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Quality Networks and Clinical Integration - Today's New Payment Models

Two recent conferences held in Washington, DC, highlighted the difficult issues that must be addressed in order to create a healthcare reimbursement system predicated on meeting quality measures. Medicare's Value-Based Purchasing initiative is an example of a quality based payment system. We have discussed clinical integration and quality of care payment initiatives in prior HIO editions (see <http://www.strasburger.com/p4p/index.asp>).

Federal Trade Commission Conference

The Federal Trade Commission ("FTC") sponsored a workshop on May 29, 2008, entitled *Clinical Integration in Healthcare: A Check Up*. This workshop focused on the creation of financially integrated physician/hospital organizations that permit joint pricing by competing physicians. A webcast of the workshop may be viewed on the FTC's website (http://htc-01.media.globix.net/COMP008760MOD1/ftc_web/FTCindex.html#May29b_08).

The FTC has also included written transcripts of the May 29th workshop on its website.

The FTC conference brought together presenters from the various stakeholder organizations to exchange information about the difficulties related to establishing clinically integrated organizations. In addition to key FTC representatives (including the Chairman of the FTC), presentations were given by representatives of the U.S. Department of Health & Human Services, the Medicare Payment Advisory Commission ("MedPAC"), academic institutions, healthcare providers, and healthcare payors. The FTC staff provided a review of clinical integration guidance previously published by the FTC in the form of the Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care

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("Statements") and a joint report issued in 2004 entitled "Improving Health Care: A Dose of Competition." The FTC staff also provided insights into the FTC's mindset regarding Advisory Opinions related to clinical integration such as the *MedSouth* (2002) and *Suburban Health* (2006) Advisory Opinions (www.ftc.gov/bc/healthcare/industryguide/advisory.htm).

The health industry has repeatedly called for more clarity from the FTC concerning how much "integration" is necessary in order for competing physicians to jointly price their services. The FTC's staff believes that the guidance given in the Statements and Advisory Opinions has been sufficient. In fact, the staff stated that they could not think of anything else that the FTC could issue to further expand its prior discussions of clinical integration. The FTC staff expressed willingness to provide additional guidance, but their position makes clear that the bulk of the innovation lies with those who want to take advantage of the clinical integration model.

Mark Miller of MedPAC presented an overview of the congressional support agency's findings concerning the existing Medicare reimbursement system. Mr. Miller stressed MedPAC's view that there is an urgency to create a value-based purchasing scheme. MedPAC projects that the Medicare Hospital Trust Fund will be bankrupt in 2019 without serious changes to the system. The more immediate concern is that, as of today, Medicare is paying out more than it is taking in.

MedPAC is advocating that Congress consider three different measures to **begin** to remedy the shortfall - gainsharing, reduction of payments to providers with high-risk adjusted readmission rates, and the use of "bundled payments." The gainsharing suggestion comes out of MedPAC's study of Specialty Hospitals and will be the subject of another HIO article. The reduction in payments for readmission falls in line with Medicare's eliminating payments for "Never Events" and poor quality care. Bundled payments relates to payments to physicians and other healthcare providers on a joint basis that relate to a patient's overall episode of care.

The Centers for Medicare & Medicaid Services ("CMS") recently announced a new demonstration project - the Medicare Acute Care Episode (ACE) Demonstration Project - that will "provide global payments for acute care episodes within Medicare fee-for-service (FFS)." The ACE demonstration is directed toward select orthopedic and cardiovascular inpatient procedures. The goal is to incent collaboration between surgeons and hospitals in the care of

certain high cost procedures. The ACE demonstration project is another brick in CMS's development of value-based purchasing initiatives.

The FTC conference provided several lessons that physicians and providers should heed. The most important of these is that the FTC will continue to pursue price-fixing investigations of competing physicians who seek to jointly price their services. The recent U.S. Fifth Circuit Court of Appeals decision upholding the FTC's determination of price-fixing in the recent *North Texas* decision has only provided encouragement to the FTC. See *North Texas Specialty Physicians v. Federal Trade Comm'n*, No. 06-60023 (5th Cir. May 14, 2008).

The second lesson is that clinical integration is not a passing fad. However, physicians who seek to integrate clinically should do so for the right reasons. Clinical integration programs are expensive. No benefit arises from establishing physician networks that use poorly designed clinical integration programs. The FTC has provided what it believes is adequate guidance for the creation of clinical integration models, and no "one size fits all" program exists.

Joint negotiation by competitors must be ancillary to clinical integration and not vice versa. Negotiations on a joint basis must come after the network is clinically integrated.

Because of the difficulty in creating a program, some physicians will not want to participate and will walk away from the project. Successful clinical integration programs will require substantial work by the physicians who seek to establish them. There is a significant lead time required for the development of a clinical integration model.

The alternatives to clinically integrated networks involve the use of the inefficient messenger model. Ultimately, the integration of the healthcare system will require that physicians and health care providers learn to collaborate. Collaboration is not accomplished through the messenger model, and the model will soon cease to be useful. Doing what is familiar may provide comfort to physicians. That being said, the integration of our healthcare system will require physicians and providers to undertake some activities that are neither familiar nor comfortable. Some will experience the pains associated with being an early adopter of any new payment methodology. Others will experience the even greater pains of those who fall behind the curve and attempt to catch up after the fact. The key is to use the wealth of available information to master the new clinically-based payment systems.

Health Information Technology and its Future: More Than the Money Conference

The Alliance for Health Reform and the Robert Wood Johnson Foundation sponsored a conference on June 20, 2008 that focused on health information technology ("HIT"). This conference focused on the use of HIT as a quality and efficiency tool. Director Peter Orszag of the Congressional Budget Office ("CBO") outlined the negative ways in which the high costs of healthcare are impacting both the overall economy and the Medicare program. Director Orszag opined that HIT was not going to be a "magic cure" that would increase healthcare effectiveness and efficiency, but that improvements could only be accomplished with general adoption of HIT. Congress is clearly focused on the Medicare value-based purchasing initiative, and the financing of HIT is one of the challenges that the CBO is attempting to address under this initiative. The materials presented in the HIT conference may be accessed at:

http://www.allhealth.org/briefing_detail.asp?bi=131.

Clinical integration and the implementation of HIT to support the development of quality-based payment programs are only two (albeit, substantial) elements of a value based purchasing program. These two conferences demonstrate that the road to a meaningful value based purchasing program will be incremental and that substantial complexity is involved when assembling the clinical, regulatory and organizational components of a value based program. While the process is daunting, it should not be ignored. The Medicare payment program will soon be driven by value-based purchasing. Physician groups will be hard pressed to compete if they have not embraced the clinical integration model.

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