The IPA Association of America

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September 19, 2003

Timothy Muris, JD
Chairman
Federal Trade Commission
600 Pennsylvania Ave.
Washington, DC 20580

RE: Joint FTC/DOJ Hearings on Healthcare and Competition Law and Policy

Dear Mr. Muris:

September 25, 2003, Morning Session:
The Physicians IPAs: Patterns and Benefits of Integration

On behalf of the more than 2000 Independent/Integrated Physicians Associations (IPAs) in the United States, representing three-fourths of the practicing physicians in America, I would like to commend the Commission for its efforts to provide detailed guidelines to physician organizations on the degree of clinical and financial integration necessary for them to bargain with payors as a group. I am encouraged that the Commission has created a venue by which open and meaningful discussions can take place on the implication of the FTC's growing emphasis on healthcare as it relates to clinical and financial integration and for your colleagues to hear about the potential impact of the Commission's efforts on patient care. I am eagerly anticipating that the Commission will further provide definition and guidelines on what is the required degree of clinical and financial integration from the Commission's point of view, and how physician organizations can effectively operate within the confines of those guidelines.

TIPAAA recognizes the importance of the 1996 Statements of Enforcement Policy that outline the framework for physician organizations negotiating economic contracts as a joint entity. TIPAAA's legal committee provided a great deal of input to the FTC on these issues as they related to community practice. TIPAAA was very encouraged to have had the opportunity to work with the FTC in developing the revised guidelines. We were also pleased to have had the opportunity to play a role in educating the physician community about the guidelines. In the later part of 1996 and early part of 1997, TIPAAA, in conjunction with the FTC and the Department of Justice, conducted

approximately 24 four-hour educational programs around the U.S. informing physician organizations of the 1996 Statements as they related to messenger-model IPAs.

TIPAAA realizes that the 1996 Statements were a major step in enhancing the concept of shared contracting and we are pleased to have had the chance to work with the FTC in clarifying the framework for physician group operations under what is now called the messenger model. At this point however, we are very concerned that the lack of clear, concise and definitive direction to physician organizations on what is permitted under the messenger model for non-integrated IPAs as well as the related question of the degree of shared clinical and financial information necessary to achieve 'integration,' is significantly interfering with the ability of physician groups ability to effectively deliver quality care to our communities. We are currently aware of several IPAs who have slowed down or halted their efforts to negotiate on behalf of physicians because of the lack of clarity in the implementation of your current guidelines. Left unresolved, this will lead to further problems for physicians to remain in practice that will result in access issues in many communities.

The historical role of the IPA has been one of ensuring that the healthcare needs of our communities are met in a cost-effective manner, while delivering quality care. The IPA has proven that it is a structure that reduces duplication and rewards quality of care. The structure of an IPA that bears financial risk is one that requires it to establish overall clinical protocols and to insist that its provider members adhere to these protocols. It is important to recognize that there is a growing national consensus around evidence-based guidelines that have begun to establish a common set of protocols or clinical guidelines. These protocols or guidelines are not unique to HMO patients. They are the clinical guidelines for all patients served by a physician regardless of their payment source. It is not functionally feasible for an IPA to have its provider members operating under two distinct sets of protocols or guidelines that are unique to an individual insurer/payor. The FTC should consider allowing flexibility in the acceptance of common evidence-based guidelines to help simplify the clinical management task of physicians, and acknowledge that adoption and adherence to evidence based guidelines is clinical integration. IPAs have historically implemented active and ongoing programs aimed at evaluating and modifying participating physicians' practice patterns to create a high degree of interdependence and cooperation among the physicians, resulting in cost controls and quality enhancement outcomes. Those IPAs who adopt these programs should be able to negotiate with payors as a group.

On a more general note, financial risk sharing has been declining in most markets in the Unites States while efforts at clinical integration have been increasing. This is particularly attributable to the introduction of the electronic medical record and other forms of online clinical data exchange. The ready availability of health information on-line greatly aids patient care, and is something to be fostered. IPAs are ideally situated to provide these kinds of networks. As the FTC recognized in its advisory letter to the MedSouth IPA in Denver, development of clinically integrated services may require a single price offering to payors, so that participation of physicians can be assured. In this way rewards from the program flow equitably among the physician participants. It may

also be necessary to enable the IPA to pay for expensive computer infrastructure. What is desirable is for the FTC to issue definitive and clear guidelines as to what level of clinical integration and oversight is required to allow the IPA to price the products. Guidelines as to what spectrum of services, what level of information sharing, and oversight procedures should the IPA implement are requested.

TIPAAA is very encouraged that the Commission is willing to engage in dialogue, which will hopefully lead to the establishment of definitive guidelines, thus enabling physician organizations to offer the benefits of information sharing and clinical integration without the present uncertainties.

Respectfully yours,

Al Holloway

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President & CEO

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Timothy Muris, JD
Chairman
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600 Pennsylvania Ave.
Washington, DC 20580

RE: Joint FTC/DOJ Hearings on Healthcare and Competition Law and Policy

Dear Mr. Muris:

September 24, 2003, Morning Session:
Physician Product and Geographic Market Definition

TIPAAA is encouraged that the hearings will address barriers to entry in physician markets and wanted to take this opportunity to request that some industry guidance be issued by the FTC that would reduce some current behavior of hospital-controlled networks that we believe to be damaging to both competition and patient care. Specifically, we believe that guidelines should be established to prevent hospitals or hospital systems with dominate market power from using their market power in hospital services to gain a competitive advantage on non-hospital services in fee-for-service (non-capitated) markets through the use of a hospital-controlled network.

Hospital-controlled networks serve as both buyers of physician services and sellers of network services to payors, which places the hospital in a position to reduce competition. We believe that a hospital should not have the power to limit competition and patient access for non-hospital services by having its network set a physician fee schedule with extremely low ancillary reimbursement (that was not required by a payor)

for the purpose of later selling the network services to payors. For example, a hospital-controlled network should be prohibited from unilaterally "messengering" a below fair market "take-it-or-leave-it" physician fee schedule to participating physicians for the "technical component" of ancillary procedures (MRIs, sleep lab studies, interventional radiology, etc.) that can be performed and billed in the physician office setting if the hospital is a competitor for these services, unless the fee is a legitimate offer from a payor. This strategy prohibits the physicians from being paid as "out of network" for these ancillary services, since they were "paid" in network at the low rate (as low as $1). This strategy also significantly reduces the incentive for physicians to provide these services in convenient office settings, thereby reducing competition and assuring that more ancillary procedures will be performed in the hospital outpatient setting (at the network "facility" rate). At a time when federal healthcare programs are encouraging services to be performed at the lowest level of service to contain cost, this practice is requiring some services that could otherwise be performed in a physician office visit to be performed in a separate visit to a hospital facility, thus reducing access sites and requiring additional time off work for employees to make a separate visit to a hospital facility.

Likewise, we believe that hospital-controlled networks should be prohibited from completely removing ancillary procedures from the physician fee schedule to accomplish the same result, absent a request from a payor. Hospital-controlled networks should further be prohibited from conditioning the admittance of physician-owned facilities to the network upon the requirement that the hospital has a specific ownership percentage in the facility.

Finally, TIPAAA believes that hospital-controlled networks should be prohibited from entering exclusive agreements with payors that ties exclusive use of the hospital-controlled network physician panel to the price of hospital services, thereby foreclosing direct contracting between physicians and payors. By providing significantly steeper discounts to payors or employers who use the physician panel attached to the hospital-controlled network compared to the hospital rate offered to those who wish to independently select a physician panel and separately contract for hospital services, it becomes price prohibitive for payors to choose a physician panel independent of the network. This forecloses the opportunity for employers to contract directly with physicians or a competing physician network to develop a case management approach to healthcare that could reduce healthcare cost and improve the quality of care and successfully blocks competition by preventing an agreement between a willing buyer (payor) and a willing seller (physician). Physicians and the payors who want to enter into an agreement for physician services through a competing IPA should not be precluded by a third party's ability to increase hospital rates. Healthcare is too important for employers/payers to have to accept what they believe to be an inadequate physician panel or accept higher hospital rates.

TIPAAA is encouraged and grateful to the Commission for the opportunity to address these issues.

Respectfully yours,

Al Holloway

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President & CEO

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