Years after the shift from risk contracting between the managed care industry and health care providers, the Federal Trade Commission (FTC) has turned up the heat on provider networks, such as PHOs and IPAs, alleging that the negotiating activity of these provider networks constitutes price fixing or other anti-competitive behavior.

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In 1996, the FTC and the Department of Justice (DOJ) issued Statements of Antitrust Enforcement Policy, which provide safety zones that protect provider network activity if such network (i) is financially integrated (e.g. risk sharing); (ii) is clinically integrated; or (iii) utilizes the messenger model. During the mid-1980s and the 1990s, provider networks gravitated toward risk contracting to become financially integrated. As risk sharing, and with it, financial integration became a thing of the past, provider networks began relying on the messenger model. The messenger model in its simplest form permits a provider network to use an independent third party to courier offers back and forth between providers and payors. Modified versions of the messenger model have evolved, including one recently approved by the FTC, which provided a non-physician employee of the provider network to act as the “messenger” and collect a minimum required reimbursement level from each member of the network. The messenger would then contract on behalf of the provider with any payor whose offer was at or above the provider’s minimum reimbursement level.

More recently, some provider networks have been developing policies, procedures and systems to improve the quality, utilization and efficiency of services provided by providers in the network. As these networks use their collective assets to improve the clinical services provided by their members, they have also in many cases begun to evaluate whether they can be considered clinically integrated within the Statements of Antitrust Enforcement Policy. Without financial integration and with most provider networks finding it difficult to rely on the messenger model for contract negotiation, clinical integration arguably provides another way to contract for the network.

Many provider networks have turned to clinical integration as justification for joint negotiation of payor agreements. However, no advisory opinions have found a provider network to be clinically integrated. There is general guidance on how to achieve clinical integration. Specifically, the FTC has stated that the clinical integration must be significant and can generally be evidenced by “the network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s provider participants and create a high degree of interdependence and cooperation among the providers to control costs and ensure quality.” There must be a logical connection between the network’s ability to control quality and costs and its ability to establish prices as a group. Clinical integration does not open the doors to joint bargaining by loosely affiliated or organized networks. Clinical integration is explained in the first FTC advisory opinion on this issue dated February 19, 2002. The opinion provides that the following are key elements of a clinical integration program:
• Establish benchmarks relating to quality and utilization of services
  o Develop benchmarks (e.g., practice standards and protocols) to govern treatment and utilization of services. These standards and protocols may include patient satisfaction and clinical practice guidelines and performance goals relating to the quality and appropriate use of services
  o Integrate access to, and sharing of, patient clinical information by providers (this is not adequate without benchmarks)
  o Establish a committee of the network (the “Clinical Integration Committee”) to approve benchmarks, report results of the clinical integration program to the Board and recommend action to the Board for deficient providers
  o Review the benchmarks annually and revise, if necessary
  o Ensure the agreements between providers and the network require provider participation in the clinical integration program and adherence with the benchmarks (including the option to expel a provider if necessary upon the recommendation of the Clinical Integration Committee)

• Evaluate each provider’s and the network’s aggregate performance concerning the benchmarks
  o Actively review care rendered by each provider in light of the benchmarks, utilizing an electronic clinical information system and/or chart reviews
  o Report on provider and aggregate performance relative to the benchmarks
  o Perform case management, preadmission authorization of some services, and concurrent and retrospective review of inpatient stays
  o Ensure that each provider is adequately integrated (e.g. performs enough services under network contracts)

• Modify each provider’s actual practices, where necessary, based on evaluations
  o Assist a provider who has failed to adhere to the standards and protocols by instituting a corrective action plan
  o Subject providers who continue to fail to adhere to the benchmarks to remedial action, including the possibility of expulsion from the network

• Take necessary corporate action to carry out the above items
  o Document investment of capital to purchase information systems necessary to gather data on cost, quantity and nature of services provided or ordered, measure performance against the benchmarks, and monitor patient satisfaction
  o Provide payors, providers and the network Board with detailed reports on cost and quantity of services and success in meeting the benchmarks
  o Hire a medical director and support staff to perform the functions and to coordinate patient care

The FTC has noted that each requirement does not necessarily have to be met so long as the clinical integration is likely to produce significant efficiencies that benefit consumers, and any price agreements by the providers are reasonably necessary to realize those efficiencies. With the FTC aggressively targeting provider networks for claims of price fixing and other antitrust violations in network contracting, reliance on clinical integration is not for the faint hearted. Many recent FTC decisions have included statements by the FTC that it is skeptical that provider networks such as IPAs and PHOs can be clinically integrated. See, Piedmont Health Alliance, Inc., Dkt. No. 9314 (December 22, 2003); Tenet Healthcare Corp., FTC File No. 021 (December
Provider networks are under intense antitrust scrutiny by the FTC and the DOJ. A provider network’s decision to rely on clinical integration must be undertaken carefully and with advice of counsel. The Robinson & Cole Health Law Group has extensive experience dealing with provider networks and the complex antitrust issues such networks present.