THE IMPACT OF CLINICAL INTEGRATION
ON JOINT MANAGED CARE CONTRACTING AMONG INDEPENDENT PHYSICIANS

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Clinical integration describes a medical practice and economic model under which independent providers work together to coordinate the medical care provided to patients. This model seeks to improve the quality and efficiency of care through the sharing of information, development of protocols, and the elimination of duplication. Successful clinical integration aligns the incentives of physicians, hospitals, and other providers in a manner that increases access to care, improves clinical quality, and reduces overall costs. Additionally, clinically integrated providers that meet Federal Trade Commission ("FTC") requirements may jointly contract with fee-for-service health plans, a practice that is typically banned among independent providers by the Sherman Antitrust Act. This article describes the background and requirements of clinical integration, explores the impact clinical integration will have on providers, and provides a case study of a successful clinically integrated provider.
Executive Summary

The Sherman Antitrust Act prohibits private companies from collaborating with other companies to jointly negotiate agreements or prices. These laws were intended to restrict monopolies and ensure fair competition and trade. Through competition, the law seeks to ensure that consumers receive goods and services of a higher quality at a lower cost.

The Sherman Antitrust laws, as well as Supreme Court decisions, historically forbid independent medical groups from jointly negotiating with managed care companies unless they are financially integrated. Beginning in 1996, however, the Federal Trade Commission ("FTC") has released opinions and other documents that indicated how physician joint venture networks organized to control costs and ensure quality could jointly contract for fee for service ("FFS") contracts. Requirements included high levels of collaboration among the separate groups, the monitoring and controlling of care utilization, active selection of participating physicians, and significant investments in human and financial capital. These requirements formed the foundation of what has become known as clinical integration.

Clinical integration seeks to align the incentives of physicians, hospitals, and other providers in a manner that increases access to care, improves clinical quality, and reduces overall costs. Through clinical integration, physicians can maintain independent practices rather than sell to large groups or to hospitals. As a result, physicians from smaller independent practices can work with hospitals and large groups to lead the improvement of quality healthcare in their community.

Antitrust Laws and the Impact on Medical Groups

The Sherman Antitrust Act of 1890 prohibits agreements among private, competing individuals or businesses that unreasonably restrain competition. With higher competition, consumers theoretically receive higher quality goods and services and lower prices. In Arizona v. Maricopa County Medical Society (Arizona v. Maricopa County Medical Society 1982), the Supreme Court found that a joint agreement among competing physicians related to a discounted fee schedule offered to managed care companies constituted unlawful price-fixing that violated federal antitrust laws.

Prior to the clinical integration exemption established by the FTC, physicians that wished to jointly contract with payers had few options:
• Merge their practices into one medical group
• Deploy messenger model negotiations
• Establish economic integration by sharing substantial financial risk through capitated contracts

Merging private medical groups into a larger common group can provide increased efficiencies of scale and higher market leverage with payers. However, merging medical groups is not always a viable option, as practices often have different cultures, organizational structures, operations, and strategies. In most markets there are substantial numbers of physicians who prefer to remain in small private practices rather than join large groups or, where it is allowed, become employees of a hospital or health system.

Messenger model negotiations allow independent physician groups to jointly market themselves to health plans as a network. However, this model does not allow the independent medical groups to collectively negotiate fees with payers, or to otherwise agree on what fee schedule they will collectively accept (Department of Justice/Federal Trade Commission 1996). Under the messenger model, the negotiations are performed by a messenger, but they must be done individually and without consideration to other negotiation processes, status, or results. The messenger model has not proven to be a successful vehicle for negotiating rates.

Economic integration in which physicians share financial risk typically involves accepting capitation from payers. Under capitation, medical groups receive fixed payments for providing medical care to enrolled patients. To be successful in these arrangements, medical groups must effectively manage patient care, avoid unnecessary care, and coordinate physician efforts. In some markets, including California, capitation is prevalent under health maintenance organization (“HMO”) contracts and many medical groups and independent practice associations (“IPAs”) have been very successful under capitation. IPAs are organizations of private medical practices that utilize the financial integration exception to accept risk and jointly negotiate capitated contracts on behalf of its private physician group members. Many IPAs have been very successful, but they do not have the ability to negotiate FFS contracts. As the popularity of HMO plans wane and more individuals move to preferred provider organization (“PPO”) plans that typically offer physicians FFS reimbursement, IPAs are facing declining HMO enrollment and revenue. Presented with this scenario, many IPAs are seeking new lines of business, including the negotiation of PPO contracts for their members.
In other markets, medical groups lack the experience or sophistication to effectively manage care or they are unwilling to accept the financial risk of caring for patients. In addition, as a result of market pressures including employee and employer dissatisfaction with restrictive HMO plans, many markets have few or no health plans offering capitation. Therefore, the joint contracting of capitated contracts among independent medical groups has been limited to certain markets. Even within these markets, HMO enrollment is declining and therefore joint contracting opportunities are becoming more limited for independent medical groups.

**Clinical Integration Background and Definition**

In 1996 the FTC issued Health Care Statement 8 that indicated physician network joint ventures could achieve integration likely to produce significant efficiencies by implementing certain clinical alternatives to the sharing of substantial financial risk. This became the concept of clinical integration, defined as “an active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality.” (Federal Trade Commission 1996)

According to Statement 8, clinically integrated physician joint venture networks would have to include:

- Establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care
- Selectively choosing network physicians who are likely to further these efficiency objectives
- The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies

The FTC further defined the requirements of clinical integration in a 2004 report on competition (Department of Justice/Federal Trade Commission 2004). According to this report, clinical integration includes:

- The use of common information technology (“IT”) to ensure exchange of all relevant patient data
- Development and adoption of clinical protocols
- Care review based on the implementation of protocols
- Mechanisms to ensure adherence to protocols

The FTC has also issued advisory letters to several organizations which outline additional requirements of clinical integration. These letters, which are publicly available, provide important insight into how the FTC views organizations’ clinical integration programs and efforts. Advisory letters have been received by MedSouth, Greater Rochester IPA (“GRIPA”), Brown & Toland Medical Group, Advocate Health Partners, Suburban Health Organization, and others.

Through Statement 8 and other documents, the FTC makes it clear that the arrangements it outlined are not the only types that can create sufficient clinical integration. It does establish, however, that critical to any qualifying clinical integration arrangement is that jointly contracting with payers must be reasonably necessary to the organization’s achievement of its stated efficiencies and goals. The objective of clinical integration must not be negotiating higher reimbursement rates from payers. Rather, the joint negotiation of rates must be necessary for the success or viability of the clinical integration efforts.

In its appeals to the FTC for approval of its clinical integration program, Brown & Toland Medical Group argued that the joint negotiation of contacts was necessary for clinical integration for several reasons (Claiborne n.d.):

- Without the benefits of jointly negotiated contracts, including reduced administrative hassle and higher reimbursement rates, physicians would be unlikely to participate in networks designed to provide clinical integrated services.
- Comprehensive, coordinated, and clinical integrated networks deserve to be paid higher than small, segmented, and uncoordinated networks because they provide a superior product.
- Without higher reimbursement rates resulting from joint contracting, physicians will be incentivized to not participate in an integrated network.
that is focused on reducing overall costs, in part through the rationalization of care.

- Even when paying a clinically integrated network higher contracted rates, it is likely that a health plan’s total expenses will actually be lower than when contracting with separate entities at lower rates. This is the result of cost containment and improved efficiencies gained by the clinically integrated network through care management, utilization review, quality assurance, reduced duplication and waste, and better outcomes. Payers have the added benefit and reduced administrative cost of contracting with one entity, rather than many.

In a speech made to the American Health Lawyers Association in 2007, the Commissioner of the FTC, J. Thomas Rosch, spoke about clinical integration and its requirements. He indicated that the FTC remained very concerned about illegal price fixing arrangements among physicians, and that clinical integration programs would be very carefully evaluated. He stated that clinical integration, as defined by Statement 8, “has turned out to be an extremely difficult and expensive task for physician groups” and that, in his opinion, financial integration was the safest and most realistic form of integration for physician network joint ventures.

Mr. Rosch’s perception that clinical integration is difficult and potentially risky seems to be supported by the fact that in the decade following the FTC’s Statement 8, very few organizations have appealed to the FTC for approval to negotiate under the clinical integration exemption. Between 1996 and 2005, only MedSouth, a 400-physician IPA in Denver, requested and received an advisory letter from the FTC. This is despite the fact that HMO enrollment declined during this timeframe, challenging IPAs’ primary reason for existence. In a 2006 article in Journal of Health Politics, Policy and Law (Casalino 2006), Lawrence P. Casalino proposes four possible reasons for the low volume of appeals to the FTC.

First, Casalino proposes that some organizations have simply begun to negotiate PPO contracts without applying for FTC advisory letters, either oblivious to the antitrust implications or simply hoping that they would not get caught. Between 1996 and 2005 the FTC took action against 22 IPAs and seven physician hospital organizations (“PHOs”) for price fixing. All but one of these organizations agreed
to cease PPO negotiations. North Texas Specialty Physicians refused and lost to the FTC in court. Brown & Toland Medical Group in San Francisco agreed to temporarily stop PPO contracting, but later appealed for an advisory letter and was approved.

A second reason is simply that many organizations fail to understand what clinical integration truly involves, so they do not pursue FTC approval and they do not attempt to negotiate FFS contracts.

Casalino’s third reason is that organizations clearly recognize that pursuing clinical integration involves significant costs, as Rosch indicated, but that the financial incentives were less certain. There is no guarantee that health plans will negotiate with IPAs or grant more attractive rates to clinically integrated organizations. Even when an organization can contract as a clinically integrated entity, much of the reimbursement is tied to clinical performance and quality scores. The organization has no way of knowing how they will score on these measures, and therefore how they will be paid. Confronted with certain higher costs in the immediate term, and only the possibility of increased reimbursement in the long term, many groups have made a conscious decision not to pursue clinical integration.

Lastly, Casalino argues that physicians themselves might be the fourth barrier to higher clinical integration adoption. He argues that most of the physicians who stand to benefit from clinical integration, namely those in IPAs and PHOs, are members of small, independent medical groups. As solo physicians or members of small groups, these physicians likely lack the knowledge, resources, and interest in working collaboratively with large groups of physicians. They also likely lack the time and financial resources necessary to pursue clinical integration. Strong leadership from physicians who understand and believe in the benefits of clinical integration is necessary to engage physicians to overcome these challenges.

Following MedSouth, several organizations have stepped forward and successfully pursued clinical integration. One of these groups, Greater Rochester IPA, is profiled in the following section.

Case Study of Greater Rochester IPA

Greater Rochester IPA was formed in 1996 as a for-profit partnership 50 percent owned by non-profit Rochester General Health System (“RGHS”) and 50 percent owned by approximately 660 physicians. RGHS owned two hospitals in the market. In addition to the shareholder physicians, the IPA contracted with an
additional 120 physicians. In total, the organization included more than 40 medical and surgical specialties.

GRIPA was originally established to negotiate and manage HMO risk contracts, and maintained full-risk contracts with several payers. These contracts represented up to 70 percent of its members' revenue. The organization had a staff of approximately 40 that provided care management, provider relations, credentialing, IT, data analysis, and financial and actuarial functions.

Most of the private physicians in GRIPA’s market were in small groups of less than five physicians. The physicians preferred the IPA model and were not interested in forming larger multispecialty groups. The largest group in the community was owned by RGHS, who employed more than 200 physicians, who were among the shareholders in GRIPA.

Capitation was declining in the Rochester market, and the private physicians were not interested in joining the RGHS medical group or forming a new multispecialty group. As a result, GRIPA turned to clinical integration as an alternative strategy for increased collaboration among local physicians. The organization felt that it already had many of the necessary components, including care management, pay for performance incentives, and clinical protocols. GRIPA’s leadership believed that physicians typically want to provide high quality care, which GRIPA saw as a good motivation for clinical integration. GRIPA also recognized the importance of physician leadership, and did not allow the hospitals to control the process. Physicians were in key positions of leadership and helped drive the clinical integration efforts.

Beginning in 2005, GRIPA formally ratified clinical integration as an organizational goal and contracted with consultants and attorneys to assist in seeking an FTC advisory opinion that would support them in that effort. GRIPA felt that obtaining a favorable opinion would give the physicians confidence and incentive to move forward with clinical integration. During 2005 and 2006, GRIPA developed a business plan, the necessary IT infrastructure, an internet portal to provide physicians with utilization and quality data, a database, and interfaces with imaging centers, clinical laboratories, and hospitals. In June of 2006, GRIPA submitted its FTC advisory opinion request outlining its program and the potential benefits to patients.

GRIPA’s proposed clinical integration program consisted of the following elements, most of which were actively developed and overseen by physicians:
- Development of evidence-based practice guidelines, protocols, and quality benchmarks, developed by the participating physicians for more than 35 clinical conditions
- Monitoring individual physicians, and GRIPA in the aggregate, for compliance with guidelines and protocols and achievement of network benchmarks
- An internet-based electronic clinical information system, which GRIPA physicians use to share clinical information about patients and order prescriptions and lab tests
- Agreement by GRIPA physicians to refer patients to other GRIPA network physicians, except in limited circumstances, in order to improve coordination of care and monitoring of GRIPA physicians
- Expansion of existing case management, disease management, and pharmacy management programs developed for patients covered under risk contracts
- Educational and training requirements for participating physicians
- Quality assurance council for peer review of individual physicians and disciplinary actions, including expulsion from the network

Following the submission of their request letter, GRIPA continued to expand its network through contracts with physicians and hospitals, developed practice management interfaces, and began to roll-out the internet portal in physician offices.

In September 2007, GRIPA received a favorable FTC Advisory Opinion. They were just the second organization to receive such a letter, and the first in five years. (GRIPA Press Room n.d.)

In their Advisory Letter, the FTC indicated that the GRIPA program met the antitrust exemption that clinical integration programs seek to control costs and improve quality at the benefit of consumers. They stated, “...it appears that GRIPA’s proposed program will involve substantial integration by its physician
participants that has the potential to result in the achievement of significant efficiencies that may benefit consumers.” (www.FTC.gov 2007)

As previously outlined, a key requirement of clinical integration is that joint contracting with payers must be reasonably necessary to the organization’s achievement of its stated efficiencies and goals. The objective of clinical integration must not be negotiating higher reimbursement rates from payers. The FTC commented on this requirement in its letter to GRIPA, which stated, “It also appears that GRIPA’s joint negotiation of contracts, including price terms, with payers on behalf of its physician members ... is subordinate to, reasonably related to, and may be reasonably necessary ... to achieve the potential efficiencies that appear likely to result from its member physicians’ integration through the proposed program.”

GRIPA’s timeline towards obtaining the FTC advisory letter is presented in the following diagram.

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<th>June 2005</th>
<th>June 2006</th>
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<td>Clinical integration identified by GRIPA as a key objective</td>
<td>Advisory Opinion request submitted to FTC</td>
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<th>December 2005</th>
<th>September 2007</th>
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<tr>
<td>Business Plan approved internally</td>
<td>Favorable FTC Advisory Opinion received</td>
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To participate in the clinical integration program, physicians must agree to certain participation conditions. Each physician must agree to:

- Follow evidence-based guidelines created by their peers
- Send a copy of practice management data to GRIPA
- Subject themselves to education, discipline, and potentially expulsion
- Service on committees
In return, GRIPA provides each physician with:

- A tablet computer, including wireless access
- Immediate access to patient information via a web portal
- Feedback and tools to improve individual and network performance
- Contracting with payers

One of the FTC requirements for clinical integration and something that the FTC specifically commented on in its Advisory Opinion letter to GRIPA is the requirement of significant monetary and human capital investment by participants. Investments by GRIPA physicians included:

- $7,000 per physician to establish the clinical integration program
- $3,500 per physician per year to maintain the program
- $7,000 per office for hardware
- Initial training, valued at $3,200 per physician based on time commitment
- Ongoing time and effort valued at $2,400 per physician per year for the contribution of data, collaboration on patient care, compliance with guidelines, and participation on committees

The recognized benefits of the clinical integration program at GRIPA include:

- Increased quality of care
- Improved efficiency of care
- Decreased costs, medical errors, and variations in care delivery
- Improved outcomes, safety, communications, and patient satisfaction
- Ability to negotiate contracts with payers
- The ability to sell services to a new market: self-insured employers
- Increased alignment between hospitals and physicians
- Increased physician commitment to and acceptance of performance monitoring
• Pay-for-performance contracting across all payers
• The ability to measure and report performance on a physician and network level
• Improved performance on risk-based contracts
• Coordinated e-prescribing using one medication list per patient across all providers

Conclusion

Independent physician practices wishing to jointly contract with managed care plans have historically been faced with few options: they can merge into a single entity, they can deploy messenger model negotiations, or they can enter for-risk, or capitated, contracts. For many independent practices, these are not available or attractive options. In addition, HMO enrollment continues to decline nationwide, reducing the availability of capitated contracts. Clinical integration represents an alternative approach to allow independent physician groups to jointly negotiate contracts with health plans.

To meet the FTC’s strict guidelines for clinical integration, organizations must demonstrate that they are designed to monitor and improve the quality of clinical care while also reducing overall costs. By doing so, they benefit individual patients. Clinically integrated organizations may then jointly contract with health plans, if it is necessary to the operation of their clinical integration program.

Strong physician leadership that understands the legal and operational requirements of clinical integration is essential to an organization’s success. These physician leaders must be the ones to coordinate the organization’s efforts to improve the quality of care being provided to patients. The requirements of clinical integration are difficult to achieve, but the benefits to the organization, its member physicians, and ultimately to patients, can be significant.
BIBLIOGRAPHY

Arizona v. Maricopa County Medical Society. 457 U.S. 332 (United States Supreme Court, 1982).


