HEALTH CARE

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The Latest FTC Pronouncements in Health Care Physician-Payer Contracting

On September 17, 2007, the Federal Trade Commission (FTC) delivered two somewhat different messages to the physician community. First, through its Advisory Opinion process, the FTC stated that it would not challenge a clinical integration proposal for an IPA, which would negotiate contracts for its competing physician members, with an express recognition that a price increase was likely to be involved. Second, on the same day, in remarks at an "Antitrust in Healthcare" conference, FTC Commissioner Rosch stated that, in his view, it was not only extremely difficult for a physician group to create a clinical integration system strong enough to pass antitrust muster, but the message to physician groups regarding price fixing "does not appear to be getting through." He further noted that physician groups simply had not made "significant progress" in fashioning successful clinical integration programs, therefore, the "most realistic form of integration" was meaningful financial integration.

The juxtaposition of these two events merits examination.

Physician Networks and Clinical Integration

Physicians who jointly share material financial risk are, in most cases, able to negotiate collectively with payers without engaging in prohibited price fixing or group boycotts, both per se violations of antitrust laws. Absent a true joint venture, or a qualifying financial risk sharing arrangement (*e.g.*, capitation), other means must be explored. One approach is to create a contracting structure that achieves a level of clinical integration among its contracting members that will result in a high degree of interdependence and cooperation among the physicians, such that there is a significant potential to achieve greater overall efficiency and improved quality, if not a lower price.

While no court has specifically sanctioned the "clinical integration" approach as an acceptable basis for joint contracting among potentially competing physicians, and the United States Department of Justice and the FTC have not established a specific set of acceptable criteria, the

DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care (1996), Statement 8, and a number of FTC Advisory Opinions indicate joint contracting is acceptable where participating physicians are in "active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure quality of services provided, and the arrangement must create a high degree of interdependence and cooperation."

Favorable opinion letters suggest that the following elements must be a part of a qualifying clinical integration program:

- A control system for tracking quality and utilization, in which the system must play an active role in tracking compliance with agreed upon clinical protocols.
- Performance goals and monitoring in the area of quality, and use of best practices in clinical care.
- A pooling of resources and expertise across the group to create the infrastructure necessary to achieve its goals.
- Disciplinary processes, including termination from the group, which is enforced upon physicians who fail to take those steps necessary to achieve compliance with established standards.

Activities establishing that the foregoing have been translated into the necessary integrative elements include:

- Collaborative patient care across arrangement sites.
- Joint disease management programs.
- A standardized formulary.
- Required training and educational programs.
- Documentation of the benefits — monetary and clinical — realized as the result of the arrangements.

GRIPA and the Dynamic Provider — Payer Contracting Market

The FTC's Greater Rochester Independent Practice Association, Inc. (GRIPA) Advisory Opinion is its most recent pronouncement addressing clinical integration in a traditional provider-payer contractual background, similar to the dynamics among many markets in the country.

GRIPA began as an IPA focused upon financial risk sharing arrangements (principally percentage of premium arrangements) with payers in the mid-1990's. To address the challenge of risk sharing, it operated a Case Management System (CMS). The system provided: individual patient assessments, case management and disease management programs, training, education, and monitoring of treatment guidelines to determine whether they were being achieved.

As is the case in many markets, over time, risk-based arrangements began to decline both in volume and significance, and resulted in fee-for-service contracts becoming the prevailing situation. This, in turn, created a challenge to continue group contracting, but without a risk sharing arrangement. In GRIPA's case, a "new product" surfaced consisting of the delivery of "interdependent" medical services on a fee-for-service basis "intertwined with a number of collaborative activities designed to improve clinical outcomes and efficiencies."

The essence of the program was the inclusion of many of the previously highlighted elements that could lead to an acceptable program of clinical integration (*e.g.*, acceptance of evidence-based practice guidelines, review of aggregate performance, and a Web-based clinical information sharing system) with specific focal points:

- An agreement to participate in the program that referred patients to other IPA network physicians. (The fraud and abuse risks of the arrangement were not a part of the FTC's review).
- Physicians would provide information to a "central data store," which monitored results, and the physicians' use of this too.

- Process and outcome measurements with the initial benchmarks at the same levels as those used in health maintenance organization (HMO) risk contracts.
- Methods to assure compliance with program requirements. GRIPA would provide in-depth quarterly reports that displayed each participant's compliance of the required performance measures, with interventions for non-compliance; and ultimately, discipline, including expulsion, for the chronically non-compliant.
- GRIPA would use the money that would be returned to the participating physicians from its risk contracts to finance $2.7 million (roughly $7,000 per physician) in infrastructure improvements. Each physician also was required to make an investment in his or her office to participate (another $6,000 – 7,000 per office) as well as pay $70 per month for an Internet connection. This investment was supplemented by the "human capital" costs of participation, e.g., an estimated cost for attendance at GRIPA programs of approximately $3,200 in lost patient revenues.

Against this background, the FTC concluded that the program was both intended and structured to produce substantial integration. It then turned its attention to the question of whether there was adequate need and justification for the collective negotiations effort, particularly because the "new product" being delivered was more efficient, with a stated objective of higher fees ("quality adjusted prices"), rather than lower.

Nevertheless, the FTC concluded that joint contracting was necessary and determined it would not challenge this arrangement because:

- GRIPA physicians were not prevented from contracting outside the network — i.e., the GRIPA network was non-exclusive, and there were other, larger, networks in the area, which mitigated potential market power concerns.
- The identification of the physicians who were to operate in the pre-determined network, participated in all the aspects of the "new product" for integrated service, and enhanced the quality and efficiency in the delivery of care.
- As a result, joint negotiation under the GRIPA program was determined to have the ability to achieve its efficiency and quality goals.

The Commissioner's Remarks

Commissioner Rosch's remarks were addressed more broadly to the antitrust issues that arise when competing physicians to collectively bargain with payers, and identified two critical areas — market power and price fixing. In the Commissioner's views:

- Non-integrated physicians' price negotiations was a "longstanding problem" for the enforcement agencies.
- The key problem (or weakness) of claims of clinical integration was the absence of efficiency enhancing integration.
- The test of successful integration is what the network participants actually accomplish, i.e., do they use the tools of contracting to create cooperation and interdependence? He also noted that in one well-reported case of acceptable clinical integration, the contracting entity lost 32.5 percent of its physicians after inception, and many of the payers were not interested in the integrated product offering.
- The integration effort must go beyond "informational" activity, in order to accomplish actual collaborative activity to attain program goals.
- To pass scrutiny, a "new product" must "fundamentally alter the nature of the services to the patients or to the payers."
- The contracting entity must operate on a non-exclusive basis, otherwise the "new product" created is undercut.

Commissioner Rosch's conclusions lead to a significant challenge — is clinical integration ultimately a strategy that bears fruit? As he notes, physician groups have not been able to overcome the hurdles of clinical integration in any meaningful way. This produces only two alternatives — a true integrated joint venture and employment arrangement, with inherent financial integration, or collectively contracting with actual risk sharing.

Where Are We Now?

The juxtaposition of the GRIPA Advisory Opinion and Commissioner Rosch's remarks paints an interesting picture. It suggests that although clinical integration remains a viable alternative to risk sharing arrangements, it is not only difficult to achieve, but is viewed with skepticism within the FTC.

These two pronouncements also suggest that the FTC will look to find the underlying reality of physician contracting relationships — are they truly necessary to create greater access, quality, and efficiency? Or do they offer little that cannot be otherwise achieved?

Finally, given the enhanced effort to reward quality, both from process (i.e., accessing and following best practices) and substantive results (e.g., fewer readmissions to the hospitals following surgical interventions, and the elimination of central line infections), and absent an existing infrastructure such as GRIPA, perhaps created in the days of robust risk sharing, are providers better off re-examining the potential of risk sharing relationships? It would appear so.

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