fees with health plans unless they are:
  - "financially integrated" and/or
  - "clinically integrated"

Who Should Care About The Legal Meaning Of Clinical Integration?

- ANY organization, formal or informal, that attempts to negotiate contracts with health insurers on behalf of physicians who don't all have the same employer:
  - independent practice associations (IPAs)
  - physician hospital organizations (PHOs)

The FTC Has actively investigated IPAs and PHOs, especially since 2000

- > 30 consent decrees against IPAs and PHOs

- the FTC has prevailed in each case involving clinical integration

The Mission of the Anti-trust Agencies

- The mission of the Federal Trade Commission and the Department of Justice is to preserve competition

- Competition is believed to result in lower prices and higher quality for consumers

The Anti-trust Agencies and Physicians

- It is *per se* illegal for competitors to attempt to fix prices, because this reduces competition
  - "naked price fixing"
- Physicians in the same geographic area who do not work for the same employer (hospital or medical group) are considered competitors

BUT . . .

- the anti-trust agencies recognize that physicians from different practices who work together to create an organization that strives to provide better value for consumers may create benefits that exceed the harm done from the reduction in competition

The Rule of Reason

- The FTC evaluates joint contracting with health plans by physicians in an IPA or PHO under "rule of reason" analysis if they have a plausible claim to be clinically and/or financially integrated
  - rather than considering them as *per se* violating anti-trust law
- Does the IPA or PHO provide benefits to consumers that plausibly exceed the costs of the reduction in competition?

Practically speaking . . .

- An IPA or PHO will likely be permitted to negotiate contracts with health insurers if the FTC believes that its physicians are
  - financially integrated and/or
  - clinically integrated
- and its market share is not excessively high.
- "the greater the likely anticompetitive effects, the greater the likely efficiencies must be"
  - (FTC/DOJ Oct. 2011 statement re IPAs/PHOs and anti-trust)

FTC/DOJ Examples of Financial Integration

- IPA/PHO contracting with a health plan to accept:
  - capitation
  - a predetermined percentage of premium
  - a predetermined fixed payment for certain complex services
- Use of significant financial incentives for an IPA or PHO's physician participants to achieve specified cost-containment goals
- The Agencies recognize that new types of risk-sharing arrangements may develop.
  - Source: **1996 Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement in Health Care**

"Definition" of Clinical Integration

"An ***active*** and ***ongoing*** program to evaluate and modify the clinical practice patterns of the physician participants to create a high degree of ***interdependence*** and ***collaboration*** among the physicians to ***control costs*** and ***ensure quality***."

- U.S. Department of Justice and Federal Trade Commission. Statements of Antitrust Enforcement Policy In Health Care. Statement 8: Enforcement Policy on Physician Network Joint Ventures, August 1996

No Cookbook, No Checklist

- The FTC and DOJ have given substantial guidance, but have consistently refused to provide a checklist
- Don’t want to prescribe what IPAs or PHOs do or to freeze innovation

Sources for FTC/DOJ Guidance

- DOJ/FTC Statements of Antitrust Enforcement Policy In Health Care (1996)
- DOJ/FTC Antitrust Guidelines for Collaborations Among Competitors (2000)
- DOJ/FTC Horizontal Merger Guidelines (2010)
- *DOJ/FTC Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (2011)*
- FTC Staff Advisory Opinions
- DOJ Business Review Letters
- FTC and DOJ Enforcement Actions

Overview of What Can Be Done

- invest human and financial capital in improving care
- develop organized processes to improve care
- measure what you are doing to guide improvement efforts
- provide incentives to physicians for quality
- take corrective action with poor performers

Suburban Health Organization

- physicians employed by different hospitals must be clinically integrated with each other if the physicians negotiate jointly for health plan contracts

Greater Rochester IPA

- highly sophisticated, informative, and up-to-date FTC advisory opinion
- higher than “market prices” per unit permissible if quality higher and/or total costs lower

TriState Health Partners

- A PHO involving one hospital, its employed physicians, and independent physicians in an IPA
- Detailed analysis, particularly re non-exclusivity

One “test”

- when rank-and-file physicians are deposed by the FTC or DOJ . . .
- will they be able to describe, with enthusiasm. . .
- the things your organization does to help provide better care for their patients?

When beginning to think about clinical integration . . .

- DON'T start by asking: "what's the least we can do to avoid being prosecuted?"
- DO ask: "what can we do, in a systematic way, using our own creativity, to improve care for our patients?"

What is Not Enough

- good intentions
- an uninformed belief in the virtues of one's organization
- words without processes
- form without substance
- a hospital-driven organization with little physician involvement
- "spillover from risk contracts"

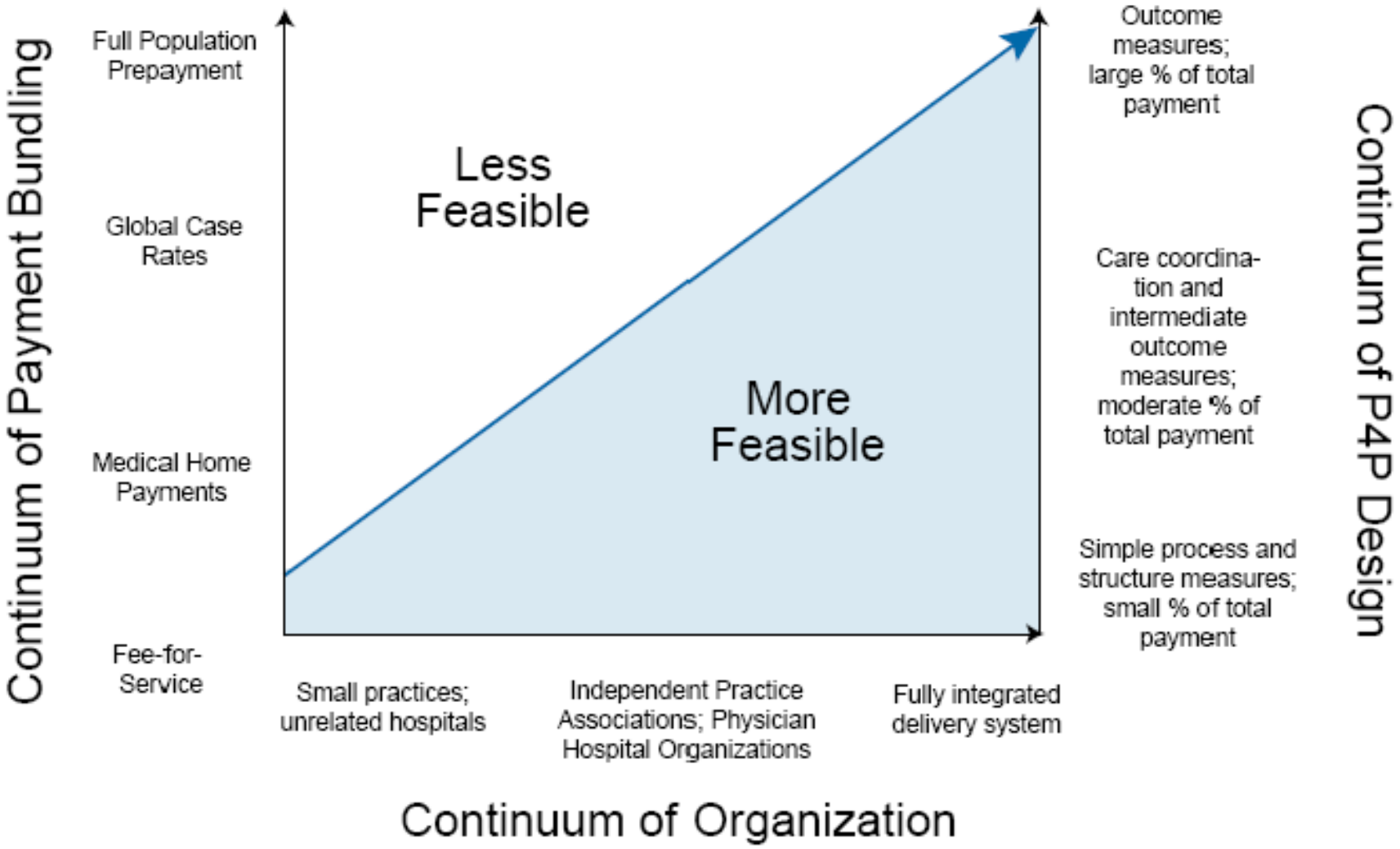
ACOs

- the goal: population-based care
- leading to higher quality at lower cost

Population-Based Care

- NOT just the patients who happen to show up in physicians' offices, while they are in their offices
- Know who your patients are
  - for preventive care
  - by type of chronic illness
- Stratify the patients by risk
- Higher risk patients get more attention
- Care goes on BETWEEN visits, not just during visits
- Help patients learn to manage their own illness
- Measure and improve the organization's performance

Exhibit ES-1. Organization and Payment Methods



Source: The Commonwealth Fund, 2008

Anti-trust Concerns about ACOs

- ACOs created to deal with Medicare may have the market power to demand very high payment rates from commercial health insurers
- Medicare might sign ACO contracts with IPAs and PHOs that are not clinically integrated
  - would then be awkward to take anti-trust action against these organizations

BUT:

- FTC/DOJ/CMS do not want to discourage creation of ACOs
- Nor to pre-judge the forms they might take
- And the processes used to provide population-based care and to succeed as an ACO . . .
- are likely to be the same processes that the FTC/DOJ would view as showing clinical integration

After CMS/FTC/DOJ consultations, proposed rules, and extensive public comments:

- CMS agreed that it will sign ACO contracts only with IPAs/PHOs that have processes in place consistent with clinical integration
- FTC/DOJ will consider IPAs/PHOs with ACO contracts with CMS to be clinically integrated
- FTC/DOJ will also assume that IPAs/PHOs that are Medicare ACOs meet the "reasonably necessary" criterion for negotiating contracts with health plans
- FTC/DOJ will monitor ACOs' performance

- FTC/DOJ "*Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*" (Oct. 28, 2011)

Safety zones for IPAs/PHOs that participate in the Medicare ACO program

- the market share in any physician specialty, major inpatient service category, or major outpatient facility service category within the ACO does not exceed 30% in any "provider service area"
- no hospital or ambulatory surgery center contracts exclusively with the IPA/PHO
- no "dominant provider" (a provider with a market share of 50% or greater) of any service contracts exclusively with the ACO
- some exceptions for rural areas

ACOs that fall outside the safety zone

- "may be procompetitive and lawful"
- but are more likely to be investigated
- may request an expedited review from the FTC/DOJ re whether likely to be considered anti-competitive

The FTC/DOJ are unlikely to investigate an IPA/PHO ACO that negotiates with commercial insurers if:

- the IPA/PHO is participating in the Medicare ACO Shared Savings or Pioneer program
- the IPA/PHO uses the same governance and leadership structures and clinical and administrative processes in its commercial contracts
- the ACO falls into a “safety zone”
- the ACO does not engage in particularly egregious forms of conduct

Conduct that may lead to FTC/DOJ concern

- Tying sales of the ACO's services to a health plan's purchase of other services from providers outside the ACO
- Unnecessary sharing of sensitive information (e.g. about prices)
- Restricting a private payer's ability to make available performance information to aid enrollees in selecting providers
- Insisting on "anti-steering," "anti-tiering," "guaranteed inclusion," or "most favored nations" provisions with health plans
- Exclusive contracting with providers

The two-edged sword of exclusive contracting

- Can lead to tighter integration; more investment by participants in the ACO; prevents free-riding
- Medicare requires primary care physicians to be exclusive with Medicare ACOs
- But exclusivity increases ACO negotiating leverage with health plans
- Exclusive contracting may the decisive factor in cases that the FTC considers “close”
- Exclusivity is generally less likely to raise competitive concerns the greater the number of competing ACOs or independent providers available to contract with private payers or to participate in competing ACOs

What is Actually Happening?

- Many IPAs and PHOs have qualified as Medicare Pioneer or Shared Savings ACOs
- Few if any advisory reviews have been requested
- No FTC or DOJ investigations of an ACO to date (apparently)
- Many ACO-like contracts between health plans and IPAs/PHOs
- Mergers/acquisitions may be challenged

Pioneer ACOs

Type	Number of ACOs	Number that include a hospital
IDS: hospital(s) + private and employed physicians = PHO	11	11
IDS: hospital(s) + medical group(s)	4	4
PHO	1	1
Hospital(s) + IPA(s)	3	3
Hospital + employed physicians	0	0
Medical group	2	1
IPA or network of IPAs	7	1
IPA(s) + medical group(s)	4	0
Total	32	21

Notes on Pioneer ACOs

- There are a lot of IPAs: 11, plus IPAs involved in "integrated delivery systems"
- Only one of these 11 IPAs explicitly includes a hospital in its ACO
- There are some PHOs involved in integrated delivery systems
- All the Pioneer IPAs and PHOs are large and well-established, with experience managing care and managing risk

Shared Savings ACOs

- According to CMS, 50% of Medicare ACOs are physician-led organizations that serve fewer than 10,000 Medicare beneficiaries.

Few if any advisory reviews have been requested

- If within safety zone, why bother?
- If outside safety zone . . . ?

Apparently no FTC/DOJ investigations of ACOs to date – but may not be a stable situation

- If health plans are trying to create ACO-like contracts with an IPA or PHO, why would they turn the IPA or PHO in to the FTC?
  - if negotiated payment rates are based on measurable value (quality over cost), where is the harm?
- FTC/DOJ waiting to see how well ACOs perform
- If health plans fail to negotiate satisfactory contracts with IPAs/PHOs, the situation could change

Mergers/acquisitions may be challenged

- Merger guidelines ≠ clinical integration guidelines
- medical groups in the same specialty (e.g. cardiology) merge to a high market share
- a hospital acquires medical groups in the same specialty that together have a high market share

RECENT M & A Challenges Involving Physicians

- Federal challenge to specialist concentration: Renown Health (2012),
- State challenges to specialist concentration:
  - State of Maine v. Maine Health, No. BCD-CV-11-08 (2011)
  - Commonwealth of Pennsylvania v. Urology of Central Pennsylvania, Inc., 2011 CV 01625 (2011)

Clinical Integration and ACOs: Key Points

- An IPA or PHO need not be an ACO to be clinically (and/or financially) integrated and therefore to legally negotiate contracts with health insurers
- The FTC/DOJ consider IPAs and PHOs that have been accepted into a Medicare ACO program to be clinically integrated
  - pending experience with performance, which is being measured
- Nevertheless, high market share or certain types of conduct may trigger an investigation

What's At Stake?

- Can physicians and hospitals bend the cost curve?
  - If not, there will be blunt payment cuts by Medicare and Medicaid and perhaps regulatory pressure on payment rates from heath plans
- Can IPAs/PHOs compete with large medical groups and with hospitals and their employed physicians?
  - If not, it may be the end for small independent physician practices

Historically . . .

- More than a thousand IPAs and more than a thousand PHOs were created during the 1980s and 1990s
- Few were successful – though there have been successes
- there is very little research comparing the performance of IPAs, PHOs, medical groups, and hospitals + their employed physicians

Meeting anti-trust requirements does not mean that an IPA or PHO will succeed!

To succeed as ACOs, IPAs and PHOs should have 8 things:

1. Physician (and non-physician) leadership at multiple levels of the organization
2. Culture
3. Organized processes to proactively improve the health of their population of patients
4. Information technology
5. Substantial investment of human and financial capital
6. A strong primary care base with patient-centered medical homes
7. Cooperation from specialist physicians
8. Cooperative hospital and health plan partners

Each of the Eight Things is Difficult!

Physician leadership

- Physician leadership is the scarcest and most precious commodity in health care
- All successful medical groups, IPAs, and PHOs have strong physician leaders
- Physician leaders need:
  - development
  - time protected for leadership activities
  - credibility with rank-and-file physicians

Culture: Two Views of Quality

- individual physician view
- population-based view

Individual Physician View of Quality

- quality is what I do:
  - for whatever patients happen to show up
  - while the patient is in front of me

- this view is necessary, but not sufficient

Population-based view of quality

- quality is also what a medical group, IPA, or HPO does:
  - for the population of patients for which it is responsible
  - using organized care management processes
- should complement the individual physician view
- are you a high quality physician if your organization does not use organized processes to improve care?

Questions

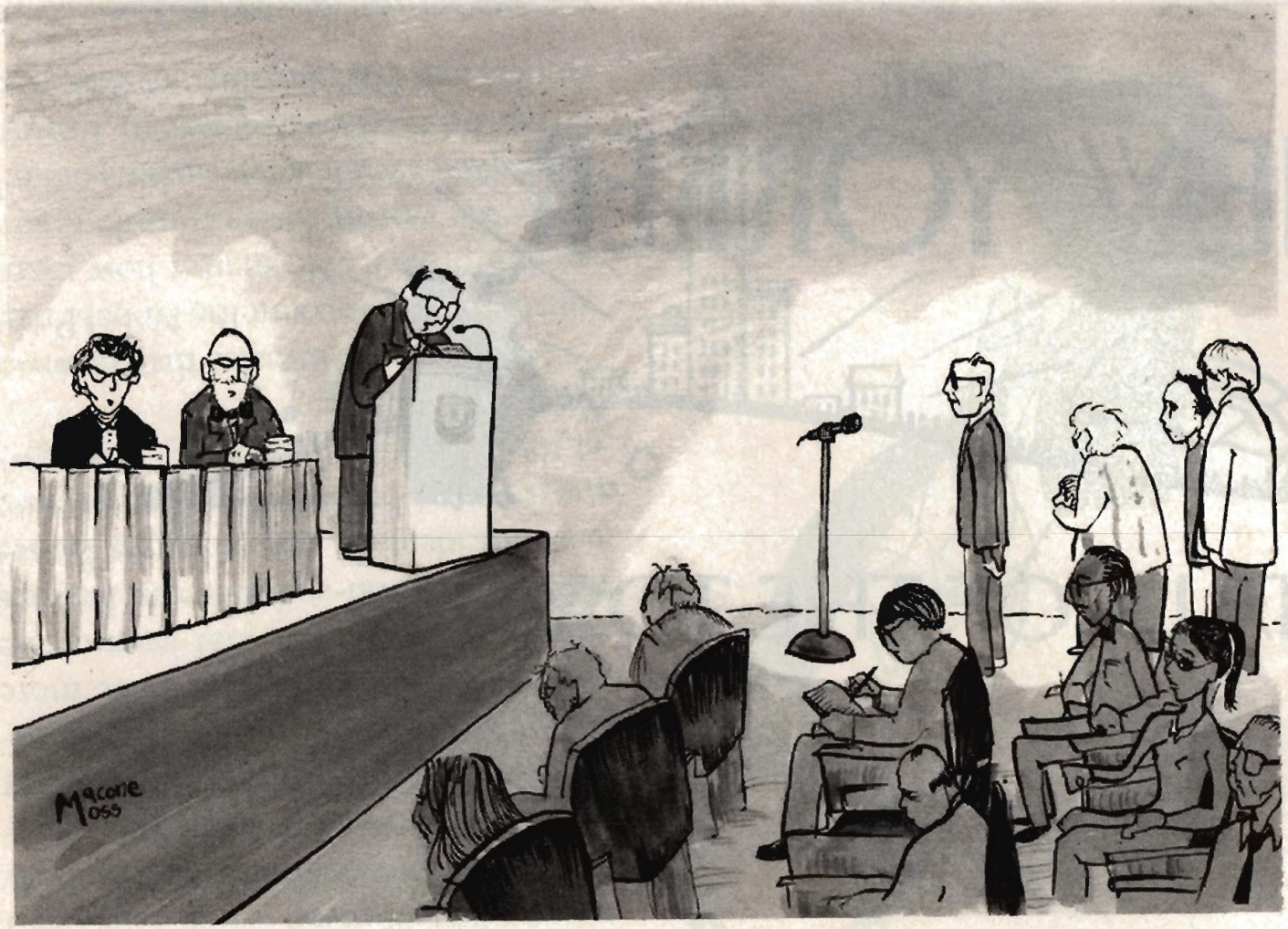
- Is CMS taking sufficient care to sign ACO contracts only with IPAs/PHOs likely to be able to reduce costs and increase quality? (NTSP?)
- If not, will the FTC/DOJ continue to deem these IPAs/PHOs to be clinically integrated, and to permit them to negotiate with health plans?
- How will exclusivity be dealt with?

Clinical Integration and Financial Integration

- Financial integration and clinical integration go together:
  - an IPA/PHO taking financial risk w/o being clinically integrated is unlikely to succeed
  - potential financial rewards provide the return on investment that makes clinical integration feasible/desirable

"Politics is a strong and slow boring of hard boards. It takes both passion and perspective."

from Max Weber: *Politics as a Vocation*



"We'd now like to open the floor to shorter speeches disguised as questions."