Antitrust Compliance and the New Network Realities

or Am I Clinically Integrated?
Topics for Today’s Discussion

- Antitrust in context – a common starting point
- Enforcement agency positions
- Best practices for effective integration
- Acceptable methods to demonstrate integration – how the question translates to payor contracting
- Risk contracting as a solution to antitrust problems
Why are we still here?

- Provider network strategies have been around since Clinton-era health reform.
- The FTC and DOJ have responded conservatively
  - 1996 Guidelines
  - Fuzzy staff opinion letters on clinical integration
  - ACO Guidelines (2011)
- Antitrust analysis is complicated
  - and lawyers don’t always help
Antitrust in context

- The law treats unilateral conduct differently from “concerted” conduct.
- Concerted conduct is judged under two standards
  - “Per se” unlawful combinations
    - Price-fixing agreements
    - Agreements not to compete
  - “Rule of Reason”
    - A non-formulaic facts-and-circumstances analysis
Assessing provider networks

- Networks that include independent providers (potential competitors) may involve price agreements.
  - Unless they are “messenger model” networks

- How are network price agreements evaluated?
  - Are they “naked?”
  - Are they “ancillary” to a larger productive enterprise?
    - A \textit{bona fide} joint venture.
Assessing provider networks

What makes a network a *bona fide* joint venture?

- Financial integration
  - Providers share “significant” financial performance risk

- Clinical integration
  - Providers share clinical performance risk
I’m integrated – now what happens?

- The competitive risks of the network are evaluated on a facts-and-circumstances basis.
- This does not mean the network is “legal”
- Relevant considerations:
  - Market share(s)
  - How payors in the market form networks
  - How providers in the market respond to competition
  - The efficiency (value added) of the network
ACO Guidelines

- Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program
  - “Safe harbor” test for ACO composition
  - Types of collaborative conduct that the Agencies consider potentially anticompetitive

ACO Guidelines

- Not all that different from the 1996 Statements of enforcement policy toward IPAs and PHOs.
- Conservative by definition.
- More useful as an insight into FTC/DOJ thinking than as an actual tool to evaluate antitrust risk.
Safe harbor

- Based on simplifying assumptions for defining the affected “product” and geographic markets
  - Not definitions that any court has accepted

- Divides the universe of ACOs into two levels of concern based principally on market share.

- An ACO presumptively presents no antitrust risks if it meets 3 criteria and there are no “extraordinary circumstances:”
Safe harbor

1. The ACO participants in combination do not provide more than 30% of any relevant service (product) in any single ACO provider’s primary service area, subject to certain defined (and limited) exceptions for providers in rural areas.

   - Very hard to measure
   - Difficult to satisfy in most markets
Safe harbor

2. No hospital or ASC participating in the ACO is exclusive to the ACO (either as a matter of contract or in practice)
   - What about a hospital-sponsored ACO?
Safe harbor

3. If the ACO includes a “dominant provider” (one with more than a 50% market share of any service that no other ACO participant provides):
   - the dominant provider does not have an exclusive relationship with the ACO, and
   - the ACO does not restrict any payor’s ability to contract with other networks/ACOs (through an exclusivity clause or otherwise).
Outside the safe harbor

- A facts and circumstances analysis
- Emphasis on “suspect behavior”
Suspect behavior

- Requiring “anti-steering” or “anti-tiering” clauses in payor contracts

- Tying ACO business to a payor’s purchase of other services from providers outside the ACO (or vice versa)
Suspect behavior

- Contracting with physician specialists, hospitals, ASCs, or other providers (other than PCPs) on an exclusive basis;
- Restricting a payor’s ability to make provider cost, quality, efficiency, and performance information available to its enrollees
Suspect behavior

- Sharing pricing or other competitively-sensitive information among ACO providers that could be used to reduce competition for services provided outside the ACO
Suspect behavior

- The five categories are not as black and white as the Agencies would seem to say.
  - Anti-tiering vs. concerns about arbitrary exclusion
  - Restrictions on information-sharing vs. assurances that information is relevant and accurate
  - Exclusivity to the ACO vs. exclusivity of the ACO
FTC Staff Opinion to Norman PHO

- **Background**
  - PHO comprises Norman Regional Hospital and 238 physicians
  - In operation since 1994 using messenger model
  - Moving to a clinical integration model, *which is not yet completely defined or operational*
  - FTC review appears to have taken almost two years

February 13, 2013

[http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf](http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf)
Attributes of the clinical integration program

- QA Committee responsible for performance benchmarking, compliance, and corrective action
  - Both cost and clinical practice metrics
  - No unusual program design
- Significant expectations of investment of MD time and effort
  - Note: no major capital investment (beyond individual practice IT)
Attributes of the clinical integration program

- Potential for withholds/financial incentives
  - No discussion of level or significance
- Mandatory participation in PHO’s payor contracts
- Non-exclusive
  - Providers permitted to contract outside the PHO, either individually or through other networks
Attributes of the clinical integration program

- No competing hospitals are part of the PHO network
  - And no combination of pre-existing networks
- Antitrust compliance protocols
- No “suspect” contract terms contemplated
  - E.g., to discourage payors from contracting with non-PHO providers
Staff conclusions

- The PHO likely has market power
  - Payors do not have an alternative network
  - PHO expects to obtain higher prices

- However, joint negotiation by PHO will not be deemed *per se* illegal
  - Justified by increased utilization of physician resources to achieve clinical integration
  - Rejects the “mere incentive” argument
Staff conclusion

- No present enforcement intentions

- Implies that PHO can begin joint negotiations with payors even though the CI program is incomplete
  - Conclusion likely flows from the non-exclusivity of the arrangement
What is noteworthy about this opinion?

- Not as cautionary as the ACO Policy Statement
- Supportive of network that:
  - Has a high market share
  - Has not fully implemented its clinical integration program
- Apparent recognition of increasing commercial payor interest in performance-based contracting
Defining best practices (from an antitrust standpoint)

- To state the obvious, every network faces different challenges
  - Economics
  - Politics
  - History
  - Geography

- Hence the unicorn theory
Best practices

- Understand the rationale for joint pricing under a clinical integration model:
  - Common contracts are necessary to create a consistent set of incentives and behaviors across providers in the network.
  - Common contracting may result in more favorable pricing, but more favorable pricing is not the (acknowledged) objective.
    - Pricing should reflect a value proposition for the payor.
  - The argument that higher prices are necessary to secure provider participation is not an accepted antitrust rationale.
Best practices - organization

- Physician leadership and governance
- Exclusivity (or not)
  - Requires advice from counsel
  - Networks with significant market share generally don’t need it
  - Often ok to restrict provider participation in competing networks, but a greater problem to restrict payor contracting outside (around) the network
- Antitrust compliance policy
Best practices – network rules

- Everybody must play.
  - Investment of time and effort
  - Commitment to EHR

- No free riders.
  - Metrics for all specialties
  - No metrics, no bonus opportunity.

- No opting out of contracts (by providers)

- A process to educate / terminate inadequate performers
  - That is actually followed
Best practices – health network vs. economic network

- Engage the customers
  - Think broadly about customers
    - Payors
    - Employers
    - Consumers (patient populations)
  - Need to consider the demand side as well as the supply side
  - Need to measure and document clinical outcomes as well as cost outcomes

- Share data
Demonstrating clinical integration

- Focus on a combination of best practices, good planning, and practicality
  - Use the Norman opinion to your advantage
- Share experience and (if you have it) data
- If a payor is stuck on a checklist, the payor’s real objective may not be clinical integration
Payor contracts

- Do not accept inappropriate compliance language
  - The payor’s antitrust risk is small (arguably zero)
  - Payors want broad compliance language for leverage
  - You can contractually agree to comply with the antitrust laws
  - It makes no sense – particularly in this area – to contractually agree to any statement of what the law requires
    - The law, and its interpretation, changes.
A closing comment on financial risk

- Most clinically-integrated networks involve some degree of financial risk-sharing
  - And most payors want commitments to move in that direction
  - Two dimensions of integration are better than one

- Upside-only risk can be sufficient
  - But be realistic

- Full risk largely solves the antitrust issue, but most networks (and most payors) are not there yet
  - Crawl, walk, run
Questions / Discussion

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Thank you.