



Physician Organizations

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Clinical Integration: Collective PPO Contracting as a Catalyst for Quality Medicine

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I. Health Plans, “Consumerism,” and Lower Cost Care

Today, doctors and hospitals face a formidable challenge in the increasingly troublesome business of caring for patients. Whereas “caring for patients” always demands that hospitals and doctors continually increase clinical quality, “business” frequently insists that they do so for less. And, just as “nothing will come of nothing,” less often comes from less—less physician time for collaborating with hospitals and each other in the implementation of quality and efficiency initiatives, less physician attention paid to the latest in evidence-based best practices, and less physician inclination to adopt advanced clinical technologies.

Many health plans are eager to enlist some new recruits in their pursuit of lower cost healthcare—the patients themselves. Often referred to as “consumerism,” the brand practiced by a number of health insurers basically works like this. The health plan, primarily using cost data with a few perfunctory quality measures thrown in, publishes a doctor or hospital “report card,”

wherein the hospitals and doctors who provide the lowest cost care at a minimally-acceptable level of quality obtain the highest marks. Patients then receive an incentive to receive their care from these “achievers,” sometimes in the form of lower co-pays or deductibles, sometimes in better benefit differentials.

“Consumerism” of this sort bears a kind of distant resemblance to an actual good idea—the ugly cousin, as it were, to “pay-for-performance.” The term, “pay-for-performance,” stands for the sensible notion that higher-performing doctors and hospitals deserve better payment for providing better care to patients—i.e., care delivered in a way designed to produce improvements in quality and efficiency. However, engaging in such “pay-for-performance” activities requires intense collaboration among hospitals and physicians who need to collectively engage health plans around these issues of quality. This is especially the case for the health plan most preferred by patients, the fee-for-service preferred provider organization (PPO), an insurance product whose design was never intended to foster coordination of care, evidence-based medicine, or disease-state management.

And here’s where the problem lies—physician and hospital “pay-for-performance” and quality improvement require collective negotiations with fee-for-service health plans in order to be suc-

cessful. Yet, antitrust laws generally prohibit otherwise competing physicians in independent practices from jointly negotiating contracts with the consumer’s most popular choice in health plans, fee-for-service PPOs. On this point, the principal antitrust enforcer in the healthcare arena, the Federal Trade Commission (FTC), has over the last several years shown itself very eager and successful in the prosecution of networks of independent physicians and hospitals that have engaged in contracting activities with PPOs.

In light of all this, the question then becomes: How can doctors (the vast majority of whom practice in small, independent businesses comprised of three to five physicians, with little technology infrastructure and even less capacity to perform quality improvement activities on their own) and hospitals (who face the deadly combination of dwindling reimbursement and high technology, staff, and capital costs) align with each other so that they can (1) distinguish themselves in the market on the basis of quality, (2) justify higher reimbursement, and (3) conduct collective negotiations with health plans?

The answer is *clinical integration*.

II. Clinical Integration and Antitrust

A concept developed by the FTC along with U.S. department of Justice (DOJ) in their 1996 Joint Statements of Anti-

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—from a declaration of the American Bar Association

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trust Enforcement Policy in Health Care (www.ftc.gov/reports/hlth3s.htm#8) (Joint Statements), clinical integration is described as the implementation by a group of independent physicians of:

an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

According to the Joint Statements, such integration affords a network of independent physicians the ability to have its collective negotiations escape *per se* illegal treatment by the FTC, and instead have its joint contracting evaluated according to the so-called “rule of reason”—a balancing test that considers the anticompetitive effects of the arrangement against its potential to achieve procompetitive efficiencies. Integral to this balancing test is the concept of ancillarity, i.e., a determination that the joint contracting is “reasonably necessary” to achieve the efficiencies promised by the joint conduct.

The first physician network to seek the FTC’s opinion on whether its clinical integration program afforded such rule-of-reason treatment was the Denver-based independent practice association (IPA), MedSouth. In a February 2002 advisory letter (www.ftc.gov/bc/adops/med-south.htm), the FTC staff concluded that MedSouth’s network of independent physicians could proceed in their plans to contract jointly with fee-for-service

payors under rule of reason treatment because the totality of its clinical integration program evidenced a real probability of improvements in clinical quality and efficiency.

Since that time, the FTC has steadily maintained this position relative to the necessary conditions for clinical integration in the many consent decrees it has reached with physician networks. Typically, these consent decrees contain the defined term, “qualified clinically-integrated joint arrangement,” to describe conduct that the FTC would not prohibit a physician network from pursuing:

an arrangement to provide physician services in which:
1. all physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, these physicians, in order to control costs and ensure the quality of services provided through the arrangement; and 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

To somewhat condense this legal framework, an analysis of any physician network’s clinical integration program is essentially a three-part test:

(1) whether the network’s clinical integration program is “real”—i.e., containing authentic initiatives actually under-

taken by the network, which involve all physicians in the network, and apply to the physicians’ practice patterns relative to patients who obtain health benefits under fee-for-service health plans;

- (2) whether the initiatives of the program are designed to achieve likely improvements in healthcare quality and efficiency; and
- (3) whether joint contracting with fee-for-service health plans is “reasonably necessary” to achieve the efficiencies of the clinical integration program.

III. Joint Contracts as a Strategy for Accelerating Quality

Surviving this legal analysis will prove very difficult for physician organizations interested only in collective negotiations as a way of extracting higher prices from health plans. Such physician groups will not likely withstand the inevitable antitrust scrutiny of an already-skeptical FTC and the hostility and even litigation of some health plans. But, for those doctors and hospitals willing to use joint contracting with PPOs as an integral part of an innovative program to accelerate the implementation of advanced clinical technologies, facilitate the adoption of evidence-based medicine, and generally reduce the underuse, overuse, and misuse of clinical resources, clinical integration ceases to simply be a matter of antitrust compliance and becomes instead a powerful business and clinical strategy. Such collaborations should allow doctors and hospitals to proceed in confidence that, with proper advice and implementation, their

efforts will not only satisfy FTC enforcers but will also leave them well-positioned to compete in their local market on the basis of providing high quality health-care, and not on the basis of unit cost alone.

To this end, it’s very clear that the establishment of a clinical integration program is not a project undertaken lightly by a network of physicians, whether among themselves or in collaboration with a hospital. What’s needed, ultimately, is a comprehensive program of inpatient and ambulatory quality improvement initiatives that provide measurable results, which are then used to evaluate physician performance, and which, in turn, result in concrete interventions toward remediation and improvement of that performance. In this regard, both existing patient safety and core measure initiatives undertaken by hospitals, as well as quality improvement activities conducted by physicians under capitated HMO arrangements, provide an excellent basis upon which to build a robust clinical integration program.

But all this requires strong leadership. From the board of directors and executives to “rank and file” physician membership, networks of independent doctors need to embrace and comprehend the goals for clinical integration. Hospital executives need to become aware of the real opportunities provided by a clinically integrated network of physicians to drive patient-safety improvements in a manner never attainable through the Byzantine politics of the voluntary medical staff.

IV. How Legal Counsel Can Help

In all of this, legal counsel can provide invaluable assistance. Attorneys armed with specialized knowledge of healthcare, managed care, and antitrust law can lend their expertise to the evaluation, development, implementation, and operation of clinically-integrated physician and hospital networks. These efforts include:

- *Clinical Integration Readiness Assessment*—the evaluation of existing infrastructure and programs to determine an organization’s preparedness to engage in clinical integration activities.
- *Network Contracting Risk Assessment*—the evaluation of past and current contracting activities to determine the antitrust risks, if any, posed by this conduct.
- *Clinical Integration Program Formation and Evaluation*—consultation and advice in the formation of clinical integration and pay-for-performance programs that satisfy prevailing legal and regulatory standards.
- *Proper Messenger Model Formation*—consultation and advice in the implementation of “messenger model” procedures that satisfy FTC guidelines.
- *Executive, Board of Directors, and Member Education*—presentations regarding the legal and business case for clinical integration for healthcare executives, physician and hospital network boards, and general physician membership.
- *Contracting and Transactional Support*—legal review and advice regarding contract

negotiations and language for clinically-integrated, fee-for-service arrangements.

- *Representation in Litigation*—aggressive legal defense in federal and state court actions, as well as private arbitration, brought by health plans seeking to attack or undermine the network’s clinical integration efforts.
- *Advisory Opinion Practice*—petitioning the FTC and DOJ to obtain regulatory advisory letters in connection with a physician or hospital network’s clinical integration program.
- *Government Investigation Practice*—vigorous representation and advocacy in response to FTC and DOJ inquiries into the contracting conduct of physician and hospital networks.

V. Conclusion

By fostering collaboration among independent doctors and hospitals in a way that both increases the quality and efficiency of patient care, the concept of clinical integration has expanded its usefulness to hospitals and networks of physicians well beyond that of mere antitrust compliance. True, it allows physician networks to assert themselves forthrightly in collective negotiations with PPO health plans. At the same time, however, clinical integration has become a powerful business and clinical strategy, providing hospitals and physicians with the ability to thrive in the advent of consumerism, pay-for-performance, and quality report cards.

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