

Bruce D. Sokler

Direct dial 202 434 7303
bsokler@mintz.com

MEMORANDUM

FTC ISSUES CLINICAL INTEGRATION ADVISORY OPINION

The Federal Healthcare Antitrust Guidelines set out a framework where multiple providers may act jointly consistent with antitrust laws when there is sufficient financial or clinical integration among them. Other than the discussions in the guidelines, there has been very little since then providing insight into the antitrust agencies' thinking regarding clinical integration. Last month, however, the Federal Trade Commission ("FTC") issued an advisory opinion about a proposed clinical integration program that contains some significant detail. MedSouth, Inc. (Feb.19,2002).

The FTC advisory opinion is analyzed below. Two important cautionary notes should be made at the outset. First, neither clinical nor financial integration provides a complete antitrust clean bill of health for participants. The presence of such integration merely – but importantly – converts what otherwise would be improper conduct, e.g., joint pricing (price fixing) and joint decision making (refusals to deal) into a situation where the more forgiving antitrust rule of reason analysis is applicable. Second, under that analysis, a network could be antitrust integrated, but still possess sufficient market power or inflict anticompetitive effects so that the enterprise could be condemned. In submitting a lengthy letter that formed the basis for the opinion, MedSouth carefully constructed the facts so that the FTC could not undertake this latter analysis, and MedSouth received no advisory protection on these issues.

I. MedSouth

MedSouth is currently a physician Independent Practice Association ("IPA") in Denver, Colorado. It includes competing primary care and specialist physicians, totaling 432 physicians in 216 practices, 101 of these physicians are primary care physicians ("PCPs") and 331 are specialists in 39 specialties and subspecialties. In general, the MedSouth specialists are those to whom MedSouth PCPs most frequently refer. Denver apparently is a market where risk contracts have had their heyday and have receded. In fact, capitated contracts have forced several Denver IPAs into bankruptcy.

II. The Proposed Clinical Integration Program

MedSouth physicians, its consultants, a health care technology service provider and a national clinical lab company have worked for over a year to develop a clinical research management program. The program will have two major parts: (1) a web based electronic clinical data records system, and (2) the adoption and implementation of practice guidelines and performance goals relating to the quality and appropriate use of MedSouth physicians. The web based clinical records system will allow MedSouth members to rapidly access and exchange clinical information relating to patients. The system can aggregate data from multiple physicians to show, for example, trends of results on tests done at different times and different places.

MedSouth is also developing clinical protocols covering the majority of MedSouth physicians' patient population. At least 48 guidelines are under development and a total of 100-150 are completed. The guidelines are intended to cover 80-90 percent of the diagnosis that are prevalent in its physician practices.

MedSouth also committed to develop measurable performance goals relating to the appropriate utilization of services that are linked to the protocols. The IPA proposes to secure members' commitments to adhere to the protocols; review the performance of MedSouth physicians individually and collectively with respect to those goals; assist members in meeting the goals; and, as necessary, expel physicians who cannot or will not meet the goals.

Armed with this integration system, MedSouth wishes to contract with third party payers on a fee-for-service basis. It indicates that it would retain a consultant to develop fee proposals. In addition, MedSouth intends to charge a network access fee to the payers purchasing the package of services that will support MedSouth's operating and administrative costs.

MedSouth committed not to negotiate or execute such contracts on behalf of its members until all parts of the program are operational. Moreover, MedSouth committed that its network will be non-exclusive, and payers will be free to contract with MedSouth members directly. **There is no indication that there is any exclusive negotiating period commitment made by the members to MedSouth.**

III. The FTC Staff Analysis

The FTC staff concluded that MedSouth's proposed program should not be accorded per se treatment under the antitrust laws and has the potential to produce efficiencies in the form of higher quality or reduced costs for patient care services rendered by network physicians. To reach that conclusion, the staff had to satisfy itself that the collective negotiation of prices was ancillary to the efficiency-enhancing clinical integration. The staff did decide that the:

“price agreement embodied in joint negotiation of contracts for services to be provided subject to the entire proposed program appears to be reasonably related

to the integration among MedSouth members, and reasonably necessary for MedSouth to achieve the procompetitive benefits it seeks.

In order to establish and maintain the on-going collaboration and interdependence among physicians from which the projected efficiencies flow, the doctors need to be able to rely on the participation of other members of the group in the network and its activities on a continuing basis. This does not appear to be possible if contracting for the sale of services is done individually. The price for professional services rendered under health plan contracts needs to be established, and if it is done through individual negotiation and contracting, then no one can count on the full participation of the group's members. **Whatever value the program has for consumers, beyond what would result from individual doctors computerizing their records and determining to follow particular guidelines, is significantly dependent on the doctors being able to function as a group within which patients are commonly referred.** In the absence of the group being able to assure continuing participation of its members in its contracts, some of the benefits are likely to go unrealized.

In addition, joint contracting may permit the network to allocate the returns among members of the network in a way that creates incentives for the physicians to make appropriate investments of time and effort in setting up and implementing the proposed program. According to your letter, it is important for MedSouth to be able to assure that the rewards from the program flow to the doctors in an equitable manner, so that some are not able to charge disproportionately high prices relative to other members, and thereby capture an excessive proportion of the value of the network's programs." (Emphasis added.)

Having said that, the FTC staff also expressed several important limiting and cautionary notes:

- ?? The FTC staff found that the mere adoption of a common computer system by its physicians would not suffice to establish clinical integration or permit joint price negotiation.
- ?? The FTC staff questioned whether the level of integration was sufficient with respect to each and every physician as to make joint negotiation of the fees ancillary. They were concerned that some specialists might not have enough "MedSouth patients" to be sufficiently involved or to have their practice patterns significantly affected by them. Because, however, MedSouth had reported that they did not know which or how many physicians would participate, the FTC did not have to resolve this question.
- ?? Again, because it did not know which physicians would continue to participate in the "new" MedSouth, the FTC staff did not have to undertake the rule of reason analysis of competitive effects but could reserve on the issue. It did discuss the issue in a way that suggested it would look at areas of Denver as potentially relevant geographical markets:

“MedSouth currently has a large number of participating doctors who are concentrated in a distinct area of the city. In a number of specialties, they constitute half or more of the physicians with admitting privileges at the three hospitals in south Denver. Of particular significance with respect to the needs of local health plans that contract for physician services, MedSouth contains a substantial proportion of the internists and family practitioners in the south Denver area. For example, MedSouth’s current members are 51% of the internists and 33% of the family practitioners at Swedish Hospital, and from 50% to 100% of the specialists in 19 other practice areas at that hospital (allergy/immunology, cardiology, endocrinology, hematology/oncology, infectious disease, nephrology, neurology, oncology, pulmonary medicine, radiology, rheumatology, hand surgery, neurosurgery, pathology, podiatric surgery, urology, vascular surgery, pediatric cardiology, and pediatric neurology). They are 44% of the family practice physicians and 48% of the internists at the two Adventist hospitals, and from 50% to 100% of the specialists in 21 other fields at those two hospitals (allergy, cardiology, cardiovascular surgery, endocrinology, gastroenterology, gynecology, infectious diseases, nephrology, neurology, neurosurgery, oncology, otolaryngology, otology, pathology, podiatry, pulmonology, radiation oncology, radiology, rheumatology, hand surgery, and urology). As noted above, however, we do not know how many of these physicians will remain members of MedSouth after the venture is launched. A significant decrease in the number of MedSouth participating physicians would lessen the risk of anticompetitive harm.”

?? The staff also wanted to make sure that MedSouth members were non-exclusive in deed, not just in word. The conclusion one would draw from the excerpt quoted below is that it would be very prudent if MedSouth is ever investigated that it be able to show some contracting activity by individual MedSouth members:

“In spite of MedSouth’s explicit policy of “nonexclusivity,” MedSouth members may have the incentive and the ability to agree not to contract independently of the venture. They have incentives to seek higher fees to recoup their investments in developing and implementing the proposed program. Negotiation of fee-for-service rates for the group will involve identification of price levels that could become the focal point for collusion on individual contracts. To the extent that the program creates greater communication and interdependence among the doctors, the easier it likely would be for them to coordinate their activities. Particularly in light of the doctors’ existing referral arrangements, MedSouth members may be able to discipline members of the IPA who might be inclined to break ranks and contract independently. We cannot conclude with certainty that MedSouth’s physicians actually will contract outside the IPA; nor can we conclude, at this early stage, that MedSouth’s operation will restrict competition unreasonably. MedSouth plans to take steps to ensure that its physicians will in fact be available to contract independently with health plans. We recognize, further, that Med

South physicians apparently did contract with health plans individually at prevailing market prices when the IPA's capitated contracts were terminated. We assume for purposes of this advisory opinion that your representations regarding the availability of MedSouth members to contract individually with health plans at competitive rates is accurate and will be borne out by the members' actual conduct."

?? Finally, the staff also suggests that the adoption of guidelines and benchmarks are not enough, but the real litmus test is to change physicians' established patterns of practice. The FTC staff recognizes that this task is easier said than done, but for purposes of the Advisory opinion, assumes that MedSouth possess the determination and ability to accomplish those changes:

"The information we have obtained in analyzing physician markets suggests that, in actual practice, it is often difficult to change physicians' established patterns of practice. Doing so does not result simply from the adoption of guidelines and benchmarks. Rather, the effectiveness of such programs depends upon a number of intangible factors, including the degree of commitment to the process by the members of the group and the effectiveness of its leadership. To change practice patterns requires an ongoing commitment of time, effort, and expertise, and it can be difficult to accomplish even when there are significant external incentives to do so. The experience of other physician groups indicates that it is harder to achieve implementation of this type of program in a large group, in the absence of direct financial risk relating to achievement of network goals, or where the physicians are not already closely connected to one another, and that each physician needs to have a significant number of patients subject to the system before it has an actual impact on his or her practice patterns.

The ultimate conclusion we draw in this advisory opinion turns in substantial measure on your representations concerning MedSouth's determination and ability to overcome these challenges. MedSouth has established efficiency goals and developed concrete plans to achieve them. We think a conclusion at this stage that MedSouth is unlikely to achieve the efficiencies it seeks is unwarranted. Nonetheless, the extent to which efficiencies actually are achieved would be an important factor in assessing the overall competitive effects of the proposed conduct."

March 7, 2002