An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and cooperation to control costs and ensure quality.
THE RELEVANT ANTITRUST LAWS

– Section 1 of the Sherman Act (15 U.S.C. § 1)
– Section 5 of the FTC Act (15 U.S.C. § 45(a)(1))

Both statutes prohibit agreements among private, competing businesses, such as physician practice groups or hospital systems, that unreasonably restrain competition.

– Only the FTC may enforce the FTC Act
– DOJ, state AG and private parties may bring suit under Section 1
Competitor-controlled contracting organizations

– E.g., independent practice associations, physician organizations, physician-hospital organizations, clinically integrated networks and accountable care organizations

– Acts and understandings in these competitor-controlled contracting organizations, such as committee recommendations and Board resolutions, are agreements among the competing providers that can violate Sherman Act Section 1 and Section 5 of the FTC Act

  – Doesn’t matter whether competing providers own the organization, only that they have control and make decisions that affect all participants
Agreements among competitors, such as those in competitor-controlled contracting organizations, on the prices of their individual services are generally per se, or automatically, illegal

UNLESS the providers are sufficiently financially or clinically integrated

AND the price agreement is ancillary, or reasonably related, to the achievement of procompetitive benefits (e.g., higher quality and reduced or contained costs)

THEN the competitive restraint will be analyzed under the more lenient Rule of Reason, which is a balancing test

AND the joint negotiations will only be illegal IF, on balance, the harm to consumers and competition outweighs the procompetitive benefits.

November 5, 2013
NATIONAL ACCOUNTABLE CARE CONFERENCE
Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program ("The Antitrust Policy Statement")

– Joint statement of the Federal Trade Commission (FTC) and the Department of Justice Antitrust Division (DOJ)

– 76 FR 67026, published on October 28, 2011


Must be read in conjunction with the CMS MSSP final rule

The antitrust agencies assume that ACOs that (1) meet CMS’s eligibility criteria and (2) are approved for the MSSP meet the indicia of clinical integration set forth in the Statements of Antitrust Enforcement Policy in Health Care (1996)
COMMON CHARACTERISTICS OF CLINICAL INTEGRATION

— Selection of high quality physicians
— Investment in the program and entity (financial and “sweat equity”)
— Declared commitment to clinical integration by participants
— Appropriate use of information technology
  — Collaboration in the care of patients
  — Quality- and cost-improvement initiatives
  — Electronic data collection/dissemination
— Accountability and interdependence
— Benefits to payors and focus on patients
The FTC and DOJ support many clinical integration models, but without a robust IT platform and program, it will be difficult to achieve true clinical integration.

- "When used to its fullest potential, a robust HIT system can serve as a hub for effective coordination-of-care efforts"
  - Reduce medical errors
  - Reduce duplicative testing
  - Increase transparency regarding comparative quality
  - Make patient health records portable
  - Data-driven UM and outcome measurement
  - Reduce fragmentation and foster interdependence
Electronic Health Records (EHR) with Clinical Decision Support Systems (CDSS)

– Making possible management of data, particularly meeting process and outcomes measures, and quality reporting

Interoperability with respect to all departments in hospitals and ambulatory settings, making patient-centered healthcare possible, along with cross-collaborative team care, particularly for chronic conditions
An mHealth platform that facilitates entry of data and review of analytics

Social medial health sites which provide support groups and other healthcare management through a patient-centered model
   – Patient networks sharing data, particularly clinical data
   – Can facilitate outcomes research

Robust telehealth/telemedicine capabilities
Ability to use Evidence-Based Medicine (EBM) and data analytics to determine whether a treatment is 100% effective for 80% of the people and not effective at all for the other 20%

For which patients is a treatment effective?

Work toward designer treatments specific to as little as one individual

Personalized treatment plans
The KEY is interoperability

Are the systems interoperable?
– not just within a hospital or system
– or including the physician and/or ambulatory component
– but wherever a patient seeks care
– mHealth can facilitate this happening
Do the interfaces really work?

Can you access the data you need to provide better quality care?
– Can a quality nurse access the data he or she needs to track and monitor data to influence quality?

EHR needs to be in a format that you can access the data you need
Increasingly, CMIOs and Chios are working with big data, informatics, and analytics for quality purposes

Other healthcare executive management has traditionally not played much of a role in this regard, and particularly from a financial perspective

It is important for other healthcare executives to see the link between quality, cost-effectiveness and better financial performance

There needs to be a cultural shift
To do so, ACOs need to align incentives, generate useful data, break down silos, and ensure that all parts of the ACO are working together

- ACOs can best accomplish all of this with robust databases and ability to query those databases
- Pay for quality and effective treatment

Personalized Treatment Algorithms (How Data Science is Transforming Healthcare, by T. O’Reilly, et al.)
IT is the backbone of clinical integration

It provides the basis for obtaining and mining the data to meet the clinical integrators

The ability to mine data and query data bases can improve quality and cost-effectiveness

Target certain issues, problems, e.g. hospital acquired infections
Personal fitness devices
– monitor HbA1c, blood pressure, etc.

Monitoring of chronic conditions through telehealth
Traditional Health IT

Consumer Driven IT/Personal Devices
What are the system’s goals?
– Integrating existing providers
– Data exchange with clinical partners
– Data exchange with payors
– Data exchange with patients
– Accumulating data
– Developing metrics/benchmarking

**POPULATION HEALTH STRATEGY?**
ORGANIZATIONAL APPROACH TO ADDRESSING IT

EMR
CPOE
Patient Portal
Telemedicine
Disease Registries
HIE
Analytics
Reports
INTEGRATING INTERNAL PROVIDER PROCESSES WITH PATIENT EXPERIENCE

Patient Data
Provider Data
Payor Data

Disease Registries
Predictive Modeling
Clinical Guidelines

Care Management

Patient Identification
Patient Needs Assessment
Care Plan Development
Care Plan Implementation
Care Plan Monitoring

NATIONAL ACCOUNTABLE CARE CONFERENCE
November 5, 2013
The “Intensivist” Model

Health system pulls chronically ill/frequent utilizers out of its medical home model and assigns them to an “intensivist” clinic.

Clinic has team of dedicated physicians, nurses and care coordinators assigned to these patients.

Patients actively monitored via in-person visits, phone calls, email, personal feedback devices (e.g., scales, heart monitors).

Care managers actively monitor medication fill rate and compliance.

RESULT: Significant drops in ED visits, inpatient admissions and overall cost of care.
The “Co-Location” Model

Health system co-locates primary care and certain specialist providers in a common building, focused around specific health conditions

Chronic patients schedule extended visits and see multiple providers in one visit rather than separate, individual specialist appointments

As part of the visit, the patient’s “care team” meets together and discusses integrated care/maintenance strategies with the patient

In between scheduled visits, providers have case conferences to monitor progress coupled with phone and home monitoring

RESULT: Significant drops in ED visits, inpatient admissions and overall cost of care
**Advanced EMR Use**

Large physician practice with multiple locations on a common EMR

Combines clinical information from its EMR with analysis of claims data from its largest payor

– Analyze patterns of care, allowing evaluation of performance of PCPs and contracted specialists

– Specialists who are outliers in care patterns must conform or be terminated

– Assignment of patient referrals from PCPs to specialist with highest match of experience and skill based on patient’s data – identity-blind to PCPs
Support for clinical integration

– Furthers a contracting/payment strategy
– Furthers an alignment/networking/market share strategy
– Furthers a legal compliance strategy

Reducing cost of care

– Solutions to reduce medication errors/safety/infections
– Solutions to reduce unnecessary utilization – volume & type of care
– Solutions to support population health
Improving quality
– Solutions to benchmark, track and report outcomes
– Unobtrusive patient monitoring/apps incentivizing behavior
Improving patient experience
– Solutions for online registration/scheduling
– Solutions for smartphone maps/navigations
– Solutions for online payment/account management
– Online test and lab results, post-discharge instructions
– Email scheduling & follow-up
– Secure messaging
– On-line price estimates