

Client Alert

HEALTH CARE DEPARTMENT AND THE ANTITRUST & TRADE
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Significant Developments in Clinical Integration: Federal Trade Commission Advisory Opinion Approves of Physician-Hospital Organization Proposal to Negotiate Jointly with Payers

On April 13, 2009, the Federal Trade Commission's Bureau of Competition, Health Care Division ("BC") issued a 37-page Advisory Opinion ("Opinion") to TriState Health Partners, Inc. ("TriState"), a physician-hospital organization based in Hagerstown, Maryland, stating that the BC would not recommend that the Commission challenge TriState's proposed clinical integration program under the antitrust laws. The Opinion is noteworthy because it provides the most detailed discussion of clinical integration in any advisory opinion to date,¹ and represents the first time that the BC has given a green light to a proposed clinical integration program that included a hospital member.

WHAT IS CLINICAL INTEGRATION?

In general, antitrust laws prohibit direct competitors from jointly negotiating, or agreeing upon, the prices they will charge. This prohibition applies to health care providers, who generally are not permitted to agree to a joint fee schedule or join together to negotiate with third party payers such as insurance companies. One exception to this general rule is where an agreement on price "occurs in the context of a potentially efficiency-enhancing joint venture, . . . and the competitive restraints [*i.e.*, the price fixing agreements] are 'ancillary' to the joint venture."² In other words, if physicians combine in order to provide better, more comprehensive and cost-effective services, they may — under carefully scrutinized circumstances — be able to discuss or negotiate prices with payers jointly.

Physician groups historically have established legitimate joint ventures by agreeing to share some financial risk, which encourages efficiency within the network. The financial risk often takes the form of a capitated rate or a withhold (a percentage of payment that is withheld from physicians and paid only after efficiency goals are reached). It is also possible for physicians to create a legitimate joint venture through clinical integration, defined as a "network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."³ How much and what kinds of "interdependence and cooperation" are necessary to permit joint negotiation with payers can be a very fact-intensive inquiry. With the exception of a few advisory opinions,⁴ there has very been little definitive guidance on how best to structure a legitimate clinical integration program.

THE TRISTATE ADVISORY OPINION

The Opinion provides the most detailed discussion of clinical integration in any advisory opinion to date. According to the Opinion, TriState is a physician-hospital organization

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(“PHO”) comprised of 212 physicians and one hospital, Washington County Hospital Association (“WCHA”) located in Washington County, Maryland. TriState began in 1995 as a joint venture with financial risk-sharing (capitation) contracts. TriState had evolved over time, and proposed to move toward a program of clinical integration that would, in TriState’s voice, “offer payers a network of coordinated services from physicians committed to improving outcomes by working together to achieve quality improvements not possible by working independently.”⁵ After a lengthy review of the facts as TriState presented them,⁶ the BC concluded that the proposed clinical integration program was an efficiency-enhancing joint venture, and that TriState’s proposed joint negotiation with payers was ancillary to the joint venture (and therefore permissible).

EFFICIENCIES

Several key facts led to the BC’s conclusion that TriState’s proposal would lead to significant efficiencies, including both improved quality and more cost-effective care. First, TriState planned to implement a web-based health information technology system that would facilitate the exchange of patient information between and among members. Second, TriState was in the process of developing clinical practice guidelines, and promised to monitor physicians’ adherence to them. Individual physicians’ performance would be the subject of “report cards” and peer counseling and educational efforts, as needed, with eventual discipline and even expulsion from the program, if necessary. Third, members would be required to refer patients to other TriState members, when medically appropriate and subject to the patient’s consent, so that the patients would receive comprehensive care under the appropriate quality standards, and TriState’s clinical patient information would be more complete. Fourth, TriState planned to require each member to invest non-trivial amounts of money and human capital in the program.

The Opinion details TriState’s proposed mechanisms to monitor its members’ adherence and compliance with the above policies and procedures. Each member was required to sign the TriState Member Participating Provider Contract — Clinical Integration” (“Contract”) which set forth each member’s commitment to, and obligations regarding, TriState’s proposed program. Specifically, in the Contract, the members agree to (1) provide TriState with patient and treatment information; (2) comply with the clinical practice guidelines; (3) assist TriState in quality, safety and cost assessments; (4) serve on TriState clinical integration subcommittees; (5) cooperate in the development of the program; (5) refer enrollees to other TriState members when medically appropriate; (6) learn and use TriState’s web-based health information technology system; and (7) comply with TriState’s rules and regulations. TriState’s proposal also included a Clinical Integration Oversight Committee that would supervise members’ adherence to these requirements.

The BC also focused on the expected investments of money and human capital that each TriState member would be required to make, including: (a) a \$2,500 joining fee for each

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new member (which WHCA matched), (b) additional investments of at least \$2,600 in computer and related equipment, and approximately \$2,500 in staff training programs, and (c) additional time and effort serving on committees, implementing guidelines, collaborating on patients, and other similar required activities.

JOINT PRICING AND COLLECTIVE NEGOTIATIONS

The BC also concluded that TriState's proposal to contract with payers as an entity appeared to be subordinate and reasonably related to the efficiency goals in the clinical integration program. The BC recognized that, for several reasons, the program's goals of increasing quality and efficiency, and decreasing cost, depended on having a steady panel of physicians participating in every payer contract. Without joint contracting, the BC noted, "TriState potentially could have different provider panels representing a subset of its membership for each payer contract,"⁷ — a situation that likely would impede in-network referrals, detract from the completeness of patient treatment data, reduce each member's commitment to the program, and add to administrative and other transaction costs. The BC concluded that, "while it might be theoretically possible to have a program without joint contracting on behalf of all physicians in the program, such an approach appears likely to be far more difficult, and potentially could compromise TriState's ability to effectively integrate its physician members' provision of care, and to achieve the program's potential efficiencies."⁸

COMPETITIVE EFFECTS

The BC then considered whether permitting TriState to negotiate prices with payers as an entity would have any effect on competition in the primary service area. The BC could not definitively say that there would be no competitive effect, and cautioned TriState on a number of possible problems. First, the BC noted that TriState has the potential to exercise market power in the sale of its member physicians' services;⁹ a serious concern, given that TriState members would set joint prices and collectively negotiate payer contracts. This concern was compounded by the fact that there were no other IPAs or PHOs operating in Washington County. On the facts presented, however, the BC concluded that this large market share would not be problematic because TriState's program would be non-exclusive. Thus, TriState members, both physicians and the WHCA, would be permitted to contract individually with any payers who choose not to contract with TriState. Although it accepted this safeguard as a theoretical matter, the BC warned that if payers continually were unable to obtain sufficient panels of physicians through individual contracts, it would "at least raise serious questions requiring further investigation and clarification."¹⁰ In short, "non-exclusivity in practice is of critical importance to [the] conclusion that TriState's proposed program is unlikely to create or allow it to exercise market power on behalf of its member participants, or to result in anticompetitive market effects."¹¹

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Second, the BC considered whether WHCA's participation in the program would reduce competition between the hospital and non-hospital providers of certain services, such as outpatient surgery. Relying again on the non-exclusivity provisions, the BC concluded that, in theory, there should be no competitive effect because payers unwilling to contract with TriState should be able to deal individually with the hospital and its physicians at market rates. The BC warned, however, that "this could be an area of serious concern if the providers' relationship through TriState were to be used strategically to benefit either the physician participants or the hospital by reducing or eliminating competition that otherwise would exist in the absence of the participants' agreement through the joint venture."¹²

Third, the BC considered the potential for "spill-over" price effects — meaning that TriState members negotiating individually (pursuant to the non-exclusivity covenant) would require payers to agree to the same fees as the members receive through TriState. TriState offered several remedial measures to address this concern, such as limiting its members' access to other members' competitively sensitive information, providing additional antitrust counseling, requiring board and committee members to sign confidentiality statements, and having a non-physician TriState staff person collect the members' pricing and destroy the paperwork after the collective price is reached. The BC also took comfort in the hope that standard market forces would counteract any physician's ability to obtain the higher TriState reimbursement rates in individual contracts, absent collusive behavior. The BC warned that it would be "greatly concerned if activity in the market suggested the possibility of coordinated interaction — either explicit or tacit — among TriState physicians regarding their dealings outside of TriState."¹³

CONCLUSION

The Opinion is an important guidebook for any organization considering a clinical integration program. It provides much-needed insight into the required components of an acceptable clinical integration program, and presents an invaluable case-study of how physicians (and even a hospital) may — under certain limited circumstances — jointly negotiate prices without running afoul of antitrust law. The BC's warnings about the program's potential competitive effects are also instructive, and serve to counsel organizations about how a legitimate program of clinical integration might get off-track. Wiggin and Dana attorneys have extensive experience advising a broad range of health care clients on complying with federal and state antitrust laws. Please do not hesitate to contact us if you would like to discuss the TriState Advisory Opinion, any aspect of clinical integration or antitrust law more generally.

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¹ Pursuant to 16 C.F.R. § 1.1, the FTC is authorized to provide advisory opinions upon request regarding proposed activity. The FTC has also authorized its staff to provide advisory opinions, where the FTC itself does not need to be involved. This Opinion was issued by the staff of the Bureau of Competition, Health Care Division, not the FTC itself, and therefore is not binding on the FTC as an entity.

² Op. at 14. *See also Health Care Statements* 8, Section B.1.

³ *Improving Health Care: A Dose of Competition*, A Report by the Federal Trade Commission and the Department of Justice (July 2004), at 36.

⁴ *See* Greater Rochester Independent Practice Association, Inc. Advisory Opinion, Sept. 17, 2007; Follow-Up to 2002 MedSouth, Inc. Staff Advisory Opinion, June 18, 2007; FTC Staff Advisory Opinion Concerning Suburban Health Organization, Inc., March 28, 2006; MedSouth, Inc. Advisory Opinion, Feb. 19, 2002; *see also Improving Health Care: A Dose of Competition*, A Report by the Federal Trade Commission and the Department of Justice (July 2004), at 36-41.

⁵ Op. at 7.

⁶ When responding to requests for an advisory opinions, the BC generally does not research the facts independently and often takes the party's representations at face value, including market share data. As such, the Opinion is only valid insofar as the facts presented are actually true.

⁷ Op. at 26.

⁸ Op. at 26.

⁹ TriState represented that its physicians comprise 64% of the hospital's medical staff and half or more of the physicians in a large number of specialties in the primary service area. *See* Op. at 29.

¹⁰ Op. at 31.

¹¹ Op. at 31.

¹² Op. at 32-33.

¹³ Op. at 35.

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