PHOs still standing
By Mark Taylor
After entering into a consent decree with the Federal Trade Commission, Advocate Health Partners President Lee Sacks says his physician-hospital organization and its parent system are optimistic about the future of their program. ...

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PHO model endures
By Mark Taylor / February 20, 2007

The recent price-fixing settlement between the Federal Trade Commission and Advocate Health Care has breathed new life into physician-hospital organizations, or PHOs—a healthcare delivery business model some characterized as hanging onto life support only a few years ago.

While the FTC challenged the conduct of the system’s 2,900-physician PHO, Advocate Health Partners, for refusing to deal with insurers and other antitrust violations, Advocate and other PHOs found a silver lining in the FTC’s stated intention that it would not prohibit the organization from pursuing its clinical integration program.

That’s significant, healthcare attorneys say, because it’s the only time the agency has investigated a PHO and allowed a clinical integration model to go forward. The FTC’s action offers guidance to other health systems and PHOs and is viewed as supportive of clinical integration as a legal means for collective contracting.
PHOs have been rocked by changing market conditions, growing physician and payer clout and federal antitrust investigations in recent years. And though they have seen the percentage of hospitals with such organizations shrink by one-third since the mid-'90s, industry observers say obituaries may be premature.

They say the vertical model that marries physician and hospital services into one care-delivery organization still has some legs left and may see a revival.

Despite annual American Hospital Association surveys reporting that the percentage of hospitals with PHOs dropped from 32% of all hospitals in 1995 to less than 23% in 2005, some existing PHOs continue to do well and serve their hospital and physician members, employers and payers. And recent government and private-payer incentives to encourage joint quality initiatives and rapid adoption of healthcare technology seem to be resuscitating the model, says a healthcare attorney who has advised more than 100 PHOs.

The AHA reported 1,710 hospitals with open- or closed-model PHOs in 1995 from a total of 5,194 hospitals that year. That figure dropped 32% to 1,165 by 2001 and another 14.2% to 1,000 by 2005.

Theoretically speaking
In theory, PHOs should lower prices while improving quality by aligning incentives of hospitals and physicians. But in reality many failed to achieve those goals and were forced to dissolve because of poor management, undercapitalization and evolving insurance markets and care-delivery systems, healthcare attorneys say.

Chicago healthcare attorney John Marren of the firm Hogan Marren, says the FTC-Advocate settlement has exerted a positive impact on the formation of other PHOs. “Advocate outlines the footprint for what the FTC will allow,” Marren explains. “This is the first time the FTC has looked at an existing clinical integration program that collectively contracts with payers and allowed it to proceed.”

In its nine-page complaint filed and settled on Dec. 29, 2006, the FTC alleged that Oak Brook, Ill.-based Advocate unreasonably restrained competition and caused prices to increase for physician services in the Chicago-area market between 1995 and 2004, in violation of Section 5 of the FTC Act, which prohibits unfair methods of competition. However, while the FTC did not approve or bless Advocate’s clinical integration program, the agency did say it would not challenge its clinical integration model, which it called “the program.”

Marren acknowledges that the FTC was not pleased by Advocate’s past use of the so-called “messenger model” of negotiating on behalf of its physicians. “But Advocate abandoned that four years ago,” he points out.

Robert Leibenluft, a former FTC official who is now a healthcare antitrust attorney with the Washington law firm Hogan & Hartson, says the FTC scrutinized Advocate’s program very carefully in the past four years.

“The FTC has not approved the program, but allowed it to proceed, and said they would not challenge it in the consent decree,” Leibenluft says. “That is a recognition that the
program has some potential and that the FTC didn’t want to stop it from moving forward. It shows some hope that if you do it right, you can pass scrutiny and continue.”

He says the FTC decision “gives some PHOs comfort that they (FTC commissioners) have allowed Advocate to operate and negotiate on behalf of its doctors, not withstanding the conduct it alleged took place before.”

Advocate Health Partners President Lee Sacks, M.D., says the PHO and its parent system are optimistic about the future of their program.

“It’s a relief after four years to have this behind us,” Sacks says. “And it’s heartening to have the FTC acknowledge that the clinical integration program creates value and that we can continue to use it.”

Strategically in the long term, Sacks says the consent decree allows Advocate “to continue to do things that made Advocate Health Partners a success.”

He says the consent decree’s three-year reporting requirements “are much less onerous than what we’ve seen in other consent decrees. They restrict nothing that we’ve been doing. This is not going to change the course of business for us. We can do capitated contracts and clinical integration contracts.”

He says the decree requires Advocate to send notices to all physicians and health plans it contracts with and update Advocate’s boards, and report them to the FTC for three years. He says the PHO has not yet calculated the cost of the logistics, printing, documentation and receipts it must submit to the FTC’s compliance bureau. “But it’s manageable.”

Sacks says the FTC settlement encourages other PHOs and independent practice associations to proceed. “We’ve been contacted by a number of organizations doing what they think is clinical integration,” he says. “The PHO model is going to exist in certain settings. It takes a unique combination of the ability of doctors to partner with hospitals, and good management and governance. There is a place outside of capitation for this model to work and this consent decree further enforces that.”

He says the model still offers strong collaborative opportunities.

“I’m not surprised new ones are forming,” Sacks says.

Advocate Health Partners was founded 12 years ago by physicians employed or affiliated with Illinois’ biggest health system, eight-hospital Advocate. “I’ve always felt that organized medical groups can deliver the best care in the country,” Sacks says. “And with hospital partners offering support, technology and infrastructure, you can do some really dramatic things. My guess is that’s why others are pursuing this as well.”

Advocate’s PHO, which includes nearly 2,900 of the not-for-profit system’s 5,000 staff physicians, grew to cover 400,000 capitated lives at one time. “The capitation business has shrunk to about 320,000 patients,” Sacks says. “But in the last few years, we created a clinical integration program designed to enhance the value of care that our PHO doctors deliver to PPO-type benefit plans. We’re serving about 720,000 PPO patients.”
Sacks says Advocate’s administrative functions have evolved as well, employing the latest technologies and applying the fiscal discipline of external auditors, “a discipline most PHOs never had.”

He says Advocate’s plan has succeeded through strong governance and leadership.

However, that didn't stop the FTC from launching an investigation into the PHO in October 2003, part of a wide-ranging federal probe into physician price-fixing arrangements involving IPAs and PHOs.

He says all PHOs are different, but sees common themes in the successes and failures. A lack of professional management plagued many. The administration of some PHOs was assigned to hospital executives working part time, dooming them to failure. “This business requires a unique skill set,” Sacks observes.

He says Advocate’s strategy has been proactive. In 1999, the system—knowing it could no longer depend on HMO capitation and with fewer payers in the marketplace -- sought new purposes for its PHO. “We had to learn how to create value based on what we learned. As other PHOs hit their financial days of reckoning and spent tomorrow’s dollars to pay today’s claims, our organization positioned itself to maintain infrastructure to achieve greater efficiencies, add technology and provide better levels of service to physicians and patients and payers.”

Not everyone endorsed Advocate’s strategy. In addition to the FTC inquiry, UnitedHealthcare of Illinois objected, taking both parties to a contractually mandated arbitration. Advocate eventually triumphed in the adjudication. “The unanimous arbitration victory was a pretty external validation of our clinical integration program,” he says.

Sacks says the financial goal of the PHO is to distribute all of its revenue back to the partners. “We’re not accumulating capital, except for short-term needs. The fact that there is no (financial) deficit differentiates us from other PHOs.”

**Renewed interest***

Attorney Marren says he's already seeing renewed interest in the model. “I’m working full-time creating PHOs,” he says. PHOs were formed pursuant to the federal HMO Act of 1973 to allow doctors to manage for capitation contracting. Hospitals sought to keep their physicians working together and sometimes shared financial risk. When HMOs began facing lawsuits from patients and physicians starting in the late ’90s and capitation contracting declined, patients and employers clamored for greater choice, and public sentiment turned against many HMOs, Marren says. Many of the PHOs that contracted with HMOs also dwindled.

Marren says the smart survivors moved toward applying HMO techniques to PPOs. “They began repurposing themselves. But physicians who want to collectively negotiate must clinically integrate,” Marren says. “Some PHOs got in trouble because they didn’t. Some who were investigated rebounded and vowed to continue to be in this business.”

Marren says recent federal initiatives designed to improve healthcare quality and reduce patient errors, such as the CMS’ pay-for-performance and gain-sharing programs, and health plan report cards, are ideally suited for PHOs.
“PHOs become logical vehicles for managing care and reducing variances through clinical integration, and they can do that both on the inpatient and outpatient side,” he says. “It’s kind of weird, like the dinosaurs from that old ‘Far Side’ cartoon screaming out that the Ice Age is coming. The hospitals have seen capitation going away, and now they want to work with the docs again.”

He says many of the PHOs that failed never cultivated the physician or hospital leadership they needed, or failed to commit to work together for a common cause. Marren says well-led and legally structured PHOs in the right markets have prospered even as many others have failed.

But Marren cautions his clients to proceed carefully before trumpeting reformed or new PHO models. “It’s very difficult getting a formal opinion from the FTC on these models, and the market moves faster than the FTC. If you wait two years, the market passes you by. They (the FTC) are in an unenviable position. They must sort out the differences between someone fixing prices and someone clinically integrated, and that’s very labor-intensive. Because this can be a high-risk business, it’s still a little too early for them to come out of the closet.”

Still, he says the pace of PHO activity has accelerated since the Advocate settlement. “PHOs aren’t dying out; they’re increasing.”

Robert Jenkins, chief executive officer of the Managed Care Information Center, a research and publishing company tracking PHOs and IPAs, agrees, though he concedes the actual increase may not yet be reflected in numbers. Jenkins says many PHOs ended in bankruptcies or dissolutions, with many experts blaming some of the model’s decline on heightened federal antitrust scrutiny.

Jenkins says some of the recent decrease in PHO numbers may be attributable to PHO mergers. However, there are many signs of life here. “Where there has been good leadership, IPAs and PHOs are doing some impressive things and taking the lead role in the connectivity of regional healthcare organizations. Things are starting to turn around,” he says. “When PHOs have thrown in the towel it’s because they lacked the vision of what could be done.”

He cites new PHOs forming in Maine undertaking disease management and outcomes for depression and another in Vermont attacking chronic conditions there. And he says IPAs in New York are establishing regional healthcare information organizations and cites a Texas PHO that is reviewing reimbursements from payers for its physician members.

“I think they’ll be around for a while,” he predicts.

In 1996, the U.S. Justice Department’s Antitrust Division and the FTC issued guidelines to encourage the formation of more physician networks and joint ventures, including IPAs and PHOs to increase competition in the marketplace and to make it easier for doctors to compete and contract with HMOs. Those agencies revised their policies to allow physicians to agree on prices without financially integrating their practices if those
arrangements were likely to benefit consumers.

As the model grew in popularity, complaints from payers and employers about escalating charges, anti-competitive negotiating tactics and price-fixing arrangements rose as well. Starting in 2001, when former FTC Chairman Timothy Muris targeted physician price-fixing arrangements, the FTC went after IPAs and PHOs in earnest. The Antitrust Division also weighed in, settling with Mountain Health Care, a PHO in Asheville, N.C., which agreed to dissolve. Those enforcement initiatives, along with other factors, curtailed the growth of a model that once boasted its own national trade group, the now-defunct American Association of Physician Hospital Organizations.

Federal antitrust regulators settled with at least 10 PHOs and 23 IPAs in the past six years. Ellen Pryga, director of the AHA’s policy development group, says regulatory limits on how hospitals and physicians could jointly contract curbed the growth of all four physician organization models: IPAs, PHOs, management-service organizations and group practices without walls. “And if they couldn’t jointly negotiate, it made it difficult to align their interests in dealing with clinical integration and delivery issues,” Pryga says.

But John Miles, a healthcare antitrust attorney with the Washington office of Ober, Kaler, Grimes & Shriver, says critics can't blame regulators alone for PHOs' troubles and gradual decline.

“Some are in the process of reformulating themselves,” says Miles, who has represented several PHOs and IPAs in FTC investigations. “They’re trying to figure out what to do with the demise of risk contracting. Both face the same antitrust issue of price-fixing, and some are wondering how to cope. They face five choices.”

'Messenger model'
Miles says PHOs can go out of business; unlawfully negotiate fee-for-service contracts and risk facing antitrust actions; or pursue legal alternatives, including developing approved clinical and financial integration models or following the ‘messenger model’ of third-party contract negotiations.

“It’s too early to tell whether the prospects are bright for those PHOs that have settled with the government,” Miles says. “The ones I’m working with are most interested in developing clinical integration models. The FTC has been listening amicably, but is skeptical. I think they (FTC staff members) believe clinical integration is possible, but their initial reaction is that this is just another way to get around its per se ban on price-fixing agreements.”

Miles says some of the PHOs have requests before the FTC for advisory opinions that would bless their models, but says the PHOs are not ready to publicize them yet.

In addition to the government scrutiny and payer reluctance to broadly contract with provider networks, Miles says PHOs typically involve political issues and reflect the underlying tensions between hospitals and their medical staffs. “There often is a deep distrust between them and the feeling (is) that one side is trying to screw the other. To varying degrees, this is prevalent because it is an inherent tension that always has to be worked out.”
FTC Chairman Deborah Platt Majoras says the commission “doesn’t seek to channel market participants into particular types of arrangements, and it has neither promoted nor discouraged the formation of PHOs.” Majoras says PHOs can raise antitrust issues, particularly because they typically involve competing healthcare providers.

“Like other organizations of competitors, PHOs may offer the potential for enhancing efficiency and promoting competition, but may also be used as vehicles for unlawful joint pricing or other competitive restraints among PHO participants. There are no special antitrust rules for PHOs. Traditional antitrust principles apply to the analysis of both the formation and the conduct of a PHO.”

Brad Buxton, senior vice president of healthcare management for Blue Cross and Blue Shield of Illinois, says that despite the decreased numbers, “We have many PHOs that are doing just fine. They not only take risk well, but have adapted to changing market conditions. Those that didn’t survive did not take risk well, were undercapitalized and/or poorly managed. For some it came down to expense management,” Buxton says.

Beverly Sepulveda, president of the healthcare consulting company SynerImages, credits government and industry efforts to integrate technology into healthcare for driving the revival of PHOs. “Even more than capitalizing on pay-for-performance incentives, PHOs have been pulling together to create electronic medical records. People want to share healthcare information in local repositories.”

Sepulveda says some rural PHOs are thriving because they’ve followed the letter of antitrust law, which allows a “messenger model”—a legally approved method of transmitting contract payment offers between payers and providers that does not involve collectively negotiating contracts. “Some of those that went by the wayside were really formed to act as one voice with payers and didn’t have a really good business plan,” she says. “Healthcare IT costs are driving a lot of this renewed movement. Electronic medical records may be the No. 1 factor here in Texas.”

One rural PHO in Texas says the messenger model works in that state. Karin Zieleck, the executive director of the Brazosport Health Alliance, a single-hospital, 90-physician PHO operated through 156-bed Brazosport Memorial Hospital in Lake Jackson, Texas, says the 15-year-old PHO was formed in anticipation of managed care coming to rural Texas. Brazosport, located 50 miles south of Houston, was never offered capitated contracts with payers.

“We had several large industrial clients who suggested we needed to have a PHO to work with managed-care companies for their clients and members. Sole proprietorships are the biggest physician practice model here, and it didn’t make a lot of sense for each (doctor) to hire his own lawyer to deal with payers, and most lack the financial resources to purchase electronic medical records. As a PHO we can work together to improve quality through integration.”

Zieleck says the PHO is not a revenue-producing organization but is judged on how well it serves its constituencies -- the hospital, physicians and managed-care organizations with whom it contracts.
She says the coming of regional healthcare information organizations have reinvigorated PHOs.

Toby Singer, a healthcare antitrust attorney with Jones Day in Washington, says that doctors are embracing the PHO model again because of the infrastructure hospitals can offer, such as computers and access to capital.

Singer and other healthcare attorneys representing PHOs that have either settled with federal antitrust authorities or are seeking FTC approval for PHO clinical integration arrangements say their clients would not comment on specifics or discuss the process.

The prospects for PHOs seeking government blessing of clinical integration arrangements weren’t brightened by the FTC’s rejection in March 2006 of a proposed model submitted by the Suburban Health Organization, a so-called “super-PHO” based in Indianapolis that includes seven smaller PHOs and 192 primary-care physicians employed by Suburban Health’s eight hospital members.

In that 19-page advisory opinion, the FTC staff conceded that proposed practice parameters, physician monitoring and disease-management practices had the potential to improve care and create efficiencies, but said the integration and efficiency benefits “appear to be significantly limited.” The agency concluded that the proposed model’s joint contracting provisions would likely restrain trade, violate antitrust laws prohibiting price-fixing and would be unnecessary to achieve the efficiencies.