Clinical Integration, Joint Contracting, and the Future of Provider Collaboration

First FTC Guidance in Over Three Years

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A recent Advisory Opinion issued by the FTC regarding clinical integration is an important update to current understanding of how the antitrust enforcement agencies analyze clinical integration arrangements. Read in conjunction with other guidance, it reveals FTC’s thinking, shifts in priorities, and the requirements that remain at the top of the FTC’s checklist.
In this era of shrinking reimbursements and tightening economics, many independent healthcare providers who are not interested in joining large systems are searching for ways to survive.

One option some have explored is developing clinical integration programs under which otherwise independent providers coordinate comprehensive and systematized patient care. The promise of clinical integration is better care provided more efficiently. And if a program qualifies, participating providers are permitted to contract jointly with commercial insurers—a practice antitrust laws otherwise generally prohibit.

For the past decade, clinical integration of independent healthcare providers has been a focus of the antitrust enforcement agencies in their quest to preserve competition among providers while encouraging the pursuit of efficiencies that can result from collaboration. Since the last major agency Advisory Opinion on clinical integration in April 2009, the concept has also become a cornerstone of healthcare reform through the accountable care organization (ACO) concept introduced in the Affordable Care Act (ACA) and the subject of significant analysis by the federal antitrust enforcement agencies, the Federal Trade Commission (FTC) and Department of Justice Antitrust Division.

Providers looking to integrate and jointly contract need to be mindful of how contractual provisions could affect the market.

A February 2013 Advisory Opinion issued by the FTC regarding the Norman Physician Hospital Organization (Norman PHO) clinical integration proposal is an important update to current understanding of how the antitrust enforcement agencies analyze clinical integration arrangements. Reading this opinion in conjunction with other guidance reveals FTC’s thinking, shifts in priorities, and the requirements that remain at the top of the FTC’s checklist. Moreover, the opinion (and the 18-month agency investigation that preceded FTC’s recommendation that the arrangement should not be challenged) demonstrates FTC’s continued commitment to giving providers guidance about the level of clinical integration that will justify joint contracting. While FTC’s Norman PHO opinion underscores that achieving clinical integration that will survive FTC scrutiny is a significant undertaking, it also signals that the agencies are willing to conditionally approve clinical integration arrangements even without direct quantitative evidence regarding the efficiencies that result, the outlay of physician resources, or market definition/market share. At the same time, it adds so-called “vertical effects” to the list of concerns that providers need to address when proposing a clinical integration plan.

In other words, providers looking to integrate and jointly contract need to be mindful of how contractual provisions such as anti-steering clauses could affect the market.

We begin here with a brief overview of antitrust principles involved in assessing clinical integration programs, include a summary of FTC’s recent Norman PHO Advisory Opinion, and translate the most current agency guidance into practical advice.

Antitrust Principles

The 1982 landmark Supreme Court case Arizona v. Maricopa County Medical Society et al. (457 U.S. 332), established the general principle that, absent exceptional circumstances, antitrust laws condemn as per se illegal any agreement among independent physicians as to the fees they will charge health plans for their services.

Since Maricopa, the antitrust enforcement agencies have indicated that independent providers not engaged in risk-based sharing who engage in joint contracting may avoid antitrust problems if there is sufficient integration of the clinical aspects of the network. The antitrust analysis to be applied to clinical integration arrangements was articulated in the FTC and U.S. Department of Justice (DOJ) Antitrust Division joint Statements of Health Care Antitrust Enforcement Policy in 1996 and has been applied several times over the last 17 years in FTC advisory opinions.

The analysis proceeds from the most basic antitrust question under the so-called “Rule of Reason”: Does the overall arrangement benefit consumers (in terms of care and cost) enough to outweigh the potential harm to competition, and are the aspects of the arrangement that threaten competition necessary to capture the benefits?

With respect to joint contracting—which may be challenged as illegal price-fixing among competitors—proponents of a clinical integration plan must demonstrate that it is essential to the success of the plan. Generally speaking, this requires a contracting structure that facilitates and requires a high degree of interdependence and cooperation among participating providers who share material financial risk. The interdependence and cooperation among providers in the delivery of care is where the benefit to consumers comes in, the idea being that the cost of care will go down and quality will go up if such an arrangement is in place.
**Background**

Norman PHO includes the Norman Physicians Association, approximately 280 physicians in about 38 specialty areas, as well as the Norman Regional Health System, a network of hospitals and medical centers owned by the city of Norman, Oklahoma, and the Norman Regional Hospital Authority. Since 1994, Norman PHO has facilitated the so-called “messenger model” of contracting between payers and Norman PHO providers, with both the Physicians Association and Regional Health System sharing operations and capital needs costs. Norman PHO revenues are derived from provider membership fees and reimbursements withholdings from contracting payers, among other sources. The organization is run by a single board comprised of leaders from the two component organizations as well as participating physicians.

Norman PHO proposed changing its infrastructure to encourage collaboration among its physicians and compliance with certain clinical practice guidelines by requiring participating physicians to commit to a participating practitioner agreement. The new structure featured committees responsible for overseeing implementation and updating clinical practice guidelines for up to 50 diseases as well as a committee focused on nine chronic conditions affecting a large number of its patient population. In addition, a Quality Assurance Committee was put in place to analyze physician performance and compliance with guidelines and to make recommendations for improvement or to impose penalties or expulsion for lack of compliance. The new structure required physicians to:

- Participate in these committees
- Support clinical integration goals
- Contribute withholdings from payer reimbursements on an ongoing basis
- Pay a one-time fee of $350 and annual dues of $150
- Acquire technology necessary to participate in Norman PHO’s electronic records platform

This platform streamlined prescriptions, improved access to clinical guidelines and information, improved communication among physicians, and increased transparency with respect to physician practices. It also helped compile information to measure and evaluate physician performance as well as facilitate utilization rates reporting and other information related to cost control.

Altogether, the rigorous membership requirements ensure that the network is “selective” and allows only committed physicians to participate.

Although Norman PHO could not specifically quantify anticipated savings and efficiencies that would result from the new infrastructure and could not identify the means by which such savings would be measured, it asserted that they would be meaningful and would benefit payers, providers, and patients alike. Norman PHO proposed moving away from a messenger model to a joint pricing and contracting model in conjunction with its new infrastructure.

**FTC Analysis**

As in other advisory opinions, the FTC considered the market share of Norman PHO as an initial step in its competitive analysis, while acknowledging that Norman PHO had not provided sufficient data to support an investigation or formal market analysis. Norman PHO estimated its geographic service area to comprise the Oklahoma City metropolitan area and certain surrounding communities but also reported on market shares in individual counties. In its reported service area, Norman PHO represented only 10 percent of physicians and hospitals; in certain counties, however, the FTC noted that 50 percent of patient discharges could be attributed to Norman PHO providers. Both the FTC and Norman PHO seemed to accept that Norman PHO included “most of the physicians who practice in and around Norman, Oklahoma, as well as the only hospital system in the immediate Norman area.” Norman PHO’s proposal called only for joint contracting among competing providers of physician services, and that was the only market scrutinized in the FTC Advisory Opinion.

Without much detailed analysis, the FTC found that the Norman PHO proposal met the criteria for clinical integration needed to allow joint contracting. It found that the joint contracting was “subordinate to the network’s effort to improve efficiency and quality” and necessary to the stated goal of “establish[ing] and maintain[ing] a consistent physician panel of like-minded physicians” with a “shared commitment” to clinical integration. The FTC specifically cited Norman PHO’s experience under the messenger model, which saw great variation in physician participation from contract to contract. Moreover, the FTC validated Norman PHO’s argument that physicians would be more likely to participate in realizing clinical integration goals if they were obligated to participate in all contracts and that universal participation would make it easier for Norman PHO to market the clinically integrated product and harness economies of scale.

The FTC also concluded that, on balance, the competitive effects of the proposed new infrastructure
for Norman PHO were procompetitive or competitively neutral. It did note that Norman PHO was comprised of “a substantial portion” of physicians in the Norman, Oklahoma, area with privileges at Norman’s only hospital and therefore had the potential to exercise market power in the sale of its participating physicians’ and hospital’s services. The FTC expressed its concern about this competitive issue as follows:

This [market power] creates a potential concern because Norman PHO proposes to jointly contract, including negotiating and setting prices, on behalf of the majority of local physicians and the only local hospital. Moreover, Norman PHO notes that the network has some expectation of negotiating higher reimbursement rates for its participating physicians because the proposed program will require increased utilization of physician resources to offer the potential to achieve greater efficiency, improved care, and, ultimately, lower costs for network patients.

For the first time, the FTC addressed potential concerns with the “vertical effects” presented by a clinical integration arrangement.

The FTC found that this concern was mitigated by the non-exclusive nature of the proposed infrastructure, which allowed any payor or employer that sought to contract with a physician or hospital for services to “bypass” the PHO and contract with the provider independently and did not seek to force or encourage contracting with the network. As it has in previous advisory opinions, the FTC noted that if the non-exclusive, non-coercive nature of the contracting arrangement were to change, it “would raise serious concerns and could be necessary to revisit the issue of Norman PHO’s market power and reevaluate whether staff would recommend an antitrust enforcement action.”

Finally, for the first time, the FTC addressed potential concerns with what are known as “vertical effects” presented by a clinical integration arrangement. Vertical effects result from relationships among parties at different levels of the market—provider and payer, for instance—in contrast to horizontal relationships among competitors at the same level. The appearance of vertical effects analysis in the Norman PHO Letter reflects the agencies’ recent focus on the antitrust impact of contracting practices in healthcare markets and uses language taken directly from the joint 2011 Final Policy Statement on ACOs.

In the Advisory Opinion, the FTC found that Norman PHO’s proposal did not incorporate vertical arrangements that would allow it to “limit competition in the sales of any other services.” Examples of these arrangements include the contractual requirement that a payer do business with all the network’s hospitals instead of particular hospitals, or provisions such as “most-favored-nation” clauses or “anti-steering” clauses that would prevent payers from incentivizing patients to choose non-network providers. The FTC also noted the absence of any restriction in the physician participation agreement that would limit a provider’s ability to contract with a payer that does not contract with Norman PHO. However, it warned that Norman PHO must take precautions to prevent the use of market power to limit competition in the sale of other services. This warning was echoed in the section addressing so-called “spillover effects,” in which the FTC counseled that Norman PHO must provide antitrust counseling and training to head off any reduction in competition outside of the services provided by and through the PHO.

Practical Advice

As noted above, the last Advisory Opinion to address a clinical integration proposal was issued in April 2009 in the TriState Health Partners matter and before then in September 2007 in the Greater Rochester Independent Practice Association (GRIPA) matter. Those opinions are considered to reflect the high standards the FTC applies to clinical integration programs. In those Advisory Opinion letters (both of which indicated that it did not recommend challenging the proposed programs), the FTC emphasized many aspects of a sound clinical integration program also emphasized in the Norman PHO opinion:

- Participation by a broad spectrum of specialists
- A serious effort to encourage physician compliance through monitoring and potential expulsion from the PHO
- Investment by participating physicians
- Implementation of benchmarks
- The necessity of integration and joint contracting to achieve these efficiencies

Reading the three FTC advisory opinions together, there are notable points of commonality and points on which the Norman PHO Advisory Opinion diverge from previous FTC analyses:
**Vertical effects.** As noted above, the Norman PHO Advisory Opinion represents the first time that the FTC expressly addresses vertical effects in the context of a clinical integration program. This may be the result of a renewed focus of the antitrust enforcement agencies on the competitive effects of contracting practices in health care, particularly where a party has market power. For instance, the enforcement agencies have recently brought actions challenging “most-favored-nation” clauses and exclusive contracting practices as restricting competition even in absence of any horizontal agreement among competitors. In any event, it represents a significant new “checklist” item for providers seeking to enter into a clinical integration arrangement.

**Paramount importance of non-exclusivity.** In the TriState opinion, the FTC established that even where an arrangement has significant market share, competitive concerns could be neutralized if the contracting between the collaboration and payers is non-exclusive. Non-exclusivity was also noted as a plus in GRIPA, although there the arrangement did not possess market power. In Norman PHO, we once again see that non-exclusivity is key to receiving approval of an arrangement where market power is present.

**Little concern about over-inclusivity.** In the TriState opinion, the FTC expressed a concern that the networks were over-inclusive and involved a “very substantial majority” of physicians practicing in the service area. Specifically, the FTC voiced concern that the program involved more physicians and specialists than required to “provide service effectively to its likely customers.”22 Although the FTC also found that Norman PHO would involve a “majority” of physicians in the service area, it did not express a concern about over-inclusivity.

**Number of diagnoses/diseases covered by clinical integration.** The GRIPA program focused its clinical guidelines on a small number of core diseases. The TriState program represented a step forward in quantifying the percentage of medical conditions to which it hoped to apply program guidelines, namely at least 80 percent of the medical conditions comprising at least 80 percent of the cost of care in the community. Norman PHO’s proposal represents a step away from percentage-based quantification, listing 50 disease-specific conditions to which guidelines will be applied plus nine chronic conditions that most affect its patient population. Norman PHO’s plan also features a committee tasked with addressing the conditions that will be the focus of its clinical guidelines.

**Agreement by physicians to refer in-network.** One of the more notable aspects of the Norman PHO proposal is that it does not require referrals within the network, a feature often cited as a requirement for FTC conditional approval. In GRIPA, the program featured an in-network referral requirement except in “unusual circumstances.” TriState affirmatively limited the obligation to situations where such a referral is “medically appropriate” and where a patient wishes to receive care from an in-network referral. Instead of requiring referrals among participating physicians, the FTC seemed to accept that several provisions in Norman PHO’s plan would “facilitate” or encourage in-network referrals.

**Outlay of capital by physicians.** Another notable difference in the FTC’s Norman PHO analysis is that it does not focus on the dollar amount of the physician investment, looking instead at the global investment of both money and time. GRIPA participants were required to invest in very specific startup technology and training costs, totaling approximately $20,000 in costs and lost revenue. TriState’s relatively low $2,500 “joining fee” (which in many instances had been paid by existing members many years ago) and other startup costs—about $7,600 total—was a source of some concern for the FTC, which concluded that this “modest” amount of financial investment was unlikely to motivate physicians to help the program succeed. In the end, it found that the time commitment was sufficient to ensure physician investment. In contrast, the Norman PHO joining fee is $350 and annual dues are $150. Norman PHO physicians must invest in the technology platform plus contribute ongoing “withholds” from payer reimbursements to support clinical integration, but the FTC did not focus on the precise amounts paid by each physician. Instead, its analysis expressly considered both the financial and human capital outlays in deciding that the outlay was sufficient, continuing a trend begun in TriState.

**Little concern about technology platform details.** In TriState, the FTC noted a concern that where patients sought care outside of the network, their electronic records would not be accessible. In contrast, in Norman PHO, the FTC seemed far less concerned with the particulars of the information platform and how it affects patient access to information. This may reflect a growing comfort with electronic recordkeeping systems and the high level of healthcare provider adoption of these platforms.

Practically speaking, the Norman PHO FTC Advisory Opinion does not have a significant effect on the list of issues that providers should consider as they assess whether clinical integration is a realistic goal for achieving efficiencies through affiliation, but it does tweak previous guidance. The FTC will continue to scrutinize clinical integration proposals to make sure that the following aspects are present:
■ Actual interdependence of providers reflecting collaboration and productive sharing of information on many levels
■ Participation of both specialists and primary care physicians
■ Treatment of a sufficiently broad spectrum of diseases and disorders with corresponding clinical protocols
■ Electronic information-sharing platforms for effective exchange of patient and practice information; tracking utilization and claims information for purposes of measuring quality and efficiency; and monitoring physician performance and compliance with protocols
■ Significant physician investment measured as a combination of time and money
■ Consequences for noncompliance by physicians and institutions
■ Joint contracting necessary to create interdependence and limited to those services that are part of a clinical integration program
■ Allowance for payers and providers to contract independent of the clinically integrated entity and systems in place to protect participating provider pricing information to ensure that such negotiations are truly independent
■ Absence of contracting practices that would impose anticompetitive restrictions on payers as precautions against anticompetitive effects outside of the services provided by the clinically integrated entity

Conclusion

Although the Norman PHO Advisory Opinion does not veer off the general course set by the FTC’s other recent clinical integration advisories, it does reveal some progression in the agency’s thinking and priorities. With the expansion of ACOs and care coordination among various providers, this Advisory Opinion provides the most current view of FTC thinking on what providers need to demonstrate to make a case that a clinical integration arrangement passes muster under antitrust laws.

References


6. Ibid. At 6.
7. Ibid. At 8,9.
8. Ibid. At 14.
9. Ibid. At 4.
10. Ibid. At 16.
11. Ibid. At 17.
12. Ibid.
13. Ibid. At 18.
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20. Ibid. At 20.

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