REVIVAL OF THE FITTEST

PHOs have dropped in number, but many are still going strong despite antitrust scrutiny—and there's even renewed interest

Don't classify them with the dinosaurs just yet.

Industry observers caution that while one reportedly endangered species—physician-hospital organizations—has been rocked by changing market conditions, growing physician and payer distrust and federal antitrust investigations, and has seen the percentage of hospitals with such organizations shrink by one-third since the mid-90s, an obituary for PHOs may be premature.

Industry experts say the vertical model that marries physician and hospital services into one care-delivery organization still has some legs left. Despite annual American Hospital Association surveys reporting that the percentage of hospitals with PHOs dropped from 32% in 1995 to less than 23% in 2004, some existing PHOs continue to do well and serve their members, employers and payers. And recent government and private-payer incentives to encourage joint quality initiatives and rapidly adopt healthcare technology may even breathe new life into the model, says a healthcare attorney who has advised more than 100 PHOs.

In theory, PHOs should lower prices while improving quality by aligning incentives. 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. The National Directory of Physician Organizations produced by the Managed Care Information Center, a research and publishing company, reported 676 PHOs in 1998, a figure that peaked at just under 1,000 in 2000 and declined to 670 this year. Many PHOs ended in bankruptcies or dissolutions, with many experts blaming some of the model's decline on heightened federal antitrust scrutiny.

However, Chicago healthcare attorney John Marren of the law firm Hogan Marren says he's working full-time creating PHOs. "We've seen a revival of interest," Marren says.

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. Many of the PHOs that contracted with them 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."

Help from the quality movement

Marren says recent federal initiatives designed to improve healthcare quality and reduce patient errors, such as pay-for-performance and gain-sharing, 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

Brazosport Memorial Hospital, a rural facility in Lake Jackson, Texas, has been been part of a physician-hospital organization for the past 15 years.
kind of weird, like the dinosaurs from that old ‘Far Side’ cartoon screaming out that the Ice Age is coming. The hospitals have seen capitulation 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. Marron says well-led and legally structured PHOs in the right markets have prospered even as many others have failed.

But Marron 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 a labor-intensive process. Because this can be a high-risk business, it’s still a little too early for them to come out of the closet.”

**Attracted to collaboration**

An executive with a suburban Chicago PHO agreed the model still offers strong collaborative opportunities.

“I’m not surprised new ones are forming,” says Lee Sacks, president of Oak Brook, Ill.-based Advocate Health Partners, a PHO that never went away. Advocate Health Partners was founded 11 years ago by physicians employed or affiliated with Illinois’ biggest system, eight-hospital Advocate Health Care, also headquartered in Oak Brook. “I’ve always felt that organized medical groups can deliver the best care in the country. 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 2,700 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 729,000 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. 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 independent practice associations and PHOs.

He says all PHOs are different, but there are some common themes in the successes and failures he’s seen. He says a lack of professional management plagued many. The administration of some PHOs was assigned to hospital executives working part time, dosing those to failure. “This business requires a unique skill set,” Sacks says.

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 endorses Advocate’s strategy. In addition to the FTC inquiry, United Healthcare of Illinois objected, taking both parties to a contractually mandated arbitration. Advocate eventually triumphed in the adjudication, but the FTC inquiry is pending, and Sacks says he hasn’t heard from FTC investigators. “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.”

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 independent practice associations and PHOs, to increase competition in the marketplace and 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, anticompetitive negotiating tactics and price-fixing arrangements rose as well. Starting in 2001, when former FTC Chairman Timothy Muris targeted physician price-fixing arrange-

ments, 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.

Antitrust regulators settled with at least nine PHOs and more than 20 IPAs in the past five years.

Ellen Praga, 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,” Praga says.

But John Miles, a healthcare antitrust attorney with the Washington office of Ober Kaler, 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.”

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 “mesher 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 acridly, 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 medi-
ical 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 told Modern Healthcare that 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" (See profile of Majoras, p. 28).

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.

For a while the bloom was off the rose on the collaborative model, agrees Robert Jenkins, chief executive officer of the Managed Care Information Center. "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 health care organizations."

Beverly Sepulveda, president of the healthcare consulting company SynerImages, credited 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 proprietors 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 either have 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 of a proposed model submitted by Suburban Health Organization, a so-called "super PHO" based in Indianapolis that includes seven smaller PHOs and 192 primary-care doctors 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." They 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."