Exploring Alternative Practice Models

Health care reform is prompting some psychologists to consider and make changes to their practice.

When Michael Goldberg, PhD, launched his psychology practice in 1994, he was a traditional solo practitioner. These days, he heads a practice that includes two freestanding outpatient clinics with 30 full-time-equivalent psychologists and other clinicians, additional practitioners embedded in several health care offices and day-to-day operations so complex “it makes my head spin,” says Goldberg, founder and director of Child and Family Psychological Services, Inc./Integrated Behavioral Associates in Massachusetts.

The practice’s ever-growing level of collaboration has been well worth it, says Goldberg. “More patients are getting care, and they’re getting better care,” he says. One key, he says, is to evolve slowly. “When I talk to other psychologists, I often hear, ‘I’m a small practice or a solo practitioner; I can’t do that,’” says Goldberg. “That’s absolutely incorrect and self-defeating thinking.”

The psychologists Goldberg encounters aren’t the only ones who are nervous, says Shirley Ann Higuchi, JD, associate executive director for legal and regulatory affairs in the American Psychological Association (APA) Practice Directorate. With the Affordable Care Act (ACA) pushing collaboration, she explains, APA and the APA Practice Organization have been fielding calls from solo practitioners wondering how they can compete in a rapidly changing health care environment. Fortunately, she says, practitioners don’t have to jump into full-fledged joint ventures. Instead, they can begin by taking easy, low-risk steps toward collaboration. “There’s a spectrum of models, from least to most risk,” says Higuchi.

A range of options
According to Kevin Ryan, JD, a member of Epstein, Becker & Green’s Health Care and Life Sciences practice in Chicago who advises health care clients on business and regulatory matters, those options include:

• **Referral system.** With the advent of the ACA and the Mental Health Parity and Addiction Equity Act, hospitals, primary care groups, home health agencies and others need help meeting patients’ behavioral health needs. Psychologists could contract with possible referral sources or simply approach them informally, saying “Here’s my card, keep me in [your contacts list] and when you need mental or behavioral health services, give me a call,” says Ryan, adding that a contract isn’t necessary. Although it takes time to identify potential referral sources, he adds, this is a low-cost, low-risk model. (Referral arrangements sometimes are more elaborate, as described in the next section of this article.)

  • **Co-location.** “Instead of just contacting those referral sources, you could go where they are,” says Ryan, explaining that psychologists could rent space – either part- or full-time – in buildings where other health care providers are located. “This gets you right there so that when providers’ patients need someone, they can just walk across the hall,” says Ryan. Although this model is still fairly low-risk and easy to do, it will probably entail a lease or other contract.

  • **Independent practice association (IPA).** In this model, independent practitioners come together to achieve common goals. Often one such goal is to contract with a managed care company or health system to provide services. The IPA, which is a legal entity apart from providers, gives payers access to providers they can contract with efficiently through the IPA. Providers are often free to negotiate individually with the payer, and they can also decide to opt out of the contract altogether. This model involves some legal risk, including antitrust concerns (see sidebar on page 8). You’ll also have to sign a “participating provider” agreement.

  • **Management services organization (MSO).** “An IPA on steroids,” says Ryan, this model contracts not just with a single payer or health system but with multiple organizations over a broader geographical area. “This is much higher on the legal risk spectrum,” he says. For one thing, MSOs typically market themselves under a brand name. That can be good news or bad, depending on how well the brand fares, says Ryan. There are also potential antitrust issues if the MSO negotiates fees for providers.

  • **Accountable care organization.** “I don’t see a group of psychologists putting together an accountable care organization (ACO),” says Ryan, explaining that this option is more geared toward physicians, primary care practices and hospitals. “That doesn’t mean psychologists can’t participate in ACOs,” he says. However, doing so requires
a huge amount of financial and clinical integration, such as risk-sharing and payments based on episodes of care.

- **Merger.** In a merger, two parties sign an agreement to become one, or one entity acquires the other. “This is the ultimate in clinical and financial integration and the highest legal risk,” says Ryan. Plus, he says, if things don’t work out, a merger is much harder to get out of than simply ending a contract.

**Models in action**

Psychologists are already developing innovative alternative practice models at all points on this spectrum, says Higuchi, and the APA Practice Organization is seeking to identify those models and provide guidance to foster that innovation.

In Rhode Island, for example, psychologists and other behavioral health practitioners have come together with the state’s largest independent practice association (IPA) of primary-care physicians to form a collaborative care network called the Rhode Island Primary Care Physicians Corporation Behavioral Health Network. “We have developed a statewide network of behavioral health clinicians and facilities,” explains Rhode Island Psychological Association President Peter Oppenheimer, PhD, adding that the growing network consists of about 100 behavioral health members as of early 2014.

The network allows the IPA’s 150 primary care physicians to search an online database for credentialed behavioral health professionals and facilities by specialty, location and what insurance they accept. Physicians will be able to provide patients with the clinician’s contact information on the spot, and they will securely transmit referral information to the clinician. Once the connection is made, the physician and behavioral health provider primarily use a secure email system to track referrals and patient care.

Goldberg’s co-location model is a step up the collaboration continuum. The model began in 2005, when Goldberg half-jokingly said to a physician who often referred patients to him and his fellow group members that she should rent them space in her office. “She said, ‘Done!’” remembers Goldberg. That was just the beginning; These days, practice members are also embedded in three more primary care offices, a neurology office and an obstetrics/gynecology office.

The next step was to develop a formal referral relationship with several medical practices. The contracts that undergird this model are simple, says Goldberg. There’s a base agreement that describes the two entities’ shared goals, such as increasing access to behavioral health services and delivering high-quality, coordinated, cost-effective care. The agreement also lays out expectations. Goldberg’s practice agrees to make a reasonable effort to participate in all health plan networks, for example. And while Goldberg’s practice agrees to see most of the other entity’s referrals, they’re not required to see all of them or turn down referrals from other sources. “I didn’t want to put all my eggs in one basket,” says Goldberg.

The second legal component is a lease for the shared office space. The third component is a series of agreements for the medical practice to pay for services not covered...
Many psychologists in small independent practices have been seeking a “holy grail” of being able to legally join with other small practices to jointly negotiate fees with large insurance companies, says Alan Nessman, JD, senior special counsel in the APA Practice Directorate’s Office of Legal and Regulatory Affairs. These negotiations would change the balance of power with big payers. The problem is that joint negotiation requires the independent practices to agree upon a price they would accept, and “price fixing” is usually a clear antitrust violation.

“Price fixing is normally considered bad because it decreases competition, increases prices and brings higher costs to consumers,” says Nessman. Done properly, however, collaborations can improve quality, lower costs and promote cost-effectiveness. Plus, some collaborations need to be able to jointly negotiate to stay viable.

As a result, the antitrust enforcement agencies have issued various guidance on how collaborations can jointly negotiate without problems. This guidance has been synthesized by Patricia Wagner, an antitrust expert at the Epstein, Becker & Green law firm.

The key is sufficient financial or clinical integration. Examples of financial integration include capitated rate arrangements with health insurers or risk pools that withhold substantial portions of compensation unless the group as a whole meets cost-containment goals.

For most psychologists, clinical integration is a more attractive route, says Nessman, who adds that psychologists considering a collaboration that would jointly negotiate fees should consult with an antitrust attorney. In addition to achieving higher quality, lower costs and more efficient service delivery, clinical integration should include most, and ideally all, of the following elements:

- **Clinical protocols.** The collaboration must develop clinical protocols that apply to most of their patient population and reflect current developments in treatment.

- **Measurable quality and utilization goals.** The collaboration must develop goals for monitoring the quality of the treatment it provides and appropriate utilization of services.

- **Assistance in meeting goals.** The collaboration must develop procedures for actively educating, reviewing and helping providers achieve those quality and utilization goals.

- **Disciplinary procedures.** The collaboration must discipline or remove providers who can’t or won’t meet the goals the collaboration has established.

- **Case and disease management programs.** The collaboration must implement specific case and disease management programs.

- **Credentialing procedures.** The collaboration must implement credentialing procedures.

- **Integrated information technology system.** The collaboration must develop an integrated information technology system to disseminate practice standards and other communications and allow providers caring for the same patients to share clinical information more easily.

- **Nonexclusive network.** If the collaboration will have a significant market share, it should allow the various practices in the collaboration to contract separately with payers.

- **Performance monitoring.** The collaboration must adopt practice protocols, standards and performance monitoring procedures that would only be feasible with joint negotiation to ensure the participation of sufficient numbers of providers.

- **Collaboration.** The practice must facilitate cooperative interaction and collaboration among providers to help ensure they provide the right care at the right time.

- **Significant investment.** Providers must invest a significant amount of time and money in the infrastructure necessary to implement the program.

Although a small collaboration may be considered a less important target by enforcement agencies, don’t think you can ignore these rules just because your collaboration is small, warns Nessman. “Many antitrust rules apply the same way to two practices working together as they would to Apple and Microsoft collaborating.”

For more information, watch for additional guidance from the APA Practice Directorate. In addition, Div. 42 (Psychologists in Independent Practice) will conduct a panel presentation on antitrust issues during the American Psychological Association’s annual convention in August 2014 in Washington, D.C.
by the traditional, fee-for-service arrangement—such as participation in treatment team meetings, consultation and training, and on-call time.

“It’s a big system and a big model,” says Goldberg. “But in terms of the lawyers, it really wasn’t difficult at all. It’s something that can be done by solo practitioners and small groups alike.”

Higher up the spectrum of alternative practice models is the MSO that Keith A. Baird, PhD, and his colleagues are developing in Illinois. The goal of Behavioral Care Management, LLC, is to improve health care and lower costs by becoming the behavioral health care provider for many of the accountable care organizations being created in northern Illinois. Behavioral Care Management will negotiate contracts for consortium members—who include not just psychologists but psychiatrists, social workers, counselors and all other licensed mental health providers—with the accountable care organizations. Eventually, says Baird, the organization may even contract directly with the insurance companies behind the accountable care organizations.

“It is a company that will manage the behavioral care and manage the contracts, but it as an entity itself will not provide the services,” says Baird, a founding partner of Heritage Professional Associates as well as the new group. As a limited liability company or LLC, Behavioral Care Management has members—the equivalent of stockholders—who can be providers or just people who believe in what the company is doing.

One key cost-saving element is an online scheduling and referral system. Developed by consortium member Jeremy Bidwell, PhD, and a partner, the software allows providers to show their availability and primary care offices, emergency rooms and others to search for them by geographic and specialty area. “In our community, I’d guess that half of all psychiatric inpatient admissions could have been prevented if people had more real-time access to qualified outpatient providers,” says Baird.

Of course, says Baird, this practice model is still under development. “The biggest challenge is that we’re trying to form a company in a new kind of industry that doesn’t really exist yet,” he says, adding that the start-up costs are enormous. “We’re hoping that if this model works, people might be interested in replicating it.”

NOTE: This article is based on programs presented during the March 2014 State Leadership Conference in Washington, D.C., sponsored by the APA Practice Organization and APA. Future issues of this Good Practice magazine from the APA Practice Organization will include more information about alternative practice models.