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Antitrust Rules for Provider Collaboration:
How to Form and Operate a Network of Competing Providers

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I. Introduction:

A. Many forms of provider collaboration include competing providers who cooperate to offer services to payers. Some examples:

1. Physicians forming a group practice;

2. Larger groups of physicians forming an IPA or Accountable Care Organization;

3. Hospitals and physicians forming a PHO; and

4. Hospital systems affiliating to form a statewide network.

B. Such joint ventures can offer great value to payers and patients, including:

1. One-stop shopping for a network that can provide care to a patient population;

2. Better care coordination and other quality improvements;

3. Cost reductions by eliminating duplication and creating centers of excellence; and

4. A network large enough to manage population health and take risk.

C. But provider collaborations also raise antitrust issues:

1. When competing providers negotiate jointly with payers without proper integration, their agreement on price may be per se illegal price-fixing in violation of § 1 of the Sherman Act.

2. Even if not illegal per se, joint pricing by providers with market power may violate § 1 under the rule of reason.

3. Agreements allocating patients to particular providers ("eliminating duplication and creating centers of excellence") may violate § 1 as an illegal market allocation.

4. If market shares are high enough, the formation or operation of the joint venture may violate § 2 of the Sherman Act, which prohibits monopolization.

D. To avoid antitrust pitfalls, providers considering forming a network must consider some basic questions:

1. What is the purpose of the network? What benefits will it offer to payers, patients

and the community?

2. What kinds of integration among providers are necessary or desirable to help achieve its goals? How much integration does the network want or need?

3. What kinds of decisions will the providers make by agreement (or through their network management structure)? Will they jointly negotiate prices? Will they allocate clinical services or patient referrals among the members of the network?

4. Will the network be exclusive or non-exclusive – i.e., will member providers be permitted to join a competing network, or to contract with payers outside the network?

5. What market share will the network have in each specialty and service?

E. The answers to these questions will determine the permissible structure and functions of the network.

F. Guidance on the antitrust law applicable to provider network joint ventures is available from the Federal Trade Commission, which has published detailed statements of enforcement policy and advisory opinions, including:

1. Statements of Antitrust Enforcement Policy in Health Care (August 1996), available at http://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf;

2. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (October 28, 2011), available at http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.

3. FTC Staff Letter regarding MedSouth, Inc. (February 19, 2002), available at http://www.ftc.gov/bc/adops/medsouth.shtm;

4. FTC Staff Letter regarding Suburban Health Organization, Inc. (March 28, 2006), available at http://www.ftc.gov/sites/default/files/documents/advisory-opinions/suburban-health-organization/suburbanhealthorganizationstaffadvisoryopinion03282006.pdf;

5. FTC Staff Letter regarding MedSouth, Inc. (June 18, 2007), available at http://www.ftc.gov/sites/default/files/documents/advisory-opinions/medsouth-inc./070618medsouth.pdf

6. FTC Staff Letter regarding Greater Rochester Independent Practice Association, Inc. (September 17, 2007), available at http://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf;

7. FTC Staff Letter regarding TriState Health Partners, Inc. (April 13, 2009), available at http://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristateaoletter.pdf

8. FTC Staff Letter regarding Norman PHO (February 13, 2013), available at http://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf.

II. Integration strategies:

A. Integration is a fundamental issue for provider networks. Networks without integration may not jointly negotiate price, allocate services to eliminate duplication, or enter into any other agreements that would be illegal for a group of competitors.

B. Messenger model (no integration):

1. A network that is not integrated, either clinically or financially, may not negotiate price or other competitively-sensitive terms with payors on behalf of independent competing providers. Competing providers in the network may not exchange price information, coordinate negotiation strategies, agree on negotiating positions, or otherwise act together to improve their negotiating leverage.

2. Such a network may use a messenger model, which the FTC defines as an "arrangement to facilitate contracting between providers and payers and avoid price-fixing agreements among competing network providers."

3. To achieve a network contract, the messenger may receive an offer from a payor, transmit the offer individually to each provider, receive each provider's response, and then transmit the responses to the payor. The payor may then choose to contract with the subset of providers who individually accepted its offer.

4. Alternatively, the messenger may poll the individual providers, asking each for a minimum acceptable level of fees. The messenger may then, with the providers' permission, accept offers from payors on behalf of providers who have indicated their willingness to accept the fees that the payor offered.

5. The messenger may:

a. Convey to a provider objective or empirical information about proposed contract terms, including comparisons with terms offered by other payors.

b. Solicit clarifications from a payor of proposed contract terms and engage in discussions with a payor regarding contract terms other than prices and other competitively-sensitive terms.

c. Convey to a payor any individual provider's acceptance or rejection of a contract offer.

d. At the request of the payor, provide the individual responses or views of each provider concerning any offer made by such payor.

e. Canvass member providers (on an individual basis) for the rates at which each would be willing to contract even before a payor's offer is made. In this situation, the messenger may be authorized to enter into a contract on a provider's behalf with payors offering prices at those minimum acceptable rates or better.

f. Take fee authorizations of the various providers and compile a schedule to present to payors showing the percentages of providers in the network who have authorized contracts at various price levels.

6. A messenger may not:

a. Be one of the network providers, or an employee of a provider.

b. Negotiate collective agreements with payors on behalf of providers, or act as an agent for collective negotiation and agreement, attempting to obtain the best possible prices for all the providers.

c. Unilaterally develop a fee schedule or negotiate a fee schedule with payors.

d. Coordinate individual providers' responses to a particular proposal.

e. Encourage providers to refuse to deal individually with payors, or prevent providers from dealing individually with payors.

f. Disclose any provider's prices to a competing provider.

g. Disclose to providers the messenger's or other providers' views or intentions concerning the proposal.

h. Recommend to providers whether to accept or reject particular offers.

i. Refuse to communicate a bona fide offer from the payor.

7. Messenger model strategies are risky, because it is easy to violate the above rules, and any violation may lead to per se illegal price-fixing.

C. <u>Clinical Integration</u>:

1. A network in which all competing providers are clinically integrated with each other may negotiate certain agreements with payors on behalf of all its member providers. Such agreements are not per se illegal, but are evaluated under the rule of reason.

2. The FTC defines clinical integration as "an active and ongoing program to evaluate and modify practice patterns by the network's [providers] and create a high degree of interdependence and cooperation among the [providers] to control costs and ensure quality."

3. Clinical integration generally requires:

    a. a clear set of goals for cost savings and quality improvement that can reasonably be achieved through integrating the network providers' clinical practices and modifying their practice patterns;

    b. selectively choosing to recruit and retain network providers who are likely to further the network's goals;

    c. significant investment of capital, both monetary and human, in the network infrastructure and capability necessary to achieve the goals;

    d. electronic clinical records systems to facilitate care coordination, reduce duplication, and enhance efficiency;

    e. development of comprehensive evidence-based clinical guidelines designed to modify practice patterns and achieve the goals;

    f. rigorous guideline implementation, performance measurement, and compliance mechanisms, to monitor and control how care is delivered; and

    g. in-network referrals to participating specialists, all of whom have committed to follow the network's clinical guidelines.

4. The key issue is whether the network's clinical integration has a real likelihood of changing providers' practice patterns and thereby achieving the network's cost and quality goals.

5. Clinical integration takes time – months or years – to achieve. Providers often ask: How much clinical integration do I need before my network can negotiate payer contracts without fear of liability for per se illegal price-fixing?

    a. The FTC's answer, in its Norman PHO opinion: The FTC will not challenge price negotiation by a truly non-exclusive network, regardless of its market share, if the network has taken at least the following steps toward clinical integration:

        i. The network has "created . . . mechanisms intended to monitor and control costs and utilization, while assuring quality of care";

        ii. The network's "electronic capabilities . . . will foster a high degree of transparency and visibility into the participating physicians' actual practice patterns and accomplishments. They will permit the network to efficiently collect and review individual and aggregate data relating to cost, utilization, and quality of care. They also will enable the network to efficiently monitor and review individual and aggregate compliance with network standards, including clinical practice guidelines";

        iii. The network's "Participating Practitioner Agreement . . . commits each

physician to participate in the development, implementation, and enforcement of the network's clinical practice guidelines, including those requiring use of the network's electronic platform. It also enables the network to undertake corrective actions, including, in egregious instances of noncompliance, the expulsion of a participating physician";

iv. The network has "made, or will make, meaningful contributions, including investments of human capital, time, and money, to the development of the infrastructure, capabilities, and mechanisms necessary to jointly realize their projected efficiencies"; and

v. The network "will operate as a 'selective' network that includes only providers who are dedicated to the network's collective attainment of its cost, utilization, and quality goals."

b. A second answer: if the network is approved by CMS and participates in the Medicare Shared Savings Program, the FTC will treat the network as clinically integrated, and analyze its price agreements (including prices negotiated with commercial payers) under the rule of reason. Statement of Antitrust Policy Enforcement Regarding Accountable Care Organizations (October 28, 2011), available at http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.

c. A third answer: independent third-party accreditation of clinical integration can provide assurance that the network's clinical integration meets FTC standards.

(a) Such accreditation is available through URAC, a nonprofit healthcare standard-setting body. A provider network may be accredited, after passing an independent audit, under one or both of URAC's Clinical Integration Accreditation and Accountable Care Accreditation programs. A network that is accredited under both programs will likely be considered clinically integrated by the FTC as well.

(b) URAC's Clinical Integration Accreditation includes 35 separate requirements, covering the network's structure and operations, health information technology, clinical management, population health management, care coordination, and performance measurement and reporting. Many of these requirements are based on examples of acceptable clinical integration in the 1996 Statements, and the standards include a detailed "crosswalk" showing how its requirements are closely aligned with the 1996 Statements.

(c) Networks that are accredited under URAC's Clinical Integration Accreditation may take the next step by becoming accredited under its Accountable Care standards. The Accountable Care standards include 43 more detailed and rigorous requirements relating to risk contracting, clinical management, population health management, and improving quality of care. Although the Accountable Care Accreditation goes well

beyond what the FTC requires for antitrust compliance, it too includes a detailed "crosswalk" showing its consistency with the 1996 Statements.

D. Financial integration:

1. A network in which all competing providers are financially integrated with each other may negotiate certain agreements with payors on behalf of all its member providers. Such agreements are not per se illegal, but are evaluated under the rule of reason.

2. The FTC defines financial integration as an arrangement by which all network providers "share substantial financial risk in providing all the services that are jointly priced through the network."

3. Financial integration creates incentives similar to clinical integration, by giving all providers a financial incentive to help the network reduce cost and improve quality. Many successful networks use both clinical and financial integration.

4. Financial integration can be created by contract or other arrangement among the network providers. For example:

   a. Providers can be co-owners of the network, and share in its profits and losses as owners;

   b. Providers can form a partnership or joint venture in which they agree to share some or all profits and losses on network business; or

   c. Providers can agree to contribute a substantial share of their revenue from network business (generally at least 15%) to a risk pool, to be paid to providers only if the network meets its cost and quality goals.

5. Financial integration can also be achieved through the network's contracts with payors. For example, payer contracts can include:

   a. Capitation or case-rate contracts under which the network assumes financial risk for the cost of care;

   b. Withhold arrangements under which the payor withholds a substantial share of fees (generally at least 15%), to be paid to the network only if the network meets cost and quality goals; or

   c. Bonus, shared savings and other pay-for-performance contracts under which a substantial share of revenues (generally at least 15%) is paid to the network only if the network meets cost and quality goals.

6. The key issue is whether financial integration gives providers incentives to reduce costs that outweigh the normal fee-for-service incentive to increase costs by performing more services.

E. Hybrid strategies:

1. Most successful networks use a combination of clinical and financial integration. These hybrid arrangements may include

   a. Offering providers substantial financial incentives to follow clinical guidelines, or to achieve cost or quality goals.

   b. Pay-for-performance contracts with payers, which offer substantial financial incentives for achieving clinical integration or for improved quality or reduced costs.

   c. Use of clinical integration to reduce costs and achieve efficiencies, positioning the network to accept risk under capitated contracts.

F. Single-entity strategies:

1. Even a properly integrated joint venture must plan to have its conduct reviewed under the rule of reason. Every action and decision of the network is the product of an agreement among competitors, and can be challenged under § 1 of the Sherman Act.

2. A recent court decision, *The Medical Center at Elizabeth Place LLC v. Midamerica Health Systems Corporation*, No. 3:12-cv-00026 (S.D. Ohio October 20, 2014), provides guidance on how providers can structure their joint venture to create a single entity rather than an ongoing conspiracy under § 1.

3. The decision applies *Copperweld v. Independence Tube*, 467 U.S. 752 (1984), to a hospital joint operating agreement. This follows *dicta* in *Texaco Inc. v. Dagher*, 547 U.S. 1 (2006), suggesting that *Copperweld* may apply to corporate joint ventures, because "[w]hen 'persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit . . . such joint ventures [are] regarded as a single firm competing with other sellers in the market.'" See also *HealthAmerica Pennsylvania, Inc. v. Susquehanna Health System*, 278 F.Supp.2d 423 (M.D. Pa. 2003) (applying *Copperweld* to a contractual joint venture).

4. The *Medical Center at Elizabeth Place* case holds that where a joint operating agreement creates central system management and tight financial integration, including sharing of all the providers' income, profits and losses, the resulting hospital system is a single entity and its members are incapable of conspiring with each other in violation of the Sherman Act.

5. In granting the defendants' motion for summary judgment, the court emphasized elements of the joint operating agreement that showed control of the participating entities had been delegated to Premier Health. For example, the court noted that Premier Health "negotiates and enters into payor contracts that bind all of the Hospital Participants . . . and manages all relationships with payors, including managed care companies." "Not only is Premier a legitimate joint venture, but the challenged conduct in this case — managed care contracting and physician relations

— is a core function of the Premier health system." The court concluded that the financial integration between the hospitals was so complete that the hospitals had ceased to be competitors of each other: "Defendants are not competitors because they are not separate economic actors — all of the money goes to one bottom line — the Network Net Income" which the hospitals shared pursuant to their joint operating agreement.

6. Key learnings:

   a. Providers that delegate all "operational, strategic, and financial control" to a joint venture manager via contract have the strongest argument that they are a single economic unit and therefore incapable of conspiring under § 1.

   b. The fact that "there is no shared ownership of assets used in the Joint Venture" is "immaterial" to the *Copperweld* immunity question.

   c. The joint venture manager can and should be authorized to negotiate all managed care contracts for the participating providers.

   d. The parties can and should share the income, profits and losses of the joint venture by agreeing on a formula to allocate the system's combined net income.

III. Ancillarity: What agreements are reasonably related to the network's legitimate goals?

A. If a network is clinically or financially integrated, it can negotiate payor agreements on behalf of its member providers, <u>but only if</u> joint negotiation is reasonably necessary to achieve the network's cost and quality goals. For example:

   1. Joint negotiation of payor agreements that create financial integration (e.g., capitated agreements) is reasonably necessary under this standard.

   2. Joint negotiation of payor agreements that include financial incentives for achieving clinical integration or for achieving cost or quality goals may be reasonably necessary to achieve those goals.

   3. Joint negotiation of payor agreements may also be reasonably necessary to achieve the network's cost and quality goals because it assures the full participation of all network providers in each payor contract.

   4. Joint negotiation is <u>not</u> reasonably necessary simply because it can achieve higher fees, even if providers would not participate unless they were paid higher fees.

B. If the network is approved by CMS and participates in the Medicare Shared Savings Program, the FTC will <u>presume</u> that the network's "joint negotiations with private payers [is] reasonably necessary to an ACO's primary purpose of improving health care delivery." Statement of Antitrust Policy Enforcement Regarding Accountable Care Organizations (October 28, 2011), available at http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf**.**

IV. Rule of reason analysis:

A. Market share and market power

1. Even an integrated network is subject to a rule of reason analysis, which asks whether the network will have market power in any specialty in any geographic market, and whether the network's joint contracting will lead to higher prices. Joint contracting that reduces competition and forces payors to pay higher prices may be illegal regardless of integration.

2. Therefore, clinical or financial integration does not confer antitrust immunity. The formation or operation of an integrated network may violate § 1 under the rule of reason if the network has such a high share of any service or specialty that it is a "must-have" network for payers.

3. The FTC's 1996 Statements of Antitrust Enforcement Policy in Health Care announced a "safety zone" for properly integrated networks whose market share in each specialty is:

   a. 20% or less if the network is exclusive; or

   b. 30% or less if the network is non-exclusive.

4. The FTC's 2011 Statements of Antitrust Enforcement Policy regarding ACOs modified the safety zone to include ACOs participating in the Medicare Shared Savings Program whose market share in each specialty is:

   a. 30% or less for physicians (regardless of exclusivity); or

   b. 30% or less for hospitals or ASCs (on a non-exclusive basis).

5. Networks with market shares exceeding 30% may be (and often are) lawful, but their shares require careful analysis of market power.

B. Exclusivity

1. Market power concerns can be reduced by making the network non-exclusive, meaning that provider members of the network are free to join competing networks, or to contract directly with payers.

2. In its *Norman PHO* opinion, the FTC approved a network joint venture without calculating its market share, based on the network's representation that it would be non-exclusive:

> "Norman PHO states that: (1) under the terms of the Participating Practitioner Agreement, network participants will be allowed to contract on an individual basis (that is, outside the network) or through other networks with payers who, for whatever reason, do not wish to contract with Norman PHO and (2) Norman PHO

will not attempt to force payers to contract with it (such as by instructing or encouraging participating providers to refuse to contract individually with payers who do not wish to deal with Norman PHO, thus forcing those payers to contract with the network in order to maintain adequate provider panels). Norman PHO will make it clear to payers and participating providers that the network is non-exclusive, and will counsel participating providers about the antitrust concerns associated with concerted refusals to deal."

C. Effects on cost and quality

1. Price increases are signals that the network may be anticompetitive, or may be considered anticompetitive by payers.

2. Significant cost reductions or quality improvements tend to show that the network is procompetitive in purpose and effect.

3. Do courts "balance" quality improvements against price increases?

   a. In *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd.* (9th Cir. February 10, 2015), available at http://www.ftc.gov/system/files/documents/cases/150210stlukeopinion.pdf, the Ninth Circuit held that no such balancing is allowed in a merger case under § 7 of the Clayton Act:

      "[T]he Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations." "It is not enough to show that the merger would allow St. Luke's to better serve its patients."

   b. The same reasoning can be applied under to a joint venture under § 1. Under this reasoning, a joint venture that both improves quality and increases price could be held to unreasonably restrain trade in violation of § 1.

   c. But note: if the network competes on quality as well as price, then quality improvements may make markets more competitive.

   d. The key question is whether there is sufficient competition to ensure that cost savings are passed on to payers, and that payers get the cost and quality choices that they want.

4. Antitrust enforcement agencies, in practice, do consider quality improvements as procompetitive effects.

   a. The FTC says it will "carefully consider evidence that the transaction will benefit consumers through improved quality, new services and/or decreased costs." The FTC recognizes that "[e]fficiencies may enhance a merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products." Deborah L. Feinstein, Director, Bureau of

Competition, Federal Trade Commission, "Antitrust Enforcement in Health Care: Proscription, not Prescription," available at http://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf

V. Practical advice for structuring and operating antitrust-compliant provider networks:

A. Integrate providers for the right reasons – to improve quality, reduce costs, and achieve better patient outcomes – not merely to negotiate higher fees.

B. Be sure that your documents reflect your proper purposes, and your discussions focus on them.

C. Build a product that payers will want to buy. Payers will pay for demonstrated improvements in quality, efficiency and outcomes. Involve payers in the development of the network, to be sure they will support it.

D. Be aware of your network's market share in each specialty, and how it changes over time. If your share is high enough that payers must have your providers, the safest course is to be truly non-exclusive.

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